March 16, 2017  
Third Thursday Webinar  
CHC Update

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>> Jen: Good afternoon, everyone. I am Jennifer Burnett deputy secretary for Office of Long-Term Living in the Department of Human Services.
I'm glad you can attend this third Thursday webinar. I plan to spend the bulk of the time today providing an update of where we are in the process and giving general background on Community HealthChoices.
The first slide is, What is Community HealthChoices.
We are putting together information that simply lays out what it is. It is a Medicaid managed care program that will include physical health benefit and long-term services and supports.
This is a trend that is kind of moving across the country. Many states have already moved their long-term care system into managed care arrangement and so what of the nice things about that we are learn willing from other states and are consulting from other states on our planned approach to Community HealthChoices.
It is -- one of the things we learned in some of the managed long-term services is that they really truly better able to coordinate care and services.
The other thing that they do in some of the more mature programs it praise an opportunity to pay for outcomes; that is not something we currently do in the fee-for-service environment.
Who is part of Community HealthChoices? Simply said community health choices are individuals who are dually he will I believe for Medicare and Medicaid or individuals who are eligible for Medicaid long-term services and supports because they need the level of care provided by a nursing facility.
I enthusiasm also mention that we have a very robust LIFE Program, which is in our state. This last bullet here talks about that individuals currently enrolled in LIFE Program will not be enrolled in community health choices unless they expressly select to transition from life to a community health choices managed care organization.
I also wanted to talk a little bit about life. It's nope nationally as the program of all-inclusive care for the elderly or PACE.
It -- what it is is an integrated managed care program for individuals aged 55 and over who need the level of care provided in the nursing facility it provides long-term care, acute care, behavioral health services, pharmacy, et cetera. Sort of soup-to-nuts services to older Pennsylvanians by using an inter disciplinary approach.
Currently, LIFE Programs are available in 39 counties across the state. The LIFE Program will continue to operate as an option for eligible individuals in geographic areas in which life is available.
I will say that it is our I intent to have life available in all county in the southwestern part of the state.
You probably have already seen this slide but it is one I like to talk about. It really does layout the goals for community health choices. These goals continue to be our standard for what we hoped to achieve with community health choices.
The fist goal first goal is to enhance opportunities for community-based living. These goals also do align with the Department of Human Services goals for meeting people's needs where they are.
Secretariary mention this often. People want to live in their own homes. The second goal is strengthen coordination of LTSS and other types of healthcare including Medicare and Medicaid services for dual eligibles. It’s an important opportunity we have to be able to strengthen that coordination. The third goal is to enhance quality and accountability, which is a really important goal for any Medicaid program. The fourth goal is to advance program innovation. In the RFP we asked the managed care organizations who were applying to DHS to be considered for Community HealthChoices. We asked them to describe what they would do in the areas of housing. How they would innovate in the areas of housing, in the area of direct care -- the direct care workforce and the area of employment of people with disabilities and seniors. Then the last area was how would they innovate in the area of teg following? We have some really good solid proposals open those kinds of innovations; and that will be included in community health choices. The fifth goal is increase efficiency and effectiveness. I want to just also say that in terms of the advancing employment opportunities, we have gone ahead and added some new employment services to our waivers; that will continue through Community HealthChoices. They include, among other things, job coaching, job finding and employment skills development and benefits could you pleasing. Our CHC roll-out, we -- zone 1 in the southwe were part of the state covers 14 Counties. The it will roll out on January 1st, 2018. Zone 2 in southeast in July of 2018. The remainder of the state will be rolled out in January of 2019. The remainder of the state are actually three health choices zones: Lehigh capitol, northwest and northeast.

So the current status of Community HealthChoices, we did announce our selected offers on August 30th, 2016. Protests were filed by unsuccessful bidders. They were found in favor of the Commonwealth, but we also have self of the MCOs, several of the unsuccessful bidders have also filed in Commonwealth court filed appeals in Commonwealth court. We are hoping that we begin our negotiations in the very near future, but right now we are pretty silent on where we are going with this. Here are our priorities as we move to Community HealthChoices: First of all, we know that we need to complete readiness reviews. We have done a lot of work and gotten a lot of support from partners in the office of medical assistance programs and the office of mental health and abuse services to help design readiness reviews and what they will look like. It will be different than theirs because it involves long-term readiness and support services so we designed a process for that.

