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DATE: January 4, 2019

EVENT: Managed Long-Term Services and Supports Meeting

>> BARB POLZER: Good morning everyone we would like to get started in a few minutes.

Good morning everyone we would like to start the meeting.

Luba how about if we start with you with introductions. Please.

>> SPEAKER: Good morning, Luba, Bayata home health care.

>> KEVIN HANCOCK: Hello we're -- the people on the phone we're starting with the introductions thank you.

>> SPEAKER: Kevin? We're just wondering two of us on the -- the non-toll free number when we dial the toll number it says, not audio enabled.

Is that the case? Or are they turned

on at a later date or you don't know the answer to that?

>> KEVIN HANCOCK: I don't know the answer?

>> SPEAKER: Have them try to dial back in.

It should be -- has been-why don't you industry dialing back in. Would that be all right?

>> SPEAKER: Yeah I don't mind trying it twice I can get back on, I'll let you know right away. All right.

>> KEVIN HANCOCK: Thank you.

>> SPEAKER: This is Estella Hyde I'll call back.

>> KEVIN HANCOCK: Thanks.

>> SPEAKER: Good morning Jesse Wilderman, SIEU health care Pennsylvania.

>> SPEAKER: Ray Prushnok, UPMC community HealthChoices.

>> SPEAKER: Theo Wrady, CILCB.

>> SPEAKER: Drew Nagele new.

>> SPEAKER: Heshie consumer

advocate.

>> SPEAKER: Kevin Hancock Deputy Secretary Office of Long Term Living.

>> BARB POLZER: Barb Polzer liberty community connections.

>> SPEAKER: Nina, life providers.

>> SPEAKER: Blair Boroch united health care.

>> SPEAKER: Jim Pieffer.

>> SPEAKER: Linda Litton participant advocate.

>> BARB POLZER: Committee members on the phone?

Okay.

All right I'm going to read our housekeeping rules.

Please watch your language and be professional. Direct your comments to the chairman. And wait until called upon and please limit your comments to two minutes. The transcripts and the meeting documents are posted on the Listserv under MLTSS, meeting minutes.

And they're normally posted within a

few days of the meeting.

The captionist is documenting the discussion so please speak clearly and slowly. And the meeting is also being audio recorded.

This meeting is scheduled to end at 1:00 p.m. to comply with the logistic call agreements we will end promptly at that time.

If you have any questions or comments that weren't heard, please send your questions and comments to the resource account.

For your reference, the resource account is listed on the agenda.

The exit aisles must remain open, do not block the aisles. Please turn off your cell phones.

Throw away your empty cups bottles upon leaving, public comments will be taken during the presentations instead of just being at the heard at thent of meeting there will be additional 15 minute period at the end of -- excuse me

of the meeting for any a decisional comments. The 2019 MLTSS sub-MAAC meeting dates are available on the DHS web site now, the emergency evacuation procedures.

In event of an emergency or evacuation, we will proceed to the assembly area to the left of the Zion church on the corner of fourth and market. If you require assistance to evacuate you must go to the safe area located right outside the main doors of the honors suite. OLTL staff will be in the safe area stay with you until you are told you may go back into the honors suite or you are evacuated.

Everyone must exit the building, take the belongings with you, do not operate cell phones and do not try to use the elevators as they will be locked down. We will use stairwell one and two, to exit the building.

For stairwell one, exit honors suite through the main doors on the left side

near the elevator.

Turn right, and go down the hallway by the water fountain. Stairwell one is on the left. For stairwell two, exit the honors suite through the side doors on the right side of the back doors for those exiting the side doors turn left stairwell 2 is in front of you. For those exiting from the back door exits, turn left and then left again stairwell two is directly ahead.

Keep to the inside of the stairwell, and emergency outside, turn left to Dewberry to Chestnut Street, turn left to the corner of Fourth Street and turn left to Blackberry street across to Fourth Street to the train station. We're going to have Kevin do the OLTL update.

>> FRED HESS: This is Fred Hess, if you can't remember those instructions run.

[laughter]

>> KEVIN HANCOCK: Thanks Fred.

>> FRED HESS: Sorry I could not be there.

I got a case of the.

[inaudible]

>> SPEAKER: This is Ralph Trainer I wanted to let you know I'm on the call.

>> BARB POLZER: Okay. Thank you Ralph.

>> SPEAKER: This is Jim on the phone.

>> BARB POLZER: Thank you.

>> KEVIN HANCOCK: Anyone else on the phone?

>> SPEAKER: Brenda Dare.

>> SPEAKER: This is --

>> KEVIN HANCOCK: I heard Brenda Dare.

>> SPEAKER: Rich Welleins, does not enable the control, someone there could make a note of it -- on the 888 number, I've had correspond answer on this before. You cannot get audio control on the toll free number.

>> KEVIN HANCOCK: Thank you we'll make sure we make note of that.

>> KEVIN HANCOCK: Thank you

very much Barb Happy New Year, when she reads this procedures has such a calming voice I think in a crisis she would be the person to stay by she would keep us all you know sane and --

[laughter]

>> BARB POLZER: Okay.

[laughter]

>> SPEAKER: Let's send her down to Washington, DC.

[laughter]

>> KEVIN HANCOCK: It could be a true statement.

[laughter]

So I'll start with a CHC update, focusing on the southeast implementation first then I'll give a quick update on southwest operations one year in, that will be the lead in we have -- little bit later on today, our quality team, Dr. Kelley and Appel and Wilmarie Gonzales will -- they will be focused entirely on southwest operations. So that will be -- something that we hope to

be able to do, fairly frequently in the coming year, talking about the progress of the program, actually measuring effective how it's going to be. That's important objective we're hoping to be using to present to this committee. Starting with the 2019 OLTL goals which are exactly the same as the 2018 OLTL goals for implementation we're going to be focusing assuring during the continuity of care period which is the first six months, of operation and any zone, that there's no interruption of participant services, and, no interruption of provider payment which are two sides of the same coin.

We'll be focusing heavily with our launch monitoring activities on those two areas as well as other activities looking for opportunities -- to address them as soon as they are are something we're aware of as quickly as possible. We are the third day in southeast implementation, haven't had any

emergent issues we have this -- we have to confess we have, identified some unforeseen data issues similar to what we saw last year, slightly different.

And, something that they're being addressed now as we speak.

But there's something we're just going to have to, fix as we go along, hopefully we'll be able to use some root cause analysis prevent them from happening again in the remainder of the State we do have, some data issues, again, and -- we're looking forward to identifying what was the cause of those data issues most of them relate to eligibility data and also, case management data and how that case management data will be going into the managed care organizations, prior authorization systems.

But -- but we are thinking we're going to be able to get ahead of it, have the problems solved much more quickly it literally took some months to get ahead

of it, the providers were very patient through the process, we think that data issues be able to be addressed not only by us by by the manage the care organizations because we already have experience in fixing them based upon the southwest experience.

And we're also going to monitor and address any other issues as they a occur and -- that is, other focus for the next -- 6 months, as we -- before we transition into what we call steady state operations. By the launch at this point we see it is going pretty well.

Just to be honest love to hear feedback otherwise we're, if there are any emergent problems you have heard, you can certainly raise them in this meeting or -- make sure that you reach out to the department so we can get ahead of them as quickly as possible. Knocking on wood so far so good.

And -- just to make sure that we are clear, even though we're implementing in

the southeast, we will continue to pay very close to a attention to the operations in the southwest. It is still very new program in the southwest.

There are still a lot of growing pains occurring in the southwest and we want to make sure that, our ongoing monitoring and over sight activities are addressing issueses as they are identified we are going to look for opportunities to begin to focus on some of our key initiatives which include as mentioned here housing, employment and nursing home transition. Also, we have lots of opportunities, to address some of the issues we see, with the contradict care work force building a robust direct care fork worse looking forward to begin to build out the infrastructure in the southwest as we continue to work on implementing the southeast.

So in addition to all of that, we also have begun to focus on phase 3 implementation which -- I have been

publically stating, in my opinion will probably be the most challenging limitation, how many people are from the T, the Pennsylvania T.

I'm not -- actually yes, I am I'm living in the T we're in the T right now.

But -- we have, it is a -- it's 3 zones we're going to be implementing at the same time.

Not as many people as what we had in the Philadelphia area.

But, that population is very disbursed a lot of smaller cities a lot of space in between.

So, we have Erie, Scranton Wilkes-Barre Williamsport, we don't have Altoona, we have -- Harrisburg, York and Lancaster.

We have Potter county, really rural areas and, it is -- what's going to be particularly challenging is to make sure that, we adapt our implementation and communications strategy to a much more disbursed geographic area that we're

very open to suggestions how to be able to do that effectively.

That includes, comprehensive participant communication. In the different modes we had a lot of challenges with communication, we think we, over came in the southeast. Largely, cultural and communication challenges, with different populations and we had a lot of support in being able to do that.

The challenges, for participant connection are -- very structurally different in the remainder of the State we're going to spend a lot of time focusing on the different ways to communicate to a population is not always that easy to reach because of where they live repost ready also, focusing on the provider the provider challenges so in the fee for service system, to be perfectly honest we are challenged by not having enough providers in the areas that will be

implementing in the third phase we're going look for opportunities with managed care to build out a more robust provider network than exists the southeast the provider networks the provider network is already strong we're looking for opportunities to build capacity as well as making sure we're taking of the capacity that is already there, that's a particular challenge. Provider communication and training that will be a challenge we'll be doing provider sessions earlier we'll be doing in the main and June time frame, hopefully the MCOs will not be surprised by that, we'll be doing at least 9 sessions across the entire phase 3 zone areas we will be doing a lot of traveling over a very short period of time.

It will not be as concentrated, I have to -- confess that, the southeast provider sessions were particularly wonderful we were -- we were able to have five of them all in the same place and, we had

two of them in the same place in the southwest we'll not have any in the same place in the phase 3 which is going to be much more disburse, much more traveling which is -- definitely, looking forward to getting where the providers the providers have their business we hope we have robust attendance in the phase 3 area. The pre-transition and selection phrase, phase 3 participants will largely follow the same time frame they did in the southeast we found that to be pretty effective also incorporating all the lessons learned from the southwest and southeast. We're beginning to compile lessons learned for the implementation and launch in the southeast as we speak we already have lots of lessons learned for the southwest. So those are the are goals for 2019 --

>> SPEAKER: Kevin I had a question.

Do you supplement the live sessions with webinar.

>> KEVIN HANCOCK: That's a great question we have not yet, had to we do power presentations they have not been webinar presentation for the provider sessions we, are open -- that's a suggestion that we're willing to consider.

Jill the jump in on that. Jill is our communications lead for that CHC.

>> SPEAKER: Hi, um so we there we go.

We are adding an additional round of communications in the fall, as well.

So not only are we doing the outreach and road show in May June time frame. But then we also added 3 additional sessions in the fall, so -- right after the notices start going out for providers that may have missed that communication over the summer.

As part of that, um, we are working on, um, wanting to record some of these sessions so we can post them also out on the web. And just reminder we do have third Thursday webinars so -- they will

be the focus of the phase 3 implementation, as well.

So, those will be every third Thursday, um, that you can also get additional information and updates.

>> SPEAKER: Excuse me is the road show for the providers or -- the participants.

>> KEVIN HANCOCK: Road show, we were just discussing is for providers.

>> SPEAKER: Okay.

>> KEVIN HANCOCK: Right.

>> SPEAKER: Question. Kevin will you be sharing the break out of the population in zone 3 by NFCE, NFI, community consumers et cetera? By county?

>> KEVIN HANCOCK: Certainly will.

>> SPEAKER: But that could be very helpful for planning purposes.

>> KEVIN HANCOCK: I think it's a great idea. We'll definitely share that public we have that available now.

And we can, we can publish on the

CHC web site if you think it would be helpful.

We'll certainly share with the committee.

>> SPEAKER: I've gotten that request a couple of times thank you.

>> KEVIN HANCOCK: Thank you.

>> KEVIN HANCOCK: I'll jump into a little bit more detail in the southeast launch.

>> BARB POLZER: Pam has a question please use the mic thank you.

>> PAM AUER: I understand it there's a lot of differences in the rural areas and -- um a lot of it is, still cultural too, the rural areas are you planning for paying for transportation for some people to get to these educational forums not a lot of the consumers in the rural areas can afford internet they will not be able to go on via webinar. They don't have transportation or if they have it, they cannot afford to use it. It's not budgeted, is there something being built

in to be able to get some of our people from the rural areas to these educational meetings.

>> KEVIN HANCOCK: Thank you Pam that's a great suggestion.

We would have to think how we will do that logistically, we will have the participant sessions in the late summer early fall, again and -- if you don't mind me recharacterizing what you're asking for, you're asking to support participant attendance at these sessions to also support transportation activities is that right.

>> PAM AUER: Uh-hum.

>> KEVIN HANCOCK: We'll take that as a suggestion for planning purposes if you could think how that will work or what kind of partners with he would use to be able to help that happen that will be particularly helpful.

>> PAM AUER: Okay.

Where they get -- in the ruraller as gather talking to the local CILs because,

where do they actually, meet up with the people.

I big part of my life was in the potter county region certain towns they can gather to or even get to, even with transportation, even if you this I about Cumberland County people out in Shippensburg they don't get very far in other parts of Cumberland County. So talking to some of the people who actually know, one of the, biggest concerns in Philadelphia had was that, their consumers didn't get to those meetings because it wasn't where they normally go. So -- lesson learned through, how -- where do people with disabilities in the rural areas go to.

>> KEVIN HANCOCK: So that's a second session, that I think it's a great suggestion finding out getting a better idea of the patterns where people, would want to normally congregate to be able to receive message like that. So --

>> SPEAKER: I think, I think that's

great. This is Rich again.

I don't know why I'm getting an echo.

>> KEVIN HANCOCK: We had to turn the microphone on so everybody so hear your question.

>> SPEAKER: All right. So -- um, the issue I think you can add you don't necessarily, that have for the webinars you could just supplement but -- supplement with toll free call in number you could have half hour, QA sessions.

