

## Third Thursday Webinar

August 18, 2016

[ Rough Draft Text ] [ CART Captioning standing by ] >> Good afternoon and welcome you to the third Thursday webinar. I'm the Jennifer Burnett, the deputy secretary for the office of long-term living and I am joined by Wilmarie Gonzalez who is the director of our bureau quality assurance and program innovations. We are also going to be joined by Kevin Hancock who is in the process of coming over here. I wanted to start out with a welcome. There is information on the password and everything on the screen right now but we're going to get started in about two minutes. Thank you. Hi, again. I'm the department secretary for the office of long-term living. I'm joined here today by Wilmarie Gonzalez who is the bureau director in our bureau quality assurance and program innovation as well as Kevin Hancock who is an Office of Long-Term Living chief of staff. Before we get started I'd like to go over a few items so you know how to participate in today's event in case this is new to you. We have a screen shot up here of the example of the attendee that looks like this in our own computer desktop in the right hand corner. To the left is the goto webinar viewer for which you see the actual presentation, the big one that says webinar housekeeping. To the right is the go-to webinar panel. It's a control panel where you can ask questions and select audio modes. It is controlled -- if the control panel is closed and you just need the slim red rectangle click on the red arrow to expand it. You're listening in using the computer speaker system by default. If you would prefer to join over the phone just select telephone in the audio panel and the dial-in information will be displayed. You are placed in listen only mode to hear the webinar presenters but you will have the opportunity to submit text questions to today's presenter by typing your questions into the question panel of the control panel. You may send in your questions at any time during the presentation and we 1:30-3:30 Remote for OLTL Transcript will answer them as we have time. Please note that the attendee control panel will collapse automatically when it is not in use by an attendee. To keep it open the attendees can keep it open and uncheck audio hide control panel. One more screen shot of it. So today's third Thursday webinar. This is actually I think this is our one-year anniversary of the third Thursday webinar. I would like to briefly go over the agenda and then we're going to get into some of the topics that we want to talk about today. First of all, we're going to go over some -- an update on what is going on with our independent enrollment brokers and what the status is of that. We also do a readiness review update on community health choices and what has been done since the last webinar. We'll be talking about the evaluation and quality strategy. We'll be giving you some resource information and then we'll be asking questions. We'll be answering the questions that you submit. So we'll start out with the IED enrollment update and I'm going to turn it over to Kevin Hancock who has been very actively involved in this. >> Good afternoon, everybody. Thank you, as a matter of background. On April 1, 2016, Maximus rescind the responsibility of participant enrollment in the aging waiver. As people as a matter of background, it provides Medicaid fund and home and community-based services in Pennsylvania to people 60 and over. 52 area states in area on age performed this function. The independent broker was needed to assume the role to maintain compliance with federal funding agency, specifically to maintain federal funding participation in the program. And for a guideline [indiscernible] states must utilize the conflict free at this time. That's the reason why we went in this direction. We fairly quickly it was recognized that there were some transition problems. There were -- one of the challenges that took place through the transition was an unanticipated number of call volumes that would have to be managed by the independent enrollment

broker. The call volume is associated with the volumes of people that would be asking for information or referrals to the program. This program is essentially the same size as many of our other home community-based waivers combined and the unanticipated call volume led to some backlogs in managing calls, and a high average speed to answer as well as some backlogs and processing for age referrals. So what we had to do to be able to address this through corrective measures was to increase staffing levels and efficiency in the call center to address the consistent volumes of the calls. This took place over a multi-month period and continues today. Those increase in staffing were intended to be able to specifically address the high volume of calls that were unanticipated in the original planning and also to make sure that the people are receiving the answers they need as quickly as possible. Also, to clarify and standardize the administrative roles, the referral to us and the financial eligibility process, and also to accelerate the enrollment of eligible consumers for service delivery. All of the efforts were designed specifically to make sure that people receiving the information they need and in as timely a manner as possible and to begin the process to move them through the eligibility enrollment process. In addition to these corrective measures we have recognized that in this process, individuals who are going through the financial eligibility for documentation for the Medicaid program need some additional support. So we're recognizing that in addition to the additional staffing, in addition to the additional staffing, the -- some support is needed for people to be able to receive some instructive support or some communicative support specifically for the -- specifically for the Medicaid financial eligibility process. More information will come on this support that will be provided but we're recognizing that this is very important component to the process of enrollment in the age waiver and in