

December 15, 2016

### Third Thursday Webinar Transcript

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DATE: 12/15/16.

EVENT: OLTL webinar.

>> **CAPTIONER:** (on standby (good afternoon, everyone. Welcome to the webinar for community health choice webinar I am Jenn burn net from the office of long term living joined by Kevin Hancock and W. Gonzalez, the quality director at WLTL who will do a presentation.

>> **CAPTIONER:** I am having trouble hearing. Jenn sound far away and tinny,.

>> **JEN:** We took a screen shot of the attendee interface you should see something this looks like this in the upper right-hand corner. To the left is the viewer through which you will see the presentation. To the right is the goTowebinar. If it is --

You are listening -- if you are listening using your computer system by default if you would prefer to join by the the dial-in information will be displayed then you can call in.

You will be placed in listen-only mode to hear the webinar presenters. You will have the opportunity to submit text questions to today's presenter by typing your questions into the question pane of the control panel. You may send in your questions at any time during the presentation.

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Welcome to the third Thursday webinar for Community HealthChoices. All of the previous presentations are posted on our websites and you are certainly welcome to go on our website and listen to these third Thursday webinars, our archive there and also the documents we present are available on our website.

So for today, our agenda is a community health choice update. We will talk about some of the waiver amendments. We will talk a little bit about person-centered counseling. Then Wilmarie will go into details of the key quality components for us.

The implementations of Community HealthChoices, you may have heard this, it went out this morning, the implementation of Community HealthChoices is being delayed.

This screen shot shows a shot of the communications announcing the delay. We are really -- the main reason we are delaying or postponing the implementation of Community HealthChoices really has to do with resolution of this protest. We had several protests. We need to resolve them before we feel comfortable doing that.

Foys 1 will now begin January 18th in southwestern; phase 2 will begin July of 2018 in southeast and the rest of the state remains unchanged.

Here are some of the priorities that we have put forward with the longer time line. I just want to go over them briefly. It is of utmost concern to us that the managed care organizations are able to develop an adequate network. We have not been able to engage with the selected offer on anything to do with the arenas, rate negotiation -- that process generally takes six to eight weeks. It would not allow the managed care organizations to meet network adequacy requirements for July 1st, 2017 implementation.

The another area we are concerned about with this time line is completing the readiness review. The experience in other programs here in Pennsylvania and then other states in our discussions with other states that implemented managed long-care services and supports, we really need a minimum of six months to really complete a thorough readiness review.

Then communications. Communicating is really going to be important as we move forward, making sure people know what is happening, all of those noted for itself.

We really feel individuals enrolling in Community HealthChoices must have adequate information about the managed care organizations, about the provider networks associated with the managed care organization. This type of communication cannot take place until the provider networks are mostly finalized. We are sort of at a loss to be able to pull all of that off in the six months remaining if we went with July 1st, 2017 roll-out date.

We delayed the implementation. We really believe that this is going to give Pennsylvania a much more adequate time to be able to make -- to get this right.

We look forward to continuing to work with our stakeholders as we have been but with a little bit more time.

Community HealthChoices related waiver amendment. These waiver amendments are currently out for public comment. A notice was published in the Pennsylvania bulletin on Saturday, November 19th. The notification was also sent out via our -- OLTL list services of stakeholders informing them of the public comment period and the ways to provide comments.

We -- I just wanted to go through these real quick with you. The four waiver amendments that are out for public comment include amendments on each of the following waivers: The aging waiver, and pant care waiver independence waiver and OBRA waiver.

The ones below list out the specifics of what we are asking for in those waivers amendments.

We would request for a waiver -- there is a request for a waiver of statewideness in order to independent care waiver services so individuals can reside in non-managed care counties.

As you know, OBRA will continue to operate statewide.

We also described the process that we will utilize to transition individuals to Community HealthChoices.

Also, discussed will be the -- transition individuals ComCare participants to independence waiver and then also describe process that will be used to transition individuals who are 18-20-year-old in attendant care and independent waivers not eligible due to their age to OBRA waiver.

We will -- structured day for independent waiver ComCare participants can be he seamlessly transitioned.

