>>CAPTIONER: Hello.
(I will be right back.
>> -- on Community HealthChoices, which is Pennsylvania's proposed managed long-term services and supports system.
Welcome to the third-Thursday webinar. I think we have a reciting -- we will be opening it up for questions as we have been doing it on all of the third-Thursday webinars.
I want to turn it over to Pat Brady to go over a few housekeeping items, which
we like to do before each of them, so that the participatants can maximize their experience on the webinar.
>>Pallet: Thanks, Jen. Let me start with just making sure that everyone can
hear us. If you are having difficulty hearing, just type a note in the chat box, we will try to work through that.
On the screen you will see on the right-hand side is the control panel, this is
where you select either using telephone and dialing in or using the microphone on your computer.
Everyone is in the everyone is muted. At the end you can type questions into
the chat box that is showing up now on the screen, then we will compile the questions. Jenn and Kevin will answer those at the end of the suggestion.
>>JEN: Thanks, Pat. We have a few items to go over today. Financing the first is to give office of long-term living update. For the most part I am giving you update on activities we have been engaged in since last webinar and kind
of giving you the lay of the land over the last four weeks.
We also want to cover the comments. I will talk about that in a few minutes.
We just recently launched health choices website. I am going to show you a
screen shot of it to walk you through the navigation of it. It is a much more user-friendly place to get information. Community hell.
Starting with the Office of Long-Term Living update, since the last webinar, we have received 2100 comments from November release, 850 comments from our December release. We released 2 draft agreements in two time

periods, one November and one December.
What is coming up in the near future are the release of the actual Community

HealthChoices RFP in February.
After that, that is considered what the State considers in the procurement world to be a blackout period, which we will be limited in discussion.
We will begin outreach campaign. I want to talk a little bit about how we see that education campaign being rolled out and how folks in the community can
get involved, then still planning for 2017 implementation in the southwestern
part of the state.
So I want to start with education and outreach. We know it will be critical for the success of Community HealthChoices. We are talking about this as a public/private partnership. We want to talk to you about what we mean by that.
We see it as an all hands on deck effort to reach all of our potential enrollees,
before they receive their first enrollment notice.
I have been saying that I would love it if 95-P of the people who are affected
by community health choices will be aware that changes April before they receive their first notice, first official notice from the Commonwealth.
We have partnerships between the Commonwealth and Pennsylvania funders
network which is a statewide network of foundations who provide support to health-related agencies and non-profits.
The statewide network has reached out to us and asked to be engaged in helping top get the word out about Community HealthChoices. We actually began that process last month when we went to Pittsburgh and joined the Jewish healthcare foundation in Pittsburgh on December 16th.
At that meeting there were a number of people they invited.
I would say a portion of those people were not much aware. They heard about
Community HealthChoices. They heard about managed long-term services and supports but didn't know much about it at all.
It was an opportunity to kind of begin engaging them in talking about the kinds of things we have been doing and where we have been going with Community HealthChoices.
This public/private partnership -- (loud background noise) -- really highlights opportunities for using existing community partners to use their experience and expertise and their local presence to assist Pennsylvania in implementing

a successful program.
Our goal, of course, as we have been talking about for many months is to improve participant satisfaction and health outcomes.
So the Jewish healthcare foundation based in Pittsburgh has agreed to support us as we engage community partners to help us with this work.
They did a similar -- played a similar role in expansion of health choices which was very successful engagement from Jewish healthcare foundation.
The kick-off meeting was December 16th. Again, comurcht providers as well
as partners. For example, the library system from Pittsburgh was one of the people in attendance. They want to figure out how to support our outreach work.
That meeting was attended by a number of individuals that included Area Agencies on Aging, nursing facilities administrators, the living independence
for elderly State program and, again, a variety of community partners such as
grocery stores and unitedway, et cetera.
A follow-up 3450E9ing is being held on January 27th, 2016. If you haven't heard about that meeting but would like information on it or would like to attend, you can go to the checkbox, send it in and we will be in touch with you. We can send the invitation to you.
Community HealthChoices, MCO meet and greet -- the initial meet and greet
in November, which we held with existing providers long-term services and supports system, they were pretty successful. We heard very positive feedback
from a lot of the participants in those meet and greets. When we talk about a
meet and greet for our purposes, this is -- it was two all-day meetings held with a number of variety of different partners and folks that are actively involved in our existing long-term services and supports delivery system.
I would, just from my own personal experience at the centers for Medicare and Medicaid services with the federal government and Medicaid, I had the opportunity to review applications and my team had the opportunity to review applications from states that were implementing and applying to CMS
to make changes.
My team was particularly expert in the community-based long-term services and supports. We had an opportunity to see that.

We did find the states that engaged stakeholders meaningfully and a lot really
had -- generally had more successful programs. They really learned and engaged their partners to mold their program to be more successful.
Our strategy for stakeholder engagement is involved in transparency and supporting people as they learn and gain more and more information so that
they are feeling more comfortable with the changes that are going to be coming.
These meet and greets really serve as an opportunity as managed care organizations and our providers, as well as our participants and other stakeholders to better understand services in the future environment and build on the successes of what we are doing today.
This round of meet and greets on January 13th and 14th were held as a follow-up to the November meet and greet. We had to brief -- after the ones that were held late last year and talk through -- it was agreed upon that other
providers were -- they were interested in hearing and learning about other providers and other entities that were part of the delivery system.
We came up with these types of the sessions that we held last week with county human service administrators as well as behavioral health managed care organizations and providers. A third one was held on housing; those were all on January 13th here in Harrisburg.
On January 14th we had a second participant panel where the consumers put
together a panel that talked about their concerns, what supports them to live
independently in the community and supports their quality of life. They asked
questions. It was a very robust dialogue and exchange of ideas. We also held
meet and greet specific to brain injury providers because it was a discreet group of providers that really focus in on a very unique set of services so survives of brain injury are able to participate in community living.
We debriefed after that with managed care organizations to kind of talk about
what some next steps might be.
The responses from these sessions have been very positive. The ability to better understand county human services led nicely into the discussions with

