

# StreamBox

DATE: 6/16/16.

EVENT: Third Thursday MLTSS webinar.

>> **KEVIN:** Good afternoon, everybody my name is Kevin hand Court or counsel with the Office of Long-Term Living.

Before beginning, I would like to make sure people participating on the phone

can send a mess aiblg ifage if they are not seeing the screen, that says welcome to the third Thursday MLTSS webinar. It says CART is available by

clicking here: [Http sph://archivereporting.1capapp](http://archivereporting.1capapp).

To start with housekeeping, as we normally do, before we get started, I would

like to go over a few items so you know how to participate in today's event.

We have taken a screen shot of the example of the attendee interface. You should see something that looks like this in your own computer desktop in the

upper rand corper.

To go to the go-to webinar viewer to see the presentation. To the right is the

go-to webinar control panel to select audio mode. If it is -- if it is in control panel and is closed, you will see the slim red rectangle click on the red arrow

to expand.

If you are listening in and your computer speaker by default, if you would prefer to join over the phone, just select audio in audio pane and the phone number will be displayed.

You will have the opportunity to submit text questions to today's presentation

by typing the questions into the question pane of the control panel. You will send in your questions at any time during the presentation. Attendee control

panel will click automatically to keep open attendees can click menu and click

auto hide control panel.

Moving on to the next slide, you can control the text to suit your needs.

With that, I will turn it over to Jennifer Burnett. She will go through the agenda and then we will begin the presentation. Thank you.

>> **JENNIFER:** Good afternoon, everyone. I am Jennifer Burnett the deputy

secretary of the Office of Long-Term Living. I want to welcome you to the  
1:30-3:30 Remote for OLTL Transcript

third Thursday webinar. Thanks for being with us today.

If you look at the agenda, we are going to be touching on a number of things

and then we will, at the end, as we always do, open it up for questions.

We are going to give you information about the updated time line. I'm sure in

of you have heard the announcement but we just want to make sure that everybody has.

We are going to go over some of the Department of Human Services priorities

through implementation and I think that's an area that we are really starting to turn our attention to and spend a lot of time with with our staff.

We want to talk about the comparison of the role of the Office of Long-Term Living in a fee-for-service delivery system versus managed care delivery system.

We want to talk briefly about how people enter into the program. I am going to touch base, again, even though we have already had some -- a previous third Thursday webinar that was relatively focused on the coordination with Medicare, we just want to keep that one on everybody's radar. We will also do

a quick briefing on the Community HealthChoices evaluation, talk briefly about the role of the extent quality review organization or the EQRO, then we

will touch briefly on the Community HealthChoices waiver, before we open it

up to questions.

With that, I am going to go ahead and turn it over to Kevin to talk -- to give you some information on the updated time line.

**>> KEVIN:** Thank you, Jenn. As you see on your screen we will go through the five phases that are associated with the Community HealthChoices rollout.

On this slide, you will see the first two of those phases. The first of those faces

was the program design phase. We have it noted here on the time line as progressing from May 2015 through the early -- Oregon the mid-winter 2016.

It provides stakeholder engagements that jeep discussed in previous third

Thursday webinars associated with discussion documents, listening sessions, the publication of concept paper and the publication of the draft RFP and draft agreements and all of the comments we received from all of the documents and all of those listening session.

Program design was basically framing the requirements of the program, stakeholder agreements and discussions reviewed with other states and information gathering helped frame out what led to the next phase, which was the actual publication of the procurement documents and the process we are in right now, which is plan selection.

Procurement phase Gannon began on March 2nd. We received proposals, 14

proposals as publicated on May 2nd and are in the scoring process for those proposals.

As you will see with the large green arrow we are in the middle of the procurement selection process.

Moving on, you will see that we will be moving after finishing procurement phase into the readiness review phase which discusses plan operations for enrollment transition, coordinate mailings and planning, LTTSS and service delivery, information systems and network adequacy.

We will validate they are meeting all of the requirements they propose they

will be meeting as well as our requirements for physical they will have, long-term

services and supports for Community HealthChoices population specific to southeast region and each will have its own readiness review process every

single zone will have a new phase important to know that because as we progress through this and especially in the last phase, we will be doing screening review processes simultaneously.

As noted, we will also southwest readiness review process and have overlap

with southeast review as Deb alluded to earlier the implementation moved from Jan 1st 2017 to July 1st 2017. We are still planning on implementing southeast zone on January 1st, 2018 there will be two overlap between two actual review phases.

The end of the readiness review is triggered by the go, no go date will

be the decision made by DHS executive leadership that they met the

requirements to go into implementation and go forward. Once that date is met and wants the plan -- essentially pass readiness review process, then we move into the implementation phase. The implementation phase involves overseeing activity for transition all includes notices. They may also need to receive notices prior to that date, but the most of the communications that's directly related to transition itself will take place through this enrollment process. It will also be period of planning for and implementing the continuity of care period, which, as we mentioned previously, it is a period when the existing plan of services for participants will continue on into a period after we go live with Community HealthChoices. It will also involve plan selection and plan choice and discussions with participants to make sure that we minimize auto assignments for plan selection as much as possible. The last of the phases after implementation successfully is completed will be what we call steady state operation normalization, when we move into the overing Sibert monitoring for the managed care contracts; that would be when the person-centered service plans are fully developed and going to be managed by the organizations themselves and then participate apts who are receiving LTSS or the dully eligible recipients will be fully engaged in the managed care organizational network. Those are the phases as mentioned before, to move back to the previous slide, we are right in the middle of the CHS procurement implant phase. We will not go through the two phases again because we have completed design procuring statewide for all five of the zones but we will, for each of the zones, be conducting readiness review, implementation and then move into steady state operations. So, we are reminded of the dates and making a change and reflection of the decision that was made to move the southeast from January 1st 2017 to July 1st 2017 we -- these are the dates for the zones for the entire CHC roll-out.