The 30-day comment period runs for these waivers as I mentioned we published it on November 19th. It is still under a week left for making comments. A week from yesterday. The 30-day public comment period runs through Wednesday of December 21st the amendments can also be viewed on our website if you want to go to the Pennsylvania bulletin.

Here is information about where to submit written comments. We have email address which is a resource [act-ra-waiverstandard@PA.gov](mailto:act-ra-waiverstandard@PA.gov) and US mail, which the address is there for you.

In addition, we have held two remember nares, one on November 30th and one on December 6th.

We received comments via those two webinars. We have begun accepting comments and organizing them.

I wanted to briefly talk about person-centered counseling. This is a bit of information available on options for additional assistance when people are engaging in the enrollment process to enroll into OLTL's program.

Person-centered counseling is offered through aging and disability resource centers called the lircg. A lot of information is available through the lircgs. I would encourage people to look into them go on the Department of Aging website and find out where your regional or local Link is. The Department of Aging is providing person-centered counseling. The counselors get thorough -- extensive training on person-centered counseling. The trained counselor is available to assist individuals in the community to access public, private, federal, state and local resources regardless of age, ability level and income.

The counselors are trained to focus on person-centered interviewing, providing an overview of options, the decision support process, creating action plans and follow-ups.

There are good resources out there. We have at this point for independent enrollment broker we developed a referral process that has been implemented by each ED to refer individuals to the lircg Links.

I will turn that over to Wilma who will discuss the key quality components within quality health choices.

>> **THE SPEAKER:** Thank you, Jen. Good afternoon, everyone. It's a pleasure to be here with you all and continue our conversation with regards to quality. I want to take an opportunity and thank many of the stakeholders and folks in the public who have really been very much engaged in the area of quality who submitted not only comments but also feedback through our concept paper, the draft agreement, the various MLTSS and LTSS committees. Many organizations have also submitted interest and feedback on really making sure that we are looking at -- identifying, what are the key quality components of quality strategies specifically for Community HealthChoices.

Today is continued dialogue on what we have already covered in many of our meetings and previous webinars.

It really is getting down on identifying some of the key areas folks are really interested in. Set a framework of what we want to do in the area of quality.

We will talk a little bit in more detail about the key components. We would also like to share with you today, for those of you who have already heard the presentation, I will be repeating some of the things I have already talked to some of our other presentations with other subcommittees. I -- proposed measures and things we are thinking are important core Community HealthChoices.

We will end with giving you a quick update on the evaluation plan that has been conducted by the University of Pittsburgh. Okay.

All right. So one of our first webinars we talked a little bit about what is quality and for many of you who participated in previous webinars, when we started our conversation in quality, we talked about three major areas regarding quality. That was: Readiness review, a little bit about monitoring and obviously evaluation.

This diagram we are presenting today is really what we are thinking what Community HealthChoices framework should be in each of these very important components or key areas.

As you can tell with this diagram, the areas where they have a yellow color, you have already heard from us with regards to what we are doing on the readiness review.

Is there is a previous webinar that went into detail of how we are planning on managing that. You also previously have heard from another colleague regarding monitoring and compliance of Community HealthChoices and the kinds of things we will be looking for both in early launch of Community HealthChoices as well as long-term and the kinds of areas and key indicators we will look for when monitoring the implementation.

We also talked more in depth about the quality review and obviously the last piece was the independent evaluation, which we have already talked as well in more detail, Dr. Howard -- talk about the strategies. I will not go too much into that. I want to highlight a few things that already happened. You already heard about -- for those of you have not had an opportunity to about hear about the webinar or participate in the webinar, the readiness review is really things that we are going to do prior to enrolling any members in managed care organization. These are the kinds. MCOs must have through a readiness review process. There will be a team of OLTL staff who will review documents. They will be making onsite visits to determine a managed care organization is able to meet all of the requirements.

All of the program requirements are listed in the draft agreement that is out in public and you should have access to it on our website.

This also includes as part of the readiness review is making sure that providers and networks and appropriate information financial capabilities, et cetera, are in place and are ready to go on day 1 when we launch Community HealthChoices.

