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>>CAPTIONER: (on standby.)

>> Broadcast is now starting. All listeners are in listen only mode.

>>Jenn: Welcome everybody. This is deputy secretary Jenn Burnett with the

Office of Long-Term Living.

This webinar will go on until 3:00. This is a Community HealthChoices third Thursday webinar. I am so glad you are all here.

I want to turn it over to Pat Brady, who will go over some housekeeping, and

then we will do a quick update in spend 20-25 minutes talking about what has been going on in Community HealthChoices and the work we have been

doing. There is a presentation by Paul Saucier who is a nationally expert in managed long-term services and support.

I will introduce him after Pat is finished.

>>PAT: Thanks, Jenn.

As in our previous webinars, we just wanted to go over a few housekeeping items. First of all, everyone is muted.

If you have questions, you can type those into online screen where you do that. There's a control panel on the upper right-hand side of your computer.

If you want to expand that, you click on the red button; that will expand it and you will see where you can select how to participate, either by

telephone

or through your computer's microphone and speakers. In this area is where you can type your questions.

For today's session, because we have two very different topics we are talking

about, what we would like to do is give Jenn's update, and then we will open

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

it up for questions, related to Jenn is covering then move on to Paul's section.

When Paul is finished, he will handle questions related to hi okay?

>>JEN: Thanks, Pat. I want to talk about our OLTL update but it's really

across Department of Human Services regarding health and community choices, we will turn it over to Paul saucier will be talking about Medicare and

Medicaid services.

We will talk a little bit about national experience, and then into Pennsylvania's plan.

We are ending in the procurement process will be released by the end of the

month. We have 60 days for proposal response. Resulting from this release will be what is called a black-out period. A blackout-period means the Department of Human Services and managed care organizations can't individually meet or have conversations because we are in a procurement environment. We need to maintain a fairness for all the people who are bidding on this RFP and we will -- that will not mean that we can't speak with

managed long-term services and supports or managed care companies. It just

means that we can't speak to them individually, can't work with them individually.

We will be, for example, doing a bidders conference but that will involve all bidders. So everybody is hearing the same thing.

It doesn't mean that providers and members of the public can't meet with managed care organizations, advocates, et cetera.

Can you hold on a second? We are having a little bit of a technical problem.

I will keep going, then.

Our focus at this point -- (echo in audio) -- hold on a second.

Our focus at this point is to shift to internal and operational preparedness in the proposal review and readiness review of managed care organizations; that

will be a very big list for OLTL, we are looking forward to it and have started doing much work in this on how to operationalize this.

We plan to plan implementing Community HealthChoices in the southwest health choices zone in January of 2017.

We received over 3,000 comments in the process that we went through to solicit comments on the draft procurement this past winter. These changes led

to language changes, improvements overall in the proposal that will be issued

later this month.

For us, it was a realize-opener on how you can hone in and get the documents

to a much better place, a much more understandable place.

I want to talk a little bit about some of the things we heard in that comment

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- those 3,000 comments, as well as what we have been hearing in all of the work we are doing to engage stakeholders in this process.

As I am out talking about Community HealthChoices with current participants

in our home and community-based waiver programs, I continue to hear concern about individuals with high-cost service plans.

There are people who are concerned that capitation, which is the per-member/

per-month rate state pays is the maximum amount that a managed care organization will pay for a participant service plan.

This is simply not true. They are not one and the same. The capitation is the

rate that the state pays. The managed care organization will have a service coordinator that will work with consumers to make decisions around what is in the participant's service plan.

So we have added language into the document that goes something like this:

For participants who are living in the community at the time of the implementation of Community HealthChoices in their zone and who choose to

remain in the community, the Community HealthChoices managed care organizations must support that choice and support participants in the community.

So we are addressing it as a requirement in the RFP.

I think people are very worried that their services are going to be -- they will not be able to get the level of the services that they need to be able to maintain their independence in the community. We have addressed it by adding that language.

We have also heard in the comment period and through the stakeholder engagement that we have been doing over the past many months about service coordination requirements and the potential -- the possibility that we should the standards from what we had in the original RFP for service coordination.

Following -- receiving all of those comments and receiving feedback from our

new subcommittee, the medical assistance advisory committee, we convened

a stakeholder group that was focused on this whole question of how do you get to high-quality service coordination?

Based on feedback, we made changes to the RFP. We added language to ensure that existing service coordinators are subject to qualifications and standards proposed by Community HealthChoices, managed care organizations and approved by the department.

We also added language for supervisors. It was revised to include a window

for obtaining credentials and require qualifications and standards proposed by

the Community HealthChoices managed care organizations be approved by

the department.

So those are changes we made in what our requirements are for service coordination. We also heard concerns about how the Commonwealth will serve the population of 18- to 20-year-olds.

As you probably know, people who are -- actually, birth to 20 are served by ATSP in Medicaid; that's how we serve those individuals.

We had originally envisioned grandfathering the existing 18/20-year-olds, the

ones currently in some of our waivers into Community HealthChoices, and then allowing EPSTD to continue to serve 18- to 20-year-olds.

