Pennsylvania Enrollment Services Webinar Series
Community HealthChoices
May 31 2017

MAURICIO CONDE: Good morning, thank you for joining us. My name is Mauricio Conde and I want to welcome you to the Pennsylvania Enrollment Services Webinar Series. Today's webinar is titled: Community Health Choices (CHC).

Before we get started, please remember if you have any questions, you will be able to type them and send them to us by typing them at the bottom left of your screen. Also, if there are any questions that we did not get a chance to get to, we will be able to send you the answers to those questions at the end of the webinar.

Also, please remember that there will be a survey and we ask you kindly to take the time to complete the survey because that will drive future presentations for future webinars.

Again, today's webinar is titled Community Health Choices (CHC) and we are delighted to have Deputy Secretary, Jennifer Burnett with the Office of Long-term Living and Kevin Hancock, Chief of Staff of the Office of Long-term Living. All of the lines are muted and please note that if you have any questions, that we did not get go, we will be able to answer those at the end of this presentation.

And without further ado, I will turn it over to Deputy Secretary Jennifer Burnett.

DEPUTY SECRETARY JENNIFER BURNETT: Thank you Mauricio. Good morning everyone, I am Jen Burnett, the Deputy Secretary for the Office of Long-term Living and we have been working at the Office of Long-term Living for some time, close to two years developing Community Health Choices, which is managed long-term services and supports for Pennsylvania.

Let me go to the next slide. This slide really just goes over some of the basics. Community Health Choices is a Medicaid managed care program that will include physical health benefits and long-term services and supports. The program is reference nationally as Managed Long-term Services and Supports Program for MLTSS. There are many states that have moved to their long-term care program from Fee for Service to managed care. We are learning from them and we are doing a lot of work with other states to understand what they went through and we have also designed our program based on what has been put forth by CMS in a new managed care regulation.

The next piece is about who is part of Community Health Choices. We are going to be including people who are dually eligible for Medicare and Medicaid and some of those individuals, many of them do not need long-term services or supports at this point in their life but we want to see coordination between Medicare and Medicaid and we hope to do that by including them. People who are dually eligible for Medicare and Medicaid were carved out of HealthChoices approximately 10 years ago and we are going to carve them back in and let them have managed care through Medicaid. We also will be including individuals who are eligible for Medicaid Long-term Services and Support because they need that level of care that is providing in a nursing facility. We do know that there are people that need the nursing facility level of care that are in our home and community based programs, which are services provided through Medicaid waivers and then we also have a number of individuals who are in nursing facilities today. I also did want to point out that we have a Life Program, which is living independently for the elders and this is known nationally as the Program of All-Inclusive Care for the Elderly or PACE. We have about 6,000 people enrolled in the Life Program. It is not completely state-wide at this point but that is

one of our goals and those folks who are in the Life Program are going to continue to receive their services from the life provider. It is a program that has an adult day center that the individuals participate in. They do not live at the life program, the live independently in the community. When we say Program of All-Inclusive Care for the Elderly that is really a very broad based program that includes an inter-disciplinary team to help people figure out what services and care they need. So Life will continue under Community Health Choices as an alterative.

Our goals, I used this slide whenever I talk because I think it is really important for people to understand what the goals are that we have set forth. The first goal is one that has been a life-long goal for me, a life-long career aspiration is to enhance opportunity for community-based living. The second goal is to strengthen coordination of Long-term Supports and services and other types of health care and that includes communication between Medicare and Medicaid services for dual eligibles but it also includes better coordination between physical health and long-term care. Today those two systems are very disjointed and physical health is provided either through hospitals or through primary care physicians and the long-term care is not connected to physical health in anyway. We think that there are a lot of opportunities for improving outcomes for individuals by strengthening that coordination. The third goal is to enhance quality and accountability and that is always an important goal and one that the Department reports to the Governor's Office on a quarterly basis. The fourth goal is to advance program innovation and with this goal, we asked the MCO's to describe to us how they would innovate in the four areas that we came up with. We asked them how they innovate in the area of housing, because we know that housing is a social determinant of health. We asked them how they would innovate in the area of employment for people with disabilities. We asked them to innovate in the area of making improvements to the direct care workforce. And the fourth area that we asked them to innovate in was in information technology and that is a very broad brush stroke of how they interpreted that, whether that would involve using health information and exchange in a way that crosses between long-term care and physical health but lots of other things came through with that one and we are really excited about that. The last goal is to increase efficiency and effectiveness which is always an important goal of good government.

Out population, this really gives you a kind of breakdown of the population. There are 420,618 people state-wide today that would quality for Community Health Choices. The breakdown is shown here so we have people who are in waiver services, those waivers are how we provide home and community-based services. We have about 64,000 people, some who are duals and some who are non-duals in waivers. And then we got duals in nursing facilities and non-duals in nursing facilities and then we have a lot, 270,000 people who are not using Long-term Services and Supports today but are dually eligible who will also qualify for Community Health Choices.