We do know from speaking with other states, as well as with our program in OMAP and ohm as you say that it generally takes about six months to complete a readiness review. The agreement and rate negotiations, we have not yet engaged with the select offers on the agreement and rate negotiations, we are hoping that that changes in the near future. Communicating. It’s really communication that will be key to a successful roll-out of Community HealthChoices. We know that individuals that are going to have to enroll in Community HealthChoices, that they will need to have adequate information about the managed care organizations and about the provider networks of each of those MCOs. We also understand in terms of communications that our providers are going to need to be communicated with certainly the MCOs will need to be communicated with and the general population will need to be communicated with.
So of those three priorities, the first one I wanted to mention is readiness review. This measures the actual readiness of the managed care organization prior to the go live -- prior to us going live with Community HealthChoices. We really need to understand and assure -- be assured that these managed care organizations are ready to operate. The readiness review criteria and benchmark are set by the department. We actually put together our tool. We have shared that information both in the third Thursday webinars, as well as with the managed long-term services and supports SubMAAC so we are trying to be very transparent about that. We will be completing desk reviews where we ask organizations to submit information to us, such as information on their procedures, information on their handbooks, what kind of provider network, how they maintain their prior network, all of those things, training requirements, etc. All of those we will be able to look at as much of that in a desk review process, then we will also be sending out teams on site to really take a look at how their billing system works to really understand how this managed care organization operates. We will have one team assigned to each managed care organization. The team will consist of approximately three to four staff on the department. Each team have up to 10 subject matter experts. They are not just from OLTL. They will be also including people from OMAP and OPM and OMHSAS and pure of data and claims management. There were will several subject matter experts that will help in terms of the readiness review. The Community HealthChoices readiness review, the team will be reviewing all aspects of review and supports. It will be reviewed in health choices. We have been talking about health choice partners on how they do their review and it's been very helpful. The consumer role in readiness review, we are working with the Pennsylvania health law problems and consumers to discuss long-term services and supports provider adequacy. There is a March 24th meeting scheduled. I need to say that anyone involved must be conflict-free. Not associated with provider that could contact managed care organizations or connected in think way. Network adequacy. The department of health -- first of all, the department of insurance licenses managed care organizations does it because it is a form of insurance. The department of insurance has authority over that. The Department of Health, is responsible for certifying adequacy for all managed care programs in the Commonwealth. A our MIPPA contract contains Medicare network adequacy standards. The Department of Health has a rich history of approving network adequacy for physical and behavioral health; however, doing network adequacy for long-term services and supports is totally new to them. I do want to reiterate the interest of consumers, which was expressed during managed long-term services and supports subcommittee of medical assistance advisory committee that the network adequacy for LTSS needs to be very robust. We have been listening to them and learning. We are taking steps to involve consumers in assisting with developing the long-term services and supports provider network adequacy standard for community health standards. I will also say that we are working with the Department of Health to understand what LTSS services might what it may look like. We have done a lot of work to support them in review of network adequacy.
There are also Medicare requirements for network adequacy on DSNP site. That's where we talk about the PIPPA contract. We have had a MIPPA contract for many years but have really beefed it up. It says DSNP shall provide Medicare covered services to dual-eligible consumers. They shall provide network materials such as provider directory to verify network adequacy.

We Pennsylvania did not participate in any duals demonstrations that CMS has been operating for the last few years since Affordable Care Act was passed. We have not been participating in those; however, we have been taking advantage of some of the learning from the duals demonstrations.

For example, CMS has integrated care resource center; that resource center has been giving us advice. They have a fidance document that state these requirement. Review adequacy at contract level rather than plan level. Once an organization's Medicare advantage contract is approved legal entity can offer multiple plan benefit packages, PBPs under approved contract, one of which could be a DSNP plan.

We get a lot of information from them and we -- when CMS is considering three measures, they consider three measures of network adequacy one is minimum number of providers by type. Two is maximum travel dance of providers to providers and facilities; three is maximum travel time to service area.

Those standards don't help us in -- they do for some things but not for much of long-term services and supports because long-term services and supports are provided right in the individual's home; that's what some of the work that we are trying to figure out.

Communication strategies and time lines, participants to be enrolled in Community HealthChoices in first phase will hear from the Commonwealth sometime in July of 2017.

Endpaijing we are engaging to assist in understanding Community HealthChoices, what it means for services and what steps they need to take to make sure they have access to providers of their own choice.

We also have Jewish healthcare foundation helping us as well as others in the state but in southwest Jewish healthcare foundation and some of their foundation partners will continue to be an integral at coordinating community forums and providing feedback to Commonwealth and documents on the processes.

We held a webinar yesterday with the Jewish healthcare foundation and some of their partners and kind of did a dry run on this webinar. I will say that healthcare foundation network has been instrumental in helping us gain access to -- (sneezing) -- get boots on the ground.

I also want to talk briefly about communications to providers. We be communicate will be communicating with them before communicating with participants. They are the first group we are selecting to communicate with because they interact with participants daily we warrant our providers to be fluent with what is happening and understand the transition to Community HealthChoices and also the possible impacts related to the transition.

Additional communications happen at the managed long-term services and supports subcommittee of the medical assistance advisory committee.

We have been -- many requests have been made by SubMAAC members to have MCOs attend an upcoming meeting. This is an opportunity to ask questions of the managed care organizations it is also an opportunity for the MCOs to discuss their experience in other stateses and how they will meet the needs of their participants.

They have asked more information is available at this web link. This is information on the MLTSS SubMAAC. The SubMAAC meetings are transcribed there is an actual tran skippings of all of the meetings on this website.
There is also any PowerPoints that were used for any given meeting are included with that transcript so you can take a look at the materials that were presented in each meeting if you wish to do so.

I want to show a couple navigation slides that will help make that hyper link a little bit more -- help it make more sense.

I will do that after a couple more slides here.

Another venue for us to communicate is through the third Thursday webinars; this is one of those webinars. We try to consistently do that each month. They have been -- we have been holding the third Thursday webinars since July of 2015. The topics for the third Thursday webinars haverawrchged from an introduction to managed care. We have done relevant updates, overviews of monitoring and readiness review activities, information on our evaluation. Lots of different topics. We welcome submission of ideas for topics for future topics at any time.

You can register for information about the CAC third Thursday webinars, which is distributed through Community HealthChoices listserve that is the name. Oltl-community-healthchoices and register to update your email address at disserve.dpw.state.pa.us.

You can get any information that we send out including the announcements for third Thursday webinar.

There is also a third Thursday web page off of the Community health choices homepage, which includes dates of upcoming webinars and then the archive of all of the presentations and transcripts of prior webinars that is made available there.