We heard a lot of feedback and concerns about how these individuals would

receive services that are not available through EPSTD.

An example of those services not available through EPSTD is home modifications. Those are available in some home and community-based waivers.

There was also concern, on the other hand, that the managed care organizations would need to put together a pediatric network for a very small

population of individuals. So we heard from advocates that this -- that this issue of the 18- to 20-year-olds so after discussion we will serve individuals who need services not available through EPSTD in the OBER waiver in transition.

We thank the various groups, including the Pennsylvania health law project and Disability Rights Network for coming forward with this approach. We hadn't really considered it. We do believe that this is a positive solution, at

least in the short-term as DHS explores other solutions to the long-term as Community HealthChoices is implemented statewide. We will continue to move forward in engaging OBER and those individuals affected.

The existing 18- to 20-year-old population that we were planning to grandfather in will not be included in Community HealthChoices. This approach will require some adjustments to the OBER waiver, which will be addressed during the upcoming renewal of the waiver with community -- with

CMS. Again, the OBER waiver renewal will be a public process we need to go

through a 30-day comment period. There will be plenty of opportunity for people to look at what we are proposing, take a look at what the changes are.

We are really looking forward to that engagement of that public process. In addition to the current 18- to 20-year-old transition in the phase-in Community HealthChoices.

When they turn 21 and if they are nursing facility clinically eligible, they will go into Community HealthChoices and the -- we will do a clinical eligibility determination to see whether or not they are eligible for Community HealthChoices and then they will receive their services in the managed care environment.

Another thing that we heard a lot about is the coordination for dual eligibles; and how that is going to work. We heard feedback about our -- the evaluations that we are doing and we are really working with the managed long-term services and support engagement, kind of making that a very robust

evaluation that will help us to evaluate the Community HealthChoices in the long-term and also along the way as we move into a new area we can learn

--

we will have lessons learned from our roll-out in the original community health choices zone

With that, I will open it for questions for about 10 minutes that are -- comments can be submitted there but the questions -- questions or comments?

Do you have some?

I am going to ask -- here is the first question that we have. I am going to ask

Kevin Hancock who should be on the line. Kevin, are you there? We have to

unmute you, Kevin. Kevin, can you hear me?

>>**KEVIN:** I can hear you, Jenn. Can you hear me?

>> Jenn. Thank you.

>> Kevin Great.

>>**JEN:** The first qef is: Will providers use EDS to determine which managed

care organization each consumer has selected? If not, how will providers easily identify the consumers' managed care organization especially when they serve several thousands consumers.

>>**KEVIN:** I think the expectation at this point is that they will be using the EVS system to identify which plan the participants are enrolled in.

>>**JEN:** Okay. And as we -- when I started out, I talked about the whole idea

of operationallizing Community HealthChoices other internal focus at offense

of long-term living and with the Department of Human Services as a larger organization is to really work on shifting to internal operational preparedness.

That question is a good one for us to consider as we figure out how most communications happen.

Okay.

The second: As provider can we have contact phone numbers managed care

contact information?

That contact information is available on Community HealthChoices website if

you go to www.dhs.gov, on the button left-hand corner there are about 5 live

links. One is to the Community HealthChoices website. We have all listed who

demonstrated interest thus far; which is one way you can get that information.

I also wanted to recognize that we had a few minutes of technical challenge at

the beginning. I see a lot of comments on there being an echo. We apologize

for that. I think we are all set now.

The next question is, the haste of the implementation is eliminated very wellknown

and proven managed care organizations from having enough time to

participate in the first transition zone for 2017.

Kevin, do you want to acknowledge that? Maybe talk about the special needs

plan change?

>>**KEVIN:** Understanding the question, do they mean [indiscernible] speech

needs plans or the --

>>**Jenn:** They are talking about Pennsylvania-specific health choices and behavioral health choices managed care organizations. The question talks about very well-known and proven MCOs do not have enough time to participate in the first transition zone for 2017.

>>**KEVIN:** Well, the special needs -- are they talking about the dual special needs plans?

>> Jenn. Very well-known and proven managed care organizations. Maybe the person who wrote it could write more detail and catch up with it. It's a little confusing.

>>**KEVIN:** Yes.

What is particularly confusing if they mean they won't be able to have special

needs plan in place, which we have addressed. If entities are going to propose

for Community HealthChoices, we made the decision that the special needs

plans -- we originally stated that the dual special needs plans would have to be in place at the present time of the southwest implementation if they were going to bid in that area.

Since -- from feedback from managed care organizations and other entities,

we made the decision to delay that requirement where plans would want to be moving through the process for enrolling to be dual special needs plan, but

they do not need to be or have a special needs plan in place until January 2018 for the southwest zone. They will have time to put the dual special needs plan in place to meet that requirement.

>>**JEN:** Thank you, Kevin.

The same person who asked that question also said, We have spoken with many of them in zone 1. We will have quite a lot less competition and choices

for your consumers.

>>**KEVIN:** Sure. Again assuming that they mean the special needs plan issue,
we believe that additional time will address that concern.

>>**JEN:** Okay.

There are a few questions asking me to go over the changes and the standards
for service coordination that we made. Based on -- I will repeat them. There
were several questions along that theme.