Here is just a quick snippet of covered services for all participants. All participants will get physical health services, primary care physician and specialty services, hospitalization, etc. (all of the things that are covered under HealthChoices). For participants who quality for Long-term Services and Supports, in addition to what we just described as far as physical health services go, they will also receive services in nursing facilities if that is where they choose to live or need to live and we will also be including home

and community-based Long-term Services and Supports. The primary service under home and community-based Long-term Services and Supports are personal assistant services, that is a direct care worker to come out and help you with your day to day routine. For some of our participants, that includes getting out of bed in the morning, getting dressed, transferring all of those kinds of things. But these are two relatively new services that we have added. We have five employment related services to help providers and MCOs to achieve that one goal that I mentioned earlier in program innovation. Another service that we have heard a lot about is the whole idea of pest eradication. Pests in a person's home can often lead to health problems and so we had included it in our waiver and we discontinued it and we got a lot of push back about that discontinuation so we have added it back in.

The roll out, we have a phased-in roll out. The first, and one of the things that Secretary Dallas asked us to do was to really mimic HealthChoices in terms of zones and many other aspects of it. The first zone is the Southwest Zone for HealthChoices, which is the 14 counties in Southwestern PA. We will be rolling that out in January of 2018, so that is just over a half a year away. The second zone will be in Southeastern PA, which will be rolled out on July 1, 2018, that is Philadelphia County and the four surrounding counties, again a HealthChoices Zone. And then the third phase is the rest of the state, which is Lehigh Capital, Northeast and Northwest part of the state and that is scheduled to be rolled out in January of 2019. We did have a procurement, we went through a procurement process over a year ago and we selected 3 of the 14 offers that came through and those 3 selected offerors were UPMC for You; AmeriHealth Caritas; and Pennsylvania Health and Wellness, which is known nationally as Centene. Those 3 MCOs will be starting state-wide from the get go. As we would phase it in, all 3 of these MCOs are going to be participating state-wide when we are fully implemented. We have a lot going on. When we selected these offerors, we made the announcement on August 30, 2016 and we immediately did get some protests and some filings in Commonwealth Court. That held us up once those protests were filed, we could not work with the MCOs to start any kind of readiness review or anything. We went through that legal process, the appeals and all that, over the course of the following months after that August 30th date and it wasn't until the middle of March that we were fully given the green light to go ahead and start the implementation. Since then though, since the end of March, we have been doing a lot of work with implantation. We had a readiness review kick-off meeting, we have held a lot of meetings with the MCOs since then, we assigned readiness review teams to each of the 3 MCOs. We are also doing a lot of work on participant and provider outreach. This webinar is amongst many, many, many other webinars that we have been holding to try and get the word out about it. We have also done our waiver submission, at the end of April we submitted our waiver and this is considered to be a BC concurrent waiver and I will talk more about that a little bit later. We have also been doing a lot of work since the summer of 2015, we have been working on an evaluation and preparing for our launch and then we are in the very late stages of finalizing out agreements with the Community Health Choices MCOs.

These are some of our priorities as we go through this implementation process. We are doing a lot of work on readiness review. 80% of readiness review is work that is done by a desk review, a desk audit basically and that involves the CHC MCOs submitting information to us. They are submitting their member material, all of their policies are coming to us and we are reviewing them, all of the descriptions

of their services are coming through, their provider materials; all of that stuff we are, the State, will be reviewing and approving or going back to them and asking for some changes. That readiness review will also be on-site readiness review where we will really take a look at all of their different information systems, we will be testing their claims processes, we will be really looking at their network adequacy, and doing a lot of work to just make sure that they are ready to launch on January 1st in the Southwestern part of the state. Again, stakeholder communication is another important part of what we are doing. We have been doing a ton of stakeholder engagement with processes such as the third Thursday webinar that we hold every third Thursday and all of those are archived on our website and we also have a Managed Long-term Services and Support sub-committee of the Medical Assistance Advisory Committee, the MLTSS Sub-MAAC meets monthly and we do transcribe those meetings so those meetings are also available on the website. At the end of these slides, we will show you how to navigate onto the website so you can find these materials. And then we are doing a lot of work communicating with providers.

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have held a lot of meetings with the MCOs since then, we assigned readiness review teams to each of the 3 MCOs. We are also doing a lot of work on participant and provider outreach. This webinar is amongst many, many, many other webinars that we have been holding to try and get the word out about it. We have also done our waiver submission, at the end of April we submitted our waiver and this is considered to be a (b)/(c) concurrent waiver and I will talk more about that a little bit later. We have also been doing a lot of work since the summer of 2015, we have been working on an evaluation and preparing for our launch and then we are in the very late stages of finalizing our agreements with the Community HealthChoices MCOs.