A lot of information for you to take in, if you want to take advantage of it.

Here is the first slide I wanted to -- or homepage. This is the DHS homepage right now, which is www.dhs.pa.gov.

If you go to this homepage and you look under "top issues", at the bottom link on the top issues, Community HealthChoices is right there; that goes directly to the Community HealthChoices web page.

Here is the Community HealthChoices web page. This is our homepage. The blue box in the middle is a link to the YouTube video that you can take a look at if you want to. We are not -- we were hoping to show it on the third Thursday webinar but decided not to because it has the dates -- they are incorrect. Since the video was posted, we changed some dates.

You also, on the right-hand side, you see a list of related topics, which is the easiest way to navigate around the community health web -- the choices website.

This -- these links, here, include information such as information on our extensive stakeholder process, including the procurement and waiver documents that we released for public comments. It also has information on historical data. It has the various iterations of the procurement, which would include a discussion document that was issued in June of 2015. The concept paper that was then issued in September of 2015 and then the RFPs and draft agreements that were put out for public comment; so all of that is available.

And then if you click on the third Thursday webinar's link, which is in that list of related topics, you can explore that link a little further.

Here is -- when you click on third Thursday, here, you can see what the dates of the third Thursdays are and you have access to all of the previous webinars, both the transcript and the presentation are available to you there. You can really kind of learn anything you want about what we have done so far. We have really remained -- we have tried to be as transparent as possible in this process.
I want to talk a little bit about waiver transitions because as you might imagine, we will be making changes to our waivers; that will involve a number of different activities. I will start out by saying live life will be continued availability before and after Community HealthChoices implementation. Individuals receiving services in LIFE Program will not be included in Community HealthChoices. This indicates where things will be January 1st 2018. A few things will occur before Community HealthChoices' implementation. If you look at aging waiver, tenant care, independence, ComCare and OBRA, just to the right of those labels (independent care) are dots. There are three dots. They all have green lines coming out of the top dot. After that, they just have dots. I want to talk you through what this means. For the aging, attendant care and independence behavior, individuals aged 21 and over will transition to Community HealthChoices. As a result, individuals age 18 through 20 in the independence and attendant care waiver in zone 1, they will not transition, because it is for people aged 21 and over. The younger people will not transition to Community HealthChoices. Instead, they will be transitioned to the OBRA waiver. I will talk more about the OBRA waiver in just a few minutes. The two green lines that go down and say "under 21" they will be transitioning to the OBRA waiver. Just for purposes of scale of the amount of people that will be transitioned into the OBRA waiver, currently, there are 7 individuals that meet this criteria in zone 1. There are 7 individuals that are under the age of 21 in the southwestern zone. Now, the ComCare waiver will become the Community HealthChoices waiver. We are using based on guidance from CMS, the ComCare waiver as our vehicle for applying for the Community HealthChoices waiver; therefore, the ComCare waiver in zones 2-5 will need to be vacated. So you will see those lines that go out to independence -- up to independence so zones 2 and 3 and phase 3 are represented by those little arrows that go up to the independence. This will attach approximately 770 individuals currently receiving services in the ComCare waiver and not residing in zone 1. The ComCare waiver participants in zone 1 will go to Community HealthChoices. The ComCare currently offers some services that are not currently offered in independence, but effective October 31st 2017 rehabilitation will be added to the independence waiver so that the people who receive those services will not go without those services in independence waiver. Individuals residing in zones 2-5 and needing those services, will be transitioned to the independence waiver from October to -- mid-October to mid-November. Now, let's go back to the OBRA waiver. The level of care for the OBRA waiver remains ICFIDD for individuals with developmental disabilities. All of these individuals will be reassessed in the OBRA waiver to determine if their level of care has changed to nursing facility clinically eligible. Individuals aged 21 or over who are determined to be NCFE will be transitioned to Community HealthChoices as implemented. Over 21 in zone 1 will need to be reassessed. We do have a breakdown by county in southwestern zone it includes 473 individuals that need reassessed. Communications are in the process of being finalized communicating about the waivers. We are -- we will have communication that goes to participants explaining the process. Individuals who are nursing facility clinically eligible will go to Community HealthChoices.
They will be told what they need to complete and who necessity are and an outline of waiver transfers. There will be -- we do have some draft letters. I will share them in upcoming months. In addition to that, I will be sharing them at the next MLTSS subcommittee of the medical assistance advisory committee.

Currently, the proposed time line begins outwardly communicating on Area Agencies on Aging. Entities and providers sometime in the coming weeks. We will sceblg webinars to walk through all of these steps and offer a form for questions for people who ask questions participate appts will be notified about two weeks following in mid-pay regarding the -- getting reassessed and then Area Agencies on Aging will start conducting their level of care determinations with participants. There is a three-month window in which to conduct the necessary level of care determinations so it will occur mid-August.

Participants will be notified as their determination is made, whether they are nursing facility clinically eligible or nursing facility ineligible. Participants aged 21 and over who are determined to be nursing facility clinically eligible will be transitioned to Community HealthChoices on January 1st, 2018.

It's a lot to take in in that slide.

How the office of long-term living and provider relationship changes in Community HealthChoices: This slide describes the office of long-term living, managed care and providers are going. We will set provider standards, monitor managed care organizations, we will pay MCOs and set/monitor capacity.

Those are the things that we will interact directly with managed care organizations over. The managed care organizations and the providers relationships: They will be decree den Nal providers, monitor providers, they will establish and maintain provider relationships, they will pay providers and they will stimulate capacity; which is something we are very interested in seeing happen.

