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>>**CAPTIONER:** (on standby.)

>>**RECORDING:** "the webinar will begin shortly. Please remain on the line."

>>**CAPTIONER:** I do not hear anything. The recording stopped and I am waiting for audio.

>> -- mailbox -- thanks, Pat, that's great.

We will try to figure out why some people are not able to hear us. In the meantime we will keep moving forward, since most people are in the listening

mode and able to hear the webinar.

I wanted to talk briefly and layout the purpose of today's webinar. We want to

go over our progress to date, and in particular, share with you some of the things we have done over the last month since our last webinar.

We also wanted to review components of the November release. We want to

go over the sections of the draft RFP, the agreement sections and exhibits, all

of the program requirements and preliminary common themes.

The preliminary common themes, you will recall that this draft RFP and draft

agreement were issued last Friday,.

Between last Friday when the comments closed, and today, we have been doing a ton of work too try to organize all of the comments. We will talk in a moment about how many comments we had. We really want to good over in

high-level what the themes are within the preliminary comments that we got.

We also are going to review components of the December release. --

(Lost audio briefly).

-- this release occurred Monday of this week. We have already been given feedback with regards to that. We are hoping that everybody is aware of that

and anxiously looking through it.

1:30-3:00 Office of Longterm Living Webinar Transcript

If people are not aware, put comments through chat section Pat mentioned Kevin can go over how and where to find it. We want to go over a high-level overview of the RFP process.

I want to talk briefly about how we got here.

The Governor announced community health choices as a partnership human

services and aging for the State to move to managed long-term services insupports in February 2015.

We did extensive research and a lot of work gathering feedback as we evolve

Pennsylvania's Community HealthChoices program. We held over 50 meetings, briefing and public sessions in which we either included information community health choices or the meetings were inclusively about

Community HealthChoices.

Some of the comments we received included the need for further input and detail opportunities.

Over comments have been submitted. We have been doing a lot of work trying to solicit feedback as we make this significant change from fee-for-service

to managed long-term services and supports.

I wanted to just also do a quick overview of our ongoing commitment to stakeholder engagement.

On November 23rd House health committees and joint informational session

was held with the House health committee and House aging and older documents committee. Health committee is Chaired by Matt Baker and overseen by -- representative Hennessey, they are the oversight body for the

Department of Aging.

They team together and held a joint informational session.

It was interesting, because usually they hold actual hearings. This was called

an informational session. I can tell you it was standing room only. It was a very packed room. Many, many representatives came for part or all of the presentation.

We had a panel by -- that included the secretaries of aging and human services, Teresa Osborne as well as myself.

There was also a panel of some of our home- and community-based providers,

which included the LIFE providers alliance, Pennsylvania association of areas

action on aging and CEO of liberty resources.

The third panel was specific to providers, which included leading age -- Pennsylvania healthcare association and the Pennsylvania home care association.

The subcommittee -- we have a lot of subcommittees, actually of the medical

assistance advisory committee. The long-term subMAAC met December 1st,

the consumer subMAAC -- the MAAC met December 10th. All of those we presented on Community HealthChoices and answered questions as well.

Yesterday we had an opportunity, thanks to the Jewish healthcare foundation

in Pittsburgh and United Way of Allegheny region held a joint community meeting to begin the conversation with the people directly affected during the

first phase of Community HealthChoices in the southwestern part of the state.

It was a really great opportunity to provide an overview of managed longterm

services and supports. Sub-MAAC there were a number of people in the room who had not even heard about it.

All ever one of the individuals that will be affected by Community HealthChoices they will be notified before they start getting notices.

This is a great example of private partnership that we have an ongoing commitment from Pennsylvania health funders group to continue.

We look forward to continuing our work in southwestern PA and use it as a model to moving to southeast in the future.

I will turn it over to Kevin Hancock who is chief of staff with Office of Long-Term Living. We will get into more of the details beginning with the November release.

**>>KEVIN:** Thank you, Jenn. Good afternoon, everybody.

The next several slides we will go into details not only about November release but also some of the components of December release, which was published this past Monday.

Starting with November release, as a matter of background we released these

documents in November to be able for the forum of open comment. The open

comment period for these documents and their components ended on December 11th -- if I am not mistaken.

We released the November, included EHE was f definitions we thought were important people understood how we were describing key components included not only in the draft agreement but the request for proposal itself, as

well as program requirements or the actual program construct, which included, as listed on the slide, which appears to be frozen on my screen -- here we go -- progress services, our process for needs identification, service

planning and service coordination, enrollment and education, plan organization and administration, network provider and requirement provisions and quality.

Each of these sections went into a great detail about individual components.

We found that our best approach since significant portion of the program was

to base the program requirements and definitions on what currently existed in

the health choices RFP we wanted to make sure it was clear how the definitions themselves would be related to Community HealthChoices and their relationship to long-term services and supports.

In addition to the definition of program requirements, we also included some

key provisions that were included in exhibits or appendices.

Provider terminations, date of support for the [indiscernible] provider directories, grievance and appeals, provider manuals, provider network composition, covered services.

From all of these different components, we received 2,134 comments.