>> KEVIN HANCOCK: Once again the recharacterize your suggestion, you would -- want to have, participant have virtual participant sessions, that would have a call in number and even potentially, a webinar participants as well. Is that what you're suggesting.

>> SPEAKER: Yeah.

Yeah. But without necessarily, having to have a computer. So -- you know, it would, congregations you may hit 10 percent of your population.

Potentially I don't know if this will work or not if you have a toll free call in number and, 3 times you say we're having a half hour session, or an hour, QA session, and all you have to do is dial like I did, dial the toll free number and -- um, you have access to hearing what is going on and having your questions addressed.

Only thing you need for that is a phone.

Had aen Hannie think that idea is a possibility. Thank you very much. All 3 -- ideas, have a lot of possibilities.

>> SPEAKER: We're still planning the participant sessions so all that is great feedback.

>> KEVIN HANCOCK: Jill I'm going to communicate Jill's message we're still planning the participant sessions for phase 3. This is a great time to start submitting those questions or suggestions thank you very much.

>> SPEAKER: Kevin it's Tanya I'm a

little late to the party today.

Another suggestion you can maybe do is you break out the -- um, the information from the webinar actually like send to people, if you could get people to call in certain places, like we need physical copies of what was the type of webinar so they could remember it, set it up so there's some way they can request it, they need to -- that way they have it read look back on everything else.

They know what is going on with stuff.

>> KEVIN HANCOCK: Tanya we email blasts that, kind of are what you're suggesting.

>> SPEAKER: Not email but physical mail. They don't have access to the -- the internet they can do it the other way too.

>> KEVIN HANCOCK: Happy to discuss I have to say, but -- it is, we the feedback we normally receive on the --

information, is physically mailed is that, it either A sometimes inaccessible or B, it is ignored. So, having --

>> SPEAKER: I agree.

>> KEVIN HANCOCK: It's also expensive. We -- are happy to discuss the idea, but -- we have a lot of experience on -- people challenging the effectiveness of the direct mail communication.

So -- some of the information -- we do send out has to be direct mail like the, enrollment information and the -- the pre-transition information as well.

But we usually get feedback that -- that people just don't pay any attention to it, if they do, they -- it is, not something that they, they -- consume, in the way we would like them to consume.

>> SPEAKER: Yeah. I'm just, I'm just saying like when I get something in the physical mail I know, it is will not coming any other time that's what I hang onto, to do -- to get I don't get that stuff

anymore.

>> KEVIN HANCOCK: Understood.

Okay.

So -- without anymore questions I'll jump into the updates the southeast launch. The first slide shows, the break down by plan selection method and by managed care organization.

And these are basically the final numbers we have, these were from earlier this week. The final numbers for implementation activities for the southeast.

So, from this point forward it will be, after the plans implemented so keystone first, ended up with the largest percentage of enrollment 52 percent.

Pennsylvania health wellness, 24 percent. And UPMC24 percent as well.

The largest portion of the participants, did auto enroll. That's 60 percent.

And, but we did have 40 percent after

selection.

So two comments I have on this, first we were really, expecting the southeast to have a much higher auto assignment rate in the beginning that didn't happen when we saw it was trend understanding this direction we were really hoping the southeast would end up having, the same or a greater percentage, than the southwest for active plan selections it turns out it was almost identical in terms of percentage.

So, we were really, we were on track to break the record in the southeast it looks leak we just tied. Which is -- which is a great story for an MLTSS program, nationally.

But, but -- we were really hoping to break the record our goal for phase 3 will be to break that 40 percent record still high auto selection rate we have to see it get better it's very challenging for so many people are paying much more attention to their primary physical health

coverage which is Medicare, fundamental challenge of getting the word out,.

>> SPEAKER: Question about auto enrollment we had six individuals who very carefully chose an MCO, way ahead of the deadline submitted it were auto enrolled in a different MCO how is that still happening.

>> KEVIN HANCOCK: That should not be happening if you have those examples seasoned them our way it will be fixed retroactive that should never have happened.

We have to -- if you could seasoned them to us we have to -- we have to see, what the cause was. Because if they -- they went through the active plan selection process either via mail, by -- web or directly calling the MAXIMUS the independent enrollment broker it didn't happen, the system failed for those individuals we have to find out why.

>> SPEAKER: The number the number of people, self selecting may be

higher than you're reporting if this happens.

>> KEVIN HANCOCK: So once again, please send these examples our way, it should not happen, you're absolutely right they're self selecting it's not happening, it is -- to be perfectly blunt that's unacceptable.

Moving onto the next slide.

This shows -- a plan selection by population. The largest portion of the population obviously are the -- individuals who are duly eligible for Medicare and Medicaid not receiving long-term services and supports the HCBS duals are individuals receiving their long-term care in the community. And also, have Medicare as their primary physical health coverage.

The HCBS non-duals, that's the 15,158 individuals, are those individuals who received long-term care in the community and have community HealthChoices as their primary physical

health coverage. This is a population where we pay fairly close attention to getting the word out not only were they, going into community HealthChoices, but they were also, required to changes plans from the physical health HealthChoices program. Significant portion of this population was already in keystone first and they were, either automatically enrolled in keystone first as the, the companion sister plan to -- to help the HealthChoices plan but, we want these people to know that they are receiving, they are getting this change because, CHC does not have the same MCOs, necessarily, as as -- as the physical health HealthChoices program, so people were very likely, going to see a change in this population. About half of them half of this 15,000 did actively select a plan and the other half were either auto assigned or assigned to the keystone first as the sister plan.

The long-term care duals are those

dual eligibles receiving their long-term care in a nursing facility and also have Medicare as their primary payor for long-term services non-duals are receiving their long-term care in a nursing home facility did not have Medicare as their primary CHC as their physical health coverage the grand total we enrolled as of -- the January 1 date was 132,743.

So then the distributions, 60 percent, auto enrolled and then --

>> KEVIN HANCOCK: For the people on the phone just ignore that.

That's happened before Pat. Yeah okay.

Moving onto the plan selection.

Plan selection by population, same distribution as you see here.

And -- we welcome you to take a look at these individual populations cells.

For a particular questions, the distribution is -- particularly, interesting for the NFI dual population.

Because those individuals, would have been in the fee for service system prior to, community HealthChoices. So -- um, very telling but it usually, it -- represents, a pretty similar percentage to what we saw with the rest of the population as well.

>> SPEAKER: Kevin can I check one quick thing if you're in a population, where you are dual eligible, and your CHC in CHC, um, you still have to pay?

Pay dual for the provider is that correct?

>> KEVIN HANCOCK: If you're in the traditional Medicare fee for service program, you do not have to make any changes, you don't -- just in general, you do not need to make any changes to your Medicare coverage, unless you want to make changes to your Medicare coverage. CHC, is Medicaid enrollment, we are certainly encouraging alignments and encouraging coordination but we have no authority to make any changes

to a participants Medicare coverage. So, participants who are duly eligible, do not need to make any changes at all if they -- don't want to make any changes to the Medicare coverage.

>> SPEAKER: If they're duly dual eligible though -- so you have Medicaid -- as primarily.

But now you're eligible for Medicare.

You have to pick a dual eligibility plan.

Is that correct?

>> KEVIN HANCOCK: No. That is not correct you do not have to pick a dual eligible plan.

We encourage it. Just to be clear we're encouraging it, we don't have the authority to mandate it.

>> SPEAKER: Okay got it.

>> KEVIN HANCOCK: Okay.

So thank you for the question. Medicare continues to be an area of opportunity for improving our communication and -- we, welcome

Medicare questions as much as possible.

So -- moving onto the CHC launch indicators, many of you have seen this slide already it is the same slide we were using we're focusing on launch measurements that will focus on readiness, continuity and program improvements, the prelaunch and continuity phases were in the continuity of period right now. We are focusing on making sure, that the managed care organizations, are providing consistent levels of services, or improved levels of services for participants who are in a program and there is a significant focus on individuals in the long-term care system whether they're in, receiving their long-term care in the community or if they're receiving their long-term care nursing facilities after we move through the launch period and moving into the steady state operations, we will be focusing heavily on quality measurements and -- program

improvements and -- Wilmarie and doctors Appel and Kelley will provide some feedback on the southwest that's a teaser for Wilmarie, Dr. Appell and Dr. Kelley how the program is doing, we're proud we've been so focusing on the quality measurement early, very intricately to make sure it's clear we know how the program is doing at the very early onset, so we're being introduced today to where we think the MCOs are at for certain categories, for the southwest, in January. So one year out, representing a picture of where we're at with the CHC.

Am I the only person in the room excited about that.

[laughter]

>> SPEAKER: I am.

>> KEVIN HANCOCK: Thank you.

So moving on the domains for launch indicators we are, focusing on service continuity, service coordination continuity, provider participation and

information transfers I can say, we have, in the southwest, areas of opportunity in all four of these domains service continuity was the most, directly, I'm just going to rehash lessons learned service continuity was most directly challenged by data integrity we're incorporating those lessons learned we're still challenged and working with the managed care organizations on service coordination, continuity.

As well as person centered service planning, it is an important part of community HealthChoices infrastructure. And we, look for opportunities to be able to continue to improve that process, provider participation is -- a key element of network adequacy we have to say at this point we do continue to have in the southwest robuster provider participation and we have very robust network engagements in the southeast.

And we're actually very happy with the configuration the networks in the

southeast for all 3 managed care organizations, information transfers is area of challenge I already mentioned, it has an impact on these other domains as well. It's too early to say, how we're doing in each of these domains, because we're only 3 days in for the southeast. These are the areas we're focusing onto meet those limit interruption of participant services and limited interruption of provider payment. So in addition to launch domains, we're measuring we're also, engaging, in significant launch communications we continue we have, daily calls with the managed care organizations we also have a weekly joint call with the all 3 MCOs the daily calls where we talk about, the emergent activities, either on our side report managed care organization sides and sometimes providing feedback from the stakeholders that are receiving on the realtime basis. Weekly calls are the roll up I'm given the

opportunity to yell at all 3 MCOs we see some systemic issue that needs to be addressed by all 3. We have not had one yet we will have one later on today so far so good. Weekly participant and advocate calls we, continue throughout the southwest launch we'll continue indefinitely I have to personally say for the individuals that participate in the calls they're invaluable to identify emergent issues probably the most most important of the participant communications we had through the launch, because we have, stakeholders who, talk their personal experience, the experience they're hearing from their stakeholders and they really have, helped us move this program forward in both ways we're very happy for those calls. We'll have the calls with the nursing if a silly and the HCBS providers they're host helpful in identifying communication and payment issues or data issues providers are facing we're

very grateful for the participants in those calls as well. We've weekly calls with the aging network that is particularly important because the aging network is well tied into the dual eligible population they can provide us feedback on populations that may not necessarily be accessing the system on a daily basis. So -- so -- these launch communications will continue throughout the continuity of care period.

>> SPEAKER: We added transportation.

>> KEVIN HANCOCK: Right. And just because it is a definitely a lesson learned thank you Jill we will be having weekly calls on the topic of transportation, transportation has been one of the biggest challenges we had in the southwest so far we're hearing it's going better in the southeast it's only day 3, lot can happen now between the months to come.

I have to say, that we recognize, how

important transportation is, as the gate way to independence for individuals receiving long-term care in the community we want to have these weekly calls to get ahead of issues as quickly as possible not be surprised by anything we're hearing.

>> SPEAKER: Can you repeat my question.

There it is.

I'm curious about weekly participant and participant advocate calls, are you randomly calling participants what -- how does that work?

>> KEVIN HANCOCK: So, the weekly participant advocates have participants on the phone.

Usually they, either have been identified by some of the partners like the health law project or or they are have some sort of affiliation with the consumer sub-MAAC. So if you have any anyone that would want to participate on that call, participants, send

them our way we'll make sure they're included. Thank you.

>> SPEAKER: Kevin I have a possiblity issues. ACHIEVA, Pittsburgh -- had a subsidiary call -- ARC of Westmoreland.

They were incorporated into Westmoreland would like to provide service Achieva is not, they reapply, for the State and -- have not heard back.

>> KEVIN HANCOCK: We can look into that.

>> SPEAKER: That may be a small population but effects me personally.

>> KEVIN HANCOCK: We'll reach out to you offline, to find out a I little bit more about that. Find out the -- find out the status of the provider.

>> SPEAKER: Okay thanks.

>> KEVIN HANCOCK: We'll probably need more information.

>> SPEAKER: Just a quick follow-up what I asked before, would it be possible for CILs to participate in those?

>> KEVIN HANCOCK: Some CILs do participate.

>> SPEAKER: Okay thank you.

>> BARB POLZER: Pam do you have a question?

>> PAM AUER: Just to follow-up with questions the last time do we have any data on improvement in transportation in Pittsburgh? I was actually down there over the holidays and -- family member of mine who uses transportation she has no clue and she feels like her service coordinator doesn't have any clue, how she is going to get her -- nonmedical transportation, I said try to again. Maybe they're doing better now.

This might have been a couple of months ago, but, have the -- the providers the MCOs been tracking you know the provision of transportation and has it improved? And -- you know, trip data, using um, using a -- what do you call it the broker? Is it working out?

Would it show the quality of the trips? Are people satisfied with it?

I think someone asked about that last month, in December. I'm wondering, are we tracking that or finding out if it's really improving.

>> KEVIN HANCOCK: We do have an operations report that will involve data collection on the provision of transportation I don't think we have a data on that now.

>> SPEAKER: No ask the MCOs they're all sitting here.

>> KEVIN HANCOCK: MCOs can characterize their own experience I think Pam is looking for something objective as well.

>> SPEAKER: Yeah I think we will be glad to provide data we don't have it before, we know before the after, we -- we feel like, the feedback we're getting is we are, offering, a you know more robust network of choices so we have the broader network we hope that is

meeting people's needs but again I think the data will speak for themselves I would like to see sort of the format, we'll make sure we live up to what we're expected.

