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>> DEPUTY SECRETARY BURNETT: Good of noon welcome to the third Thursday webinar for community health choices.

My name is Jennifer Burnett I'm the deputy secretary, for the office of long term living.

And, I am here I'm joined here on with several of my staff, I have Kevin Hancock chief of staff and Virginia Brown who is our policy director, in the office of long term living.

Today we're going to talk about, we're going to give you an update where we are with community health choices -- and then, Virginia is going to work -- going to present some slides, and walk you through, our plan to apply for concurrent BC waiver she will go through some slides that will layout what that is going to look like.

In terms of an update where we are community health choices -- second -- in terms of an update, our probably saw that our request for proposal was released on March 1st.

The proposals are due back to OLTL on May 2, 2016, because the RFP is currently out for bid, we are in what is considered a blackout period and I wanted to talk about what blackout period means because I think I've been getting a lot of questions there's some confusion what it means.

The standard language in the RFP says the following -- I'm

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

going read this to you.

It also, you can also take a look at it on our web site.

From the issue date of this RFP, until the department selects proposals for award, the project officer is the sole point of contact -- hold on a second we're having some technical issues.

[pause]

Should I start over?

Okay.

From the issue date from the RFP until the department selects proposals for a word the project officer is a sole point of contact, concerning the RFP -- any violation of this condition, may be cause for the department to reject ascending officers proposal, if the department later discovers that the offerer has engaged in violations of the condition, the department, may reject the offers proposal or rescind the award, offerers may not distribute any part of their proposals, beyond the

issuing officer.

If an offer, who shares information, contained in the proposal, with other Commonwealth personnel or competing offerer personnel may be disqualified.

So, the purpose, I mean the reason why we have this language is, the department never really, never wants to communicate anything on the RFP that would benefit a particular bidder or make them privy to information that is not available to all bidders.

So the blackout period, technically from the issue date, to the date the contract is awarded.

If there are any questions from a bidder, they should communicate with the project officer, Max Spiker.

Did he might this, we're continuing to hold public stake holder engage meetings like today the third Thursday webinars, and -- also, the MLTSS sub MAC meeting chose are sunshined. We may not be able to answer specific questions on the webinar regarding the RFP, but we, can provide information on progress that we're making.

So today, no questions, directly related to the RFP can be answered all questions rrelated to the RFP must be referred back to the project officer.

Who as I mentioned is Max spiker, information about the blackout period is also included in the RFP.

And that can be found by your Googling the Pennsylvania E-marketplace which is our Department of General Services web site, where the RFP is technically hosted and we also, to make it a little easier to find we have also posted it the CHC web site.

The CHC web site, is easily found if you go to www.dhs.pa.gov the bottom left hand side is a list of several hot topics, CHC is the hot topic there's a link to our web site, there the CHC web site you click on that link and, for community health choices you get to our web site then on the right side of our web site, I think it's the third -- second or third link down is the RFP document.

So you can take a look there.

I would recommend if you go look at the RFP, something to orient you, there is a summary document, listed there.

And you're welcome to take a look at that.

We had a proposal conference which Kevin is going to talk briefly about.

Yesterday, it was actually yesterday.

And, we received many questions as a result of that 450 questions have come in, we're working our way through those.

I wanted to briefly mention communication outreach and education because this is an area that people are asking me, many questions about -- asking questions about, our roll out start January 2017, and, in the southwest zone.

And, in the 14 counties that make up the southwest zone, for health choices in that zone there are approximately 100,000 individuals who will be enrolling into the community health choices.

We have a goal of reaching at least 95% of those individuals who are moving from CHC, into CHC from existing fee for service systems.

Advance -- I would like to reach them in advance of them receiving their first notice, from the department of human services, so I want to somehow get those people aware that a change is coming and be looking out for the notices for this come.

To do that, we'll be doing an outreach and education campaign we'll be targeting that education and outreach campaign to individuals currently enrolled in OLTL programs.

As well as, to let them know about this change.

We are also going to be reaching out to dual eligibles who will be people dually eligible for Medicaid and Medicare we will ask them, we will make sure that we explain to them what to expect in this process and inform them, of the change and help them understand what they're going to have to do so that they're at least, familiar, somewhat familiar with the change that is going to be made before they get that first notice.

We have contact information for all of those who will be enrolled.

So we'll be developing educational materials starting this summer to make sure people are informed of the change, know what they need to do and, are not, falling through the cracks to so speak.

With that I'm going to turn it over to Kevin, to provide a brief summary of the conference that was yesterday and, also he

is going to talk briefly about an up coming addendum.

>> SPEAKER: Good afternoon, my name is Kevin Hancock I'm the chief of staff project coordinator for community health choices we did have a preproposal conference for the issuance of the community health choices request for proposal yesterday on March 16th.

In attendance were some stakeholders including managed care organizations, I believe we had in excess of 10 managed care organizations present.

We provided an overview of the background and purpose of the community health choices initiative.

And, some of the ground rules that are associated with the procurement process.

Prior to the preproposal conference and through the preproposal conference, we received as Jen mentioned an excess of 450 questions, those questions will be paneled and posted on our -- on the E marketplace web site and by March 31st, those questions related to the procurement process itself and, specific program requirements and the opportunity to be able to answer them and to post them for clarification, hopefully bring clarity to the proposals when we receive them.