The remainder of the state will be January 1st 2019. That would be for Lehigh-capitol, northwest and the northeast.

So in discussion of time frame and some of what we are planning to accomplish with additional time, obviously it gives us more time with our systems. We had really solid plan in place to be able to implement on January

2017, but this gives us opportunities to increase automation and increase overall efficiency in the way that the roll-out will take place across the state and also allow us to consider other opportunities for automation of the endrelated

services for Community HealthChoices. It gives us additional time to ensure adequacy, additional time for development distribution, communication of member, materials and services.

It will give us a lot more opportunity and we plan to take null -- I'm sure Jenn

will talk about this in greater detail -- full opportunity for the additional time for additional participant communication with caregiver, education for providers as they go through the transition and communication with opportunity for providers in given geographic areas.

Also, lots of opportunity to speak with the public in general about what Community HealthChoices is and what it will be accomplishing.

Also, it will provide better opportunities for the Department of Human Services to train staff, coordinate between offices, including the office of medical assistance programs, key partners in this process and another crucial

partner will be the office of mental health and substance abuse services and

building out a general sense of streamlined health choices oversight and community choice health oversight as we move forehead.

Some of the priorities for Community HealthChoices, specifically in implementation phase as we go forward -- you will hear this throughout the implementation process -- we will ensure no interruption or disruption of participant services. We will make sure that the providers get paid throughout

the implementation process. We will assure network adequacy, which will be

part of the work we will do in partnership with the Department of Health. We will limit MCO out owe-assignment and participant MCCO choice, limiting assignment in this process making sure that the participants can as much as

possible make their own selection, which is a key component of the  
emplenty  
satisfaction.

Moving on to steady state is to improve service quality, improve provider  
performance based on quality, improve innovation and do everything we  
can

to make sure that the move to Community HealthChoices will be a positive  
participant experience across the board.

Just touching on some of the changes that will be reflected when we move  
into Community HealthChoices; that's what this slide represents. When we  
move into Community HealthChoices, right now in the fee for service  
environment, we have one-to-many relationship with the Office of Long-  
Term

Living and providers.

While we believe we will be successful in managing that relationship, one  
of

the challenges we have is that it limits our opportunity to focus on the  
participant and experience in our programs.

We -- the provider relationship -- one-to-many relationship with providers  
requires a lot of spifng provider oversight.

What we would like to do as we move forward to Community  
HealthChoices,

is to allow the MC Os manage the provider network and a larger part of the  
provider relationship. It will give the Office of Long-Term Living more  
opportunity to be able to focus on the participant experience and making  
sure

we are doing all we can to augment the quality and opportunities for service  
coordination for the participant, especially participants who are -- well, not  
specially, but certainly in view of participants duly eligible and of course,  
those leaving long-term services and supports.

With that, I will turn it over to Jenn Burnett who will talk about some of the  
goals for population.

>> Jennifer. Thanks, Kevin.

As you just heard from Kevin there's a lot of work happening here at the  
Office of Long-Term Living and in the Department of Human Services to  
build

out our capacity to be able to do this.

He mentioned some of the priorities that we have now that we have been --  
the decision has been made to postpone the initial enrollment and initial  
kickoff

in the southwestern part of the state by six months.

I just want to reinforce the opportunities that that presents us with here at OLTL and in DHS.

We view that as a tremendous opportunity to be able to more fully develop materials that will go to the people who will be members of managed care organizations so educational materials, materials to make sure that they are

aware of what is going to be happening to them.

We have a particular interest in making sure that those who are duly eligible

for Medicaid and Medicare are not -- and not currently in long-term services and supports system. We want to make sure that they are made aware of this

change so that -- to really reduce confusion for them.

There's just a lot of opportunity for doing a better job of communicating with consumers.

We have -- we hope to engage our partners that are made -- that have, you know, put up their hand to say, We want to help you with this, including the Pennsylvania health funder collaborators and many, many disability organizations, organizations representing seniors have indicated that they really want to help us make this a smooth transition.

You know, the overarching opportunity here, with this extension, is a smooth transition.

The second thing Kevin touched upon is the readiness review and having a robust solid time line with January 1st implementation in southwest part of the state. The readiness review process would have been trunkated. This six

months gives you us the opportunity to get into the details Kevin just talked about in terms of our readiness review.

We are looking forward to that.

Then, the last thing I just want to touch on. He has mentioned it but I want to

reinforce it, that we at OLTL really have to work hard to make sure that our staff is ready for this new body of work. We have been -- we had a meeting yesterday with all of the staff and kind of laid some of this out. We want to work with the staff to make sure that they are comfortable with what this means for them. That they understand what their role is, that they get the training they need. All of those kinds of things are kind of -- all of those things

are -- we have a better opportunity -- an opportunity to do a better job of that

because of this extra six months.

The real reason why we decided -- the real focus of this change really is about

making sure that we get to everybody who is going to be affected by this, all

of the consumers and participants and members, all of those folks, we want to

make sure that that is happening the first eligibility notice that they get is not

the first time that they have heard of it.

