An Introduction To Managed Care in Pennsylvania

The Provider Alliance

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XtraGlobex Inc.
Strategic Business Development

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Creating Your Exceptional and Sustainable Competitive Advantage

XtraGlobex is a consulting firm that provides strategy, analytics and communications services to organizations specializing in healthcare, community-based and professional organizations serving the Medicare and Medicaid populations and Long Term Services and Supports. We work with our clients to create exceptional and sustainable competitive advantage, turning existing challenges into positive solutions and future hurdles into launchpads for growth.

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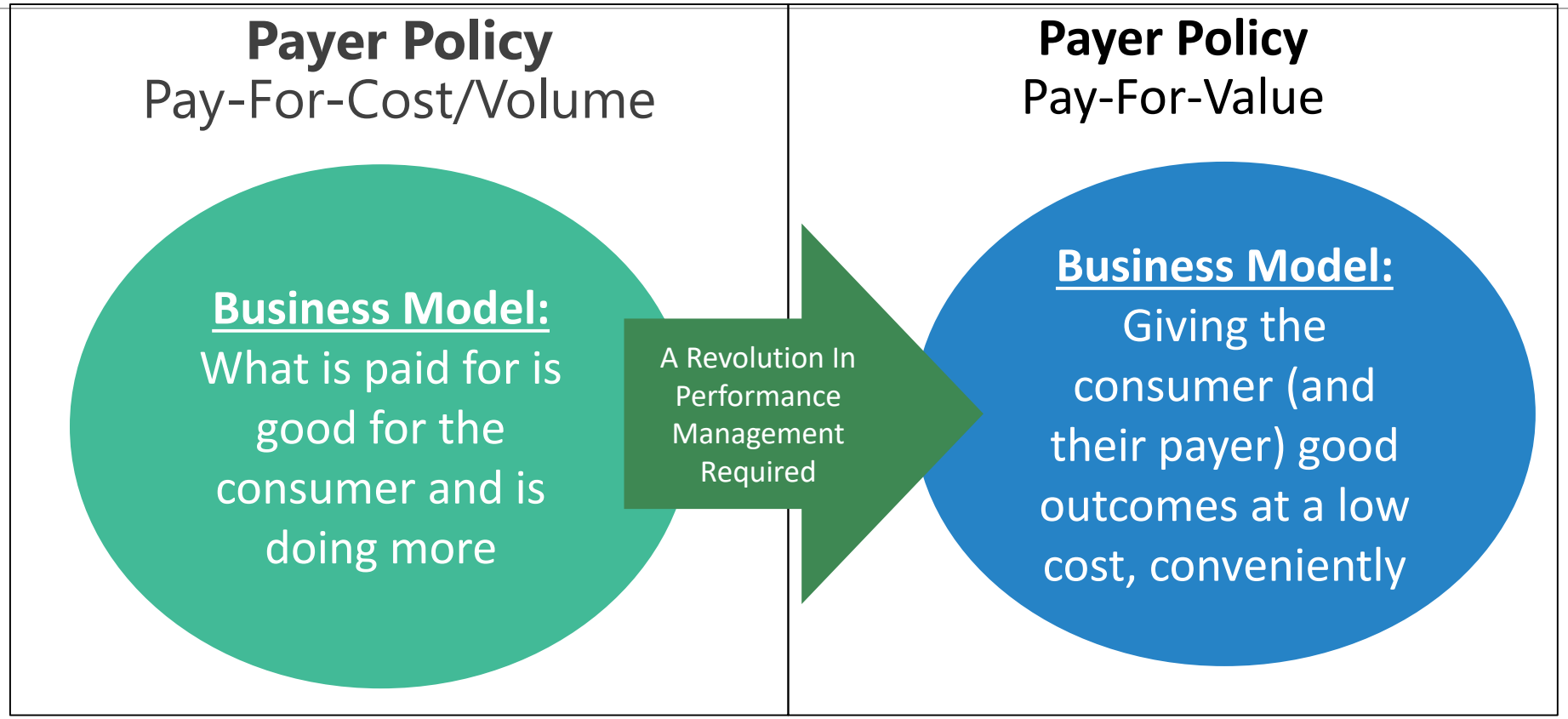
Business Model Transition For Provider Organizations



