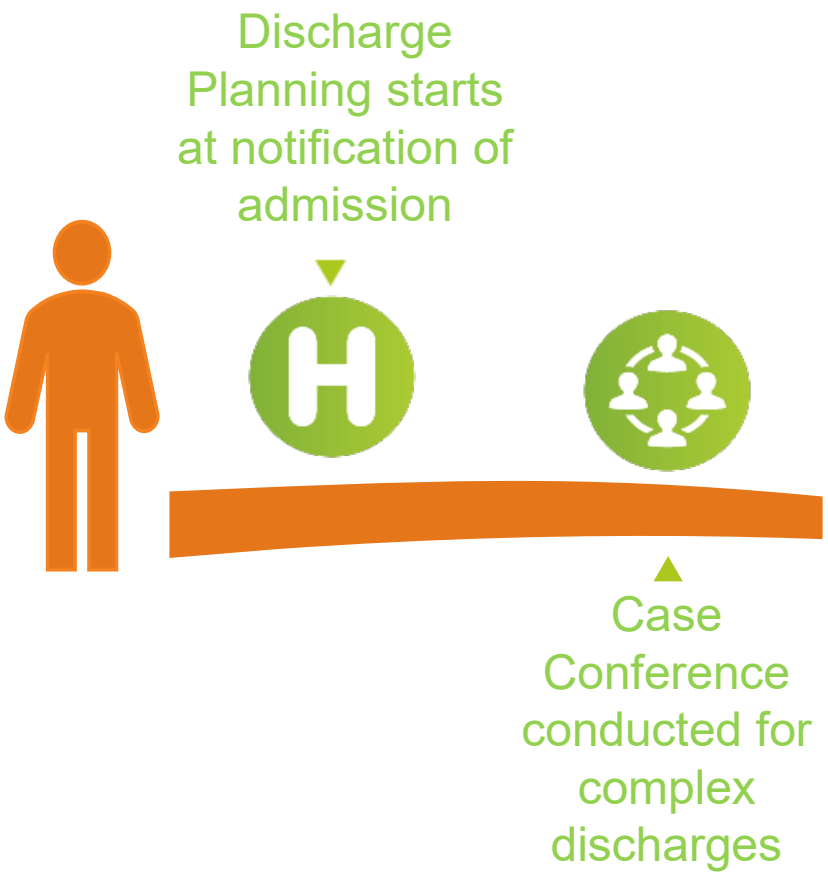
pa health & wellness™

Care Coordination Between the Community Health Choices (CHC) - Managed Care Organizations (MCO) and the Dual Special Needs Plans (D-SNPs)

January 5, 2022 / MLTSS

Confidential and Proprietary Information

A Holistic Approach



Elements which may constitute a complex discharge:

- Difficulty with securing a Skilled Nursing Facility
- Behavioral Health concerns
- Ventilator user
- Lack of willing/available providers

Consideration for Case Conference Attendees:

- Participant if able
- Family/Caregiver
- Facility
- PHW Service Coordinator
- PHW Integrated Care Services Specialty Team Member
- Current providers (both physical and behavioral health)
- Other CHC-MCOs
- Other D-SNP MCOs
- Behavioral Health Managed Care Organization (BH-MCO) as indicated

Integrated Care Services Specialties

(Voluntary) Programs	Program Summary	Referral Examples
BH Care Management	Case Management Program for participants identified as having unmet behavioral health needs.	• Participant in need of behavioral health care coordination. • BH-MCO coordination need. • Unstable/unpredictable behaviors causing barriers to care intervention
Clinical Case Management	Case Management Program for participants identified as having unmet physical health needs.	• Participant in need of physical health care coordination, usually with multiple co-morbidities and moderate to high clinical risk. • MCO Coordination.
Special Needs Unit	A program that provides an organized and timely response to the need for support of complex and hard to place participants.	• Participants with special needs (including but not limited to) traumatic brain injury, ventilator dependence, super-morbidly obese, recently released from the prison system with care needs.
Transitions of Care	A program that supports participants in transition from one care setting to another by coordinating the care, identifying and mitigating potential barriers, and taking action and planning to prevent any unplanned readmissions.	• Complicated discharges with barriers and need for post discharge monitoring • High risk of readmission that need assistance with discharge • Referral for a Nursing Facility Ineligible (NFI) participant who needs discharge assistance because of barriers including but not limited to lack of home support
Behavioral Health / OpiEnd	Program for participants who are at potential risk for opioid misuse or opioid use disorder. 3-to-6-month case management program with a focus on pain management.	• Participants abusing opioids and in need of pain management options. • Participants with history of overdose. • Participants at risk for opioid use addiction

If determined Behavioral Health services are warranted, inquire with BH-MCO or Primary D-SNP MCO if there are existing services/providers in place

Behavioral Health Care Manager (CM) collaborates with BH-MCO on most appropriate behavioral health providers to assist with Participant's unique circumstances.