>> PAM AUER: I guess her experience was really bad -- calling the social service coordinator trying to get the broker, trying to get it all set up she said what do I have to do here? You know.

>> KEVIN HANCOCK: So, before you guys jump in, we take that as feedback, the service coordinator needs training.

How the transportation is supposed to be working the service coordinator should be an expert on how to be able to -- how their participants are able to access transportation.

So -- that service coordinator, is not doing his or her job.

>> PAM AUER: I asked her to try it again because I know, it was maybe October when it happened, maybe they

got more training since then, given the benefit of the doubt she is going to try it again she was really frustrated I think about how many other people out there, that may have tried it earlier we're still frustrated with it, maybe, is there a way to get the back out to them, service coordinators talk together consumers about transportation, on a regular basis or you know, what's being done to educate reeducate the consumers on their options.

>> KEVIN HANCOCK: And I would agree with Randy the MCOs should speak up on that.

>> SPEAKER: Thanks Kevin.

One of the things that we have done over the last quarter to maybe five six months is, is working in our training sessions, with service coordination. To talk about transportation. Talk about the options available, what is available for folks, what is available for folks. More importantly a lot of confusions or

misconception of what I am eligible for versus what I'm not eligible for, when we communicate that through the service coordinators to the participant, I think the outcome is, is -- a far better outcome than what your family may be experiencing in terms of confusion and/or -- not knowing, what is going on.

We have been working on that, over the last several months I know, UPMC has I'm sure Chris can attest what AmeriHealth has done.

>> SPEAKER: So -- we've done a similar process as we've had these discussions about transportation we've made some changes to our processes, um, we've actually brought in MTM as well as the service coordinators had training to make sure they fully understand the process. So um, and I think, probably all 3 of us if you're having that specific issues with a service coordinator we want to know about that, so we can, identify it, it is an individual

training, or global training issues looking to address, with the entire service coordination team.

But that service coordinator is the point person to help coordinate get that squared away as part of the serviceman.

We do monitor the trips we do make sure there's anything that missed or early pick up or identified what are the issues figure out is it a inest work issue, a timing issue when the trip was scheduled same day scheduling there's no transport available we monitor that and we have weekly calls to address that with our broker as well.

>> PAM AUER: Something can go out on the web site we keep asking for data, data.

Is there a way, to be able to monitor how it's progressing that way we can see if there's areas someone comes into the their region you know we ask for data here is there a way to put stuff out like what the trips were month-to-month,

whatever. quality -- out on a web site we can see it, we would not have to keep bugging here because I have another question besides transportation I have a question on quality of services around durable medical equipment the hoops people have to go through, to get DME. Through the MCOs.

Is there another way that we can be getting the data so we can see how continue to monitor and give suggestions to MCOs?

>> KEVIN HANCOCK: For it to be publically released it would most likely come through the department we are as I said we are collecting the data specifically on trappings as a separate operations report sharing on the web site is something we can discuss but having it, made available to the committee is something we will definitely do.

So make it available in this meeting as well. So the way we would, potentially do that is -- publish.

>> SPEAKER: Excuse me Kevin.

>> KEVIN HANCOCK: One second Fred, one thing we could do is include in the MLTSS presentations and, we could publish the MLTSS presentations on the web site that's one way to do it, just thinking logistically how to make it work.

>> KEVIN HANCOCK: I'm sorry Fred, go ahead.

>> FRED HESS: That's fine.

Have you gotten in touch with the transportation alliance and see if they have any good ideas how to -- make it easier or anything?

>> KEVIN HANCOCK: I'm not sure I understand the question.

Is that a specific transportation provider.

>> FRED HESS: They have a transportation committee they may have suggestions to make the transportation, the communications go a little easier and better, they might even be able to figure out a way to be able to train the service

coordinators to do a better job of transportation.

>> KEVIN HANCOCK: Are the MCOs familiar with the organization.

>> SPEAKER: Is he saying triple.

>> FRED HESS: NCIL, national Center of Independent Living.

>> KEVIN HANCOCK: Oh thank you Fred. Didn't know the acronym.

[laughter]

Okay.

That's a great suggestion.

Actually.

Especially I think, national CIL association would, understand national, or state -- specific state barriers of transportation.

And it is a great idea for the department and for the 3 MCOs to reach out to NCIL, to -- the national Centers for Independent Living, to look for suggestions and possibly for training.

>> BARB POLZER: Kevin we have a comment.

We have a comment, from the Lavell, inition to contacting OLTL, participant or participant advocates that are interested in joining the weekly participant and participant advocate calls are welcomed to contact the chair of the consumer subcommittee, Sanya Brookings or the Pennsylvania hailth project Levell will gladly take calls at his email lmillerwilson@Phlp.org.

>> KEVIN HANCOCK: Thank you for the feedback we'll look forward to opportunity to talk about how this is going in the southwest it is a -- it is a pain point. It's an area where we need to focus on our communication.

Continuing with the launch communications we, have our participant help line, continuously staffed to talk about issues we recommend if people have issues in CHC they contact their managed care organizations first.

They have long term managed care organization they have issues reach out

to the managed care organization first it's their job to resolve those issues for you to capture complaints if it turns out, you're not getting in I relief from the managed care organizations we have the participant help line available it's staffed, by the Office of Long Term Living and that number is 18007575042.

If you have any issues relating to the plan in general, you're not happy with the plan your plan you want to make a change which you can do at any time call the independent enrollment broker is MAXIMUS.

And their number is 18448243655 and -- the TTY line are the hearing impaired line is 18332540690 make your change for a plan at any time, the way that would work if you make a change in the first half of the month, it will be effective the first of the following month, if you make a change in the second half of the month, it will effective of the first of the month after that. So if we make

a change today that change will be effective February 1, if you make a change on January 18th that change will be effective on March 1st.

Okay.

>> BARB POLZER: Margaret.

>> SPEAKER: Hi thanks PPL, the units transitioning from a year to the month of January bulk of them we have noticed are wrong like 89 percent we're concerned people are not going to get paid today.

>> SPEAKER: Let me give you my card you give me the information.

But I just want to make sure everyone knows that all of the MCOs and PPL are having regular multi-calls a week.

The information did transition successfully.

Over to the MCOs, and -- actually the first payroll paced off MCO data is not data, is later this month, if something is incorrect we need to look at from a

department perspective let me give you my card you can send me the information. Thank you.

>> KEVIN HANCOCK: What you're saying Jill it could be a problem with the source data.

>> SPEAKER: Uh-hum.

>> KEVIN HANCOCK: That's something we would want to look into.

Then continuing with launch communications, the CHC, MCOs are required to mail out enrollment packets to participants within the first five days, of the enrollments, it is our understanding those packets were mailed out last week.

And, that should be at this point in the hands of the participants.

We had some challenges with that last year, which is -- all issues with those challenges were corrected this year, if you have any feedback on whether or not participants are not receiving those packets let us know. The requirement is

that, enrollment packets are received by recipients within five days of enrollment. And -- in addition, the -- behavioral health care manages the organizations are going to send out enrollment, two populations are brand new to behavioral health MCO, individuals receiving long-term care in nursing home facilities and individuals formally in the aging waiver. Both of those individuals received, behavioral health service through the Medicaid fee for service program.

Behavioral health MCOs will being sending out packets to everyone, who is new to CHC but many of the individuals in CHC are enrolled in the behavioral health MCO those two populations those will be receiving eastbound rolement packet from their county based behavior health MCO from the 7-10 days days of enrollment, so they should have it some time next week.

That's where we're at. Day 3, for

the southeast implementation.

Does anyone have any --

[laughter]

Does anyone have anymore questions.

>> SPEAKER: Do you have any updates on LIFE enrollment and can you give us any data on the southeast compared to the southwest?

>> KEVIN HANCOCK: So we do want, is as everybody remembers the LIFE plan is enrollment alternative to community choices we have the program to expand the program, so -- did is not only a -- a viable alternative but a robust alternative we are very much committed to the expansion and -- promulgation of the program it's a great model of long-term care and managed care system at this point we do not have any day 3 we do not have any data compiled for the southeast compared to the southwest. But -- next month we will commit to doing it a comparison and

talking about the impact for the -- for the southeast enrollments. We -- broaden communication about the LIFE program for the southeast implementation, we really do want to make sure to see how it worked.

Thank you.

Also incorporate lessons learned for the next phase as well.

Jim?

>> SPEAKER: I was going to ask about the LIFE program as well. Thanks.

>> BARB POLZER: Pam?

>> PAM AUER: I'm going ask for the record again, for the document we were going to be getting for months now the comparison of the waiver versus a LIFE program so people really know the differences what they're getting in each.

Where are we at with it, are we going to ever get something like that.

>> KEVIN HANCOCK: We have something like that, drafted and --

developed, it is -- it's taken a long time. Because -- Jen do you want to provide a quick update we think we're close to a final draft at this point we're hoping it will be finalized later this month we have it drafted I don't know if we're ready to share it.

>> PAM AUER: How can you make a choice without knowing the difference.

>> SPEAKER: Um we do have a draft and we actually were going to share the draft, of the comparison chart we worked pretty closely with the LIFE providers on in the participant and participant advocate calls so we can get some feedback whether individuals individual understand and understand what we have drafted so far. That will be hopefully next Tuesday report next participant or participant advocate call, then we can finalize it and send it out.

>> PAM AUER: Some of us, you know --

>> KEVIN HANCOCK: We'll share it,

we'll send it to you Pam.

>> PAM AUER: We'll look at it and make comment, we've been waiting for a really long time.

>> SPEAKER: Sure absolutely.

>> KEVIN HANCOCK: Definitely make sure that Pam auer gets it.

>> KEVIN HANCOCK: Great feedback, when we we wanted to make sure that we were providing what is -- special about the those programs what differentiates the programs as well.

>> SPEAKER: Kevin, in addition to those six that I mentioned, who chose an MCO and were, assigned somewhere else we have 8 individuals that chose an MCO.

And our nonassigned to any MCO they are not showing up in HHA exchange or in EBC, two of them without medication, we are the pharmacy told us they were just enrolled from the health insurance programs on the December 31st. So -- um, what do you

want me to do with those individuals.

>> KEVIN HANCOCK: Send them our way you check EVS they're not in Medicaid anymore. We need to explore those.

Pretty quickly.

Is it possible that we, something could have happened what they would lost Medicaid eligible.

>> SPEAKER: No. They would not have been able to, pick out for any other reason.

>> SPEAKER: Obviously we need to say the cases.

>> SPEAKER: Okay.

>> SPEAKER: Gene is the leaden on eligible issues that's for both of those cases.

Okay.

>> SPEAKER: Also have a question about HHA exchange. Authorizations are not, showing up for PPO and speech this is the problem in the southwest and HHA exchange had put them on a

different we were told they were on a home care portal instead of the MLTSS portal they said they were going to fix it, here it is -- you know, southeast implementation of it is not fixed.

>> KEVIN HANCOCK: MCOs will have to answer the question they had different schedules when they were planning to load the questions.

Chris -- Jay and ray would you be willing to jump in on that.

>> SPEAKER: Um, in our case, you need to register for the nonhome care forum.

For the registered for the home care forum.

>> SPEAKER: Why.

>> SPEAKER: PTOP and speech are generally activities fall into EVV in the long term with services, that are the reason the only reason there's a nonhome care port follow is for services that we want to bill through a familiar platform.

In order to -- extreme line our operations. Known home care is built for -- fell into HCBS, you know, time to be original purpose of the platform.

>> SPEAKER: All LTSS services in the service definitions. So why -- why would you be happy to do that, someone else to make that.

>> SPEAKER: It's how we're configured. There's two entry points, the providers need to have, it hasn't been an issue before -- in the last, we have many providers that go into both sides.

>> SPEAKER: Well, they're doing that but -- with the understanding that, it was going to be, um, combined into one, for all LTSS services.

>> SPEAKER: I'm not sure we ever gave that indication.

>> SPEAKER: So I'm -- that's what, the brain injury providers were told in the meeting. So -- um, two weeks ago and -- I don't know, if it was your guys

folks that said that.

>> SPEAKER: Thanks for raising this issue this might be something it's -- it's in the weeds it also related to the MCOs made to the brain injury provider you may want to talk about is this offline we'll give Pennsylvania health wellness and keystone first a chance to respond as well.

>> SPEAKER: We're in the same same position so, there are two different portals depending upon the type of service.

As to whether it's a considered home care versus a nonhome care there will be two entry points for that as well. This is, actually something that -- we just entered into from a -- non-health care portal from AmeriHealth and keystone first we did not utilize the non-health care portal until January 1 I'm not, so yeah -- I would definitely like to get together with you and find out where that information came from, where

you're finding that.

>> SPEAKER: I'll be reach out to you offline you know what is communicated to you exactly what we need to do to address this concern.

>> KEVIN HANCOCK: Okay.

Any other questions about the southeast.

>> BARB POLZER: Luba.

>> SPEAKER: Just a question about the screen, what health risk assessment did they receive, does the consumer receive?

It's one of last bullets, where it says risk assessment, provider change form et cetera.

>> KEVIN HANCOCK: All 3 of the manage the care organizations are required to do a health screening for everyone in the HealthChoices some will go through a comprehensive needs assessment if they're in need of term services and need, are you talking about the specific screening they use.

>> SPEAKER: Do they receive an individualized health screening assessment or outcome.

>> KEVIN HANCOCK: They're required to receive a individualize the health screening the 3 MCOs can provide the specific screening they use.

>> SPEAKER: We have a -- a it is, the same health, screening we also use for our dual eligibles SNP population we have a consistent data set, across both of the lines of business.

The it is a relatively short 20 you know question you know survey that is either you know a person will submit directly or is, you know, administered telephonically someone doesn't respond we go through the survey with them, it's our first pass to get to know the NFI members where we won't have the same sort of comprehensive screening from the INTERRAI, we use this to focus the care resources identify unmet needs one area we found it very helpful are people

self identifying as having LTSS needs that may merit further assessment.

