Introduction to the
Implementation Council Meeting

Healthy Connections Prime
May 11, 2016
Agenda

• Overview of Healthy Connections Prime
• Enrollment and Related Activities
• Partners and Resources
• Implementation Council
• Questions
Overview of Healthy Connections Prime
• **New program** for seniors age 65 and older with Medicare and Medicaid

• **Healthy Connections Prime** is part of a **national initiative** jointly administered by CMS and SCDHHS, designed to integrate all the services of Medicare, Medicare Part D, and Medicaid under a single Medicare-Medicaid plan

• **41 counties** participating
Healthy Connections Prime is designed to promote:

- Better care through a single set of benefits representing all services under Medicare, Medicare Part D and Medicaid
- Better value through a care team and care coordinator that works with the individual and his/her providers
- Better health through flexible benefits that help seniors stay at home as long as possible
Covered Services

**Healthy Connections Prime will cover the following services:**

- 24-hour nurse advice line
- Adult day health services
- Care manager (*coordinates care from different providers*)
- Community long term care
- Dental services
- Diabetes management services
- Doctor visits (*unlimited*)
- Help transitioning back home from hospital or nursing home
- Home health
- Hospital and urgent care
- In-home safety assessments
- Lab tests, x-rays and imaging
- Medical equipment (*blood sugar monitors, walkers, wheelchairs, etc.*)
- Mental health services
- Nursing facility
- Nutritional supplements
- Personal care
- Prescription drug coverage
- Prosthetics
- Skilled nursing facility care
- Support for family caregivers
- Therapy (*physical, occupational, speech/language*)
- Transportation to medical appointments
What does Healthy Connections Prime offer beneficiaries?

<table>
<thead>
<tr>
<th>Services*</th>
<th>Healthy Connections Prime</th>
<th>Original Medicare</th>
<th>Medicare Part D</th>
<th>Healthy Connections Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor Visits and Lab Tests/X-rays</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td></td>
</tr>
<tr>
<td>Urgent and Hospital Care</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td>Nursing Facility Care</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td>Medical Equipment (blood sugar monitors, walkers, wheelchairs, etc.)</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td></td>
</tr>
<tr>
<td>Community Long Term Care (CLTC) (personal care, home-delivered meals, etc.)</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td>Right to hire, fire, and manage your home care attendant</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td>Support for family caregivers</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td>Transportation to medical appointments</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td>Dental Services</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td>Vision Benefits (offered by some plans)</td>
<td>★</td>
<td>★</td>
<td>★</td>
<td>★</td>
</tr>
</tbody>
</table>

Plus...

- One plan
- One insurance card
- One member services number to call
- No insurance premiums
- No costs for doctor visits and hospital stays
- A personal care coordinator
- A care team of the member’s choosing
- 6-month continuity of care
Continuity of Care

- 6-month continuity of care period
- Members maintain providers and services
- No change in service authorization levels for direct care waiver services
- Standard Part D transition rules apply

CONTINUITY OF CARE OPTIONS

1. **Full Contract**
   - Serve any member

2. **Single Case Agreement**
   - Serve one particular member beyond the six month transition period

3. **Transition Process**
   - Serve for up to six months while member transitions to a Healthy Connections Prime provider

Out-of-network providers reimbursed at current Medicare and Medicaid fee-for-service rates
Enrollment and Related Activities
Eligibility for Enrollment

Individuals may be eligible to enroll if they are:

- Age 65 or older;
- Have Medicare benefits;
- Have full Healthy Connections Medicaid benefits; and
- Are living at home

<table>
<thead>
<tr>
<th>Enrollment Phase</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Enrollment (~51,000</td>
<td>• Ongoing</td>
</tr>
<tr>
<td>(eligible enrollees)</td>
<td>• Medicare-Medicaid enrollees choose to participate with Healthy Connections Prime</td>
</tr>
<tr>
<td>Passive Enrollment (~12,800</td>
<td></td>
</tr>
<tr>
<td>(eligible enrollees)</td>
<td>• Will occur in two initial phases, and is on going monthly</td>
</tr>
<tr>
<td></td>
<td>• Eligible enrollees are automatically assigned to a Medicare-Medicaid plan</td>
</tr>
</tbody>
</table>
Timeline

Passive Enrollment Timeline*

Wave 1

• Effective April 1, 2016
• Upstate Region
• Projected Eligibles = 5,300

Wave 2

• Effective July 1, 2016
• Coastal Region and CLTC Waiver Population
• Projected Eligibles = 7,500

*Members with comprehensive insurance or who have previously been passively enrolled into a standalone prescription drug plan are excluded from passive enrollment.

