

8/20/15 Webinar

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Hello!

>> The broadcast is now starting. All attendees are in listen-only mode.

>> THE SPEAKER: Good afternoon. We will begin the webinar on managed long-term services and supports in a few minutes. Thank you!

(Announcement made at 1:33 p.m.)

>> THE SPEAKER: Good afternoon, this is Jennifer Burnett deputy secretary for the Office of Long-Term Living. I want to welcome people to today's webinar. This is the third Thursday webinar that we are planning on conducting for the next -- for the foreseeable future while Pennsylvania rolls out managed long-term service and supports.

One moment, please.

Good afternoon, everyone. This is Jennifer Burnett the Deputy secretary for Office of Long-Term Living.

We are doing technology checking. If you could sit tight while we make sure we are being heard. Thank you.

>> Good afternoon, everyone. This is Jennifer Burnett. Welcome to today's webinar. I'm sorry. We are having a little bit of technological difficulties. I think we are okay now.

This is the third Thursday meeting the Office of Long-Term Living will be conducting every month in order to roll out managed care in the Commonwealth.

I wanted to give a quick update today on what has happened since the July 22nd webinar and give folks some information to share and then we are going to turn it over to Alissa Halpern, who will do a presentation on managed care, a basic presentation on managed care and how it works. We are calling it managed care 101.

We are intending to use these webinars to

provide information on a regular basis out to people in the community across Pennsylvania. We are really looking forward to hearing feedback on the webinar.

Last month 22nd webinar that there would be an email but it will be coming out yet this month to those who provided their email address.

Since the last webinar we have been working to develop a concept paper and a requirements document. We are planning to publish those two documents on September 8th, right after Labor Day.

Our plan is to distribute it widely to a broad group of stakeholders, and will be open for comment until October 5th.

There will be significant detail in those two documents, based on the input and feedback that we received on the discussion -- the earlier discussion document that was published at the beginning of June. We had a lot of comments, over 800 comments, commentators and a lot of participation at our -- during the listening tour that we did. All of the input

an need back we did, was considered to create a more detailed set of documents that we are going to be sharing with the public.

The concept paper will describe the current thinking on Pennsylvania's managed long-term services and supports program. We will propose a number of innovations in the concept paper. The concept paper will be submitted to centers for Medicare and Medicaid services.

We will use the concept paper to work with CMS and determine the Medicaid authority necessary to implement the Pennsylvania managed long-term services and supports program.

We do anticipate a lot of feedback on the concept paper, and this will assist the State to make improvements on the paper.

The requirements document, the second document that will be issued on -- we are shooting for September 8th, will be used to get feedback on what will be going into the managed care organization or MCO procurement document; so the procurement announcement which is slated to be issued later this fall, we are using the

requirements document to layout our -- the requirements that we would put into a procurement document, an RFP, and then we will be soliciting input on that as well.

I want to talk about a key decision that has been made and then I am going to turn it over to Pat Brady for some housekeeping on today's webinar; and then we will go ahead and introduce Alissa.

The key decision that has been made is that behavioral health will be carved out of Pennsylvania's long-term managed care services and supports program.

This really is in response to the public's comments to our MLTSS proposal. We made a decision to carve out the behavioral health services. The thinking goes along the lines of the current -- the fact that the current behavioral health choices plans have well-developed networks and provide quality care for participants. The Commonwealth really does want to avoid any disruption in services.

We know that a significant portion of the

dual-eligible population already receive behavioral health services in the existing behavioral managed care system, including behavioral health services and managed long-term care services and support could create a disruption of service for the dual eligibles.

To ensure coordination of care, managed care organizations will be required to coordinate between physical health, long term services and supports and behavioral health, in order to ensure quality outcomes.

We believe that there are tremendous opportunities for collaboration. We are working closely with the office of mental health and substance abuse services in the department of human services to focus on a more collaborative approach in terms of how we roll this out.

We also think opportunity for serving older Pennsylvania in a more holistic way in this new environment.

With that, I will turn it over to Pat Brady to talk us through some logistics for

today's call, and then we will turn it over to Alissa.

>> PAT: Okay. Thank you, Jen. Good afternoon. We just wanted to cover a few items on the go-to webinar system itself, for those of you who are on the call previously, you are familiar with this. For those who weren't you will see a rectangle where the PowerPoint presentation is as we go through it. On the right-hand side is the control panel.

You can see the area where you can type questions, everyone is currently muted and if you have questions throughout the presentation, you can type those in that area and then we will be answering the questions at the end of Alissa's presentation.

You can type those anywhere throughout the presentation. You can also change if you are currently using telephone and want to switch to your computer, in the box that you see towards the left-hand side of the screen; that's where you can switch over from the telephone to the microphone and speakers on your computer and this is an area where you can ask your

questions.

All right. With that, I am going to turn it back to Jen.

>> JENN: Thank you, Pat.

I wanted to just quickly introduce Alissa Halpern, who is our featured speaker today. At the end of Alissa's presentation, we will be opening it up for questions, similar to what we did last time, questions can be asked through the chat box, or by sending in emails to the resource account for managed long-term services and supports.