behavioral health providers and managed care organizations.
Those meet and greets were helpful to support engagement of the providers
with interested managed care organizations that are interested in applying to
become Community HealthChoices MCO.
We plan to post contact information for managed care organizations on our website -- it is posted -- I just learned it is posted.
If you are interested in reaching out to any of those managed care organizations, their contact information is now available on the CHC website.
The next one I am going to kick off and turn over to Kevin to talk in more detail. This -- here are a couple of the theme -- not a couple but 6 themes that
were pretty standard in the comments that we received almost 3,000 comments that we received on the documents that we put out publically.
So what we decided to do was group them into the themes so that we could
talk about them even though we heard from 20 agencies about coordinated care requirements, there were different opinions and different proposals on how we should handle these things.
We came up with our direction, based on that feedback, but, again, many, many different diverse opinions on how we approach each theme.
Do you want to kick it off?
>>KEVIN: Sure.
>>JEN: I will turn it over to Kevin hand Court or counsel our chief of staff.
I'm sorry I forgot to introduce you at the beginning. Kevin will talk us through
the themes we heard from the open process that we have had.
>>KEVIN: Thank you, Jen.
As Jen mentioned, we had six themes that have really stood out in the comments we reviewed through the release of the draft RFP, draft program requirements and some of the components that would be included in draft agreements for Community HealthChoices.
These include CHC coordination of care requirements, which relates to Medicare and med okayed coordination; continuity of care, meaning length of
time mentioned in the draft program requirement.
A lot of enrollment-related questions, that may or may not be directly associated with the draft agreement with MCOs but just understanding how

the process works.
Questions related to service definitions.
Some questions relating to grievance appeals and complaints. A fair amount
of suggestions on how to make the process work better.
Last certainly not least capitation.
When we get to the capitation section or cap capitation I will turn that over to
our expert who will provide detail on the comments and some of our current thinking.
>>KEVIN: Starting with coordination requirement, we received a lot of questions and suggestions on how to I am prove Medicare and Medicaid coordination.
Our intent is to require all of our CHC-MCOs to have a companion D-SNP which covers the service area. The object is to build a coordination platform that allows managed care organization the opportunity within the same plan's
framework to share information and create seamless conversion in the service
system.
The object in that requirement will be help facilitate seamless transition.
As a point of clarification, the participants enrolling in Community HealthChoices will not be -- there is no mandatory requirement that they enroll in a D-SNP or special needs plan Medicare special needs plan. The object is to allow the opportunity for this coordination, but participants in this
program will certainly be able to maintain their traditional fee for service enrollment if that is their preference.
What we will be looking to do is to maximize the regulatory authority we have for coordination with the managed care organizations. Also support MCOs connect and make enrollment process between Medicare and med okayed as straightforward and as uncomplicated as we possibly can.
To be able to facilitate a lot of this coordination we will be using our MIPPA agreement. The MIPPA agreement is an area state signs providing Medicare
advantage services in Pennsylvania.
We have opportunities within that agreement to require certain components of their service design that will help facilitate this coordination objective.
Through the comments process, we received a lot of suggestions on making

sure that we are building participant protections with the managed care organizations and also suggestions on how we can continue to better facilitate
that coordination while maintaining integrity of participant choice in this program.
As mentioned, we are looking to, through the MIPPA agreements and other areas of components to make model of care as consistent as possible between
special needs program and Community HealthChoices.
Medicare/Medicaid benefit package will remain as it is. We look to improve the coordination and opportunities will be to require and to encourage plan development that enhances that coordination wherever needed.
Where we have -- we have an example here where we talk about service coordination. In cases where service coordination is needed, we are looking to
encourage plans for participant enrolled both in corresponding D-SNP or special needs plan and Community HealthChoices-MC sop, there will be one
service coordinator working across Medicare and Medicaid program to coordinate services so that there is seamless management of their care when
they are enrolled in both programs.
As a matter of background, the vast majority of people will be enrolled in Community HealthChoices are dually eligible for Medicare and Medicaid.
A lot of comments we received wanted to make sure that that program is enhanced as much as possible.
>>PAT: Exefn can you explain what D-SNP is?
>>KEVIN: Sure. It is a plan that is designed specifically for people who are dually eligible for Medicare and Medicaid. It provides opportunities for people
dually eligible to receive enhanced services, if it's determined that clinical requirements or management requirements require enhanced services.
If people are familiar with physical health choices, there has always been a special needs unit in physical health choices. Dual special needs plan or DSNP
we like to call it, is an augmentation on Medicare side for focusing on the certain needs of eligible participants and making sure that the program components really do address special requirements for people who may have
augmented clinical needs to require certain higher level of service

coordination or care management and also require a better facilitation between their Medicare and Medicaid services. It would not necessarily need
a more traditional Medicaid program or fee-for-service Medicare and Medicaid.
>>PAT: Just hitting some of the questions coming in, another one they are asking for is what does MIPPA stand for and what does it do?
>>KEVIN: I would have to look that up.
>>PAT: I will Google it.
>>KEVIN: The acronym name doesn't --
>>JEN: [indiscernible] . We will look it up and publish it.
>>KEVIN: We will post it and speak it out.
This MIPPA agreement is a requirement that Medicare advantage plans have
to sign with the state to be able to participate in a state and provide Medicare
advantage services.
It allows states an opportunity to be able to include the Medicare advantage plans as part of their broader managed care service system and to take into
consideration state-level managed care requirement.
It gives certain authority to -- especially whether if comes to coordinating between Medicare and Medicaid services, opportunity to be able to streamline
enrollments and other types of service packaging that can improve the participant experience in both programs. That is really the way that we are hoping to use this MIPPA agreement.
The MIPPA agreement can be broadly defined to allow improvement in -- especially in the enrollment process and as much as design for participants and also data exchanges and information in exchanges.
We are trying to do all we can to maximize that authority between Medicare advantage plan -- special needs plan and the Commonwealth to make sure that that agreement does facilitate the best degree of seamless transition between the programs as possible.
>>JEN: We looked it up. It's Medicare improvements for patients and providers Act of 2008.
The idea of doing a MIPPA agreement is actually voluntary. States have the
choice of doing them or not doing them. Pennsylvania has been doing it since