What

this generally means is we generate a lot of great suggestions and thoughtful

feedback on what was published. These 2,134 comments were received from

115 commenters. They were a cross-section of managed care organizations, current long-term services and supports providers, advocate/stakeholders, other groups offering different ways to make sure that

the program works better. We appreciate it very much. As a plug, also relevant to the December release, we are particularly grateful to -- for those individuals to use the template. The template may go much easier and continues to make the process much easier. There is an aggregation process used for comments because we are trying to use as much as possible to include it in the final request for proposal and final draft agreement. We are encouraging people, if they are planning to comments on December release to use that template as well. Our current activity is we are going through those comments, the 2,134 comments. We are looking for how they can be incorporated into the documents we are hoping to be able to release in the final publication of the RFP and draft agreement in late January. Some of what we are seeing in those comments: Provider and plan specific themes. There were a lot of requests for clarification of standard terms and conditions. The standard terms and conditions are largely based on what existed with healthchoices it's not surprising entities not as familiar with healthchoices program that there would be a lot of questions. A lot of comments and questions on technical proposal requirements, which included age limits, fund types -- this is also very similar to these types of releases in the past. People -- especially the managed care organizations that may be participating in the procurement process are looking for ways to make sure that they are as clear as possible in what they are presenting to us. All of those questions were not really that surprising. A lot of questions related to rollout of contract duration and timeline. We are looking at those questions to determine where we do need to make sure that we have to improve our clarity. A lot of questions about some of the geographic components of the program and some of the Community HealthChoices proposed -- and other key

overarching terms of the contract.

Some of the more specific comments related to the provider and plan relationships -- we did receive comments specific about qualifications and credentialing in that relationship. We did provide some information and held some webinars associated with the credentialing processes. Those webinars

and communication events took place in September and October. They really

did help provide a great deal of feedback in a way that credentialing process

could be framed out.

It included participation from nursing facilities, home and community-based as much as providers and managed care organizations that would be involved

in variety of transitioning for the transitioning process.

What we learned was that generally, from the perspective of the participants

Office of Long-Term Living in current configuration collects more information

than managed care organizations in credentialing process.

Some of the information collected that are not currently collected by OLTL, may be worth considering in review as well.

In short, when we receive -- discussion about comments, we found that the credentialing process should incorporate some components that were currently practicing with the Office of Long-Term Living and fee for service program and may include some additional components from managed care organizations that they currently practice in other states and other programs as well.

So there is opportunity to use what exists and improve on what exists with what is being proposed for the comments.

Some other areas we received a lot of comments were service coordination qualifications.

Service coordinators -- this is a point we will make sure that we are clear in the document that we publish in late January.

Service coordinators in the continuity of care plan will -- we had a lot of comments and questions about that. We wanted to make sure that that is clear. Service coordinators during continuity of care period will be considered

a service. The expectation is managed care organizations will be coordinating with service coordinators as they currently exist to make sure that that transition is as holistic and as complete as possible. Commission, qualifications proposed to improve service coordination and ensure participant safety were designed to improve quality. We did receive a lot of questions about that as well. The next -- we are actually going to go into a little more detail about service coordination and what currently exists and really what the objective for improvement. The current service coordination requirement requires a bachelor's degree, including or supplemented by at least 12 college credit hours in some sort of social welfare or social work field sociology, gerontology or another behavioral science or a combination of experience and training which adds up to 4 years of experience in education, which includes at least 12 semester college-level courses in sociology, social work, et cetera, as mentioned before. Under Community HealthChoices, however, we noted that the credentials would be augmented and must be either a registered nurse, RN, and have a bachelor's degree in social work, et cetera and at least three years experience in coordination of services. Just to be clear, the purpose of all of this background -- the goal of changing beyond the current requirement, which were instituted in 2012, the purpose of this is to augment the opportunity for quality. We received a lot of very thoughtful comments in both directions on a way that the service could be developed and managed. Also trying to make sure that there is an opportunity for the existing service coordination participants that have a greater participation in Community HealthChoices and be assured that these comments and questions are certainly going to be under consideration as we frame out the final program. We are looking forward to having continued discussions with program participants and with service coordination entities as we continue to frame up the individual requirements. Additional themes, just to go through it quickly and leave as much time for questions as possible.

We had participants in service specific themes. We received services related to the settings of where services may be received, questions related to the opportunity related to assisted living facilities, sheltered employment, service providers for the deaf-blind population, institutional-based respite care and nursing home transition.

A lot of interesting questions on how the location of services and components of different types of services and opportunities to add different types of services in the program.

In addition, we have received a lot of comments on grievances and appeals. I

am going to stop there to make it clear that we really were hoping to receive a

lot of comments in the grievance and appeals process.

We largely -- published in November, what existed with healthchoices and everything why we did it we know it has been successful in that program.

We

want to make sure that that process and the way it is executed is very much

mindful of the spirveg requirements of long-term services and supports.

We are grateful to the comments to help us look at different ways to improve

that and to ensure that that participant's needs are protected.

Across the board, we have different questions and concerns that were raised

related to protection in grievance appeals process in appeals and again across

the board those comments were much appreciated because we are sure they

will help make the program better.

Another key area where we received com thoughtful comments in the way the

financial management services and fiscal employer agent components are employed.

A lot of questions were requested for a better understanding on how the financial management services or FMS provider will interface with managed

care organizations and look -- and also look for opportunities to continue to

increase consumer choice and educated consumer choice through the opportunity -- and also to make sure that that choice is available through the

FMS provider themselves, possibly offering more than one.

That's the November release.

Now I will take a few minutes to talk about what we included in the December release. As mentioned, the December release is currently open for

comments. I believe that that comment period is open until January 8th. I am

going to look at mycal dpar just to make sure that I am correct; thack. It is open until Friday, January 8th and what we included with the December release, which was significantly smaller, as expected. The program requirements in November were obviously the nuts and bolts of the program.