Alissa Halpern has a long history of advocacy and just support for long-term care in general. Her advocacy spans -- we welcomed her to our team as a consult to help support us as we roll-out managed long-term services and supports.

Alissa will go through the training outline, which is on the screen right now, and then we will be going through the PowerPoint. Alissa?

>> Alissa: Thank you.

We are going to start this discussion with

just sort of a general overview of managed care so that people can understand the difference between managed care and fee-for-service.

Then I will talk you through how a little bit of managed Medicare works, justening e generally going through that and the requirements there.

Then I will explain a little bit about med okayed managed care to let you know the difference. Finally we will spend time discussing long hitch term systems work regarding Medicaid, then we will take questions from everyone. Next slide, please.

>> So, what is managed care? Managed care is both the as much as delivery structure and a financing arrangement. Next slide, please.

It is helpful to discuss managed care in the context of understanding how fee for service works. Let's just take a minute and discuss how fee for service works.

In fee-for-service we have payments made for each service that is rendered. It is not a single monthly payment to cover any services that someone might need, it is payments for

each particular service. You can go for a specialist and it is not provided across different cover areas.

Standard pack aiming with prior authorization requirements as well as benefit limits imposed with or without exceptions.

Provider network tends to be any willing provider so that any provider who wants to participate typically is allowed to if they accept the defined payment.

Historically, states structured their Medicaid programs as FFS delivery systems; however, since 1990s, many states started moving towards managed care for Medicaid populations on the healthcare side. It's only been in recent years they started to look at moving their Medicaid populations to managed care on the LTSS side.

Next slide, please.

So, managed care, generally -- this is how managed care looks in the private market as well, there is a managed care organization that serves as primary gatekeeper for access to benefits.

Typically the PCP, primary care provider is charged with serving as gatekeeper for access to specialists and referrals are required.

The benefits package tends to be defined set of covered services that may vary by insurance company there may be prior authorization required.

The provider network generally, in managed care, tends to be a limited network, a selective contracting with certain providers is what happens and so, typically, people have to see providers that are under contract with their managed care plan to provide services.

There traditionally is a formulary, which is a list of pharmaceuticals that will be available. They are usually tierless so certain pharmaceuticals are available. If they fail you can move on to the next tier and there are usually systems like that in place.

Managed care often -- usually always -- has a utilization of management process where staff is set aside and they manage things such as inpatient admissions, length of stay as well

as approving set services; it's usually a whole department within the managed care organization.

Other characteristic of managed care, generally, is the capitated payment. The managed care organization agrees to cover serviced for a fixed monthly payment, a capitated payment. They agree to provide whatever the participant needs, you know, even if it is more than, you know, the payment that they get or if it's less than the payment that they get, then they make money on it.

Typically, managed care organizations have a defined service area. Maybe they operate in several counties, a certain portion of a state. They are not necessarily likely to be a statewide entity and in one managed care plan. A company might have plan in all parts of the state. So there are three different types of managed care. The most common are managed care organization, health maintenance organizations, they provide plan defined set of benefits and contracts with providers to provide full range of benefits to enrollees. They are centered on

PCP as organizer. Non-emergent care requires prior approval.

The way it differs from preferred provider organizations is that managed care organization has a closed network. Preferred has open network. The member can select provider of choice, and, you know, initial PCP visit or specialty prior authorization is not required.

The point of service option for managed care -- again, these two are less common than the managed care organization, 'version of managed care. It is a plenty. There is a network. You can see the provider in the network but you can choose at the time of services whether you want to go in the PPO direction the providers who are not in your plan's network.

Next slide, please. One of the rules of governing managed care of private marketplace. There are federal laws: The HMO Act of 1973 set established federal standards, there is HIPAA of 1996 that applies federal minimum requirements; then State law Act 68 of 1998 which has a lot of good requirements for

managed care, generally.

Next slide, please.

So now that we have had an overview of managed care, how they work, let's talk a little bit about Medicaid managed care and how it differs from managed care in the private marketplace.

Next slide, please.

The Medicaid managed care is when state government pays an entity to provide a defined benefit package and meet quality and performance standards established in a contract to a district portion of the state's Medicaid population. They do this in exchange for a fixed or other payment.

It is very similar to general managed care model, you know, what I just described; however, Medicaid managed care has different rules governing and therefore very different features that come from the federal regulations.

Next slide, please.

Key features of current Medicaid managed care regulations include articulated

participants' rights, grievance and appeal requirements, a requirement that there be participant choice of at least 2 plans, there are rules how marketing can be done. For example, cold-call marketing or door-to-door marketing is not allowed.

There are rules around credentialing. There are also rules around how the enrollment processes have to incur. Limits on cost-sharing that need to be imposed on people that are in the Medicaid program. There are requirements around external quality review and also rules around network access and adequacy and, you know, states in designing their own program can modify the federal rules, as long as they are requiring something that is better than what the federal rules, essentially, require.

If the federal rules that require, you know, there be a certain number of providers within a certain system, states can provide something better, typically, it has to be something more favorable to the consumer.

Other features in Medicaid managed care

there are carve-outs. Some services will be carved out. As Jennifer just described with behavioral health, it is very common states will carve out dental or behavioral health services as some examples.