>> SPEAKER: Hi -- Court and counsel I Gordon with AmeriHealth Caritas keystone first we use the prowl plus, created by Hopkins it gives us a physical health score and LTSS score if they score high for LTSS needs, then we sent someone out to do the InterRAI and send the referral to the IEB for the evaluation to see if they are eligible for LTSS if they score high for physical health needs they will go into care coordination.

So someone will follow them and -- until they're stable.

>> SPEAKER: And we use the similar process and -- what we found is that a lot of the, participants who are identified as community wells actually have a lot of health care needs, we've used it successfully in the southwest and reached out to the participants in the southeast as well.

>> KEVIN HANCOCK: Thank you are there any other launch questions.

>> SPEAKER: Can you talk a little bit about the transition from yearly to monthly authorizations in the participant directed side? And what the intent of that is, the impact we think, that will have on the services.

>> KEVIN HANCOCK: I think did we transition monthly with the southeast.

>> SPEAKER: We did and there was communication that was sent out to the SCs follow-up information about moving to a monthly authorization.

It is the -- it's to support the way the managed care organizations are authorizing.

Those services.

If you want more information, Jesse I can get you more.

>> KEVIN HANCOCK: And -- Barb made the point this is something that is already been in place for the aging waiver.

It's been in place for some time it wasn't new to the department to have a monthly configuration, but -- the question your question on impact, I'm curious about, go foresee it as being a challenge.

>> SPEAKER: It has to happen accurately which I think has been raised earlier.

Um, wondering if there's something else behind it, around if the department of the MCOs if there's some other issue behind it around wanting to have tighter analysis control on around hours connected to personal assistant services in the consumer directed system, if there's some sense that somehow, authorizations in that universe have not been accurately done or, just trying to understand what, if there's motivation beyond logistics how it, how it gets processed if that's all it is, that's all it is --

>> KEVIN HANCOCK: Just shorter

time period.

There's no broader policy objective from changing from monthly to yearly I will have to say you do, a much more thorough job of analyzing the the services on a monthly basis than a yearly basis because of you have a lot of -- you can recognize more emergent issues from month-to-month. No objective other than it is required for the MCOs.

>> SPEAKER: Thank you.

>> SPEAKER: So part of the other Rationale part of the discussions with, PPL as we're going through this, is individuals could change on a monthly basis if you're doing annual authorization from an MCO, someone switches, it causes issues from a payroll perspective. Um, if the -- authorizations are not backed out timely the new authorization is in play in the system that's another reason, why that we moved to a monthly authorization.

>> SPEAKER: Thank you it was

really driven by the financial management services vendor.

Because of the fact that we can have changes and, participants can change plans at any time.

So, it actually, was not really driven by requirements of the MCOs, more so requirements of the financial management services vendor in being able to accommodate the changes from MCOs.

>> BARB POLZER: Pam?

>> PAM AUER: Stick with the question, would that be monitored from the consumers perspective? I worry when I see the shorter time frame monitoring one month I used X number of hours I used ten the month before. You know -- I think are they going to be saying okay you didn't use those hours maybe you don't need them we'll cut them, is that going to be monitored to make sure that has happened generally in the past, back when we just had Act

150 they would be monitoring like that, say okay well -- you didn't use so many hours we're going to, bring you back I know that's going back a long time ago. But still, from a consumer's perspective I would like to know that's not going to be a major impact on consumers.

>> KEVIN HANCOCK: So we have an ops report that shows a reduction in hours so it's something we'll be monitoring, pretty much on a -- monitoring on a monthly basis.

Just to be clear, can't be like -- changes and hours can't be arbitrary that's the whole point of person centered service planning, so it is something we'll be looking at very closely if we see arbitrary changes across the service plans that's something we'll be challenging the MCOs about.

We have once again we're collecting data on changes to service hours, but that would be, fundamentally undermining what we're trying to do with

the person cents service planning.

>> SPEAKER: We have a number of questions that came over the phone.

>> KEVIN HANCOCK: Let me do the clarification I received a request on your ability to change plan you can change at any time. Generally speaking if you change in the first half of the month, it will effective the first of the following month, if you change the second half of the month will be the first of the month after that.

But every single month may have a different date based upon when the cut off can occur it may not be the 15th versus the 16th of a given month.

It may be a change on -- February 11th, will be -- the cut off date, for a March 1 effective date.

Versus a -- could be even a -- March 18th date for a April first date. So it can -- the date it can be different from month-to-month but generally speaking, it is the first half versus the

second half when the date the change will be effective.

>> SPEAKER: Dating rules are posted on the web site.

>> KEVIN HANCOCK: Dating rules are posted on the web site. Thank you Jill.

>> BARB POLZER: I love dating rules?. Laughter]

Okay.

Question, what are the specific data issues this came from mark on the phone, I apologize, this was, really early on I did not get the message.

>> KEVIN HANCOCK: So, some of the data issues we've seen so far are similar we've had some, some -- we're actually still exploring what those data issues are at this point. We have heard there have been some data configuration issues with -- this is Daniel Hull everybody MDS we're ashamed he is wearing Ravens gear.

>> SPEAKER: It's purple Friday

12346789.

[laughter]

>> SPEAKER: Ray likes that.

>> KEVIN HANCOCK: So we're exploring it we think at this point some of the data it result toss the source data legacy case management system we're looking into it, more to come on that that's what we're looking forward to.

>> BARB POLZER: We have a question regarding health risk assessments do they include housing safe stability, behavioral health dental care needs and transportation barriers.

>> KEVIN HANCOCK: We'll turn it back to the MCOs to answer that question.

>> SPEAKER: I should just pull up a chair.

>> SPEAKER: Yeah I am confident that they are, our risk assessment includes, most of those points I know it does talk about behavioral health housing I'm not sure if it touches on

dental.

That's something I can confirm, I have it on the form in front of me.

>> SPEAKER: I don't have the form in front of me either but I'm pretty sure all of those factors are included there, of course.

No make or social determinants of health we want to make sure it's included in the over all assessment of the participants health.

>> SPEAKER: So that's the same for the -- that actual scoring I told you LTSS physical health the transportation and are outside of so any identified need for that causes a referral for housing or transportation.

>> KEVIN HANCOCK: The only other thing I would add is part of this risk screening purpose is identify a unmet needs for participants to see if they need a more thorough comprehensive needs assessment the expectation that raises a good point about dental services that

may not be listed something that is covered I agree with Morris that is a social determinant but a health determinant of health but -- we would expect that, unmet needs are -- identified comprehensively through the risk screening.

We being the department.

>> SPEAKER: Linda Litton.

I can only go by my own experience which I was going to do after the meeting, but I think it needs to be brought up.

I did not make a choice by December 13th so I was auto assigned.

I did go and make my choice prior to the 21st.

They put me through starting February 1st.

And no one, I just yesterday, got -- the packet from the auto assigned people and then they got the letter of change. From the second one that I chose.

I got both of those things yesterday.

I didn't have a -- a card in either of the packets no one has called me so now I'm starting to see the frustration that is brought up by a lot of people that come to this meeting and, you know, tell us about what issues they're having.

>> KEVIN HANCOCK: So just to be clear. The you selected a managed care organization prior to December 21st?

>> SPEAKER: Yes.

>> KEVIN HANCOCK: It should have been effective on January 1st.

>> SPEAKER: Kevin I talked to her before the meeting I followed up with Ginny you're open UPMC as of January first. It must have been a miscommunication from the IEB caller you're open to UPMC January 1.

>> SPEAKER: Okay I'm still waiting for them to call me.

>> SPEAKER: UPMC should be in touch with you sending you packets out ray you can follow-up make sure she has

everything.

>> SPEAKER: We've started our you know our -- HCBS initial outreach calls focused on service disruption those are occurring in the first two weeks, we're still early so -- hopefully you'll be receiving a call very soon.

>> SPEAKER: Okay thank you.

>> SPEAKER: We're doing the same we're calling all of our members and we're, only day four we're going through, everyone and we have a lot of staff dedicated to reaching out to all of our participants.

>> KEVIN HANCOCK: Just a point on -- Linda's case you might want to talk about what word you received, where long-term care is a little different.

It's up to you.

>> SPEAKER: Yeah I am, long-term care eligible I'm at Inglis house.

>> KEVIN HANCOCK: The question for the MCOs how you're doing outreach to the nursing home facilities during the

essential period as well.

>> SPEAKER: Large population.

>> SPEAKER: With institutions, like in the case of UPMC the service coordinators have begun visiting facilities so they will go to each facility and make an introduction to each participant, that is with us, so -- that may not happen as quickly as sort of our initial HCBS phone calls.

So, that -- but um, I'll -- check in to see what is happening with your situation in particular.

>> SPEAKER: My other question was, since I made a choice prior to the 21st, why was I showing up as an auto assigned.

Because that would throw all the numbers off, in the research.

>> KEVIN HANCOCK: So actually in the numbers the numbers we have yesterday you would not have been shown up as auto assigned you were auto assigned because you didn't make

your selection in the November time frame. So you were, plan was automatically selected for you at the initial auto assignment date you over road that auto assignment by making the plan date prior to December 21st. That's the way the data will show.

But in the system you would be shown as auto assigned when you -- just -- just, by the way we, manage the enrollment data.

Any other southeast questions.

>> SPEAKER: Can I respond to the first question.

Before I forget it.

Just how we're reaching out to our nursing facility homes you have the nursing facility service coordination team they're out in the field right now they're going to all of our facilities and meeting with all of our nursing facility members.

>> SPEAKER: We're doing the same this is Kathy from the AmeriHealth Caritas, keystone first we're actually

going out and meeting with the administration, finding out what their policy is how they want us to come into the building sign in introduce ourselves do they want us to stop by, the office first so -- we're working through that process.

Um, I was director of nursing in a nursing facility I would not want people walking in and out without them -- ensuring the safety of the residents.

>> KEVIN HANCOCK: Good point as a department we support that the managed care organizations are working with the nursing facilities themselves to schedule and configure how they're going to be doing outreach to the residents.

Any other southeast questions for me.

Okay.

Imagine many more southeast questions for me next month.

Okay.

Going to give a quick update on southwest operations I think that -- then Randy are you going it jump in to the -- the monitoring report data?

>> SPEAKER: Sure.

>> KEVIN HANCOCK: Sure. So -- first off, we still have corrective action plans in place for the managed care organizations on person center the service planning.

That is evolutionary process as I said before.

And, we're developing mutual degrees of comfort on the person centered planning process is taking place involves a lot of education a lot of communication and coordination, with the participants Medicare coverage and Medicaid coverage and behavior health coverage. Issues like transportation and service provision need to be taken into consideration.

Communicating into participants is important in all of this, as I said it's an

evolving communication with the MCOs and then until we have a comfortable level of, of the communication that corrective action plan will continue.

And with regard to the denial notices UPMC and AmeriHealth Caritas have both been approved to send out denial notices, Pennsylvania health wellness had has been approved to send out the denial notices and continue to work with them on some of the key language points that they have in those denial notices as well.

Then I'll turn it to Randy so when will talk us through some of the monitoring reports how they're doing in the southeast in answer to your earlier question this is where we would show transportation delays data and what we're doing and something we can have listed on the web site as well.

>> KEVIN HANCOCK: Randy is a little under the weather today.

>> RANDY NOLEN: Little under the

weather did know I was doing this until 3 seconds ago.

[laughter]

>> KEVIN HANCOCK: I like to keep my staff on their toes it's good for you.

>> RANDY NOLEN: We'll discuss it later.

[laughter]

All right the first one we want to take a look is the ops2 report is the participant hot line call results collect these on a -- a monthly basis you can see the number of calls that come in per thousand participants they fluctuate up and down, January is going be to the heavier month, call volume for the first couple of days in January for the southeast are, incredibly high.

As you can see, what we measure is the -- whether to answer the calls within 30 seconds all meeting the requirements for that, the requirement is it would be 85 percent or above.

They're all well over 90 percent for

October and November they're in pretty good shape for that.

So that's -- kind of part what we're looking at on the monitoring for ops2.

The second piece we look at for that is, the number of -- calls that were abandoned and -- the agreement states it needs to be less than five percent and they're meeting that criteria as you can see from November, all below 5 percent they had been below 5 percent for that period of time for the first week as we move into the southeast I think the call volumes have been higher than the expectations in the MCOs so for the first couple of days they're not making their SLAs but they are working on moving staff around to answer calls in a more timely manner they are, putting things into place and the call volume and how it was handled better than it was on Tuesday, it is a work in progress for them, yes. Pam.

>> PAM AUER: When you say hot

line calls, are these calls that are people calling with complaints or anyone calling in IEB for.

>> RANDY NOLEN: Anyone that is calling the MCOs participant hot lines. Participant line for the MCOs.

>> PAM AUER: Um, all right.

Apply or complaint.

>> RANDY NOLEN: Any questions from the MCOs ID card, eligibility, provider network issues.

Providers calling in and if they have a provider call center also that asks about claims and -- eligibility so it's anything question they may have for the MCO.

>> PAM AUER: Okay thank you.

>> RANDY NOLEN: Uh-hum.

So move willing onto ops3 and 4 that's the complaint and grievances.

This is the report we're collecting as you can see we collected by quarter the number of complaints, filed by per 10,000 participant the complaint numbers are very low.

They're a little lower for AmeriHealth they have a process in place where they try to resolve stuff online before it becomes a full blown complaint.

But they're all within good proportion in regards to the number of complaints that go through.

Complaints can then go to a fair hearing if they're not initially resolved by the plans. And we do have some information in regards to that as well.

So complaint wise, that's what we're looking at.

The next slide talks about the number of grievances per ten thousand participants.

Again the numbers are below 20 per 10,000 is a fairly low rate in regards to that, it includes any grievances that, may be asked about, whether expedited or regular grievances top 3 types of categories for grievances -- for AmeriHealth it has to do with prescriptions, medical or dental, PHW,

begin interruptions past services and home health services UPMC, prescriptions home health and DMAs prescriptions are are a major concern. And a lot of those center around with issues around pharmacies most of our population, should have prescription coverage through Medicare.