all of our home and community-based waivers so the next step is to look for an opportunity to be able to fill that gap. More information will become forthcoming. By the time we commence our next third Thursday webinar we're hope to go have something in place to be able to address that issue. So with that I'll turn it back over to Jen who will begin to go through some of the updates for the community health choices program and we'll be happy to answer any questions that may arrive throughout on the independent enrollment process. >> Thank you, Kevin. I wanted to -- before I start, before I discuss with you our status on our readiness review process I wanted to share with you that the announcement for the community health choices selected offers is going to happen sometime in the very near future. So be looking for that. We're very excited about it. It's a big step forward. And I want to remind everyone. I know I said this before but our priority as we move through readiness review and into implementation and steady state monitoring, our priority is to ensure that participants continue to receive uninterrupted services and providers get paid. So that is a big part. That is a big part of why we're being so careful. We're going to be so careful as we move into doing readiness review. We have a team of staff at the office long-term living who have really dove into and dug into doing readiness review. We do see it as an integral step in being able to implement community health choices as we move forward. But we are by ourselves. We really have a lot of support and experience in doing readiness review because our office of medical assistance program has been doing readiness review for close to two decades. So we're meeting with our colleagues in the office of medical assistance programs to -- they have shared with us all of the tools that they use, all of their procedures, and they really given us some good foundations on which to build our readiness review process. I will say that we will be borrowing and using part of what they do in the office of medical assistance programs but we're going to be adding to it because we need to do readiness review on the long-term services and support side of community health choices. And, in other words, office medical assistance programs conducts readiness review today for physical health services and what we're going to be doing is physical health and long-term services and support. So

we're going to have to have a component of our readiness review process be focused on long-term services and support. For that the readiness review team has been looking to other states, talk to other staff in other states, to learn how they conduct their readiness review process for the long-term service and support program. I want to remind everybody, too, that readiness review is a requirement that we must fulfill for CMS. It's in regulations that managed care goes through the process of readiness review. This process that we go through will ensure that managed care organizations are ready and able to fulfill the contract requirement that is we set forth in the agreements and their proposals. The agreements that we enter into with managed care organizations lays out a number of requirements and this readiness review process really checks on their ability to fulfill those requirements. That will include fulfillment of meeting covered service requirements, such as things like our employment services. All of the services that are available in our 1952 waiver making sure the managed care organization is ready for that so there's just a lot of information that's getting reviewed in readiness review. We will also be reviewing the additional services that plans specifically have asked us, so plans have some -- the plans have in their proposals to us have laid out additional services that they are interested and will be doing - - conducting readiness review on those unique services that aren't necessarily in our current system. This does include review of the managed organization plan and the process through which appeals will be filed. The managed care organization's ability to communicate and share files with the commonwealth and other partners such as independent enrollment broker, behavioral health MCO and fiscal management services and the ability to share files and communicate between those different critical components of our system will be looking at the managed care organizations readiness to do that. As readiness review moves into implementation which will happen next summer the results of the readiness review teams will be shared with contract monitors. In addition to doing readiness review we are also standing up contract monitoring procedures in the office of long-term living. Contract monitoring is going to be a very critical component of community health choices. We take it very, very seriously but readiness review and the findings of the readiness review process will feed right into the contract monitoring processes, as well. So we'll definitely be keeping communication open about the areas that need improvement and need additional strength. So we're really -- that's we have really rolled up our sleeves and working on creating a very solid and comprehensive readiness review process. We are starting to get questions on what we're going to do is wait until the program is over and then we'll respond to all the questions as well but we are keeping those questions and we'll just file them here and be able to respond to you -- respond to them at the end of today's presentation. With that, I'm going to turn it over to Wilmarie Gonzalez who is the director of the bureau of quality assurance and program innovation and she is going to talk to us about two very large activities that are occurring at the Office of Long-Term Living and one of them is our short-term and long-term evaluation plan of meeting health choices and the other is our quality strategy. >> Thank you, it's a pleasure to be here with you today to give you all sort of a global perspective of what we are doing with community health choices with regards to evaluation and quality strategy. I think for the audience I think it would be important to note that the bureau quality assurance and program innovation is the bureau that is going to be working -- that is working very closely with all the other bureaus within the office of long-term living and what we are charged with is quality assurances for the waiver programs and obviously community health choices, ensuring that we are over seeing the performance measures as well as meeting CMS requirements and working with each of the -- with each of the bureaus to make sure that we have a good quality community health choice program. This presentation was presented as an MLTSS meeting on July 6. For those of you who are listening in I did identify a couple of updates so it will be something