So I just wanted to reinforce those things.

I want to talk about the goals will by population, I have that slide up here.

The first population that we should talk about are nursing facility residents.

If

you remember, we said in the RFP that nursing home -- nursing facility residents will not be forced to leave the facility that they are in, if it is a good fit for them. They will have an opportunity to leave if they want to.

We have the first bullet of enhanced transition opportunities that will certainly be a focus as we roll out Community HealthChoices.

For those individuals who are comfortable and not interested in moving, we will not be forcing anyone to move. So that availability -- I was recently at a meeting where an older woman who lived in a nursing facility let me know loud and clear know she didn't want to move. She came to the meeting because she thought Community HealthChoices meant she had to move and I

reassured her it did not.

We are continuously improving quality of care and quality of life for nursing facility residents. With he think there will be opportunities in this new managed care delivery system continuous quality improvement to insert managed care organizations make improvements in their care.

You will recall we have the five waivers, five home and community-based waivers. They will be consolidated into the Community HealthChoices waiver.

We believe under -- one of the goals under Community HealthChoices is to improve quality of life for those individuals and also the addition of additional

services have been added.

For example, pest eradication.

We will be doing a lot of work to make sure that the managed care organizations understand what we mean by person-centered planning, including person-centered goals.

We will be, working with colleagues in other parts of Department of Human Services to tap into the resources that are out there around person-centered planning; that's important.

Another area, which is sort of a focus that we want to have in Community HealthChoices is making sure that people have employment goals if they want

them. If they do have them, that we support them to achieve those goals. And then the nursing facility ineligible the dual eligibles I spoke of earlier --

I think last month or in the last two months we did have a Morrow robust connecting Medicare and Medicaid can really help improve coordination of care and coordination of services; that the outcome of that will be improved participant experience.

You may recall some of the statistics in that presentation. Tee e up a couple of these. If you compare Medicare only or duly eligible for Medicare and duals for Medicare and Medicaid are four times as likely to be institutionalized in a

nursing facility or other institutions making. Connection through this dual eligible concept we can provide better care to them and make sure they stay out of nursing facilities.

Another area for this improved coordination between Medicare and Medicaid

for duals is the is the opportunity for doing a better job of managing chronic conditions and also for doing a better job of preventive care. I think there is a

lot of opportunity for all three of our populations.

I want to Dauphin County about the responsibilities here at Community HealthChoices. There are a number of procurements in the work. The first one

I want to talk about is the independent enrollment broker. The independent enrollment broker will have additional responsibilities to what

they have today in the fee-for-service system. They will become experts on thing manied care plans that we procure; they will be responsible for providing managed care choice counseling. Once an individual makes their choice, they will be possible for sending the application package and the other

thing that they are going to be helping with is advanced plan selection.

They will have independent enrollment broker will have information on Medicare but they will not be Medicare experts. They will refer individuals to

Apprise through the areas agency on aging. The Apprise counselors are really

Medicare experts. If an individual has a number of questions about their Medicare choice, we would want to be able to refer them to Apprise for Medicare counseling.

Maximus is currently the vendor for the IEB today. We are finalizing a request

for proposals for procurement of a new IEB for Community HealthChoices.

The procuring independent assessments, we are going to be engaging with an

independent assessment entity who will conduct out reach and education to

participants in advance of Community HealthChoices. They will also be determining clinical eligibility determinations, which is the determination of whether or not somebody needs long-term services and supports.

So we expect that to be something that you will be hearing more about in the

future in the near future, I just wanted to put it on your radar that it is part of the infrastructure that we are creating to support Community HealthChoices.

Education and out reach materials will stress the importance of making Community HealthChoices/managed care organizations plan selections with

the IEB prior to implementation.

The county assistance office will continue to conduct the financial eligibility and the criteria for financial eligibility as well as the processes at least for the

time being will remain the same.

We are exploring opportunities for automating some of that but it's down the

road. CAOs will continue in the role they have been fulfilling.

I wanted to talk about what Medicaid LTSS syst community hell conditional looks like. It will be Don by a conflict free facility for people under 60 as well as 60 and over.

The financial eligible is determined and conducted by county assistance office for both ages.

Enrollment and options counseling will be conducted by the independent enrollment broker, which includes those folks under 60, as well as 60 and over. I tell you on the the 60 and over side we only recently transitioned that

responsibility from the Area Agencies on Aging. This started on April 1st to the independent enrollment broker. We are going through a transition period right now as we speak.

So in -- under Community HealthChoices, all of those processes will continue

to happen and then once the choice of managed care happens the MCO will

be responsible for the overarching care including both long-term services and supports and physical and acute health care.

So I want -- the boxes underneath the gray MCO box talks about the administrative functions as well as the services.

Under the administrative function we certainly have service coordination and

service coordination can either be conducted in-house by managed care organizations or the managed care organizations could choose to contract out

service coordination and in that environment they may choose to contract out

to the Area Agencies on Aging. They may contract out to the Center for Independent Living. They may contract out with other service coordination entities.

They can contract it out. It's going to be up to them.

The other column there is, really, many other administrative functions such as

billing, payment, quality, contracting, et cetera.

The next big bucket is long-term services. This is not an exhaustive list of long-term services and supports for us, but certainly nursing facility services,

adult day, personal assistance, cognitive rehab, home health and that's just a smattering of all of the different services we will provide.