This also means a systems must be tested to ensure that the MCOs can change information easily and electronically between us and each of their companies.

This area was also discussed, again, as I previously mentioned in other presentations as well as.

With regards to monitoring compliance. When it comes to the monitoring compliance there will be teams dedicated to monitor MCOs to ensure compliance with the.

You will all have access to the draft agreement that is out there and list the various requirements we expect managed care organizations to follow and meet.

This, again, is also part of a previous webinar. It is available to you all for listening on our website.

When it comes to networks grievances, appeals, some of the other white boxes you see in this diagram our hope is that we will cover these in another webinar. For now, I can give you we believe each of these key components are very important and what is going to be very important is for our stakeholders to really understand what our strategy is going to be in order to manage and oversee each of these particular areas.

So when you are looking at the network standards, MCOs demonstrate they have adequate and appropriate networks in place that meet the needs of all of its members; that's key and again, very important.

MCOs must submit information to us demonstrating this.

The Department of Health ensures that providers are appropriately licensed and VHS will monitor the network for ongoing adequacy.

During the continuity of care period, managed care organizations must offer contracts to all of its existing long-term services and support providers; however, providers are not obligated to accept contracts from the MCOs.

Again, more information will be covered in a following webinar later on in the future.

In the area of grievances and appeals, members are encouraged to raise any grievances or concerns they have directly with managed care organizations so that the MCOs can address those concerns quickly and adequately.

Members may also appeal a decision made by an MCO that impacts them negatively.

If a member and/or participant doesn't agree with decision an MCO has made, they have the ability to be able to file grievance with the MCO as well as with the state.

Things such denial of request for hours. All grievances must be monthly. Our hope would be to mofn tore and look for those kinds of things to make sure they are responding quickly, timely and to the satisfaction of individuals.

Members also retain the right to request a fair hearing with the state, if they are not satisfied with the MCO's response.

Again, more information will be available to you at a previous webinar. Our home would be to provide you more details within that particular area for grievances and appeals.

Regarding critical incidents, MCOs must report critical incidents to us. Critical incidents include injury, abuse, neglect, theft, death and alert type of events.

We will continue to use enterprise management system, which is a system we currently use in our fee-for-service system.

The goal will be to use what we refer to as EIM, to continue to collect monitor and follow up on critical incidents that are being submitted by our networks.

CMS requires DHS report all incidents. This is very important. Again more information is going to follow in this area.

For purposes of our discussion today, I really want to spend a little bit of time on performance measures. I think it is really important. This is, again, something that we are responding to based on many of the feedback we have received from the public, as well as via public comment.

Let's talk a little bit about performance measures. They are very specific items that are collected and reviewed to see how the program is actually doing. The goal would be once we collect performance measures we have to have the ability to compare similar programs to compare MCO to MCO, use data to compare provider to provider from one side of the state to another. We can do it by County. The goal is to make sure all of the performance measures we identify are able to continue to be what we have been doing and that is being transparent and holding the managed care organization accountable.

We thought that the easiest way to sort of begin the conversation of how to -- you know, what kind of performance measures we should be looking at. We identify three major areas for performance measures; that is national -- indicators established by not only CMS but by other organizations, which include -- sorry. I think this slide gives you a better understanding of the kinds of things we are thinking of.

On the national measures, and a lot of the managed care organizations already seeing this and are already capturing this information. Healthcare effectiveness, data information sets or as referred to HEDIS measures, which is a comprehensive set of standardized performance measures designed to provide consumers with healthcare performance.

Obviously, it makes perfect sense for us to include that as one of the performance measures we are going to be requiring MCOs to submit to us.

Another area is going to be CMS Medicaid adult core measures. These measures are published on an annual basis by health and human services. These are, again, there are a number of them. I think that that's going to be very important for us.

Again, the MCOs already collect them. The kinds of things that are under the adult core measures are things like annual monitoring for patients and medications, timely transition of transition records, things like discharging of an inpatient individual to a self-care or another facility.

Again, there is a long list of performance measures for each of these major measures we are identifying.

Another area we are looking to include as part of our performance measures is consumer assessments and healthcare providers and systems.