The next step in the process is, after answering those questions and, posting an addendum to the agreement, which will reflect changes that had been discussed prior to the preproposal conference and through some additional changes, that were recommended for the program, we're hoping to post an addendum by March 31 as well.

So the addendum will be any changes that we're posting to the draft agreement for the program.

And they would be used for the bidders.

The next step after the posting of the addendum and the questions, will be the receipt of the proposals themselves from interested managed care organizations and we're hoping to have those, proposals returned to us by May second.

With that, I will turn it back to Jen

>> DEPUTY SECRETARY BURNETT: Okay.

Thank you I would like to introduce Virginia Brown before I I do that I wanted to make people a ware of the fact that we have a hard stop at quarter of 3, we're not going to be able to go all the way to 3:00 today.

There's a meeting that Kevin and I have to get back to in Harrisburg.

So, I just wanted to give everybody a heads up that we have a hard stop at quarter of 3.

So, turning it over to Virginia Brown our policy director, at OLTL.

>> **VIRGINIA BROWN:** Thank you Jen good afternoon everybody. As Jen said my name is Virginia Brownie work in the OLTLs bureau of policy.

Thank you for joining us today, for the third Thursday webinar and, the subject for today's my presentation today is, around the community health choices waivers that OLTL plans to submit to CMS.

So before I get started talking about the waiver applications I just wanted to bring a lay of the land and the as is, for the current long term services and support systems.

Pennsylvania's current long term services and supports system is as it standing community option but not rapidly enough to keep up with growing demand.

The current LTSS system operates separately from the Medicare and medicine physical health system, leaving participants to navigate the complex programs their own.

As many of you probably know, we have five discreet home and community based waivers serving five very different target populations.

We have some individual that's receive physical health benefits through health choices but others do not.

So for example, individuals who are enrolled in the aging waiver, get their physical health services through the fee for service system as do dual eligible individuals.

In addition, we have individuals residing in nursing facilities, who are also carved out of health choices.

As a result we see very little coordination of long term services and supports, with physical Medicaid and Medicare benefits.

Between 2002 and 2014, these challenges have been documented by stake holder was in ten significant planning groups, study commissions and work groups on long term services and supports.

The vision for CHC is an integrated system of physical health and long term Medicare and Medicaid services, that supports older adults and adults with physical disabilities, to live safe and healthy lives with as much independence as possible in the most integrated setting possible.

For those who reviewed the CHC concept paper, and I'm sure this has been documented elsewhere, two of the five overarching goals for CHC is strengthen coordination of long term services and supports and other types of health care including all Medicare and Medicaid services for dual eligible individuals better coordination of Medicare and Medicaid health services and long term services and supports will make the system easier to use and will result in better quality of life, health, safety and well being.

And one of the other goals so into increase efficiency and effectiveness.

It is OLTLs goal to increase the efficiency of health care and long term services and supports, by reducing preventable admissions to the hospitals, emergency departments, nursing if as and high cost services, primary HCBS and health choices.

So let's get started talking about the community health choices waivers.

So as Jen said, Pennsylvania will operate a concurrent 1915B, 1915C waivers for community health choices.

The 1915B waiver allows for the use of managed care in the Medicaid care program through managed care organizations, makes that program, eligible Medicaid participants to receive services.

The 1915C waiver, allows for the delivery of the long term services and supports, in the home and in the community.

You've also heard us talk about coordination with the Medicare. A major policy objective of CHC is to improve the coordination of benefits across the Medicare and Medicaid program for dual eligible participants.

Pennsylvania, will be exercising existing statutory authority under section 1859 of the scattered showers act, which allows Medicare advantage plans to create specialty plans, targeted to special needs individuals, including those who are duly enrolled in Medicare and Medicaid.

Under this authority, the States can use DSNP contracts to

link Medicare services to Medicaid long term services and supports programs.

CHC, MCOs will be required to offer companion DSNP scattered showers for dual eligible participants if they choose that, they will have all of their benefits seamlessly coordinated by one MCO they also receive supplemental Medicare benefits offered by the MCO.

Dual eligibles, who do not wish to enroll in a companion DSNIP will not be required to do so.

They will continue to have all of the Medicare choices offered in their region including traditional Medicare.

However, CHC MCOs will be required to coordinate with the participants Medicare health plan or the original Medicare fee for service programs.

CHC MCOs will also be required to work with the Medicare fee for service providers selected by the participants.

So this is a little bit more in-depth on the 1915B waiver.

Let's talk a little bit more about the application.

Health choices, Pennsylvania's statewide managed care delivery system for children and adults, operates under the 1915B authority.

OLTL is modeling the community health choices 1915B waiver after the current health choices waiver.

The provider network standards for CHC will mirror those of the existing health choices programs.

The 1915B application requests authority for Pennsylvania to mandate participants in CHC to obtain services through managed care organizations.

The waiver application waives the requirement for all services for categorically needing individuals to equal amount duration and scope.

CHCMCOs will provide wellness, care management and other services, that are not available to other Medicaid participants not enrolled in CHC.

Waiver participants, in the CHC region, may only receive services through the CHC MCO.

The CHC population will include individuals with Medicaid only coverage, who receive or need long term services and supports and individuals with full Medicare and Medicaid coverage including those with and without long term services and supports

needs.

So now we're going to move onto the 1915C waiver.

Which is a bit more complicated.