These are some of our priorities as we go through this implementation process. We are doing a lot of work on readiness review. 80% of readiness review is work that is done by a desk review, a desk audit basically and that involves the CHC MCOs submitting information to us. They are submitting their member material, all of their policies are coming to us and we are reviewing them, all of the descriptions of their services are coming through, their provider materials; all of that stuff we are, the State, will be reviewing and approving or going back to them and asking for some changes. That readiness review will also be on-site readiness review where we will really take a look at all of their different information systems, we will be testing their claims processes, we will be really looking at their network adequacy, and doing a lot of work to just make sure that they are ready to launch on January 1st in the Southwestern part of the state. Again, stakeholder communication is another important part of what we are doing. We have been doing a ton of stakeholder engagement with processes such as the Third

Thursday Webinar that we hold every third Thursday and all of those are archived on our website and we also have a Managed Long-term Services and Support Sub-Committee of the Medical Assistance Advisory Committee, the MLTSS Sub-MAAC meets monthly and we do transcribe those meetings so those meetings are also available on the website. At the end of these slides, we will show you how to navigate onto the website so you can find these materials. And then we are doing a lot of work communicating with providers. We do, about every 2-3 weeks, we have been issuing a blast email and people can sign up for those emails on our list serve and they need to get sign up on our list serve to get those blast emails but really focusing on questions that providers have. A recent one really did a comparison of the difference between HealthChoices and Community HealthChoices. We have also had a provider email that talks at a pretty high level, but kind of give an idea of what the coordination between behavioral health and Community HealthChoices is going to look like. And then we are certainly doing a lot of work participating with the public. The DHS preparedness that involved my staff as well as across the Department's staff, really understanding what is going on. We are doing education of the County Assistance Offices; we are going to be doing educating of the staff to make sure staff understands what is happening. We do a lot of work with training and making sure our teams know what to expect and what their roles are going to be. That is just a little snippet of our own preparedness. I did want to point to the launch indicators. We know that we are not going to have signification data on either encounter data or claims data and those things are all used for quality oversight so we have been working on what we call the launch indicators. So for the first 5-6 months of the program, we will be collecting special data from the MCOs, we will be asking them to submit information to us so we can really be able to monitor this launch. One of the things that is different, that is significant to recognize, is that with Long-term Services and Supports, it touches people's lives on

almost a daily basis so it is not something we want to see launched in an ineffective way because it really does involve people's day to day lives.

These are my essential priorities through the implementation. For the reason that I just mentioned, I do not want to see any interruption in participant services. It is different than scheduling a doctor's appointment and missing it; you can't miss Long-term Services and Supports. If a person misses Long-term Services and Supports, it might mean that they aren't getting out of bed in the morning or they might not be getting dressed to go out and go shopping or whatever it is that they may need to do so we need do not want to see any interruption in participant services. We also don't want to see any interruption in provider payments. We are going to be working very closely with the MCOs to make sure that those claims are effective, that they can actually practice with providers to make sure that there is no interruption in provider payment. If there is an interruption in provider payment, that puts the first essential priority at risk.

I am going to turn it over to Kevin Hancock, the Office of Long-term Living Chief of Staff, who is going to go through some of the next few slides.

KEVIN HANCOCK: Thank you Jen. As you see on your screen, this timeline, which may be difficult to see, unless you really look at it close up, details the timeframes associated with Southwest, Southeast and the remaining phase for CHC roll-out, specifically to readiness review, communication and DHS

preparedness and launch monitoring. The first phase reflected on the timeline is the Southwest readiness review which as Jen had mentioned is currently in full flight. That timeframe started on April 1, 2017, we actually had a meeting with the Managed Care Organizations to begin the process of what they are required to provide during the readiness review process and what the deliverables are. That phase will continue through October of 2017. We actually have a date that is called a go/no-go date in readiness review and that will be within that timeframe for the Southwest and as Jen had mentioned, this is the way that the Department certifies that the Managed Care Organizations are ready to take over Southwest operations for the programs that are under the umbrella of Community HealthChoices. The Southeast readiness review will begin immediately after we complete readiness review in the Southwest. Since we have a six month time period between the implementation dates for each of the phases of the Community HealthChoices, there is going to be a lot of overlap in activities for each of the phases in each of the zones. We do expect some activity occurring for the Southeast readiness review and Southeast implementation activity while we are finishing the work for the Southwest phase. As noted here, the Southwest conversion date is currently set for approximately November 20, 2017 and what that means is at that point, the individuals who are in the Southwest who will be moving to Community HealthChoices and may have already made their plan selection will go through the conversion process where that plan selection will be added to their eligibility record and the Managed Care Organizations will be informed that these individuals are going to a part of their program. That is also the date where, or approximately, where and auto-assignment would take place if Community HealthChoices participants did not select a Managed Care plan. We are going to do all we can to encourage individuals in this process to select a Managed Care Organization. If they elect not to select a Managed Care Organization, one would be assigned to them and they will have an option to change that plan in the future if that is what they would like to do. Community HealthChoices is a mandatory