Note: Aiken and Dorchester counties are eligible for “choice only” enrollment. In addition, the following counties are not participating in Healthy Connections Prime: Lancaster, Horry, Darlington, Sumter and York.
Passive Enrollment Intelligent Assignment Criteria

**Rule 1 – Enrollment History**
- Uses previous 6 months of enrollment history
- Considers how member disenrolled from previous plan:
  - Voluntarily, or
  - Involuntarily

**Rule 2 – Most Frequently Utilized Provider**
- Identifies most frequently utilized provider (MFUP) through historical claims data
- Uses MFUP to assign plan
- Uses Rule 3 if the MFUPs are contracted with multiple plans

**Rule 3 – Family Health Plans**
- Assigns member to the same plan as the other family member
- Assigns member to the plan with the majority of the family members
- Uses Rule 4 to assign member to health plan, if a tie.

**Rule 4 – Health Risk Score**
- Balance the assignment to the available plans in the county based on health risk score.
Wave 1 Communications to Members (2016)

- **January 22**: 60 Day Notices mailed
- **February 25**: 30 Day Notices mailed
- **April 1**: Earliest Effective Date, New members enrolled!
- **January 25**: New members receive 60 Day Notices
- **February 1**: MMP may contact new members
- **February 28**: New members receive 30 Day Notices
Wave 2 Communications to Members (2016)

- **April 26**: 60 Day Notices mailed
- **May 25**: 30 Day Notices mailed
- **July 1**: Earliest Effective Date, New members enrolled!

**April**
- April 21: MMP may contact new members

**May**
- April 30: New members receive 60 Day Notices

**June**
- May 29: New members receive 30 Day Notices
Sample 60 day passive enrollment notification to beneficiaries
(30 day notice is almost identical in content)
Members will now receive their prescription drug benefit from their new Medicare-Medicaid Plan.

- Enrollment triggers disenrollment for existing comprehensive insurance and stand-alone Medicare Part D plans.
- Medicare Part D plans will notify beneficiaries of their disenrollment from their Part D plans.
- Individuals cannot be in both a Medicare-Medicaid Plan and a stand-alone Medicare Part D.

Sample Part D disenrollment letter

Exhibit 10c: Confirmation of Disenrollment Due to Passive Enrollment into a Medicare-Medicaid Plan
Referenced in section: 50.4.1

IMPORTANT INFORMATION ABOUT YOUR UPCOMING DISENROLLMENT FROM YOUR MEDICARE PRESCRIPTION DRUG PLAN

(Date)

Dear <Name of Member>:

Your state has enrolled you into a new plan that will provide all of your Medicare and Medicaid benefits, including prescription drugs. You should have already gotten a letter from your state telling you about the new plan.

This letter confirms your disenrollment from <PDP name>. You will continue to get your Medicare benefits from <PDP name> until <disenrollment effective date>. Beginning <day following disenrollment effective date>, your new plan will cover your health care.

You will be automatically enrolled in your new plan starting <day following disenrollment effective date>, so you don’t have to do anything if you want to be a member of this new plan. In a few weeks, you should get a letter from your new plan confirming your enrollment. There will be no gap in your Medicare and Medicaid coverage, including your prescription drug coverage.

You can call your new plan with questions about your new coverage or to see if you can still see your current doctors in your new plan. You can also ask for lists of network primary care providers, covered drugs and pharmacies.

If you have questions about your disenrollment from <PDP name>, please call us at <phone number> (TTY users should call <TTY number>). We are open 8 a.m. and 8 p.m. (EST). If you do not wish to be automatically enrolled in a new plan, call your state or call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. Call 1-877-486-3048 if you use a TTY. You can also call 1-800-MEDICARE if you have questions about Medicare or need help with your Medicare options.

Thank you.
After our member’s hospital stay, her Care Coordinator worked closely with the doctor to review her post-discharge care. During the discussion, the Care Coordinator discovered that she missed a gastroenterology appointment because of the hospital stay. The appointment was quickly rescheduled and during that appointment, some serious issues were identified. The Care Coordinator’s involvement helped our member uncover a serious issue and possibly avoid another hospital admission.

“I tell everyone about my plan. I love it, my doctor loves it, it’s great!”

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## Top 3 Disenrollment Reasons

### Disenrollments (as of March 31, 2016)

<table>
<thead>
<tr>
<th>Disenrollment Reason Description</th>
<th>Members</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Initiated</td>
<td>600</td>
<td>50.7%</td>
</tr>
<tr>
<td>Involuntary Cancellation – Loss of Program Eligibility</td>
<td>214</td>
<td>18.0%</td>
</tr>
<tr>
<td>Desires to Remain in FFS</td>
<td>117</td>
<td>10.0%</td>
</tr>
<tr>
<td>All Other Reasons</td>
<td>252</td>
<td>21.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,183</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Top 3 reasons = 78.7%

Source: Truven Healthcare Database March, 2016
Disenrollment Analysis

Disenrollments By Month (Feb 2015 – March 2016)

Key Points
• Disenrollments have been decreasing in the last quarter
• Not included in the chart are transfers (65 in total since February 2015)