Business Model Transition

FEE FOR SERVICE	MANAGED CARE
Units of service	Needed Services
Defined Autonomous Services	Combination of Services
Billing Based on Type, Duration, Frequency	Contracted Price Services / Combination
Quality Measures Based on Process	Quality of Results and Outcomes
Little / No Reward for High Performance	Pay for Performance
Broader Networks of Providers	Contracted Network of Providers

How is Medicaid MLTSS different than HCBS Waivers?

HCBS Waiver services become part of the managed care service package and are provided as determined by the managing entity based on a participant's assessed needs and goals; first appeal is to the managing entity

The managing entity assumes risk for providing all services to their participants within their total capitation payments while meeting quality and performance standards set in the contract

HCBS waivers can cap spending per person or the number served by discrete target groups and can use narrow service menus; appeal is to the state; supports coordination must be conflict-free

Key Features of MLTSS Programs

- Passive or automatic enrollment
- Enrollment Lock-in Periods
- Varying array of Covered Services
- Broad Provider Network with Choices (including choice of care manager)
- Continuity of Care in providers and care plans upon launch
- Person-Centered Care/Service Planning by managing entity
- Advocate for Participant – Independent Ombudsman
- Information Technology Plays Integral Role
- Care Coordination Approach – Interdisciplinary Team
- Continual Data Feedback and Analysis
- Evidence-Based Practices
- Accessibility Requirements

Pennsylvania current Managed programs

HealthChoices since 1997 for only physical health care for Medicaid-eligible adults and families; statewide through 9 MCOs; choice of at least 3 MCOs in 5 regions; mandatory enrollment; does not serve dual-eligible adults; **over 2M participants; uses 1915a authority; requires escalating amount of value based purchasing (VBP)**

Behavioral HealthChoices since 1997 for only behavioral health care for Medicaid-eligible adults; statewide through 5 BHMCOs with one operating in each county; no choice of BHMCO; mandatory enrollment; expanding to serve CHC dual eligible participants; uses 1915a authority; **requires escalating amount of value based purchasing (VBP)**

Community HealthChoices since 2018 for physical health care and LTSS for Medicaid-eligible adults; not yet statewide through 3 MCOs with choice of 3 in all five regions; mandatory enrollment; serves all dual-eligible adults; coordinates with Medicare and BHMCO services; now serving 80,000 participants in SW, 130,000 in SE (ultimate enrolment of 421,000); uses 1915b and c concurrent authorities; **will require value based purchasing (VBP) by 2021**

Pennsylvania current Managed programs

LIFE (Living Independence for the Elderly) program since 1998 for all services for adults age 55 and over; not yet statewide; defined service areas for each LIFE provider; voluntary enrollment as alternative to Community HealthChoices; fully integrated MLTSS program with Medicare services; services are center-based; Pennsylvania has the largest program; projected to serve 7130 unduplicated participants in FY18-19; uses Program for All-Inclusive Care for the Elderly (PACE) federal authority

Adult Community Autism Program (ACAP) since 2009 for all services for Medicaid-eligible adults with autism through one provider; operated in only 4 counties; voluntary enrollment; authorized to serve up to 200 participants; uses PIHP authority for managing entity

WHAT ARE THE GOALS OF CHC?

GOAL 1
Enhance opportunities for community-based living.