program so if individuals elect not to select a Managed Care Organization, an auto-assignment process will be enacted to make sure that the assignment does take place. Southeast readiness review as mentioned will cover from November 1, 2017 through May of 2018 and the conversion for the Southeast will be approximately May 20, 2018. There will also be a go/no-go date for the Southeast period as well. And then the third phase, which is the remainder of the state which includes Lehigh Capital, Northwest and Northeast, will be from May 1, 2018 through November 1, 2018 with an approximate November 20, 2018 conversion date and as mentioned, there will be a go/no-go date for that phase as well. Throughout this process, activities for readiness review will be taking place as well as participant and provider communication and also preparedness activities for the Department of Human Services Office of Long-term Living and launch monitoring. Launch monitoring are activities that are designed to make sure that the Department is measuring and overseeing the entire conversion process from our Fee-for-Service Programs to Managed Care. We have a number of variables that will be touched on I think a little bit later that cover what we know we need to look at to make sure that the program is working appropriately for participants. And also to make sure that, as Jen had mentioned, that the providers continue to get paid without interruption.

So moving on to the next slide and talking briefly about communications, throughout these phases that we had talked about in the timeline, there will be ongoing communication activity and these are our

communication goals. The first is to make sure that we are educating and informing participants, providers, families and all relevant stakeholders on what CHC actually is and what is Managed Care. A lot of people, although Managed Care has been around for quite a long time and Managed Care in Pennsylvania has been around since the mid-1990's with HealthChoices and even longer for some of the voluntary plans, a lot of people still are not necessarily familiar with what Managed Care is so there will be a lot of communication going out to make sure that people understand the difference between Managed Care and Fee-for-Service and also to help people to make informed choices and be informed consumers in this new program. We are also going to be doing all that we can to eliminate any confusion regarding transition plans and what this means is that people who are currently receiving services or currently overseeing services for participants, they'll know what steps will be taken and what the continuity of care process will look like and to make sure that the participants will know that there will really be no risk of interruption of any of their services as we go through this conversion process. We are also, as I mentioned previously, we are doing all we can to minimize auto-enrollment through education and also to encourage participants to select their Managed Care Organizations so that they are selecting a Managed Care Organization that not only reflects their service needs but also the providers that they wish to use, not only as part of their Long-term Services and Supports but also for their physical health services as well. We want to make sure that participants are selecting the MCO that best reflects theirs needs and their preferences. The last key goal is aligning HealthChoices and Community HealthChoices and doing all we can to make sure that there is a good partnership and communication, especially for people who are going to be transferring between the HealthChoices Program and the Community HealthChoices Program. That is an important part of this program. State-wide, there are approximately 15,000 individuals who are currently receiving Long-term Services and Supports that will be moving from HealthChoices to Community HealthChoices and we want to do all we can to make sure that there is as little confusion as possible in that transfer.

Some of the strategies that we are trying to accomplish with communication, specifically, for phase 1, we are going to do all we can to communicate to participants either by mail or we will also have opportunities for in person visits specifically for participants. First we will be sending out what we call a general mailing to all potential Community HealthChoices participants for the Southwest in July of 2017 and that will provide information on what Community HealthChoices is and will provide a telephone number where more questions could be asked. We are expecting that to go out the first week of July and that will be the first formal information that individuals who are going to be participants in Community HealthChoices are going to receive, specific to the Community HealthChoices Program. And the next major communication that will be going out to participants is the actual pre-transition notice and that will be going out in early September 2017 and that will provide much more specific details on what participants will need to do not only to contact the independent enrollment broker to select their Managed Care Organization but also information on appeal rights, if individuals who are receiving the mailing think that they are not an appropriate individual to be converting to Community HealthChoices. So as mentioned, for the Southwest, that will be going out in the September timeframe and there will be a lot more detail in the pre-transition notice that will provide steps that people need to take to know what they need to do next. We will also be using Aging Well, which is an entity that will be using community partners including the Area Agencies on Aging to host community forums for individuals

such as our well duals or individuals who are not at this point in need Long-term Services and Supports so that they know what this change will mean to them and also know what they need to do to reach out to the independent enrollment broker. Part of these community forums will talk about the relationship between individuals and Medicare and Medicaid benefits for these individuals and what opportunities are offered with moving into Community HealthChoices. There will also be efforts by Aging Well to train, specifically service coordination and nursing facility staff; those individuals who work very closely with individuals receiving Long-term Services and Supports and that training will help service coordinators and nursing facilities understand how to educate their participants on what are the steps for the change and how this change is going to be effecting participants so the participants have all of their questions answered and also that participants will know how this will be relating to their individual service plans or the plan of care they currently receive in a nursing facility. A third area is that we will be using significant stakeholders. Specifically in the Southwest, we will be using The Jewish Healthcare Foundation to provide community forums and also provide feedback throughout this process to help with the CHC implementation and to also reach providers who will be affected by the change and to provide as much information as possible to make sure that there is a real minimization of confusion and also to make sure that everybody involved in this change is as educated as possible.