it's been available.
>>Kevin: Right. Our current MIPPA agreement is pretty straightforward. It really is meant to be focusing on Medicare advantage and take it into consideration the fee-for-service system that exists for people who are dually
emI believe between Medicare and Medicaid there will be a change with the
MIPPA agreement and Community HealthChoices.
As I will mention a little later, we will be publishing the draft agreement for comment as we go forward and for suggestion. Great question!
It's a complicated area but it is critically important in Community HealthChoices -- and as mentioned -- the vast majority of the people enrolling
are dually eligible and affected by the agreement.
Some additional information -- some of the comments we received suggested
we really did need to augment what the coordination requirements will be with the Community HealthChoices MCOs, and with Medicare, and also with
behavioral health services and LTSS and the entire provider system.
We will be adding additional questions to the RFP, when it is published. We will talk specifically about that coordination most specifically with Medicare and Medicaid with alignment relating to the D-SNPs or dual special needs plans and also Medicare fee-for-service.
We will have the plan in this environment and based on their understanding of the system as it exists, how they are planning to facilitate and augment that
coordination for people who will be dually eligible and enrolled in the plan.
We will also describe tools used to underwrite the program.
One of the most important components of coordination between Medicare and Medicaid is a shared information system platform and we believe that if plans are given the opportunity to be able to share information, relevant information, that relates to coordination of care, that that coordination will be
enhanced.
The RFP will have question-specific -- we already included questions relating
to management information systems. We are planning to augment the questions to make sure that they are specific for the platform, associated with

the Medicare and Medicaid programs.
When the RFP is published, that is something you can foresee.
In addition to the coordination of care, we received a lot of questions relating
to continuity of care. When we talk about continuity of care, there really are two different ways you could be describing continuity of care. First is when people are first converted from the current fee-for-service system or current long-term services and supports system to Community HealthChoices and as
published in the draft agreement, the continuity of care period is 180 days for
that conversion time period.
There will also be an ongoing continuity of care period that reflects current stands in physical health choices; that is for people who are enrolled already
in Community HealthChoices and may be transferring from one plan to another; that continuity period will be 60 days as standard requirement.
Some of the comments we received on continuity of care related to specific services, one of which was service coordination. There was some confusion
whether service coordination is couldn't fewity of care provision. In the conversion period, service coordination will be part of the continuity of care period. Service coordination entities will be part of the 180-day continuity of care period during the initial phase.
The additional suggestions we received would be to look at different time periods with types of services and all of those comments are currently under
evaluations.
>>JEN: I just want to make note on continuity of care for service coordination. This was sort of a no-brainer for us because in Pennsylvania, we
pay for service coordination as a service. It actually gets billed as a service. It
is not an administrative cost. It made sense for us to put it into the continuity
of care provision.
>>KEVIN: Thank you, Jen.
As mentioned earlier, we received a lot of questions associated with the enrollment process. As a commitment to this third Thursday webinar we will go through with much detail the enrollment process in the near future.

As described, independent enrollment entity will be used in Community HealthChoices, not only to facilitate managed care choice, which currently exists in physical health choices, but also to assist in filling out application information and also scheduling and identifying people who may be in need of the level of care assessmentment or clinical eligibility screening process. The enrollment entity will be working with County assistance offices to help facilitate financial eligibility and working with participants and conflict-free entity and if a till Tate clinical as well.
Third Thursday webinars and other public sessions we will use conflict-free entity to be able to provide the service for clinical eligibility determining if a person is in need of long-term services and supports.
The county assistance office will continue to be involved for providing financial elogyibility determination issuing all notices related to eligibility and
ultimately being the entity of record recording final Medicaid eligibility for our systems.
Managed care organizations will be responsible for contacting the new enrollee within days of enrollment, especially if they are in need of long-term
services and supports; facilitating the development of person-centered plan that they are eligible for and providing comprehends itch needs assessment to
begin that person-centered planning process.
So all four of these entities are critically involved in the enrollment process. We will provide more details in the webinar following sessions. It is complicated and with he want to devote a great deal of time to go through the steps involved in the process and to be able to answer specific questions
people may have.
Service definitions were an area we received a lot of comments. A new service
is pest eradication we received comments and suggestions regarding that service and how it should be defined. We appreciate those comments. You can
foresee that they will be included in the final draft agreement.
Transportation is an area where we received a lot of questions, specifically for
the dual eligible population specifically, what is the role, for example, medical
assistance transportation program versus shared ride program and how will

non-medical transportation be provided for people who are eligible to receive
it if there are long-term services and supports.
We provided some of that language in draft agreement but revising it to make
sure that those services are clear.
Another area that we did receive -- we already mentioned service coordination as noted on this slide here. Another area we received a lot of questions was assisted living. We will be providing clarification and final draft
agreement to make sure that it is clear that assisted living is a service setting
and not an eligible service in Community HealthChoices.
We have received a lot of suggestions about the process associated with grievances, appeals and complaints. For people familiar with physical health,
health choices you would have noticed there is little differences.
In characterizing some of the suggestions they suggested a great deal of streamlining between Medicare and Medicaid. We agree with that and are going to look for opportunities to be able to do that. We will look for ways to certainly speed up the process.
I am going to characterize, in general, nobody -- none of the comments we received told us that the process that in physical health, health choices needs
to be drastically changed. The suggestions were, any type of characterization
they were tweaks. So we are going to make sure that we build on the successful approach in physical health, health choices when we roll out the grievance and appeal process.
>>JEN: I would just say, what we do know is that we want to make sure people understand the processes; that it is clearly articulated for them.
We will be working with a focus group to -- or a workgroup -- to come up with language that would go with those notices so it is clearly articulated for what they need to do. Sort of a cover sheet for legal language around grievances and appeals.
>>Kevin: Great. The last of the comment areas we are touching on I am turning over to Pat Brady who will walk us through this slide and the discussion we have been receiving.
>>PAT: Thanks, Kevin.