Or as most folks refer to it as CAS. It approves and validates a number of various survey tools. One of the things that we are going to be recommending is that under the surveys, we are looking at the nursing home questionnaire. The MCOs have experience in this and it is something that they are already collecting.

New to the industry is an [inaudible] tool announced by CMS. This will be included as part of community healthcare choices. We make sure it is included as part of the requirements.

The other ones that we are also thinking of is the health plan, adult Medicaid survey. Again, MCOs have experience in this area so this is something that we want to make sure we are including it as part of our national measures.

The other one is CMS, as many of you know, we do have person needs plans that operate in Pennsylvania. One of the -- within the draft agreement was one of the things we talked about making sure that the MCOs are coordinating services between the special needs plans and them.

We want to make sure that not only they are coordinating care with for participants with the special needs plans, but we also want to be able to collect data they are collecting and then coordinate them so that we are looking at that data.

I want to talk a little bit about the state measures these are indicators established by us, by Pennsylvania to gauge performance, monitor compliance with state and federal regulations and guidelines. We want to make sure that our participants are receiving good services and in a timely basis.

So some of the areas that we are looking into for the measures will be complaints and appeals, looking at, let's say numbers and types of complaints by MCO. Making sure that those complaints and those grievances that are being submitted by participants are solved in a timely basis.

Things like critical incidents reported and investigated as well on a timely basis.

We are interested in making sure that timely issuance of denial and changes of notices are also done on a timely basis.

Again, these are some of the things that we are thinking of including as part of our performance measures, but we are definitely going to make sure that we are not only sharing that with our stakeholders but we have an opportunity to hear feedback from all of you of the kinds of things we should be considering, specifically for Pennsylvania.

Manage we know that there are no national loaning-term services and supports measures. We know there are states with MLTSS implemented. We reached out to many of those states and identified some of the performance measures that other states are already using and we would like to adopt in Pennsylvania.

Things like members who use consumer-directed services by benefit types, I think that will be important. Other states, again, are using it.

We want to make sure that we are seeing members who have received, let's say, for instance, advance planning objectives counseling. Again, it's another area that other states are using and that's something that I think will be important to Pennsylvania.

There is an enormous amount of various performance measures that, again, we are compiling. We are putting it together as part of our quality strategy plan. This is something that, again, will put it in a comprehensive list and our hope will be that we get feedback from the public regarding some of the performance measures that we are considering.

The other thing -- again, I won't go too much under the program launch because we have already -- you've already heard from Mike Hale who gave a very extensive presentation previously on monitoring. I know that he covered early launch, early implementation as well as steady state and the kinds of areas and things that they will be looking for and then looking at Community HealthChoices once they are up and running.

More importantly, as part of our state performance measure, we want to make sure that we are meeting CMC requirements. One of the requirements that they want is for us to meet specific assurances.

There are about 29 assurances that we have identified, and it is part of our CHC application, that we are including within your performance measure; again, that will all be compiled as part of our performance measures list. It will be included in the quality strategy plan.

Okay.

With regards to the Community HealthChoices long-term evaluation plan. I want to take an opportunity as well to thank many of the organizations and stakeholders who submitted comments to the evaluation plan that is on our website. We received over 200

comments from various organizations and we have included many of the comments into the evaluation plan. Both an executive summary, as well as a revised evaluation plan is on our website.

We are -- our hope would be to continue to provide updated -- updates to our stakeholders at the various subcommittee meetings.

That's the link on the evaluation plan on our Community HealthChoices' website.

Did we receive questions?

Thank you, Jen. Thank you, all.

>> **JEN:** Thank you!

One of the -- we are starting to get questions here today. Please feel free to submit questions for Wilma. She spends time going through the evaluation plan. As you can see, we are doing a lot of thinking about what our strategies will look like.

One of the questions that came in is, How will this all change with the announcement that this has been delayed until January, 2019?

For the most part, things will not really change all that much. We are committed to ensuring an effective and smooth transition and there are not a lot of changes with the exception that we have more time now to get it right.

Some of the things I highlighted during my discussion about the delay to January 1st of 2018 are -- I highlighted some of the reasons for the delay. The main reason is, really, stemming from the protests.