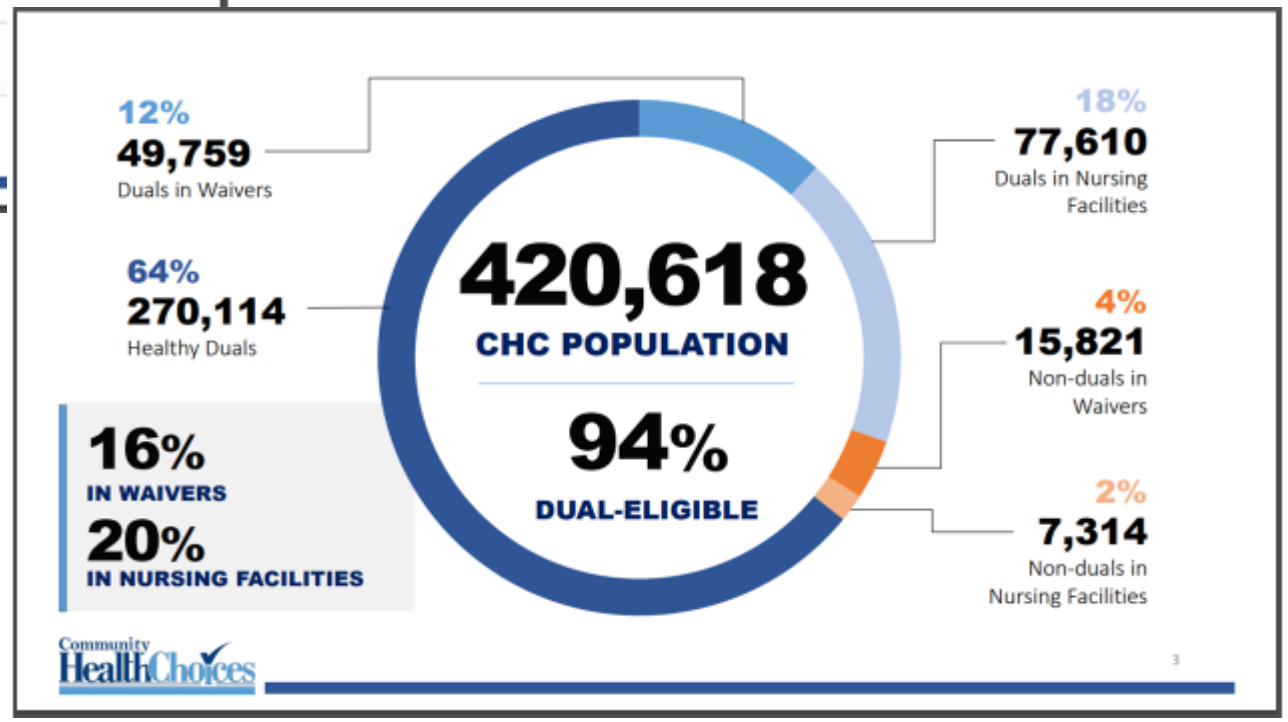
GOAL 2
Strengthen coordination of LTSS and other types of health care, including all Medicare and Medicaid services for dual eligibles.

GOAL 3
Enhance quality and accountability.

GOAL 4
Advance program innovation.

GOAL 5
Increase efficiency and effectiveness.