Language was added to ensure that existing service coordinators are
subject

to qualifications and standards that get proposed by the Community
HealthChoices managed care organizations, and we as a department
approve.

In doing that, we and that Community HealthChoices and managed care
organizations will come to us with qualifications that they use for service
coordination or care coordination and we would have to approve them after
that. As we make those approvals, we will be looking at that existing
network

and reflecting on what we have in our own regulations.

The language on the supervisor's side for service coordination was revised
to

include window for obtaining credentials and same qualifications.

Can we get a copy of Community HealthChoices PowerPoint? Yes, you
can. It

will be posted to our website, which I just discussed.

Which waivers will be included under the Community HealthChoices
program

and if all the waivers are being [indiscernible] into a single waiver.

Yes, all will be collapsed into a single waiver. We will use the ComCare
waiver; that will become our Community HealthChoices waiver. We will be
working to move that waiver along. We are planning to put all services that
are available in the five waivers that we currently operate into a single
waiver.

They will all -- all of them will be -- those services will all be available into a
single waiver.

The Community HealthChoices waiver will be rolled out as Community
HealthChoices gets rolled out. We will continue operating in the fee-
forservice

remainder of the state, the fee-for-service waivers.

Individuals in ComCare will be transitioned into the independence waiver.

The independence waiver will be amended to be included on ComCare not available on the independence waiver.

I am looking for other questions.

Will current consumers in the OBER waiver remain there?

They will remain in the OBER waiver if they are not nursing facility clinically eligible. So we will be doing clinical eligibility determination of all consumers

that are in OBER; that will be conducted as we roll out community health choices. We will be starting in the southwestern part of the state. Anybody that is determined clinically eligible for nursing facility care we will transition as we roll out Community HealthChoices and they will be in the Community HealthChoices waiver.

Please address how nursing homes will have rates set cost reporting continue?

We don't have answers to those questions at this point, but as we move into

those discussions, you will be hearing more about it.

This is my first time joining this webinar. How will this affect home healthcare

agencies, existing patients? Is there anything that home healthcare agencies

need to do to get ready?

Home healthcare agencies should, if you are providing any waiver services currently and want to continue to provide waiver services, you should be talking with managed care organizations over the course of the next year and

engage them in discussions around contracting with them.

To clarify comments about requirements does OLTD feel responsibilities will

be -- MLTSS services or could MCO coordinators who a coordinate [indiscernible] integrated care coordination and serve in the role as service coordinator for enrollee therefore by managing the enrollee's entire spectrum

of service.

It got cut off. Entire spectrum of services and care, I guess.

We will look for the managed care organizations to submit their [indiscernible] what that will look like.

I have about two more minutes. I am going to take a couple more questions,

here, that I can.

What is the compliance time frame?

Kevin just mentioned that. Kevin, correct me if I get this wrong, we are envisioning that the DSNIF compliance will need to happen by the end of 2017; is that correct, Kevin?

>>**KEVIN:** That's correct for the southwest and southeast and for the rest of

the state, I think we were thinking -- you would have to have your DSNIP in place by the following year.

>>**JEN:** Okay.

Thanks to -- I will read this one last --

Thanks to secretary Burnett and OLTL.

Will you be planning any other meet and greets with managed care organizations? If so, would you plan on meeting with LGBT community?

We and doing meet and greet with managed care organizations after blackout

period. I am not sure. We will be checking to see what kind of work we can do in that space.

The second question is -- that's a good idea. I think it is a very good idea.

When do you plan to start educating consumers in zone 1 about these changes? We have already begun engaging consumers in zone 1. We will continue to do that.

We will be doing a lot of work to help consumers in zone 1 become educated.

We have a public/private partnership with Pennsylvania's health funders who

offered to support us as we engage stakeholders in southwestern part of the

state that have been very well-attended and, basically, with those two sessions

with the Jewish healthcare foundation have provided the department and all

of the work that we are doing. They have given us a lot of good ideas about how to reach stakeholders including some really untraditional ones, the ones

that the Department of Human Services doesn't normally think about grocery

stores, mom and pops and libraries.

We have already begun educating stakeholders.

Will stakeholders be able to review and comment on letters, et cetera? Yes, they will. We look forward to engaging through managed long-term services

subcommittee and other venues to have all of our materials vetted so that we are speaking in plain language that people can understand. We also are committed to making not only the educational materials, but also the notices that we are going to be -- the official notices come out of the department will also be doing review and updating of them.

With that, I am going to turn it over to Paul Saucier. Paul is with truth and health analytics. He has a great deal of knowledge about the coordination of Medicare and Medicaid for dual eligibles and how that can impact better coordination and improved health outcomes.

Paul, take it away!

>>**PAUL:** Okay. Thank you, Jenn.

I am just getting this up on the screen. Can you see it?

>>**JEN:** No, not yet.

Hold on a second.

>> You won't be able to, Jenn.

>>**JEN:** Oh, okay. You will drive it. Good. We don't see it but I am assuming that the participants are seeing it

>>**PAUL:** I am going to do a brief walk through both Medicaid and Medicare,

which will be the majority of people enrolled in CHC will have both Medicaid and Medicare.