that I will be going through. So when you think of community health choices, you think of the waiver programs as it is today, our goal really is to move consumers or participants from a fee for service system into managed care. The three area that is we think is going to impact is observable consumers who will be accessing services very differently as well as long-term services and support providers who will be receiving payment differently than what they do today as well as Medicaid eligibility information and how that will flow differently than the way it has been operating in the fee for service. So it's very important to note that. So it will be shifting from overseeing providers to overseeing managed care organization. Obviously with community health choices, Medicaid will be -- [indiscernible] -- instead of paying claims. That's a framework to better understand how our system is moving from fee for service into managed care. Overall, our goal is to continue to be transparent. Continue to have stakeholder engagement and the reason for all of this is so that we can hold each other accountable to what we're doing. Next slide. Here are the phases of quality and again this is sort of high level to get you a better understanding of what we're doing with regards to quality and how we are approaching the three -- the various cycles of quality for community health choices. We have done research with other states on how they implemented the fee for service system. We are using experiences and best practices from our sister program office, health choices program. We want to take advantage of that. We have incorporated experts as farther of the LTSS field. We are getting expertise while we're designing our quality strategy. Obviously we want to meet federal requirements which is something that is required in a managed care environment. More importantly is we have been getting feedback from stakeholders, managed care organizations, providers, advocates, consumers, we are a public forum, community meetings and the various comments that we have received from our published documents regarding community health choices. Here is a sort of -- the big picture of our key components of quality assurance and improvement. Sort of our strategy on how we are trying to sort of manage and over see how community health choices will operate. Prior to live date, Jen already talked about readiness review and what that means. I will talk a little bit in the next slide but I wanted to give you a big picture of readiness review will begin prior to the live date. That will then jump into early implementation. Readiness review will give us the opportunity to identify things that we want to make sure are working well and then address those things that are not working. We want to make sure we're looking at it in day one in early implementation. Day one when community health choices begin. That will then take us into the ongoing monitoring of quality performance. That is the -- that is what we are considering steady state. That's the ongoing monitoring and it's not different than what we do today in the fee for service waiver program. And then the independent program evaluation, many of you recall probably have already heard and seen -- heard presentation by the university of Pittsburgh, both at the MLTS meetings as well as other forums where we talk about a federal requirement that we must have an independent program evaluation and the university of Pittsburgh is implement that go for us. That's one of the global perspectives of what we're doing with quality. Obviously the data is going to be coming from various sources. So all of this has a lot of different components. So that includes making sure that our IT systems are working and also making sure that we're coordinating all of what we do with the other bureaus and other DHS program offices. Real quickly on the readiness review, Jen has already covered a lot of this stuff. Basically they must pass a readiness test before they can enroll anyone. Obviously that is starting prior to implementation date. Some of the elements, this is a very short list but we want to make sure the provider network capacity is ready. That the service coordination capacity is ready for the MCOs. The IT systems are actually working and the policies and procedures are in place. And that's a lot of the stuff is all required by the contract that is we already have out in the street and, in fact, should be -- that