We had touched on overlaps between HealthChoices and Community HealthChoices and I think this is particularly relevant for the audience who is on the phone today. We recognize, as mentioned, that about 15,000 people state-wide will be moving from HealthChoices to Community HealthChoices and those are the people who are currently receiving Long-term Services and Supports and in waivers that serve people who are under the age of 60, which includes the Independence Waiver, the Comcare Waiver, the Attendant Care Waiver, and specific individuals in the Ober Waiver who will be into Community HealthChoices. We wanted to make sure that we had a lot of communication partnership with the HealthChoices Program to make sure that these individuals will not be confused and the way

that we approached that is that we have coordinated the implantation dates for HealthChoices and Community HealthChoices. Specifically for the Southwest, the physical health start dates and the Community HealthChoices start dates will be on the same date. There will be a bit of a difference for the Northwest because of contracting issues and also for the Northeast also for contracting issues so there will be special communications going to those individuals in the Northwest and Northeast to know that they may have an immediate conversion to HealthChoices in the short-term but in the long-term, they will be moving into Community HealthChoices if that is relevant for them. The remaining dates for the Southeast and Lehigh Capital, the implementation dates will be the same. These coordination dates are meant to address the needs of the largest portion of this population of people who will be moving from HealthChoices to Community HealthChoices. We had some contracting limitations that affected the Northwest and the Northeast and we will make sure that special communication goes out to these people so that they know what to expect in the weeks and months to follow so that their communication will not be any more confusing than it has to be.

And with that, I am going to turn it back over to Jen Burnett who will talk about program evaluation.

DEPUTY SECRETARY JENNIFER BURNETT: Thank you Kevin. I wanted to just go back to one slide that Kevin had on earlier and I am not going to go back to the slide itself but in talking about communication and The Jewish Healthcare Foundation, we are actually getting support and it is basically a public partnership with health foundations from across the state so in addition to The Jewish Healthcare Foundation in the Southwest, First Hospital in the Southeast is helping us and this is a foundation in Philadelphia. We had a meeting with about 175 providers and other stakeholders last week that they sponsored and what is really great about that partnership is that they are reaching people that the Department doesn't necessarily reach in our natural course of business so they are really getting down to community and getting engaged with very basic community supports like, for example 211. If there is a good 211 line like there is in Pittsburgh we would want to make sure that those people are educated about what Community HealthChoices is so that if somebody gets a notice in the mail and says what is Community HealthChoices and their go to place is the 211 line, they go there and 211 knows what to expect. So we are really excited about that partnership with the foundations and in the summer of 2015, the Pennsylvania Health Funders Network came to us and said "we would really like to help you get the word out about this" and since then we have really built a good relationship in terms of that kind of connection.

I will start out here with the program evaluation. We have engaged the Medicaid Research Center at the Health Policy Institute at the University of Pittsburgh to help us with an evaluation. This is a long-term evaluation and we started working with the Health Policy Institute in the summer of 2015 to start designing the evaluation. The evaluation plan is posted on our website and you can take a look at what we are doing to evaluate. We did do a report of our year 1 activities for the evaluation at the MLTSS Sub-Committee of the Medical Assistance Advisory Committee back in March and that is also posted on our website. Our Community HealthChoices webpage has an evaluation tab so you can really learn more about what we are doing but it really involves a lot of data gathering, and that includes holding focus groups and gathering information from those focus groups and then doing key informant interviews where surveyors are actually going out and talking to providers, to the Managed Care

Organizations, to participants, to the Area Agencies on Aging for example, to the Centers for Independent Living and they are gathering data through that process and that is all sort of outlined in the evaluation plan but you can see the first year activities for the evaluation. It is anticipated that this is going to unfold over seven years what we are envisioning this evaluation to really look at. We want to use information from the evaluation to make improvements to the program and the only way we can do that is, similar to what Mauricio started out with today, if you will out the survey at the end of this webinar, and give us feedback, we can make improvements, we can present the kinds of things that will help you understand what is going on.