I will say, this is meant to be, by no means a technical detailed discussion on
capitation. I think, because of some of the questions and comments we received, we wanted to make sure that we provided some information to everyone that gave a high-level explanation of what is capitation? What is a per-member, per-month amount?
How can the managed care plans do creative things with that funding?
I will apologize in advance to any actuaries or MCOs that are on the webinar
and think it is making it way too simplistic.
Simply, when capitation rates are developed, the idea behind that is there is a
set amount that is paid by the Commonwealth for each member that's enrolled in a managed care plan; that is to cover all of the services under their
contract. How do they go about doing that? The historical cost for everyone who was covered by the program are pulled together. So those costs get extracted from whatever data is available and then the actuaries who were developing the rates make certain assumptions around the types of utilization
that might occur, what happens with some of the population.
Then once they have had that piece developed, then they are going to try to
create incentives to encourage that the departments want to happen.
So, for example, you know, some of the assumptions might be that there's incentives to encourage nursing home transition, use of community and home-based services, better care coordination and less unnecessary hospitalizations.
Just to go through a very, very simple example of how a rate may be calculated, let's say that we have 10,000 people that will be covered under our plan; let's say that those 10,000 people have costs that are -- equate to $120 million. So you would take the $120 million, divide it by the 10,000 people; that comes up with $12,000 per year on average for an individual. So then dividing that $12,000 per year by 12 months, you come up with $1,000 per member per month. So a managed care plan would get paid that
1,000-dollar for every member that is enrolled in their plan each month.
The thousand dollars is important to remember that it is the money the plan is
getting; it's not an individual cap; that's not saying to the plan, Oh, you

cannot pay more than $1,000 for that person; that's how Pennsylvania's waivers used to be set up years and years and years ago, where there was an individual cap and you could only spend so much money on a person, before they moved to a global cap.

This is more similar to the global cap on the waivers, where a plan is going to get the $1,000 for every member that is enrolled, then they can choose how they want to spend that money. It gives them flexibility. Let's say a plan has 3,000 members; that means they will get $3 million every month to spend. If one member costs $1,500 and another costs $500; that works out for the plan. Of course, they still need to cover administrative costs and other related expenditures, but in general, it's a simple example of how they can use some of their funding.

When the actuaries developed the rate, they need to think about what services are covered. We have been looking at what services are covered under the state plan? What services might have been covered under the waiver? They will develop those amounts.

What happens is, in the managed care world, they have flexibility in how they can use that capitation payment. So if a plan wants to use some of the funds that they receive to provide personal care services to someone who is at risk of a nursing home placement, they can choose to do that, even though the state does not make that benefit available to non-LTSS or long-term services and services consumers.

Within some ranges, the plans have some flexibility in what they can choose to pay for; that's how they can afford to provide some, what we termed, value-added benefits; things that wouldn't normally be covered under the state plan program or under a waiver.

>>KEVIN: Thank you, Pat.
With that, I will turn it back over to Jen, who will introduce our new community hell choices website.
>>JEN: Thanks, Pat. I just want to highlight something Pat said, that I think is an important takeaway for people.
That is the per-member/per-month amount that the plan receives is not the same as the amount of funding that they have available to them to develop a
care plan for an individual.
I have had some questions about that capitation rate being a maximum amount managed care organizations is able to pay for an individual's care plan. The two are not associated. I just want to really drive home that point because I think that's something that people have expressed concern about.
Okay. What you have before you now is our new health choices reorganized
website. It has the same information that the original website had on it but we
tried to make it a little bit more user friendly by offering those navigation tools on the right-hand side rather than rather than expecting individuals to scroll through the entire front page to find the documents they are looking for.
For example, we have, over on the right-hand side, you can see the communicated health choices concept paper. You can see the RFPs and the
program requirements, other supporting documents, all the third Thursday webinars have been archived, of course, the transcripts of the public hearings.
As we get material, we will be, again, adding it to this website. Where would
they find managed care organizations?
>>PAT: At the very bottom of the site.
>>JEN: Okay. The very bottom of the site is the information on the managed
care organizations.
Still read through the front page there. There are live links available that you
might want to take a look at.
As we gather larger volumes of documents, we will be putting them into the box in the right in grouping them and putting them in there, just to make it

easier.
I want to thank folks who are participating on this call who have, in the past, also filled out our evaluation forms. We have found those evaluations forms to
be providing us with good information about how to make improvements to these webinars.
I just want to reinforce, when you get that E. emails please fill it out.
We are trying to line up sort of a proposed schedule of third Thursdays so that
people can start planning for ones they think are of interest to them and get them on their calendars.
With that, that's the end of our content for today.
We do have a slide up here with resources, including the actual website, the
link to the Community HealthChoices website.
Separately from the Community HealthChoices website, we have a separate
managed long-term services and supports sub-MACC webpage, which takes
you to all of the documents related to the work we have done with the MLTSS
sub-MACC.
At the bottom of this, if you are not on the listserv and did not receive an announcement about the webinar, please register for the listserv.
This link that says register for a ListServ to stay up to date gets you to the place on the website with a lot of ListServs. You may decide to participate in
other ones. It is listed as Community HealthChoices?
>>PAT: OLTL-Community HealthChoices.
>>JEN: Feel free to sign up for that if you are not signed up and stay connected with the work that we are doing.
With that, I think we are going to open it up to questions. We have been compiling questions from all of those who are participating on the call. We have already answered two of them. I will turn it over to Kevin.
>>KEVIN: The first question is -- the question was asked whether or not the
petition has been made -- MLTSS consumer. They site specific system HCSIS,
SAMS or something else and do we know when it goes into effect.
I am making the assumption that the person is asking specifically the case

