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DATE: February 6, 2019

EVENT: Managed Long-Term Services and Supports Meeting

MS. POLZER: Good morning everyone. We would like to get started in a minute.

Good morning everyone. Let's get started and we will go with introductions. Linda will you start.

MS. LITTON: Linda participate advocate.

MR. BOROCH: Blair united healthcare.

MS. DELGRANDE: Good morning life providers.

MR. HANCOCK: Kevin Office of Long-Term Living.

MR. ZINMAN: Consumer advocate.

MS. HYDE: Good morning PC O A and A R P.

MR. NAGELE: From the brain injury association.

MR. PRUSHNOK: U P M C health choices.

MS. POLZER: Committee members on the phone.

TELEPHONE: Yeah. Fred Hess.

TELEPHONE: Tonya.

TELEPHONE: R-A-L-P-H trainer.

MS. GRAY: Juniata grey.

MR. TRAINER: Consumer 150.

MS. POLZER: Thank you. Any other Committee members? All right. Thank you. I'm going to go through the housekeeping talk points. Please keep your language

professional. Direct the comments to the Chairman until called upon and keep your comments to two minutes. All of our transcripts and meeting documents are posted on the list serve and they are normally posted within a few days of this meeting. Captioning interpreters and /AUD recording are taking place please speak clearly and slowly. The meeting is scheduled until 1:00 To comply with those logistical agreements we will end promptly at that time. If there were questions or comments that were not heard, please send to R A -- P W C H C at PA /PWOT go. That is on the alleles agenda. The exit aisles must remain open. Please turn off your cell phones and clean up the cups and wrappers before leaving. /AUD there will be a 15 minute period for any additional comments.

The 2019 M L. TSS sub M-A-C meeting dates are available on the Department of Human Services website and now we will go through the emergency evacuation procedures. In the event of an emergency or evacuation we will proceed to the assembly area on the corner of 4th and market. If you require assistance to evacuate, you must go to the safe area located right outside the main doors of the honor S-U-I-T-E. OLTL staff will be with you until you are told to go back to the honor suit. Everyone must exit the building. Please take your belonging with you and do not operate your cell phones. Do not try to use the elevators they will be locked down. We will use stare 1 and 2 to exit the building. For stare 1 exit the S-U-I-T-E turn right and go down the hallway by the water fountain stare 1 is on the left. For stare 2 exit through the side doors on the right side of the room or the backdoors. For those exiting from the side doors turn left and stare 2 is directly in front of you. For those exiting from the backdoor exits turn left and then left again and stare 2 is directly ahead. Keep to the inside of the stairwell and merge to the outside. Turn left and walk down-D- U-B-E-R-R-Y alley to chestnut. Turn left to the corner of 4th. Turn left to BlackBerry street and turn left to the train station. Anyone have any questions. All right. Thank you.

TELEPHONE: I have an announcement to make.

MS. POLZER: Okay.

TELEPHONE: This is Fred Hess. This is Fred Hess. I have an announcement to make. I will no longer be a member of the Committee. I have had to resign for massive health issues. So from this moment on, I will no longer be the Chairman or a member of this Committee and I'm sorry to do this to everybody. I mean, I have had a wonderful run with everyone here. We have done fantastic work here. We have accomplished things that they said we could not accomplish as Committee and I was so happy to prove them wrong in my term.

Unfortunately, I can't stay on this call long. So I bid everyone A-D- I-E-U in my style and I thank everyone here for the privilege of letting me be on this Committee and letting me be the Chairman of this Committee. Thank you guys very much. (Applause.)

MS. POLZER: Thank you, Fred. I hope you heard that round of applause. We really appreciate having you with us. We wish you well and hopefully you will keep in touch.

MR. HESS: Absolutely.

MR. HANCOCK: The only thing I would add is Fred has been a tremendous advocate for a really long time and we hope that you will not stop being an advocate even if you are resigning your role as president of this Committee. Your voice is an important voice especially in Western Pennsylvania and we absolutely need to hear it.

MR. HESS: I will never stop being an advocate. That is not going to happen and will never stop caring about this Committee and everything that we stand for, everything that we do, everything we have done. I will be listening in or if they want, they can actually send me something where I can make a comment or two. But yeah, no. I will always always be involved. I have been involved with since it was a rumor back in the last T-O-M governorship. I plan to stay with it as long as I can.

MS. POLZER: I got a text that the audience members also thank you for your service.

MR. HESS: Thank them. I thank them for their input. I thank them for everything they have done for us and everything they have done for all people with disabilities, all around the country, all around this state and everywhere else.

MS. POLZER: Thank you again.

TELEPHONE: It is Tonya, I just want to say thank you to you real quick for making me stick with stuff out when I didn't necessarily know if I really belonged in this. I really still don't know the answer to that but thank you for showing me the ropes on some of it.

MR. HESS: Tonya, you definitely belong in this group. Trust me. You are one of the best advocates out there.

TELEPHONE: Thanks.

SPEAKER: We love you Fred.

MS. POLZER: Did you hear that Fred.

MR. HESS: I heard I love you Fred.

MS. POLZER: There you go.

TELEPHONE: Thank you Fred.

MR. HESS: You guys are welcome. I wish I could continue on but my health is not allowing it. I just can't do it.

MR. HANCOCK: And just as a follow-up to Fred's announcement, we will be announcing the new Committee members in the next Committee and they will actually be here in their roles and they won't be a surprise to anybody I don't think.

MR. HESS: Do I get a say so on who is taking over for me.

MR. HANCOCK: You can certainly weigh in Fred.

MR. HESS: Okay. Good.

MS. POLZER: All right. Then we are going to move on and have Kevin present the OLTL updates.

MR. HANCOCK: Thank you Barb.

So I will be providing the quick inn production and then Randy N-O-L-E-N will be provided on phase 3 implementation as well as the breakdown of the phrase 3 population that we introduced in the -- later in January. And Randy will be providing some updates on how the southeast implementation is progressing as well as some updates on some quality metrics with southwest ongoing operations or steady state operations. Just to introduce the -- reintroduce the 2019 OLTL goals. We are focusing on the three areas -- we are now focusing on the whole state in 2019. The focus for the south West obviously is implementation, making sure there is no interruption of participate services and no interruption of provider payments. Our conversations and our discussions have at least during the month of January been move heavily focused on the former participant service interruptions. /RAPBLD /KWREU will go into some detail to show the actual interruptions, the number of actual interruptions that had to be addressed were relatively small in the southeast. They were smaller than the southwest. Another area of focus that has been the largely attributed to the work is eligibility and enrollment issues. We did have like with the southwest a significant number of eligibility issues that occur at the very close to the point of implementation and the two triggers for those issues were the date in which participants were -- the last date that participants were able to change plans as well as those people were sort of in the process or close to the end of the process, closer to the January 1 st date. Gene /KWREU and her team and office of Medical Assistance Programs and office of income maintenance have been working to be able to identify and address those issues. To be perfectly honest because of our eligibility process is so many steps and so complex, they are almost unavoidable and what that could lead is where participants might receive duplicate information from the managed care organizations or because the transfer from one managed care organization to another may not have happened in the system as we would like or another example would be if a participant was not able to have their eligibility or enrollment finalized by the January 1 st date. It is the Medicaid eligibility process which literally has not changed with community health choices but we are able to once these issues are identified work through and have them corrected as completely as possible. So that has been a heavy focus on making there is no interruption of participant services and making sure that participants are receiving their services in the

new system as quickly as possible and as completely as possible. So that has been a heavy focus for January. February, is much more focused because -- in fact, virtually all of the eligibility issues that were transferred are largely addressed at this point. We will be focusing and we did focus in January but we will be focusing much more heavily on the later of the two provider payments. Provider payments for nursing facilities for example really do begin in February. In fact, they have already largely taken place and there have been a number of claims that have been processed and claimed in the southeast by the managed care organizations. There are some issues and Randy will present some of the background of how that is progressing in the southeast. We don't have nearly as much in the southeast as we did in the southwest and even in the subject west, we were able to identify them and the M COs were able to work with providers and make sure the payment was going out the door. We are in a much better place in the southeast than the southwest but we do expect issues, missing information and some manual processing potentially. All of that being said, being at a better place, we are able to get ahead of those issues and the managed care organizations are able to get ahead of those issues as quickly as possible and we do believe that we are going to move much more quickly with stability in the southeast than we did in the southwest. Even though the southwest in our /AO*U view went well. We continue to address any issues that occur. The issues are individual issues. I have to say that the issues that we are focusing on were issues that we were focused on in the May, June time frame last year in the southwest. What we are focusing on now is basically getting the program to stability and in fact, we are moving through it very quickly as certainly, certainly positive sign that the southeast implementation is going well.

Randy will detail the metrics about southwest operations that will eventually include southeast operations as well and how it is going there. We are really focusing now in the southwest on not only day-to-day operations but the more -- the more aspirational goals of the program, improving housing, improving opportunities for employment. There is some transition. Building out a robust workforce and opportunities with technology and all of the goals that we have with the program to be able to make the long term services work better and also to make sure that the participant experience in the long-term care system has improved as well. So the southwest is really shifting to -- to the broader objectives of community health choices and we are seeing right now in terms of direction that we might be able to roll in the southeast as part of those conversations, quickly, actually hopefully earlier than we hope. All of that being said.

MR. HESS: I have a question. Do you have any numbers on the southeast and southwest as far as sign ups and issues. Or is that going to be later.

MR. HANCOCK: Ongoing operation data is going to be presented later Fred. The percentages of enrollments as we presented last month in terms of who was auto assigned versus who actively selected a plan were almost virtually the same in the southwest compared to the southeast. We had 60 percent auto assignment and 40 percent active plan. The only big difference the west and the east were the total numbers involved and the number of people actually signed up via the web on the

independent enrollment broker website. It was much higher in the southeast than the southwest but the percentages were the same.

MR. HESS: That figures.

MR. HANCOCK: Our goal is to do better in phase 3. I'm going to use that as a lead in. Jill is going to talk about our communications and planning activities for phase 3. We are with the southeast, we have a time line already in place for how we are going to be looking for communication for phase 3. Phase 3 is very different from both the southwest roll out and the southeast roll out for a lot of different reasons. One key example is we have many many more people receiving their long-term care in nursing facilities in the final phase, the final three zones compared to the earlier two phases. Another key difference is that most people in the program who are dually eligible and the vast people who will be enrolling in phase 3 are in traditional Medicare. We have many more people who are not enrolled in Medicare advantage plans in the final phase compared to the other two phases. We are hoping that changes actually because we think we get better alignment with Medicare advantage but it is a consideration. You have a lot more people -- so you have a lot more people --

MR. HESS: I'm sorry. I'll mute.

MR. HANCOCK: It is all right. I moved the microphone away.

So the challenges with the phase 3 will be a different animal. It is very rural. Many more rural than any of the other two phases certainly much more rural than the southeast implementation and the relationship between nursing facilities and the community itself is different in this final phase. So it is going to be a really different focus on communication and looking forward to Jill providing some updates on that. So 2019, February, second month of the roll out for the southeast. We consider it to be going pretty well but it is early so we have a lot more to pay attention to when it comes to the roll out and we look forward to continuous feedback. We continue to have our daily huddle conversations with the managed care organizations and have weekly calls with participant, participant advocates as well as the Area Agency of Aging network, nursing facilities and home and community based providers as well as the M COs and those conversations provide a lot of what we need to focus on in the southeast roll out and ongoing information with the southwest and we also look forward to -- to receiving feedback from this Committee and the other sub M-A-C committees. I receive a lot of feedback from the consumer Committee on how things are going and how things can be improved and with that, I'm going to turn it over to Jill who is going to walk us through the phase 3 population and talk us through the communication strategy for phase 3 as well.

JILL: Good morning everyone.

Okay. I have got the fun part of planning out the next phase here and like Kevin said, our population for phase 3 is definitely different from the southwest and southeast.

Something that we really want to point out for phase 3 is that it is three separate zones. And that is really important with how we are going to be approaching phase 3 because there are three unique zones that we are going to be focusing on. There will be three different phases of provider outreach and participant outreach.

So as you know, we model our health choices zones. So we have Lehigh capital. We have the northwest and we have the northeast portions of the state. And up on the slide, you will see the breakdown by those three different zones. And you will see some straggling numbers the 22 and 13 or the southeast and southwest zones. Those folks are getting long term benefits in phase 3 but they are in counties outside of phase 3. So those are -- those are the anomalies there. This is a population breakdown by the three different zones and as you can see the total population is 143000. So it is a little bit higher than southeast implementation. In the breakdown, like Kevin had touched on, the breakdown is we have more folks that are actually residing in nursing facilities. We are looking for Lehigh 16 percent, 17 percent in the northeast and 14 percent in the northwest in compared to your dual and nondual home and community based folks so that is different than the southeast. So here you are going to have the breakdown by the different zones. Again, by county. You can see that the large portion of the Lehigh capital zone, we have in Berks and Lehigh. Just to note, as we move into the communications planning, and for folks just so you know, we are going to be sharing this slide next so you will have all of this information. As we do the planning for the participant communications, you will see we are going to be focusing on each and every county in phase 3. So we hope to touch every county for participant communications.