Another example is readiness review. There is an extensive readiness process in which the state must, you know, evaluate and determine a whole bunch of elements to confirm that a plan is ready and able to be, you know, operational.

Crystal, can you send me the message in the webinar? I am not sure if the message was that I am going too fast or slow. I cannot look at email while also presenting.

Typically, Medicaid managed care includes decrease dense shaling requirements. I think I alluded to that earlier. You know, there are certain Medicaid participating provider requirements.

In terms of rates, there is always a capitated payment to MCOs, but there is a requirement in Medicaid managed care that it be actuarially sound; that is a requirement that

the federal government has so that the rates, you know, are based on what services to the population have cost over recent years and what they should cost based on the needs of the population.

Emergency and urgently-needed services must be available. There can't be limits on access to those when someone is out of network.

Next slide.

There are rules. There are federal regulations. They layout a lot of details. It is what I just explained some of the features.

There are also new, proposed federal Medicaid managed care regulations. They went up for comment on June 1st. The comment period ended July 27th. You can see the links here or just Google it.

They outline a bunch of elements that, for the first time, actually, address the LTSS issues. We will talk more about that in a few minutes.

You know, until these proposed rules came out, Medicaid managed care rules were only focused on sort of physical health needs and

requirements related to that.

Next slide, please.

Medicare managed care. Now we will talk a little bit managed care generally and how it works in the private market. We talked about Medicaid. Let's also talk about Medicare's managed care. There are Medicare managed care plans also.

Next slide, please.

So Medicare managed care plans are also referred to as Medicare advantage plans or Medicare part D plans. Medicare managed care provides everything covered under part A and B, A is hospitalization. B is medical insurance. But they are provided to a private managed care company under contract with the Medicare program.

Most Medicare advantage plans provide parts D, which is a prescription benefit, although people can be in a managed care plan for their healthcare and in separate one which is just part D pharmaceutical benefit.

Many Medicare managed care plans also add supplemental benefits beyond just what part A,

B and D cover A they are aloud to do this. CMS allows them to add over-the-counter drugs but are not covered under part D. Typically you will see Medicare advantage plans will look for supplemental benefits that they can add that, you know, may be helpful to them in marketing or enticing new people to join, also, that would be beneficial to enrollees.

One example is not just over-the-counter coverage but over the-counter cards. Several plans awfuller a card for personal hygiene items or other perks that may be appealing to the population.

Enrollees usually pay a monthly premium to be in a managed care plan in addition to paying part A and B plan they have.

They pay different cost-sharing amount and what are charged under parts A and B. Next slide, please.

So there are Medicare managed care rules as well. Fixed minimums are around many areas, including but not limited to rights, grievance and appeal processes, which happen to be detailed but very different from the Medicaid

managed care grievance and appeal processes.

They have marketing rules. Very expensive marketing and enrollment rules, they too have access and adequacy requirements under managed care regs.

Next slides, please.

So, Medicare advantage plans or part C plans, there are regulations that govern part C plans, but those that offer part D benefit also have to comply with part D regulations. We provided a link for both of those. Then there are also -- a whole bunch of policies outlined in the Medicare managed care manual, which goes into more details than what is in the regulations as to what is required.

Next slide, please.

Now we have tried to -- I tried to lay the groundwork and we will talk more specifically about managed long-term services and supports.

>> VOICE: Come in.

>> Alissa: Next slide, please.

We can hear you. I am not sure, Jen, if that's you. You need to be muted.

>> JENN: I will go back and mute. If

everybody can mute, please. Hold on a second.

>> Alissa: What is MLTSS? Managed long-term services and supports is a managed care program through which a state pays an entity to manage delivery of LTSS through capitated payment arrangement.

There are example in different states. Some states have done just all LTSS services. Some states have done just all of their Medicaid services, including LTSS. Some states, you know, just focus on having a federal PACE program, which we call LIFE in Pennsylvania.

Some states, more recently, have been focused on trying to develop integrated care plans and programs that include all of Medicaid services, including LTSS. Also, all of Medicare services so that they are coordinating and responsible for providing coverage for all services that a person might need, if they have Medicare, as well as Medicaid.

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What are the legal requirements for States that implement MLTSS? States have to have

federal managed care authority and states must have federal home and community-based authority in their Medicaid programs.

There are several different vehicles through which they can get the different provisions of federal law that allow them to pursue this. This is what the concept paper will address, some of the questions about authority and the direction and decisions that will need to be made.

There are also federal regulations, as I already described for Medicaid managed care. If a state is implementing an integrated program, they will have to follow Medicare managed care regulations as well. And then we also have -- this is what I alluded to earlier about the Medicaid managed care regulations that were just proposed -- finally including something specific related to LTSS.

In 2013 CMS issued guidance to States on how to design their MLTSS program. These items have now been incorporated or being incorporated into the new Medicaid managed care federal regulations.

If we could go to the next slide, I will talk to you a little bit about the guidance the states may have.

It outlines 10 key elements to a good state program, a good MLTSS program. They call for thoughtful and adequate planning, as well as stakeholder engagement in the process.