So we are -- part of our communication strategy is that we are preparing some quick tips to address some areas we anticipate questions from providers in the upcoming months and those include things like what the continuity of care period, how providers will bill and be paid in Community HealthChoices and their coordination with Medicare; that's another area.

I did want to briefly mention the evaluation plan on our accountability and transparency to stakeholders. We have a three-prong approach in our quality vision. The first includes our evaluation, which is a long-term activity. The Department of Health and policy management graduate school of public health at the University of Pittsburgh health policy institute. These folks have been working on developing with the team here at OLTL and members of managed care long-term supports subcommittee. It is available to look at on our CAC website which I showed you earlier (CHC website).

We will likely have the evaluators come in and actually conduct a third Thursday webinar in the near future because they do have information that they can start reporting to us and showing us. We will be doing early monitoring of the Community HealthChoices program. This includes launch monitoring. Data we will collect from managed care organizations through the implementation in each zone.

So that really is going to be critical. We recognize that we are not going to have a robust data set within the first six months of operating community health choices but we recognize that we do need to do monitoring of the actual launch of Community HealthChoices.
And then we have our steady state approach which is ongoing monitoring of Community HealthChoices. In addition to our state staff that will be doing the ongoing monitoring and teams that will be doing ongoing monitoring of the MCOs, we also have our external quality review organization, which is required in managed care and they will be working to validate data provided to us by managed care organizations.

We have worked with partners across the Department of Human Services, including office of medical assistance program to draft a copy of managed care quality strategy, which has not yet been “unveiled” if you will, there is review at state level, but in the near future it will be coming out.

My understanding is that it is coming out by the end of April, hopefully!

Some of our next steps: We are anxious to proceed with each of the bullets listed on the slide. As I stated, we are looking to hopefully begin the activities in the near future, hopefully by early April, which are doing agreement and rate negotiations with the selected offerors, the MCOs that were selected, we will also be doing readiness review of them. We have our communication with participants and providers. The managed care organizations. We also have the 1915 (w)/(c) concurrent CHC waiver submission on fully in April.

We want to finalize quality strategy and monitoring measures.

There is much more to come on all of this.

I wanted to talk briefly because we have talked about this before, but I did want to mention briefly the governor's proposed budget, which includes the creation of a Department of Health and human services. There have been a number of questions about how the Governor's proposed budget will affect Community HealthChoices and how -- what the impact might be. I might take a couple minutes to run through one of the hallmarks of this year's budget which is the proposed remanaging single Department of Health and human services which houses four prior departments: Department of Aging, department of drug and alcohol programs, the Department of Health and the Department of Human Services.

We have realized that there are a number of areas in which we can make our government more efficient; therefore before serving our fellow Pennsylvanians those receiving services and those providing them. We think there is a lot of opportunity here.

The budget address. He continued his priorities, which is the government that works, jobs that pay and schools that teach. I want to focus on government that works. It is really in there, that priority, where it is clearly explained the concept of health and human services, merging of services, program functions and departments will help us with more collaboration, less confusion for providers, eliminate duplication and multiple licensure processes and really renews administrative costs.

There are -- last week or two weeks ago, the budget hearings and I guess they were last week. The budget hearings and they really did focus on both -- the consolidation as well as ongoing activities.

The House held three separate hearings the department of helming and department of drug and alcohol programs have always gone together in their hearings.

The Senate held joint hearing of departments of aging and health and department of drug and alcohol programs and human services. There was a panel of all four of those secretaries before the Senate appropriations hearing. There was an exercise that was talked through by charm Brown which gave the secretaries a good opportunity to speak about the programs of the people that are sevened by their department and with that, it made it pretty clear that this consolidation makes sense.
For the Department of Health and human services and Office of Long-Term Living, I first wanted to say that the Office of Long-Term Living is not in the budget it appears in the budget under a new office, which is the new office of aging and adult community living S. some of the appropriations from the department of aging, as well as the existing Office of Long-Term Living appropriations are contained within that new office of aging and adult community living. We believe that senior -- benefits for seniors and programs delivered to seniors will be bolstered by the ease and focus of single agency. They will have a single agency as point of contact within state government to receive health and human services. Some of the areas that we will all be working on together with our partners is the prescription assistance from PACE program, the aging waiver as interfaced with the options program, information on the quality of nursing homes and we can collaborate with the Department of Health and Department of Aging to really pull together some quality measures that make sense for Pennsylvania. I do want to point this out because this does get asked, this single Department of Health and human services will have no impact on how lottery fund moneys are used to help support nursing homes and senior live.

Reducing the complexity and confusion for seniors and individuals with disabilities. Currently at least 21 separate services across the departments provide care and services for individuals with physical disabilities and seniors. Combine department can eliminate the unnecessary duplication of effort and confusion among consumers and their families. Continue to provide the quality of services for seniors and individuals with disabilities, dramatically improve the delivery of services like health screenings, programs to allow individuals to remain in their homes, et cetera.

One other area I think is worth highlighting is the proposal will really reduce red tape for providers and non-profits that are subject to regulations. Providers ranging from hospitals and childcare centers to substance use treatment facilities and nursing homes are licensed by multiple agencies, many times for the provision of the exact same services. Requiring these businesses to subject themselves to multiple duplicative inspections and audit costs, which cost them money.

We believe that this will -- providers will be better able to focus their resources on our mission to improve the health and quality of life.

With that, I am going to open it up for questions.

>> KEVIN: We have three or four questions.

>> JEN: Kevin Hancock has joined us today.