Source: Truven Healthcare Database March, 2016
### Top 3 Cancellation Reasons

#### Wave I Cancellations (from Jan. 22, 2016 to Apr. 22, 2016)

<table>
<thead>
<tr>
<th>Cancellation Reason Description</th>
<th>Members</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desires to Remain in FFS</td>
<td>739</td>
<td>64.7%</td>
</tr>
<tr>
<td>CMS Initiated</td>
<td>166</td>
<td>14.5%</td>
</tr>
<tr>
<td>Involuntary Cancellation - Loss of Medicaid</td>
<td>76</td>
<td>6.7%</td>
</tr>
<tr>
<td>All Other Reasons</td>
<td>161</td>
<td>14.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,142</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Top 3 reasons = 85.9%

Source: Fusion Database, SCDHHS internal document. Note: Data is as of April 22, 2016.
Opt Out Analysis


- Never Enrolled Opt Outs: 11
- Disenrollment Opt Outs: 105
- Cancellation Opt Outs: 664

Total = 780

Key Points
- Cancellation opt outs make up 85% of the total opt outs

Source: Fusion Database, SCDHHS internal document. Note: Data is as of April 22, 2016.
Early Outreach Activities Summary

Wave I Early Outreach (as of April 27, 2016)

*Self-reported Data from MMPs*

MMPs completed early welcome calls on April 15, 2016

- **2,949** calls completed (71%)
- **1,796** expressed interest in program/plan (61%)
- **237** requests for cancellation (8%)

Source: Early Outreach Activities Report as of April 2016, SCDHHS internal document.
Top reasons for phone call *(Average of 143 calls per day)*

- Eligibility
- Members requesting new ID card/handbook/formulary
- Benefits
- Prior authorizations
- Adjust claims

Summary of Implementation Experience

Demonstration Statistics

- 1,183 Disenrollments
- 1,142 Cancellations (passive enrollments only)
- 780 Total Opt-Outs
- 664 Opt-Outs for Wave 1 Passive Enrollments only

70% proposed retention goal program-wide
(MMP-specific goals range from 65% to 70%)

Source: Fusion and Truven Databases as of April 2016, SCDHHS internal document.
Partners and Resources
Medicare-Medicaid Plans

www.mmp.absolutetotalcare.com  
(855) 735-4398

www.advicarehealth.com  
(844) 564-0143

www.firstchoicevipcareplus.com  
(877) 703-9109

www.molinahealthcare.com/duals  
(855) 701-4887
SC Thrive

• Helps individuals interested in enrolling or who want to learn more information about Healthy Connections Prime.

• Available to conduct education sessions for beneficiaries, caregivers and advocates

SC Thrive Customer Service | 800-726-8774 (TTY/TDD: 711) Monday to Friday, 8:30am – 5pm
Please visit our Website:

www.scdhhs.gov/prime

- FAQs
- Educational events
- Member stories
- Program data
- Latest updates
- Provider toolkit
- Additional materials
- Contacts
Serves as the demonstration’s ombudsman and as a consumer advocate

Offers services such as:

- Member assistance with billing and service related issues
- Member education and support on appeals and grievances, including the State Fair Hear process

Lt. Governor’s Office on Aging
844-477-4632 (TTY/TDD: 711)
Monday to Friday, 8:30am – 5pm
http://www.healthyconnectionsprimeadvocate.com/
Implementation Council
In July of 2011, SCDHHS created an Integrated Care Workgroup (ICW).

Goal: To provide assistance with designing the model and implementation plan for Healthy Connections Prime.

The ICW focused on:
- Program design and care delivery
- Financial elements
- Program sustainability

ICW evolved into the IC.
The Implementation Council (IC) is a group of volunteers which:

- Provides input to SCDHHS and CMS about Healthy Connections Prime
- Serves an advisory and liaison role to SCDHHS

Recommendations and input from the IC to SCDHHS leadership will be taken into account and used where appropriate.
IC Roles and Responsibilities

Roles and Responsibilities

• Assist in monitoring and implementation activities
• Provide input on policies and procedures
• Host open forums and other education sessions
• Promote transparency and accountability, and disclose program evaluation results
• Advise SCDHHS on issues brought before the IC
• Examine members’ access to services, including but not limited to medical, behavioral health, and home and community-based services
IC Member Makeup

Who Can be a Member of the IC?

- Member
- Family member
- Caregiver of Member
- Interested Neighbor or Friend
- Advocate for Members and/or Caregivers
- Provider for members
- Member of Provider Association
- Medicare-Medicaid Plan Representative
- Staff of a Public or Private Agency
Healthy Connections Prime needs your help!

- Serve throughout the term of the Healthy Connections Prime demonstration
- Become familiar with key issues
- Raise awareness of the program and its benefits
- Participate in education and outreach activities
- Provide program feedback
Questions
Thank You!