For the northeast, you can see the breakdown there. It is large number of counties in the northeast and as you can see, you know, Luzerne is one of your top participant numbers as well as Lackawanna.

And then northwest, northwest, as you can see, Erie tops the list with the population. So then we looked at language breakdown. This is going to be most important as you know, we do have the communications with the -- with our top five statewide prevalent languages but for the southeast, we also did additional participant communications for -- by additional groups or communities that had some prevalent languages and we will be using grassroots communication vendor to assist us again for phase 3.

We really got great feedback from those additional sessions and I think that it was really useful to do that last outreach to participants and make sure that they knew that C H C was coming. So our breakdown is on this slide for additional languages. And we also have this by county if anyone is interested, we can share that as well.

So our phase 3 communications time line as Kevin said, you know, we have gleaned a lot from the southwest and the southeast for lessons learned. We are conducting an internal lessons learned session for the southeast coming up next week to try and discuss some additional items that we would like to incorporate in outreach for providers and participants for phase 3.

We are doing things a lot earlier. We thought we were doing it earlier for the southeast. This is even earlier for phase 3 because we have three zones. We are in the process of finalizing all of the venues right now for the provider sessions. They will begin May -- the week of May 14th. We are also incorporating a dedicated transportation session at the end of each one of those zones. So we are going to have four days at each -- in each area. Lehigh cap and northwest and northeast. And we will do our -- the same type of venue for the providers, a morning session with overview and then break out sessions by provider types. And then the fourth day being dedicated to transportation providers. That way if providers that may be home health or service coordination want to also attend a transportation session, they will be able to do that So the schedule is there for you, for those sessions. And then, of course, June 30th marks our end of continuity of care period for the southeast.

In July and August, we have our initial touch point flyers going out to our participants and, again, we are engaging aging well to do the participant sessions and their outreach flyer will go out August 1 st and then our pretransition notices are going to go out a little bit levellyer August 19th through the 30th. In September and October, we will be conducting the participant sessions. If you recall in the southeast, we had aging well hold 72 sessions. We will be doing at least that, if not more considering we have a little bit larger population for phase 3 but we are -- we are going to be broadening the locations. So already, we have done some outreach to different entities that may be able to host for us and we have also gotten offers from providers that would be interested in hosting participant sessions. But we are looking at incorporating locations such as health systems, those are locations that participants are comfortable and able to -- to access easily as well as using some of our county assistance offices.

MS. AUER: Have you talked to any of the housing authorities too.

JILL: Not yet but that is a very good suggestion.

MR. HANCOCK: Can can we build on that question a little bit. So housing -- so housing -- sorry. I hear you have a problem with your voice Pam. So housing authorities will probably be helpful in Lancaster York, Harrisburg maybe even Williamsport but do you have suggestion on the more rural areas.

MS. AUER: I think about Elk County and they have a couple of high-rises in the major towns. There was one high-rise but that is where the people are or can get to because there might be some activities. Even -- Mifflin Juniata, they may have a counselor joining for their housing. Snyder and union do everything together. They use community rooms and places to connect with and we asked actually our consumers who live in rural areas where should we direct you guys to go to and that is one of the first things they said was the housing authorities and any of their -- like, some towns have community event places, like, in -- I -- I talk about Elk County because that is where I grew up. They have a place in the center of town where people go and if they can't get to Penn State, the college, they have a place you can go and use their computers and

connect in with the classes and stuff like that right in the center of town and most of them are accessible in the community event places.

JILL: Great suggestion. We are also in the process of doing some additional data analysis on this population to identifying those nursing facilities so that we could do some outreach to the nursing facilities where folks are residing and asking if they host sessions as well.

So yeah. Absolutely open to any suggestions there for making it easier for participants to attend.

MS. HYDE: So give me a sense of how many of these listening sessions or these information sessions you think you might hold.

JILL: Well, in the southeast we held 72 so we are going to be holding at least 72 because we have about 12, 13,000 more participants in total of phase 3. Also, we are finalizing a -- I don't know if everyone is familiar with all of the training that we have out on our website, the provider narrateed training. So we are on the last legs of developing the participant one that is -- is the narrated training and currently under review right now with a consumer group. And we will have that posted out on the web. So we will be doing a lot of outreach and making sure folks know about that so that individual groups, if they want to help educate the participants about C H C, they can actually use that -- that training as well as any other additional materials that we have out on the web.

MS. HYDE: May I ask how responsive has the AA A been.

JILL: Right now aging well has put together a proposal for us and we are in the process of reviewing that. As soon as that is finalized we will release that information and let you know where we are going with the sessions.

MS. HYDE: I live in Crawford which is rural also. A lot of people congregate to Meadville and there is transportation and you have a couple of large centers and there is a senior center for the AA A.

JILL: Good. Thank you.

MS. AUER: It would be really bad of me --

SPEAKER: Can you use the microphone please.

MS. POLZER: She is.

MS. AUER: The AA As have the contract to do that. Connecting with the C-I-Ls for our expertise too. Philadelphia it didn't happen it was senior focused than C-I-Ls.

MR. HANCOCK: We are taking that as a lesson learned. The C-I-Ls were loud and clear and we want to make them a part of participant communication.

MS. AUER: Can we be part of the contract.

MR. HANCOCK: The expectation would be anything that aging well would propose would take C-I-Ls and other participant organizations into consideration but certainly the C-I-Ls not only because of our connection to the under 60 long term home and community based but you have locations that are accessible and a great place to have some of the sessions.

JILL: So we are absolutely open and that is kind of why we want to expand the variety of the locations to make them easily accessible for folks to get to. I think that was one of our feedbacks was -- was transportation for participants to get to locations for these sessions. So we are trying to address that through, you know, a variety of ways including, you know, using locations that they are already able to get to as well as coming to where they might be. So it will make it easier to get the messaging out. Any other questions on that.

MS. DELGRANDE: Are the sessions always during the day are there also even being sessions.

JILL: There are some evening sessions. Yes.

MS. DELGRANDE: Just because I know for Cumberland and Franklin that the life centers would be more than willing to host sessions and are obviously handicap accessible and can hold a large group of people. That is just something to think about.

JILL: Okay.

MR. HANCOCK: Just we are going to give a quick update on the life program a little bit later. Life is not completely statewide in the T at this point but we do have that objective but we also have other life centers in the T that actually could fulfill that role as well.

MS. DELGRANDE: Yeah. Albright Geisinger.

MR. HANCOCK: Right. And Geisinger.

JILL: So more to come on the participant information sessions.

So with this last round and the round before, we did identify that even though we did the provider summits in the summer, we still had providers that really weren't engaged until the participants started getting those letters and coming to them with questions. So for this phase, we are incorporating an additional provider session in each zone in the fall after that first round of notices goes out. So we can hopefully touch with all providers that may have missed the first round of communications.

And then the round 1, 2 and 3 of the enrollment packets and the pretransition notices are going to be going out and then November 13th will be the last day for plan selection before the auto assignment. So that is the consistency for the systems that we need to have that cutoff. But, again, participants will be able to change their plan at any time and if they make that choice by December 20th, they will have the plan effective date January 1 and if after the 20th it will be effective February 1.

So any additional questions on the communication plan?

All right. Great. Thank you. Is this Randy.

MR. HANCOCK: So next up Randy is going to come up and present an update on the southeast launch as well as southwest ongoing operations.

MR. NOLEN: Good morning folks. This is Randy N-O-L-E-N. I'm going to talk about the launch indicators. I can tell you for the last time, I'm honored to sit in the Fred Hess seat today.

So walk through the launch indicators. The launch indicators is a collection of data that we have requested from the M COs for the first month of implementation. So it is data collected all the way up through the 31 st of the month. After that the same data that we have been collected will be collected on operation reports that the M COs have to fill out either monthly or quarterly. The reason we did launch indicators is it is information we gained on a weekly basis to determine if there were any issues or concerns with the initial implementation. So the first indicator that we took a look at is the weekly random enrollments into the southeast zone and as you can see, we are showing by the first four weeks enrollments in each plan Keystone first and PA health and wellness and then U P M C. It shows how many were new and identifies new long-term care and new home and community based. The largest population that came in was new H CBS individuals. You can see the population that came in across time of the new enrollments after the first of the month.

Launch indicator 2 talks about the weekly plan transfers. These are individuals that transferred from one of the M COs to the other one. As you can see, as far as the breakdown weekly week, we show which ones went from one plan to the other. Keystone first had a majority of gain over the first month. As you can see each week they had a positive gain and then each week, the other two M COs had a negative -- had a loss of participants. A lot of that was due to the fact that individuals were auto enrolled and once they started getting paperwork and realizing that their providers were in a different network or for familiar with Keystone first, they choose to make that change. We did see the same type in the southwest. It was U P M C that had the gain because of the more familiarity of them out in the southwest. So we expected this same type of trend to happen in the southeast.

Next launch indicator is in regards to critical incidents that were reported. We break these down by service interruption, neglect and abuse. Most of them were around

service interruption. As you can see, the first couple of weeks it was very limited. Once there was more communication with the participants and the outbound outreach phone calls that the M COs did, we saw a lot more numbers in week four. Again, this is something that we will continue to monitor going forward. All of these issues have been addressed by the M COs when they occur.

SPEAKER: Thank you. Is it on? In the service interruption, did you quantify medical service interruptions or just O L. T L.

MR. NOLEN: We looked across the board whether it was home and community services, passwords coming in or an issue with transportation or they weren't picked up for their appointment or missed an appointment and it was a physical health issue. All of them were looked at.

SPEAKER: Just physical health and mental health, I'm asking in service interruption, in these numbers, did you quantify if there was service interruption because of the switch on the medical side. I'm guessing these are O L. T L. Side.

MR. NOLEN: These are interruptions across the whole program.

MR. WELLINS: C H C.

MR. NOLEN: Yes.

MR. WELLINS: Okay.

MR. HANCOCK: Do you have a concern?

SPEAKER: My concern is -- I was going to talk about that later. My grandmother is a participant and had issues on the second week of January, she went to Temple and is a participant of PA health and wellness and Temple rejected her from her cardiologist appointment that she needed to pay a $40 co-pay. So her service was interrupted and I'm /WOPBD sistering in these numbers, if you are quantifying in the healthcare side of people that were not serviced because of some miscommunication at the least, if you will.

MR. NOLEN: The three M COs and they can all address this, yes, they should have been reporting those service interruptions.

MR. HANCOCK: That is a good example because -- so whatever this network status is of a particular provider with a particular M C O, the -- your grandmother or whoever would be affected by this should have been covered by a continuity of care period if she was dually eligible. So we would consider that to be a service interruption if that provider, that Medicaid provider was not recognizing the requirement of the Medicaid system that they should have been aware of. We would have expected that to have been reported yes.

SPEAKER: These numbers also act -- the dosage.

MR. NOLEN: Yes. They should have reflected. Yes.

MS. POLZER: Would the people on the phone please mute themselves. Thank you.

MR. NOLEN: Next slide we want to look at is launch indicator to talk about complaints and grievances. Again, very few complaints. Just a handful of grievances. Again, they picked up in week four. These are issues that came in for participants that the M COs have been working on. These are about where our number of expectations are at this point in time because of continuity of care so we will continue to monitor this as we move through the continuity of care period.

We had a number of indicators that we looked at call line stats and the next one is weekly calls that came in the OLTL participant line. These are calls that came in through the department. As you can see, the first couple of weeks there was a much higher volume and then they trended downward into the last couple of weeks. We also broke it down by what we considered urgent calls and nonurgent calls. Urgent calls were service related calls direct care workers not getting paid and those kind of things that need to be handled immediately the M COs and broke it down by the total calls by the population of 10,000 per unit. So as you can see, the number of calls that came in, like I said, went down as we hit week four and by population, they all had a -- a pretty average amount of phone calls that came in.

And these calls came in on a daily basis. They came through the monitoring unit who sent them out to the three M COs to handle and each out to either the participant or the provider to make sure they resolved the issues.

Then we had the next indicator is weekly calls that came to the participant line. We do contract out for implementation another service that gets phone calls that come in. Most of them are calls that end up being referred to the i.e. B. As you can see the numbers went down significantly. The first two they were the same and after that they dropped over 100 calls and close to 200 calls the last week. Most of the calls were referred to the M C O or to the I-E-B if it was an enrollment type of an issue.