is available on our website. And obviously readiness will identify priority areas both for early implementation as well as a steady state monitoring. So the quality really begins with readiness review and I think that is really important for us to recognize is that we're not waiting a year from now when community health choices has already been implemented. We're starting it right at the beginning and so it might be that's important to note. Early implementation monitoring is day one, the early days of community health choices. Our primary aim is to make sure consumers get the services that they need and the providers are actually getting paid. And so this is where I think it hits continuity of care. So early implementation emphasizes daily contact with managed care organizations and a lot of these steps that we're going to do in the early implementation of things that other states are already doing when they move fee for service. So we're going to make sure that we have obviously open communication with managed care organizations to talk about the good things working and talk about shortfalls or things that we need to fix. We are going to make sure that we are covering daily enrollment, consumers and providers hot lines. We want to make sure that our management system -- we'll be looking at the data that is coming in and issues, critical issues that are coming in. And we want to make sure we're monitoring the various services and the claims that are coming in based on the services and what the network is providing to participants. Obviously, that is very key. Definitely want to make sure that we are reviewing and looking at the complaints that are coming in and any grievances. Also short-term implementation will mean that the university of Pittsburgh will be -- we will be working very closely with them to help us do that as well as part of our long-term range evaluation or community health choices. Ongoing monitoring of quality and performance. This obviously is a real big one for all of us. Systemic monitoring, measurement, evaluation of the quality and appropriateness of care and services provided to participants to quality of care studies and related activities with a focus on identifying pursuing opportunities for sustained improvement. That's a big mouthful. What it really means is making sure that we understand and recognize that there's a lot of different pieces that go into monitoring -- the ongoing monitoring of the managed care organizations as well as all of the various pieces that make up community health choices. So we want to make sure that we are including as part of our strategy reviewing the data that's going to be coming in as well as the report that MCOs are required to submit to DHS. We want to make sure that this is not different, to do that on site monitoring business of the MCOs and so that's not different than what we do today. It's not going to change when we move to managed care. Very new to us is going to be working with the external quality review organization or stated the EQR. What they do is they conduct analysis and evaluation of aggregate information on quality, timeliness and access to health care services that managed care organizations and their contractors provide to Medicaid recipients or participants. The EQR is a requirement. Our plan is to make sure that we also meet each of the mandatory protocols or mandatory requirements. We want to make sure when we work for the community health choices they are helping us ensure that the MCOs are in compliance, performance measures, performance improvement and making sure they are overlooking and helping us on information systems. And the EQR, I want to make sure that I -- the EQR is external quality review organization. So sometimes in this world we get too hung up on too many acronyms. That's what the EQR. Hear EQR, hear EQRO but it is the external quality review organization and so that is required in any managed care system. So states must have an EQR entity to be able to help do that analysis. Let's get and talk a little bit in more detail about quality measure. That's obviously a real big one. We talk -- these are the easy ones, the Medicaid adult measures and that's as many of you know it is used by more than 90% of health plans to measure performance on care and services. And one of the things that we want to make sure is that the national community for quality assurance or

NCQA and the national quality forum, NQF are working very closely on identifying LTSS measures. We know by the time we implement community health choices we will not have LTSS measures available to us and so we want to make sure that we identify state defined long-term care services and support measures. While it is in progress, we do have some measures that we have identified and it really is a collection of things from several states that we have identified. We are putting a list together that we will be able to engage other stakeholders in the process. Our goal is to be able to share a draft of these measures as part of our quality strategy draft plan which will be published for comment later in the fall. And that's coming very soon. But really important too as well is we want to get a pulse. Want to be able to hear what is happening with consumers and so while a lot of this is a requirement, we have what is called a consumer experience or consumer assessment of health care provision and system. These are -- this is an organization that has a number of tools that organizations can use that are validated and tested. We are very interested and already as a requirement under our contract is to make sure the MCOs implement capped tools for consumers but it also makes sure that we hear from providers as well as a requirement provider satisfaction surveys will also be included and that will include LTSF providers, nursing facilities, dental providers, hospital and providers of conciliary services. We want to make sure that we are hearing both from consumers, providers, service coordinating entities on how community health choices is working. This takes us into the independent program and evaluation. This is the longterm plan for community health choices. Again, it's a federal requirement. We must have an independent evaluation. There has been an enormous amount of presentations and information that we have provided to the community at large by the university of Pittsburgh. They develop a plan for us and we have posted a draft of the plan on our website, on the DHS website, public comment period ended on July 8. I do want to give you an update on that and that is obviously that we have received over 200 comments. We are in the midst of reviewing all of that and our goal is to provide a much more comprehensive summary at a later date. So some of the themes I think that you will appreciate is some of the things that we have seen so far, a lot of the questions have been more for clarification