Again, I mentioned earlier about expanded employment services, those are in

that service bucket right there. One that I didn't mention that is a change to the current long-term services and supports home and community-based waivers is the idea of pest eradication. It was one that was suggested in the procurement -- all of the stakeholder engagement we did in advance of the procurement being issued in March of 2017 -- 2016. We did a -- we have done

a lot of work to gather feedback on our -- what the RFP might look like. One of the suggestions that has been loud and clear is to include pest eradication.

We have gone ahead and done that.

Coordination with Medicare, I did mention this briefly. Coordination with Medicare is really, really important to us. It's an important -- very important component for dual eligible individuals in the community health choice status.

Clear and understandable communication about how to transition to Community HealthChoices can impact Medicare coverage but doesn't have to.

It is important for participants.

We do expect to look at working with the Apprise counselors. I will talk briefly about the Apprise counselors in a minute. I did want to mention that we are -- do have some additional language built into what is called our MIPPA agreement, which is an agreement that really operates to -- it's a threeway

agreement between CMS Medicare, CMS the state Medicaid office and duals special needs plan to require them that there be some level of coordination.

We put a lot more teeth into our current MIPPA agreement going out to managed care organizations as we speak because they have to sign off on them and get them out to CMS. We put a lot more teeth in those so we have

pretty clear expectations around coordination between Medicare and Medicaid agreement.

I want to talk about what the counselors can help with. Certainly they can help understand Medicare benefits by explaining what services are covered under Medicare parts A and B and your Medicare summary notice, which

many people get confused by.

They also help you understand the Medicare prescription drug or part D benefits. They can help you make informed choices about Medicare coverage

options, medi gap policies and Medicare advantage plans it's our intention to

make sure that these counselors -- there are over 700 of them statewide -- these counselors also have a again awareness and understanding of Community HealthChoices; so that there is no confusion out there.

They will help understanding financial assistance programs that may be available to help pay for Medicare premiums, deductibles and co-pays, as well

as prescription drug needs like Medicare savings plan.

They can help understand and assist with the Medicare appeals process.

They

certainly help understand benefits under the long-term care policies and by making presentations on Medicare to groups or organizations, they spend a lot of time-out there just heightening awareness for people.

Pennsylvania's network of Apprise counselors will continue to counsel Medicare eligible individuals about options on the Medicare side.

They will also have tools to refer patients to IED or independent enrollment broker to make informed choice on the Medicaid side.

Apprise counselors am Hi-level opportunities by dual-eligible special needs plan if a person has chosen a Medicaid plan.

This is a slide that talks a little bit about our evaluation plan. I want to let you

know that the evaluation plan has, actually, been posted for community on our website. It's open for 30 days. The last -- the day that it's due back is -- do

we know what date it is?

>> July 6th.

>> **JEN:** We will check on that.

Anyways, I want to talk a little bit about the evaluation plan. This listing here of five questions are important questions to the evaluation.

So we have partnered with the University of Pittsburgh to conduct a multi faceted evaluation plan. The evaluation plan add invests key research questions that are listed on the.

If you are familiar with goals of community health choices, you will be very aware of these priorities.

How the evaluation will work, it analyze administrative data. It will analyze

enrollment and utilization data. It will analyze cost data from the Pennsylvania Medicaid and Medicare.

The evaluation will also incorporate data from a variety of sources, including

the Community HealthChoices MCOs, nursing facilities, person-served centered plans and level of care assessments.

Narrative describes time line of evaluations. I will talk a little bit about the time line of the evaluation research questions and data questions and methods and analytic strategies the narrative in the plan. If you do decide to

take a look at the plan you will get narrative that really describes that time line, the research questions, the data collection methods and analytic strategies.

It's posted on the Community HealthChoices website under related topics. Click the evaluation link.

Let me just say, these evaluations questions are really the fundamental evaluations for the plan and it starts out by -- the question, Does

Community

HealthChoices result in greater access to home and community-based services? Does CHC include long-term coordination and mental health improve quality of care and quality of life participate apts and family caregivers? Does CHC lead to innovation in the delivery of physical and healthcare and LTSS? And the last one is does CHC reduce unnecessary utilization of services and reduce growth and aggregate costs?

As I said, the link is on our web page, but some of the areas that it will really

be looking to do is really just helping us follow what is happening in Community HealthChoices.

Oh, yes. We originally posted it for two weeks but we extended it two more weeks. There is information on how to submit comments on our web page.

Next slide is -- I want to talk briefly about the external quality review organization. We are getting ready to issue a procurement in early July, but

I

wanted to touch base with you all on it so that when that procurement is released, you will have some context for it.

All managed care is required to have an EQRO and/or external quality review

organization. I will tell you the office of medical assistance programs and the

office of mental health and substance abuse programs has had an EQRO in place that they've used for a number of years. We are in the process of reprocurring that EQRO. We are really doing the Department of Human Serviceswide rather than having each of the offices do a procurement for EQRO.

States are required to have an EQR in place when contracting with managed care organizations. It is required as a part of the recent release of the managed care final rule by CMS. It's right in line with what CMS requires. Some of the functions that the EQRO will do, it will be -- they will help Office

of Long-Term Living with early monitoring of Community HealthChoices and

on individual assessment of each MCO's performance. They will be able to help us do that.

It will coordinate data submission for the -- from the managed care organizations to ensure quality timeliness and access to care for all participants.

As I mentioned, we are developing a departmentwide procurement in EQR contractor to consistency and streamline MCOs. We want it to be an easier process for them so we are coordinating across all of the offices.