Can you provide an answer on whether or not HCSIS and SAM will be used to manage the services that the MCO will be taking over as part of managed long-term services and supports? For example, will MCO staff and support coordinators use SAM?

I know in the past it has been discussed but the details have been vague. If you can't answer, how do you have -- if you can't answer now, do you have a time frame on when this decision will be made?

The managed care organizations will have access to service plan information in both HCSIS and SAM. They will have the option, however, to transfer that information to their own care plan systems.

The second question is: Am the community will the community have access to the tool for review? Participant, advisers and representatives from the community will have the opportunity
to be part of the readiness review process and to coordinate the review and development of readiness review tools.

We will actually talk about that more in detail because we have been holding meetings with participants and the help law project health law prog secretary and they will come to talk about what that process is like.

We will not share it with the general community, however, because it is -- it's not a tool that gets shared. We did do an extensive presentation on information that is in the readiness review tool at a recent MLTSS subcommittee meeting.

Will the community be able to review the benchmarks in advance of the providers for comment? As I mentioned participant advisers will be part of the readiness review process and review of the tools.

Will OLTL participants, advocates and home and community-based providers on network adequacy before training the Department of Health?

OLTL will engage with participants, providers and others in the training efforts associated with the long-term care network adequacy with the Department of Health. So the answer to that is, Yes.

>>&nbsp;&nbsp;Kevin: We have a few more questions. I will read this one here: Where do gateway and Amerihealth fit in now as it pertains to Community HealthChoices?

As we reported in the past gateway was not one of the [inaudible] at this point. This is a long question. After a few conversations with one of the selected offers it seems there is no smooth exchange of information as to when it comes to the transition to managed care. They are saying they are waiting for information from OLTL. Same goes other selected plans. When is OLTL finalize the process so all informed can be informed? This is supposed to start in eight more billing cycles many questions remain unanswered. It seems neither MCOs or OLTL will be ready January 1st.

That is not the case and it is set to start on January 1st, 2018 in southwest region when will MCOs be able to get things moving to date only one is reaching us providers for letters of intent in initial contracting they do not know how they are going to handle home mods, other services because of a lack of guidance.

Just to be -- pause of other activity associated with the departments, it is true that we have had limited conversations with selected offerers; that will continue until we are given open license to have much more directed conversations. We have, just to be very clear, in the planning process and the planning process readiness review, built a process for exchange with the selected offerors and managed organizations to built readiness review and answer questions of managed care organizations and once we are given the freon light to have full conversations, then we believe that that engagement will be -- that we will be able to fill some of the gaps that are raised in this question.

Also, general comments. We believe we will be able to meet the January 1st, 2018 for cannelwest, recognizing that there is always an opportunity to use more time but we believe at this point we have enough of an infrastructure to be ready to go and hit the ground running.

>>&nbsp;&nbsp;JEN: So service plans will be created and maintained in HCSIS and SAMs moving forward after the six-month transition period?

>>&nbsp;&nbsp;Kevin: I will answer that question. Thank you, Jen.

The answer to that would be it's up to the managed care organizations and it's most likely the managed care organizations will want to use their own case management systems.
JEN: The Medicaid application for aging waiver can be a lengthy and complicated process. Managed care organization representatives assist applicant with such applications? If not, who will do it? The Medicaid application will continue to be operated through the independent enrollment broker it's actually a retirement and through the county assistance offices and through the level of care determinations for med long-term care eligibility; that will continue to be through the indent enrollment broker in coordination with area agencies on agencying and the -- for the level of care determination and with t assistant office.

Will oversite be -- what the CUMETS are doing today monitoring an oversight of our providers will be a function of the managed care organizations. As one slide indicated earlier. Do ahead.

KEVIN: Next question: Will NHT services be contracted with MCOs? The answer to that is, Yes.
Next question: When are the MCOs scheduled to be coming to the MLTS SubMAAC and questioning when they will be part of SubMAAC for presentation? I don't believe it's scheduled yet.

JEN: Not until we are given green light.

KEVIN: We will schedule it right away as soon as we have the green light. We want MLTSS SubMAACs to have access to that as soon as possible.

Next question: Will there be limitations MCOs can set with providers and will MCOs being able to lower than current rates than in fee-for-services? They will be negotiated with MCOs and network providers. The rate conversation will be between the MCOs and the providers that they contract with for services.

This next question I think I will give to Jen because it relates to consolidation.

JEN: Okay. Will regulations and/or licensure requirements change? For example will provider examples compliance change also will Department of Health still handle annual licensure? Will the Office of Long-Term Living and QMET monitor compliance? OLT under community health choices will monitor managed care organizations. The managed care organizations will monitor providers. If a Department of Health -- if the consolidation goes forward, or reorganization goes forward, there will be no Department of Health. There will be an office can you bear with me?

KEVIN: While Jen is researching I am picking up another question: Is there any indication that the federal government will cut funds to CHC programs and if it will affect PA in general? At this point there is no such indication for such a cut at this time. We are paying as close attention to it as everybody else.

JEN: Just finishing up on the Department of Health question. There will be no Department of Health there will be health and human services and that department of health and human services will include a deputy secretary for healthcare quality and licensure and the description that is in - - in the governour's budget book describes it this way: Deputy secretary for healthcare quality and licensure oversees licensure and certification community program licensure and certifications, managed care and program integrity.

So there will continue to be annual licensure. As for the regulations or licensure requirements changing, I don't know -- I am not sure whether or not there is anything in the works to change any of these licensure requirements with the exception, I know, that the Department of Health is doing some work on the nursing home side.