The waivers, I had mentioned the waivers. Community HealthChoices waivers is actually a concurrent (b)/(c) waiver that has been submitted to CMS. CMS has come back, that was submitted at the end of April, CMS has given us informal requests for additional information on the (b) waiver already and we are going through that to get information back to CMS. When we apply, now these waivers, the 1915 (b) waiver allows us to have mandatory managed care in the Medicaid Program and using Managed Care Organizations, paying them a per member per month rate for each individual that they cover and it

makes the program mandatory for people who are eligible to receive these services. So that is the (b) side of the waiver so when I say it is a concurrent (b)/(c) waiver, the (c) side actually allows us to provide home and community based services to people who would otherwise need institutional care. If states participate in Medicaid, they are required, they have a mandatory service of providing services in nursing facilities and that is a mandatory state plan requirement that CMS has put forward. So what waivers do is allow us to waive that state plan service and provide services to these people who would otherwise be eligible for nursing facilities in home and community based setting. So all of the work that we do on the home and community based side primarily is supported through these Medicaid waivers. Currently Pennsylvania's Long-term Living System has five waivers to nursing facilities, five (c) waivers and we are going to be moving all of the services that are included in those five services into one Community HealthChoices waiver. Both of those waivers are currently with CMS. As I said earlier, the (b) waiver is one that has come back with some questions from CMS so we are really excited that CMS has already engaged with us. We need to have these two waivers approved by CMS in order to actually do that launch that I have been talking about on January 1st. So we have some time and we are going through that process. The (c) waiver actually, we posted that for public comment as is required in the 1915 (c) regulations and we got a lot of comments back, over 1,000 of them and that helped to again give us feedback to help us make improvements to that application. Over the course of the next few months we will be working closely with CMS to really get to the point where they can approve it.

The next slide, the readiness review process again that does measure the process and measures the readiness of the Managed Care Organizations prior to our go-live, with the Community HealthChoices going-live. The readiness review team reviews criteria and a number of benchmarks that we have set in the Department. Again, I mentioned this already but it is completed as both the desk review and an on-site review. Our teams, I will just talk about them briefly, we have one team assigned to each Managed Care Organization. Those teams have already set up meetings and they are meeting on a weekly basis with the MCOs and they consist of 3-4 staff from the Department. In addition to the 3-4 staff members assigned to the MCO readiness review team, there are subject matter experts throughout the

Department that will be reviewing other areas of the documents. Our readiness review team will be reviewing all Long-term Services and Supports components and then we will be teaming up with our colleagues in the Office of Medical Assistance Program who can help us as we really take a look at the physical health components of Community HealthChoices. Those subject matter experts that are on that third bullet down under readiness review, that includes subject matter experts from third party liability and these are from all over the Department that really can help us kind of sort through what has been presented by the MCOs and we have subject matter experts from Hearings and Appeals, we have subject matter experts from all around the Department that are helping with this process.

I wanted to just navigate you to the website for Community HealthChoices. This is the Department of Human Service's homepage and you can get to that by going to www.dhs.pa.gov. If you take a look in the bottom of the top issues, here is the Community HealthChoices website, right there on the homepage and that is a live link to it and if you go to that, it takes you to the Community HealthChoices website. On our homepage, front and center is a video, it is about a 4 minute long video with infographics that really help you understand what this change looks like. We are encouraging people to

download it and to show it at meetings and really try to get the word out about Community HealthChoices. This page needs to be updated because the red above the video there has now been changed to, we now have a new live link that will allow somebody to go directly to and sign up for our list serve and we are really encouraging people to get on the list serve. It is by doing that that you will get all of our information. But on the right hand side we have lots of information out there. We've got the Community HealthChoices Concept Paper, we have the discussion document and these are documents that we started out back in June of 2015 and we did six meetings around the state that were listening sessions to gain input and all of that information is, we put out a discussion document for starters and then we changed it to a concept paper, we did a second paper which was the concept paper that was issued in September of 2015 and it was really based on all of that public input. We have also done public hearings. We have the Third Thursday Webinars and lots of other ways for people to get in touch with us but all of this information you can download stuff right from our website.

The last slide before we turn it over to questions, again Third Thursday Webinars are here and they are at 1:30pm every third Thursday and we send out announcements to the list serve. We also post announcements about it. We have all of our previous webinars as you can see here are actually archived on the website so you can look at, you can listen to the transcript or you can look at the presentations that we include and we include all of the artifacts from the Third Thursday Webinars. I think that is a really good way to stay in touch with what we do. Generally it is similar to what we are doing here today but we do what are the hot topics of the month and lay those out and then we do significant question and answer.

And with that, I am going to go to the last slide which is the question and answer. Mauricio, do you want to look at your chat and see if you can find some questions that we can answer?

MAURICIO CONDE: By the way, I just want to remind everybody that the slides for the webinar will be available on www.enrollnow.net this afternoon. Subsequently we will also have the transcription of the webinar and also the audio file which will be in a couple of days. If there are any other announcements

or any other information as a result of this webinar and any other questions, we will make sure to send you a link.

So it looks like there is a comment here, and it says when does Social Security get the data from Human Services for example Medicaid, TANF, SNAP, Application?