management system that willing be used in Community HealthChoices. HCSIS
and SAMS are both case management.
To be case management is part of the management system's responsibility.
With that being said, they may be using a version of is SAMS, but most likely,
the Commonwealth will not be managing that.
>>JEN: We are investigating some platforms that are available and looking at the inter-RAI tool, a tool out of the University of Michigan that we have been investigating. We are looking at case management platforms in terms of
long-term services and supports.
>>Ken: The platforms Jen mentioned will most significantly be involved in the way the plans would be collecting information for the --
>>JEN: For developing a care plan.
>>Ken: For the needs assessment we talked about previously and development for the service plan.
And then the expectation is that the plan will take that information and manage it and provide us with information we would need for managing our quality assurance program.
>>KEVIN: The next question: How will providerrers identify consumer selected when a service thousands of consumers.
Will there be.
>>CAPTIONER: Can somebody ask him to read questions slower, please?
>>KEVIN: Great question. It is our understanding we have systems that currently identify the managed care organizations that people are enrolled in
and we would be using those same systems and we will make sure that providers and managed care organizations are well-versed on that to present
the information.
The EVS system is currently available and provides a lot of the enrollment eligibility information people may need to be able to answer the questions and identify MCO information. We appreciate the question and more information to come on that.
>>PAT: You had a request to read the question slower by the captioner.
>>Ken: Thank you, Pat. I tend to talk too quickly. Something I've been working on my entire lis life.

In next two web nares -- part several there have been no mention what is plan
home modification portion of wares if there will be home modification broker,
if so, what is the plan if no company will take on that task?
At this point we are still planning to release RFP for home modifications that
will be out in the very near future and the plan will be to use home modification brokers to facilitate the home modification requirements to participants in Community HealthChoices program.
What that means is Community HealthChoices MCOs will work with brokers
to facilitate home modification requirements for participants.
If it does happen to turn out there are no entities to assume the role. I will say
in unlikely event that there are no entities in taking on the role of the home modification broker, then it may be an opportunity to look to the plans themselves to be able to manage that work.
I am going to stress once again, that that is an unlikely occurrence, because
we have had expressed interest in entities that want to -- [indiscernible] -- (noise in background).
>>KEVIN: I apologize reading too quickly. Hopefully that last question was an improvement.
[LAUGHTER]
The next question, I am not sure I completely understand but I will -- will CHC affect people in the waiver programs?
All of the people who are currently receiving services in the long-term living home and community-based waivers will be enrolled in health and Community HealthChoices.
If they are long-term services and supports and receiving their services in home and community-based waivers. I will read them off and make sure that I
get them all this time; that would be aging waiver.
OBER waiver,.
Independence,.
Attendant care waiver.
ComCare.
All of those waivers will be included in Community HealthChoices.

Next question is MCO applicant does not currently operate dual special needs
plan in Pennsylvania or geographic area for perspective CHC-MCO can they
still apply to become CLC-MCO, if not is Pennsylvania limiting contract with dual special needs program?
The point they are making is the plan may not have enough time to obtain CMS approval to be in dual special needs -- (noise in background interfering
with audio) -- what we are doing is evaluating time line required for approval
for CMS to determine if we need to include flexibility in the language.
There will be more to come on that. Be very clear, we are looking for the opportunity to maximize as much participation with managed care organizations as possible, if this is a limiting point we will look to flexibility in the way that we release RFP and vocalize in the draft agreement.
We are going to require plans in Community HealthChoices to be special needs plans with the question that the date that that requirement would have
to be in place.
The next question: How does D-SNP -- I will just use D-SNP from here forward -- how does it affect existing service coordination in agencies when CHC rolls out?
As Jen had mentioned earlier, we are planning to have the service coordination entities to be administrative function of the plan, regardless of how they decide to contract out for that service.
The thinking is that if a person is in need of service coordination and they are
dual eligible, the plan is if they happen to be enrolled in both the D-SNP and
the CHC-MCO, they are enrolled in both programs and same umbrella MCO,
they would look to have that service coordination function be consolidated.
The existing agencies that would be contracting to perform the service with the Community HealthChoices program would be looked to be able to coordinate this service for both programs.
I think the plans themselves will look to frame out how that process would work. I think that that would be an area where the existing service coordination agency would see a change.
Next: Just confirming the MIPPA agreement will be published in draft for

comment.
To answer that, yes, that's correct. It will be published in draft for comment.
Moving on.
We have a lot of questions. Hopefully we will have enough time to get through them. Part of the time I like to read them so quickly -- [LAUGHTER]
Explain how service coordination will differ from care coordination by the CHC-MCOs.
Great question. A area we received a lot of questions and comments. The way
I will explain it is that it is more related to the plan process itself.
Care is generally coordinated with physical health services and services where
people may have a particular diagnosis that requires a degree of coordination
like, for example, type I or II diabetes. Service coordination is more directly associated with long-term services and supports.
The assumption is that the plan will look for opportunities to be able to facilitate broad communication and team-based approach when it comes to these two services. When they talk about developing a person-centered service
plan or a plan itself, the umbrella requirement for planning will make sure that both of these components will be included.
So there is a distinction between the two, but there is a lot of coordination that would have to be occurring between the two; that is one of the advantages of managed care because in both cases, the same entity, the managed care organization, is responsible for both of those services.
Next question: What happens after coordination of care period? Most states
under managed care do not have service coordination agency anymore. Are --
[indiscernible] -- phased out like other states?
I will answer the question. It's a great question. The expectation service coordination will be a function of the managed care organizations an administrative function. It will not be phased out. Its role will be different than it is as a fee-for-service service in our current configuration but not be phased out but under administrative management of the managed care organization.
Next question: You may have mentioned this somewhere along the line, but
who will be the independent enrollment entity?