The draft agreement components we released in December related to a lot of

what we normally call boilerplates language of the contract, plus also key components that may not have a whole lot of deviation from the physical health choices program.

We included sections on applicable laws and regulations. There are applicable

laws and regulations that well overlap between the physical health, health choilses and community health choices, but there are very specific laws and

regulations that are applicable to Community HealthChoices.

Also discussing program outcomes and deliverables; that was also something

tailored for Community HealthChoices, but also keeping in mind there is a physical component to this program as well.

The physical health component -- or the physical health choices or components that really did reflect a lot of characteristics of physical health choices draft agreement included as noted here on this slide incorporation of

documents, relationships of parties. I will not go through them all but they really did reflect what would be included in the physical health -- as well as Community HealthChoices program.

One note reporting requirements we did augment that section with some specific reporting requirements directly relevant to long-term services and

supports; so that would be an area to pay attention to. Across the board you will find that if you do a comparison between the Community HealthChoices draft agreement and fiscal health choices past agreements or current agreement in process that you will find that they are a lot of similarities between the two.

For the December exhibits, these are the areas that we are asking for a lot of

comments. Specifically, we note managed care regulatory compliance the paperwork performance program not a lot of detail on paperwork performance program. We are still looking for comments. Standard terms of conditions, specific regulatory -- prior authorization guidelines for participating managed care organizations. These components will reflect some

of what exists in physical health choices but we are looking for comments in

these areas as well from managed care organizations and for other -- from other interested entities to talk about how they believe that these -- clarification is needed or where it may be needed to customize in program for

Community HealthChoices.

In other areas where we are looking for a great deal of comments related to the four quality exhibits we call them M exhibits.

One note about the quality exhibits that we list here for quality management and utilization, as mentioned in previous webinars and public discussion there

doesn't exist a sort of national standard for quality measurement for long-term

managed care programs. So we are basing our quality program on what currently with physical health or physical health managed care and what is being proposed in long-term services and supports.

We would love to hear from people for areas where we might be able to augment that -- those quality assurance components.

We also note the notice of denials. The notice of denials are literally exactly the same as health choices notice of denials. However, we published the actual notices themselves so that people can get a sense of what they look like. We included a couple enrollment components which are listed in automatic assignment which describes it also talked about the automation process where individuals who do not let the plan eventually enrolled in a plan for auto assignment through auto -- the algorithm that will be in place

for how plans will be assigned to individuals.

We also talk about participants rights and 1307B89s we look forward to receiving comments on that.

We briefly touch in the FFF exhibits on the MIPPA agreement.

We mention that because we want to make clear that the MIPPA agreement as

a matter of background is an agreement that exists between the Commonwealth and with special needs plans Medicare advantage plans for

how those plans are going to be conducting their business in this state and we

outlined a responsibility that we think would include the coordination between the special needs plans DSNIPs and our Community HealthChoices

we are hoping to help facilitate service coordination between those two managed care entities, especially if they are sister care managed care agencies

and we are looking to -- any interested party on the way that those agreements can help facilitate that enhanced coordination.

Lastly are performance measures and data attributes.

We would love to have people take a list of these and look for areas we may

have missed or look specifically at data attributes reflecting to do an evaluation this is San area we are hoping to receive feedback on measurements for Community HealthChoices program.

We we know getting into the level of details that is in that particular section it

is an effort that will pay off for all concerns making sure that that has the highest measurement of quality possible.

So with that, touching again, reminding about the procurement process, we will be planning to release request for proposal tentative time period in late January for the release of that RFP.

When that happens, we will be beginning the blackout period. That means that aside from -- through procurement process, the formal procurement process itself, we will not be able to have these types of questions and answers and this type of public comment.

That's the reason we are taking as much -- to receive and incorporate comments as much as possible to make sure that the final procurement documents are as complement as successfully developed as possible.

In the blackout period we would be constrained from what we can answer.

In that period, after we release the RFP we will have the fee proposal conference. The purpose of the pre-proposal conference is to allow the formal submission of RFP-related questions answered. Also allow to a publication of those questions as well.

And then we are planning to allow for 60 days for proposals to be developed for that RFP so we are expecting at this point to be receiving those proposals in late March and it will begin in April for the proposals on our part. So that concluded the formal presentation for November release documents and also the December release documents that we released in the beginning of this week and also talking about procurements.

Right now, we are going to be leaving ourselves open for any type of questions you may have relating to those documents or any of the other parts of the program that we are -- where you still have questions or a new areas of the program where you may have questions as well.

Just some information as well, while waiting for the questions to be printed. The un-- on your screen you will have key resources available to you. If you go to the Community HealthChoices remember site you will see a lot of these documents that have been published. We have an MLTSS SubMAAC web page link that is available on the MLTSS SubMAAC as well as information on the presentation and some of the transcripts that have been collected on those public sessions.

We are encouraging people to you can see the website here.

Email to our RA mailbox listed on the power point.

With that, we will leave ourselves for questions and comments.

**>>JEN:** Until they printout, I can start to read some of them.

**>>** First question is, what are the different RFP documents being asked for January 6th through 8th, I think it is the December release document?