Specifically, they want to see that all MLTSS programs are implemented in a way that is consistent with the ADA and Olmstead.

Under the law, MLTSS must be delivered in the most integrated fashion and in the most integrated setting in a way that you have offers the greatest opportunity for active workforce participation and CMS says, we want to see that when you come to us, States, with a program that you are proposing.

Next slide, please.

CMS also wants to see that payment structures and goals are aligned. They want to see that states are providing payment structures to support the goals of their MLTSS programs and the essential elements. They want, you know, providers to be held

accountable to performance-based incentives and/or penalties and on an ongoing basis they want to see states are evaluating their payment structures and make changes necessary to support the goals of their programs. Goals that, you know, could have more home and community-based services than were previously available, you know, whatever their goals are, they really want to see that the payment structures are aligned well.

Support for beneficiaries: CMS wants States to make sure that participants are being offered conflict-free education, conflict-free enrollment/disenrollment assistance and advocacy in a manner that is access I believe, ongoing and consumer-friendly.

They want to see that all of the MLTSS programs include person-centered processes; that they require and monitor the implementation and use of these in terms of needs assessment, service planning and service coordination and they definitely want to see opportunities for and encouragement for the use of self-directed services through the

person-sented processes of service planning.

They would like to see states have comprehensive and integrated service pack ages.

Managed care organizations should provide and/or coordinate the provision of all physical and behavioral health, as well as all LTSS services and ensure that participants receive the services that they need in the amount, duration, scope and manner that are identified in the person-centered assessment and service planning process.

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CMS has called for states to eastbound sure states are enchurring qualified LTSS providers, such that they ensure access to all services. I think when I mentioned earlier about the Medicaid managed care regulations having rules around network adequacy, none of those rules, thus far, address access to LTSS. So, you know, how far you might travel to see a specialist is certainly different than how far, you know, it might be necessary for someone providing LTSS services to travel to see you and to serve -- [indiscernible]

They want to see during transition states are encouraging and requiring through contract provisions, even, the incorporation of existing LTSS providers into the MCO's network to the extent possible. They want States to provide or require the managed care organizations to provide support to the LTSS providers, as they transition into MLTSS.

They suggest that this could include information technology support, billing support, other systems operations support, because most traditional LTSS providers have no experience with MLTSS. CMS wants to see that the transition is eased for them.

CMS wants to see participant's protections. They want to make sure health and welfare is assured as well as outlining participants rights and responsibilities including incident management system which prevents abuse, neglect and exploitation and included in MLTSS plan. Protections that include continuity of care, essentially or continuing benefits pending and appeal.

And then, CMS wants to see that states are

maintaining the highest level of quality in their MLTSS operations and services through comprehensive quality strategies. They want to see that the strategies are integrated with any existing state quality strategies that are in place.

The design and implementation of the strategy needs to be transparent and appropriately tailored to address the needs of the population.

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What are some of the legal requirements for states that implement MLTSS on the state side?

State agencies often need authority from the state legislature to develop an MLTSS program or to develop licensure requirements around a new kind of entity. For example, an estate that has a plan that is only going to be offering LTSS services and not any healthcare services, you know, they may need to develop a new type of insurance licensure.

Some states also set requirements in regulations. Many contract provisions. State

managed care or insurance laws like our Act 68 often apply.

Next slide.

What is the current landscape of MLTSS? Currently there are 114PACE programs in 32 states. I don't mean pharmaceutical program for elderly. All inclusive care for the elderly, which we in Pennsylvania call LIFE. There are 114 of those in 32 states as of this year.

As of May 2013 there were 22 states offering managed long-supports and services. There are dual demonstrations which states offer fully integrated managed care services or long-term supports and services programs in 9 states and there are 4 more on the way.

States that have had MLTSS programs are looking to make changes. They are developing new or additional programs or they are taking MLTSS program and, you know, in a demo state turning it into fully integrated states or adding new services or new populations. New York is adding a program for its IDD population. Or they are expanding into other

service areas, maybe they started only in some service areas and now they will be expanding. There is a lot happening nationally around MLTSS.

Next slide, please.

Some of the goals of MLTSS are to improve coordination of services as well as to resolve some of the fragmentation of care and accountability that actually occurred when healthcare moved to managed care under Medicaid and LTSS remained in fee for service made it harder to actually coordinate between the two.

Also to develop a person-centered system of care that addresses the range of individual needs. Some states use MLTSS to increase access to home and community-based services to more people, both more people that are NFCE as well as to have some being available to people who are NFI. I'm sorry, I should spell out the act knit clinically eligible and ineligible. Savely decreasing institutional utilization. Improving clinical and quality outcomes, building consumer choice and med budget predictability.

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Now we talked about all of the requirements and what states are doing, let's talk about some of the features of state MLTSS programs.

When you look across the various states that have these programs, you will see that many of them have passive or automatic enrollment of a population into the program. They cover a varying array of services, as I mentioned. Some of them just cover LTSS services, some may only cover community-based LTSS services, some cover the full gamut of Medicaid services. Some have certain carve-outs. It varies. There is no consistency across states in terms of services.