Community HealthChoices



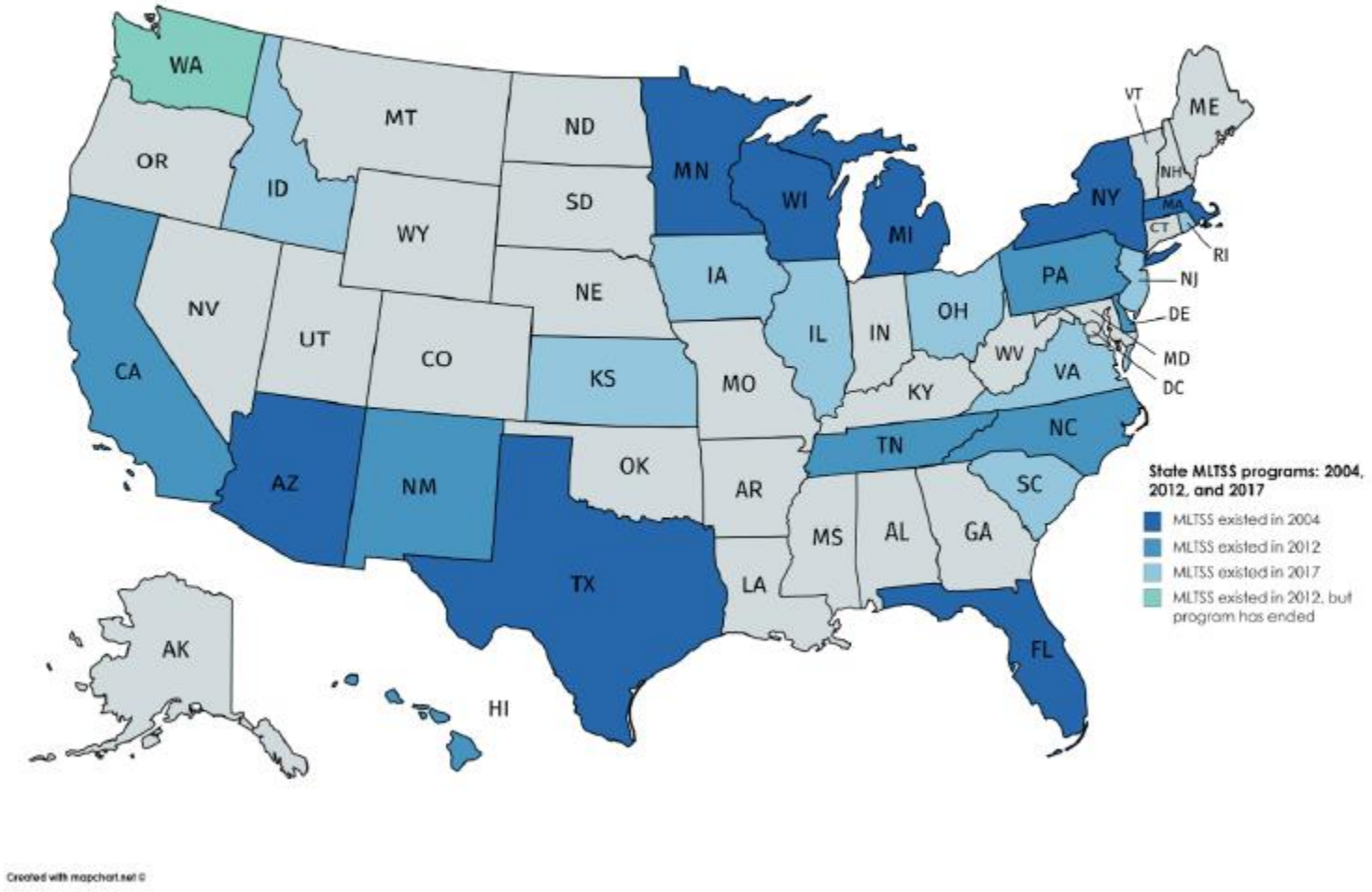
Community HealthChoices

What is Driving States to MLTSS?

States are motivated by many different things

- Need to improve coordination of services
- Resolve fragmentation of care and accountability, which has become a bigger problem as LTSS remains in FFS while other types of care are in managed care.
- Budget deficits
- Increases in Medicaid Spending
- Increased demand for LTSS
- New incentives/opportunities for integrating or coordinating care and for increasing HCBS availability
  - Many states were motivated by the “Duals Demo” opportunity
- Need for Budget Predictability

Figure 2.1: Prevalence of MLTSS in 2004, 2012, and 2017



The Growth of MLTSS Programs: 2017 Update

Pennsylvania status of IDD programs

Four statewide HCBS waivers; all have waiting lists (all use 1915c authority); as of Jan. 1, 2019 all services are on a fee schedule