The EQR will fit into the development of a comprehensive departmentwide quality strategy, which will also include the work of University of Pittsburgh through the program evaluation.

OLTL is required by haul waiver assurances to have oversight.

Comments? I want to talk briefly moving from EQR which is getting ready to

be posted as procurements so we are looking for people to bid on it and move

on to the Community HealthChoices waiver.

We released the cop current 1915 (b ?ie. c) waiver which closed sometimes

last month. from that time we -- during that time we received over 350 comments from 86 commennators. The themes were similar to those set forth

in other public comment periods.

I want to talk to you briefly about what kind of themes we heard in the comment period.

On C side of the waiver we heard about accessibility requirements for

providers and managed care organizations serving persons with limited English proficiency. The department agrees with this. Managed care organizations and providers are held to an extensive LEP requirement which

is limited English proficiency requirement and those are, actually, outlined in Section (b ?ie. 8) cost neutrality calculations; that was another comment we heard.

There were a number of people who asked for -- a number of unduplicated resp corrects to be served and the what about cost neutrality calculations? These numbers were not available when the waiver was released for public comments, but they will be included when we submit this to CMS. Because of

the lag, we just were not able to be comfortable with our data at that point. (the audio is break for CART provider, not sure if anyone else is having problems.)

Request for changes to existing performance measures were also numerous

and are being considered in potential revision. We are looking at that.

These are some links to our Community HealthChoices web, the MLTSS SubMAAC webpage is there. The SubMAAC webpage is under an area of DHS

website talking about advisory committees. We are over there underneath the

medical assistance advisory committee.

We also have a listserv if you want to stay up to date and sign up.

We also have a resource account for people to add comments and send in comments. We would be glad to have you submit comments to us on today's

webinar. We will be following up with an email to include a brief survey to help us better communicate the technology in the future.

With that, we have questions or comments? I think we received comments in.

Kevin, do you want to start out?

**>> KEVIN:** Sure. The first question we received -- I will read them verbatim: Because the decision has been made to give all state business to managed care

organizations, wouldn't you agree that this will lead to hundreds of thousands

of home care companies going out of business? Why is that okay?

180-day transition period will not prevent this from occurring nor will meet

and greet sure to sheer number of home care companies.  
In answer to the first question I do not agree it is the case. We believe home care companies that present themselves to managed care organizations and have a history and a presentation of quality of service will be able to contract with managed care organizations and their businesses will most likely thrive in managed care environment.

We believe that this is an opportunity for quality home care organizations to be able to present themselves as a quality provider and also to possibly even increase their business in managed care environment.

We believe transition of care period in addition to meet and greets and other opportunities for these providers to speak to managed care organizations will be able to present opportunities for that network development with the managed care organization.

The second question that I have, when will the CHC roll-out for the southwest be? July 1st 2017.

>> **JENNIFER:** I have a couple questions and Kevin is getting some more. We are getting questions in. Thank you very much, everybody.

The question is: When we move into Community HealthChoices act 150 -- (audio breaking up).

The second question is, can you please restate the date you are expecting select managed to select MCOs for the program and the answer to that is roughly mid-July. We will be reaching out. We will be contacting selected offers. Making some kind of public announcement will likely be made as well.

Then we will continue with contact notions negotiations.

We want to get it right but we are not changing our procurement time line for

Community HealthChoices for the MCO procurement. We feel we need the time with them in place to be able to stand it up.

How will the MCOs know what services each consumer is receiving at the time of transition to the Community HealthChoices waiver.

The answer so that is that the state will share the individualized service plans

with -- that information will be shared with the MCOs. It will be transfers from which ever system that ISP information fits in whether in SAMs or HCSIS. We have two information systems that collect data on long-term and

community-based services population.

Both of those systems will be providing that information ISP information to the MCOs

Will consumers still be able to choose service coordination entity or will the managed care organizations provide service coordination internally?

Consumers may choose through the managed care organizations and we expect that managed care organizations will do this differently. Some of them

may provide service coordination internally, others may decide to contract with a high-quality service coordination entity and be able to use them.

The IED, one of the questions reads: Is maximus -- the IED will be procured.

Maximus is part of southwest implementation but we will be reprocurring the independent enrollment broker.

Will there be an independent contract between navigator system? We are working on the concept. Mainly in view of the moneyed care final rule that came out of CMS. There is a requirement for a beneficiary support system so

we are working on what that means for Pennsylvania you will be hearing more about that.

The I dependent assessment entity that will be used for education of current

participants, a new entity or existing entity such as Area Agencies on Aging --

aging well is the procurement that we are seeking right now and are in the middle of it. I will tell you that we expect that a number of different types of organizations will be working with us to educate current participants and we think there is a lot of interest out there. I've heard from many organizations, non-profits that have held up their hand and said, we want to help you get information out. We and that there is going to be a lot of good information out. We just need to make sure that it's coordinated.

Timeline for OLTL Community HealthChoices MCO selection been moved to

the end of June to later date? We are looking at mid-July at this point.

Are you saying CILs will be able to do enrollments instead of maximus?  
The independent enrollment broker will be procured.

[inaudible] -- Pennsylvania LIFE programs in your slides since we are an important part of Community HealthChoices; that is a very good point.

Maybe

we will take it as a take-away for the next webinar to do a few slides on how

LIFE works and provide information on LIFE. Thank you very much for that comment.

On pest eradication is that one-time thing or can it be done more than once?

>> **JENNIFER:** I'm pretty sure it can be done more than once but as-needed.