I am going to talk about what has been learned through the brief history of these programs, and how some of those lessons have been built into the design of Community HealthChoices.

Then I will end with a very brief overview of how Community HealthChoices will be evaluated and continued to contribute to the knowledge base both in Pennsylvania and nationally. This map shows you the early experience MLTS

between 1889-2004 there were seven states that developed programs; that's a

long period of time. Fifteen years and seven states.

It was obviously slow-going in the beginning. It started early in 1989 when Nevada started the first and went statewide right from the beginning.

Those of you who know the history of Arizona Medicaid, when they came into

Medicaid as a state, they went managed care with everything. For a long time they were considered an outlier and it took a while for MLTSS to catch on. There were a couple of things that started happening. A few states thought that they would try similar ideas and came in through their Medicaid programs as MLTSS programs and at the same time, a few states started really paying attention to people with Medicare and Medicaid. You see on this map the red states, Minnesota, Wisconsin, Massachusetts all applied to the federal government for special permission to do dual eligible demonstrations. These became known as the first wave of dual-eligible demonstrations. Minnesota senior health program, the Wisconsin partnership program and Massachusetts senior care options program. At about -- in this same time period, the program of all-inclusive care for elderly was also developing and expanding across the country. Many of you know that PACE is a very specific program model that started San Francisco capitated payments from both Medicaid and Medicare. a lot of the services are focused around a day center where people receive both health and social services. After the success of this the federal government in 1990 allowed replication sites to begin. There were a number of them across the country in the 90s. Then the federal government came to the conclusion that it was a successful model. In 1997 decided to make it a permanent option for states so that they wouldn't have to seek any special waivers. Since 1997 -- since the balanced budget act. A state can choose to have PACE program by amending its state Medicaid plan so through a state option. Pennsylvania, of course, had probably the most ambitious -- I think still is the most ambitious PACE initiative in the country called the WIFE program I say

that because the state has more sites than any other states, as far as I know;
that started in 1998 under a different language the long-term care capitated assistance program. The providers suggested to the state that a better name might be good for the program and the State agreed. It is known in Pennsylvania living independently for the elderly or the LIFE program. So you had some states that were doing their own MLTSS or dual-eligibility demos. You have the PACE program going. Through this period there was real growing awareness that people on Medicaid and Medicare were really important to both programs for lots of reasons, which I will get into in a minute.

The results from these early programs was promising. These are results -- I am assume rising. When you get the PowerPoint you will be able to see the studies that are being summarized here.

The results were certainly encouraging. Not a huge number of studies, and the studies didn't have a you broad scope. Nonetheless, the results that have been reported encouraged a lot of other states to move forward with initiatives.

Nursing facility use declined. This is true in all but one of the programs that were studied, all of the early programs.

Interestingly, the programs where a nursing facility didn't discipline it was carved out or outside of o the managed care program, so it remained fee-for-service.

States have certainly learned from that that it's important to include both community services and nursing home services in the program; that is, certainly, the design of Community HealthChoices.

Hospital use declined in all but one program where that was studied. Physician services increased. So better access to primary care, in particular, is an outcome you will see in these programs.

In terms of the outcomes for people, whether they get healthier or lose function or gain function; that has not been studied as often. Where it has been studied, there has been shown to be a slower rate of functional loss and lower mortality or lower death rate.

This is an area where a lot more outcomes work would be beneficial for

everybody and Pennsylvania is attempting to include a lot of that in its evaluation.

So two big federal developments have accelerated, efforts to improve coordination of Medicaid and Medicare. As I was saying earlier, there's been

growing awareness of how important duly eligible beneficiaries are to both programs.

Medicare improvements or patients and providers act, which we often refer to

as MIPPA. You will hear it referred to a lot as CHC rolls out, because the MIPPA-required Medicare due-eligible special needs plans, if they were going

to operate to have agreements with state Medicaid agencies.

So the special needs plans are a type of Medicare advantage plan that are targeted to certain individuals. There are more than one type but we are primarily interested in the dual-eligible special needs plans.

These had actually been authorized a few years earlier. They instantly exploded across the country. There were a great deal of interest but the states

didn't feel there was leverage or ability to coordinate with those plans.

So MIPPA made it a requirement that in order to have one of these plan, there

needs to be an agreement.

Pennsylvania will be one of the key levers that the state has to require close

coordination of Medicare and Medicaid for duly-eligible members of Community HealthChoices.

Affordable Care Act of 2010, of course, is famous for having created Obama

care it did a lot of other things as well. It really recognized in a significant way how important Medicare and Medicaid coordination is to the future of both programs.

So it created the Medicare/Medicaid coordination office within CMS, the Septemberers for Medicare/Medicaid services.

A special office was in CMS, a very large agency, special office to pay close

attention to coordination and promoting coordination across these two payers.

There is a center charged with experimenting in continuous way to improve both programs. The legislation also authorized CMMI, the centers for

Medicare and Medicaid innovation to operate a dual-eligible demonstration, which was called the financial alignment initiative.