But a lot of times the pharmacies don't understand how how to bill properly and then, -- participants are not getting their medications right away. So there's some complaints and grievances that come in based upon that, there's also some issues where maybe the medication has been changed because they're attempting to get people off some of the medications that they're on.

Or -- you know like the pain medications stuff like that. So there's some grievances come in based upon that.

Gosh I'm terrible.

[laughter]

The other thing on Ops3 is the grievance decisions in favor of the participants so this is once the, MCO takes a look at them, how many are found in favor of the participant, um, as you can see, it ranges from 33 to 59 percent based upon the plan.

So -- for 2-3 plans at least half the time it is found in the favor of the participant.

And in situations where they're not, these can go to a full appeal for that service.

Any questions about Ops3 or 4?

All right ops7 is information in regards to our LEP, or -- alternate formats for language.

As you can see, requests have come in for TTY and PA related sign language for 1,000 participants is 0, 0.

For UPMC is fairly high.

The reasoning behind that is -- they have mistakenning put the TTY on another letter they got a lot of phone

calls into that line based upon the fact they had a wrong phone number on one of the letters. So they just basically used that number is closer to 0 than it is they reported that based upon the error they had in the letter.

Another monitoring piece of that report is number of telephone calls, that have requested language interpreter, again, the number is fairly low in regards to that AmeriHealth had about 43 per ten thousand and the other two plan had less than 10 percent, 10 individuals per 10,000, so the numbers are fairly low once requested a traditional plans. Some of the requests that came in for additional languages is -- um, Spanish Russian, ukraniian and a couple for Chinese and hand full for Vietnamese and other languages.

So, it has been a fairly, small percentage have been done with that.

Our anticipation is that in southeast we'll probably see a lot higher numbers,

because of the more diverse language population out there.

The other piece of the ops7 report is the number of inperson language interpreter requests that they have had, they all have been fairly low.

These are individuals that require someone to go with them on appointments or meet with them in person to translate.

And those requests have all been very low from what they're showing.

Another piece of that report is, the number of translated or alternative format materials that were requested so we have the inperson piece and the -- the material requested.

As you can see, the from the request, it is, still a fairly low percentage.

In regards to what they're doing.

There's been minimal requests for alternate formats some for large print information and there was a small amount for Braille and it was one request

for electronic format for an individual.

Number of complaints related to the communication barriers again very low per ten thousand, AmeriHealth and UPMC did not have any, PHW had a very small amount.

About 3 complaints is what it was in the third quarter so it is -- um, their handling the situation with those requests fairly well.

You guys can ask questions as you go along we'll answer them but -- um, where we are on the Ops8 report, missed services report the first show is percentage of hours, the agency could not staff.

Again, percentages are very low less than 1 percent for all 3 of the plans.

So this is information, on the number of home health or home health services, past services that were not provided.

By the agency.

We have been working really hard over the last six months to get this report

formatted reformatted and accurate we have got a lot of input from providers out there on the type of stuff they could report in the type of format they could report it in.

We've probably changed the format on this report a dozen times.

So to meet the needs not only of the MCOs but to meet the needs of the providers out there. So there's been a lot of information, that's gone back and forth with this.

A lot of it was based upon what could be reported back through HHA, so we've collected a lot of information based upon this.

So really reporting on when the agencies were unable to staff the service and therefore the services wasn't provided they didn't have staffing for it.

Concentrating on services that were not provided but it's because the participant or family received the service.

Or a family member was there to

provide the service for the individual.

And then, the third area that we're reporting on is, services that were not provided because the participant was actually hospitalized unplanned hospitalization. Where the agency did not know they went out to provide the services found out the individual was in the hospital.

So we're taking a look at all of those types of situations with that again the percentages are very low as far as missed services are occurring out there for all 3 of the reasons actually.

Because they're all even if you look at the second part of it is the number of hours participants refuse services it's less than 1 percent. Then the number of services, that were missed because of unplanned hospital visits is less than half a percent for 3 MCOs. So our missed services are fairly low as far as what we're collecting.

Then the next report is ops21 which

is person centered service plan changes. These are changes to the service plans obviously in the first six months we have very little service plan changes -- as new service plans are being done and we've shown increase in services -- still less than 2 percent across the Board.

More category that you're probably interested in is the number of person centered plans had decrease in services.

Less than half a percent, across all plans in November, and anticipation is is that as all 3 of the MCOs are now in the process of issuing the denial notices and change in services we may see increases in the numbers is something the department will continue to monitor.

As far as the decreases in services and the denial notices but you may see these numbers start to go up somewhat based upon that.

And the other thing we look at is the percentage of decreased due to the MCO's decision to reduce services

following assessment.

This is the chart that we're really changing the based upon the fact that we look at denial notices and numbers across the Board up until this month are either 0 or .1 percent.

So, the anticipation is we will see some changes in that as the service plans are redone and denial notices are issued.

That's what the next two slides show, as far as the table goes.

As far as the decisions made, reducing plans so -- we will take a look at these and continue to monitor the amount of hours that are being reduced.

We will look at any service plans that are reduced by a certain percentage, 25 percent or more, we will look at those hours, we continue to review all of the denial notices on a -- um basis they send them in they have to send them simultaneously we have to continue to look at those as we go through there will

be certain ones we will pull, we will ask for the assessments ask for the person centered plan, we'll be reviewing some of that information, as it comes in also I think the last report I have is the QMUM7 report that's the denial log we get in that take's look at, the denials across physical health, transportation, different things like that.

As you can see the percentage of HCBS, authorization denied, is fairly low.

We have made again this is one of the reports we made numerous changes to. We have separate tabs for physical health separate tabs for pharmacy.

Dental.

Transportation.

We're looking across all of the -- the services, we will be reporting out more on the physical health side of it starting in January we'll see more reporting coming out based upon that this is reporting as far as authorizations are being denied we had to do a lot of

modification to the report to be able to capture how the requests are requested from the physical health side, dental and pharmacy side we made some multiple changes to the report to capture the data appropriately we'll be able to start gathering accurate data, as we move forward in 2019.

>> PAM AUER: When you were you able to it's great to hear what the denials are for, is there going to be a break out we can see what kind of types I don't know that's the way I understand it I agreed to hear you say it, if I could see the -- the categories of denial reasons, that would help.

That would also see you know, more from this reason or more for that reason or -- you know if it's more for the pharmacy, percentages are lined up with the denial types. Thank you.

>> RANDY NOLEN: Uh-hum.

>> KEVIN HANCOCK: Okay.

Thank you Randy. Anything else?

>> RANDY NOLEN: No, I think that's the rest is yours.

>> KEVIN HANCOCK: Okay.

Okay.

>> SPEAKER: We're tracking the reduction in hours, is there analysis, maybe it's not -- out yet also the average -- new hours that are approved in other words, it will be interesting it understand under managed care whether there's any change in the average plan to get approved going forward as compared to where they were in the past one thing to reduce a current person's hours another question to look at, future people entering the system are they somehow ending up with more or less hours than before the transition.

>> KEVIN HANCOCK: I agree with you we would want to look at both to be honest we would want toic Miranda sure that we want to make sure the plans are designed, and the hours are design, for the person so the part of person

centered planning process if that reflects a lower number of hours it is possible, that -- that the, existing service plan hours were inflated, but what's important is the service plan hours are tracking to the needs of the person.

What we want to evaluate regardless where they're in the program, their hours are reflecting their expressed needs and preferences. So -- it will be part of the validation process.

>> BARB POLZER: Ma'am? Could you please identify yourself.

>> SPEAKER: Rich Wellin.

>> BARB POLZER: Hang on a second.

Thank you.

>> SPEAKER: Hi there, Pam from the Pennsylvania health law project I just had a -- quick clarification here. When you're saying, percentage of requests denied is that just including complete denials or also including cases where request is approved other than as

requested or cases like that.

>> RANDY NOLEN: Any time they're denying a requested service even if it's altered or another service is put in place, say you request 80 hours they give you 70 that's considered a denial.

>> KEVIN HANCOCK: For this report.

>> SPEAKER: Thank you.

>> SPEAKER: My question is, this is Rich.

Is there any metrics on the quality of service provided? So um, what I've heard is really encouraging but where are the metrics whether or not people are happy with the services that are being provided.

>> KEVIN HANCOCK: So Rich we're so happy you asked that question, in just a few minutes we'll start -- the quality presentation -- that will talk about how the department is doing. We'll be printed by Wilmarie Gonzalez, Dr. Kelley and Dr. Appel.

>> SPEAKER: Great.

>> KEVIN HANCOCK: We have the CHC MCO contact information, that includes the -- email address, web site and -- 1800 or 1855 number and, we also have the standard resource information which includes the Listserv, the information on the community HealthChoices web sites. And then we also have the MLTSS sub-MAAC web site that includes these presentation as well as the transcript from the session you can also submit questions to our E mail for CHC, RA opinion PWCHC@pa.gov we gave you the numbers. 800-932-0939.

Providers (180)932-0939 and participants (180)757-5042 for participants. And then the independent enrollment broker line is 18448243655 I don't have my glasses on. And -- you can also visit their web site enrollchc.com, if you want to make a plan selection or plan change on that.

With that are there anymore

questions.

Any questions about southeast and southwest before we jump into quality.

>> SPEAKER: This is Kevin just more of a comment now we're kind of live in 2 out of 3 big regions in the State which is I'm sure it will be part of the quality discussion as well which is the, as we continue to expand the opportunity for people to enjoy community living having a well trained with living wages health insurance, work force is going to be critical.

In making this reality not any new to you or anybody else in this committee in trying to figure that piece out.

But, it would be important to understand, what is the reimbursement rate that managed care organizations are providing or able to provide to providers to be able to meet those standards and what is the impact of the community HealthChoices on the ability to do that? And so, that is just something and -- I

think, I'm not sure the MCOs talked about started to talk about this previously there are some work force ininitiatives I think were included as part of the original conception of the community HealthChoices being able to check in where are we at that in the southwest you know we've been live for a year outside of the continuity of care period, and -- the other reality is not all providers are, created equal so to speak in terms of their investment in the work force and, their ability to provide a high quality you know, consistent well paid work force and so, understanding, the needs have a reimbursement rate rewards provides investing in the work force in away that allows them to have a work force is high quality as -- is critical so just more of a comment I know it will be part of the I imagine it will be part of the thinking about the measuring quality but the idea I'm happy to hear the paper performance ideas and other ideas that

are kinds of, part of the next phase of this.

It will be a really important initiative to making home and community based living more you know, more accessible and reliable and, consistent for everyone.

>> KEVIN HANCOCK: Just to be clear, the department agrees completely, that to be able to do what we need to do or want to accomplish with community HealthChoices requires a robust direct care work force and that includes a -- a viable, viable employment opportunity for direct care workers as well so how that shapes out, is very much open to frequent discussion. And -- we look forward to talking about that here as well as any other venue that we'll be willing to be open to that type of a discussion but, I would also offer that should be a focus of, a future MLTSS sub-MAAC what the MCOs have been doing and reporting back to activities they committed to do, not only as part of the proposal for the

program, but also, what they discussed publically in what they were planning to do, in the long-term care council and other venues.

Thank you.

>> BARB POLZER: Bridgett.

>> SPEAKER: This is Bridgett from Main Line Rehab associates I have a question for the MCOs I gives guess, since many of the service authorization forms we have for the consumers that we're serving were end dated 12/31/18 and we can't see the majority of the people that we're serving in HHA we can't see new authorizations many the MCO portals should we continue services as usual as part of that continuity care period, even though there's in there's no authorization for them, I'm suing we should continue.

>> SPEAKER: So Bridgett for it's a yes, from we reconcile get everything right.

What we've been asking for providers

to do is checking HHA, you know -- there are authorizations that don't look right, make note of that.

Make note of that, send to in the spreadsheet we're working through the fixes generally speaking -- if there's an authorization, that -- is different than what you expect -- there's any provider time Sunday us a screen shot what is many HIXUS or SAMs verification for us, that's enough -- when the information plan -- moving forward -- continue servicing with the authorizations in place, we'll work with you on the -- on the getting the this right in the system.

>> SPEAKER: With HIXUS I thought people were removes from switching over to CHC we don't have screen shots right now I guess, if we have the old SAF form that will suffice.

>> SPEAKER: Yeah.

>> SPEAKER: Okay.

>> SPEAKER: For keystone first community HealthChoices you'll follow

that the SAF if you're not seeing them in HHA or the -- number of units or the -- duration you're not seeing that, we are, honoring those are 12/31 we extended through our system through the couldn't intoity of care period throughout the continuity of care period there will be reassessment -- in the -- that will be coordinating in the, working with the providers -- if there's any change in that service plan.

It is someplace on 12/31 continues through the continuity of care period. We'll ask for a copy.

>> SPEAKER: Even if it's end dated on 12/31 it's okay.

>> SPEAKER: You're seeing authorizations as end dated 12/31 please continue to provide that service we'll work with you to address the inconsistencies that are in the authorization.

>> SPEAKER: Okay thank you Kevin and Randy and now we're going to hear

from Wilmarie Gonzalez of course the CHC quality activities.

>> SPEAKER: Good morning everyone.

I think I'm sicker than Randy.

>> SPEAKER: You were in the islands you can't be sicker.

>> SPEAKER: I know I came back from vacation I'm sick as a dog I'm here because this stuff is important.

I have a pleasure to be here both with Dr. Kelley and Dr. Appel we'll talk about the quality and -- just to echo what Kevin has said before -- um, community HealthChoices -- um, really has been focusing on everything that we're doing, impacting quality so you heard today, from Randy, with regard to the monitoring reports all the data that -- that the MCOs have been submitting that is really important to know, because -- there's no point of collecting data, if we're going -- we'll not do anything with it, so this is, this is the form to do it this

is the form, to -- for us to share with you, what we have been receiving, by the managed care organization and have a dialogue so we can continue to improve and strengthen the community HealthChoices program. So today we'll talk about is home and community based Cahps, is a survey, we adopted in Pennsylvania we have done, multiple presentations, last year, on the importance of the survey, this survey really gauges and measures experience of care by consumers -- we ask the MCOs to implement the survey in the southwest for our participants and today we'll talk a little bit about some of the findings and the results from that survey.