Medicaid long-term care have to go directly to CAO or IEB manage case for them?

The answer to that the IEB will be independent enrollment broker is point of entry schedule an assessment and also reach out to the county assistance

office and CAO will manage the financial eligibility process review.

Can you please extend deadline to evaluate project fairive? We just did that.

We increased it to two weeks.

What is the date? We are going to find out the actual date. We did have it originally for June 24th. We extended it two weeks which takes us to July 8th.

There's a lot more time. Allow do I know which region our facility is located?

That would be based on counties. There are 14? Southwest -- although, Georgia can we put up on a webinar a list of counties?

>> **Kevin:** Sure. We have a map.

>> **Georgia:** I have a map.

>> **JENNIFER:** We have a map that doesn't list the counties. If you need more information reach out to us through the resource account if you cannot

figure out which county you are in. It is based on county.

Shouldn't they do the study first? I am not sure what that means here I go.

Here is a -- Kevin is going to take over for a time.

>> **KEVIN:** Thank you, Jen: Question are peer groups facilities to be included

into Community HealthChoices. The answer to that is yes.

And some additional questions that we received -- this is a long question but I

will read it verbatim because it represents a good question.

DHS stated it is concerned about reaching all individuals to help them understand the program. If DHS released time line document for participate apts which includes day-one has been done whorks why and who comes to home this may assist individuals in understanding the process aids concerns stakeholders have.

I agree with the comment and think it is a great suggestion. We are looking for a lot of different approaches for communication with participants. We will

definitely include this as a smart consideration for how to communicate and we have very welcome to other suggestions to stakeholders on how to best

--

how we might be able to best respond -- reach consumers and have them understand Community HealthChoices.

Next question, this was done initially -- there were three additional MCOs that

responded cedar woods care, management ascend and and trusted health plan. Those are three managed care organizations that did bid for the plan; that is correct.

Can you talk a little bit about EPS participants and if they will stay in OBR waiver until they turn 21.

Community HealthChoices will not be covering EPST I think we said that in previous third Thursday webinars.

If an individual is between the ages of 18 and 21 and in need of long-term services and supports, they may be eligible to be able to receive those services

through OBRA.

EPST participants may continue to receive those services in health choices. It

depends on the case to be able to answer that question specifically. It is a great question but depends on the individual, where they are currently receiving services, and the nature of those services.

There is a possibility that people will receive long-term services and supports

in the OBRA waiver. It's also possible that people will continue to receive

services through EPSDT and there may even be a combination in some cases.

Great question.

Next question: When will provider reimbursement rate be determined? Largely, the provider reimbursement rate will be part of the conversation between managed care organizations and their network providers. So my expectation is that that reimbursement rate will be part of the network development and rate negotiation process.

So most likely, they would will be developed. I make an assumption it will be

most likely those rates will be developed and known to network providers long before the actual date in a given zone it's hard to say what that will be for southwest zone but expectation will be that it is before the go-live date.

Next -- but that assuming providers are participating in continuity of care are

networking into the Community HealthChoices program.

If they didn't like the network during or through the Community HealthChoices program, their rate information may not be known until after the go-live date. A couple scenarios how that could work.

Next question: Will you provide contact information or support for MC Os. We are in active procurement we published the names. In many of the cases

they have websites. We are really not in a position to provide contact information during act of procurement, but be assured we published those names and the managed care organizations have websites where that information may be contacted.

Next question: When and how do you expect to notify consumers by letter for

CHC changes? It continues is this still on track for late summer and letters to

be sent out?

I assume when they mean late summer they mean this summer 2016.

Because of the time frame change since southwest is moving to July 2017 that

notification will go out later. We want to make sure that notification and all communication is meaningful to participants. We are planning at this point not to have direct communication with participants until after January 2017 so the communication with participants directly will be between January and July

time frames.

Prior to that, a lot of more public information about Community HealthChoices in general will be relayed to participants in a general way.

The

specific communication will not commence until after January 2017. At least

that is our current thinking at this point.

Next: Do you know who managed care companies are?

We know who the offers are. We do not know who are the selected offers because it's still in active procurement.

During 180-day period will the providers be paid same fee-for-service rates.

The assumption is yes unless they come to a net-level agreement otherwise.

Next question: Currently the IEB is maximus. Are they going to be replaced? It

sounds like new RFP was selected to signed new IEB.

>> They will be the new enrollment broker for home complaint based enrollment until we go live with health and community choices they will be also part of implementation of southwest zoning. We will publish a request for

broker services that will -- we are planning to have that published in late summer 2016 this year and they will most likely be transition but there will be publication of RFP and another procurement process for independent enrollment broker that will occur in 2016.

How are rates going to be set?

We had talked about the continuity of care period. The continuity of care period will take into consideration existing rates, but the rates themselves will

network providers will be set by the managed care organization.

Next question, can a person who has services through the ID waiver still get

services through CHC? As mentioned, if somebody is in intellectual disability

or one of the ODP waivers such as consolidated waiver or the person family

directed services waiver with ODP, they will not be enrolled in Community HealthChoices.

Next question: What is the time period for the bids and selection of the new IEB. I already mentioned this earlier but we are planning to have the RFP process take place in late summer 2016; the selection will follow thereafter.

|

imagine we will have a time period where hopefully the selection will be known by the end of 2016.

Next question. How does an FCE begin process of collaborating with and/or

contracting with MCO at this stage?

If managed care organization does not contract or employee FEE does that mean it is out of business.