DEPUTY SECRETARY JENNIFER BURNETT: We don't have an answer to that but we can look into it.

MAURICIO CONDE: Absolutely. How do I obtain a copy of the PowerPoint slides? They will be available on www.enrollnow.net this afternoon so make sure you check on that.

And then there is another question. It is my understanding that Medicaid is the payer of last resort as related to Medicare. Will the Long-term Services and Supports be after Medicaid services have been exhausted?

DEPUTY SECRETARY JENNIFER BURNETT: I think the question meant to be was will the LTSS be after Medicare services have been exhausted and the answer to that is yes. Medicaid continues to be the payer of last resort. Do you want to say something Kevin?

KEVIN HANCOCK: The only thing that I would add would be that to be clear with LTSS services, normally LTSS services are not eligible through the Medicare Program. Medicare services would have to be exhausted before Medicaid physical health services are paid for but Long-term Services and Supports are usually not eligible under the Medicare Program so Medicaid is still the payer of last resort but usually they are the sole payer for those types of services.

DEPUTY SECRETARY JENNIFER BURNETT: Right and I would just add to that by saying people are often unaware that Medicare does not provide Long-term Services and Supports. There is a very limited benefit under Medicare and it is generally for rehabilitation so for example, if somebody were to have a hip fracture and need Long-term Services and Supports on a temporary basis at a rehab for example, Medicare would cover that but it is only on a limited basis.

MAURICIO CONDE: We have another question. Will people who do not qualify for Community HealthChoices now due to income and resources guidelines, be able to enroll once their resources have been exhausted and finding themselves needing long-term care?

KEVIN HANCOCK: So the answer to that question generally is yes. There are two qualifying factors for people who are in need of Long-term Services and Supports. There is a functional eligibility and financial eligibility. You have to pass both of those eligibility tests to be able to receive services in Community HealthChoices for Long-term Services and Supports. So if an individual meets the requirement for functional eligibility, which means that they have limitations in activities of daily living that would assessed through a survey, then that would prove that they are clinically eligible for Community HealthChoices. And then you would go through the standard Long-term Care eligibility process to determine if you are financially eligible for Community HealthChoices as well. So a long answer to a short question, the answer would be yes.

MAURICIO CONDE: We have another question. Will Fee-for-Service still exist once Community HealthChioces starts in an area?

KEVIN HANCOCK: Yes with a lot of caveats. There will be a Fee-for-Service Program available in two key areas. For people who are initially going through the eligibility process, specifically for nursing facilities, there will be a period of time for newly eligible individuals where their services would be paid for in the Fee-for-Service Program. Another area where Fee-for-Service will continue to exist is specifically with the OBRA waiver. OBRA will continue to exist as a non-community based waiver and it will be considered to be a Fee-for-Service Program for individuals who will qualify for the specific requirements for the OBRA Program. Just to be very clear, while we have a very narrow eligibility for Fee-for-Service, it will continue to exist but it will be much, much smaller than it is right now, especially for people involved in Long-term Services and Supports and for the entire dual eligible population no longer in need of Long-term Services and Supports. So the Fee-for-Service Program and Medicaid will be much smaller for this population.

DEPUTY SECRETARY JENNIFER BURNETT: I would also add that the Office of Long-term Living runs the ACT 150 Program, which is a personal assistance program generally for people who work but it is a non-Medicaid state funded program and that will continue in a Fee-for-Service environment. ACT 150 is not part of Community HealthChoices.

MAURICO CONDE: And when you talk about the small window for Fee-for-Service, that is similar to HealthChoices when somebody becomes eligible for Medical Assistance, they have 4-6 weeks to make a selection for a plan. That will continue I would assume?

KEVIN HANCOCK: Not exactly. Currently, if people are in HealthChoices and are moving into nursing facilities, they will continue to stay in Managed Care. For people who are newly eligible for Long-term Services and Supports and they are going to be receiving their services in nursing facilities, there is going to be a window of time from their application dates and their eligibility determination date that would cover, the time period might be the same but the eligibility process is a little different. Right now, HealthChoices has a Fee-for-Service window that they use to help support their eligibility and Managed Care plan selection process. Our program is going to be a little bit different. Right now, actually for our Long-term Services and Supports population, people are going to be eligible for coordination with Managed Care programs on day 1 if they are eligible for Long-term Services and Supports, a significant difference for Community HealthChoices as compared to HealthChoices Program. And another difference is that we might have a Fee-for-Service window for our healthy dual or well dual population, which is similar to HealthChoices but it really will be a different process compared to what is available for the Long-term Services and Supports population. So there are some differences and recognizing because we have eligibility differences just in general, we have a lot of eligibility difference between the long-term care population and the physical health population, we recognize that that has to be part of our communication process. A lot of our questions that we receive are the differences in eligibility and how Community HealthChoices is impacting that and we will make sure that all of that communication is made clear when we do these public forums and also when we send out information to people.