We had some of the non-collected offers, if you will recall we had 14 managed care organizations submit applications to us and proposals to us.

During the summer of evaluating all of those proposals and on August 30th we announced that 3 of the MCOs were selected. We notified those MCOs on August 30th of this year.

Soon after that, we received a number of bid protests, which came from from the non-selected offers.

Because of the bid protests, it puts us in a position of being in a stay. So the stay means that we cannot communicate with the managed care organizations. Because we cannot communicate with the managed care organizations, we have not done any work on rate negotiations. We have done no work on finalizing the agreements, which is, basically, to contract on what we call grant agreement with the managed care organizations.

Without these fairly final documents, the agreements and the rate negotiations and all of that being finalized, without final agreements between the Commonwealth and the managed care organizations, the MCOs cannot finalize many things: Provider manuals, all of the provider networks network adequacy, all of it is challenged in the stay.

I mentioned this during -- when I was talking about the delay earlier, the managed care organizations really need more time to develop adequate works for this new program. We are especially committed to making sure that that happens. We really felt that there needed to be more time to do that with this delay.

We also recognize that we need time. We need significant time to be able to complete readiness reviews in an effective and comprehensive way. So other programs, programs in other states as well as with our own health choices here in Pennsylvania, it really takes upward to 6 months to do a thorough readiness review.

We also talked a little bit about the communication, both communication participants and providers. As noted here, development of readiness review, managed care organizations need finalized agreements with the Department of Human Services to build provider networks and the participants will need to review the MCO -- to know what they will transition to.

Because of that we are delaying the implementation for 6 months. We believe that it will give us -- give managed care organizations enough time to be able to really develop their networks and have sufficient network adequacy to meet review of them as well as our own readiness review of them.

To be able to really develop (.

Because we have been in a stay we have not been able to get to work in making decisions around it.

>> **Wilmarie:** I received a question, what states are you looking for LTSS measures? Thank you Brenda for submitting this.

We have looked at Texas and New York. We have also been participating in a number of other discussions with CMS. Most recently, CMS had their quality conference yesterday where they had experts from various fields, hospital, medical doctors, various states, really talking about quality.

This is all they talked about, there were over 2400 folks in attendance. There were representations from NCQA, the national "for quality a someones.

NQS another very well-established and recognized national quality forum organization. Obviously CMS was also there. There was a lot of talk about -- with regards to, you know, making sure that there were national, you know, LTSS quality measures that are identified that states can adopt.

There has been a lot of talk. I know there are some organizations here in Pennsylvania that are part of that national dialogue.

So there has been a lot of, you know, making sure that we identify some of the things that are very important.

I want to point out that some of the performance measures I talked about today is really specific to the managed care organizations. So, you know, there are other things that are going to be put into play because there are other things that are going to impact Community HealthChoices as a whole.

We also have other vendors as well, we want to make sure that quality is also spilled into those areas. Things like the independent enrollment broker, obviously the EQR which is external quality review organization and how do all of those things work together? How do they share data? Analyze, identify special studies, evaluate what we are doing and making sure what we are doing is right.

I also want to reiterate that the quality strategic plan that is going to be -- oh, hopefully posted in the Pennsylvania bulletin in the first quarter of next year, is really the technical document that is submitted to CMS, it's a requirement for all states to do; that means that every -- a State that is operating in managed care program must submit this quality plan to CMS.

So all program officers at VHS are working out each of their sections. Here at OLTL we want to make sure Community HealthChoices is included.

That's why it is so important for us to begin designing a framework for quality but really looking at the kinds of performance measures we want to make sure we are including; so these going to be part of the quality strategy plan for our portion and, again, as soon as we find out when that is posted on the Pennsylvania bulletin, we will make sure that we are sharing it with our legislation serve via communication department.

>> **JENN:** This I want to highlight one thing Wilma mentioned regarding long-term supports. There are significant measures that are already out there regarding nursing facilities and we will be certainly tapping into those. CMS has those posted on their website and we will be using those.