I wanted to today we're not going to cover the evaluation plan survey that has been conducted by the Medicaid research center. At the University of Pittsburgh as many of you know we do have a 7 year evaluation plan for CHC.

But just would note that the survey

has been completed and this is a follow-up, 6 month survey, from a server this the MRC team have conducted with the HCBS consumers in the southwest we hope to be able to provide that information, and up coming -- MTLSS meeting as well so you know what findings, have come up in the comparison between the original survey when we survey, consumers and then six months after, community HealthChoices was implemented in the southwest.

Really important today, we're going to share a little bit about, what we've been referring to as KPMs key performance quality measures we'll walk through some of the information we've gathered.

We are also talking about the Pennsylvania performance measures this is some of the new measures that we have identified that have been important.

We have been able to gather a lot of the information not only historical data

data we have collected -- but, there's been a number of resources has helped us sort of identify, what these quality measures should look like so we can work with the MCOs, to continue to improve, um, and strengthen the community HealthChoices program and just for clarity, there's a number of data sources that we collect a lot of the information we collect them from the independent vendors that the MCOs contracted to do the various surveys, we use IPRO is a company that is required for every managed care program, which is the EQR.

The Medicaid research centers I mentioned before they look a lot of our historical data you heard from Randy today a lot of that data, that he talked about today, also, impacts some of the stuff we're looking at as as far as quality measures and obviously, monitoring -- making sure that we have to do on the oversight of the side, also impacts what

we do with community HealthChoices, next slide.

So this is just a diagram to just kind of, highlight some of the things that, we're going to talk a little bit about today. And, again this slide is a repeat slide so a lot of you have already seen this slide but for us it's really important, to sort of -- kind of -- put in plain view what we're going to talk about today we'll talk about the quality measures -- you'll from we will share with you the status of where we are, with the performance improvement project.

As well as some of the area of focus for this year. We'll walk through some of the southwest findings from the 2018CAHPS survey we're requiring for this survey in Pennsylvania to be administered on a annual basis if you have not heard about the survey across disability orientation for the survey tool it's a validated and tested tool been used in other states HCBS environment we

wanted to adopt in Pennsylvania. Last year we invited Connecticut to actually share their experience we have a consumer that shared her participation participating on the survey itself.

Across disability consumer experience survey.

It is -- it's intent to he little It's feedback from beneficiaries receiving many he had okayed HCBS services and support across different target populations as you know the folks we serve and HealthChoices are diversion from the individuals of physical disability, individuals with intellectual developmental disabilities -- um, individuals with brain injury and, other individuals with serious mental illness. So this tool was really designed, to be accessible to as many people with disabilities as possible including those with cognitive disability. This for us, in Pennsylvania, this really is important, for us to one of two surveys that the MCOs

are going to implement this is the first time we asked the MCOs to do a sample.

So, the slide just really gives you the high level detail about the -- what we did, with the survey one of the things we asked the plan to also do, besides using the tool and identifying a vendor to implement the survey is to adopt the supplemental employment survey which you know is very important we want to make sure that the consumers we are serving on CHC also have the opportunity if they want to be able to be employed we also added very specific questions, you'll hear some of the feedback we heard today about people asking questions you know what is happening with person centered planning what about transportation housing and debittal this is the opportunity, we adopted with the survey to be able to ask participants directly tell us a little bit about your experience so if you, if you received an offering on housing, or, employment

dental did you actually get it, this is where we added those kinds of questions specifically for Pennsylvania, which, because we know it's very important.

We decided because it's the first time we did in Pennsylvania, we asked the plans to only conduct the survey via telephone this last year, but this for 2019, our plan is to -- connect expect that the MCOs will implement the survey, both telephonically and by person as well.

Interviews last year were conducted during the period of August 23 to September obviously, it varies within some of the MCOs did it shorter periods. Some of them, took the whole time period they did pretty it, they asked to do a collective sample 400 surveys. They went over that.

They did over 708 completed surveys listed there, where the plans how many people they actually interviewed.

That is by each plan good news is the

MCOs submitted their findings on a timely basis which is important right?

They also made sure that, as we looked at the reports, there were some inconsistency and some of the data, so obviously we work with the MCOs to have them resubmit they did, we're still in the process of reviewing them but to the we'll share a little bit about the preliminary findings.

Next slide.

The role of the survey, really is as I mentioned before is to really look at cross disability and ensure that there's opportunity for participants having a voice.

On their experience of care so for obviously for Pennsylvania CHC is really important questions reflecting a lot of different areas I'll talk about that. The important thing about the survey is that we want the information to be meaningful not only to us as a state, to improve, the quality of services for

consumers, but we also want to make sure that if there are areas for improvement by the MCOs we need to be able to do that.

Next slide.

So here's a list of the domains again this is a repeated slide. But it just gives you an idea of the kinds of things that the survey actually asks consumers there are 9 domains and domains we need categories. And -- the ones that are important Dr. Kelley will walk through them, out of the 9, domains, some of the things that really important I think are, getting needed services from personal assistant, or behavioral health staff, getting needed services from homemakers.

How well, did your homemaker communicate with you and treat you.

And choosing your services.

Really important for people to know that they have a right and a choice, to be able to select what services they want so

as I mentioned before, last year, this survey was only, done for the southwest. And this year, our hope is to include both southwest and southeast combined.

Next slide.

Some other services and provider focuses of the survey included common services, in common providers and so -- the kinds of services, again, you've heard it today, throughout, um, people are interested in transportation. How will are they receiving services, have those options ever been offers to the consumers and employment assistance I'm highlighting some of them they're very important with regards to the providers area case manager and homemaker are also important n slide.

So some of the characteristics of the Respondents who participated in the 708 surveyed as you can see the age group, was a 50 almost half and half of over and under 60 participant which is is good that's good for us to be able to get a sort

of a balance of the consumers that we're serving under community HealthChoices with regards to whether male or female we're serving under the CHC program this confirms the majority of the folks we're serving are if he yay females rock.

[laughter]

With ethnicity and race, sort of varied those numbers I think we need to look at them a little bit more.

I think important on the education category 67 percent of the folks participated on the survey had high school grad, GED or some college that's really important to know because as we offer employment opportunities for consumers if they are interested in employment, this really shows we do have you know we have faux folks out there, providing services is that may be eligible for employment. Next slide.

With regards to other characteristics of the folks that participated in the survey you know as far as health status

is concerned and again, a lot of these responses are responses by the consumer.

Is they -- they share that their health status was good or fairy think that's important.

Over all mental and emotional health, 64 percent, shared with us that -- that they felt good or, fair as far as their emotional health.

With regards to residential independence I think that we highlight that had in in red that's really important you know we're 50 percent of the folks that participated, in that survey and while the survey I think is still small, um, it really shows that there are a lot of folks that are out there, who are living alone and that's really important to know because -- consumers that are out there living alone, really do need that support in services for the individuals. So I think for the MCOs I think that's really important for you guys to understand

that.

There's got to be some support, um, supports and services that are available for consumers that are out there, so there's definitely opportunity for them.

And then this number for under the you are been and rural county of residence, 76 percent is urban.

Which is natural because that was a southwest and so we hope to see those numbers change when we do the, when the survey is implemented again this year, combining both the southwest and southeast region.

Next slide.

I'm glad this is my last slide.

With regards to assistance received this -- slide, just really -- talks about -- someone else was present during the interview and helped respond to complete the survey. This is going to show you that consumers who wanted someone to assist them in participating as far as providing responses, provided

consent to an individual to help them, fill the survey out with that I will invite Dr. Kelley to walk us through the results.

>> SPEAKER: Okay.

I do want to emphasize these are preliminary results.

They're not finalized we're still going to be working through some various issues we wanted to really get some preliminary information for you. Part what we wanted to do is show you what are some of the questions, that are on the survey what are the things that we're actually, monitoring then there are various ways of presenting the data, part of what, the feedback we need from you is how do you want the data presented to you and, in the future and we publically report this, so -- don't necessarily pay attention to all of the statistics, the in terms of the structure the questions and think in terms of the how, in the future this needs to be presented and again, there were over

700 Respondents, Respondents rate did vary, again there may be some concerns there.

That will be you know working forward in the next year when we do this more extensively we'll require the plan, each plan to submit a much higher volume so we can actually do some comparisons between plans you'll see no comparisons between plans today because of statistical questions.

>> PAM AUER: Question number 8.

>> BARB POLZER: Come to the mic.

>> PAM AUER: That's notify' question.

>> DAVID KELLEY: This is not us making the survey, this came nationally there's an issue around the definition of homemaker services.

>> PAM AUER: How does that fit us.

>> DAVID KELLEY: I'm going to point that out, these are this is a survey.

That comes from it's vetted nationally, been used and -- various

programs so -- again, this is not our survey.

And, I was going -- that is the first thing I was going to points out you're ahead of me is the definition of homemaker is very confusing. Nationally we saw a big denominator drop there, so -- again that's one of the issues, this is not a perfect survey.

Again there's -- only things we can really change on the survey are some of the PA specific questions, that I'll -- get to in a little bit.

So -- the homemaker services, again is defined in the CAHPS survey it certainly can be confusing individuals, did a whole range of personal services.

So I don't want to --

>> PAM AUER: Is that a question our people are being asked.

>> BARB POLZER: Pam please come to the mic people on the phone can't hear your question.

>> FRED HESS: I was about to say

that I didn't hear anything she was saying before.

>> DAVID KELLEY: She wants to know if individuals are being asked about homemaker services.

>> PAM AUER: Question 8, received homemaker services are we looking at -- questions that people in our state were asked and those are the responses because -- that's not a service that should skew the whole results and -- my question, how is that even a fair question.

We would love to have a homemaker services in Pennsylvania, but are these being submitted to the feds -- is that the see you that for.

>> SPEAKER: CAPHS survey, we know this term nothing is an issue a national survey, our vendors have to go the MCOs have been vendors to do the survey they have to go through the normal survey process. Let's ignore the homemaker portion that definition I'll not

get into definition from our standpoint we would just these questions are how are you getting services again for the most part, for personal assistance services and service coordination, folks are using, these services, however I would like to see perhaps those services used a little bit more extensively. Behavioral health services, again this is an issue around, making sure that individuals, with the behavioral health conditions, have their, um, conditions, addressed.

Their getting services this is something we'll be monitoring over time.

One of the previous slides we have 90 percent of these individuals reported, very poor mental health so again, again, this is just, to give us a basic idea of what is happening within the program. Next slide.

This focuses on the personal assistants, staff, this looks at some attributes about coming to work on time.

Are they there as long as their supposed to be there question 15, goes along with one of their key performance measures in Ops8 in looking at -- missed services and again, 81 percent of the time you know people are being notified or they were being told that, someone is not going to come out and -- question number 16 the last 3 months did you need help from staff?

To get dressed or take showers this gets into the specific, activities of the daily living and again you can see, some of the results there, not everybody needs to have help in some of these activities of daily living the question number 17 if you do, how many of you, were able to do that, when you needed to.

So again, next slide.

These just look at some of the activities of daily living and whether or not, individuals have those needs and whether or not those needs are being met. This next slide continues to look at

personal assistant staff looks at some of the services that are looking at individuals whether or not they need help, getting their medicines laid out for them and then, reporting whether or not they were taking their medications.

And in a timely way.

Again, I'm not going through all of these this looks at some of the specific, activities, of the daily living.

>> THEO BRADDY: Can I ask a question.

Are you doing the same type of break down for service coordination in bullet detail?

>> DAVID KELLEY: Yes.

There's actually, another section that looks at the terminology they use it's case management but that is, more specific to service coordination.

>> THEO BRADDY: Like how many times --

>> DAVID KELLEY: We'll get to that, there are questions associated with that,

they use the care management as the -- terminology but it's really service coordination.

So again.

>> SPEAKER: Going back to Pam's point could you just for the audience, identify the definition for past versus what homemaker would be.

>> DAVID KELLEY: The survey I think homemaker services were more related to -- working around doing housekeeping items for those individuals helping them to shop to keep the home safe, to keep the home clean.

Those types of things that are homemaker services so again when we looked at the surveys, again we see a denominator drop in folks did seem to not fully understand what is exactly that meant.

I don't want to get caught up in the homemaker definition I will tell you it's a key thing on the radars as far as we go to rationalize this, next year we'll have to

do some education around the folks that are administering the survey but also to the consumers part what we're also going to be doing is we're going to be providing feedback to the folks that actually develop the survey.

So this will be --

>> SPEAKER: Basically your homemaker would be your care person that came for so many hours to help you on such and such day.

That would be the same thing deck.

>> SPEAKER: Yeah.

>> SPEAKER: Yes.

>> DAVID KELLEY: Some of those services are provided, so that's where it gets confusing because some, some folks may not, differentiate that between personal assistant staff where that may be more focused on the activities of daily living.

Where they're helping you to bake, helping you to dress, helping you to get in and out of the house they're helping

you to prepare meals. So -- again, that is where you know unfortunately this is not our tool this is not perfect.

It is -- again what we, it's the only one that's out there, has been validate.

>> WILMARIE GONZALEZ: Next slide.

>> DAVID KELLEY: This looks at what falls under the homemaker staff, again it looks at household tasks cleaning laundry, et cetera those types of things.

So again, it's not a term that we may not you know, individuals may not be fully aware of what that definition is that may be confusing as is obvious today.

So, again unfortunately it's not our, terminology.

>> SPEAKER: Are you talking about a separate person coming to do that type of work other than a care person?

>> DAVID KELLEY: That's where it gets confusing it mayor -- maybe the same person or may not be the same person. So that's why again two

different domains that are looked at.