MS. POLZER: Randy we have a question that came in over the phone. Do the M COs have MO Us to work with O A P S & A P S?

MR. HANCOCK: I can answer that question I can start and then let the M COs.

MR. HANCOCK: So the acronyms adult protected services. All of the organizations have been trained on what a reportable incident is when it comes to adult protective services and older adult protective services and they know they are a mandatory reporter on those as well. The relationship really is they are a mandatory reporter. That being said they could characterize how they conduct meeting the requirements. I wasn't

sure if the three M COs would want to talk about that quickly but it is a very good question.

MR. PRUSHNOK: This is ray from U P M C. We have a critical incident team that spend as a large amount of time communicating with older adult protective services and older adult protective services. Simply it is a pass on a report and in other cases and this is more rare but very intensive. There have been various cases where the team spent a great deal of time and energy working with the protective services.

SPEAKER: This is Kathy Gordon from Keystone first. Same thing as U P M C. We work closely with A P S for any issues we identify or they identify or someone in the community identifies. It is not that they needed a contract. We are mandatory reporters and all of our staff are trained on what that requires.

SPEAKER: Anna Keith with PA health and wellness and similar, we have a department that oversees any of the complaints grievances and then with the A P S reports complete service coordination and the team to reconcile whatever the issue is and work with A P S closely.

MR. NOLEN: Okay. And just to follow up, we do have regular meetings with staff both from A P S and O P S and we have regular trainings and it is an ongoing relationship that we are cultivating. We ask the M COs indicate a specific contact person for both entities so they have someone to get ahold of 24/7 if an issue arises and we do continue to work on that.

MS. POLZER: The people on the phone, can we ask you to please mute yourselves?

MS. AUER: Can I ask a question follow-up to that. So there are specific guidelines that they all follow that make sure that they report? There are specific levels that they have to hit to make sure it goes to A P S or O -- I'm trying to think of the way I want to ask the question. They have certain guidelines that the staff meet to report an adult protective services. Abuse, neglect, exploitation, whether it is the in house, out of house. It is being accused -- I don't know how to ask the question. I'm really sorry. In house or, you know, there are some staff there responsible for or outside abuse neglect, they have guidelines each individual or is it state guidelines that they follow, clear guidance.

MR. NOLEN: It is the same guidance on the fee for service. The reporting requirements from the regulations and laws surrounding A P S and O P S have not changed. They are the same ones they have to adhere to. Those guide lines under fee for service to be the mandatory reporter for this.

MS. AUER: The only reason I ask is sometimes when you call the protective services hotline, whoever is answering, they make that judgment whether they are going to forward it on. You may believe it is, you know, an abuse situation but when you make that call, we hear, well, we will send it to the supervisor to see if it should go to as an A

P S. There has got to be a layer of the way they make their decisions. That is what I'm asking about.

MR. NOLEN: It is the same situation for the M COs if they /SUS secretary or think an issue is going on, they are required to report that and the workers are the ones that make the decision on whether they go out and open investigations. It is the same criteria that they have that we have had in the past.

MR. HANCOCK: The only thing I would add is that the regulators who are involved in A P S and older protective services and A P S and O A P S, they are the ones who train, you know, provided the guidance to the M COs. So we have the expectation that they are following through on mandatory reporter requirements on the same way service coordinators or any way other would be reporting as well and consistently. We also have built on top of that the incident reporting requirements as well as in the agreement. We have specific criteria that goes beyond A P S and O A P S incidences and I'm sure you are familiar with the bulletin it follows the same guidelines that was outlined in the critical incident bulletin and submit and in the enterprise management system to be able to -- to report on any contextal issues or challenges that participants are facing. But that being said, we are always open to feedback and how to make that work better. I think the two units that are involved in overseeing adult protective services and older adult protective services would welcome any feedback as well.

MR. NOLEN: I got to figure out where I left off here. I think it is launch indicator 9 weekly calls to the participant line. We talked about. 14, we are tracking claims that come in. So we track them by how many claims have not been adjudicated yet meaning that the M COs are monitoring and working through with the claims. How many claims have been rejected, some of the claim reasons for rejection are just improper billing or they are billing for a participant that is not with that plan. You will see larger number there in the middle for pH W, that was caused by a glitch in their system with H H A exchange which has since been corrected and 90 percent of the claims have been reprocessed and claimed. That is why you see the claims denied a little bit higher for them or claims rejected. Claims denied are some that were denied. The participant is not with that M C O or billing for something that is not appropriate and then the total numbers of claims paid. As you can see U P M C has paid more claims. They are allowing things to go through the system a little quicker and adjusting their quality and look back as they move forward and try to process things through. The number is a little bit lower for Keystone. Expectation was they had some glitches with a large number of their home and community based services claims that were coming in through H H A. Once they corrected that, they have been getting the claims out and then my discussion with them on Monday in their latest check run they had 45,000 claims that processed out. They are catching up on home and community based claims now that the file situation has been corrected. So they are moving forward with that.

14-B is other claims that have come in. So we are taking a look at any other claims that may be that they hit that are physical health, nursing if a cement, subcontractors dental or vision. Our volume on that is somewhat low. It is just in the last couple of days that

the nursing facilities have started to submit billing. It is actually at a lower rate than my expectation is. So hopefully over the next week, we will see nursing facilities get the billing in. The other providers seem to be pretty consistent in what -- how they are billing whether it is weekly or biweekly. So the amounts on the home and community based side have stayed consistent as far as the claims that are coming in.

MR. HANCOCK: So just stepping back for a second to the older adult and adult protective services. There was a webinar where a presentation went through the requirements. We -- Steve T-E-R-C-E-L-L from Philadelphia Corporation for Aging sent me an e-mail reminding me about that prep takes. It should be on the website. We will make it available to the Committee if there are any further questions as well.

MR. NOLEN: All right. The next indicator is weekly calls that come into our provider line. The office's provider line. As you can see week 2 and 3 were extremely busy providers calling in and just checking about their status and billing status. It has started to calm down in week four with the number of providers calls that are coming in. On both of the indicators a number of participant calls coming into the office and a number of provider calls coming into the office have been fairly low considering the population that we are working with in the southeast and it is the same trend that we saw in the southwest. What that means is participants and providers are reaching out to the M C O before they are coming to the department. They are going through the M COs. They are getting the answers they need. They are getting the direction they need. And the calls that are coming into the department are either ones that maybe they haven't been able to get ahold of the M C O or some of these are individuals that are used to calling the department for different services when they were under fee for service they feel comfortable calling the department. A lot of times we are passing those calls back onto the M COs to handle. The numbers have stayed consistently to what we saw on the southwest also.

The next indicator shows some PPL payment failures. Some issues related to authorizations that have to be corrected. As you can see our numbers have gone down in week four. Week 3 we had U P M C had a number of issues with authorizations and made some corrections in the system and make sure authorizations are showing so that providers can see them to bill off of it. So we continue to monitor issues with PPL. We are not getting a lot of concerns or complaints about direct care workers not being paid. When they do occur, we are handling very quickly to get them resolved.

And the last launch indicator we talked about is calls that come in to the actual M COs through the participant lines. As you can see, the call volume is fairly significant compared to what the call volume coming into the office is. Expectation is numbers meet what we expected. I think early on, all three of the M COs had some issues in meeting their requirements and answering calls within the acceptable service level agreement which is to answer 85 percent of their calls within 30 seconds. They are also at a level where they have to have 5 percent of abandoned calls. There were some issues with that initially with call volume. All three of the M COs adjusted their staffing patterns to be able to handle that and have greatly improved the calls coming into the

participant line. On a secondary line that they use for service coordination calls, there has been identified some issues with long time -- long wait times. Sometimes anywhere from 30 to 45 minutes getting through that line. I have talked to all three of the M COs they are adjusting staffing to handle that. And work through that process to improve the call waits that they have on that. It is something that we don't monitor through a launch indicator. There is no service level agreement -- an agreement about it but we are monitoring it and it is something that I talked to the three M COs on a daily basis on where they are at on their service coordinator line to improve the access through that.

Some of the initial problems where a lot of the service coordinators were call anything on that line instead of the participant line and that was tying it up and not allowing participants to be able to get through and that line. So they are making adjustments to address that and improve those wait times.

MS. AUER: Can I ask a question.

MR. NOLEN: Yes.

MS. AUER: Charts are not something that are easy for me to follow. I'm trying to follow.

Do we have information on why -- and maybe you said it and a lost it. Why people are calling in? What are the complaints? What are the types of complaints you are hearing. Do you have data around people being denied for home modifications and assistive technology in the southwest, southeast.

MR. NOLEN: Yeah. One of the things -- when I talk on the daily phone calls that come in when I talk to the M COs on a daily basis, they provide me the top five or six call drivers. For the participants, it is mainly centered around benefits and eligibility. PC P questions and provider inquiries and making sure they are in the network.

Those are usually the top three drivers and then there are some lower drivers that make regard to service coordination or authorization. There has been very few service disruptions, issues with transportation have been very few. Not a lot of questions in regards to home mods at this point in time. That is the drivers from the participant side. On the provider side it is similar and checking eligibility for individuals and checking plan services. They are making sure that they are credentialed and in the last week or so, it has been a little bit heavier on claims and making sure claims are getting through the system and when the payment is going to come out.

MS. AUER: The consumer should be calling the provider. If they know they need a home modification and it is denied or adjusted to what they want it to be. I'm hearing people saying that they are -- the consumers are requesting certain types of things from their M C O but it might be something different. Something more low tech than what they need. But so how would you hear those types, like the nitty gritty type of things or should consumers go to you directly. I don't know if you guys are hearing that as an advocate, we are hearing more people saying that they are -- the people are being

denied the technology they are looking for and especially the modifications or the modifications are not what is recommended when something different might be recommended or there is long delays in getting them.

MR. NOLEN: We are hearing limited on that and some of that in the participant line that comes in through the office, a lot of that we are monitoring it in is through the denial notices that go out. If the M COs are altering what was asked for or denying. We see all of the denial and monitor it from that perspective. There are different ways that we look at that. The volume of those calls coming in, they are not real high at this point in time. I think a lot of participants might be following through the hearings and appeals when it is not what they requested. They are starting to go through that process also.

MS. AUER: Is there a chart -- I'm sorry. Is there a chart -- you told us the top six but is there a chart that might help us breakdown what the calls are kind of for. I think last meeting or the meeting before, I had asked for that kind of thing. It helps me see the complaints and issues but what are they around that way we can -- we can look at it a little bit more and what are the denials and what are people saying compared to what we know they are asking.

MR. NOLEN: That is something we can work with the M COs and put together for next month's meeting is a chart of call drivers.

MS. AUER: That would be great.

MR. HANCOCK: I think we can -- just clarifying question, Pam, I mean, the calls are, you know, going to the Customer Service unit.

SPEAKER: This is Customer Service. This is isn't all related to denials or that type of thing.

MR. HANCOCK: I'm just thinking breaking down the Customer Service calls will be probably not that helpful for you.

MS. AUER: No.

MR. HANCOCK: It will all be about claims.

MS. AUER: Maybe a little bit of why are people providing and what are the real issues and the stuff that they are being denied what type of stuff are they being denied or are they saying it is not what they are asking for. I recommend, again, too another go around of people knowing their rights. I'm curious of how many people out there might not know if a service coordinator says we can't get you this we will get you this. You can appeal this.

MR. HANCOCK: Yes.

MS. AUER: Is there another round of training going around to educate the consumers.

SPEAKER: It was about this time last year that we did that.

MR. HANCOCK: So what Jill is saying is that it is about this time last year that we did provide that. It would be a good opportunity to present data on complaints and grievances and focus on complaints and grievances in a Knerr term M L. T S sub M-A-C. The Pennsylvania law project and some of the community partners that are involved in legal aid services are often engaged in providing that communication and training to participants and participant advocates as well.

MS. AUER: Is that stuff going out with intakes when the M COs are doing the intakes what are your rights and responsibilities, is that going out so that the consumers have that up front too and every time they are being reassessed they get the list these are your rights and responsibilities.

SPEAKER: It is part of the letter.

MS. AUER: In a plain speak.

MR. NOLEN: It is part of the welcome packet that the M COs send out that lists the rights and responsibilities. The I mean, the three of you can talk whether that is something that you reaffirm during your service coordination meeting with the individual.

SPEAKER: This is Kathy Gordon. Pam, that is a requirement of our agreement with the state is that we review that and we sign off on it that we did that review. So -- and we also -- I yesterday was training and showing the staff where they could find it and show the participants on our website so that if they didn't have the paper copy they can go on line and see it. Okay?

MS. AUER: It is so important.

SPEAKER: Speak we do it on the initial and then we have 90 day visits that we have certain things they have to check so that would be part of their visit checklist to review that.