However, on home and community-based service side of long-term services Sean supports, it really -- there really is -- there really is no lack of standardized measures we are paying very close attention to -- as Wilma mentioned, the NQS, which is the national quality forum they contract to develop measures in all kinds of healthcare settings, including home and community-based services.

About two years ago, they started their home and community-based service -- maybe three years ago, they started their home and community-based service project for home and community-based measure project.

They brought together a large committee of people who were experts in the field from across the country. It includes representatives from social services, other communities, support services, providers, payers, caregivers, advocates and consumers were all on that committee.

The result of that committee actually got published earlier this year. It's the NQF report on measuring quality. In that report, they really note the challenges to measuring ACDS qualities, which includes the lack of standardized SCDSs me Evers.

Also it includes -- this is pretty significant -- decentralized nature of the home and comint-based service system, the variability of reporting requirements that cost federal, state and local privately-funded programs and administrative burden of collecting -- [inaudible] -- those things are all noted in that report.

There is a tremendous collective interest at the federal level that Brenda, you certainly should be tapping into and others on the call.

The report, just as a sort of summary of the report, it highlights 11 areas of ACDS measurement developments such as person-centered planning and coordination, caregiver support, consumer choice, consumer control. These areas these 11 areas encompass 40 measurement topics with short-term, intermediate and long-term action, along with measure progress for further development.

A lot of work is being done. Pennsylvania is watching that work and paying attention to it. We will definitely adopt some of this stuff once it has been endorsed. We are paying a lots of attention to it in terms of our own work.

I do recommend that you go on to the NQF. If you Google national quality forum, HCBS measure developments, you willing be taken to that website and find the report on that website.

>> **WILMARIE:** A question came in from math you Kularotl.

He says you mention performance reference for medications. Is there a list we can reference?

I will refer you back to what we have identified. We have not identified specifically which performance measure we are going to be selecting that is most relevant for our community health choice participants, we are -- we have identified HEDIS measures, which you know, is a number of various measures more specifically to medical side is, but they are HEDIS measures that we will be looking at.

Again, we will also look make sure that we are working with our sister program office. They are operating the health choices program. We want to coordinate a lot of that.

Our goal will be that we will have an attachment within the quality plan. We are going to list that they be highlighte per measures.

We want them to help select what they are and provide feedback.

We are proposing HEDIS measures, the Medicaid adult core measures we have not identified which in each section which of the performance measures we will select.

Our goal is once we share that with stakeholders, that they will provide us with feedback.

The other thing that we are hoping that we are going to do. Again, because we understand it is new to Pennsylvania, particularly to our network here in Pennsylvania for Community HealthChoices, it's we are also going to be providing links to each of these areas so that you will have an opportunity to look at all of the measures within each of the sections.

So it will make it a little bit easier. We will also be providing you with a description for each win.

The same thing goes for the nursing facilities me measures. They both have long and short-term measures we know that some of our organizations here in Pennsylvania have already recommended we look at those.

There is a number of those for each of those subsections. Our goal is to receive feedback from the organizations in Pennsylvania to identify which ones we should be including within our performance measures.

I hope I answered that question.

>> **JEN:** I have a few questions here also.

Can you remind us what the dates will be for the other regions?

We have Phase 1 southwest, January 2018; southeast Philadelphia and four surrounding counties is July of 2018; the remainder of the state, that implementation is not changing; that remains January of 2019.

Will there be more than 3 managed care organizations?

Community HealthChoices will forward 3 selected offers unless something changes with Commonwealth court. At this point, we are envisioning moving forward with the 3 selected offers.

What is the status of the ComCare waiver?

ComCare recipients will be moved to the independence waiver, if they are not yet part of a community health choices zone.

The ComCare waiver is being repurposed to be home and community-based part of the Community HealthChoices waiver. You will recall that the CHC waiver is going to be a (b ?ie. c) concurrent waiver.

The (b) waiver gives authority to do mandatory managed care.

The (c) waiver gives authority to operate home and community-based services.

This change will still take place in 2017.

How long could these protests last? Will there be legal challenges, do anticipate? How will that affect the time line?

It is hard to anticipate we hope the appeals will be taken care of in early 2017.