>> WILMARIE GONZALEZ: To Dr. Kelley's point this is the first time we're doing in Pennsylvania, we purposely, wanted to do it in the southwest. We -- asked the plans to randomly, lookat at least 400 individuals and asked an independent reviewer to look at it, whatever questions they used they had to use the same questions so these, the results we're looking at today is giving us an opportunity to really make sure that when we do it again this year the definitions are done right the sampling is much larger because obviously we're combining both the southwest and the southeast.

Making sure, that the vendors understand what we're looking for and like Dr. Kelley mentioned educating our consumers this is really an important for our consumers directly to he will it us how well is their experience of care receiving services under community

HealthChoices.

>> SPEAKER: Yeah, as far as I know, people going from long-term care into the community they would have so many hours of a care person Cox and help them they're also expected to help them with shopping prepare meals do their laundry maybe some light dusting all that type of stuff because when people need the help it doesn't necessarily have to be split into a care person and then, just anyone coming in to help with the other stuff.

>> WILMARIE GONZALEZ: That's a good example of perhaps -- some of the questions on the person services and homemaker.

Could have been we can then we can probably say there's an assumption that the folks that participated on the survey looked at all those questions and combined them both.

>> SPEAKER: Yeah, considered the same person because you have a -- a

trust issue with that person and then you trust them, to do your shopping to use your credit card or hold your money or whatever whatever the case may be.

>> DAVID KELLEY: So that's part of why we're presenting this as we wanted this type of feedback we saw this in the results but -- you're spelling out exactly the, we don't necessarily differentiate it's not a term we use.

Unfortunately it's what we're stuck with.

Next slide, yes.

>> SPEAKER: I don't understand I didn't say I'm the smartest person but this doesn't make any sense there is no difference between what the attendant does or whether it does home care it's all the same, how is a consumer going to understand your questions and this be something accurate, when we don't have homemaker, and -- they don't care what the definition is, it all has to be one thing, attendant care service or personal

assistant services all in one, how are you explaining this to consumers they can answer I don't understand this survey.

>> DAVID KELLEY: So again, when we looked at the actual responses most folks, the way the survey I think the structure the PAS services were asked first and there's good numerator and denominators we saw in the homemaker questions come up we saw the denominators dropped we weren't sure people were not sure how to respond this is an area we'll look at the structure of the survey, and -- educator I don't know if we have the option to delete certain questions we certainly want to make sure we're getting kind of the pulse of what is actually happening.

>> SPEAKER: Look at the percentages, they're very high in response to those questions.

So -- to make an assumption, which I shouldn't do. But I would think it would be personal care assistant.

>> WILMARIE GONZALEZ: This is -- this will be an area to follow-up with regards to the definition of the how the vendors actually use the home care definition, and ask questions because you're right.

The response rate is very high.

I would assume, this is an assumption, in a the consumers who participated on the survey, saw homemaker questions as well as personal assistant questions the same.

>> SPEAKER: Right which is why they don't want services cut, because these people are doing all these different things for them.

>> WILMARIE GONZALEZ: Right.

>> DAVID KELLEY: Again the other thing that we'll look at is as we present this with the final information we'll be breaking it out also into a lot of questions, are structured such that you know, do they always do something, is it always and usually we're presenting

most of the time here there's some exceptions always, and usually combined.

We'll be certainly we can make both of those available so that, folks can differentiate you know, between always and the usually responses.

So, again that's why we're presenting this so we're getting, getting good feedback so -- keep going here.

This looks at again the term they use as case manager.

And, I would, you know fill in the blank there with service coordinator.

And again you can see, there's an opportunity for improvement.

86 percent of folks knew who they're -- I'll say case manager I'll use case manager. A lot of room for improvement again but if you know who they were did you contact them in the last 3 months you can see a fairly high contact rate we were asking previously, the questions about are people getting

DME equipment et cetera the 48 percent are folks that, said yes.

You know, I did ask my case manager about that.

Not everybody is asking their case manager. If you look at question number 51 the case manager worked with you to get the services and yeah 84 percent, said yes is is that really good enough that's an area that, if you -- if you -- there's a perceived need the case manager should be working with you to get that service so begun don't focus on the numbers here focus on some of the things we're trying to get to.

>> THEO BRADDY: Another question.

I believe there's going to be some misunderstanding there, whether it is a -- case manager, service coordinator, MCO, versus a case manager in independent living specialist or Center of Independent Living. So again I think there's going to be some confusion

there, and in regard to the participant answering correctly.

>> DAVID KELLEY: Yes and again that's where I think with more education we need to make sure that we're asking these questions, unfortunately we're stuck with some of the terminology of the construct of the survey it's going to be an educational effort that you know that really should be, is these are questions about your in our program service coordination, that is the key element, of really care management.

Case management.

Obvious will you MCOs also have, individuals that are working with those service coordinators, um, but again, you're right.

Again, terminology is, what we were given.

As a construct and -- again, as we're implementing as we're rolling out and more of the surveys we want to make sure that we're doing this in the way that

individuals have a full understanding what is being asked.

>> SPEAKER: I had a quick question. Related to the -- the assessment of the care managers and the personal assistants service providers.

Earlier there was a slide with number of people that had assistance filling out the survey are there questions who provided that assistance so you can determine whether say you notify what percentage the people say their service coordinator is 100 percent great all the time. Had this service coordinator assisting them and filling out the application, it seems like there might be some biases, some people may not be as comfortable being as honest when their getting assistance from the person they're assessing.

>> WILMARIE GONZALEZ: We have that information as well we'll be -- we have that information as well okay.

We have that information as well.

Again, these are all preliminary findings I mean, part of the reason we wanted to share with you all today was because this really is a way for our consumers to really voice their experience of care. It is not the service coordinator asking the question now, the consumer has a choice, if they want their direct care worker or their service coordinator helping them answer the survey they can choose to do so as well we did ask the vendors to capture in those instances if someone assisted who the who role that person has with should be able to provide that information as well. Thank you for the question.

>> DAVID KELLEY: Next slide again.

>> SPEAKER: So just a quick question I understand about being an actual survey we do that home health all the time I'm just curious because I get the whole words are different in different states in different even areas of our state have we considered, contacting other

states to see what they did or how they over came that just, we mentioned you know, reach other to other states have we thought about doing that?

>> DAVID KELLEY: We have.

>> WILMARIE GONZALEZ: Yeah.

So, so -- we have last year when we talked about we have a consultant that is helping us her name is Susan Wrightsman she has been helping us for the past year year and a half, she has been part of the pilot testing of the tool she worked with other states she helped us secure from someone from Connecticut with a TBI, to participate and share her story as to, participating on the survey.

And she did bring some of the experience you know as far as the definition was concerned so we have the ability in Pennsylvania, to tweak just like every other -- any kind of other tool that are out there we can took to make it our own in the service of definitions we

wanted to make sure because it was the first round and it is, let's test this, let's see because we can define it.

But how that our consumers they still don't understand, so let us do the testing first and then let's really see what kind of results we're getting from consumers, and then, narrow it down more and -- make it more so that, better training is conducted for the -- for both consumer service coordinators and maybe in some instances, some of the MCOs.

Did I just say that.

>> DAVID KELLEY: I we will loop back with some states we're in the same phase we're at, to see what their concerns are, obviously working with the MCOs around the areas of definition, and -- you know how to make this better.

So -- yeah.

>> SPEAKER: There is nowhere to note that as the question was asked of somebody that they would say, the wording would be homemaker, they

would say oh you mean by care person or my personal care assistant.

>> DAVID KELLEY: Yes.

>> SPEAKER: I think I'm more concerned about the person that is saying, well, I have been educated enough on my waiver I don't get homemaker services on my waiver. So being more confused about it.

So, that's where my concern is, we're making such an effort to educate, participants on -- with services are available to them, so when we throw out words like homemaker and they were told that's not service, um, but get some of those things were captured, um, underpass, so -- it makes it very confusing, I think, for the person that you're trying to get the information from, in that respect. So we wanted to offer that as some feedback, that -- you know, I think that's important yet you have -- tasked attached to the authorization that I mean, by 60 you have a list of tasks

there.

They're in both places homemaker as well as task, it makes it difficult, you know to figure out as a provider, when you're looking at and you know, surprising 11 percent I think is really different between homemaker and task when you look at the scores.

>> DAVID KELLEY: Thanks. So the next slide -- I have a whole host of slides.

>> SPEAKER: Real quick related to homemakers moving forward -- as SCs using InterRAI tool there's a specific definition for homemakers as part of that tool.

That might be somewhere to look to see if we can get a alignment across the system, tools that could be more helpful as we move forward with the future.

>> WILMARIE GONZALEZ: Thank you.

>> DAVID KELLEY: I'm going to try to move I have a bunch slides I'll move

through them quickly.

Again this feedback is really great.

So again, this looks at again, -- service coordination and asking did you ask for help.

In part of this question is, getting places, or finding a job and so -- again I think there's a lot of opportunity for consumers to be asking get to know your service coordinator, don't be afraid to ask for those services and again obviously you know the next question when you did ask, did you get the services that is a much higher number.

I think there's still, opportunity for consumers to get out there and ask for those services if they feel they really need those services, especially those nonmedical transportation related services. There's some questions coming up about that later on.

And again, says 54 looks like an over all reading of the case case manager. Again there are different ways we can

present this data we lump together 8, 9 and 10 we can certainly present just the 10s, just the nines and dates typically, I think, in this one --, probably -- 70 percent had ten most were nines and a few 8s we can present this data so you can do the math this is a way that, HealthChoices, some of the thing we -- report on the CAPHS survey we have lump 8, 9 and 10 beings we want feedback on that, if you wanted to, you know it's broke down, we can certainly do that.

Next slide.

Again this looks at choosing your services, and again, this looks at whether or not, the individual thought, that all of the things were important were on the service plan the next 57 percent, said, all.

30 percent said, most.

So again, room for improvement.

Again you know, want to make sure that individuals needs are being met.

So, this -- this shows that -- um, you know, in -- majority of folks they feel like that all of their needs are being met you can see there's a substantial number of folks that, perhaps there's some continued unmet, unmet needs out there.

Did you feel the staff knew what was on your service plan again that is fairly high the last 3 months, who did you talk to? There are several whole host of responses what I did I look at case manager and other staff.

Only 56 percent of the time. So again, I think there's this opportunity to really improve, you know, individuals need to be, you know, out there, asking their service coordinators service coordinators need to be listening.

Sounds like really looks like there's room for improvement, perhaps there's -- training opportunities that the MCOs can be training their service coordinators probing individuals about unmet needs.

Such as transportation next slide.

So um again, this is, ride was available for medical appointments, slide this out.

Always and usually.

And -- again, little higher, little surprised again, that these results -- the next question question 6 is asking about whether or not some other transportation services other than your own.

Again, about -- 45 percent of the folks, said yes.

If so -- did the ride, was the ride easy to get in and out of, 87 percent said yes.

Ride arrive on time I used always is the point here certainly some opportunity for improvement there.

Getting more timely service next slide.

>> BARB POLZER: Excuse me I've had a request to have the people on the phone -- please mute your phone because we have a lot of background

noise.

>> DAVID KELLEY: These are supplemental questions that the department asked in addition to the CAPHS survey and again, this looks at, some more specifics, and -- actually being able to unable to attend the medical appointment, again, 11.5 percent again huge opportunity for improvement here we don't want individuals missing their medical appointments, the next win looks at, nonmedical appointments events, work errands huge opportunity for improvement 20 percent, said you know what? Yeah -- I'm getting this.

So again I think there's a --

>> BARB POLZER: Excuse me people on the phone would you please mute your phones.

Thanks you.

>> DAVID KELLEY: Next question, asks -- courtesy and respect again. Fairly high.

Positive response.

And again, fairly high response rating transportation again 89 and 10 are lumped together we can present that in broken out in a broken outs fashion looking at just the tens or just the dates 8 or 9s. Next slide.

Personal safety.

This is a domain that, obviously we're you know, very concerned about.

And again question 64 looks at whether or not you feel comfortable communicating with someone.

If there's something someone hurt you or did something you did not like this is high, I would like to see this number even higher we want everyone to feel like they're safe and someone they can communicate with, if there are issues.

And then, there are a series of questions around whether or not, there are individuals or staff or others that did things that quite honestly should never have happened.

And -- there is something that is very, very important we want to make sure that the training opportunity this is an opportunity for quality improvement, I would like to see those numbers much lower than what they actually are. Next slide.

Dental program, we have dental services and -- you will see that, later slides we actually look at measuring for quality there were supplement it will questions that were stated again about -- a third little bit over a third of patients did see a dentivity about 70 percent of those had one -- 30 percent had more than two visits again they had the ability to rank the care provided on a scale 1-10 we want 8, 9 and 10 we did alternative ways reporting that the next slide okay.

Community inclusion and empowerment, this asks about do you have family members nearby. You know are you able to get together with them visit them?

Again I think there's a huge opportunity for this to -- these numbers to really go up and perhaps, this is related to transportation some of the conversations we had earlier about service coordinators not knowing about nonmedical transportation.

This is a huge area about opportunity for improvement, the next two questions asked about friends.

>> BARB POLZER: Excuse me, people on the phone would you please mute your phones.

>> DAVID KELLEY: There's an opportunity for individuals, to -- to be able to visit more frequently with friends and family within the community we have an opportunity to do this, hopefully advancing the nonmedical transportation services next slide.

And -- questions 78 talks about how often could you do things, and be in the community, mostly usually.

41 percent of the time.

And, yeah. Huge opportunity for improvement.

We don't want to, it's great to live within the community and a community setting but it's even better to be able to get out into the community and enjoy that community fully.

So, again there is a very important -- area that we want to continue to monitor -- question 79 do you need more help?

Again, over 25 percent, said yes.

We need more help.

So again, this is -- an educational opportunity the MCOs, in the room should be looking at this and saying, you know this number you know there's ways that we can certainly, improve this number.

And then the last two questions, get into deciding you know what you're going to do during the day and, deciding when you get up and go to bed those numbers are favorably high you know, a lot of room for improvement in the

question number 78 and 79 next slide.

We did have some supplemental questions on housing so I did want to put that up.