**>>KEVIN:** That's correct.

The document that we publish this Monday will relate specifically to agreement sections and exhibits that as mentioned a little bit more -- the

agreement sections are more of what we call boilerplate language we are looking for comments on that. We are more specifically looking for comments

on the exhibits that are in the later section of that document.

Most specifically, on our quality components and some of the elogyibility components that were also published. We do have questions printed out. I am

going to read them aloud.

First question, what is the different RFP document -- I'm sorry. That was already read. I will go to the next.

Would license professional counselor in the State of PA also be considered for

service coordination supervisor position?

I believe the answer to that, and I am going to say -- I am going to qualify what I say that it depends. I will say broadly, yes. That individual will have most likely a licensed professional counselor would most likely have the education and possibly credentials that would be required of a supervisor position but if there is a specific level of credentials associated with the licensed professional counselor, I think we would have to evaluate it. It is a very good question and I would actually be able to research more and come

back with a more specific answer to see if there is a standard that we could identify for a licensed professional counselor to see if it sits with the service coordinator position and supervisor position.

We appreciate the question. That will be followed up with further research.

The next question: How will the new program work with organizations being able to provide more than one service?

Currently you can't be a supports coordinator group and provider for conflict

of issue issues; that's still going to stand.

The question is whether or not -- I believe that the questioner is trying to determine whether or not there still has to be a remove ail between people providing direct services and people involved in the development of the service planning process.

In this instance, there will still have to be a real separation between the two services to make sure that the service coordination entity, whether that be administrative function of the plan or in some other configuration, if not also providing the direct services and -- to make sure that there is a clear evidence

choice available for the participant in a way that those direct care services are provided.

The answer to that question is, Yes.

The next question is: Can you talk about how behavioral health and LTSS will be integrated and coordinated?

The question continues: Are you open to holding -- [indiscernible] -- specific examples to make sure that behavioral health needs to do not fall through the cracks in Community HealthChoices.

Very grateful for this question.

We are planning to use the contract components of closed Community HealthChoices and behavioral health MCOs to be able to facilitate and enforce

that coordination we are very much open to meeting with stakeholders to discuss -- examples to ensure all of that coordination is going to take place.

We loved to have some specific outreach on where stakeholders believe there

might be opportunities for enhanced coordination between these two programs.

Just to be very clear, in making the decision to carve out behavioral health services and Community HealthChoices, we have also made this commitment

that there would be a high degree of coordination between MCOs and community health choices MCOs this is important to us and we do believe

Community HealthChoices will allow for an opportunity to allow more augmentation of that coordination for populations that may not necessarily have been served in their current behavioral health configurations.

We look at it as an opportunity and would love to have opportunities to talk about it publically and get suggestions and feedback on how that integration

may be enhanced.

The next question: Are the service coordination requirements final? The

question continues: The person supervised coordination for eight years with

master's degree would not be eligible any longer to supervise staff.

The first part of the question are service coordination requirements final?

At this point, there is nothing in the documents that have been published that are final. The reason why we published them we put them out in draft for comments because we wanted to receive feedback like this comment made by the individual with master's degree [indiscernible] (printer printing in background).

-- there will be further discussion and examples -- clarity on requirements and

looking for opportunity -- [indiscernible]

Also as plug for managed long-term supports services SubMAAC in January

this will be on the agenda for sure.

Next question, do these changes require current providing agencies to reenroll?

If they -- you mean by re-enrolling Medicaid provider, the -- as for all of the long-term services and supports providers, the answer to that question

would be, No, at this point.

There would be enrollment component with managed care organization, however.

Depending on what they mean by providing agencies, service coordination will be for continuity of care period there will be no re-enroll.

>>**CAPTIONER:** I cannot hear because of background noise. Kevin is not close enough to the microphone and there is too much noise in the room.

>>**KEVIN:** Next question. Specific procedure to respond to comments for December 11th and January 8th? FAQ on Community HealthChoices on this

website?

I appreciate the question. So the specific procedure, we do have a template that has been published specific to -- just to be clear, the comment period is

closed on the November documents that were released. That closed on December 11th, but for the January documents, we do have a template that

was published on the website and we are really strongly encouraging people

to use that template because it makes the ago gas station of those comments

easier [indiscernible] -- much more equally identify which section in the

requirements or in the draft documents that -- where the comments are being referenced. It is particularly helpful.

In terms of -- what we are asking people to do is use the template and forward

it to us our website. Thank you very much for that question.

Next question: When do you and submitting new waiver application to CMS?

The comment continues: Please describe how the public will be able to submit

feedback. For example, will there be an opportunity to submit comments before the applications are submitted to CMS?

So the first part of the question, we are ending that we will be submitting a new waiver application to CMS in early -- late winter or early spring and then

we will absolutely be an opportunity for the public to submit feedback and to

provide comments on those documents.

We would do it regardless. There is also a component of the process of CMS.

CMS, like the Department of Human Services appreciate and very much is appreciative of the value that stakeholders across the board provide to these

types of documents and that will definitely be part of the process.

Next question: Can you offer clarification to the department work group discussed as a source for data elements [indiscernible] excuse me one second.

3-G we had an internal work group -- we called them internal subject matter experts. The reason they are called that is because they are very familiar with

long-term services and supports that are currently being provided in the fee-for-

service environment for the waivers.

They are also subject matter -- subject matter experts on existing system meaning our promise -- I mean, managed information system our eligibility system and our case management system.

So they understand the data that is often associated with long-term services

and supports.

They are the individuals who get the credit for taking first crack at data

elements in GGG.