As we said on an earlier slide, the 1915C waiver, allows for the delivery of long term services and supports in the home and community.

The existing 1915C waiver, the aging waiver, the attendant care waiver and the independence waiver, will continue to operate under the fee for service delivery system until community health choices is implemented in each of the respective regions.

The OBRA waiver will continue to operate across the State in the current form to accommodate those individuals who are currently in the OBRA waiver, who will not qualify for CHC.

Beginning this spring, individuals currently live served in the OBRA waiver living in the South Western CHC counties, will be reassessed to determine clinical eligibility for CHC.

Individuals who meet the clinical eligibility criteria, will be transitioned from the OBRA waiver to CHC.

Individuals residing in the remaining 2, CHC regions that would be the southeast and then the remainder of the State, will be reassessed prior to the implementation of the CHC in that particular region.

OLTL has significant experience transitioning individuals from one waiver to another as demonstrated by the closure of the mic call Dallas waiver, ELWIN and HIV waiver.

HIV AIDS waiver, OLTL will be working closely with individual service coordinators to effectuate a seamless transition for these individuals.

OBRA waiver will also serve 18 through 20 year olds, who require certain long term services and supports, that are not offered through the Medicaid state plans until they age into CHC. Pennsylvania is choosing to repurpose an existing 1915C, HCBS waiver, rather than create a new waiver to ease compliance with the Federal HCBS final rules.

States that have had existing 1915C, HCBS waivers in March of 2014 have until March 2019 to bring them into full compliance with the Federal HCBS regulations.

Any new HCBS waivers adopted after March 2014, must comply with the Federal rule immediately.

Compliance with the CMS rule on home and community based

services will be a requirement for providers to participate in CHC.

MCOs will be responsible for ensuring providers in their networks are compliant with OLTL policies related to the HCBS final rule, that CHC-MCO must provide in the least restrictive most integrative setting as stated in the CHC agreement, the CHC-MCO must provide services in the most -- in the least restrictive most integrative setting with services and supports must be provided in accordance with 42CFR, section 441.301C4 and 5. Which outlines allowable settings for home and community based services.

This includes that CHC -MCOs shall only provide long term services and supports in settings that comply with Federal regulations.

The CHC-MCO must submit documentation to OLTL on a quarterly basis containing a list of settings that are noncompliant.

Bar I was just told to speak up.

[laughter]

So moving along.

As a result, selecting an existing waiver to use as the CHC waiver vehicle makes the selected waiver no longer available in the fee for service region.

Participants in the selected waiver, who live outside of the southwest region will be transitioned to another fee for service waiver until CHC is implemented in their region.

Pennsylvania will be using the existing COMMCARE waiver as the CHC waiver vehicle making the COMMCARE waiver no longer available in the fee for service region.

Individuals currently enrolled in the COMM care waiver who reside in a fee for service region will transfer to the independence waiver, until, CHC is implemented in their region.

COMM care was selected for several reasons -- it allows for an ease in transition, it includes the fewest individuals of all of our waivers, it is similar to the independence waiver which will serve as a transitional waiver for current COMMCARE participants that reside in fee for service regions and the expire agency data shows for a longer transition period than other waivers, OLTL will need to address dental rehabilitation and structured day rehabilitation to the independence waiver in order to make the services packages

equivalent.

COMMCARE waiver participants will be transitioned to the independence waiver in the non-managed care counties, beginning in October of 2016 or to the CHC waiver, in the southeast zone beginning in November.

As part of the transition, two services as I said will be added to the independence waiver, to make the packages equivalent. Again, the transitions, and this change should be seamless to program participants.

In addition to the reference amendments to the independence waiver, OLTL will also be submitting minor amendments to the aging and attendant care waivers to facilitate the implementation of the CHC.

So the next couple of slides are just visuals to give people an understanding of what we're talking about with regard to the roll out of CHC waiver, and, how it may effect the other waivers in the fee for service delivery system.

So starting in January of 2017, in the 14 southwest counties that will be moving to a managed care delivery system we will have the CHC waiver available and the OBRA waiver available. In those counties that have not yet transitioned to community health choices or who are not operating under a managed care delivery system, the aging waiver, attendant care waiver and the independence waiver and the OBRA waiver will continue to operate as they do today.

Beginning in January of 2018, when the southeast counties come on board, again, we'll have the CHC waiver and the OBRA waiver available in both the southwest and the new southeast counties.

The aging attendant care and independence and OBRA waivers will continue to be available to participants operating under a fee for service delivery system in the remainder of the State.

And then, in January, 2019, the waivers that will be available will be CHC waiver which will be operated through the managed care delivery system and then the OBRA waiver which will continue to operate through fee for service.

So just to give everyone an idea of our time frames -- we are anticipating that we will be publishing a -- several public unleses in the Pennsylvania bulletin on April 2nd.

Those notices will be announcing the 1915B, C, CHC waiver applications.

As well as the amendments to the aging waiver, the attendant care waiver and the independence waiver.

The announcement will also be distributed to our stakeholders as we have done in the past.

And DHC will engage stakeholders throughout the -- through the subcommittees of the MAC as well as the MAC, through dedicated webinars and through the public comment process.

We will a 30 day public comment process which will begin on April second it will end on May 1st we're anticipating we will be submitting the draft applications to CMS to begin the approval process on June 1st.

Those draft applications have any comments we receive through the public comment and stake holderring process included in them.