MS. AUER: Thank you.

MR. NOLEN: All right. Now we're going to go out of order here.

SPEAKER: Just a question. Do you collect data on circumstances where consumers have called in and their questions are still unresolved so they are making multiple calls or issues that week after week they are feeling they are not resolved. Do you collect any of that data in any way shape or form.

MR. NOLEN: We can track that if that comes in through the office participant line. We would be relying on the M C O if they are getting repeat calls on their participant hotlines.

SPEAKER: Can I ask a not related follow-up question. I think Kevin brought up Pennsylvania health law project. Do we have any data on how many people have contacted them regarding what or is that one of the slides.

MR. HANCOCK: We are asking for and getting data because it is kind of the beneficiary requirement. If they are willing, we will be happy to share the data they are giving us.

SPEAKER: Thank you.

MR. HANCOCK: Thank you.

MR. NOLEN: All right. So we are going to move forward and come back to the life enrollment. Kevin can do that part of it and he wants me to talk about the southwest service denials.

Just to come back, Pam, to your point, we have an operations report. It is called O-P-S 2 that does track a lot of the call statistics and a lot of the reasons for the calls. So we are working through that also. So we will be able to provide some data off of that next month too.

All right. So on the service denials. The first chart that we are showing is from our operations report 21 which is changes to the person centered service plan whereas we track increases, decreases to service plans. So you can see the first top of the chart is the percent of the that have increases and the bottom chart is the number that have had decreases. As you can see even in December, this is all southwest data, the numbers and percentages are fairly low less than 1 percent for the most part across all three of the plans both in increases and decreases. Again, we don't have this documentation yet for the southeast because of the continuity of care. We will be collecting that data as we are going forward. The other part is percent of decreased due to the M C O decision to reduce services following the reassessment of the individual. Again, as you see in the November and December data out in the southwest, it is less than 1 percent of individuals that have had change based on the reassessment. As we move forward, we will see if those numbers increase. One of the things that you have got to understand is these numbers will probably go up. And the reason for that is all three M COs now have the clearance to send out denial notices and that is fairly new. U P M C has had the clearance since September to send out denial notices. You have seen higher numbers from them. AmeriHealth has had permission since December. They have not denied a lot of services up to this point because they have done internal training on the process so their service coordinators know what they are supposed to be doing and how to handle service related issues and pH W has just gotten the okay in the last couple of weeks to send out their denial notices. That is why the numbers are low through the end of 18 but there may be some increases as we move forward with that.

MR. NAGELE: Question about that. If you do expect it to increase, could you maybe next time we meet talk about some examples of what actually has occurred because the numbers are so small, that doesn't really mean much. Some of the types of changes that are made in plans would be useful to know.

MR. NOLEN: I think what I'm seeing so far in the denial notices centered on two services. One is home mods, vehicle mods and in that same category where things are being denied. The larger percentage of it is past worker hours. So that is what we are starting to see with services right now with denials that are coming in is probably /# 5 percent of the denials that are coming in are either decreases in the current pass service hours on the new assessment or if it is a new request for additional hours, they may not be being approved or fully approved so that is primarily what we are seeing right now in the small sample that we have.

MR. NAGELE: That would be good to know. Those are two distinct categories reducing a plan that was already in place versus reducing a plan that is requested or whatever. So it would be good to know the difference there.

MR. HANCOCK: We could actually just to add to that, I think that is a great idea walking through an example scenario because the numbers are low. These are not physical health, health choices numbers for complaints and grievances at this time. The numbers are much higher in the physical health program but walking through examples of what -- what would lead to a grievance and as Randy stated, most of the grievances that I'm seeing are past personal assistance hours, approved other than requested or reduced from the previous assessment. So it would be interesting to have all three M COs individually walk through particular cases that -- that they -- that -- where they would have made a determination that would have been lead to go a grievance.

MS. AUER: The home mod stuff, too, if the denials are around the home mods not just the attendant care.

MR. HANCOCK: We have examples.

MR. NOLEN: Home mods that were totally denied and ones that were provided other than requested. Those are two distinct categories also. So we can look at that. I will work with the M COs over the next couple of weeks and get them to put data together to present at the next meeting.

That is an agenda item.

MR. HANCOCK: I'm sure that they will capture that.

MR. NOLEN: So those are the numbers. I mean, the other O-P-S 21 slide shows in regard to the number of participants that have seen decreases based on the reassessments and again, the same caveat with these numbers here. Expectation as

we get through the denial process and continuity of care process we will see some changes in these numbers.

The next report that I want to talk about is Q-M-U-M 7. That is the report that captures the authorization denials. Again, this is broken down for 2018. As you can see the numbers are fairly low. Expectation is that U P M C is at 3.2 percent. That would be expected by the fact that they had at least three months that they were issuing denial notices on services. On Q M U M 7, we have a number of categories that we collect distinct information on. One of them is pharmacy denials and one is home and community based M L. T S services and there is a separate tab for transportation, physical health and dental are collected separately. So we -- we will be able to break that out also for you. I mean, this is general across the whole report at this point in time but going forward, we will be able to break that out by the individual tabs that were collected the data on. I will be able to have a more expanded chart on that then also.

SPEAKER: Could we get that information by next month?

MR. NOLEN: Yes.

SPEAKER: Thank you.

MR. NOLEN: All right.

MR. HANCOCK: Is the next --

MR. NOLEN: Unless you want to me go over general what is going on with implementation of monitoring.

MR. HANCOCK: Yeah.

MR. NOLEN: While I have the microphone, I'm sure all of you can hear me. Most of you can hear me without the microphone. I was in a meeting. Kevin was in his office and I was in the meeting. He said who was that speaking. I said you couldn't hear me? I was kind of amazed. To give an update of where we are at follow-up in the southwest and in the southeast. As you know, as we keep saying, we have not forgotten the southwest. We have continued to monitor what the M COs are doing out there and continue to handle all of the related issues that come in. For the most part, the southwest is going fairly well at this point. There has been some continuing transportation issues that we have had to work through. Some of that is just continuing to follow up on what we created with the initial transportation issues. Service wise, it is not going well, with service coordination or home mods. We seem to be working through the issues in the southwest. There are a lot with individual indicates that come in but it /STK-PBD seem to be any overriding systematic issues. So we are continuing to work ton that. In the southeast, honestly, it has been a lot smoother than I think we expect it.

We continue to meet with the M COs and talk with them on a daily basis at our daily huddles. We have those every morning where we go over their call statistics and provider and participant related issues and issues with authorizations in H H A and issues with PPL and direct care worker payments. We talk about anything specific in regards to a participant or a provider or within the system to work it out. So we have been able -- we continue with those calls and continue to have weekly calls with the M COs to discuss any issues both southwest and southeast. So we continue to work through that part of the process. So we have that open dialogue and open communication. As Kevin said earlier we continue to have weekly calls with the nursing home associations and the home and community based providers and the participant advocates and the M COs we continue that open communication. In the southeast. We have seen very limited issues related to transportation. We have dealt with some issues in regards to service coordination, especially centered around the issue of we have had a handful of service coordinators not to continue providing services. Even through the continuity of care period and then the larger issue of PCA, Philadelphia corporation not working or contracting with U P M C to provide service coordination and then working with U P M C as they address those issues of providing either alternative service coordination for an individual or allowing participants to make plan changes. At this point, we are coordinating that between U P M C tracking and what we are tracking through the I-E-B on plan changes and to date, there has been 171 participants who have changed plans because of the service coordinated related issue. We continue to monitor that. U P M C has sent -- attempted to make phone calls to all of the participants accepted. There was 1398 for those individuals that were not able to get ahold of by phone, they have sent out additional letters telling them they are trying to get in touch with them and encouraging them to call into the service coordinator line. We will continue to work through that issue if people do decide that they want to make changes, we will do what we can to make those plans work.

So that has been kind of the big issues that we are running without there. Just working through a lot of training of providers to make sure claims are going through appropriately and can enter things into the system. We do continue to have some clean up issues with some of our data out of Sams or H-C-I-S and we are working through cleaning up files back and forth. A lot of stuff comes into Gene's unit to work with the I-E-B and with O-I-M to clear up eligibility related issues and she has been getting those done in a speedy time frame. So we are working through some of the issues, the growth issues that we expected. But we are not seeing any real big blow ups at this point in time.

MR. NAGELE: Is there a way to get a clean list of who the current service coordinators are and working with which M C O. Because it kind of amazed us that some of them would decide not to work through the continuity of care period and not answering their phones. We don't know who is on first.

MR. NOLEN: Yeah. I mean, M COs can provide that list. So if you guys want to provide that back to me we can certainly provide that out. One of the things we asked the M COs to report on a weekly basis. They had to report on the network accuracy through

us and the Department of Health. We ask them to report on the weekly basis their -- the network for nursing facilities, their network for hospitals, and their network for service coordination. We do have that that comes in on a weekly basis. We will be able to confirm that with them and make sure that is right and be able to pull that data out on the Friday reports that we get from them.

MR. HANCOCK: The only thing I would add, I'm only aware of one service coordinator issue with one managed care organization. It was one of the largest service coordinators in the state. So it was very noticeable but if you hear of any others let us know. We know service coordinators with all three of the M COs that haven't been terribly responsive during the continuity of care issue could be a bigger issue and that is concerning to us and we would want to hear that kind of feedback not only from the M COs but from providers who are, you know, hitting some roadblocks and making sure the participants are getting their care.

SPEAKER: May I add and your presentation, thank you. This managed care, I don't hear anything on the health service side on the matter that in Temple Hospital staff were telling their patients oh, we don't take PA health and wellness change to U P M C or the other one and there is no way to collect how that happened it just happened and this is great that you are reaching to all of the long-term care side of this provider, consumers. If you don't do a check on Philadelphia and the surrounding area, every hospital, Temple is a major hospitals. What about all of the little providers. There is no cross check with all of those on your weekly call /TPH-Z your list of things, you did not add any health or mental health or physical health entity. Possibly there is something added. It is very concerning and we are changing into a managed care system the health side of the managed care is being completely not discussed.

MR. HANCOCK: I think that is important feedback. To be perfectly honest, our reporting focuses on long term services and supports. I think now, we are in phase 2, we do need to start recognizing the fact -- so one of the challenges that we have in our system as you know, especially with your own personal situation is that the vast majority of our participants are dually eligible. Most of their physical health services have a primary pay with Medicare. In a lot of cases we may not have immediate transparency about the services that participants are receiving. But we are also a physical health managed care -- C H C is a physical health -- as long as I long term services and supports program. We should be reporting on this. We actually don't even really have enough representation on this Committee for physical health providers as well. So you are right. You are actually -- you are --

SPEAKER: What are we going to do about it.

MR. HANCOCK: We got to report back. We have to do more thorough reporting.

JILL: I do want to assure you though because based on my background I came from the health choices side so I have had a focus on the physical health side and I do want to assure you that we are actively engaged with the hospital association and the PA

medical society and regular communications we have regular and recent meetings with health systems -- I personally went out and spoke to physical health systems in the Philadelphia area for phase 2 and plan on engaging. We have actually worked with our F Q H Cs and done training and dedicated C H C training with the F Q H C association. So it is happening. We clearly don't have some reporting here for you guys around that. But they are actively engaged. They have actually included information in our newsletters, in their newsletters to their members and that kind of thing. So there is activity going on but like Kevin said, because it is a -- you know, the dual eligible population, a lot of times the Medicare kind of gets that lost in our reporting but there is engagementes. I just want to make sure that you do know that.

MR. HANCOCK: Can I -- would I be all right if I provided a background not about your particular situation but what you are alluding to.

So the largest Medicaid provider in the state is Temple and they are also -- they are the -- you know, very large hospital in the Philadelphia area. There has been ongoing contract negotiations with one of the three managed care organizations. It is not yet finalized but there has been some communication confusion about that largest Medicaid provider in the state, Temple, and what coverage would be available for that managed care organization. I believe that that managed care organization is working through those communication issues as well as contracting issues with the provider but that being said, it has created some examples of confusion that need to be worked through. But I'm just going to reiterate what your point and also in view of the engagement that we have had and the M COs have had with physical health providers. We do need to report more, we do, on physical health services and we would love suggestions from the Committee and also for -- for -- for individuals who are -- are interested stakeholders on what you would like to see.

MR. NOLEN: I can tell you that I have been working with the entity that is dealing with Temple and talking to them about how they need to communicate back to Temple. You are right, Temple is a large entity and has large outpatient clinics and off site doctor's offices and the word is not getting spread that even though they don't have a contract with the M C O that they are still responsible for continuity of care services and still responsible for those co-pays of services and pay as an out of network provider. I have had the discussion. I'm going to have that discussion internally in how to reach out through us directly through Temple or through the hospital association to speak with Temple so that they understand that message that they should be providing services not cancelling appointments. Not turning people away. Because they are going to get paid for the services they provide. They are going to get paid for Medicare and then they get paid secondly through the M COs through a contracting relationship or an out of network relationship. Part of that is communication and education and we need to continue to provide.