We -- that doesn't mean that they are not open to suggestions by any means.

We are very much appreciative of people commenting on this section for completeness, for clarification and certainly for opportunities for improvement.

I appreciate your question very much.

Next question.

Will current SCS being grandfathered in?

That decision has not been made at this point. It is a comment we have frequently received.

The next question: Have the requirements for service coordinators and service

coordination supervisors change from what was introduced in the draft RFP?

Is there a possibility that it could be changed?

To answer the first question, the service coordinator requirements have been

released in draft and they have at this point, we are still accepting comments

to answer the question honestly.

We have not changed them because we are accepting the comments we received.

Is there a possibility that they can be changed?

The answer to that question is partly yes.

The reason why we are looking forward to going through the suggestions and

comments.

Next question, I said service coordination agencies will be there for the continuity of care period. What happens to them after that time frame? How long is that time frame?

The continuity care period is 1280 days. The service coordination entity will be providers -- part of the continuity of care during that time period. We want

to make sure it is clear.

The question of what happens after that time period -- service coordination --

managed care organizations -- we are giving a lot of flexibility with plans on how to manage service coordination.

Plans may elect contract service coordination -- existing service coordination

providers or they may develop a different type of relationship for service coordination entities that would be more of an administrative service.

So that is a point that certainly is open to decide to continue this discussion,

but after the continuity of care time period, the plans are going to be responsible and accountable for the way that that service coordination is going to be delivered with the program.

Agencies that provide personal home healthcare through local triple A's will they have to re-enroll?

The question if they are Medicaid enrolled provider, the expectation is that they will not have to re-enroll, but they will have to enroll to be part of a network with a managed care organization.

So depending on what the -- where the question is directed, really is how that

question will have to be answered.

Next question: Licensed psychologist also qualify for service coordination supervisor?

Licensed psychologists they are master's level licensed psychologist and PhD level

licensed psychologist.

It is also a very good question. It really depends on the qualifications. We are

expecting that the individuals would be licensed psychologist with the right amount of experience, would be able to qualify for service coordination supervisor.

Referring back to the answer I replied before, since you are asking for a specific qualification standard, based on the particular position, I think it is going to be better if we research those particular types of position descriptions

and then answer them specifically.

So broadly, we will get back to you on that.

>> Kevin, before you move on to more questions, we received a comment about background noise that sounds like a printer. You are correct. You may

hear a printer in the background. We are printing the questions off for Kevin.

Thank you for the comment.

>>**KEVIN:** Thank you, Pat.

Next question average -- [indiscernible] -- health choices RFP for reference purposes so that bidders could propose their SBD shipments at -- [indiscernible] -- MTSS -- this is a very specific question. I am going to have to

say that I am not going to answer any -- [LAUGHTER] just to be honest, I think for the sake of this call I will not be able to answer anything that specific.

We will look for opportunities to be able to respond to more specific questions like this.

I do have the email of the person who submitted it. I promise I will get back to you specifically.

Next question hopefully with no specific math problem: The outlines in DGG

is determine service needs or toll used by the outside entity that will be responsible for assessment -- whether just rephrase we are asking if comprehensive needs assessment outlined in GGG is toll MCOs will be using

to [indiscernible] (printing) -- determination for nursing facility clinical eligibility for our program.

The answer specifically is needs assessment will be used for determination of service needs.

There will be a relationship between the two tools where the one will be informing the other.

Most specifically the level of care assessment will be most likely informing the needs assessment but the needs assessment specifically will be

used to assess service needs and help frame out the service plans.

Thank you for that question.

Next question: Can you address that means services of needs for dual-eligible

-- chiropractic care.

I am going to take a moment to research in the service list itself on chiropractic care. Just bear with me for one second.

We mentioned chiropractic care when we talked about self-referral and direct

access. We based -- participant may access chiropractic services in accordance

with -- [indiscernible] in medical system -- 15-07-01 we also mention physical therapy services.

Chiropractic services would be an eligible service and we mention how it would be able to be accessed in the program.

Next question: Can you -- I am just making sure if there are other services listed on that question. Moving on to the next question can you share more detail on January 13th and 14th meet-and-greet session?

We are planning to -- it's an extension of the meet-and-greet sessions. We have had scheduled earlier in November.

I am actually going to look to Pat to see if she would be willing to provide more details.

**>>PAT:** Great question. Thank you, Kevin.

We just received the confirmation on the logistics next meet and get is Wednesday January the 13th and Thursday January the 14th. They will be held at the Harrisburg Hilton.

We are looking at entities -- that are interested in participating in community health choices.

We are -- sessions specifically on getting behavior managed care plans in Pennsylvania, together with the interested managed care plans for Community HealthChoices, also holding a specific session to get together various housing entities. Housing providers, housing authorities, managed care plans.

We are also looking to have a specific session for the county entities in Pennsylvania. We have such a strong county-based system that we really thought that there should be an opportunity to have the managed care plans

get to know a little bit more about that county system and then we are also looking to have an expanded consumer session.

Then, also, a managed care only session, similar to what we did the last time

to talk a little bit more with them and answer some specific questions they may have about the existing system.

Additional details will be coming out shortly. We will be sending something out to the managed care plans by the end of the week and then we are working with the office of mental health and substance abuse around coordinating with the behavioral health managed care plans and county commissioner association of Pennsylvania in working with county piece of this

and then working through the department's dedicated housing individual to

work on the housing piece and then finally with various consumer groups, including the MLTSS SubMAAC on the consumer session.