We are requesting an effective date of September 1st, 2016 for the aging attendant care and independence amendments.

So that we can effectuate first of all the transition from -- for individuals from the COMMCARE waiver to the independence waiver.

And so that we can also move forward with the CHC implementation in January.

And we are also, requesting an effective date of January 1, 2017 for the two CHC waivers.

And that's it.

>> DEPUTY SECRETARY BURNETT: Okay thank you Virginia. That was very helpful and, it's complicated.

>> VIRGINIA BROWN: It is complicated a lot of moving pieces a lot of puzzle pieces that need to fit together.

>> DEPUTY SECRETARY BURNETT: Okay.

It is a lot of puzzle pieces to put together.

Very much so.

I think it's going to be a -- it's simpler system having the one waiver.

>> VIRGINIA BROWN: I think so.

>> DEPUTY SECRETARY BURNETT: That's something we have gotten input over the years we really should move to having one waiver just one, OBRA waiver, CHC waiver, this is not the first time we've contemplated doing one waiver.

So great.

Thank you very much Virginia B

>> **VIRGINIA BROWN:** You're welcome.

>> **DEPUTY SECRETARY BURNETT:** We're at the end of the presentation what we'll start doing now is we're looking at questions.

Again I want to remind folks we can't take RFP specific questions and, but there are questions, I think we're receiving here, that are not related to the RFP.

So I will start with the first question, we received here use the chat function on the webinar to submit your questions everybody is muted.

During the last few webinars we were encouraged as providers, to reach out to the proposed MCOs, upon contacting the MCOs we have discovered most of them did not know what to do with our information, is there some sort of script we should use with the MCOs when trying to contact them?

I think, I won't -- I don't think that we have a script, nor were we contemplating putting a script together I think, each type of rider has its own information, that they want to impart to the MCOs and give them.

The point of the contact -- is to help them, become familiar with what you do.

And what your role is currently to engage them and discuss with them the potential for contact with them.

I don't know that it a script will help with that it's incumbent upon each of the providers to figure out what it is I have to offer in an MCO environment and, how do I tell them about it.

How do I talk to them about it, what is my value add?

I do know that, when hearing from other states about the MCOs and their contracting processes, that they, wanted to have a -- they're going to want to have, to be able to contract with a variety of providers, they will be required to have what we call network adequacy, so they're going to need to have providers available to do the long term services and supports work.

Do you have anything else to add Kevin?

Virginia?

Second one, can the CILs help to transition and can we do training sessions will you furnish materials to help us teach

it.

Yes.

I have said before that, educating and helping people understand what the changes are all about, is really going to be an all hands on deck process.

And we would like to engage all stakeholders in supporting consumers to learn about this.

We will be providing information materials as are requested here but in advance we have providing those materials we have to develop the materials.

We will be engaging our MLTSS sub MACC and other stakeholders to provide us with feedback on what that will -- what those materials should look like.

During the next few months we're going to be working to develop those materials.

We're also going to be doing a lot of training and exacting a lot of training to be happening with regards to making sure the providers know what to expect making sure the consumers know what to expect and making sure that the managed care organizations understand the expectations around MLTSS.

Do you have anything else to add?

>> SPEAKER: No.

That's great.

>> DEPUTY SECRETARY BURNETT: Okay.

First question, as of Monday, March 14th, the compass application has changed.

We are a life provider and now our compass application is being sent to Maximus and verification documents are now asked to be sent to a different Philadelphia district office.

No choice for LIFE, second question, as of April 1, will the AAA continue to do medical eligibility assessments for LIFE.

I know the answer to the second question, the AAAs will continue to do the level of care determinations for LIFE, however, we are having a -- the independent enrollment backer Maximus do the actual enrollment either into and referrals to LIFE or enrolling into one of our waivers.

So that is a change.

I will also say that medical necessity that assessment has to be done by a physician's certification.

On the first question, on the compass application do you know

the answer to that Kevin?

>> SPEAKER: It is true that the applications will be sent to the independent enrollment broker Maximus for the time being and, the plan at this point is for the independent enrollment broker to send the applications to the LIFE plans so that's -- we'll make the clearest steps and the procedure are communicated to the LIFE plan as well as the independent enrollment broker that's the plan at the point if they receive an application through -- if an individual is requesting home and community based services or the LIFE program, and it is transferred to Maximus they will make sure it's referred to the LIFE plan.

>> DEPUTY SECRETARY BURNETT: Thank you Kevin.

Will the consumers reach receiving PAS and service coordinations services stay with their current OLTL providers during the continuity of care period?

The simple answer to that is yes.

We have the continuity of care period, but if you want to put any caveats on that?

>> SPEAKER: Service coordination services are part of the 180 day initial continuity of care period, service coordinators will be treated as a service provider during that continuity of care period.

Following that continuity of care period the initial continuity of care period, the service coordination will be administrative function of the managed care organizations, and won't be considered to be a network service provider it will be part of the managed care organization.

Individuals receiving, personal assistant services through -- would be on the person centered plan the providers will continue to be a network provider hopefully that provides a clarification to the question.

>> DEPUTY SECRETARY BURNETT: Okay.

There's some questions related to the waiver application, which I'm going to ask Virginia to answer.

>> VIRGINIA BROWN: Okay.

Thank you so the first question is pretty easy.

There were two questions around a copy of the slide presentation.