Currently, we are going to be -- the plan at this point is to procure the function of independent enrollment for Community HealthChoices. We have an enrollment broker that supports our fee-for-service waivers that independent enrollment broker is current Maximus. It is assumption that the enrollment agency will be procured. More information will be coming in the very near future about the procurement process.
There was a procurement process in serial 2015. We made the agreement to --
the original procurements did not broadly cover the -- Community HealthChoices we recognized we need new procurement.
Next question: How will independent enrollment entity work with the LIFE program?
Great question!
The LIFE program is going to be presented by the independent enrollment entity as an enrollment option to Community HealthChoices. Community HealthChoices is the mandatory program. LIFE program is the voluntary option.
The independent enrollment entity will be providing -- or presenting the LIFE
program as enrollment option to [indiscernible] (background noise) -- longterm
services and supports.
Next question: Do you have a specific number of days for managed care organization to contract take place?
I am not completely sure I understand the question.
>>Jen: I would assume it means after we receive proposal back the amount
of time it takes to go from that gointd -- [indiscernible] (back ground noise).
>>Kevin: We are allowing a 60-day -- we apologize for background noise --
>>JEN: It might be the heat. Radiator.
>>KEVIN: Procurement question, plan has 60 days return proposal to us after the RFP is released.
It relates -- if for long-term services and supports entity that is notified that individual is going to be part of their plan, the managed care organizations will have a very specific time period where they have to be in contact with the
member to be able to pro [indiscernible] (background noise).
We mentioned meet-and-greet with comments -- finalize that date in the very
near future.

Next question: With four eligibility processes, will they run concurrently in order to shorten eligibility determination? What is proposed time frame for complete eligibility's determination?
This is a great question. The expectation is that they will run concurrently. The proposed -- the current independent enrollment contract we wanted the
eligibility determination to be completed within 60 days. The federal standard
is 90 days. We certainly don't want to take 90 days. The current contract standard is 60 days we will look for every opportunity to shorten that time frame as quickly as possible in the new procurement process.
Thank you very much for that question.
Next question: In determining capitation rates, will the state also look at historical data from the dual special needs side and does the state have the data from the dual special needs plan?
I am going to speak generally. We have access to Medicare data. We are gaining access to Medicare advantage data.
For capitation rates, since capitation services are really for the Medicaid program the primary focus is development of those rates will be looking at Medicaid historical data and other data we might be able to receive.
The focus of the development of the capitation rate will be primarily on Medicaid data.
Pat, is there anything you would like to add
>>PAT: I think as you move forward, there will be some review of the Medicare side of things to help in providing the Commonwealth some of the benefit from reduced hospitalization.
>>JEN: Right.
>>PAT: As a result then, you may be able to negotiate some benefit from the
imagined care plans.
>>KEVIN: Thank you, Pat.
Next question: As an advocate, how and what protections do we have to ensure consumers receive needed services.
It is a very broad question. In the contract itself, we do have participant protections that are delineated and we also have a lot of regulatory productions that exist that will continue to exist that serve as protections for the participant.
The role of the Commonwealth itself will be not only -- will be really evolving
as well, where we are going to be moving away from the direct payer of

services and management of entity to fee-for-service where we will have an oversight as well.
The new role is to ensure participant protections are in place and consumers
are receiving needed services.
It is an opportunity for us to really focus on role and making sure that the protections continue to be in place.
>>JEN: I would also say that the managed care organizations have -- certainly have an incentive to keep people healthy and living independently in
the community.
One of the goals in the program -- stated goal by the secretary is to serve more
people in the community.
So I think that there is a lot of -- there will be a lot of precautionary measures
put into place that will support people to live independently and live with the services that they need to do so.
Again, managed care is organizations really have incentive to keep people living safely and living independently in the community, because, in general,
it is to their advantage. It also keeps -- it's also a good thing for marketing.
They will want to attract people who want to use their managed care organizations, so they will want to provide the services that are needed to support people to live independently.
>>KEVIN: Thanks, Jen.
Next question: Will these capitations be determined by waiver type?
Capitation will not be by waiver type. There will be broad considerations for dual eligible requirements. If they are not in need of long-term services and supports and for those who are.
Specific characteristics that are represented by the home and communitybased
waivers will be considered, especially in terms of existing historical utilization, but waiver type itself, it's not a direct variable in the capitation calculation.
>>JEN: Right.
Ultimately we will have Community HealthChoices waiver that supports all people who need services.
>>Kevin: Great.

Next question: As a provider, do we have a connect to MCO to apply to be a
provider or will they contact us to work with them as a provider?
Our recommendation is not to wait until the MCOs contact you. As mentioned
earlier, the information is published on our website. Providers interested in participating in Community HealthChoices going forward are suggested to reach out to them and let them know who you are and be as proactive as they
develop their network.
The next question: How does the statewide transition plan fit into all of this?
I am not completely sure of the question.
>>PAT: This is home and community based goal.
>>JEN: The statewide transition plan is a -- has been posted. It was posted last week or maybe a week and a half ago. It is out for public comment right now. It was also published in the Pennsylvania bulletin. The statewide transition plan is something that we will be folding into Community HealthChoices. We are going to have to on 1915-C side of Community HealthChoices, because we will be seeking 1915 (c) waiver in order to implement Community HealthChoices the statewide transition plan will be part of that.
>>Kevin: The only thing I will add, correct me if I'm wrong, Jen, the statewide transition plan, we have a period of time where we go through a transition process. Our objective with Community HealthChoices waiver is to
continue with transition plan as it exists.
If we were planning to apply for a new waiver, we would be required to have
the framework in place by day one. We are planning to continue with the transition plan.
>>JEN: Yep. That is out for public comment. Once it's 30 days public comment is over the department will be making changes based on comments
we received and then submitting it to CMS.
>>KEVIN: Next question: Individual ACBS home or community based categories continue under Community HealthChoices?
I am assuming here they mean the existing waiver categories. As mentioned
earlier, individuals who are in need of long-term services and supports, they