>>**KEVIN:** Thank you, Pat.

>>**PAT:** Sure.

>>**KEVIN:** What are the requirements for home care providers?

They will be required to meet minimum requirements established by the department. They must be credentialed.

There will be particular credentialing standards that will be developed, as mentioned earlier, that will be a combination between what currently exists in

the Office of Long-Term Living and may be augmented for improved credentialing standards in practice with managed care organizations.

So more to come on that question.

Credentialing standards are something that we want to make sure that we are

published in our MLTSS provider community is well aware of as we go through this process.

Next question: How will coordination occur with a member's Medicare benefits? If the person is original Medicare. What they mean by original Medicare is fee-for-service and not Medicare advantage plans.

The direct RFP the question draft RFP does not seem to recognize that for duals or primary insurance [indiscernible]

The Community HealthChoices does recognize that for physical health services primarily Medicare will be the primary payer, whether fee-for-service

or Medicare advantage plan.

We are planning to -- if the individual is in fee-for-service Medicare, a lot of the coordination requirements are largely on the Community HealthChoices managed care organization to be able to facilitate that coordination with the individual Medicare providers.

It's still going to be an expectation in the program.

The draft RFP does recognize that the primary payer for physical health services is going to be Medicare and the Medicaid managed care program will

be responsible for wraparound services as well as LTSS or long-term services

and supports.

We do believe they will have received suggestions on ways we can make sure

that we clarify how those requirements are characterized in the RFP and make

sure we include them. I appreciate the question very much.

Next question: Hearing tests, ear care, eye care, dental, durable medical equipment, assistive devices, behavioral health changes from fee-for-service

behavioral health, prescription co-pay amounts referral for specialists, et cetera. I believe these are all services people are questioning whether or not

they will be covered in the program.

Probably for the sake of moving through these questions, we wouldn't be able

to answer for a specific services. It's probably -- I could say for sure that some

of these services will be covered under the program and other services may be

part of wraparound services that the plan may provide; however, for the sake

of the program, if these are specific services, hopefully this individual submitted a comment about the specific services.

If they were not outlined in the requirements documents and -- it may be an area we may have to pay closer attention to with something included in the covered services exhibit.

So let me take some time to do a comparison between the covered services

exhibit that was published in November and this list and then I am going to reply back to the individual who submitted the question directly.

Next question: To ensure a seamless transition to CHC, do you expect to recognize a grandfathering -- education and training requirements for service

coordinators?

We already answered this question. We received a lot of comments on credentials and requirements for service coordination from November publication. We are definitely going to be having discussions on these different suggestions. We did receive several comments on this grandfathering

provision mentioned in the question.

Next question, will you be able to hire in-home attendants for care under the

waiver.

I think the question is whether or not an individual would be able to continue to be able to hire their own in-home attendants under Community HealthChoices. The answer is question. We will continue a consumer-directed model as part of Community HealthChoices.

There is a background noise -- I'm sorry. I think that was already mentioned by Pat. I think that it was minimized at this point. Although the more questions we have, the more printing we will have to continue to do. Another question. Great question. Medical assistance transportation program, how is this going to be affected?

At this point it is anticipated for individuals who have Medicaid eligible and receive transportation for physical health services and use MAT program -- that would be primarily the dual-eligibles not receiving long-term services and supports will still have access to MATT.

The configuration of MATT itself will not change.

MATT currently does not cover non-medical transportation. Non-medical transportation is still expected to be service -- non-medical transportation will

not be a service provided by MATP. I guess the expectation at this point is that

current service -- MATP will not change.

Next question, can you please clarify which ATBS waivers and state programs

will be included in Community HealthChoices? That would include Community HealthChoices the waivers that are currently planned to be included are the OBR waiver, independence waiver, ComCare waiver, attendant care waiver and we are also planning to include individuals who are receiving their services in nursing facilities. We are also including individuals who may not be in a waiver but they are duly eligible, fully duly eligible and receive their services through Medicare and Medicaid.

Hopefully I answered that question.

The next question, how many managed care companies are anticipated? I think they mean how many are expected to be in the bidding program.

Personal assistance agency have to enroll with each one separately or one enrollment.

The plan at this point we are not really sure how many managed care

companies are added. Using physical health, health choices is procurement right now and anticipated).

They had significant interest in their program. Just to be clear significant interest as well, although it is impossible to say at this point how many plans will be part of the procurement process.

The second part of the question, will personal assistance agencies have to enroll with each one separately?

The plan at this point is we are going to allow the managed care organizations to have control over how they are going to be developing their own networks.

Personal assistance agencies will want to enroll with as many managed care organizations as they want to work with and -- so the answer to that question

is, at this point, yes.

Next question, MCO solicits to already enrolled home care agencies.

I am not completely sure I understand the question. I am going to make the assumption questioning whether or not the managed care organizations can

market to enrolled home care agencies participants.

If that's the question, we are going to have some pretty clear guidelines and

what type of marketing can actually take place in this program.

It's quite -- so the -- well, what this program will be focused on is making sure

that individuals are provided with as much independent choice as possible; that's the reason why we are planning to use an independent enrollment entity to facilitate planned choice.

We will be limiting or restricting the types of marketing that take place with managed care organizations and their participants.

There may be some allowance for some marketing between the individuals who are in a dptewl special needs plan and have a sister Community health choices managed care choices program the reason we want to do that is it would provide a high-degree opportunity for individuals to have a high degree of integration when the programs are -- have a direct relationship.