And, it's my understanding that the PowerPoint was sent out just as we started this afternoon but it will also be posted on

our web site where we have all of the historical information from the third Thursday webinar.

The second question I'll go ahead and read the question -- can you please clarify the purpose of the redetermination for the OBRA waiver recipients between 18 and 20?

What are the possible outcomes of this redetermination.

So the actual, the redeterminations are not just going to be -- are not going to be limited to individuals between the ages of 18 and 20.

The redeterminations will be targeted to individuals living in the counties that are getting ready to roll out into managed care to identify a level of care.

The OBRA waiver, currently has a different level of care than the other four OLTL waivers.

The OBRA waivers level of care is ICS, ORC whereas the other four waivers require a nursing facility level of care.

OLTL anticipates that many of the individuals in the OBRA waiver will meet the nursing facility level of care criteria and those are the individuals over the age of 21 that will be targeted for transition to community health choices.

The next question pertains to the aging waiver.

What are the changes being made to the aging waiver?

So the changes to the aging waiver are we are including, we have to amend the aging waiver to include the enrollment through the independent enrollment broker.

That is a change that is happening I believe it is next month or the month thereafter.

The other changes to the aging waiver are -- will also be made to the independence waiver and a tentent care waiver we need to identify or we need to really articulate what the transition looks like between the fee for service waiver to community health choices.

And then we're also making some changes around the entity that is responsible or that we're delegating the level of care determination to so we need to reflect that in the application as well.

The third question again has to do with the aging waiver.

And let me read the question -- the aging waiver in the central -- in the Central Pennsylvania will convert as part of the third part.

So I think the question reads, will the aging waiver participants transition to community health choices in the third region?

The answer is yes.

As noted on the third map, in the slide deck the central part of Pennsylvania will transition to managed care in 2019.

So individuals in the aging waiver nothing will change for those individuals in the central part of the State until 2019.

And I think the rest of these questions were for Jen actually.

>> **DEPUTY SECRETARY BURNETT:** One more.

>> **VIRGINIA BROWN:** I just got one more.

Let me read the question.

Will the eligibility criteria of each of the waivers be being folded into CHC carry forward to CHC?

Also, will there be any caps to the number of individuals who can participate in CHC similar to COMM in each of the waiver programs.

The first question, let me take that first, the level of care criteria will be the same.

The level of care will be nursing i facility level of care.

We're looking at the clinical eligibility tools and revising it so that it is more streamlined for participants shorter for participants, shorter assessment for participants and focuses on functional needs.

So essentially the eligibility criteria, really should not change.

The second question, related to caps, we are required to put in our C waiver application an estimate the number of unduplicated participants that we expect to serve.

And so the same will hold true for the community health choices waiver, the C waiver.

That we will need to estimate the number of individuals unduplicated number of individuals we'll be serving.

Just to clarify, we currently don't have any caps if we did, we would be instituting a waiting list, we've been lucky we've been able to increase the number of unduplicated recipients each year.

One more.

Okay.

And then, another question actually really good question and

I neglected to mention this.

The question is, will home delivered meals will be added to the CHC waiver?

Excellent question because what we're proposing and I think, you may have seen this in many of the documents that have been released previously, that we are not -- we're not terminating or eliminating is a better word, we're not eliminating any of the current services that are currently offered to any of our waiver participants.

So all of the waiver services that are offered across the five different waivers will be available in the CHC waiver including home delivered meals.

We are including some enhanced employment services which will be included in the OBRA renewal and the independence amendment that I referenced earlier.

And we are also including pest eradication.

And one more

[laughter]

I just handed another question.

So the question reads, so consumers in OBRA who are going to move to CHC will stay in OBRA until the regional roll out.

Not be put into a consolidated waiver with independence and COMMCARE prior to the CHC roll out.

So the answer to this question is that is correct.

And CHC is rolled out in each of the different regions, the individuals in the OBRA waiver will be reassessed to identify whether they are eligible for CHC.

If so, they will transition to the CHC waiver.

We are trying, we don't want people to have to transition multiple times if we can help it.

Which one did I miss?

Oh I think I did that one, yeah.

>> **DEPUTY SECRETARY BURNETT:** Okay.

Great.

Thank you.

All right no more for Virginia we'll go back to the more general ones and just as a reminder, we are in the blackout period so a number of these I will read them but we can't answer them because of the blackout.

So some of these things I just can't talk about at this point.

For nonresidential facilities that may require heightened scrutiny under the HCBS rule will OLT pursue heightened before turning the compliance over to the MC Os may not choose to deal with the heightened scrutiny appeal.

Under the CMS, the State, under the HCBS setting these rules the State is responsible for doing heightened, conducted heightened scrutiny for those nonresidential facilities that will require we have a few that will require heightened scrutiny it's the OLTL responsibility to go out and do an investigation of those facilities and, make a determination and put forth to CMS that's our responsibility.

Will MCOs provide the support as service coordination entities?

That is a blackout period question.

What is your plan if there's a shortage of qualified supports coordinators, again that's a blackout question.

How will this transition effect current service providers such as service coordination entities I think we've been talking about that at length.

And what I said so far about service coordination, for instance, service coordination agencies, to you know, work with MCOs and engage with them and again, at the end of this month, we'll be publishing an addendum that may have some clarification on the service coordination entities.

Is there a time line for when the MCOs will be selected?

I believe that there are 12 MCOs in the bidding process.