Here you see how MLTSS generally and programs targeted to dual eligibles

have just exploded since 2010. There are now 22 states that offer 1 or more

programs, 31 programs in all. The dark blue ones are the states that now have

more than one program.

The states with stars on them have financial alignment initiatives, the dual demos.

So the experience of the prior 10 years combined with changes in federal policy and new federal supports through demonstrations and a special

office really accelerated the experience that we have had.

In the meantime, federal policy makers have continued to examine dual eligibles. MPAC federal Congressional advisory group that advises Congress

about Medicare, MACPAC is similar body that advises Congress on Medicaid.

For the last two years they have been publishing a special data book on dual eligibles.

I want to share with you some highlights from their January 2016 data book, because it really tells the story.

We often use the shorthand of -- you know, anybody in the system who is not

using long-term services and supports, sometimes get described as "the healthy duals".

The healthy duals are anything but healthy. They are, certainly, I'm sure some

healthy ones out there. Just look at some of these statistics. This compares dually-eligible beneficiaries to those who only have Medicare. Compared to Medicare-only beneficiaries duals are three times as likely to have 3-6 activity

limitations. ADLs or activity of daily living is one of the ways in which disabilities is measured. The higher the number, the more significant the disability.

So more than three times as likely to have very significant functional disability.

They are also 3 times as likely to report they have poor health. So in self

discussion of -- (audio breaking up) -- rank themselves as having poor health.

This one is particularly important to states. They are more than 4 times as likely to live in institutional setting. Compared to people with only Medicare, much more likely to be in a nursing home or other institutions compared to it

Medicaid-only beneficiaries duly eligible bury beneficiaries are more than 4 times as likely to use institutional long-term services and supports.

They are only half as likely to be enrolled in Medicaid managed care.

Duly-eligible people have been the group that has been the most often carved,

as they say, of state managed care initiatives in the past. States have implemented managed care, they said, well, the duly-eligible people are too complicated. We will wait to do them later or, you know, well, they have got Medicare, we are not quite sure what to do with that so they get carved out. I think that that contributes to the fact that they have more significant coordination problems.

You see at the bottom of this slide, 50% of Medicaid spending for duly-eligible

beneficiaries is for institutional services. So if CHC is about expanding community options and reducing reliance on institutional services, then dulyeligibles

beneficiaries are certainly a group to focus on.

One of the reasons researchers believe that duly-eligible people can end up in

nursing homes quite easily is because the downward progression, if you will,

to getting into a nursing home and getting stuck there starts on the Medicare

side. It often starts with a hip fracture or other accident or a chronic condition

that is not well-managed and a person ending up in the hospital after a hospital stay they go to a Medicare-funded skilled nursing facility for 21 days

and it then if they are still unable to return home at that point, they often will convert to a Medicaid stay that can become a long-term stay and then they are, at that point, very -- it can be difficult for them to move. Maybe their living situation at home is no longer available and so on.

So the Medicaid system is not identifying and picking people up early enough

during the Medicaid phase.

You can see from the chronic conditions of dual-eligibles, why they might end

up in a hospital, particularly if their conditions are not well-managed.

Diabetes, 22% of duals under 65 and 35% of 65 and over.

Hypertension is almost 40% and 66%.

Heart disease, anxiety and depression. All significant conditions all of these can be life threatening, of course, if not all treated. They are all treatable.

They represent a real opportunity for health promotion.

Now, early financial alignment findings from implementation were just released by CMS.

We have been studying those to make sure that where appropriate we are building in the right design features into CHC.

Now, these are the financial alignment initiatives have been going for either one or two years, depending on which one -- the states were staggered.

These were very early findings about how the implementation has been going.

I am just going to walk you through these. On the next slide, I will tell you about how CHC is responding to these findings.

In terms of enrollment, there was a lot of confusion about member materials.

The evaluators found that when the state tested the materials consumer input

it increased greatly.

Relying on more than just sending letters out, but actually engaging the community organizations and helping getting the word out, helping talk to people and explain what is going on, answering people's questions was very

beneficial.

The financial alignment initiative all had special feature in them, which was to allow Medicare enrollment to be passive; that is to initially enroll people for both their Medicaid and Medicare and then if people didn't want to stay in

for Medicare, they could get out.

That resulted in large waves of passive enrollment evaluators have found that

that's been very confusing for beneficiaries; and that in some cases it overwhelmed the managed care organizations that they were being passively

enrolled into.

Those are some of the enrollment findings.

Care coordination. The finding that care coordinators were not always welltrained

in the needs of the members. They may be very well-trained in generic care coordination functions, but maybe didn't know about Alzheimer disease

or didn't know about something else that was important to the population being served.

Some of the states did not require integration of service plans into the electronic system so it made it difficult to monitor what was going on essentially on the care coordination side.

In terms of stakeholder engagement, states have used multiple methods, and

the evaluators found that it is necessary and really improved planning and programming implementation when many different forms of stakeholder engagement are used.

They also noted that managed care organizations are obtaining input through

member advisory committees.

And then, finally, on specifically on aligning Medicaid and Medicare systems,

the administrative nuts and bolts of trying to get these two systems to work together, the evaluators found that the sites pretty much all found it difficult in taking more time than they intended.