What if they want to keep it and not change to MCO, FCE.

A couple ways to answer this question they should reach out and contact managed care organizations as soon as possible.

As mentioned, we have a list of the managed care organizations that have submitted bids to us and it will not hurt service coordination entities to reach

out to all of those managed care organizations and let them know of your services that you offer.

It is true that if a managed care organization does not elect to contract or employee the FEE they will not have a contract with the managed care organization.

If the participant wants to keep their FEE, they will have a continuity of care period, once the managed care organization goes live, and that -- during that

continuity of care period they will be able to continue to have that same service coordination entity, but once that continuity of care period moves into

[inaudible] managed care organizations will need to select a service coordination entity that is directly affiliated with the managed care organization.

Next question: If Act 150 is staying the same, who will do the service coordination if MCOs have their own and who will do eligibility determination? Who will approve service plans and provisions?

Great question. For Act 150 service coordination will be offered the same as it

is right now. It will be offered with a service coordination entity that is currently in line to be able to coordinate services for Act 150 service plans.

Who will do eligibility determination? The eligibility determination, again will be the same as it is right now. Ultimately, the decision for eligibility determination will be made by the Department of Human Services, Office of Long-Term Living and also who will be approving service plans and revisions.

Once again, that will be under the authority of the office of long-term living

directly.

I was asked to slow down in answering the questions. I appreciate that comment very much and that feedback.

I think that I answered that.

I have two more here. I am not sure if we have new ones.

>> No more.

>> How will providers know which MCOs Kuhn saw every selected?

Great question. Expectation that providers that are in a network MCOs there

will be communication between managed care organization and the providers

themselves.

If through the continuity of care period, we will have to develop a robust process to make sure providers providing service in the continuity of care period know which managed care organizations the participants have selected. It's a critical question. I believe that we still have to map out the process.

It is definitely a point of communication, especially during the continuity of care period.

Next question: What about dual-eligibles that do not have individualized physical health service plans? Individuals I am assuming what they mean is how will they go through the implementation and transition period?

The dual-eligibles that are nursing facility ineligible and not enrolled in longterm

-- existing long-term services and supports programs such as the nursing facility or home and community based waiver will transition into Community HealthChoices. They will go through a planned selection process certainly there will be a lot of outreach that will involve our communication strategy Jen had talked about and also involve the independent enrollment broker,

for plan selection and have the opportunity to select their plan. We will work very hard to make sure that they have that opportunity to minimize auto assignment.

If they do not have an individualized service plan as it currently exists they will transition into Community HealthChoices.

In many cases, managed care organizations may do their own screening or needs assessment to determine the dual-eligibles' needs are being met by the

program and it's also most likely the case additional gaps in service needs are

met, managed care organizations will bridge those gaps with additional services.

I will turn this over to Jen to answer additional questions.

>> **JENNIFER:** Thank you, Kevin: The question is, under the impression that

the selection would not be made until consumer and family input was addressed.

We will be expecting to have consumer and family input as selections are made we are working with independent enrollment broker. Family members can participate if the cop assumer would like that to happen; that Colonel certainly can happen. Ultimately if we don't have somebody enrolled in an MCO, we will do an -- was it called? Intelligence assignment, which means -- I

am hoping very few people end up in this position whereby if we have -- if we

have known individuals that are either in the long-term services and supports

systems or duly eligible that have not signed up for Community HealthChoices, we would be putting them in the most appropriate managed care organization based on who their providers are and based on where they

are. For example necessity live in nursing facility, we would put them in managed care organization that is contracting with that nursing facility.

How will the process of qualifying and joining an MCO happen for a consumer who becomes duly eligible after nursing home entry? What will happen to a consumer who is financially ineligible due to a penalty period?

>> **KEVIN:** Great question. Let me look at it hear again to make sure I answer it completely.

The person who has emailed -- the person who sent this question but if the person is financially eligible during the penalty period they -- a lot of different

scenarios in the way that -- if a person is not -- if a person goes through periods of ineligibility due to resources, they -- if they are moving in and out of eligibility due to different levels of resources, the decision was made to keep them in the fee-for-service program, to make sure that their services are

not interrupted.

If they are ineligible due to penalty period we are try trying to work out specifically when they can be enrolled. We are trying to work on a complete answer to make sure that it is forwarded on to the listeners. It is a detailed

question and we want to make sure we answer it as completely as possible.

**>> JENNIFER:** Okay. I have a couple questions, which are, where can we access the list of potential managed care organizations?

Since I have your addresses, I will send you an email with a direct link to where on the website we have posted the list of managed care organizations

that we have received bids from. There are 14 of them we will send you direct

link to that. I had at least two and I think you had one as well, Kevin.

I am not sure what this is. What is FDE and FDO stand for? I also have that person's email. I am not sure. I don't remember referring to that. I will just reach out to you directly. The person who wrote that. We will have a conversation about what it exactly referring to. I probably need context. You might have gotten letters wrong or acronym wrong we can work it out that way. Will you provide it and -- we cannot provide the contact information per

say, however they all have websites and you can look up on their websites ways to get in touch with them. On the website you will see a section that says for providers, go ahead in there you will learn how they want to be contacted.

**>> KEVIN:** The other thing I would like to add we are limited because we are in active procurement in what we can release about the offers. Also, what

we can say about those, the process itself.

It presents this particular challenge to us. We do apologize for the inconvenience.