KEVIN: Can you explain how development of budgets for participants will change as MCO per member per month per capita rates.
It is expectation managed care organizations will develop person-centered service plans for all long-term services and supports individuals and individuals with unmet needs and the process will be largely-developed based on the MCOs vision of the development plan. There has been specific requirements developed as part of the agreements as to what that service plan will contain and consideration will be the number of units per individual services that will have to be managed for individuals.

During the continuity of care period, however, which is the first 6 months of the roll-out of each zone, the existing budgets that were approved at the time of the transition will remain intact for the first of months.

The third question, will MCOs be keeping existing care managers or provide their own team of care managers?

As managed previously MCOs may contract with existing coordinating care managers or use in-house care managers. It is prerogative of the managed care organization.

During continuity of care period, however, during the six-month period, they will be using existing service coordinators during that six-month continuity of care period.

Next question, what will happen to PPL, which is the financial management services agents? Currently, in use for home and community-based fee for service waivers PPL will remain in place under managed care to provide payment for the consumer directed model direct care workers. The only difference in endpayment is managed care organizations will be working with the financial management agent and it won't be with individual direct care workers in the departments. MCO will be an agent involved in the exchange.

Next question: When will the final RFP be issued? We are hoping within the next few weeks. It's going through final reviews at this point. We are looking forward to that being issued in the very near future.

This is a follow-up to the question earlier. Instead of an audit by the department of health or Office of Long-Term Living could be subjected to audits one by each MCO they will be responsible for monitoring providers. For the service delivery for Medicaid purposes but the Department of Health will continue doing licensure inspection those surveys will not stop.

Is there going to be some cry tear yarr to make sure direct care workers will be able to make a better working wage once the system is transitioned over to the managed care organization?

We haven't thought about criteria.

**Kevin:** I am not sure I understand the question.

**JEN:** Here.

**KEVIN:** Thank you.

I am assume what this means: Will MCOs be given direct guidance on how much workers need to be paid?

Just to be clear, rates will always be something that will be negotiated between managed care organizations and the individual providers. The direct care model, however, it is expected the managed care organizations will be responsible for offering a range through which the participant employers will be able to set salaries for their direct care workers so that there will be some guidance with managed care organization with that range. Very good question.

**JEEP:** Okay. We got that one.

When is FMS fiscal management services request for proposal being released?

**KEVIN:** One against, like the RFP we are hoping it will be released within the next couple days or a week.

**General:** We are just at the press piss of getting it out.
If OBRA waiver individual is determined nursing facility ineligible, what will be the process for them? If they are determined to be nursing facility ineligible they will remain in OBRA. (Jen).

**KEVIN:** I have another one it's a follow-up to a question I answered previously. Although OLTL is ready for transition how long will MCOs be given to -- at current pace a lot of cramming seems to be needed done. Do they plan on all of the software being the same? It depends -- I will answer the last question first. We do not have an expectation at this point that all of the software will be the same. The answer to that would be, No. The MCO software has to interact with the department's software, especially for key file transfers we do not expect the softwares to be the same.

Regarding the rest which is about provider training during transition. We recognize that the timeframe will require some intensive training but we still expect it to be completed. We would like to remind the everybody -- in addition to the roll-out date of January 1st, 2018 there will also be a six-month continuity of care period. As it exists will remain in place during six-month period to address trainings and transition requirements that would be required as we go live with Community HealthChoices.

**JEN:** When MCO goes live in January will all providers be set up at that point for billing and service implementation. Yes, it is pardon of readiness review. We make sure testing is done, the MCOs will conduct sort of mock billing and service coordination, they will do some, like, dummy examples to ensure that the are able to -- that they are able to pay providers. As I said before, and I will say it again, we want to make sure throughout this transition that providers are paid and consumers get the services that they need.

**KEVIN:** We received a question I will not be able to answer. It is from managed care organization. We are not in a position at this point to be able to answer the question on third Thursday webinar for managed care organizations. We apologize. There will be vehicles made in the near for.

**JEN:** Will a person who wants to change MCO aging waiver -- let me make sure you understand we will not have the aging waiver we will have the community health choices waiver. The MCO Community HealthChoices waiver to life or from life to managed care organizations CHC waiver, will they be required to have a new level of care done? I don't know the answer to that question. That one I would have to research.

**KEVIN:** Another -- I can answer that question. Will a person -- just to repeat it: The level of care determination that is used for both the LIFE program and the aging waiver generally it is similar. This is not really relevant to -- I guess what I am assume willing they mean is MCO transitioning from Community HealthChoices to LIFE and vice versa. Since both -- if they are in long-term services and supports and in the LIFE Program you need to be nursing facility clinically eligible. Functional eligibility is the same. Functional eligibility will transition between the two programs. There will have to be certainly some information exchanges between managed care organization in the LIFE plans but the designation will be the same.

**JEN:** Thank you. How does the continuity of care period help providers? Isn't that just to protect the consumers?

**KEVIN:** It is definitely to protect consumers but it affords opportunity to provide more training with providers and also more network development. We are recognizing that the
continuity of care period will also involve network built up and the -- certainly the augmentation of the long-term care networks, as well as the physical health network for program participants. It's an additional opportunity. While at the same time protecting the service plan for participants while they transition fully into manage willed care environment.

>> JEN: What happen pes if managed care organizations do not pass readiness review in time to meet consumers at roll-out.