ensuring the public has timely access, updates and reports. We want to make sure that's exactly what we're going to do is making sure we are again transparent. Holding ourselves accountable as an organization as well as letting know the public where we are at, what's evaluating community health choices and how we're doing. Other things that have come up through the comments have been more geared toward the monitoring of functions. A couple of the questions that came in was what happens if the data being evaluated by the university shows that there's a decrease in service, complaints are either received, increasing, network advocacy and a lot of these questions really fall under the monitoring function that DHS as the agency responsible for oversight will continue to do for community health choices. Another thing that has come out and we have seen it a lot and heard it in some of the public forums is that is making sure we are including additional languages besides English and Spanish to capture diverse options which obviously also include the American Sign Language. So those are just some of the comments obviously that does not give you the full list but our plan is to be able to share a much more detailed summary at a later date. So the next step for us is going to be like I said before. Our commitment is to continue to be transparent and to make sure that the public at large knows what we're doing. And we definitely want to make sure that we are providing a summary of all of the comments we received on the evaluation plan so that should be coming very shortly. The other big project that we're working on, which is going to be critical, this is the road map for community health choices and that is working with other program offices within DHS in designing the state quality strategy and the plan will be for us to publicize the plan later this fall for public comment. So the public will have

an opportunity to also provide further comment on the strategy. And I think that is all I have. I don't know if anybody else has any other questions. >> This is Jen, thank you so much. That was very helpful. As you can see the Office of Long-Term Living takes quality and oversight of community health choices very, very seriously. And we view it as a key component of the success of the program. We're going to have to have a good monitoring process. We're going to have to have a good readiness review process and have to have good quality oversight as we move into community health choices and long term services and support. I wanted to bring your attention, I want to make sure folks knew about this but we recently published a frequently asked questions document. That is now up on the community health choices website. And there is also some other information that might be useful. Really trying to put out some very simplified information. We're going to have a short video up on the website, as well, which is about a three or four minute video that just meets with cartoon graphics that kind of lays out what we're planning to do with community health choices. But that will be there as a way to inform people. The other thing I wanted to make all of you aware of in our September webinar, third Thursday webinar, we will likely have some more detailed information on our communication strategy and but I did want to bring your attention to the fact that we're going to be vetting some of the communications that we're putting together with the managed long term support and the medical assistance advisory committee. That kind of vetting will be happening in the very near future. So with that I think we're going to open it up for questions. Wilma, thank you so much for all the detail on the evaluation and quality strategy, very exciting. >> So I'll answer the first two questions because they pertain to some of what I had provided. First was will -- the question will we be notified by email once the MCO announcement is made or will we have to continue to check online every day? There will be an announcement through the list serve once the selected offers are known to us and in addition there will also be a press release. So there will be two forms of communication. But I would recommend also continuing to check the website online for the foreseeable future to continue to receive updates on this. The next question, is the enrollment period for referrals going to be available for 24 hours? Currently the call center hours are not going to be available on a 24-hour basis. But it is possible that online functionality may be able to support the referral process whenever the participant wishes to be able to access that information and we'll provide more information on that as we move forward. Next question, can you give any details on the contract monitoring process? Will there be penalty for non-compliance? Just to be clear, depending on the infraction penalties may exist and our penalties are outlined specifically in the draft agreement. So there are penalties that currently exist. An example of areas where penalties do exist is in the billing process with providers. So that is a great question. Next question, in addition to the IEP assisting with MA eligibility, the MA eligibility process they need to provide assistance with correct assistance certification form. The IED is just sending consumers with a denial letter. The consumer calls and they say it is incorrectly completed and the consumer does not know how to be correctly completed. It's a great suggestion, it may not be a function of the independent enrollment center. We want to make sure of what the individuals are required to have it completed correctly. As we address the ( static ) as we address the requirements for the financial eligibility form -- ( static ) -- we may add the information relating to verification. Great suggestion. Thank you. >> Hold on. We're having some technical issues. Did you open up the line for someone? No, okay. Sorry about that. Okay. The next question -- thank you, Kevin. >> [indiscernible]. >> The phone is open for Lester Bennett. Did you have a question you wanted to ask us? >> How did you know -- I didn't mean to. I was actually typing it, miss Jennifer. >> Okay. Go ahead and type it then. >> Okay. I'm sorry. I must have hit the wrong button. I'm typing it, though. We're going to mute you again. Okay. Let me go back to that question. If UPMC is one of the MCOs managed