You will see a broad provider network trying to address, you know, adequacy and requirements around LTSS providers, since there are no regulations specifying that.

You will even see, you know, states that include a choice of care manager or service coordinator as being network access and adequacy requirement that they impose.

States that adopt MLTSS programs all have continuity of care provisions as relates to existing providers and existing service plans at the time that people enroll. They set, you know, requirements for how long those existing service plans and access to those potentially out-of-network providers has to be allowed during the transition to the new plan.

Typically they -- states provide between 90 and 180 days. Some states will say, you know, 90 days or until a new service plan has been developed, whichever is later, just to cover the bases, in case there is a delay. They don't want anything to stop at day 90; and that is -- I haven't seen a state that doesn't have a continuity of care provision.

Another feature is person-centered care/as much as planning.

There is a great deal of emphasis -- you will note that this was one of the CMS elements to a good program of really trying to make the processes of assessment and service planning much more person-centered and having the individual be involved and the individual being

offered more choices and focusing not just on needs but also on preferences and, you know, personal goals.

We see a lot of these elements built into some of the requirements that are set. Having an advocate for the participant. This became a requirement in the dual demos. A lot of states now have an ombudsman. It differs from a long-term care ombudsman which is focused on residents of long-term care facilities address issues they may have with providers or long-term care facilities.

This is specifically an ombudsman that is designed to help people in MLTSS address issues with their plans and understand the rules of the plans and the rights they have with the plans and navigate the appeals process within the plan.

And then there is definitely a -- an importance and stress on the use of health information technology. As we see a more person-centered service planning process, we see more people being involved. We see a different approach to service planning in many

ways the growth of inter-disciplinary teams where there are more people involved there has been attention paid to making sure that health information technology is being used to communicate and make sure that everybody is well-informed about the services someone is receiving, as well as what their needs are, as well as any changes that might need to be made to a service plan so that if a person is -- a family member participating into an inter-disciplinary team, they too can have access to information related to the individual service plan.

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Then care coordination approach has been changing. A lot of states are moving to more of a team approach to service planning and service coordination and having, you know, PPPs and specialists and the actual home care aids or nursing facility staff involved in the service planning with the participant and their service coordinator so that, you know, it's a group of people at the table and -- very much like what happens in the LIFE program, where

there is an inter disciplinary team approach. Even the person who provides transportation weighs in with -- [indiscernible] -- really having a nice dialogue to talking with the participants and helping do service planning.

And then we are seeing a lot of systems for continual duty a feedback and analysis, as well as participant feedback. Many states are requires participants advisory committee within the plan and having the plans have to meet with participants, have participant advisory committee, participant town halls where they are required to gather feedback and report to the states on both the feedback that they are getting, as well as how they are incorporating that into any changes, you know, a lot of states are monitoring these programs very closely and doing, you know, setting a lot of reporting requirements and trying to analyze, you know, what is happening and what successes they are seeing and where their areas have changed.

There is a lot of reliance on evidence-based practice siss. You see it in

general these days.

There is particularly with MLTSS a heightened requirement around accessibility. You are dealing with a population that definitely has accessibility needs. States are strengthening the requirements that they impose, generally, as relates to this specific population.

And many states are highlighting participant-directed services. Whereas it may have been available before, you will see more and more states justifying that it must be mentioned at every service planning meeting as an opportunity. You know, that clear written materials must make greater mention than currently the option of participant direction.

As I mentioned earlier, with some of the supplemental benefits you will see that Medicare advantage plans can offer, there are some value-added services. Even in MLTSS, the sample that I gave previously about, you know, a card you can use at CVS or Walgreens to buy shampoo, soap, tooth paste and make sure that personal hygiene, you know, is taken care of.

Some of thieves add-ons that may entice, you know, people into specific plans, there are all sorts of add-on services that states can allow their MLTSS plans to consider.

I know in one instance, there is a plan that is sort of tying into the federal free cell phone benefit and adding on extra minutes to ensure that people who don't otherwise have access to a phone can have access to, you know, a coordinator, which is an added benefit that is not covered through the Medicaid program.

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With that, I think we will open it up for questions. I will questions related to the presentation and Jen will answer questions related to what, specifically, is being discussed and developed.

>> Thank you, very much, Alissa. It's been very helpful to have you do this presentation. We've been getting a lot of feedback on the chat and resource account mailbox and we really appreciate it.

Before you open it up for questions, I just wanted to make a couple of comments:

First of all, we apologize for the audio difficulties. We got a lot of comments about that. We will work on our audio for the next webinar. We apologize for that. We want folks to know that the webinar will be posted within 48 hours on the DHS website. If you go on the DHS website, there is now a managed long-term services and supports link from the main page.

In there, you will see the links to webinars. For those of you who were having trouble with audio, maybe listening to it in second time, it will help with that.

I will start out with the questions we received in the question log, which people submitted on the website for the webinar. I will start out with the first question that I have is -- hold on a second.

If a patient -- the first one is, if a patient is not appropriate for Medicare rehabilitation or maintenance, do you still need to bill Medicare prior to MLTSS.

I do want to say that I invited Kevin Hancock, our chief of staff to join helping to help with some of the more technical questions

that we have, but I will start out with the answer to that, which is N o. Kevin?