SPEAKER: So continuity of care period you are going to continue what you are supposed to get. That has been our complaint all along that this process has moved that you are not getting this care. It is miscommunication because there is not time for

them to know what is going on. These things should not be happening. The state is responsible and the M COs that it should just happen and you have such a huge network out there. It is not getting out there. People are wasting their time and money going to appointments not getting what they need. Shouldn't that have happened at continuity of care but it is not happening. I don't think there is enough time for that information to get out to all of these providers and that has been our complaint all along because I don't understand what continuity of care is.

MR. NOLEN: Were you going to say something.

MS. AUER: I'm confused about the out of network thing. If I go out of network, it is going to cost me more, will it cost the consumers more if they are being the medical people as out of network? So we have different co-pays, it would be more expensive for our consumers or --

MR. NOLEN: No it shouldn't impact the consumer at all. It is the relationship through the M C O and the provider. They have an out of network relationship, they are going to determine what their cost is and what they are going to pay them and they are going to continue to work with them and continue to make them a network provider. It is a contractual relationship even if it is a single agreement for that person of what they pay but it shouldn't -- it will have no impact on the participant's co-pay or anything like.

MR. HANCOCK: It is contractual in our system. But -- especially if a person is dual, they can't be balanced billed. It is the fee for service Medicaid program. If it is a provider that provides a service that can't be found in the Medicaid role that the M COs go forward with an out of network contract. Every contractor has to be Medicaid --

MS. AUER: Just have the regular co-pay. You would just have your regular co-pay.

MR. NOLEN: Yes.

MR. HANCOCK: Or whatever is specified in the agreement.

MR. PRUSHNOK: Maybe to chime in from M C.O.'s perspective on this. I think the piece of the context that we haven't talked about today is that we are first and for most -- because of the filings earlier, we meet time and distance, you know, network -- there have been contracting for -- we have been contracting for the southeast more than a year in advance and to go live and throughout the summer and into the fall, you know, weekly reporting and phone calls with Randy and his team on our network and, again, to meet the Medicaid and Department of Health standards, we each have, you know, a very robust network and in order to do that and then on the continuation of care for physical health providers, we -- and this is a health choices requirement as well so this is part of, you know, on both the physical health program and C H C where any provider that a person is with for their first 60 days whether it is the beginning of the program or somebody comes and joins us a year later or what have you, we honor that provider choice and we, you know, we will, you know, pay that provider accordingly and

sometimes, you know, providers don't always realize that so even though it has been a feature of the Medicare program for a long time, there is continual education and making sure providers understand that that yes, this person can receive services and being sort of a newer brand in the southeast market, we have done a lot of education. So providers that we have a network asking us questions and providers, you know, sort of just getting a feel for it and I think another positive thing from sort of first year to second year is we are getting a lot fewer questions around the primary secondary issues providers seem to be understanding, you know, how C H C fits in and for the Medicare population and secondary payer. The issues are hugely important when they occur but I do think that they are increasingly rare and we are not getting a lot of these type of network issues which would be a sign of a successful launch so far.

MR. HANCOCK: I would agree. The only thing I would add is unfortunately, these situations happen all the time in the fee for service system. The opportunity we have now is that we have the managed care organizations that can provide cohesive training to their participants as well as any out of network partners they may have on being able to address those issues. So people used to get bills all the time in the fee for service system inappropriately and that is one of the opportunities we have with managed care to address.

MR. BOROCH: I would add too M COs, you know, decent program, we do, you know, try and make it abundantly clear and do a lot of education with the providers. When you talk about Temple University or large health system, that is not one person, that is hundreds of employees.

MR. HANCOCK: Thousands.

MR. BOROCH: They have to understand anyone help -- anyone helping needs to understand that they have staff change and things like that. It is even going effort and it is never perfect but as long as the M COs are continuing to do that education and outreach, keep it to a minimum.

MS. AUER: I just wanted to say one thing to support what Nancy was saying for the possible extension of a continuity of care. If it is training, the big healthcare providers and then all of their staff, you know, it might be important to delay it a little bit longer to get them educated. Like Nancy said, it may not be much to us working full-time when you are putting your resources and time and energy and the time to go to a doctor's appointment and the continuity of care period that you should be getting these healthcare services and when you get there, they are saying no, you can't have these services. I think it is to our consumer's benefit to get things straight and then have the -- the healthcare situation clear as well as our home care stuff, might be beneficial to delay things a little bit just making sure that people are educated and not wasting a lot of our consumer's precious resources.

MR. NOLEN: I think in this point, the issue is not continuity of care. It is the lack of contract and the educational piece of the Temple, that practice that they were supposed

to be providing the services. So I think this contractual issue went further than continuity of care and we would still have the issue. It is a matter of addressing the educational piece so that everybody knows that this service will be paid for. They weren't changing the care and weren't turning them away for care because of the continuity of care period. It was simply a misunderstanding that they were going to get paid for the service. So my push is to make sure these M COs get their networks in place. A lesson learned with some of the large health providers. We had some larger health systems in the southeast than we did in the southwest. The definite push will be as we move into the phase 3 and the other zone we have some large healthcare systems that the M COs start quicker and more aggressively work in getting the contracts done prior to January 1 of 2020 so we don't run into this contracting issue. So that is where I see the push as being.

All right. Well, thank you for your time. And if you have any questions afterwards, we can answer them.

MR. HANCOCK: So bear with me for one second as I get to the right slide here. N-I-N-A in the previous meeting asked for life enrollment. We decided to break out the life enrollment by the two phases. The first slide shows life enrollment activity for the southwest which would have overlaps with their implementation period into operations for community health choices and all the way into 2019. And obviously, these slides will be made available so you don't have to --

MS. DELGRANDE: Okay.

MR. HANCOCK: As we see, we have had a few months where there have been decreases in enrollment but the majority of the months have seen increases for the life program statewide.

So if it is my understanding and Jonathan, correct me if I am wrong the average increase in the southwest was four to 5 percent is that right.

SPEAKER: That is about right.

MR. HANCOCK: So that is a net increase is that right.

SPEAKER: Correct.

MR. HANCOCK: So as a matter of background, some other states had seen some significant enrollment in their pace or life program when they -- Pennsylvania was hoping for the same increase in our life program as well. Largely because it is the enrollment alternative to community health choices and it is a fully integrated managed long term services and supports program. So we were looking for an opportunity to grow the program that sometimes happened with -- with the implementation of an M L. TSS.

We didn't see that as much as we would like. We did see some increase in enrollment but nearly as much as we would like. We were hoping for 10 percent and we were seeing a lower percentage. And that percentage is statewide. So we don't know -- we have made a lot of effort to beef of communication. The life program during this C H C enrollment process and ongoing operations. We are looking at different ways as ways to improve communications about life programs as an offering for participants and we are looking forward to seeing that continue to increase enrollment as well.

MR. NAGELE: Question about that. Is there a greater representation of life providers in the southeast region compared to the southwest? Or the central region.

MR. HANCOCK: I would say that the life representation in the southwest has more life providers and there is a presence in every county now. So in the southwest, every single county has a life plan. In the southeast, one of the five southeastern counties does not have life although one is in development or it is being discussed. Chester County right now may not have a life offering as compared to all of the counties in the southwest. The remainder of the state, however, has very -- we are -- we have a plan to go statewide with life for a roll out but there are many that do not have any presence of the life program. So it is -- it is something that we are looking forward to seeing grow in phase 3 remaining CHC zones.

MR. NAGELE: Just a follow-up to that. How are you proposing to encourage that or to kind of increase it over time?

MR. HANCOCK: In the very near future, we will be releasing an opportunity for entities to propose the remaining areas that currently do not have a life program available. And those proposed proposals will be reviewed and assigned.

MR. NAGELE: Does that go through an RFP or contracting.

MR. HANCOCK: No. It is similar. It is kind of like a market study on how they are going to be able to roll out the program. There is an evaluation but it is not a traditional RFP proposal. It is a – it is more like a provider assignment proposal. It is not more -- not a traditional procurement per se. But there will be a public notice and an announcement and interested parties can submit a proposal.

MR. NAGELE: This is more of a question for Nina. I don't know if your group -- well, the parent group, what do you call it PALPA.

MS. DELGRANDE: P-A-L-P-A.

MR. NAGELE: Would you involve P-A-L-P-A in that. Some providers may not --

MR. HANCOCK: P-A-L-P-A is heavily involved in this process. They are heavily involved in this process. And we -- we need their feedback obviously for the engagement. But P-A-L-P-A is made up of members that may be bidding. We want to

make sure that the process -- they are aware of it happening engaging with the department in making it as successful as possible. Great question. Then moving onto the southeast, this shows a little bit of a longitudinal volume of enrollment as well. Increase -- we saw some significant increases in the 2018 timeframe even though CHC was not even there. But we did see an up tick in enrollments in October 2018 and more significant enrollments between August and December. We can't directly attribute that increase to the enrollments information that was shared about the life program. But the fact that that was the time period that the enrollment information was being shared with participants, we think maybe an indicator that some of the communication ended up being successful. So there was an increase in enrollment last fall for the southeast for the life program. And we are looking forward to see how that continues in the southeast as well. So life, there is a statewide strategy for life roll. We are looking forward to growing this program. What is particularly attractive to the program is it is full integration between Medicare and Medicaid behavioral health services and long term services and supports. It is a fully integrated program for those people who are dually eligible and we believe that that model of care is a great model of care for people who want to be able to receive all of their services in one lot. CHC in contrast is a coordinated model. We mandate coordination. There is a difference between the two programs. Any questions about life enrollment? And we will continue to update.

MS. AUER: Of course. Thank you. Is there a way to see some of the service plans from life so we -- people can see it from a different perspective what a service plan might look for CHC and what a service plan might look like for a life program if they have service plans or what that would look like. Sorry. I'm thinking about the different options under the CHC versus what are all of the different options under the life program. I am looking at -- and I thank Jennifer, if you are over there, for letting me see the comparison chart and I really appreciate that. I'm looking at it and I will be making comment to it. I'm just kind of curious because it is so positive for the life program and my first glance and then you look at CHC and it is kind of blah and I want to know more about the life program so I know why it is so much more fuller and vibrant than CHC. Is there a way to see that stuff?

MR. HANCOCK: Just to be clear. We think both programs are absolutely wonderful.

MS. AUER: It doesn't appear that way.

MR. HANCOCK: That is feedback we need to hear.

MS. AUER: Somebody else I showed it to. One was mandatory, one voluntary. Words pop out like that.

MR. HANCOCK: That is a true statement.

MS. DELGRANDE: It is true.

MR. HANCOCK: CHC is mandatory and the life program is voluntary.

MS. AUER: That is the first line. It is words like that. Positive –

MR. HANCOCK: That is good feedback.

MS. AUER: Any way, you know, I think that I would love for more people in the -- in the physical disability community to see that but I would like to know more about the life program and the comparison what would a service plan look like for a life program and, you know, what is -- what is -- when it comes to the services, choices and options, what are your choices and options under the life program and what are your choices and options under CHC because sometimes when it said life – my understanding of the life program and you correct me if I am wrong you go with the providers that that person – the healthcare providers, whatever they contract with, you don't have a choice that you go with what that life program's providers provide. And it said you may have a choice. And some of the language in it. So I would like to know more about what the options really are.

MR. HANCOCK: So another way that I would characterize your request is to have a life plan walk through the interdisciplinary team approach and how they develop their own service plan. What is the name for the service plan in the life program.

MS. DELGRANDE: We just call it a care plan but the IEB develops an interdisciplinary care plan. It includes every discipline and what their entire plan of care is. Instead of a service plan, it is called a care plan.

MR. HANCOCK: CHC a person-centered service plan is built on the interdisciplinary team model and it is available in the pace program and common in the pace program. I think that is a great suggestion Pam to have a life plan walk through how the process works and what a plan will look like.

MS. AUER: The other parse of is it someone is already on the waiver, how do they -- who is connecting, like, if a --someone who is on a waiver talks to the life program, who is involved in all of that. I have had a couple of situations where someone went from the waiver to the life program, service coordinator didn't do anything about it, some of the people helped the person get that waiver stuff and the person went to the life program where is the communication between that and my last was question too is how easy is it, if you are on the life program and you want to go back to waiver? Do you have to go through the whole application for waiver again? Is it -- say -- it sounded really smooth to go from waiver to the life program but if that person decided then that they didn't want that life program anymore, is it just as easy to go back to the waiver or do you have to go three, four months through the application process for waiver.