These work parallel to one another. Getting them to merge around the number of administrative areas, was very difficult.

So how are we working to build on that national experience in Community HealthChoices?

In terms of enrollment, you've already heard Jenn answer a question earlier about this, there is a strong commitment to developing enrollment materials with member input.

It is occurring both through community organizations that will be doing that activity in

a formal way and then also through health funders voluntary efforts done in the community to help get the word out and make sure that people understand what is going on and can get their questions answered.

And perhaps most importantly, there will not be passive Medicare enrollment

in CHC. The program is designed certainly to enable people to keep whatever

Medicare option they have today, including the original Medicare, if that's what people have or if they are already in special needs plan because Pennsylvania has a lot of them, the program is being designed to allow them

to continue in that arrangement, but not to passively change people's Medicare options, given confusion that occurred elsewhere.

There are requirements for training in CHC. The MCOs will have to ensure that their service coordinators are well-trained; that will be something that

is monitored initially in readiness reviews and ongoing.

Service plans will be uploaded into the state system for both being able to monitor what is going on with service coordination and longer term research

and evaluations.

Stakeholder engagement. Pennsylvania has and will continue to use multiple

methods to engage stakeholders. What we are doing today is one of those methods. As you all know, there is the MLTSS subMAAC that is a statewide

group and there is the website of several other activities and vehicles for people to engage.

The contracts with MCOs will require them to have member advisory committees so that once the program is up and running, the MCOs themselves

can get direct feedback from their members about what is working and what

is not.

Finally, in terms of aligning Medicaid and Medicare systems, Pennsylvania is

taking an incremental approach to alignment. This is in recognition that in other states, this has been a difficult area. It's taken more time than expected.

It's not something that can be completely integrated overnight.

So the strategy in Pennsylvania is, step 1, to require that the CHC/MCOs have

dual eligible special needs plans as an option for their CHC members.

So CHC members are duly eligible, they will have the option of also receiving

their Medicare services through the same company that is offering their Medicaid plan.

As Kevin explained in response to a question, in Phase 1, that requirement will be deferred for one year, just to give all of the plans time to catch up with

this because there is a whole Medicare process around this that takes time. As of January 1/2018, all the plans will be required to offer a dual eligible special needs plan.

Then Medicare/Medicaid coordination office is committed to working with the state and the plans to, over time, pick issues of importance like grievances,

appeals, enrollment, as a whole number of them and improve the alignment of Medicare and Medicaid around those issues over time.

The state is planning a robust readiness review process for CHC. This is, again, a lesson learned from the national experience that although you cannot

predict everything there's a lot you can predict and prevent through a good readiness review process.

Once contract awards are made, there will be enrollments for any CHC/MCO

will be contingent on passing a readiness review process. In that process, the

State and its contractors will test the MCO's interface with providers, with service coordination entities, with the financial management services organization, with independent enrollment entity, with the level of care determination interestity.

There will be a process whereby the systems are tested to make sure that these parties can communicate because information flow across and among

these organizations will be key to a well-coordinated, well-integrated experience for beneficiaries.

Service coordination process will be examined in detail. The experience and

knowledge of care coordinators will be looked at and the information systems

that the MCOs are using for service coordination will be looked at.

The network adequacy for HCBS will be assessed and the readiness review

process will also be a key data source for the state to flag high-priority areas --

[indiscernible] it doesn't end with readiness review but begins with readiness

review.

(Audio is not good right now).

-- network adequacy but just barely that can be flagged to make sure that the

HCBS provider network is monitored particularly closely for that MCO.

So finally, coming to the evaluation, the -- more information will be available about the evaluation shortly, but today we just wanted to provide an overview

for you. There are --

In the short run, the evaluation will learn some things about how -- (audio difficulties) -- understand and learn things about the impact that the program is having.

It gathers data from multiple points and types of people so that it incorporates

multiple perspectives. Let me just go through some of the major components.

The first big block implementation meaning how is the plan implemented?

How

is it going in is it going okay? Are people confused? Are people getting what they need?

First of all, there will be stakeholder views on this question. So the evaluators

-- by the way, I should have mentioned right off, the state has commissioned

the University of Pittsburgh to conduct this as an independent evaluation so it

will be conducted by the University.

They will go out and talk with stakeholders. There will be key informant interviews and focus groups and in Phase 1, these will be conducted early in

the first half of the year in Phase 1 in the southwest, in order to have time to

come up with some conclusions, like the ones I just shared with you about the

duals demos; so that there will be for the state to act on those early implementation inclusions before the program opens up in the southeast.

Consumers will also be engaged in the longer term outcomes evaluations.

There will be interviews done with representative samples of subgroups over time. So there will be samples of people 60-plus who use LTSS. Those younger adults, 21 to 59 using LTSS. There will be a sample of duals who do not use LTSS. There will be a sample of unpaid caregivers so that the perspective of all of those important groups are gathered in terms of how the program is working.

Those will be groups of people, if they agree, will be interviewed several times over the course of the evaluation. So we will get the perspective over time as the program matures as well.