>> Cerch: The way it works in managed care.

>> CAPTIONER: He is too far from microphone. I am having trouble hearing him.

>> KEVIN: -- community choice participating provider MLTSS participating provider, under that umbrella the organizations will help you determine what will be an eligible service under MLTSS program versus what will be an eligible -- [indiscernible] -- for this rehabilitation question, it was determined to be Medicaid eligible service CMS will provide guidance whether -- [indiscernible] -- serving people first any balances will be billed through the Medicaid program.

In this case, if it is not appropriate for Medicare, it wouldn't be -- [indiscernible] --

>> THE SPEAKER: Thank you, Kevin.

The second question is, has the department analyzed how the new program will impact nursing facility reimbursement rates and

whether there will be different rates for specialized care services, for example, ventilators, as there are now. If so, is that information available for public review and comment?

That is under analysis right now. We don't have an answer to that question. We certainly look for for input. It is something we will be working on over the course of the next couple years as we move towards managed long-term care and supports.

There is a question about posting webinar registration information and connection information on DHS website. It was posted. I think at one point we might have delinked it. I know it was posted at the beginning -- at the beginning of this webinar.

There is a question about the concept paper that Jen Burnett mentioned that the concept paper will be submitted to CMS. Will it be submitted before the comment period is over; before October 5th, or will it include feedback given during the comment period?

Good question.

We are planning, at this point, since it is a concept paper, it is the beginning of a discussion with CMS. It is not our application. We are planning to submit it concurrently with -- as we put it out for public comment; however, we will take public comment into consideration and the comments that we receive on the concept paper will be incorporated to the extent that we can, they will be incorporated into the concept paper going forward.

>> KEVIN: A question was posed specifically about the coordination between Medicare and Medicaid benefits for providers. Question was asked: Medicare expects providers determine whether a person meets Medicaid criteria, but MLTSS and Medicare regulations and definitions they don't always match. By MLTSS -- [indiscernible] Medicaid and Medicare and Medicaid managed care [indiscernible]

What is a provider to do -- [indiscernible] if the regulations is different. Excellent question.

The expectations in the managed care

environment is that the managed care organizations will help providers determine which services are appropriate for Medicaid and Medicare or both when msm LTSS needs to be -- [indiscernible]

That is the expectation at this point it is something we need to pay attention when talking about specific services and also working with managed care organizations to make sure that the guidance for Medicare versus Medicaid is very clear and when the services are covered under both -- [indiscernible]

>> THE SPEAKER: -- life independence for elderly because we have a different acronym prescription drug program for seniors that is funded through the lotly that is why it is called PACE. We use LIFE. Actually, we have more enrollees in our PACE program than any other state. We have over 5,000 individuals covered in our PACE individuals. It is in many counties, not all. The information is posted on DHS website.

The next question is, do any of these changes affect non-medical home care providers

who do not receive payment through private or federal health insurance companies?

I am not sure I understand. I am not sure I understand that question.

>> KEVIN: I think -- we will make the assumption that the home care providers are not enrolled in Medicaid. If they are enrolled in Medicaid, the home care providers will be affected by these changes. If they are asking -- if the individual is asking that they are not enrolled in Medicaid, they would not be affected by the changes directly.

If they are enrolled as Medicaid provider, they are in a region that will be part of managed long-term services -- roll out they will be affected by the change.

>> THE SPEAKER: I am reading another question which is, there is a rumor that home modifications will not be provided to people who rent homes; is there any truth to the rumor? Many people with disabilities do rent their homes and home modifications is an essential to helping people with disabilities and the elderly to maintain their independence.

We anticipate continuing to provide home modifications where people live in the community. We do not anticipate stopping the -- we anticipate providing continuing to provide home modifications to people, whether they rents their homes or own their homes; that is a rumor. Rest assured, we home modifications will definitely be part of MLTSS.

Will these frequently-asked questions be posted on the website indicated on the first slide as it is hard to hear.

We will be posting -- we will be grouping our frequently-asked questions and -- attempting to group them into buckets and provide and post frequently-asked questions to our website; that is definitely being planned.

We are looking at getting the questions. Is it possible to get the webinar handouts prior to the webinar? I am going to look too -- we can send the webinar PowerPoint out in advance, as long as you provide us with a correct email address when you sign up for the webinar.

When is the rollout expected?

We expect to begin enrolling people in the southwestern part of the state using health choices -- southwest health choices zones. That first enrollment will begin in January of 2017.

What parameters will there be in managed care for employer models?

As we said in the discussion document, we plan to have robust consumer-directed program and that will be -- we will carry our requirements for the employer -- consumer employer model that we are currently in existence we will continue to -- have requirements for the consumer employer model.

Will MLTSS affect waiver home care services through the Office of Long-Term Living? The answer to that is yes. It will affect waiver home care services just in terms of how we pay for it, not so much as Alissa talked about during the webinar, we anticipate having a rollout that does not disrupt services. So as we transition both individuals, participants and providers over the course of the three-year rollout that we

are planning to do, we will be ensured continuity of care.

How much per hour will they pay for LIFE or PACE?