These MCOs will be selected just a reminder on May second that's when the RFP -- proposals are due back for the MCOs who are bidding.

And, our anticipation is to, in this summer sometime in the summer of this summer 2016, we will be making selections of the MCOs.

Out reach and education materials be available in multiple languages?

Yes.

We are required to do that.

>> **VIRGINIA BROWN:** We got another one me.

Okay.

I was handed another question.

And the question reads, did you indicate the number of

participants or caps in the CHC waiver?

We do not have that number in the draft waiver at this time.

We are relying on our metric individuals, metrics staff and Mercer to help us look at the number of people that we're currently serving and estimate additional individuals to come up with those numbers.

So at this time, we don't have a number nailed down.

>> DEPUTY SECRETARY BURNETT: Okay.

Back to me.

This is Jennifer.

This is Jennifer Burnett what is being done to ensure that people certified COMMCARE when we assess our drops from services?

Well, it's our intent not to drop people from services, it's really, to ensure that they're not dropped from services.

They may not present as other people that meet NFCE.

>> SPEAKER: We can say the level of care assessment will be tested to make sure they consider specific requirements for COMMCARE recipients.

>> VIRGINIA BROWN: For the COMMCARE individuals transitioning to the independence waiver they will not need to go through another level of care assessment.

We're only talking about the individuals in the OBRA waiver, to identify those individuals who may meet the clinical eligibility requirements for CHC.

>> DEPUTY SECRETARY BURNETT: Nursing facilities clinical eligibility.

>> VIRGINIA BROWN: Exactly.

Any transition time lines for current fee for service Medicaid residents in SNIPS.

Which is, nursing facilities.

Transition team time line is the same as for all of CHC, both for people in nursing

facilities as well as the home and community based providers

>> DEPUTY SECRETARY BURNETT: P Providers need to reapply to provide services under CHC?

That is a blackout question.

They don't have to reapply if they're already Medicare provider

>> MALE SPEAKER: They don't have to reapply for Medicare.

>> **DEPUTY SECRETARY BURNETT:** They don't have to reapply for Medicaid.

[pause]

Okay.

Clarification.

The aging waiver in central PA will consort as third part which 1/1/2019 that's correct.

>> **MALE SPEAKER:** Defining Central Pennsylvania as what would have been the health choices Lehigh capitol zone northwest zone and northeast zone.?

So that is correct.

>> **DEPUTY SECRETARY BURNETT:** Okay.

How can service coordination agencies, find a step by step process of how far to apply to the MCOs?

Not -- there is not a -- we do not have a step by step process available.

As I said earlier, each provider has its own unique way of selling themselves to the managed care organizations.

But the MCO contact information is available on the CHC web site.

All of the MCOs have indicated interest, have allowed us to put up on the web site, very specific contact information. I can get a list of the MCOs on the CHC web site.

Will there be a separate RFP for the SMS and home modification services yes there will.

Okay.

My question for today's webinar -- is what rethe current independent enrollment broker regulations contract requirements as it pertains to the time frame for enrolling a participant to services for the last step of the IAB I have heard this may be changing, but do not know where we are currently with that.

We have in the current, in the existing contract, up until December or March of -- March 1, 2016, we were, we had required 90 days we actually have 90 days in a settlement agreement that people, the total enrollment takes 90 days I'll tell you we've been working very hard to bring that time frame down, we're down around 62 days.

The new contract that we are in the process of implementing is 60 days.

So we have an expectation that people are enrolled in

the independent enrollment broker contract requirements in 60 days.

Where is the best place to find information on current MCOs in reach region.

Again the health choices web site.

Which is very easy to find, it's right on the home page for the DHS web site and you can just click on that it takes over to our web site, CHC web site.

There's a listing of the managed care organizations in each region there.

[pause]

I'm just looking through some more questions.

Will providers continue to build product of excellence for waiver -- answer to that is yes.

Yes.

CHC for dummies, can you recommend information, to read to understand the complexity, we have

extensive information on our web site about CHC.

I would definitely recommend that you read the summary document that is up on CHC web site.

It has a summary of what the procurement looks like.

I've been going to a variety of organizations to walk them through and help them understand kind of call it my 101 and, at some point maybe we will do a 101 on the third Thursday webinar.

Okay.

How much time will providers such as PAS providers have to contract with MCOs if we're not southwest region?

Again that's a blackout yes.

MCOs provide a same support as service support entities in the RFP you can find information around the expectation of the service coordination.

[pause]

Not clear.

As of April 1, who will do the actual clinical eligibility assessment for LFE, PCA or MAXIMUS, PCA or area ages throughout the State will be continuing to do the clip eligibility assessment, that has not changed.

Have you considered the LINK meetings a training stakeholders the region ins the west have a great collaborative network that

may be beneficial in the communication campaign.

Just a suggestion I really appreciate that question.

Yes, we will certainly be considering the PA links meeting as an avenue for training.

To the extent that anyone has, has opportunities for us to be able to come to nationally occurring meetings we're certainly doing that, extensively, this week I was at several of them I went to a meeting of the county commissioners here in Harrisburg. I also went to a meeting in Gettysburg with the Pennsylvania council on aging and the Pennsylvania association of area agencies on aging spoke with them.

So any opportunity that I had, we have, all of us have to speak at what is going on, we are doing that.

Okay.

Have you -- let me see.