There will be restrictions in marketing and we will make sure that there is a lot of public consideration on how the marketing process for managed care

organizations will exist in Community HealthChoices. We are very much going to be following suit on what we currently do on fiscal health, health choices as well. We are following a lot of same guidelines and same restrictions and we believe that there are also regulatory constraints.

I do appreciate that question very much.

>> We received a comment asking for clarification. When you talked about the waivers that were going to be included, someone thought you may have missed the aging waiver.

>>**Kevin:** Yes, I did. I do apologize. The aging waiver will be part of it. I appreciate the clarification. Thank you, Pat, and thank you to the commenter.

I will repeat the number of waivers, testing myself, the aging waiver, OBR wafer, ComCare, attendant care and independence waiver as well as individuals in nursing facilities and fully dual-eligibles.

I appreciate the comment and thank you for the correction.

We received another question, how will the state view the potential conflict of

interest between managed care organizations as an insurer and as a provider

of any of the various services that will be offered under the new MLTSS system?

An example they provided, a potential MCO that is also owned or administered large health system will be -- both MCO and also provider of care to any of its recipients.

It is a great question. What we will be challenging MCOs to present to us in their proposals, they will make sure that the firewalls exist to be able to maintain participant choice when it comes to service providers. The participants will have to provide -- have a choice of service providers as part

of the network that they are participating in and MCO regardless of whether they own a large health system or not, they will have to be able to provide that choice.

That is -- that will be a challenge to the MCO and how they will be presenting

that as the debt procurement process.

Another question, where is the funding coming from to pay the capitation rate to the HMOs?

The general -- generally, the answer to that would be the same source of funding we have for Medicaid, long-term services and supports and the waivers and nursing facilities now will be coming from the budget appropriations that currently support that program.

Next question, since this is a, there is a large disparity between the intellectual

disability waivers and the waivers under OLTL and rate of payment to providers of services rendered.

The Department of the OLTL recognize this fact and how -- parties MCO help

lack of services -- [indiscernible]

To answer the question generally, there is going to be -- the oversight party that they mentioned the managed care organizations will also be developing

their network and developing the pricing arrangement with participants in the

network so that it is quite possible that there might be opportunities to be able to first of all, since ID is not part of this program, it may not necessarily be a direct consideration, but there may be opportunities for the way that services are contracted between the MCOs and providers and also -- way they

may be negotiated.

Younger individual in OBR waiver who for all intents and purposes are ID or

intellectual disability but not recognized as such by the state of PA -- I think this person is making a comment -- in the fact they are placed in a waiver no

means of recognizing their poor adaptive and executing functions et cetera, they are not physically disabled but need 24/7 supervision and programming.

How will they.

Able to have access to services they need, stay in their homes and community

and will model service to ensure MA dollars are used effectively and model of

service needs to be same as and funded meaning the same rate of similar to

ID waivers?

Individuals raising interesting comment about the OBR waiver. Not to go into

too much detail but we will look at participant's need OBR waiver is unique in

system of waivers because it has a different level of care assessment in

the way that people have access to services.

We will -- since we are look to standardize the level of care, (printer noise) -

-

will present some easy questions for us as we transition into the new program.

We will -- I would love to continue to receive input from participants or their families associated with the OBR waiver or certainly other providers in the way that we try to impress those specific questions.

They are raising an interesting question in -- OBR waiver and the population

itself; so that will be an ongoing point of discussion and how they will be integrated in Community HealthChoices or if they are more appropriately served in another one of the Department of Human Services programs.

We had already mentioned some of the questions related to funding and rate.

The question -- next question, where are our RFP [indiscernible] located.

I will go back to that slide. If you look at the website you will be able to see where the appendcies -- both for move and December releases.

Thases at dhs.pa website forb community health choices.

The next comment, I believe, I can anticipate that the comment template helps to put all comments together to analyze the template may be difficult for consumers to use, especially those who don't have Excel. It seems to restrict people from making global comments.

Also, nothing is on the website that indicates other than using template.

We are strongly encouraging people to use the template but they can submit

open comments through the RAMLTSS mailbox if that's their preference.

Going to encourage a fourth time to be able to use the template, but if they need to submit their comments at the -- using our comments mailbox, then that would be great.

>>**PAT:** Kevin, there is also an "other" dropdown box that they could use for

global comments as well.

>>**KEVIN:** On the template itself?

>>**PAT:** Yes.

>>**KEVIN:** People without access to Excel if you wanted to make globe all comments there is opportunity to be able to do that so thank you.

Next question: There is a list of MCO -- is there a list of MCOs interested in participating and their addresses?

>>**Kevin:** We can't -- at this point I think we can make available the list of the MCOs that participated in our meet-and-greet sessions we would assume

that those MCOs are interested in participating in the -- participating in the procurement process.

The next question, will there be more meet and greet sessions for home-care

providers? The answer is, Yes. We are open for opportunities to have more sessions with -- between the MCOs and the providers.

>>**PAT:** Actually, I believe what we have tried to do is encourage them to -- we had initial meet-and-greet session to get to know each other and do their

conversations outside of o the department, particularly as you move into the

blackout period.

>>**KEVIN:** Right.

We are -- when we go into the blackout period, again, we are anticipating to be starting in late January, we will not continue to have these types of conversations, but the department will be able to facilitate.