>> KEVIN: The definitive question is how much will home care workers get per hour in the program? The rate with home health -- the home care agency and PACE programs is negotiated between the program and the provider, so we can't answer the question specifically. It really depends on the provider and negotiated-rate.

Next question: How will home care providers who provide -- [indiscernible] -- ComCare and tainted care will be affected by this trail?

Home care providers in the regions that are implementing managed long-term service and supports program will be asked to contract with managed care organizations for the provision of their services. Like with all providers, they will be working with the managed care organizations as part of their network to provide their services.

>> THE SPEAKER: Managed long-term care seems to counter intuitive to person-centered planning and personal choice. There are limited networks and set budget for each person. How does MCO make sure the person who exceeds the budget gets all of their needs met?

I don't know that -- first of all, I would like to say that one of our requirements will be, as we contract with managed care organizations, one of our requirements will be that person-centered planning gets continued and we will make person-centered planning a hallmark of our expectations in our managed care environment; so that will not go away.

>> KEVIN: The second part of the question is: Limited network -- set budget for each person. How does MCO make sure a person who exceeds the budget get their needs met.

The expectation is managed care organizations will develop robust networks and the -- they will be very will not a budget but a plan -- [indiscernible] -- a process or lack of better term needs assessment, which will determine -- that will be interactive with the

program participants, their caregivers and families and the providers, that the person's individual needs were met.

The point of it being counter intuitive for person-centered planning.

[indiscernible]

Moving away from population planning.

How will MCS make sure a person exceeds budget gets all needs met.

As mentioned, it is based on a person's need, not on a given budget; so that's not the way the program is designed.

>> THE SPEAKER: Okay.

The next question, what changes will occur in medical assistance transportation program under managed long-term services and supports?

Very good question. At this point, we are not anticipating that the managed long-term care program will be driving medical assistance changes, but we will be following -- we will be following the direction of the department at large when it comes to the management of transportation and the program in general.

Whatever changes happen with medical

assistance transportation, will be something that has to be accommodated by the new managed long-term care program. (That was Kevin).

>> THE SPEAKER: Can you speak to those consumers that are dual Medicare Medicaid and how fee-for-service fits into the managed long-term services and supports?

As we have been talking about, we are moving from a fee-for-service system to a managed long-term care support system and delivery system, we anticipate it will happen over the course of several years starting with the southwest in January of 2017, moving to the southeast in January of 2018; and to the rest of the state in January of 2019.

We anticipate that dual eligible Medicare and Medicaid recipients, people who are participating in both, will be able to participate in this must managed long-term services and supports system. It is our -- we anticipate that it will provide for better care coordination and coordination between those two health insurance products which doesn't happen in current fee-for-service delivery system.

We anticipate this will actually provide for more streamlined, efficient and coordinated care for individuals who are dual eligible; however, dual eligibles can choose on the Medicare side, can choose not to participate in the Medicare advantage program and in terms of MLTSS, there are potentially people who are in the MLTSS for Medicaid, but choose fee for service Medicare. We will be doing a lot of education for individuals to help them make the right choices, the choices that fit the best for them over the course of the next few years; participant education is one of the key activities that we have on our radar for making sure that we provide individuals with opportunities to learn how to choose and make the right choice for themselves.

Do you want to say anything else?

[NO RESPONSE]

Okay.

Will all current waiver services be covered in managed care?

Yes. All current waiver services will be covered in managed care.

Since beneficiaries cannot be forced to participate in -- what happens to those who opt out of MLTSS?

They can opt out of the Medicare advantage, but we anticipate that they would be part of MLTSS from Medicaid.

In MLTSS, how does the MCO, the managed care organization, make sure that the appeal process is decided in a timely manner? Because Medicaid MCOs, it's not.

We will address this in our contracting process, procurement process. We anticipate we will have a timely appeal available to individuals.

How will service coordination services work under managed care?

Service coordination and care management are both critical services that will be provided in MLTSS, and we anticipate that they -- that they will be part of what the managed care organization is required to contract for.

How do I get copies of the handouts?

They will be posted on the DHS website. There is a new MLT link on that website that

will be posted on there.

Will life remain as distinct program or be incorporated into the new system?

We are anticipating that it will remain as a distinct program and option for individuals who come through our eligibility and enrollment process.

There are a few questions about that.

Much research has been done in other states that have managed long-term care system and home mods is not a known or provided service. How is Pennsylvania going to ensure that home modifications are both a known service and a provided service?

Again, we will be making sure contractors have layouts for provided home modifications and right now we are in the process of gathering input on what a potential home motion denied broker model might look like, but we do anticipate home mods being part of the service package for MLTSS.

Is behavioral health carved out how will referrals be handled? Will there be a separate webinar?

>> KEVIN: I think it is a great idea. I think we can anticipate at this point there will be a separate behavioral health webinar. The coordination itself -- the current thinking -- will be mandated by both contracts.

In addition, there will be trick toured process for -- [indiscernible] -- for both programs. We are doing all that we can to make sure that the services in both -- will be coordinated as much as possible.

(Background chatter interfering with audio).