>> KEVIN: It's not our requirement but also federal that they must be certified ready before we do live with Community HealthChoices. It is a non-stop requirement. It they have to pass readiness review.

I have another one here: I will paraphrase this question, the question is, will FMS still be under PPL or will another provider be provider this service?

Just to answer the question, for 2017, our current financial management service provider will be PPL but also as mentioned, we will be releasing a request for a proposal any day now in the very near future and we will have an offer or process that may determine who the financial management services entity will be under the new Community HealthChoices program.

>> JEN: How will stakeholders be endpaijed with planning for the proposed consolidation. This is going back to the budget (engaged).

Stakeholders, that question -- stakeholders will definitely be engaged but the engagement of stakeholders is being happened he willed by the governor's office. I have not (handled by the Governor's Office. That has not yet exactly been explaipped to me; however, it is definitely going to be stakeholder engagement for planning for this.

>> Jen. Again, on consolidation, what conflicts of interest have been identified with proposed consolidation and how will they be addressed.

To my knowledge there are none that have been identified. Have you heard of any in the consolidation?

>> KEVIN: Not that I am aware of.

>> Jen: We are not aware of any.

Keep them coming.

>> KEVIN: Next question, assessment to determine nursing facility clinical eligibility available to you at this time? The person is requesting a copy.

I think it is still under development. I am assuming they mean the new functional eligibility determination tool that is still under development at this time. Since it's still under development enand go through the pilot process it is not yet available for finalized view.

>> JEN: We can get you a copy, however, of the existing level of care determination tool. We have your email addres. We will reach out to you to provide you with what is in existence today; that exists today.

>> Kevin: Will MCOs or DHS determination of qualifications necessary to perform waiver coordination services for consumers? I guess what is being asked her, who is going to be determining the credentials for service coordination at this point?

Since service coordination will be an administrative function of the plan and since the department has already established what the requirements will be for service coordination in the draft agreements, the MCOs will be responsible for determining qualifications for service coordinators based on the the requirements already published.

>> JEN: Okay.

>> KEVIN: I think we will leave it open for a few minutes.
JEN: We don't have any questions at this time but will leave it open for a few more minutes.

KEVIN: Will there be a choice for FMS provider in the future? I believe that we are procuring the FMS provider statewide. I do not believe -- although I am not completely sure. This is something -- the question every will follow up in his question and respond to it at a later time. I believe -- we may be able to answer it in the next couple minutes I believe at this point we are procuring statewide for FMS vendor.

The next question is one we are researching right now will there be FMS services regional offices for consumers. We did require a regional presence as part of the procurement.

JEN: I want to go back to a question that Kevin answered earlier. The question was, Did Iness the day they are coming to the SubMAAC if I didn't miss it when will they be there? We haven't scheduled it yet because we are in limited communication with the selected MCOs. As soon as we are given the green light, which we hope will be happening in the very near future we will make sure that the MCOs come to the next MLTSS SubMAAC meeting. It could very well be that the -- that they come to the April meeting but I don't know. We just don't have a definitive green light to proceed with engaging with managed care organizations. To be determined.

As soon as we can do it, we are going to bring them in.

KEVIN: Next question: Would you be able to share level of care documents with me as well? We have the email for the person who asked the question and we will share the existing level of care determination with the individual who is requesting it.

The next question I am going to give to Jen which is about the bureau organization the bottom question.

JEN: Are you able to comment on the proposed regionalization of county assistance offices and how it impacts eligibility for Community HealthChoices?

I am not able to comment on regionalization of community assistance offices other than to say that the expectation is that the reorganization will take the -- kind of the behind-the-scenes work that the offices have to do and regionalize it and there will still be a front-facing county assistance office in it with people in it to answer questions and deal with the public.

All of the work that they have to do to get information is going to be done in those regional hubs. I don't think this will impact eligibility for Community HealthChoices. Do you think it would impact Community HealthChoices?

KEVIN: No, not at all.

JEN: It will not impact eligibility for Community HealthChoices at all.

KEVIN: We are hoping it will improve the eligibility process in general.

JEN: Yes, we hope it will help the eligibility process go more smoothly.

Who does green light for negotiations need to come from?

This comes from the governor's office.

FMS statewide do you mean only one choice again?

KEVIN: That's still being researched we will respond to it hopefully before the end of this webinar.

JEN: Did you say Governor will oversee Community HealthChoices, no, I said the governor office is setting up the engagement not in Community HealthChoices but in the reorganization of state government. The Governor's initiative appeared, that was in his proposed budget that he announced last month.

KEVIN: One of my questions. Would you repeat the last question and answer on service coordination.
Because we had have had a couple questions, whether or not the MC Os managed care organizations are going to use service coordinators in-house or contract with existing service coordinators; since service coordination is administrative function of managed care organization, they may use existing service coordinators as contractors or they may have service coordinators and care managers the -- expectation during the continuity of care period; however is existing service coordinators will be used during that time period.

Jen handed another service coordination related question to me I will read it again and answer it. Will MCOs or DHS determine qualifications necessary to perform waiver service coordination for consumers the response to that as I mentioned is that we have published our requirements for service coordination and the draft agreements we expect the managed care organizations to adhere to those requirements and it will be up to the managed care organizations to make sure that service coordinations are meeting these requirements.

My next question, could you highlight what those qualifications for service coordinators and supervisors?

At this point, it's in our published draft agreements those requirements have not changed at this point and we would encourage the person asking this question to go to our website, do to the Community HealthChoices page where the information is highlighted, look at the draft agreement that was published from -- in March 2016 and look at the service coordination requirements published in that document at this point.