There will also be administrative data analysis. By administrative data, we mean data that is just produced in the course of running the program. So both for purposes of implementation and outcomes.

Some of those data sources just -- this is not an scottive list but to give you the kind of information that will be available to the evaluators.

The person-centered service plans. Remember I said they would be uploaded into a system, a State system. Those will be available.

Level of care determination data.

Medicaid and Medicare claims -- claims being fee-for-service system from before and encounters sort of like claims but managed care version of claims.

So looking at actually what services are delivered in Medicaid and Medicare.

Then nursing facility metadata set, which is a very rich data source for nursing home residents; and other data as available.

We are, certainly, hoping that the Pennsylvania evaluation contributes to the

knowledge in Pennsylvania and both the short-term and long-term to -- so that Pennsylvania can make program improvements and I'm sure that it will also be of great interest to the rest country and make an important consideration to knowledge overall.

With that, I would be happy to take some questions.

>>JEN: Any questions come in?

Hi, Paul. I think -- were the questions sent to you?

>>PAUL: I am looking.

>>JEN: Hold on a second. We are dealing with.

Paul, do you see the questions there?

>>PAUL: Yes.

>>JEN: There are probably questions for me.

>>PAT: Go to the very bottom.

>>JEN: There at the very bottom.

>>PAUL: Yes, okay.

What measures will be used to monitor the impact of CHC on people with Alzheimer's and other dementia?

I can't speak to specific measures. I can tell you that Alzheimer's dementia have been flagged as important issues. More to come on the specific measures.

Question: (on standby) am I understanding you correctly that all agencies will

have to have dual licenses for Medicare and Medicaid by 2018 in order to participate with the HMOs?

No. At the provider level, you know, whatever your line of business is, if you are a Medicaid provider, you can continue to be a Medicaid provider. If you are a Medicare provider, you can continue to do that.

You will have to have relationships with the MCOs.

What I was -- what the program requirement is is that the MCO have both a contract from the state to operate CHC/MCO they will receive Medicaid payments from the state. Then they will be required to have a separate contract with CMS Medicare as a Medicare advantage special needs plan. They will -- the MCO will maintain both a Medicare network and a Medicaid network.

As a provider, you will be able to keep making the same business decisions you have in the past, whether you want to participate in one program or the other or both.

Okay.

Let's see. Historically, what roles have centers for independent living played?

That really varies from state to state. In some states independent living centers have played a role as a provider, providing independent living services

to people under contract to the MCO.

In other states, they have been an information and referral service sort of either part of an ADRC or -- aging and disability resource center.

In other states they have been hired by MCOs to provide independent living training to their care coordination staff. So it depends.

I would say establishing relationships with the MCOs is a great first step.

Understanding yourselves what role you do want to play in the system.

When will the PowerPoint be sent?

Shortly but I am not sure when. It will be available.

>>JEN: The PowerPoint will be posted on our website. It takes two to three days to happen so look for it early next week.

>>PAUL: Great.

Here is an interesting question: I just learned IBN is buying Truven; that's true. It will be part of the IBM Watson Health. How does it impact our research? I hope it only enhances it. I don't know because it is way above my

pay grade, I can tell you that.

I am scrolling for more.

>>JEN: Paul, while you are looking, I will answer some of them I can answer

and I will pause and give it back to you to see if you found any others for yourself.

>>PAUL: Great. Thanks, Jenn.

>>JEN: Thank you, so much, Paul for that presentation. I think it really demonstrates that there is a lot of opportunity to serve the population of dual

eligibles, as well as people in our long-term services and supports delivery system better.

In particular, I would just draw people's attention to that one slide that he had

that talked about how many people are getting served in institutional settings.

One of our main goals in this program is to serve more people in the community and that is -- those are opportunities that we have as we move into a managed care delivery system.

I am going to go through a couple of other questions: What is DSNIP compliance time frame? It was just mentioned by Paul.

Again, the dual-special needs plan compliance time frame, we are expecting

the managed care organizations to have DSNIPs do a special needs plan by

January 2018 in southwest and southeast part of the state and the remainder

of the state the deadline is 2019.

All individuals under 21 are being compliewded from Community HealthChoices such as 18-21 attendant care waiver people?

Yes, if there are individuals who are 18-21 in attendant care, they will get served by DTSTD -- up no 12 -- through 20, I guess I would say. They would

get -- they are getting served currently under DTSTD.

In the southwestern part of the state, we will be serving these consumers in the OBER waiver.

Another question: How many clients are currently covered that will be rolling

into the managed care organization?

Statewide we are looking at approximately 450,000 individuals that will be eligible for Community HealthChoices.

How many managed care organizations will eventually be awarded contracts with the State?

We are awarding 2 -- from 2 to 5 contracts in each zone; that that's the number that we are envisioning. There is a big range there, if you go to the all

statewide. It could be 10 to -- 5 times 5 is 25. I doubt, though, there will be 25.

Will they follow the same geographical service areas for traditional Medicaid service areas.

I would expect two per each says for choices; that is correct.

There was one other question in a longer group of questions: Will you be providing basic education about managed care for those who are not familiar

with this model of care?