will be transitioning into community health choices.
As Jen mentioned, we will have one Community HealthChoices 1915 (b ?ie.
c) waiver.
>>JEN: Called con current waiver.
>>KEVIN: Categories were developed for existing fee for service waivers will
be all merged --
>>JEN: Folded into Community HealthChoices.
>>KEVIN: To answer question specifically, the existing categories, developing a person-centered program so the population categories that we
used for the existing waivers will be as Jen mentioned rolled into the 1915 (c)
waiver.
>>JEN: As well as the services.
>>C Kevin: As well as the phs ises.
Next question: Are you considering offing comment health choices access to
ombudsmen? That's still under discussion at this point.
Next question: Can you review Department of Human Services current thoughts on service coordination and the service coordination supervisor requirements that will be included in the RFP? It is a great question we received a lot of comments regarding credentials. Just to be very clear, these
comments came from a broad range of individuals interested, including service coordination agencies currently providing services in our fee-forservice
waivers, as well as managed care organizations and other types of providers.
For that reason, we are going to be forming a workgroup focused on this issue
and credentials to see if they need modified or changed.
That workgroup is evolving out of the managed long-term sub-MAAC members in that group and convening in the next few weekends.
The plan is to have that group convene before the request for proposal is published.
Next: How will the conflict-free entity determine clinical eligibility be held accountable for that mandate?
I am not sure what they mean by that mandate.

Role of conflict-free entity -- they are actually going to be assessing elogyibility determination, which is always a function of the Commonwealth. To be very clear, when we talk about eligibility functions, that is definitely a function of the Commonwealth.
Conflict-free entity will be providing the assessment that will be determining whether or not a person is in need of long-term services and supports.
How will they be held accountable for that mandate? Their results will be determined by -- there will be a lot of measures when it comes to quality assurance.
One area of measure will be certainly the number of appeals that occur that are relating to the determination -- or the assessment for long-term services and supports.
Other opportunities will be the length of time it takes for them to complete that assessment. The consistency with which a particular -- providing assessment provides against standards we will be setting against the service
from a statewide perspective.
Jen?
>>JEN: I would add that there would be a contract in place between the department and the conflict-free entity, which will play out, not only deliverables in terms of time frames and expectations around testing for things like interrelated viability and reliability of the tool, but also there will be an expectation within the contract that there is reporting that is done to us
in which we are measuring all of those things that Kevin just laid out.
>>KEVIN: Thank you, Jen.
Next question: When do you expect to issue the request for proposal for financial management services, and is the start date for financial management
contract January 1st 2017 with roll-out Community HealthChoices in the west?
The answer to that question is, at this point, we are evaluating the requirements for the request for proposal for financial management services.
We are not in a position at this point to publish that start date. More information to come on financial management services.
>>Jen: In the very near future.
>>KEVIN: We appreciate the question.
Next question: The Community HealthChoices proposed RFP announcement

also suggested people should commit on long-term services and support service package and whether or not were adequate and if other services should be considered.
Can you reflect on these comments that are under review? Is the state considering adding new community-based LPSS services based on any of the
comments?
We actually received a lot of comments under service definitions that were published but we didn't receive a lot of comments on new specific types of services.
One area we received comments outside of the formal comment process related to pester rad indication clutter irradication. People would be made available for a service to help remove clutter from their home that could lead
to health and safety issues. We are considering that as an augmentation of the
service.
Other than that,.
>>JEN: Value-added --
>>KEVIN: Within the contract framework, Jen was suggesting there are always opportunities to add value life added services. The managed care organizations will be looking for opportunities and suggestions to be able to do that.
Next question: What if a person is in a nursing facility paid for by Medicaid but CHC-MCO cannot agree on payment to keep that participant there? What
happens?
So the there will be a responsibility on both the nursing facility and managed
care organization to come to an agreement on payment. The assumption is that they will be able to come to an agreement in terms of payment, especially
if the person is part of the grandfather provision, part of the conversion into Community HealthChoices at the point where there their geographic region is
rolled into the program.
The expectation is that they will be able to come to an agreement.
>>JEN: The department really has a commitment to making sure that people
who are currently residing in a nursing facility do not get dislocated and get

moved against their will. They may choose and let the managed care organization know that they are not happy with living where they are. On the
other hand they may say I am perfectly content where I am and I want to stay
here. We agree that that kind of disruption should not happen.
>>KEVIN: Our expectation is that managed care organizations and the nursing facilities do come to an agreement to make sure we meet the expectation.
We will make sure that the agreement occurs. On the individual cases where
there is some problem, we will cross that bridge when we come to it. Most likely it will be the case where we have to be engaged.
>>JEN: Right.
>>KEVIN: We are thinking that those terms can be finalized between the two entities.
Next question: A provider rate-setting plan was not released in the draft documents. Will the document be setting provider rate floors as -- with MLTSS.
We didn't release rate-related statement because it is still? Development. The
rate setting process for capitation is complex and will most likely not be finalized until early spring of 2016.
The process itself has not been finalized. [indiscernible]
Will the department be setting up provider rate floors -- this has been a point
of discussion. No decision has been made at this point about rate floors. We
certainly received a lot of comments in this area.
Next question: If a person is in a nursing facility under spend-down and wants
to transition into the community would not be eligible for [indiscernible] in the community? What happens?
Great question.
We continue to look for opportunities to have home and community-based spend-down program. We have a lot of questions about modeling -- at this point if they want to be able to transition into the community and they are in the spend-down process, it is a challenge; that challenge will continue in Community HealthChoices, unless we can find the keys that would help us model and make a more predictable case for home and community based