We also did some supplemental questions on employment we did not have a chance to actually get into those complemental questions we'll be again as I mentioned previously this is all preliminary.

We're going to be looking at all of the questions that were included in the survey. Believe it or not I did report on every question.

On the survey.

One of the challenges of the survey it is very long.

And some of the feedback I think we got from the MCOs you saw the response rate, is a very long survey.

So -- hopefully, this is done by telephone in the future hopefully, you know we're going to be telephone and in personally think we need to have some

internal discussions around ways of perhaps we could still streamline the survey, to get to the essence are there areas where we can leave out total homemaker questions, ways we can still get the answers that we need without confusing people of definitions they don't understand.

So the next slide.

>> WILMARIE GONZALEZ: Only thing to add for the last slide here on the HCBS survey before we go into the KPMs we mentioned before, we are planning on internally finalizing the results, we hope to share that with you all.

We'll bring back as a follow-up, the definitions of the home care and -- some of the other questions have come up today. So, that has been very, very valuable.

Our plan is to implement southeast and southwest combined we hope to iron out some of the inks before we do that.

More to come on that so with that I'll

indrite Dr. Appel to go into the next slides.

>> LAWRENCE APPEL: Thanks so much.

Thanks so much and -- good afternoon.

Concious of the time, so I'll be brief I did want to take the opportunity to go over, some of the performance measures that we're asking the MCOs to submit there are reports on so we can monitor the care this goes back to that second -- diagram that shows what we're asking the MCOs to report to us, to -- the Office of Long Term Living, related to several quality measures I have with identified several key performance measures for 2018 and some other measures, that I just wanted to touch briefly and give you some preliminary data on.

So -- the key performance measures that we have, we have some preliminary data they're non-validated, on some of the measures.

I've talked about these before, in-patient utilization we're talking here about hospitalizations and we're monitoring the rate of hospitalizations the hope is that -- you know, some things like urinary tract infections short term diabetic complications upper respiratory tract infections these are things that often can be monitored outside of the hospital setting and, the hope is to encourage the MCOs to work with service coordinators participants and all involved, to decrease the sort of unnecessary hospitalizations that occur.

Second, we have AB, ambulatory care, that's the measure of the emergency department visits it similar it focuses on emergency department visits in that we're hoping that, the MCOs will focus with their service coordinators and providers, and participants together, and encourage use of urgent care centers where appropriate other clinics where appropriate other than the ED, which

obviously has long waits and, is sort of, you know, where everybody goes of last resort and, they estimate that 13-27 percent of ED visits are unnecessary.

So, we're monitoring that as well.

The third thing we're monitoring are all cause readmission anyone that goes to a hospital and is readmitted within 30 days, that's a readmission we're monitoring that as well the classic disease that, we think about there, is an internist we think about any way is congestive heart failure so, if someone has congestive heart failure any other disease specifically this, they get a good medication reconciliation so their medications are lined up when they leave, and transferred to their primary care physician appropriately, and -- they get, appropriate services in the home sometimes that includes a visiting nurse sometimes that includes telehealth monitoring and scales sometimes that

includes monitors on the back to see the levels in the lungs they get that, and they CHF clinics that are out there now, if they get the appropriate service questions see rates are very very low for readmission, without those kinds of implementations set up the rates are 20-25 percent of people returning within 30 days to the hospital that's something we're monitoring. And we're very focused on behavioral health, and we need to be clear we have multiple aspects to our behavioral health focus and I'm going to touch on, the rest of behavioral health some other aspects of behavioral health focus in a minute, 2 key performance measures that we're monitoring among other behavioral health measures, are -- adherence to meds for individuals with schizophrenia and, schizophrenics on antipsychotic medications. And obviously the adherence relates to decreased relapse, and decreased hospitalizations.

And, schizophrenics being on antipsychotic medications, medications are known to prevent hallucinations, disorganized thinking and suicide, among the behavioral health focus two aspects, are these monitors.

So, we also have the, access to personal assistant services which we saw earlier, Randy touched on that.

With the ops8 reporting rebalancing which talks about nursing loam transition to the community.

Next slide -- so -- this is our very preliminary data our first data on the key performance measures that the plans are reporting.

And I would not focus so much on the, sort of numbers interplan but in general, on in-patient utilization, um, so -- here we obviously have some room to improve as we're establishing the baseline we're looking at days per thousand member months and we will go forward with this, and -- talk about best

practices and strategies for improvement. Same with ED utilization.

And, readmissions you'll notice, the average here is, somewhere in the 15 percent, range this is preliminary non-validated data. We do need to validate it.

We have room to improve there as well.

Also talking about I had haves with schizophrenia, um, it looks like you know the percentage of persons on medication, and medication adherence, it looks like there's reasonably high percentages but still plenty of room to improve.

And this is just our -- preliminary data going forward. But this is our first snapshot we wanted to present it to you.

>> DAVID KELLEY: This is data that is specific to populations with plans actually managing the full benefit either Medicaid only, or they are in a aligned DSNP so -- as we talked about the last

couple of meetings ago why are we focused on these particular metrics it is really about better care coordination and service coordination.

In the future we'll ask the plans to actually look at that broader population so that we're making sure we don't really want to see the service coordinators and the medical nurse care managers that are working.

With the service coordinators they're really helping to make sure that individuals, um, don't get readmitted. They get the right care at the right time they never have to go into the hospital they never have to go into the emergency department.

>> SPEAKER: Couple of comments on that.

I think it's very important to recognize, in your next analysis that you will be doing you'll have at readmission numbers need to be looked at differently because of that, in Philadelphia. You

don't really ask you ask if they know the service coordinator you only ask do they know the physician that would be a police to start as far as care managing in the case, so will any of those things be considered in the future?

>> LAWRENCE APPEL: Thanks for doing that, that actually kind of goes with the next slide -- next slide.

The next slide, talks about some of the, the performance measures, that we, are going to be asking the plans to report on.

And -- we're asking them to report on 2018 encounters for 2019, they're just starting to gather the data.

And one of them is the, LTSS long-term services and supports.

And we're going to be measuring, you know, how many participants had a comprehensive assessment in plan at 90 days after enrollment? And then -- a comprehensive service plan update at 120 days after enrollment and then the

next thing is sharing that how many shared that plan, service coordinators shared that plan with the primary care provider, 30 days after that.

And then, finally are there reassessments after any in-patient admission.

Either behavioral health or hospitalization and this is for the HCBS and/or nursing facility population.

So it goes right to that.

Sure.

Another thing that we are going to be asking the plans to report on is dental care access.

So, we're asking the -- the plans to report on participant number of participants, who visited a dental practitioner at least once during the year and, as -- Dr. Kelley pointed out in the HCAPH survey the survey results reflect a lot of room for improvement and so we're going to ask the plans to report too get a very robust picture of this, we

suspect there's room for improvement there.

Just back to the behavioral health focus for a minute we started to talk about with the two key performance, next slide okay.

The two key performance measures so -- it is a much more robust picture than just those two key performance measures.

We are, actually going to be asking the plans to report on anti-depressant medication management, so -- those participants that suffer from depression we do want to see, how much -- how many are managed with appropriate meds and how much management is going on in the field of depression as well.

And then we're also going to ask the plans to follow-up on report on follow-up after hospitalization for any mental illness, and follow-up after any ED visit for any mental illness. This is a key

area of focus as follow-up.

Talked to several psychiatrists and, a lot of the issue that they have, is that, if somebody is an in-patient setting or in ED setting, they're not sure that the follow-ups are occurring so we suspect there may be some room to improve there.

Also, initiation and engagement of alcohol and drug dependance treatment we want to see that the rate of that occurring, certainly bi polar disorder other aspects of mental illness and physical illness are very intertwined related to this. And we want to follow-up on that measure as well of course, hope use of opioids at high dosage we'll be following asking the plaints report on that.

And -- concurrent use of opioids and Benzodiazapenes it's truly astounding the physical harm that can come and mental harm that can come for participant that is are taking both opioids and Benzoss at

the same time.

Working in a hospital setting for a long time, it was, too many people, that came in, with stark mental status changes and sometimes permanent who had were taking you know, Valium and Percocet or, veil yum and oxycontin this is going to be a real effort to monitor the use of the two. We finally talked about adherence. Briefly -- I do mean briefly I want to talk on the performance improvement projects that we have going.

We talked about this last last time there are two performance improvement project main topics strength and care coordination and transitioning from nursing facility to community.

Just wanted to give you all an update.

Those have started, as of 3 days ago.

Implementation with all 3 plans we have, numerous tracking measures, to gauge a whole set of things, to ensure that care is coordinated most importantly

to ensure timely care to emsure that care is done the right place, at the right time each plan has many tracking measures these are similar to these measures regarding this everything, from coordinating medications, to -- making sure that service coordinators are there on time.

And that, doctors the providers are informed.

And that's -- Wilmarie wanted to briefly address up coming topics thank you all very much.

>> WILMARIE GONZALEZ: Thank you.

So as we mentioned before, um, we will be able to provide, some final results on the HCBS CAPHS survey we'll be able to be in a better place to talk a little bit more about -- the key performance results once we validate the data.

And, up coming, in the up coming MLTSS meeting, we will ask the MCOs to do their own presentations on each of

their performance improvement projects and share some of the statuses. Um, and -- as we normally do, um we usually ask the Medicaid research center, who has been doing the 7 year evaluation, plan for the program to come in and provide an update.

And -- as always, we'll continue to provide a further updates on some quality measures as they get developed.

With that, the only other thing that I wanted to also make sure is that we have begun the discussions with the nursing home associations, we I know this question has come up several times and, just wanted to let everyone know that we are working with the nursing home associations, to look at nursing home quality measures, and we hope that in an up coming meeting we'll share a little bit what those activities and discussions are going to be so with that I don't know if Dr. Kelley you have a question sir please.

>> BARB POLZER: Eric please come up to the mic.

>> AUDIENCE MEMBER: When you transition from the nursing homes, I make a suggestion that you contact the independent living center that is located here in Harrisburg to get better help in doing that.

>> LAWRENCE APPEL: That's an excellent suggestion we will certainly take that.

>> BARB POLZER: Wilmarie I have a question that came in on the phone.

Um, why is there low UPMC response rate. That would be good for you to address sample size for the next year.

>> LAWRENCE APPEL: And I think the answer is, that right now data is very preliminary and not validated so -- I would, hesitate to comment on any particular response rates at this point.

And as we validate we'll go forward and certainly we will comment on sample size, going forward we agree.

>> BARB POLZER: Okay.

>> DAVID KELLEY: For UPMC, in fairness to them, they're response rate is actually very high.

Some of the other plans have lower response rates but they -- cast kept casting a wider and wider net to include more individuals so G I this I your response rate, was -- probably on the higher range compared to others.

So -- again, the over all number though was I think you hit your target number, that we gave you -- really good response rate.

>> BARB POLZER: There's also a comment that came in, same feedback we got from participants who took the survey are -- being able to complete it in two sessions it could be a lot to do in one sitting for the MCO to be able to get open-ended question data and feedback in the consumers own words from the survey vendor, about areas that are having problems in or what is working

well, regarding the quality of in-home services, service coordination, delays or things resolved quickly.

>> WILMARIE GONZALEZ: Thank you that's very good feedback.

>> BARB POLZER: Liam.

>> SPEAKER: Liam Doughety, Philly Adapt I believe you mentioned, the -- the consumers survey, you were going to implement in the southeast but you -- you there might be a problem there, or something.

If you could speak do the barriers there, it's really important to capture the compare the data.

>> WILMARIE GONZALEZ: Yeah.

>> DAVID KELLEY: Yes.

>> WILMARIE GONZALEZ: Go ahead.

>> DAVID KELLEY: Again, we expect the plans to implement the CAPHS survey in the southeast and Cavalier 2019 we're going to ask all -- of the plans to have a certain sample size,

probably will be over 400 we will expect them to sample in bodily injury the southwest as well as the southeast. So -- we do intend to implement, this CAPHS survey in the southeast as well as the southwest.

>> SPEAKER: That will be with the all the recommendations that were brought up in this meeting.

>> DAVID KELLEY: We are hoping that's why we're presenting this we're hoping that -- the next time around it will be, better.

It will tell you, you know just in looking at the number of questions the length of the survey, I mean, the comment from the person on the phone I feel the pain of having to sit through such a long and complex survey. So yes we are going to take, all of these comments and into consideration.

>> WILMARIE GONZALEZ: Thank you.

>> BARB POLZER: Thanks. Well

thank you -- we have one more.

>> SPEAKER: Tony we have to --

>> SPEAKER: My name is Tony brooks I'm from Philadelphia I will suggest on your the surveys, what you should -- like go through, zip codes, so you can specifically know, what is happening in that section of the area. Possibly.

It was a southwest that you did all of the -- or it was southeast.

You said it was, what percentage that you got.

>> DAVID KELLEY: This survey was just in the southwest again the response rate, really ranged from you know, somewhere around 12 to 29 percent, so -- yeah.

We'll be working with the plans to make sure that, the sampling, especially now we're expanding to both southwest and the southeast, it will be getting appropriate sampling and whether it's a zip code or other levels.

>> SPEAKER: Region or county or something like that, because -- some of us, live in rural areas, where communication or, communication getting to the person is very difficult.

So I will suggest that, you -- you do it in a way where you can really find out this person these people in this neighborhood this is the issue.

Because -- I could be better off in a -- with some things I have but other thing I'm having problems with.

So, I will suggest that this, survey that you are doing you really, find out, what is really needed.

As for me I can tell you right now what is really needed for me.

I need -- a affordable housing integrated housing in the community.

I want my services to be in the community.

Not in a nursing institution.

Thank you.

>> DAVID KELLEY: Thank you very

much.

>> WILMARIE GONZALEZ: Thank you very much.

>> BARB POLZER: Okay.

Thank you Wilmarie and doctors Kelley and Appel we really appreciate your presentation we're going to wrap up the next meeting will be, February 6th.

And thank you for your attendance and participation.

[meeting concluded]