Please, could you list the MCOs.

We will include it in summary but, we're trying to -- we're trying to do that on the web site on the -- is this on the webinar this is showing up there?

>> **VIRGINIA BROWN:** I'm going to go to the community health choices web site.

>> **DEPUTY SECRETARY BURNETT:** We're going to walk you through how to get to the community health choices web site.

So -- we will go ahead and also, find the list of the MCOs.

And where it is.

So you can find it.

I read somewhere that, when CHC is implemented, the consumers will be able to keep the same provider for the six first months, is that accurate as far as the implementation process.

Is that a -- continuity of care question?

Right here

>> **SPEAKER:** Blackout question.

>> **DEPUTY SECRETARY BURNETT:** That question is a blackout question.

Although as I've been saying there's a six month continuity of carry think Kevin clarified that a little bit earlier.

Will the eligibility criteria be folded in CHC carried forward to CHC?

Yes, they will.

Also, will there be any caps to the number of individuals a

consumer can participate in CHC?

Similar to current caps in each of the waiver programs.

At this time we don't have any caps and we're, we're not anticipating that there will be caps for CHC.

Okay we're going to walk you through how to get to the web site.

This is the DHS take over just explain where we are Pat?

>> SPEAKER: Sure, this is on the department of human services main web site.?

And on the left hand side, you can see community health choices link.

If you click on that link, it takes you to the community health choices web page.

And, as you scroll down, first of all there were some questions about where you could find some basic information on programs.

We'll go there in a minute, but, to answer the question about how do I know what MCOs are interested in community health choices if you towards the bottom of the page, click on the link MCO contact information, that will take you to a list of MCOs that have expressed interest in participating in community health choices you'll see the plan name, contact information and then there are also email addresses there.

So those would be the MCOs that are interested as well as the contact name or individuals.

And then, of course, the department, at this point would not know who is, what MCOs will be interested in each of the region, so, if you have the question, your best bet would be to reach out to those contact individuals and ask them those questions.

>> DEPUTY SECRETARY BURNETT: I want to say on that list MCO contact information, those are the MCOs who have shown an interest in and come forward in our meet and greets et cetera, et cetera if there are additional MCOs that are contemplating applying in Pennsylvania, I'm going to recommend that they would let us know that so we can expand that list and add them.

>> SPEAKER: Yes.

Great point Jen thank you.

Then related to some of the information that basic

information that is available around the health choices, the concept paper that was previously published provides some very good information.

If there's an interest, from an individual for historical data summary that provides a lot of information about the current programs that the Commonwealth offers as well as historical data for the various programs, claims data, LIFE information.

Information by county and zones related to services.

Nursing facility occupancy and then, chronic condition costs and services by CHC zone.

That is in that tab.

The request for proposal, from the requirements document these are all of the various documents the drafts are down here, that were issued in November and December.

There are also, the department posted all of the comments that were received, for the November and December releases, so that's out there if you want to read through comments that came in.

There's supporting documents.

And this is a fact sheet around managed long term services and supports which may be helpful to individuals who want to learn about MLTSS.

Adds well as, additional historical documents.

Then, here's a link for the webinars, I believe, Virginia had previously mentioned this, there's transcripts and then there are YouTube videos of all of the previous webinars, that are out here.

And then, finally the transcripts so there's a lot of information.

I'll turn it back to you Jen

>> DEPUTY SECRETARY BURNETT: Okay.

Thank you.

I think that was helpful.

So did I understand that after 180 day period there will not be individual service coordination entities?

Go ahead refer to the draft agreement that you see there I mean, I would look at the draft agreement because it outlines what our expectation is around service coordination entities as I mentioned, some of that may, we may do some clarifying language in our addendum that we're posting at the end of month.

But, we are, we have the continuity of care period, so that the -- the service coordination entities that are in existence, are able to provide, to continue providing services and also, so that they can, demonstrate to the managed care organizations their value as a service coordination entity, that's really what the continuity of care period this is how, all other states do it, so I would recommend that you start reaching out to these managed care organizations and, talk to them about your quality oversight, talk to them about your information systems, et cetera.

Will we still have audits.

Yes?

In the fee for service areas and this will be QMET's role is going to be changing and we are in the process of working on a different operations for the QMET as well as our other operations. For duals who opt out of or do not enroll in a DSNIP for a fee for service or function for fee for service function in the same way as today in terms of covering Medicare copays et cetera?

Yes.

We will, they will still cover, Medicare copays will continue to be covered.

Did you indicate the number of participants or caps in the CHC waiver?

There is no cap in CHC waiver.

When will the RFP be available for service providers?

The -- RFP was posted on March 1st and it's available on the CHC web site as Pat just went through.

Did a navigation orientation to the CHC web site, that RFP is posted it's still up there.

The related topics button the third -- third button down, the third link down, that is where the request for proposal and program requirements are.

So you can take a look at that as well.

Let me just see.

How will I waiting list work on CHC once -- once cap is reached, it is our intent with CHC to better manage our program -- we have got efficiencies and we know the aging population is growing in Pennsylvania.

I think there was a recent report out of the Pennsylvania legislator, if -- if anticipated to grow to 23% in the coming

years.

The aging population we know nationwide there are ten thousand baby boomers turning 65 every day.

So we have a big population, influx coming in and, more and more people are going to need long term services and supports we need to get our programs ready to deal with those so we're looking at really an expansion of services and ability to serve people in a more effective and efficient way with CHC.