Considerations for potential behavioral health services as a result of a Physical Health Transition of Care:

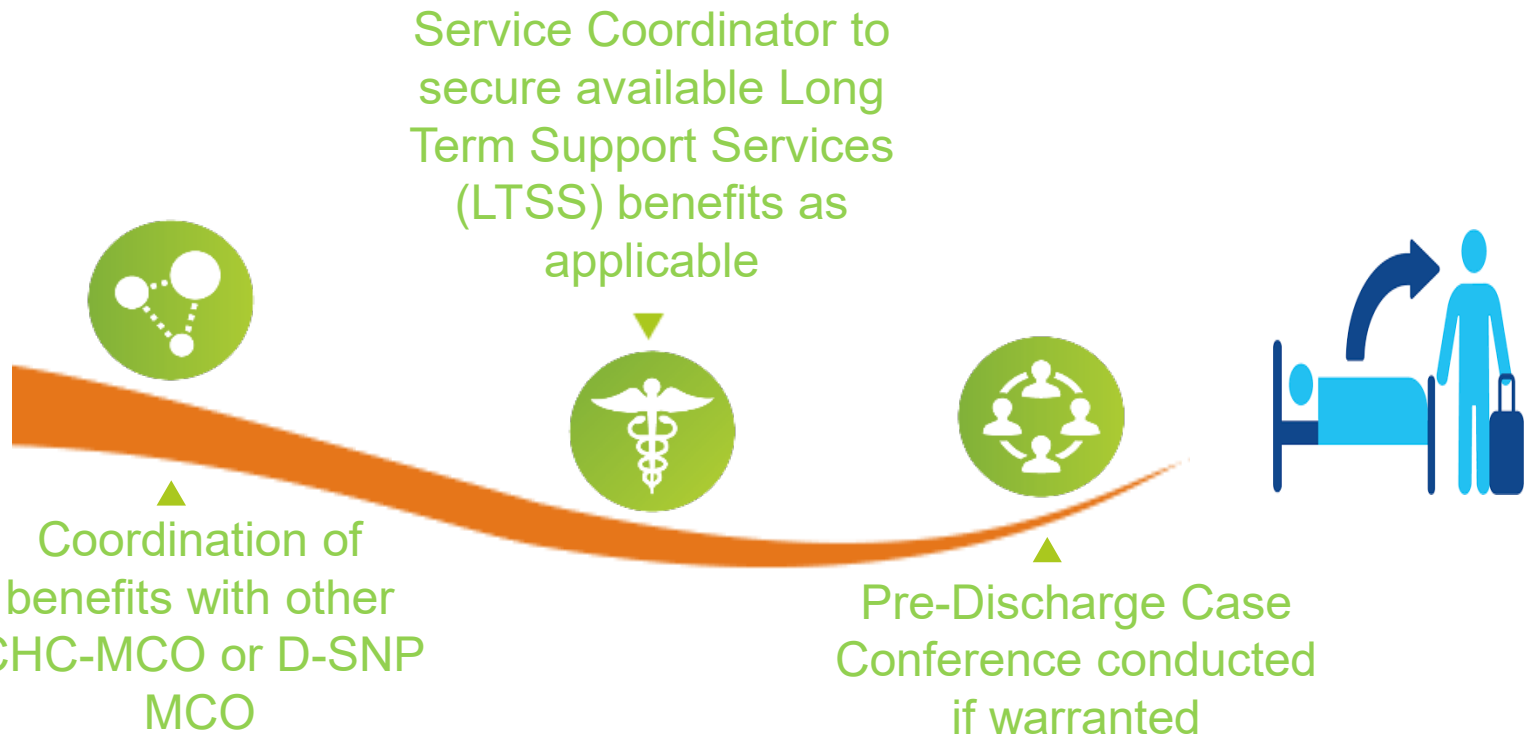
- Newly identified chronic health condition
- Lifestyle changes
- Possible permanent disability
- Mobility limitations