Home care providers -- the home care associations themselves did schedule a

meet-and-greet between MCOs and the home-care providers I believe it was a

successful meet-and-greet. We will continue to look for opportunities for meet-and-greet Mr. Blackout period if it is possible.

Being mindful of the blackout period as well.

With that being said in the commenter has particular -- if you participate in the association and want to reach out to the association to see if they want to

schedule a neat-and-greet on their own as well, we would encourage to you

do that.

Next question: Will MCO limit number of providers for home care?

>>**KEVIN:** We have an expectation that MCOs will be adequate for

participant choice. The adequate or robust network for lack of better term may eventually lead to limit of number of providers for homecare but they will need to meet work adequacy standards to be able to demonstrate that participants have real choice in this program.

The next question: Will CHCs or Community HealthChoices MCOs being open

to allowing more providers to be enrolled in the network?

At this point -- we just closed -- just on FMS, we just closed a comment -- request for information on the program itself. We just closed the comment period on December 4th. We are evaluating some suggestions on the way that

that service would be configured.

I think that the CHCs will follow the departments lead on how many FMS providers to be enrolled with the CHC network.

At this point we are -- the current thinking is that it will be more than one.

Next question: Roughly 35% of the OLTL waiver participants use consumer employer models to help direct their services.

Will MCOs be required to meet benchmarks to assure they are promoted and

encouraged by the MCOs?

>>**KEVIN:** Speaking broadly the MCOs will be expected to meet the participant preferences when it comes to the way their services are delivered.

So the preferences will dictate for this -- how the MCOs will be providing the

services. For people in need of personal assistant services if they wish to participate in consumer employer model, the plan will -- since it is a service that is a requirement for the program, the plans will have that available to the

participants. So when we are talking about specific benchmark percentages it

is more on individual participants an the way they want their services to be delivered.

We appreciate the question. It is a thoughtful question. At this point we are not -- such a specific benchmark.

Next question: Will the waiting list for waivers to appear when managed care

program is fully functional? Will the application process be faster?

Currently we do not have a waiting list in any of the office of long-term living home and community-based waivers.

None of those programs manage a wait list. So there wouldn't be one to manage or transfer to at least -- hopefully continue to be continue to be the case --s no wait list for this program.

The second part of the question: Will the politic process be faster? The application eligibility application is what I assume they mean; that will be more a function of the independent enrollment entity in our county assistance

offices, which is a separate procurement vehicle and with the way that that's

going to be managed under not only under Community HealthChoices but prior to implementation of Community HealthChoices there are components in that program that will be changed to all that is possible to speed up that process.

Next question, what will the Department of Health have with the managed care organization? It is a great question. The Department of Health has f licensing relationship with imagined medical care organizations.

In both Is cays they will be directly involved with managed care organizations

and Community HealthChoices as they are with all managed care programs. I

appreciate the question very much.

Next question: What is going to be happening with services my way?

Services my way will continue to be a program that will be made available in

Community HealthChoices.

We believe it is mentioned in the program requirements.

Next question: A long question: Currently? The waivers, respite is a service that people can self-direct using the consumer employer model.

It appears that the proposal includes only personal assistance as a selfdirected

service.

Can you talk about why respite isn't included and can you talk about why community integration, non-medical transportation and supported employment are not included in the services that can be self-directed?

There is precedent for these services being self-directed services. They are selfdirected

services in ID waivers. Would the department consider expanding the list of services that can be self-directed?

In the first part of the question, any service that is part of the consumer

employer waiver would also be a service that is available for self-direction in Community HealthChoices.

So if there is any point of clarity, we appreciate the comment and look for opportunities to make sure that we provide the clarity in any of the future documents we would receive as part of formal procurement process for the program.

You talked about community integration, non-medical transportation supported employment are included in services that can be self-directed. Since they are part of the ID waiver I hope this person submitted the comment

but we have it now and we will take it back and include it as part of the comments that will be evaluating when we talk about the covered services Community HealthChoices. We appreciate it very much and will take it into evaluation.

A question was asked again whether MCOs can be released we can certainly do that.

The next question, will there be any requirement that will prevent some of the service coordination entities to be enrolled in the MCOs?

As mentioned, part of the continuity of care process the MCOs will have to work with service coordinators as a provider of services for that 180-day continuity of care period. When we talk about requirements that will prevent some service coordination entities to be enrolled with mch COs, to my knowledge there is no restriction in the way the service coordination entities will have to be enrolled with MCOs.

The next question: Do you think it will hurt small business owners. In general

I do not think that. I think that all providers in this program will have an opportunity to do work with MCOs.

In fact, I think for the small business owners to provide quality services, this is

going to be a real opportunity and really an opportunity for growth whether it

is shown to be not only in the Commonwealth of Pennsylvania with our managed care programs, but also with other states and managed long-term services and supports programs.

For the, I will say emphatically it is an opportunity for quality small business owners that provide quality services in the interest -- [indiscernible] to work

with you and to contract with you to be part of our knelt work.

>>**PAT:** That is all of the questions we have.

>>**KEVIN:** I will close up by wishing everybody happy holiday. We appreciate your participation in this program.

Continue participation in all of our efforts for stakeholder feedback. We are particularly grateful for all of the comments we received for the documents to

be released in November. We look for this continued dialogue and feedback to

help make Community HealthChoices the best possible program it can be throughout its deployment and through its delivery of services for every participant.

Thank you and have a great holiday, everyone.

(concluded at 3:00 p.m.)

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