We're not anticipating, we're not anticipating caps per se.

Okay.

I read somewhere that when CHC is implemented all consumers will be able to keep their same provider for the six months, even if the provider is not contacted.

I think we answered that question.

Okay.

Couple more here.

[pause]

What is the State doing to support or improve area agencies on aging that can't keep up with level of care determinations presently.

We're working very closely and will be entering into a contract that is going to layout our expectations for levels of care determinations to be conducted in a very timely manner, our contract will layout those expectations and we will hold them accountable through that contract.

I know that there are two counties that are working very diligently to catch up with and do faster level of care determinations do the level of care determinations within 15 days and, we're working I know that P4A Pennsylvania area agency on aging is working very hard I have heard, I was given a report from them, when I was with them whenever that was, this week -- I think, Tuesday.

That they are at 82% in compliance with the 15 day requirement.

So, they're working very hard to come into compliance.

are home care medications are

required to contact with MCOs they are going to want to contract with the home care agencies it's part of the services they're going to be providing as an important component of the managed care.

We have no requirements but, if there are home care agencies that are currently working in the fee for service Medicaid program they're going to want to be getting in touch with managed care organizations.

Will the MCOs replace the local area agency on aging offices will this be a partnership with the AAA offices involving aging waiver programs?

Again, when we roll out community health choices, the MCOs will be responsible for the oversight and through their a per member per month payment from the State to the managed care organizations they're going to be responsible for service coordination and they will, certainly, it will be in their best interest to engage with the local area agencies on aging, they have a tremendous amount of local expertise and contact and information, so I would assume that MCOs will be partnering with a variety of providers throughout the State including area agencies on aging.

What other counties are getting a LIFE program.

>> SPEAKER: At this point, the plan is to -- the literal plan for LIFE is to expand in the Somerset and Bedford areas initially because that's part of the southwest we're hoping to have a LIFE plan available in all of the southwest counties when we roll out the community health choices, LIFE program will also be expanded in Montgomery and Chester Counties as well and they will be a release of requests for proposals, within the next few months.

That is in addition to the expansion that's already been announced for Perry County.

>> DEPUTY SECRETARY BURNETT: Okay.

When is the SMS, RFP expected to be released.

We are planning to release that later in 2016.

And we are engaging in discussions about some changes in the nearer term.

But we will be releasing it later in the year.

Who will be doing service coordination for Act 150 programs since they're carved out of the CHC?

Eligible service coordination providers will be doing the Act 150 we don't anticipate that is going to change.

How are we handling current COMMCARE participants reside understanding a group home, that they can continue to reside in

the group home and receive needed services?

Community health choices will focus on continuity of services.

So we're going to be really looking at continuity of services, we have made a commitment that if people are residing in and desire to stay in the residence that they are currently in, we do not want CHC to -- community health choices to displace them and that includes whether you're in an existing COMMCARE funded home or you're in a an existing nursing facility and so we're not, we do not anticipate, and we have an expectation we're not going to kind of displace anyone through this process.

Will the current FMS will be required to have the local office services until the RFP is released.

This is under discussion right now.

Okay.

>> MALE SPEAKER: The questions have been answered about service coordination, during each of our webinars are the reason why the SCEs are all concerned.

Question is why won't OLTL tell the CFEs what the ultimate plan is, most if not all managed care states do not have FCEs they need service coordinate writingennityities they use care managers ininside the MCOs the gentleman from Tennessee confirmed he no longer has a FCE managing his budget it's going to impact many job he's if this happens to the FCEs.

Is there any language you can use to explain this, a little bit better?

It seems, that OLTL is being forced to give political answers rather than direct I mean, no offense by this comment, but you have to know that these agencies are scared they're going to lose their jobs.

I do not, belong to an FCE but understand the concern.

So the response to this is that, the way that service coordination services is managed is, part of the procurement process and, it is not meant to be a political answer it's really meant to be an answer that takes into consideration, a requirements during the blackout period.

This is, this question in the way that service coordination is going to be managed is part of what managed care entities have proposed

we can't go into

any more comment about that.

We've talked about, what we're planning to do service coordination prior to the release of the RFP the reason we're being being hesitant in the point is because it's part of the procurement process

>> **DEPUTY SECRETARY BURNETT:** We have talked at length about the service coordination and, you know explained it as part of the responsibility, will be with the responsibility of the managed care organizations.

They can, they can go about establishing or contracting with service coordination entities or they may bring it in-house.

I don't think it's a correct statement to say most states, have service coordination as or service coordinators that are strictly a function

or not

a function but a employee of the managed care organizations.

There are many different ways that this kind of coordination of care is provided.

So I know that Truven did a paper on this.

Where they talked about the different models and, what the -- they have different models including a hybrid model where some of the care coordination is made available through an employee of the managed care organization.

And then, other parts of it, other coordination is done through a contract.

So, there are many ways of going about this.

I think we have been very transparent about discussing this and as Kevin said we're at a point where we rally can't go into my nor detail other than pointing to existing things are in the public domain.

With that we're a little past our hard stop which is quarter of 3.

I thank you for your participation in this and we look forward to hearing from you as the topics you would like to hear given the blackout period, it will be great to hear from you, when we send out the evaluation, suggestions for future webinars.

So thank you very much.

[webinar concluded]

Notes