care organizations bidding on a contract how can the university of Pittsburgh participate in the review process in another manner without it being a conflict of interest or are these considered two separate business entities? There's no direct relationship with the university of Pittsburgh to our knowledge as an academic institution and UPMC as an insurance company. We do require all vendors to demonstrate that they have no conflict of interest as part of our procurement process for the functions for which they are receiving payment. So those kinds of guarantees are in the procurement process we undertake. Do you foresee any issues implementing this program given that major insurance carriers are losing money on ObamaCare and withdrawing from populations similar to medicare populations. We do not see any issues similar to this with what is happening with ObamaCare. This is very different to ObamaCare. Will this webinar be accessible after today? Yes it will. As all of our webinars we post them on the community health choices website and the community health choices as a reminder to people to get to the community health choices website go on the department of human services website which is.DHS.gov. In the bottom left hand column there's a hot topics list. You can then find the archives of the third Thursday webinars. These are actually recorded. You can also find the transcripts from our managed long-term service and support subcommittee meetings and all of the documents that we have issued in the past more than a year starting with the concept with discussion documents in June of 2015 all of those documents are available on that community health choices website. So please visit there for information. As a matter of fact, what Kevin was just talking about with what is in the draft agreement, those draft agreements are actually published on the community health choices website. They are available for you to look at there. These will be accessible after today. It does take us a couple of days to get it actually posted. Look for it mid next week.. >> This is Wilmarie. The question is how does it plan to share the quality measure data it collects. Will consumers and caregivers have access to quality metrics to help select and the CHC providers to best meet their needs. Hmmm -- if this question is will we have benchmarks and data? Benchmarks and dashboards for aggregate data, that is part of our plan to be able to share that aggregate data and be able to analyze it because that's going to help us make sure that we continue to strengthen community health choices. The other part of the question says, will consumer and caregivers have access to quality metrics to help select the MCOs and CHC providers to best meet their needs. That is a good suggestion. It won't be available obviously in the near future but it's something that we will consider doing down the road once we have some of that information available to us. >> That's good feedback. >> The other question is what is the difference in functions between the independent evaluation and external quality review or are they the same entity? This question is two parts and the short answer is not two entities. The external quality review entity organization is independent, it is -- it is an organization that works -- gets the data directly by the MCOs and the data gets validated and it's submitted to the EQR who then sends the information book to us and to CMS. The independent evaluation as which you all know is we contracted with the university of Pittsburgh, it's a little bit different. It is a requirement under the 1950 date. One of the things that the independent evaluation, it is a long-term evaluation and so one of the things they have already begun doing. This is again part of the presentation we have already begun, and that has been conducting focus groups to sort of get a pulse on what is happening with our waiver program today. It includes -- receiving data by [indiscernible] and will also a year from now when the EQR is in place be able to get that aggregate data that's already been analyzed to then compile the information and help us better understand how community health choices is working. What is interesting to note under the EQR or the external quality review organization, based on their analysis, this entity will help [indiscernible] identify special studies and also performance improvement projects if we need to depending on the data that

we're getting. I'm hoping that I answer the question for you. The other question that also came in with regards to quality and that is once some of the federal long-term care services and support measures are finalized will OLTL consider incorporating the measures into community health choices. The short answer is, absolutely, yes. >> Thank you. Next question we have the this on site monitoring visitors just for managed care organizations or will current fee for service providers have monitoring? I'm not quite sure about that question but it could have two -- there could be two ways of reading it and I'll answer both. The on site monitoring visitors that OLTL conducts in community health choices will be through the managed care organizations and we'll be monitoring and MCOs to make sure that they are monitoring their -- the providers that they contract with. We'll be looking at the monitoring that they do and making sure that they are monitoring and asking the right questions of their service providers that they contract with. However, if the question meant will current fee for service providers have monitoring current fee for service providers if they remain in the act 150 program and that which will continue in fee for service, they will continue to get monitored in the office long-term living. It really depend on the