Considerations for potential behavioral health services as a result of a Behavioral Health Transition of Care:

- New diagnosis
- New symptoms not previously experienced
- Treatment non-compliance
- Need for support groups

Routine Coordination of benefits occurs when there is a:

- Planned or unplanned inpatient hospital and skilled nursing facility admission and discharge
- Emergency department visit
- High priority health concern such as a cardiac or orthopedic diagnosis requiring a procedure or an oncologic diagnosis requiring chemotherapy identified through the member's health assessment



Post-Discharge

For **Psychiatric discharges**, Behavioral Health Care Manager (CM) outreaches 2 days post discharge for discharge assessment and coordination of appointments/services

Service Coordinator follows up with Participant within 14 days post discharge for reassessment

Service Coordinator updates Person Centered Service Plan as indicated

Update other CHC-MCO or D-SNP MCO by sharing discharge planning documents & any significant medication changes

Service Coordinator and/or Behavioral Health CM follow-up as prescribed

UPMC Community HealthChoices

Care Coordination: CHC-MCO and BH-MCO

January 2022

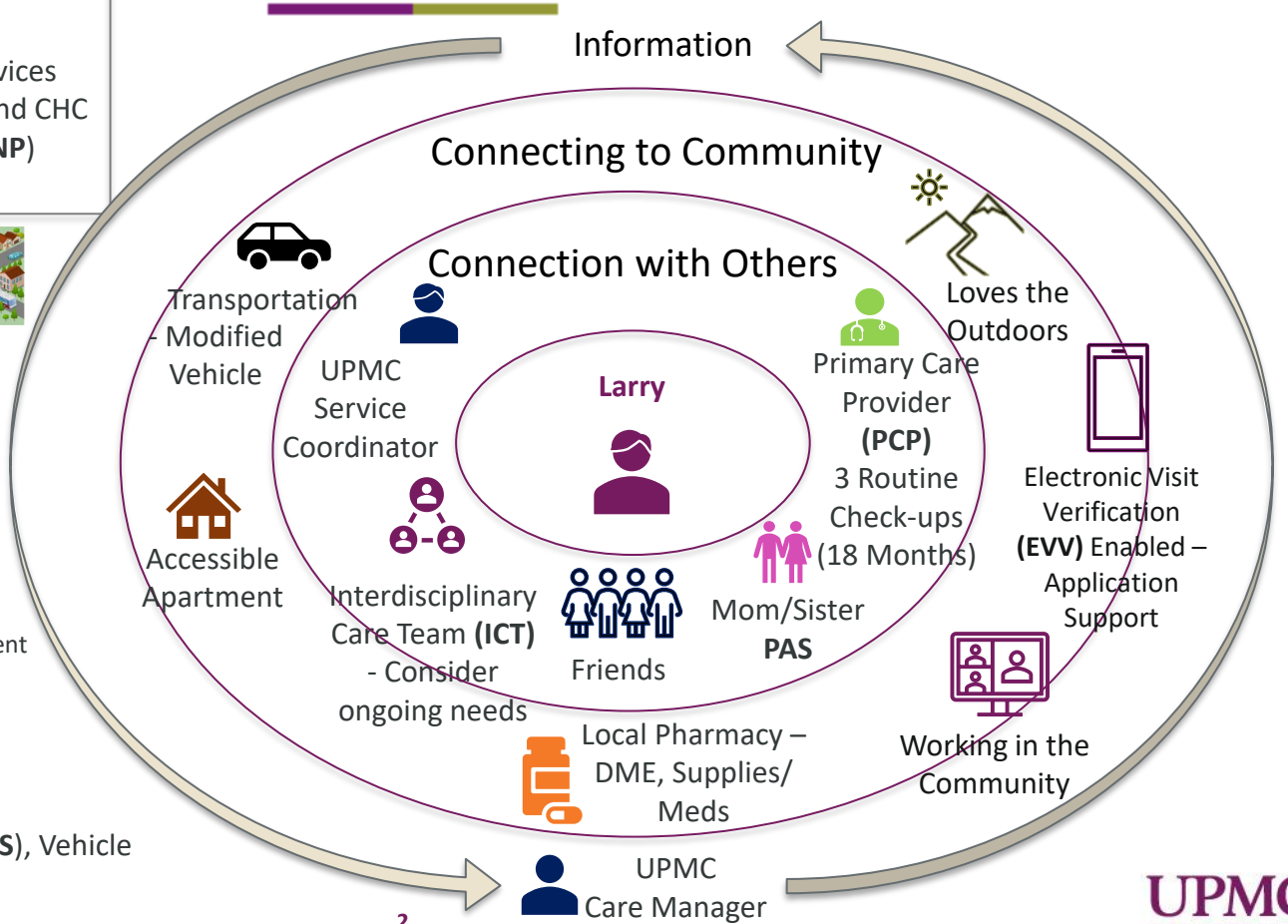
UPMC
LIFE CHANGING MEDICINE

Participant Journey Through the Health Plan

Larry, 60 years of age
Goal: **Living in Community**
Eligibility: CHC Long-term Services and Support (**LTSS**) benefits and CHC Dual Special Needs Plan (**D-SNP**) benefits (or Fully Aligned)

Larry is living in the community in his own home with help of his family

- Paralyzed in Car Accident
- Multiple chronic conditions
- Ultra light manual wheelchair
- Employed working remotely
- Agency Model
- No Incidents
- Care manager **(CM)** assessment
  - Durable Medical Equipment **(DME),** Supplies and Medication management
  - Catheter Care
  - Eye/Retinal Exam
  - Wound Avoidance
  - Inhaler use
- D-SNP DME and services provided
- LTSS Personal Assistance Services (**PAS**), Vehicle Modification, etc. provided