>> **JEN:** At this point, we are without any further questions. I am just looking through my documents, here.

For those of you on the phone; I hope that everyone received the announcement of the day. It was sent out slightly in advance to some of our committees like the managed long-term services and supports subcommittee and new long-term care council committee.

I would urge you to submit ideas for our account mailbox to submit ideas for further webinars.

With that, it doesn't look like we have any other questions. I think we will end early and give you back some time. Do we have any other questions?

Oh, wait. There is one more coming in. We are waiting for it to arrive. Please bear with us.

Is OBRA waiver still carved out as previously stated?

We will be assessing consumers that are in the OBRA waiver to determine whether they are nursing facility clinically eligible. If they nursing facility clinically eligible they will go into Community HealthChoices; however, some people may be determined not NFCE, they will remain in the own roo waiver and we will continue to operate the OBRA waiver.

Also, those individuals that are age 18-20 will be able to stay in the OBRA waiver.

I.

How will this affect services that participants are receiving from providers if aging waiver is going away?

The aging waiver is part of -- we will have Community HealthChoices waiver which will include the services available through the aging waiver. We will -- people will be able to continue getting services and we will have continuity of care provider with current providers. So services -- it will not affect services current aging participants are receiving they will continue to receive those services under Community HealthChoices.

Top notch choice counselors will be key to success will you expand on progress to date? Is operation centralized? If so, where can talent apply to be considered?

We are currently contracting with maximus to do independent enrollment broker. In the future there will be a new procurement for the independent enrollment broker.

In the future, I am not sure. We are not sure what vendor will we will be providing that choice counseling will be provided through independent enrollment broker and so it's really an unknown because it's in procurement process at this point.

If you would like to do choice counseling today with maximus, you could apply to maximus.

With that, I think we are done with the questions.

Are there two more coming in?

Bear with us for a minute there are a few more questions coming in.

Can I get the PowerPoint on DHS website?

>> **JEN:** Yes, the Community HealthChoices website, you will be able to find -- it's actually up on the screen right now and you can easily navigate to the Community HealthChoices website from the DHS homepage [www.dhs.pa.gov](http://www.dhs.pa.gov) there is a link to Community HealthChoices website from that page.

Any updates on navigators? Who will be doing this?

No updates on navigators. We haven't -- it will likely -- I don't think -- we have to fulfill the requirements of the managed care rule for support systems it's likely that that will be a procurement. Kevin: Will aging waiver be part of tannive system or will everybody be transferred over to HCSIS system?

We are not planning to change the case management system. People who are supporting this the aging waiver will continue to be in the system until enrolled in Community HealthChoices. (TANF system).

It looks like there is one more question.

>> Will home and community-based providers receive more information closer to 2019 about becoming a provider with selected managed care organizations?

We anticipate that once we are able to start working with the managed care organizations, that those managed organizations will be working on networks. We have a service delivery system that relies on a network of providers across the state, all different kinds of providers and managed care organizations in order to provide those services need to contract with existing providers on some level. So, yes, they will be receiving more information.

We also are going to be doing provider communications. We met recently with a number of provider associations to begin discussing what that will look like.

They just gave us recommendations for how they plan to -- how they -- how to best communicate with the providers that are members of those associations.

Did one more come in?

>> **KEVIN:** There is an acronym I am not familiar with. Will there be a check box on FCF -- I want to make sure I am interpreting what step CF -- if a person could reply what this acronym means, I would appreciate it very much.

>> **JEN:** I believe that relates to a recently-passed law in Pennsylvania that requires us to -- I am not sure.

>> **KEVIN:** I am not sure either.

>> (Unclear speakers).

>> **KEVIN:** Standards application form. I just want to be sure. If she mean standard application form I will assume that they mean financial eligibility form.

>> [inaudible] authorization form.

>> Service authorization form.

>> **KEVIN:** Good question, actually.

>> **JEN:** With that, I think we will give you a half hour back to your day. We have no more questions. Thank you very much. We will see you next third Thursday webinar next month.

I hope everyone has a happy holiday. Thank you.

(Third Thursday webinar concluded at 2:31 p.m.)

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