Absolutely, we will be putting together a different presentation in order to do that. We did use one of the third Thursday webinars early on for basic education about managed care. We can certainly do that again, if you think that that would be helpful. We will also be putting together PowerPoints and we would really and, as I said this many times, support from many, many different community organizations in addition to the more formalized discussions we have been having with the Pennsylvania health funders network to assure that we are getting the word out to consumers.

Will Act 150 be included?

No, it won't. It is carved out. It is not a Medicaid program. It will continue to

be a separate fee for service program.

Will the LIFE/PACE programs be part of the ComCare waiver?

No, the LIFE programs will remain independent of Community HealthChoices.

They will be an option for individuals as they come to the -- come through the

door, whether they go to the independent enrollment entity and get education. There is a lot of opportunity there for LIFE to really become -- as it

is, it is a strong network in Pennsylvania and we and that that will continue. Our managed care organizations going to allow service coordination providers

to contract with them or will MCOs have their own staff?

We and that the managed care organizations will come in with different proposals around those kinds of arrangements but you will remember that we

have the continuity of care period for service coordinators so that service coordinators will continue to provide service coordination as individuals are moved into Community HealthChoices for the first six months.

During that time, the managed care organizations will be evaluating that service coordination and engaging in discussions around whether they want

to continue to contract with those coordination entities or make some other arrangements.

Will meals be included in the combined waiver? Many PDA consumers on waiver receive meals on wheels.

I am not sure about the detail of that one. If Meals on Wheels or meal services

-- I do not think those are waiver services. In fact, they cannot be waiver services. The waivers are precluded from providing food or meals and room

and board -- board being the meals.

Paul, did you have any others?

>>PAUL: Yes. How does a consumer know if they are in the special needs category?

I think the question probably came from the discussion of special needs plans.

So in the way I was using the word, if you are a consumer who has both a Medicare card and a medical assistance card, then qualify to joins special needs in Medicare.

>>**JEN:** Okay.

All right. I have a couple other questions that have come in for me. What will be the process of transferring from ComCare to LIFE programs. The ComCare consumers will be transferred not to the LIFE programs but to the independent waiver programs. Independence waiver programs -- (no audio) -- is almost identical to the ComCare waiver with the exception of a couple services which will be added to independence over the course of the next few months.

Should the service coordination agencies wait until the managed care organizations are chosen to start decree den shaling with them?

My recommendation and I think Paul said this during his presentation, is to start networking as soon as you can. Get to know them, develop relationships

with them. Talk to them about what you can do.

Much of this has been occurring through the meet-and-greet process we did in

January and November, where we brought different groups of providers to meet with managed care organizations that have shown an interest in the Community HealthChoices.

At that time, those managed care organizations were able to meet many different provider types. We had meet-and-greets with a brain injury providers, for example, we had meet-and-greets with Area Agencies on Aging.

We had meet-and-greets with the service coordination entities. We had meetand-greets with consumers.

In that process those managed care organizations began developing relationships with the people who attended these entities, these things.

They continue to dialogue with them. I was recently at a Center for Independent Living.

As I was leaving, one of the managed care organizations that attended the meet-and-greets a group of individuals that meet at those managed care organizations were coming out of the directors offense.

There is networking happening now. I advise that you continue to do that.

Has there been a consideration to allow people in self-direct additional -- to self-direct additional service like community interest dpraition, non-medical transportation respite and -- no, that has not come into consideration for us.

That is not an OLTL has not considered that actually is the first time I've

heard of that.

It's interesting. I will bring it back to the staff.

When managed care organizations will participants choose which managed care organization they join and could managed care organization decline a participant? Participants will choose which managed care organizations they

join. They will do that through the independent enrollment entity. They will also be -- if they do not make a choice, at some point in advance of the initial

implementation of community health choices, we will do an auto enrollment that includes some information that will help us auto enroll them appropriately.

For example, do they have family members in a different -- in a managed care

plan participating in Community HealthChoices? We would probably auto enroll them.

We are building some processes and decision trees to auto enroll individuals

into the most appropriate managed care organizations.

Managed care organization decline participant? The answer to that is, no, they will need to take the people that come to them.

When will handouts about the new program be given to medical offices in Pennsylvania?

It is a good suggestion we will work with the Pennsylvania Medical Society as

well as the hospital association to make sure information about the program is

given -- is provided to them.

Home delivered meals are in the aging waiver. Thank you very much. I learn

something every day. That surprises me.

That is something we will continue if it's approved by CMS. Yes, that service

will transition to the Community HealthChoices.

All services that are provided in the waiver will be part of Community HealthChoices.

There is more questions about waiver participants getting home-delivered wheels -- [indiscernible] I guess I was mistaken in that assumption I worked at CMS for four years at CMS it was the impression that I had that meals were

not included.

I stand corrected by several of the Area Agencies on Aging; thank you very much.

Let's see if there is anything else.

Well, with that, actually, we are out of time.

Again, we will be issuing FAQs, if there are any additional questions here that

I did not answer, these questions will go into our FAQs Q & A.

We are ending now. Thank you very much. See you next month.

(Webinar concluded at 3:01 p.m.)

Owe.

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