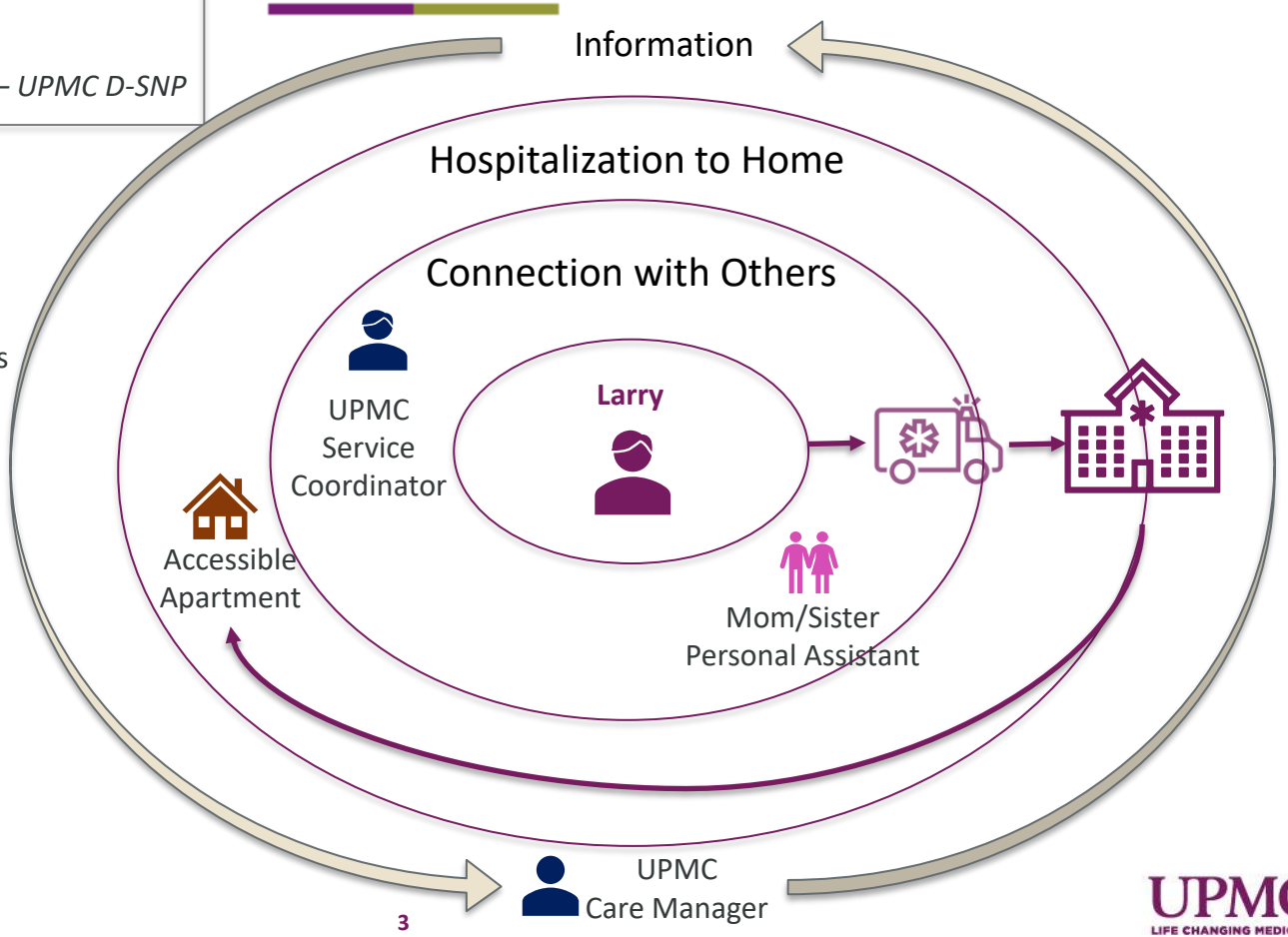


Participant Hospitalization

Larry, 60 years of age
Goal: **Returning to Home**
Eligibility: *UPMC CHC LTSS – UPMC D-SNP*

Larry
is hospitalized

- Larry Suffered a Heart Attack
- Notification on the Hospitalization
  - Participant/Provider/Data from Hospital or Other D-SNPs
- Trigger Event Assessment Conducted
- Behavioral Health (BH) need identified
- Establish Services for Return Home
  - Skilled Home Health Services
  - Medication Reconciliation
  - Discussion Loss of Employment/External Activities
  - Laboratory Workups /Transportation
  - Outpatient BH services