**>> JENNIFER:** Did you send out the slides? We don't actually send them out

but we post them on our website. We will be sending out a follow-up email so

that you can fill out what you think of this sort of an evaluation, if you will.

One of my main goals in sending out that post email we will definitely put a link to where we posted these slides on our website.

One of my goals in rereceiving -- I have two goals in receiving feedback on evaluation of today's webinar is to make improvements in the webinar; that's

one of my goals.

The other goal is for you to submit ideas for other things you want to hear about, what should we do in our next webinar, we are always looking for

ideas on that.

Another one, where is the list of managed care organizations? We certainly have that link and we will get that to you.

This is a question I do not need to read.

Maximus has not notified us that the consumer has chosen our service coordination entity.

Well, it's too early for that to happen. We have not gotten to that phase.

You

will not see that until next spring, anything until next spring. We have delayed the implementation of Community HealthChoices to July of 2017.

You are not going to see any activity around maximus doing enrollments into

managed care until I guess probably Aprilish. That will be happening in April.

Do you any more?

**>> KEVIN:** I do.

Next question: We found many MCOs have a process for and are willing to Taylor of independent but are not willing to move forward until the award is given as not to waste anybody's time.

When do you and the awards to be issued so we can move forward with the

regularship beyond the relation of intent.

I appreciate the individual asking this question because it's not something I can say but I can read. That being said, what the questioner stated makes sense. It's most likely the case that the offers will be made aware that they are

part of the selected offer process in July and contract negotiations begin in August. It is most likely the case that the managed care organizations will be

involved in and around that time frame.

**>> JENNIFER:** Okay. We have a question or a comment that the list of potential MCOs need updating. The contact people that are on that list are not accurate.

I appreciate that. We probably do need to clean that up. It's the old potential.

We don't have the --

**>> PAT:** There are no-contact people on the website.

**>> JENNIFER:** We don't have interested.

**>> PAT:** We do have list of interested managed care organizations but it

does not -- as Kevin stated a bit ago. Most of the MCOs have website with contact information available.

>> **JENNIFER:** We will not be putting contact information out there. We will let the managed care organizations do their own outreach as they are ready to.

It says: Are only the current committee members, are they the only ones to have input to the selection that is going to be our choices? I am not sure what

that refers to. I guess I could do a follow-up email on that one as well. If you are talking about the current managed long-term services and supports

committee members, they don't have actual input into the procurement, per say. They have been giving us advice along the way on the procurement so it

would be, um, the procurement process is an internal process DHS internal process. We are following that process almost verbatim. It requires us to use

state staff only.

>> **KEVIN:** Next question: After speaking with many MCOs the qualifications

they are asking for, for example, accreditations, we don't have. What should

we do about this?

I think -- home care agencies -- I think it really depends on the managed care

organizations. Some may not have a network in Pennsylvania so they may not

understand the way that Pennsylvania licensure works for different types of providers.

So it may be a conversation that home care agencies want to have with managed care organizations to educate them about different types of licensure or different types of accreditation and different types of

qualification standards.

This also might be an area where your association, if you are home care agency and belong to an association your association may be helpful in communicating with --

>> **JENNIFER:** Also, we will take responsibility for -- as a matter of fact I had

a recent meeting with Department of Health and the Department of Health definitely wants to help us as we outreach to licensed home care agencies and

licensed home health agencies and licensed nursing facilities.

Our partners in the Department of Health are very much aware of what we are doing with Community HealthChoices and they stand ready to help us. Thank you for that comment. Do we have any more? Here comes one more.

Can you have a class on denials and how to get them fixed?

We will pass that on to provider support section who can certainly do a webinar just specifically on promise and promise denials. I will make sure we

pass that along.

This might be -- if DHS chooses to include time line document for participants

could DHS include time frames for applications, assessments and any renewals through IED, AAAs and county assistance offices. Steps may be completed behind the scenes and not known to participants; however, an individual may need to make a life choice quickly and understanding the procedure and time line/time frame for each individual step could make a drastic difference in the choice made.

A short description of each entity involved and each step be very useful if someone needs to make changes; that is a great suggestion.

>> **KEVIN:** Absolutely.

>> **JENNIFER:** We will certainly take that to our staff. I think that is really appreciated.

>> **KEVIN:** Some of of the suggestions the way to communicate this entire process to participants are strongly encouraged to continue to provide those

suggestions. This is something we can take back and inin the messaging process. Thank you very much.

>> **JENNIFER:** The next question non-medical do not require accreditation but certified nursing does. We will have to work with our managed care organizations around the accreditation of the non-medical providers that are

in our long-term services and supports.

For example, we have home modification providers. How do we make sure that those managed care organizations are comfortable with contracting with

them? I think that's a different kind of conversation and different kind of

"credential" we will have to be working with them.  
We will probably be reaching out to those different provider types to come up with something that is meaningful for the managed care organizations in terms of their own NCQA with accreditation requirements.

Any others?

[NO RESPONSE]

Okay. I think we have finished the questions that have come in. I want to thank everyone for participating. Please accepted in your suggestions using the RA-MLTSS&pa.gov e-mail address if you have either questions or comments you want to make on webinar we will send out a follow-up email to make sure that you can evaluate this program as well as give us input on future webinars.

Thank you very much. We are signing off on the third Thursday webinar. (Webinar concluded at 2:51 p.m.)

The following printout was generated by realtime captioning, an accommodation for the deaf and hard of hearing. This unedited printout is not certified and cannot be used in any legal proceedings as an official transcript.

## Notes