>> THE SPEAKER: What is the role of AAA service coordinators with managed care?

We are anticipating -- at this point we have not made any decisions around what the role of the Area Agencies on Aging is going to be. We are working with the Pennsylvania association of Area Agencies on Aging who have submitted -- they have submitted their ideas and -- in sort of a proposal for what their role might be in a managed long-term services and supports environment.

We had asked them to provide us with more

detail about firewalls, because conflict of interest is something that CMS is going to be looking very carefully for. In addition, we have asked them to do some silo typings of the document that they gave us, so that we can have a better sense of where -- what their roles might potentially be.

There is no decision that has been made on the role as AAA or Area Agency on Aging service coordinators and managed care.

How willed Medicare Hospice benefit be offered?

>> KEVIN: That's a very good question.

Medicare Hospice benefit, depending on whether or not it is under the Medicare advantage program or managed care fee for service, we are not anticipating that changing; however, we do believe that with MLTSS program, there will be more far-reaching coordination for individuals who are duly eligible.

Great question. It is something -- actually, we had touched on -- when talked about service design, it is something we could probably receive some thought from the provider

community and how you would like to see the services coordinated between Medicare and MLTSS.

Will direct care providers need to be Medicare certified to be part of the MLTSS network?

>> Also a great question. I would answer that it is depending on the service. Some services are not Medicare eligible. Obviously, those services will not require Medicare certification. Sometimes it falls under the larger umbrella of what Medicare calls [indiscernible] care.

However, there are some services that are duly covered between Medicare and Medicaid. It is quite possible and certainly in the best interest of the providers, if you provide the services covered under both programs, that you would want to look and be certified in both programs.

I don't know that we have --

>> JENN: Let's just take a look here. We are trying to gather new questions, here.

We have about 9 minutes left. We will see

if we can answer some more of these questions.

How do you get involved to become a provider?

Kevin has talked about this. We are really hoping that providers are going out and getting to know the managed care organizations that are in their area, introducing themselves to managed care organizations to talk about what they are good at and what they can provide in an MLTSS program and providing it in times -- [indiscernible]

The expectation would be that providers contract with managed care organizations, developing those relationships and those connections really is going to require networking on the part of the providers.

In the RFPs are available for providers to apply, where can we find them?

We will -- RFPs for the managed care organizations will be available sometime in November. They will be posted to our website but we will also be doing a mass distribution. Do you want to say anything else?

>> Kevin: The procurement process is

structured. There will be -- normally a release for where the request for proposals will be made available and if you are on that distribution list, you will receive notification for which length you need to be able to see those proposals. If you need to be part of a distribution list, please let us know and we can make sure that you are added.

>> JENN: Okay. The next question is: Is the OLTL going to ensure that the managed care organization that is selected, is going to provide shared supports coordination with the current providers?

As we talked about a little bit earlier, it is our intention to have continuity of care for individuals; that would be -- the provider that individuals have will be transitioned under managed care and with the expectation that over over the course of time it becomes a contractual arrangement.

How many MCOs do you anticipate will participate throughout the state?

We anticipate at least -- we anticipate procuring at least 2 managed care

organizations, potentially more, per region,
per health choice's region.

[indiscernible] do current providers need
to -- enroll with current providers if so how
eastbound.

-- we have not yet gone through the
procurement process, so we cannot tell you
exactly who those managed care organizations
will participate.

As I said on an earlier answer, it is
really in the best interest of providers to get
out there and start talking with managed care
organizations. Let them know what your value
is. Let them know what you are good at and how
you fit into the current long-term services and
support system. Talk to them about how they
plan to do contracting.

When members are admitted to nursing
facilities, skilled nursing facilities, will
their health choices plan be termed after -- I
am pretty sure it is inerm ated after 30 days
like it is now?

Currently, health choices covers, under
managed care, the first 30 days. When

individuals are terminated from health choices and enrolled into fee-for-service.

We don't have an answer to that quite yet. It is something we are working with the health choices staff to get some clarification on that. Once we have an answer to that, we will make sure that it gets posted.

I want to just -- there have been a lot of questions about where people can get the materials that were presented today. We have a link on our website, the Department of Human Services website is www.dhs.state.pa.us.

On the homepage for the DHS website there is a link to the new MLTSS page. The MLTSS page is where you can find all of the document as of tomorrow we will post it on the webinar.

Next Monday, or if you want to look over the weekend, you will be able to find it at that point.

I also wanted to just say thank you to Alissa for her presentation.

I think people certainly are definitely interested. There are a lot of questions. I'm sure they are walking away with a lot more

information than when they started the webinar.

I encourage people to fill out the survey. We are going to be sending out a link to an online survey. Not a lot of questions on there. We are looking for feedback on what future webinars people might want to be interested in us conducting. We got an idea today to have a separate behavioral health webinar, but we are looking forward to getting feedback both on how this webinar was received, as well as -- as well as inputs on how to make it better.

Finally, input on what future webinars might be useful to folks.

I apologize, again, for the spotty audio. We will be working on that.

Hopefully the next one will be a little bit easier to follow along with.

Thank you very much, folks.

I say good guy!

(Webinar concluded at 2:58 p.m.)

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