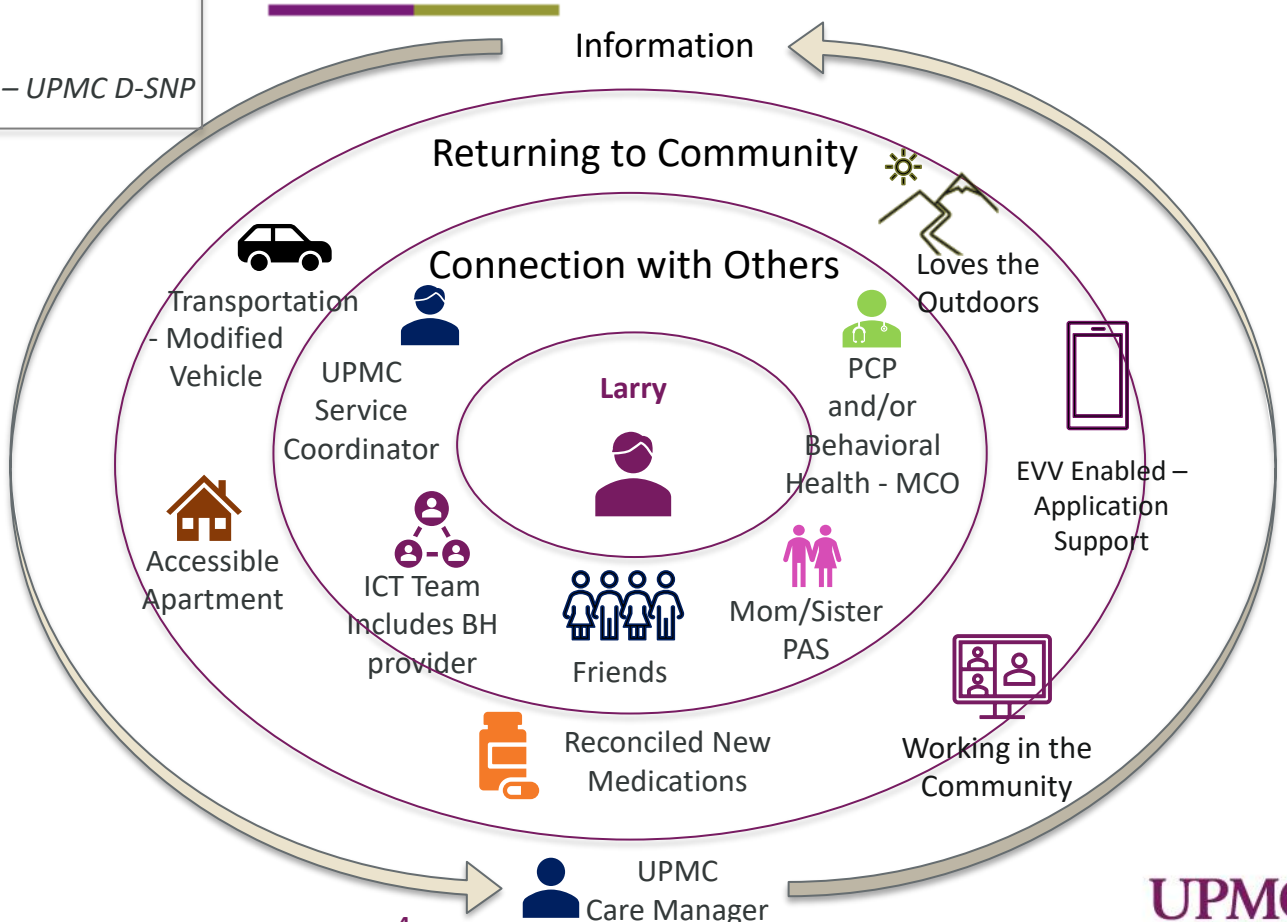


Participant Journey Through the Health Plan

Larry, 60 years of age
Goal: **Returns to Home**
Eligibility: *UPMC CHC LTSS – UPMC D-SNP*

Larry remains healthy in his home and active in the community

- Set Goals/ID Barriers/ Develop Interventions
  - Determine types of services required to meet needs
  - Updates to home
  - BH Referral
  - 21 Day Follow-up by SC
  - Determine Employment next steps
  - Reconnect with Friends
  - Address Pharmacy/DME Needs
  - Consider possible impact on being outdoors
  - Impact on Driving
  - Ensure/update life planning



Care Coordination Between the Community HealthChoices Managed Care Organizations (CHC-MCOs) and the Dual Eligible Special Needs Plans (D-SNPs)

January 2022 MLTSS SubMAAC

Presenter: Jennifer Rogers, Director of LTSS Program Management and Quality

AmeriHealth Caritas

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Delivering the Next Generation of Health Care

AmeriHealth Caritas Pennsylvania (PA) Community HealthChoices' (CHC) Assignment

How does your plan arrange care for a CHC Participant after returning home from a skilled nursing facility (SNF) stay for a broken hip?

Specifically, what role would the CHC plan and the Behavioral Health Managed Care Organization (BH-MCO) play? Please consider this Participant might have behavioral health needs based on lifestyle changes, mobility limitations, possible permanent disability, or other behavioral health factors.

AmeriHealth Caritas PA CHC Response:

Service Coordinator Responsibilities:

- Schedule and conduct a “Trigger Event” comprehensive needs assessment
- Facilitate a Person-Centered Service Planning (PCSP) meeting
- Coordinate “who does what” with the Care Manager from the D-SNP
  - Coordination should focus on the Participant’s assumed mobility limitations