MR. HANCOCK: You wouldn't have to go through the three or four months. We can talk about the eligibility process. In the very new process, the eligibility would be a good refresher for the Committee. It is complex and it hasn't changed with Community HealthChoices the only thing different is the managed care selection. Moving between CHC and the life program and vice versa would have been basically the same as

moving between independence waiver and the life program. So walking through that process, I think, it is a great suggestion for the future. In the near term, describing the interdisciplinary team and the life program and how that translates to a service plan or a care plan would be an important presentation and I think that -- I think we should look in the very near future to have one of the life plans and our life program.

MS. AUER: That might help the comparison chart.

MR. HANCOCK: With the comparison chart. Too. Great. I appreciate the suggestion.

MR. NAGELE: I think Kevin knows what I'm going to say. Communication is like the crux here and how participants are going to perceive what is written about CHC may sound to them like their sentence to that but they could choose life. You got to think about how it comes across to a participant.

SPEAKER: The way that you said that.

MR. HANCOCK: Thank you for that feedback. So we would not – the last thing we want and any of this communication is to be misleading. So we like that feedback. We want people to make sure they are making their choice with eyes wide open. Thank you.

SPEAKER: In regard to the life program in Chester County. It is my understanding that there are Zip Codes in Chester County covered by the life program that is a neighboring county. I don't know if that is still existed but there are some specific areas where you service Chester County. Is there any thought to expanding the Zip Codes that are being covered so temporarily Chester County would have the opportunity to have a life option.

MR. HANCOCK: So it is in flight right now. The development of the life program is on -- under way in Chester County. It is a partnership development and it actually involves all of the Zip Codes in Chester County. That is something in the works. Thank you. So you know, the history of Chester County. There was a life program there and it -- that life program went out of business and Chester did have it developed, was developed but it has -- it is in the process of being restored for life -- life -- life recipients for people interested in the life program. Great. Anymore questions about life enrollment? Okay. Then just a quick update on enrollment -- is southwest or southeast first? Southwest. Okay. So this slide shows new southwest enrollments. It is starting -- this is enrollment date is February 1 st, 2019 and it shows individuals, the breakdown of individual by individual category. The southwest just in general, you can look at the numbers but I would have to say the southwest is very -- it grows but very incrementally and the individual categories in the southwest tend to be the same level of growth across the board. It is a very stable growth population in the southwest. It is really interesting because -- because there is incremental growth in the long-term care program and it generally follows the same pattern consistently does. It is very interesting how the continues to grow. The ladies and gentlemen start are the N F I dual and then

throughout every single one of the categories has seen some consist sent growth. Do you have a question?

SPEAKER: In light of the Temple discussion and understanding, I'm concerned about the service interruptions. Having less than 25 reported it means the M COs are not reporting or not collecting information well. That doesn't make any sense having Temple being one of the largest.

MR. HANCOCK: Do you mind if I repeat what you just stated. The concern you are raising is you think the data that is reported is under reported.

SPEAKER: Having been one of the largest service providers only 25 service interruptions. It doesn't make sense.

MR. HANCOCK: So we do monitor what the M COs are reporting to us. We don't take them at their word. We do monitor what they are reporting to us and when they validate it. That being said it does not necessarily mean that -- and it certainly is a good question to ask, the managed care organizations are necessarily -- as we have it defined for the report.

SPEAKER: Thank you.

MR. HANCOCK: Thank you. So then moving onto the southeast enrollments. The southeast however in community HealthChoices is very different and it is -- this is -- this is one month of enrollments. So they have seen an increase in long term population in one month by 3100 individuals. The southeast as I stated here before with this Committee and every else I can. Growing like crazy. If you look at the populations that it is growing the HCBS duals and nonduals are growing. So we hit about 200 enrollments in the rest of the state for H CBS duals. So they are growing at 3 times the rate as the rest of the state for home and community based services. Long-term care growth is very low in the southeast but the home and community based duals in the southeast are growing like crazy. I'm not sure what exactly that means for the southeast. Obviously, they have a growing population for in need of Medicaid long term services and supports but the reality is that phase 3 has a larger population enrolled in the program. So phase 2 is where all of the growth is for the program right now. It is very significant and it is primarily for people that N F I dual and people receiving care in the community. Three times as much as the state. It is a lot. So any questions or comments or thoughts about that? It is a lot. When we talk about budget season, that is something that I always have to be able to explain and to be perfectly honest, the only explanations we have are antidotal that it is largely driven by providers bringing people into the system or service coordinators bringing people into the system.

MR. NAGELE: Is there any thought to trending of aging?

MR. HANCOCK: We are done that.

MR. NAGELE: As contributing to this particular growth in this population.

MR. HANCOCK: The southwest is a direct corollary between aging and the population.

MR. NAGELE: It is well established that Pennsylvania is one of the most populous states and one of the most populous aging states. And so we may be unlike other states in that regard.

MR. HANCOCK: I mean, we are not even second or third anymore. There are other states that have a larger aging population. The southwest does have a direct relationship of growth in aging population to the growth and population. The southeast is not representative --like, we are talking about, you know, 30 percent a quarter in some cases. We are not growing that fast. It is just -- it is driven by other forces.

MR. NAGELE: Well, I just -- I think about all of the snow birds that have to come home and live here.

MR. HANCOCK: Okay.

SPEAKER: Again, what are these numbers the southeast enrollment.

MR. HANCOCK: For one month.

SPEAKER: For January.

MR. HANCOCK: For January. Yeah.

SPEAKER: New or existing.

MR. HANCOCK: New.

SPEAKER: Community and nursing home.

MR. HANCOCK: If you look at the data, it includes -- NFI dual, those individuals –

SPEAKER: Stay with grand total. New?

MR. HANCOCK: New.

SPEAKER: I have a concern and I will leave it at that. I know just from my grandmother's sense, Temple was suggesting that people were in the other one to Keystone first. That is what they were telling people. The staffer, people down at reception. We don't take PA health and wellness change to Keystone first and that is it. Hopefully, we will see some good data following up on how this is resolved.

MR. HANCOCK: With Temple for sure.

SPEAKER: At least, I would hope that before the continuity of care ends in the southeast, all southeast medical providers are directly reached at consumers --

otherwise, we wouldn't know for sure that people are getting the services that they need and the care that they may need to be extended.

MR. HANCOCK: Jill made a clear statement of us doing all we can. But you have to have -- and in many cases like with participants you have to have a willing audience. So we can do all the communication we want but in many cases providers only really pay attention to if they are a Medicare provider, they may not be necessarily paying attention to as much of what is happening on the Medicaid side or community HealthChoices as we would like. We could probably go to every single office. We as the department can go to every single office and talk to every single employee? That office and every single physical health provider and they may not necessarily -- may not necessarily care. We hope that they do. We will try to do all we can to get them to care but you can make the argument, it is never going to be 100 percent. We are doing all we can.

SPEAKER: It sounds like contractual than the continuity care issue if there are such issues existing perhaps –

MR. HANCOCK: I don't understand.

SPEAKER: Well, by some recipients not receiving a service where they wanted it because that office wasn't fully informed, it is not the consumer's fault or the patient's fault in this case and they shouldn't be -- they shouldn't suffer when that happens.

MR. HANCOCK: We agree. Of course.

SPEAKER: I would imagine if the state is forcing and you have been preparing for this for five years when we first started talking about managed care.

MR. HANCOCK: Four. Four years.

SPEAKER: Four years. Thank you. Then it is here. It is funded. It is happening that the state does what it should do for its residents.

MR. HANCOCK: I'm still not sure I understand.

SPEAKER: If -- Philadelphia has hundreds of thousands of healthcare providers.

MR. HANCOCK: And they do.

SPEAKER: They do. We all know that. And if not -- if all of them are not directly reached and explained about these changes how are they to understand?

MR. HANCOCK: So you are saying –

SPEAKER: And the value and the work of this as you sold it to us. People with disabilities were told that this had to be the program.

MR. HANCOCK: I'm concerned about raising a standard where every single physical health provider has to be acknowledged and completely be on board about a program that they may not -- in the physical health system, many of those 100,000 providers never paid any attention to Medicaid if they were providing care to a dual eligible or Medicare was a primary payer. I think it is an unfair standard.

SPEAKER: They will get paid –

MR. HANCOCK: They will get paid by the Medicare program.

SPEAKER: I get it but –

SPEAKER: Can I add something. This is Nancy. So I think you need to change the information you are going to send out to the next phase 3 that to let everyone know who is on Medicare, you need to start telling your doctor now that you will be going into a managed care plan and these are the three. And you will get paid. I think you need to put that there. What we were told if you have Medicare and Medicaid, don't worry about it, you will keep your provider. That is not necessarily true. If you let consumers know now, you need to tell your provider and there will be word of mouth and we will be switching and these are the three M COs and you are going to find out they are going to cover me and you will get paid. Start putting that out.

MR. HANCOCK: I agree -- first of all, it is -- we do include that as part of the information that goes out to participants. The challenge that we had in the first phase and some of the challenges we are seeing in the second phase, in the second phase it has been a lot better than the first phase. Providers that -- physical health providers that primarily offer services through the Medicare or mid care advantage programs don't focus on the Medicaid program. And it is a real challenge for the Medicaid program to get them to pay attention to our program. I'm just trying to level set expectations. We agree that getting that message to participants to make sure that they know Medicare coverage primary for physical health services they don't need to make any chances or their providers unless they want to make changes to the Medicare providers is a true statement. They don't need to make any changes to Medicare related providers or services unless they want to make changes.

SPEAKER: They need to tell their provider this is what is going to happen. They don't have to make a change they need to tell them or there will be a change whether they like it or not and then they will listen.

MR. HANCOCK: Conceptually, I agree. You can say managed care is a variable. I do think that managed care is a variable for improvement because you at least have a managed care organization that will be developing a network that will most likely include that provider to help get the message out. The issues that you are talking about have heard in the fee for service system since the beginning of the Medicaid program Medicare and Medicaid together just we will -- we will do all we can and we appreciate all the feedback that you are giving us but the reality is that the standard of 100 percent is impossible.

SPEAKER: Last question on this, Kevin, if I may -- a provider speaking managed care whole system. Can providers suggest HCH programs. Use this one --

MR. HANCOCK: What providers would normally say which managed care organizations they participate in whether it is Medicare Medicaid or otherwise. Whether they market those managed care organizations is a different question, but they can tell their patients which managed care organizations that they do participate in.

JILL: And I just want.

SPEAKER: That is not my question.

JILL: Historically it does happen. It is not something that is a provider agreement that says you can't say to one of your patients choose this plan over that plan. It does happen. Historically, it has happened in the HealthChoices program. It will continue to happen. What we try to do and what -- you know, I just want to reiterate with you and I'm sorry Nancy stepped out, I want to make sure that you guys know that we are escalating the situation and making sure that not only the hospital association is aware of this situation that occurred but also, the PA medical society because that has been the way that we have been able to communicate with the providers that are Medicare primary, right? So they are doing a lot of the outreach to make sure that all of their providers are aware so you are getting it at the physician level or the office administrator level and that kind of thing. So we are going to continue to do that and make sure that we use this example as another way to reinforce for phase 3 and in the existing zones that the providers need to be aware that, you know, this is in place and just making them aware. We haven't prohibited them from saying, oh, use this plan over that plan. We are aware that it happens and, you know, it is just something that the managed care organizations are also aware of.

SPEAKER: Thank you.

SPEAKER: Going back to the hospitalization part, it seems it would behoove all of the MCOs to belong to all of the hospitals in the area because if you make a choice of who

you want through your CHC provider and they don't deal with that at one of the hospitals, you have to make a choice that you may not necessarily want to make.

MR. HANCOCK: I couldn't agree more with that statement. Unfortunately, in this system -- it is even true for the Medicaid program in general. Sometimes, you can't come to terms between a provider and a managed care organization. That is in Medicare, that is in Medicaid and that is in commercial insurance as well and sometimes it is even -- it is part, like, we might have providers that might not want to participate in the Medicaid program either. We have a lot of providers that participate in Medicare and do not participate in Medicaid. I couldn't agree with you more. It would be much better if everybody -- we had as big as network, the hospital based services, they all participated in all of the programs. But it is like the southeast comparatively speaking, we have one issue being worked through with Temple and one of the managed care organizations and another major health system in Philadelphia that didn't contract with another of the managed care organizations. In the southwest it is more pronounced. The division is much clearer there. I wish they would all get along.

SPEAKER: Thinking about the T now too because if that is the issue we are having in the southwest and southeast, that is about to be said about what is going to happen in that T.