MAURICIO CONDE: Here is another question. How do you get on the list serve for the Third Thursday meetings?

DEPUTY SECRETARY JENNIFER BURNETT: Again, there is now a live link on the Community HealthChoices homepage but I will make sure that I send that live link to Mauricio after this is over and he can get it out to his list serve so people can easily go and sign up for it. We really want people to be participating in these things and we also like the idea of you getting the provider communications because the provider communications, they are very simple, easy to understand one pagers. There is one that I mentioned earlier that compares and basically gives the difference between HealthChoices and Community HealthChoices. I have had a lot of feedback that it is very easy to understand and so we really want people to be taking advantage of that information.

MAURICIO CONDE: Before I jump to this other question, I think it is important to note that Deputy Burnett and Kevin Hancock have joined us at almost every HealthChoices Consumer Advisory Committee Meeting including the ones in the Southeast and Lehigh Capital and we have the Advisory meetings coming up in July, starting on Thursday, July 6, 2017 in the New West in Erie and then on Friday, July 7, 2017 in Pittsburgh and I believe that Kevin Hancock will be joining us at both of those meetings as well.

So as the questions and the dates and the notices come close, Kevin and Deputy Burnett I am sure will be joining us and if needed, we can always have another webinar closer to the time.

There is another question. Can a provider balance bill a member if the provider is not an MA enrolled provider?

KEVIN HANCOCK: So just to repeat the question, can the provider balance bill a member if the provider is not enrolled in Medical Assistance? Just to be very clear, to be a Community HealthChoices provider and participate in the Community HealthCare Managed Care Organization network, they have to be an MA enrolled provider. In circumstances, they have to be enrolled in the Medical Assistance Program to be able to enroll in a Community HealthChoices provider. If there is a circumstance that requires out-of-network services to be paid by a Managed Care Organization, it is almost universally the case that the provider still has to be enrolled in the Medical Assistance Program, even if they are not a network provider for Community HealthChoices. So it is hard for me to envision a circumstance where a Managed Care Organization would be asked to pay for a provider's services when the provider is not enrolled in Medical Assistance. It is possible for Managed Care Organizations to pay for and provide services out-of-network in special circumstances where, for example, that provider is providing services that may not be available in the Managed Care Organization or more likely if an individual has certainly eligibility circumstances that allow them to be grandfathered to continue to receive those services with that provider but in most cases, those providers would be enrolled in the Medical Assistance Program.

MAURICIO: Okay, thank you so much. There is another question here and this seems a bit technical. When do you get the Gene Roberts Medical Part II therapies?

KEVIN HANCOCK: So I personally am not familiar with that service so it is something that we will have to take back and research. If the individual is in a position to be able to even send us a procedure code for this service or send to Mauricio a procedure code for the service, we could determine if it is an eligible

service under the Medicaid Program. This might be something that our physical health HealthChoices partners would be able to help us answer.

MAURICIO CONDE: And there is a similar question I would assume. When does WIPA help with Medicaid? So maybe you can send me also that question and I will be able to forward this for further research.

KEVIN HANCOCK: So the people on the phone may not see our confused look.

MAURICIO CONDE: But I am taking pictures which also will be available on the website.

So another question, where you please repeat where you obtain a copy of the slides and the transcript. So again, this transcript and the audio file and the slides will be available at www.enrollnow.net. Now remember, if you signed up for this webinar, you also have access to my email address so if there was anything that you wanted to ask, you can send me an email and I will make sure that I forward that on to Deputy Burnett and Kevin Hancock to make sure that you get the answers that you need.

So at this point I want to thank Deputy Burnett and Kevin Hancock for always being so flexible. I know that many times, at the last minute, and you always have been very flexible, that you can see the audience is a lot different from the Community HealthChoices audience that perhaps you are used to speaking to and that is because of the interest of Community HealthChoices and the impact that it is going to have in some of the HealthChoices zones starting in the Southwest. I want to thank you so much for participating in this webinar and I look forward to having you join us during the HealthChoices Consumer Advisor Committee meetings starting in July in the New West and the Southwest.

DEPUTY SECRETARY JENNIFER BURNETT: That sounds great Mauricio. Thank you so much for inviting us. One of the things that I did note as we are looking at the webinar screen here is that there are a lot of names that I am not familiar with so the more people that we are able to reach, which this has given us a forum for doing that, we really appreciate it so thank you very much for your invitation. We would be glad to come back.

MAURICIO CONDE: Thank you.

KEVIN HANCOCK: Thank you for the opportunity.

MAURICIO CONDE: Thank you and at this point, the webinar will end and thank you so much for your participation and please do not forget to fill our your survey form. Thank you.