  - Pay close attention to potential behavioral health needs due to newly acquired condition
- Update the PCSP
- Submit authorizations for chosen providers
- Connect the Participant with community based resources
- Coordinate care and service delivery pre/post discharge

AmeriHealth Caritas PA CHC Response:

During the completion of the assessment, which includes the administration of the Patient Health Questionaire-9(PHQ-9), the Service Coordinator will explore with the Participant any behavioral health concerns or needs they may have, considering the lifestyle changes brought on by a potentially permanent disability.

Is the Participant currently connected to behavioral health services?

- If yes, then assist the Participant with setting up an appointment, if the appointment is not already established

AmeriHealth Caritas PA CHC Response:

If no, then ask the Participant if they want to be connected to behavioral health services.

- If the Participant does not want to be connected to behavioral health services then the Service Coordinator will set an alert on their calendar (2 weeks) to follow-up with the Participant

AmeriHealth Caritas PA CHC Response:

If the Participant does want to be connected with behavioral health services, the Service Coordinator will refer the Participant to the plan Behavioral Health Coordinator.

- The Behavioral Health Coordinator will contact the BH-MCO and the D-SNP
  - If the desired behavioral health service is covered by the D-SNP, the Behavioral Health Coordinator will follow the process established by the D-SNP
  - If the desired Behavioral Health Service is not covered by the D-SNP, the Behavioral Health Coordinator will work with the BH-MCO to identify providers and work with the Participant to be connected to behavioral health services

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