path the particular provider takes. We are currently a participating provider with UPMC for Medicare, managed care and Medicaid. Once managed care Medicaid is effective will we have the option to negotiate our current contract? So I'm assuming this is a provider who is participating for Medicare managed care so -- the Medicare program but then also in health choices which is Medicaid. So we currently don't have any of the -- the R agreements in place. The question will you have you as a provider have the option to negotiate your current contract. You'll have to ask the managed care organization and I will say that if -- that's going to be a question between you and the MCO, UPMC, in terms of the Medicare managed care contract as well as your Medicaid health choices contract. In the future, if UPMC is one of the selected offers then you would want to talk with them about participating in community health choices. How can I get information about the managed care -- about the managed care organizations and community health choices via e-mail? I have announced this in several other LTSS meetings but I will repeat and it also in our third Thursday webinars, there is an opportunity to go on the department of human services website and sign up for a whole menu of list serves you can sign up for. That is the best way for you to get information. There is one on community health choices. To register for a listserv and stay up to date, you would want to -- I can give you that -- the web address for that is <http://listserv>. If you don't get any messages in the next week then I would go ahead on to that link right there which will be available this webinar will be available on our website next week. >> The next question, how many consumers have been approved for services since April 1, 2016 through maximus. I'm making two assumptions in this question that you're asking for the age waiver and you're asking specifically for enrollment that has been processed from beginning to end. Just to be clear, between April 1 and today, we had thousands of enrollments completed. More than 2,000 enrollments completed actually. Many of which were initiated prior to April 1 and many which were transferred over to maximus through the conversion process. But since maximus took over enrollment they have processed 734 enrollments on their own since April 1. Next question, how will provider being affected. We're assuming how will the process of provider billing be affected once we move into community health choices to managed care arrangement for the way we're paying for services. The implication is providers that are part of a managed care network will be billing directly. Their network providers will bill them directly for payment. >> We're still getting questions so going to take a little pause here to make sure we have -- understand them. If we are already on the listserv will we be notified then? Yes. When the announcement is made on the sell equited offers for community health choices which is going to happen in the next week or so, hopefully less than that, it is getting -- we're really ready to

make this announcement but if you are already on our listserve you will get that. It is going to be issued as a press release and you will be -- the press release will be issued to the community health choices listserve. So please sign up for the listserve. Again it's the third bullet down. It is information about how to register for a listserve and stay up to date and we're looking forward to being able to communicate with people through our listserve. We can continuously do that. I wanted to also mention about the -- some of the questions in our frequently asked questions document that is was published on our website on August 9. We have question that is range from what is the purpose of community health choices. There is a simple explanation of what is managed care. We have got the time line for when CHC will take effect in my area as well as will the continuing Office of Long-Term Living waiver program continue to operate. What will happen to the life program? A whole -- several pages worth of questions that are -- that we responded to on that frequently asked questions. That's a really nice document for you to get more information. That's pretty simplified I hope folks will make that available to your own networks and stakeholders. >> The next follow-up question to the billing questions that I answered earlier. Will the MTS be required to provide billing training? Absolutely. We have an outline of the requirement in the draft agreement and would refer the individual who asked the question to that document. A provider is part of the network for a managed care organization, they are required to provide that training. Yes. >> We are still waiting on questions here. They are coming in. I want to also bring folks' attention to the RA e-mail comments. E-mail address. It's RA-MLTSS@pa.gov. If you have any comments on topics you'd like us to present. Please send those in to our resource account. The program today regarding the evaluation and the quality, our quality assurance processes, those were suggested by people who attended former community health choices third Thursday webinars. Please send in your ideas on what you want to hear on the third Thursday webinars. We really do take them seriously and want to make sure that we're providing as up to date information as we can to our stakeholder community. >> So this looks as if it is a follow-up question or similar to a question I already answered. Are the specialist available 24/7 for enrollment in community health choices? At this point we're not expecting to have 24-hour service for enrollment services for community health choices. Mechanisms that will allow people to go online and process application requests but at this point we're not anticipating that enrollment or community health choices would be independent enrollment broker would be a 24-hour service. Next question is there a fee for a provider to join an MCO. Complicated question and really more of a question that would be asked of the MCO. But