In future date we may be able to review this again.

Next question will MCOs be paying out home modifications. Home modifications are an eligible service under Community HealthChoices for people eligible for long-term services and supports and the way that that will work is that managed care organizations will be responsible for the delivery of the service if it is warranted.

Next question: Do you know what program measures are used for CHC in the future governor's proposed budget. It is a good question. At this point it's open for discussion but I don't think we have firmly proposed program measures for Community HealthChoices but we are happy to discuss them.

>> JEN: Do you know if the proposed merger of departments will affect waiver payments? Many times in the past when significant changes happen, payments were delayed to providers. I don't anticipate it will happen but it's something we will keep on our radar.

Does all of the talk of the reduction of Medicaid expansion impact Community HealthChoices in any way?

We are moving forward with Community HealthChoices regardless of what happens in Washington. Things will continue to work to develop our program and make sure that it's a program in which we provide higher levels of quality of care to some of our most vulnerable citizens.

>> KEVIN: Kevin, can you provide update via email on answer of FMS state provider question if you don't have the answer before the end of the call? The answer is, Yes, I also have the individual's email. I hope to get the answer before the end of the call.

Again, assuming it is a statewide procurement but I want to be sure. It's not a procurement I worked as closely as I have with the other procurements.

Beyond continuity of care time period should home care companies be concerned not getting contract with MCOs.

We talked about this before. It's a really good question. What home care entities and all providers should be doing is reaching out to managed care organizations and
presenting yourself and your case for why would you be a high-quality provider for which a contract would be warranted.
In terms of concern, I think that people should be looking at it as an opportunity to present their case for why they think they would be quality provider with the managed care organizations.
>> JEN: The time frame for county assistance office is 45 days for working eligibility, it's not realistic. Will this chaisk if a participant needs home modification? Who will pay? Thank you. Home modifications, we will get -- if the person is eligible for long-term services and supports, home modifications are available to them so individuals in Community HealthChoices who need a home modification, they will be able to receive a home modification. The home modifications are built into our rate assumptions.
I am not -- I don't really have any comment on the CAO, 45-day eligibility not being realistic. I am not sure what the question means.
We are considering one more question, here.
If you beer with us for one moment, we are going to -- we are researching one additional question.
>> Kevin: I am looking at the plan at this point. So it is possible in this procurement that the department will select an offeror or offerors to coordinate FMS in a manner that is fiscally and efficient for participants in the Commonwealth.
What this generally means is that it is possible for this procurement that there may be more than one # offeror selected. So it's to be determined, in other words.
Hopefully that answers the individual's question. We appreciate the patience in our ability to be able to research it. Thank you.
Good question.
-- MCOs are not responding. Any advice?
Part of the reasons the selected offerors may be hesitant is largely because the prohibition in conunfion from the department which we hope will be lifted soon.
Will there be.
>> CAPTIONER: I cannot hear his reading of the question.
The process is between managed care providers.
This is not a question but it is a comment.
We know it's not easy to answer everything this time around you have been very informative thank you for sharing your knowledge with us today.
Thank you for the nice comment.
>> Kevin: Thank you very much.
Next question: Requesting we provide members of managed care organizations so they can do their part and we will certainly do that once we are in a position where we can engage with the managed care organizations more fully.
>> Jen. We will give it another minute for any final questions. Here comes one or maybe a few. Thank you.
>> Kevin: If consumer is picking their own managed care provider, who are we to call should this be an automatic turnover since we are providers for the client for a long time.
The continuity of care mered will allow the -- the six-month continuity of care period during transition will allow opportunity for transition as needed if it's determined the provider who are providerring services are not part of the managed care organization that is selected by the program participant transitioning into Community HealthChoices.
It will be -- if the provider is providing services and part of the managed care organization, it will be part of the discussion with the managed care organization itself. Another compliment. Thank you very much.

We appreciate your time in answering the questions and time you are taking inquiring the clarification. It is truly appreciated. We appreciate the complements and we appreciate your patience as we waited for the clarification.

>> JEN: Yes!

>> KEVIN: Two more questions.

>> JEN: That will probably wrap it up.

>> Kevin: Will MCOs have a limit on how many providers they can manage or to contract with? I know of no such limit at this point. It's really a question the MCOs will determine for themselves. They will have a lower threshold. As we assess network adequacy, we will make sure that enough providers are available to certainly provider services that individuals need as well as to provide choices to program participants. On upper limits, that would be a discussion will with the managed care organizations.

>> JEN: Yeah. Okay.

All right. Well, thank you very much for participating on today's third Thursday webinar. Again, if you have any thoughts on what topics to include on the third Thursday webinar, please submit them to us. We would -- we are entertaining any kinds of comments or ideas -- if you could hold on for one more second, I am just going to see if I can get an email out of here. I've asked Georgia to explain how to submit comments for ideas for future webinars.

>> GEORGIA: Good afternoon, everyone. We send out an evaluation. It's approximately 24 hours after the webinar concludes. You should all receive it tomorrow. Through that evaluation, there are some questions related to whether or not the information that was shared was useful, whether it was shared in a meaningful and helpful fashion and there's an open text option at the end for folks to submit comments. So if you have suggestions for future topics, they could easily be submitted that way; that would be appreciated.

>> Jen. Thank you. One more question?

All right. Thank you all who Dave gave us complements today. It was really appreciated. Thank you, everyone, for joining us for the third Thursday webinar. We will see you next month. Bye!

(Webinar concluded at 2:57 p.m.)

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