spend-down. We are looking for input. We have been working with a lot of external entities looking for suggestions. We are definitely making clear we are very much open for suggestions on how to make it work. We are looking
for a model that will be successful.
[indiscernible]
We recognize it's value. We recognize that people who want to be able to stay
in the community but still need long-term services and supports, are disadvantaged. I can't say often enough that we are going to [indiscernible]
We have about seven more minutes. We will continue to go through as many
questions as we possibly can but we may run out of time.
Question: You said people do not have to choose to enroll if they receive a waiver such as OBRA. Can they choose to not be included in community health choices and not under jurisdiction of MCO.
To be very clear when we talked about choose to enroll, that was for Medicare. There will be no requirement of enrollment in special needs -- or Medicare advantage plan.
Community HealthChoices will be mandatory involvement, meaning people who are envolumed in the OBER waiver long-term services and supports they
will be included in the mandatory program.
I appreciate the question to be able to provide that clarification.
Next question: Please clarify about assisted living. May a consumer use their
Social Security to pay for room and board and have community-based services
provided to them in that setting? The hope is that we are hoping to have assisted living as eligibility setting for home and community based services --
>>JEN: We believe our regulatory framework allows for that in the 1915 (c) program.
>>KEVIN: We think that would be allowable and will continue to evaluate whether there are concerns with that, but we are looking at that for an opportunity for augment takings for home and community-based services.
Next question: How long will you be accepting comments or feedback via the
mailbox? People can continue to send questions or comments into the mailbox

as long as it is open.
We closed our comments for the November/December documents we published, but we will continue to receive and respond to those questions as
they are received.
>>JEN: That RA mailbox will continue to be available through -- even after Community HealthChoices is up and running. We will continue to have that.
>>KEVIN: Next question: How will we know when the RFP for home mods is
released? It will be published -- we will make sure that we have a link on Community HealthChoices website and our DHS website.
It will be made available where the DGS website where they are normally published.
Just continue to go to our website and look for the link. We will make sure that it's available.
Next question: We are a home and community based provider of personal care services we have been following all of the info available the managed care organizations are chosen will we be responsible for contacting MCOs?
I think we answer this question: Yes, you will be responsible. You should be
proactive as possible and look for the contact information on our website to do the outreach. The recommendation is to be proactive.
Next question: Suggestion: Would it be add advantageous to have one to two
care management systems rather than a dozen [indiscernible]
Great question. As Jen had mentioned earlier, I think we will be providing the
framework for how the comprehensive needs assessment is developed. The
comprehensive needs assessment will feed into the comprehensive service plan, which will have standards. I think it would be the advantage the of MCOs to have one or two. It would be the advantage of the Commonwealth to
have the plans using those systems because it will be easier for us to be able
to communicate with them and develop standards for transactions.
That being said, it's my recommendation that people who have suggestions do
reach out to MCOs to have this conversation with them and we will continue

to have this conversation with them as well.
>>PAT: Kevin, this is a question that was asked from a couple people relating to that as well as outreaching to MCOs about contracting, the question is: How will they know what MCOs are serving each geographic region? The response I sent sent back to a couple individuals is, the departments really will not know will the plans respond to the RFP.
What they may want to do is reach out to each of the HMOs that have expressed interest and are listed on the website and ask them if they are interested in serving specific geographic regions.
>>KEVIN: Thank you, Pat. He with are running out of time. I will try for two more questions. We have many more. Unfortunately we will not get to them all but find a way to publish the answers to the questions, as soon as possible.
Next question: Will reimbursement rates to providers remain the same? The function of reimbursement rates will be between the managed care organizations and their network providers. So at this point, we cannot guarantee they would remain the same. They would be part of the negotiation
process with provider networking.
Next question: Do current revalidated providers need to do any other type of
enrollment/application with the managed care organizations about waiver, ComCare, et cetera.
The response to that question would be that we are looking to be able to use
as much of revalidation process as possible. We are also looking to use as much of the revalidation process as possible to facilitate the credentialing process.
It is possible that there might be additional questions that the plans may need.
Part of their own credentialing process. We will look to do it on the revalidation, the work that has been done as much as possible.
So there is the possibility, but we are trying to build on that as much as possible.
I think I have time for one more: Last question: Currently the home and community-based service coordinatation entities take care of person's plan and home modifications. It seems these rules will be the responsibility of managed care organization. What will the role of service coordinator be under
Community HealthChoices program?

Great question. As we mentioned already, service coordination is still a requirement of thing managed care organization. It will be an add markettive
function of the managed care organization. the current service coordinators will be working for the -- assuming that's continuation of the plan to follow -- current service coordinators will be working for the plans, managing directly for the -- [indiscernible]
>>JEN: It could be that that is done through a contract with the service coordination entity. There are different configurations that the MCOs may choose in terms of making that happen.
A reminder that the service coordinators will have continuity of care that they
will be responsible and required to contract with service coordination entities
for that time period; so that continuity of care 180 days.
During that time, managed care organizations will be evaluating the quality and the service that is being provided during service coordination entity.
We are not really sure what the final discussion will be it could be hybrid where they have service coordinators that work for them or others that work for agencies that they contract with.
It may purely be for long-term services and supports entities they contract with. We just don't know. It will be the choice of the managed care organizations through evaluation of this current service coordination entities in 180-day period.
>>KEVIN: Thank you, Jen. With that being said it's all of the time we have for questions.
I will turn it back over to Jen to give closing remarks.
>>JEN: We are out of time. I just want to thank everyone for participating today. We had several hundred people on the webinar and we are really committed to trying to keep people informed of what our current thinking is and where we are taking community health choices.
Our next webinar is on the 3rd Thursday of February; that is the 18th of February. We hope that you will jump on to that call and set aside this time period for participating on the call.
Thank you very much.
With that, we are going to hang up.
(Webinar included at 3:02 p.m.)
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