MR. HANCOCK: So what is particularly a challenge in the T is the rural nature of a lot of the areas and the fact that you may only have one health system available to you. So I couldn't agree with you more. But we will keep you posted on this. And as Jill has made very clear, we are not going to stop until -- I think the goal that Herman had mentioned about reaching all of the providers is critical. I mean, just – also setting the expectation in the healthcare system as complex as it is, there is only so much we can can mandate. This is all voluntary and willingness when it comes to the provider participation and engagement. So we are going to do our very best and never give up. I would guarantee the managed care organizations are going to take on the same attitude but having -- it is just -- we don't live in a world of absolutes.

SPEAKER: My name is Maryanne I'm a participant slash consumer. I kind of, I guess, my age, have the depth of history and when I lived in northwestern Pennsylvania, I don't want to make it sound like a penal code, I did 45 years out of there and now I'm down of Lancaster and happy to be out of the snow. This seems to me déjà vu because I was a long term advocate for people with disabilities and elderly and I can remember a time when the managed care or the healthcare providers sat in the Welfare offices and bombarded clients as they came in and then they were banished from doing that. I can remember a time when healthcare providers were knocking on a door and somehow they got lists in a rural community of who was a welfare recipient and they walked around with like holes punched with everybody they had flipped and then we had a

massive problem in Crawford County Erie northwestern PA where we had disenfranchised the clients from their healthcare provider. We had some that were 8 and 9 months present. You opted out of the healthcare that I belong to. What I'm listening to and what I'm hearing, it sounds like not only do we need an educational consumer piece but we need some guidelines on the road for the managed care folks. I hear you deflecting the responsibility of it is complex, it is oh well. It sounds -- that bothers me because I think you can do much better and I think with the managed care folks we need to put guardrails on the road so that they also have to be able to suggest to the consumer that they may be switching, flipping, or is now stuck with them that there are certain things that are and are not going to happen. And appeal is kind of a harsh word but I have had -- up in northwestern PA to get people back to their provider that they had had a long term relationship with. And from a communications piece and educational piece, I really kind of see that missing. And I feel like haven't we learned anything. I mean, this was in the 80s. I'm disappointed.

MR. HANCOCK: So can I -- we actually took the lessons of what you are describing. The managed care organizations are strictly prohibited from direct marketing with participants. They are strictly prohibited. That is not in the agreement but in our waiver communication with our Federal participant. The managed care organizations are prohibited from any direct marketing.

SPEAKER: It sounds like they are a little too prohibited. They are not being expressive enough from the situations I'm hearing at Temple and some of the others that have been expressed today and some of the other things I'm hearing. I feel like we haven't quite found that in your lane kind of thing because people are not well informed it sounds like or informed, what we heard today, what I think I heard was when they showed up at Temple what happened was if you would enroll in -- was it Keystone first, I think I heard, then we could take care of you. It is like the managed care is kind of driving the vehicle when it really ought to be the consumer hand in hand with Department of Health and services. I'm a little concerned that I'm not hearing or seeing that.

MR. HANCOCK: I'm a little confused on how to respond to you. The MCO don't direct --

SPEAKER: Don't respond just let it marinate. I'm getting close to being a senior I'm not going to tell how old I am. I'm also in a dual situation where I'm getting bombarded with phone calls you are getting to be 65 and others. I have a little script that I read. My prescriptions are $76 thousand a year. I have 8 pieces of medical equipment. I have attendant care and I have had people hang up on me, you know, because, okay, thanks. I'm sorry. I think maybe I called the wrong number. That is what is happening to me at this point from a personal perspective and I'm also doing a lot of healthcare out

of what you would now call network because I still go to Pittsburgh for some things. I'm now going to Philly which is why I came down here to Lancaster. I'm really confused as to what is going to happen especially when I see the kind of Trump care kind of thing, the whole issue of Trumpism. It doesn't seem like it is going to care about what happens to me.

MR. HANCOCK: It is great you are willing to share your story. I think that part of what you are giving as feedback would be once again messaging and we are -- we are committed to do what we can especially with the provider community to get the message out there and make sure that they are understanding what community HealthChoices is. I think using the Temple situation, the Temple situation is unfortunate and it really does relate to the networking issue between managed care organizations and providers. I hope it is corrected in the very near future. Linda's point the core systems are participating with all of the managed care organizations and community HealthChoices. But we appreciate -- you are now part of the third phase. You would have been if you were in the Erie area and you will be if you are living in the Lancaster area now. We hope you continue provide us feedback on how to make this better.

SPEAKER: I feel like where should I move next to be left alone.

MR. HANCOCK: Hopefully you stay in Pennsylvania at least.

MS. POLZER: Kevin I have a question off the phone. Could the panel discuss in more detail the provider payment issues that happened in the southeast so far and what we think the issues may be tied to? I'm not sure what a spice system is.

MR. HANCOCK: H-H-A.

MS. POLZER: Data exchange. I'm not sure.

MR. HANCOCK: Sams. I think we are going to assume.

SPEAKER: It is source.

MR. HANCOCK: There were once again with the southeast the two source systems for care management were Sams and HCSIS in the fee for service waivers prior to the implementation of community HealthChoices. So there were -- most of the data integrity issues were largely addressed in this implementation because we learned from the southwest implementation. With one of the managed care organizations we learned of system configuration issues that caused a lot of manual work and created a lot of the claims issues that occurred and that were occurring described by Randy. We believe that all of those manual entries have been completed but it was largely data issues and data configuration issues for the core system that created some of the claims processing issues earlier. Is there anything you would add to that Randy.

MR. NOLEN: No.

MR. HANCOCK: So it was – once again it was data configuration of the source data. Source data once again was the case management system Sams and HCSIS.

TELEPHONE: Kevin.

MR. HANCOCK: We have a couple of questions ahead of you Tonya, if that is all right.

TELEPHONE: Okay.

SPEAKER: Should she go to the table?

MS. POLZER: Please.

SPEAKER: Hello. My name is Marsha. I'm the program director for deaf blind living services for the Center for Independent Living of Central Pennsylvania. My question today is -- which is an issue that has been brought up by some of my colleagues in the room and I would like to see if there is a status update. I believe at one point when I met with one -- I don't remember if it was with you Kevin or someone else but we talked about identification of folks who are deaf blind.

MR. HANCOCK: Sure.

SPEAKER: If that is still the case that that information is not obtained from consumers, if they have a hearing or vision loss but further about the communication of those individuals I back a few years ago through Maximus and IEB and when I called they didn't know anything about deaf blindness. They didn't know anything -- nor did they know to ask about communication methods. And I have also heard from other deaf blind individuals who have tried to apply through maximus and have called the M COs and had issues with communication. And so I guess the No. 1 thing is when folks call into either the MCO or the maximus IEB is that information obtained about their hearing and vision loss too? Is the information obtained about communication methods? And three, it should be asked if it is not already, it should be asked. Because you are not necessarily going to know just from talking with somebody over the phone or through V. P or e-mail or whatever the case may be but that person might have sometimes complex communication methods. Obviously, as you all can see hear today. I'm able to orally speak for myself but I use a sign language interpreter for communication to receive information. Other people use different methods that may be different or similar to mine. And all of those communication methods are not being addressed currently. So that was a question and comment. Thank you.

MR. HANCOCK: Thank you. So I have three responding to your third

comment and also answering the first two questions. You and I have met twice, actually about this particular topic and we also met with other stakeholders about opportunities for better communication with the deaf blind community and also capturing the language requirements for individuals who need interpreters support like with American sign language. So we have had those discussions. We have made sure that the independent enrollment broker and the managed care organizations both are -- are recognizing the communication requirements about the deaf blind community. I have to say, is it perfect at this point? We would have to probably say no. But the training certainly has been improved and it is largely been driven by the questions from the -- concerns that have been raised by you as well as some of our other stakeholders who work with the deaf blind community. The second question as to whether or not the language requirements are captured for individuals who need this type of interpreting supports. At this point we know that the managed care organizations and the independent enrollment broker are capturing this information. It is currently not part of our eligibility system in the Medicaid process. But it is something that we are discussing. And we hope to continue to be able to hear your voice, be able to continue to pursue that. American sign language, for example, is not one of the primary languages that are used or captured for interpretation but it is something that is certainly being discussed. I think probably -- and you and I have talked about this. Part of it is the newness of the designation of the American sign language but we look for opportunities to be able to make it much more of a structured part of the process. And we hope to continue to receive your feedback as well as well as any stakeholder that works for -- works for and with the deaf blind population.

SPEAKER: Okay. Thank you.

MR. HANCOCK: Thank you.

MR. BOROCH: Along those same lines Kevin. Is there any availability could customize the communication plan, or invitations based on -- based on fee for service care plans or other sources to customize for those individuals whether it is literacy that particular method of sending something in the mail wouldn't be effective.

MR. HANCOCK: Is it something that we would strive for, yes absolutely. We have

customized packages based on need. That being said it is still not perfect. We need the feedback is what I would say.

MR. NAGELE: If I'm not mistaken, isn't that a requirement in the contract already.

MR. HANCOCK: We did want them to talk about their communication strategies.

MR. BOROCH: I was thinking about individuals receiving services and running fee for service. I didn't know if the data was in a format and could be captured and used to do that rather than waiting for someone to say I have a need and it isn't working for them.

MR. HANCOCK: So I think Tonya had a question as well.

TELEPHONE: And yeah. Kevin I did. As you were talking about the provider network as a huge light bulb went off in my head. I have some ideas about how to improve but it is kind of too complicated for me to explain right now. Is it okay if I e-mail the ideas in the next couple of days.

MR. HANCOCK: Sure. Absolutely Thank you and we will make sure the Committee hears them.

TELEPHONE: I don't know any – if any of them will actually work or can be done but under the MCO system, they have a chance as being able to be done, I think. Yeah. Just give me -- just give me a couple of days okay.

MR. HANCOCK: Absolutely.

SPEAKER: I just have a question related to the direct marketing issue. It came up a couple of times and one of the things that I would like to do at my Center for Independent Living is I would like to educate consumers by inviting all three M COs to come and talk about themselves in an information session and then let them leave and then have my staff help consumers sign up to be enrolled during that period of time. Is that going to be allowed with what you have been saying about the direct marketing prohibition.

MR. HANCOCK: Probably not. It depends on -- it was a department

sponsored event. Normally, the way that we would suggest that being.

SPEAKER: Even if, for example, one of the information sessions that the -- that OLTL did happened at my center --

MR. HANCOCK: That would be different.

SPEAKER: And all three of the MCOs were there.

MR. HANCOCK: They would not be there.

SPEAKER: They can't be there.

MR. HANCOCK: Right.

SPEAKER: Okay so when do consumers get to ask questions of their potential -- how do they make an informed choice.

MR. HANCOCK: So they can start with -- that is a great question. They can start with the independent enrollment broker to talk about what the – different service offerings are between the managed care organizations or they can call the managed care organizations themselves but they -- where it gets tricky is if they are in a room with a participant and they are given a direct access to participants through the process, the process has to be independence of anything that would be -- the participants can't -- there can't be any appearance of coercion and I see the point that you are stating all three of them would be there but the reality is that -- I think that it would sort of still spread the line because we can't always monitor the activities of the managed care organizations with those individual participants. So we would be allowing a session that would potentially allow for opportunities for direct marketing to occur.

SPEAKER: So okay. As a second thought, can staff then after you leave, after the IEB leaves, after all of this happens and consumers are scratching their head wondering, I still don't understand what I'm doing, can staff then support that individual through that phone call where they call directly.

MR. HANCOCK: Yeah.

SPEAKER: To that MCO and I ask this for two reasons because is that in any way a contract violation if a contracted entity, such as voices or CILCP help as a consumer make a phone call to any of the M COs for choice?

MR. HANCOCK: A CIL -- the CIL like the AAAs have a different role that goes beyond the scope of the direct provision of services.

SPEAKER: Correct.

MR. HANCOCK: As fulfilling your role as a CIL, which I am universally assuming you will be objective an independent when it comes to addressing the participant needs.

SPEAKER: Yes. Completely different staff.

MR. HANCOCK: As part of the information and referral work you are doing so I think that that is okay.

SPEAKER: Thank you.

MR. HANCOCK: It is the MCO involved in that. It is a great question.

MS. POLZER: I think we need to move on in all fairness and let the MCOs and Randy finish up with the participant communication requirements and then we will have questions at the end.

MR. NOLEN: What we are going to do is go through some communication discussions and answer some questions that were brought up at the last meeting basically going to turn it over to the MCOs at this point in time. So I invite Keystone and pH W to come up and since ray is at the table we will start with UPMC.