at this point I'm go refer that question to the MCOs. We are not aware at this point of fees for providers to Jonas part of a network but the relationship between the managed care organization and the network providers is something that -- their prerogative and we are -- that would be a point of communication that we would want providers to have directly with the MCOs themselves. Is it possible for a potential MCO to enter into a contract with a provider. I think it's most likely -- it's a great question and it is most likely the case that managed care organizations that are going through the process of procurements and not identified as the selected offeror would request letters of intent with providers or potential network providers as part of the development of the network. But most likely they would not go into a contract arrangement with those providers prior to being chosen as part of CHC. It's a great question. That would be between the provider and MCO but most likely it would be more of a letter of intent and less about a contract between the two providers. >> Looks like we have more questions rolling in. I wanted to take a moment to just reinforce something that Wilmarie mentioned and talked about briefly which is the consumer assessment of health care providers and systems. There are a whole suite of tools that are -- that get the tap trademark and also get an endorsement from the national quality forum and I will tell you that the

tools for really measuring experience, to participant feedback on experience with the Medicaid community based service and support system, this tool is not yet approved by the trademark but it is pending. This tool has undergone a funding opportunity for Medicare and Medicaid services made available under section 2701 of the affordable care act. They have been testing this tool in nine different states and -- I believe it is nine different states -- we're really excited that this instrument and the testing has been very rigorous. They have done a lot of work. CMS required the survey instruments function as across, for intellectuals with physical disabilities, cognitive, or developmental disabilities. The focus of the tool is on specific experience not a -- it is not a consumer satisfaction survey but on the experience of care or service. And it addressed dimensions of quality valued by home community based service participants and then it aligns with the existing tools. There are many tools. One for hospitals. One for physicians. Primary care physicians. Many special care have their own tools, nursing facilities, so this is just one more in a whole suite of tools that have been validated and tested and get that endorsement from the consortium and we are planning to use this. We'll be requiring it of managed care organization. Again it is data that we'll be collecting by taking a look at what people's experience of care has been. So I'm excited about that. >> So we have a few more questions. Next question, as a provider currently and hopefully in the new program. What time frame can we expect payment. Now we can bill weekly and paid within two and a half weeks. Any thoughts? Great question. We do have some billing standards that the managed care organizations are required to adhere to in the draft agreement. I'd reference the individual to that appendix. Honestly I don't have the draft agreement in front of me. It is one and you can see it in the table of content. It is very similar to the time frame that we follow for future service in the product system. So you can expect that you should be paid within the same time frame and managed care organizations will be held accountable for that. That's a performance standard. So thank you for the question. there are many in the adult older generation that can't access the site. That's why we have the call center. The hours will not be 24 hours but they will be made available for as convenient as possible so people can speak to somebody directly if they have questions or need information about the enrollment process. The next question, what is the status of navigator? Agent Well will be our entity to provide the assessment service to determine clinical eligibility. At this point we're still in a great deal of planning discussions for the navigator role. We're not sure what the scope of that role will be. How it will be inserted into the process and what is actually the requirement. So we are not sure yet, in other words. So a lot of discussion yet to take place on that role and there will be more to come. >> This is just a follow-up to the question about paying a fee to join a network and we don't believe that is the case but I just want you to comment. It says we shouldn't have to pay a fee to join a network if we don't want to limit choice of providers for consumers. Consumer choice and then a managed care organization requiring a fee to join the network. They should be dismissed from community health choices. Thank you very much for that feedback. >> What I would add to that is we are -- as with -- in managed care the relationship -- the contractor relationship and the payment relationship are between the managed care organization and the providers and we have to emphasize that. That that is a point of conversation between the managed care organizations and providers. But at this point we do not believe or not sure that we are aware of fees for managed care organizations asking providers to join a network. >> Okay. We don't hear anymore questions coming in. So we are ending 25 minutes early and give you 25 minutes back in your day. Thank you very much for attending this third Thursday webinar and again I want to remind you to send in your comments if you have any thoughts on future topics for community health choices for the -- on community health choices for the third Thursday webinar. We'll be glad to entertain them. All you have to do is send us an e-mail to the resource account. Thank you Wilmarie for

participating today and thank you Kevin for participating today. And we're signing off now. Good-bye. ( webinar concluded ) Notes