- **Consolidated Waiver** – projected to serve 18,522 unduplicated participants in FY18-19 ; no individual cap; includes residential services
- **Community Living Waiver** – projected to serve 1,800 unduplicated participants in FY18-19; individual cap of $70,000; no residential services
- **Person/Family-Directed Services Waiver** – projected to serve 14,548 unduplicated participants in FY18-19; individual cap of $33,000; no residential services
- **Adult Autism Waiver** – projected to serve 709 unduplicated participants in FY18-19; no individual cap; includes residential services

Base-funded county ID program serves 23,914 participants generally not waiver-eligible

Targeted Service Management and Supports Coordination are provided to waiver participants and individuals waiting for waiver services

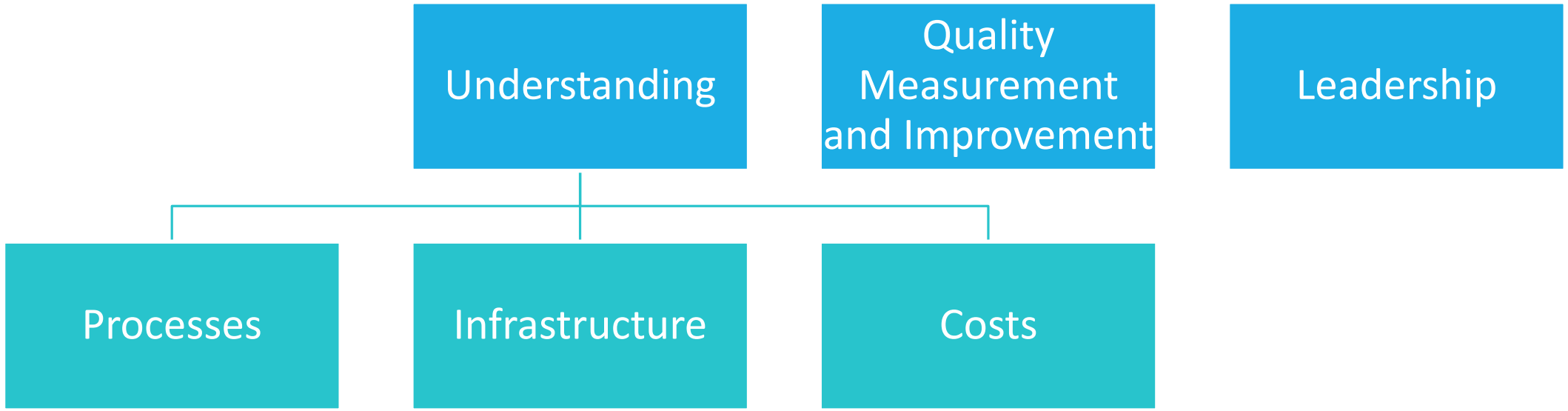
Private ICF/ID serves 2053 participants in 172 facilities ranging from 4 to 190 per home

Public ICF/ID serves 728 participants in 4 facilities known as State Centers

Recent Events in Managed Care

- Conversation about Behavioral Health Carve Out
- Position Papers on the options of I/DD Model
- DHS Perspective on Managed Care and Value Based Payments
- Outlook for Stakeholder Involvement and Concept Paper
- The Timeline!

Getting Ready for Managed Care



XtraGlobex I/DD HCBS Managed Care Readiness Assessment

- Customized for your organization
- A team of experienced subject matter experts
- Access to a wide range of proprietary data sources
- Focused and Time Limited
- Fixed Cost

Targeted and Specific Deliverables

1

Phase 1: **Managed Care 101** education on site, customized for your agency to **orient your staff to potential changes ahead and provide an overview of the new shape of service delivery which could impact your business.**

2

Phase 2: **Conduct a Capacity and Needs Assessment** – evaluating your plans, objectives, programs, IT, HR, board support, quality, regional resources, organizational structure, and the competitive landscape.

3

Phase 3: **Management Presentation of Findings** to **leave you with a laser-focused image of your preparedness for operating under any managed care model** to help you choose your best path forward.

A Team of SME's

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New Team Members

Onward!

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