MR. PRUSHNOK: I'll go ahead. In general, I guess, starting with communications and, you know, I know that many of the questions were around cognitive and sensory disabilities, unfortunately, many of these disabilities are unknown until self identified. They are not sort of things that come with the enrollment files but as we learned, we do track in our care management system and track communication preferences. We do have a vendor that provides audio and braille documents upon request. We also have a service for American sign language and tactile interpretation upon request. Our community team that is focused exclusively on CHC does some in home one on one work with participants who would like additional help identifying benefits and we are staffing that now in the southeast. All of our materials are generally shooting for 6th grade reading level for written material. In addition we have a health education advisory Committee that convenes quarterly and we at our most recent meeting had a focus on this very issue. Another thing to mention is that UPMC and the health plan operates UPMC disability resource center. To date, they do a lot of work making sure our provider sites and offices are ADA accessible and create different tools like picture boards for common procedures and have language and cultural guides that are available, you know, throughoutmany different facilities and where somebody prefers it, they can have a personal rep designee that can assist with communication if they identify that they would like to another person. In terms of, you know, some of the questions, there are numbers and population size, we have in our southwest home and

community based population, 45 participants who are identified as deaf, three who identify as deaf blind, our other language data is really small. So we are -- you know, we have about .1 percent or 49 people that have a primary language that is not English in the southwest. In the southeast, that number is a lot larger. It is over 10 percent. So we have, I think 89.7 percent of our members are English speakers. So that diversity is clear an these resources are there to support that like language line and translation services and we have a diverse set of service coordinators who speak many different languages. In addition, so also in our southwest data, we have 1311 people who have severe hearing loss and one area that is tougher to identify are cognitive impairments or traumatic brain injury. Those things are not always clear on enrollment or you know clear on the inter ride. We have 15 individuals in the South west who are living with a traumatic brain injury. I'll stop there and allow the other M COs to speak and maybe we can take questions.

MR. NAGELE: I have a question before we hear.

MR. NOLEN: Go ahead.

MR. NAGELE: So it is great, ray that you have special help available especially for folks who may need additional help understanding things and, you know, specialist they can go into the home. The issue comes about if they have to self identify because people with cognitive impairments may not self identify. So that is why the Brain Injury Association is recommending that all MCOs have training in how to work with people with impairment so your people who are going out can actually pick that up on their own. So so far, UPMC is the only organization who has not had that.

MR. PRUSHNOK: In fact, all of our service coordinators are trained in this area. It just -- we did not conduct it through, you know, your association directly. So it is something that we continue to consider but it is a part of our core curriculum and our six week training course with service coordinators.

MR. NOLEN: Thanks ray. Kathy.

SPEAKER: So I wanted to start with our numbers. So we out of -- this is southwest by the way. Out of the 1952 HC deaf participants we have three participants who have identified as being deaf. We have 2 participants who are deaf blind. We have 141 participants who have hearing impairments that average age for those participants is 72.4. Cognitive impairment, 259 average age is 65.7 and nonEnglish speaking 664. I also pulled vision impairment and 174 participants and average age is 67. So to start with, you know, for our communication issues and how to address them, it starts with training and you are correct, we did have the brain injury 101 and 201 and our staff had both of those in addition with March being national brain injury awareness month, we will be doing additional supportive training at that time to reeducate and confirm that

everyone understood, you know, how to work with our membership. We also require cultural competency training as soon as they are hired. And also annually and that includes class training, which is culturally and linguistically appropriate services. They are also required to have training on our resources available to them. And we use -- give me a second -- language service associates and that is interpretation by phone, that is interpretation in person, video remote interpretation, American sign language and inter culture consulting.

MR. NOLEN: Any questions for

Kathy? Anna.

SPEAKER: All right. Hi everyone. For PA health and wellness , just add a few things that are outside of the contract requirements that we have. We have extensive training to address alternative languages for our internal staff, our call center or service coordinators go through extensive training on identifying additional needs that individuals may have. In addition to that, we do contract with the brain injury alliance or R CP S O to provide training to service coordinators. In 2019, that expands to our PC team and external service coordination partners that are contracted with us so that they are able to identify not only cognitive needs but how to do service planning when appropriate when an individual does not identify that they may need certain things and that support is really important to help them guide through just the interviewing techniques. A language formats available, PA health and wellness identified as we moved into the southeast particularly that based on the information OLTL provided on languages, we ensured hiring staff that had background in Spanish speaking, Korean, Chinese and Russian. So we have that representation on our staff as well as our system through CENTEEN that provides over 100 different languages for interpretation. We printed materials in the five top languages that OLTL provided us in addition to that, we have addressed requests for braille items and fulfilled those as well as audio requests. And then our website, we have monitored our website for compliance as well as working with Pennsylvania advocacy groups to review our website and provide feedback as well as to how user friendly it is. We have got our call in and then our final page just to save time, these slides were presented or provided to OLTL so they should be on your site with the notes from today but our vast slide, our participant numbers we have 162 presenting with cognitive impairments, 112 who identify as deaf, 16 reported as being deaf and blind, 16 that report as hard of hearing and 1335 nonEnglish speaking participants. So that is why we are at.

MR. NOLEN: All right. Any questions about those presentations?

MS. POLZER: I have a question that aim came in over the phone. Could you please ask each MCO to identify who they use for interpretation. How are participants able to rate their experience getting language support from each MCO.

MR. NOLEN: Anna.

SPEAKER: We use a company called Boyance that is across all of the CENTEEN companies.

MR. NOLEN: Kathy.

SPEAKER: That would -- that was the language service associates that I mentioned for you. That is who we use.

MR. PRUSHNOK: Primarily use a company called Via Language for translation services. I need to check on our telephonic support.

MS. POLZER: And can any of you offer how you enable participants to rate

their experience getting language support?

MR. PRUSHNOK: All of our Customer Service calls have a post call survey. What I don't know and what I have not seen are data that correlate those -- those satisfaction reports with people that use language line on a call, for example, that is something I would need to investigate but it is not something that I have gone to ask. I will see if I can find it out.

SPEAKER: So this is Kathy. I think that is an excellent question.

MS. POLZER: Didn't come from me.

SPEAKER: I would like to know more too about that. I would like to know how we are doing with that. So I will figure out who I need to get that information from.

MS. AUER: Can I ask I 55 question.

MR. NOLEN: Hold on. Anna.

SPEAKER: I say the same thing Kathy does or did. We have a survey that we run after every call but I'm not sure how it is broken down for the language services. We can get that information.

MR. NOLEN: Question in the back.

SPEAKER: Thank you this is Melissa Hawkins from the office of deaf and hard of hearing. Going back to all of the documentation that you provide in different languages

and you mentioned quite a few languages. Do you offer A S L. Videos that you would have on the website or provide to participants that you have identified. You have identified so many that you have and that is the primary language for the number of people that are deaf and they might prefer that kind of communication. Do any of you provide that?

SPEAKER: This is Anna. I'll follow-up on that. I understand that we have got some extensive supports for individuals upon requests. So let me check and I can report back to Randy exactly what we have in that regard.

MR. PRUSHNOK: I do not believe we have any A S L. Videos on our website but I will see and go through the disability resource center.

SPEAKER: The same for Keystone first. I reviewed the files for any of the participants who were identified as deaf or deaf blind and none of the individuals were English speaking or -- and we took, I believe, that one of the service coordinators took a -- you know, someone with them who couldn't use sign language because they didn't understand it. They weren't ever trained in it, the participant wasn't. So we actually took steps to find out like how we could start addressing that in the future so that when we went, we had the right individual with us.

SPEAKER: I think it would be very good to have that with all of the paperwork you hand out and everything you have, A S L. Videos outlining the paperwork and addressing the choices and there often would be much better communication for them. Like you said, if you are learning about communication and learning what the needs, deaf culture is very different than our culture and that would very greatly benefit the deaf community so thank you.

MR. NOLEN: Thank you. Pam?

MS. AUER: I just want to ask each of you have people who are deaf blind that you are serving. Have you all considered at all because Marsha has been advocating for S S P services. Have you in your added services considered that at all? -- added value services.

MR. PRUSHNOK: We have a provider that does, you know, they call it tactile interpretation. They do offer that service. I'm not familiar with how many requests we have had or fulfilled.

MS. AUER: It is different than S S P is different than just a communication. The S S P is a version of what we might consider and Marsha can correct me if I am wrong of attendant care. This is the way they get out in the community. How are they served? You know, the way Theo normally explains it the S S P is that, what, 30 years ago we

didn't have attendant care we were stuck in our houses. This is another community that is highly under served and getting out and being part of the community and this is, you all have people that are receiving services already and I'm not sure maybe Marsha can explain but maybe blending some of their services with S S P services will help them get out of the community. Marsha is that okay what I asked?

SPEAKER: Yes. Do you want me to expand.

MS. AUER: It is up to you guys? Is there more needed?

SPEAKER: I think I would just like to clarify.

MS. AUER: Okay.

SPEAKER: Thank you, Pam. Yes Support service provider and S S P is the bridge that gaps -- I'm sorry is the gap that -- the bridges of communication -- I'm sorry. I totally messed that up. Nevertheless, you understand what I'm saying. Interpreters help with formal communication whether it be explaining what the doctor is saying or what a nurse is saying. But what happens to a deaf blind person who needs to go to the doctor that needs to check in or have the paperwork filled out. What happens if they need to get their weight checked. An S S P can help with that. If a deaf blind person needs to go to the pharmacy and pick out personal care items an S S P can help with that. A deaf blind person needs to go and work out at the gym to maintain a healthy weight or lifestyle, an S S P can help with that. Those are types of situations an interpreter cannot help with. An S S P is important and if you are not already have been trained on deaf blindness and I know that a few of the M COs have already taken up our offer to do such, I encourage you to learn more about deaf blindness and support service providers. So thank you.

MR. NOLEN: All right. We got about two minutes left. Any other questions on any topic for the M COs at this point.

MS. POLZER: Question from the phone. Do all plans have a personal rep designee form?

SPEAKER: Personal rep?

MS. POLZER: Personal rep designee form.

MR. HANCOCK: Power of Attorney?

MR. NOLEN: A designated person that can sign off and talk for them? Okay. Kathy.

SPEAKER: Yes. That is one of the first things we do is consent management and walking through the process to identify who those representatives are. It is also part of

the plan care where we identify who is the legal representative, authorized representative and Power of Attorney.

SPEAKER: Same. We have a document that identifies who the individual allows us to have conservations with.

MR. PRUSHNOK: We will take an audio recorded, you know, personal rep designee or a letter of any format basically so we are fairly open as long as it specifies, you know, what decisions and what authority you would like to give that representative.

MR. NOLEN: Question in the back.

SPEAKER: Yeah. Thank you a few meetings ago I brought up the issue of employment. My question is the hoops to get to employment of the M COs. Can any of you speak to how many participants are actually receiving, you know, employment services from you, have successfully navigated through those hoops?

SPEAKER: Let me just throw this -- I think on our last count it was nine or ten individuals actively in employment services in the southwest. I think we are still trying to gather what the southeast looks like in that regard.

SPEAKER: I don't have the exact number for that but it is -- it is low and I agree. We -- we have reeducated our staff. We encourage how the approach is to engage but I -- we haven't seen an increase.

MR. PRUSHNOK: Our numbers are very low in terms of services. I don't have them in front of me but I just to be frank, I would be shocked if they were much more than, you know, in the 10s or 20s. However, we have implemented an employment survey with all of our participants and so it was a part of our Inter rise we do screen people and if a person identifies as wanting to seek employment services, I think we have by the last count we had we had over 400 people who self identified. Our first step is to refer the individual to OVR and to Social Security for a benefit screen and then once we get through those two steps, we then work with authorizing services. So we are -- I'm hopeful that our numbers will begin to increase in the southwest as we get further into sort of down the line with follow-up.

SPEAKER: I mean, I brought this up, 400 people expressed an from that means 300 something are probably sitting in line at OVR. I think at some point there needs to be a conversation between M COs and OVR and OLTL. I would like to have that sooner or later.

MR. PRUSHNOK: And there was a meeting with OVR last month. All of the M COs and OLTL was there. It was successful meeting. I think there is a desire to make sure we are making these hand offs and making sure they are successful and employment

first is a goal of the administration and built into our contracts and so we are dedicated to promoting that. It has just been slow so far.

SPEAKER: My concern is not really -- it is the process here of everyone having to go through OVR first and a concern. Thank you.

MR. HANCOCK: Just to respond from the department's perspective. We are trying to develop a relationship with OVR to shorten the process and make it more streamlined. The low numbers of up tick for the use of our enrollment services and fee for service and managed care are just unacceptable. We really want -- this is a main goal for CHC to make employment services known and available to people because we want people to work if they want to work, you know.

SPEAKER: Right.

MR. HANCOCK: This is a struggle.

SPEAKER: We do want to work.

MS. POLZER: All right. We are going to wrap up a minute early. Thank you everybody for attending, participating and presenting. Our next meeting will be March 7th at 10:00 a.m. have a great one.