MLTSS SubMAAC Transcript 5/4/16

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>> GINNY ROGERS: Testing the captioning.
Ralph trainer.
>> RALPH TRAINER: Testing the captioning.
Karen Swartz.
War war testing the captioning.
Caryn Swartz.
Darlene Sam son.
>> SAM TRYCHIN: Testing the captioning.
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Subcommittee.
Howard keg Holt.
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>> SPEAKER: Testing the captioning.
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>> SPEAKER: Testing the captioning.
>> HOWARD DEGENHOLTZ: Testing the captioning.
>> DARLENE SAMPSON: Testing the captioning.
Amy high.

>> AMY: Testing the captioning.
>> RALPH TRAINER: Can we have introductions?
[introductions]
[introductions]
>> RALPH TRAINER: The people on the phone please?
>> SPEAKER: Tanya .
>> SPEAKER: Brenda dare.
>> RALPH TRAINER: Good morning, anyone else.
All right.
Welcome everyone.
If I may --
>> JENNIFER BURNETT: I want to point out, this is a different room than we're usually in, there are no mics, for the

folks on the phone we're going to have to, kind of capture what is being discussed and repeated if you can't hear it.
>> RALPH TRAINER: If you speak, speak aggressive like a am.
>> FRED HESS: As he tears up the table.
>> RALPH TRAINER: If you're giving comments please wait will until your called upon, keep the comments to two minutes.
The meeting minutes and the transcript are posted on the Listserv.
HTTP/lists
>> FRED HESS: Can you hear us?
>> JENNIFER BURNETT: It muted again.
>> FRED HESS: Can you hear us now?
>> SPEAKER: I can't hear them I can hear you though.
>> RALPH TRAINER: New meeting place, new technical difficulties.
Again the documents are posted.
Within a few days of this meeting.
We have a captionist she is documenting and the discussion, please speak clearly and slowly, turn off your cell phones.
Felix.
Clean up around your area when you leave.
Pick up any empty cups or bottles area wrappers.
Public comment is at the end.
In event of an emergency we can hope that a staff person from the temple will university will direct us.
Evacuating the building.
>> RALPH TRAINER: We'll begin with OLTL updates.
>> JENNIFER BURNETT: Thank you I want to recognize one more member came in.
>> SPEAKER: Rick from UPMC.
>> SPEAKER: United health care.
>> JENNIFER BURNETT: All right.
Well, good morning everyone.
I wanted to start out with the CHC update.
We are as you know, the we closed bids at 2:00 on Monday that was the last point which we could receive a bid and we got in a quite a few bids on this right now.
I have a team of 7-8 people sequestered for the month of May just reviewing the bids.
So they came in very, very large trucks.

There is going to be a release, press release coming possibly today I'm pretty sure it will come today.
That at least lists all of the bidders.
So you'll be able to take a look who we heard from and what proposals we're reviewing.
The rest of OLTL and DHS is working very hard on developing and working on the operations.
We're in system design in the middle of system design work and we're doing a lot of work around, the organizational structure and also significant work on the development of our readiness review process.
We have a number of state readiness review documents we have received and taking a look we have about ten of them.
And we are also, of course, looking at what health choices is doing.
Health choices made their announcements and, last week and, so, we'll be actually able to shadow the health choices team as they do their readiness review which will help my, the folks at OLTL really understand what all is involved in that readiness review process.
Based upon the health choices model, in health choices we will, we will be enabling, we will be actually we have recruited a small team, representing this sub MAAC the consumer sub MAAC and long term services and support sub MAAC they will be working with the Pennsylvania health law project which is the group for a number of years helped health choices in their reviews of the proposals.
They will serve in an advisory process, Rob a reasonable doubt Cobelskey has agreed to be on it and Carl bailley representing the seniors AARP from the LTSS sub MAAC.
So we're really, excited to be able to use this process, I don't know a whole lot about it, but my colleagues in the office of medical assistance programs, in particular, Barry Bowman who came here and talked about their process, has described it as a very valuable process, for getting input from consumers.
So just so you know, I had recruited -- tried to recruit bill white who is on our committee to represent but he will be in Portugal poor soul.
I think that's, a very exciting process.
I think what I would like to do is perhaps get Levall Miller

Wilson in the Pennsylvania health project, law project to come in to the next meeting and provide us with the description of exactly what that process is, and, Richard possibly can as well.
As I said, we're issuing that press release and the details an the actual bids we receive requested.
Not only will that go out as a press release we'll make sure you all get it and we'll send it out through the Listservs posting it on the community health choices
>> FRED HESS: Are we going to get the entire -- entirety of the proposals?
Are we going to get a summary.
>> JENNIFER BURNETT: We're going to get a summary the group which I described which Richard will be representing us, will be getting the entire --
>> FRED HESS: Any way, any way I could get the entire?
>> JENNIFER BURNETT: No.
Because you're potentially, we had to really, find someone who is, completely independent and would not potentially be subcontracting with the managed care organization, managed care organizations, anyone.
That made it kind of difficult to identify and Richard, fits that bill.
>> SPEAKER: Yes, he do.
>> JENNIFER BURNETT: Richard will give reports here and tell you what is going on all that kind of stuff.
>> FRED HESS: We're supposed to help on the choice correct? Supposed to help make the decision on who is accepted?
>> JENNIFER BURNETT: That is our process.
You can give us advice on what we should be looking for.
>> FRED HESS: Okay.
>> JENNIFER BURNETT: That's what this whole process is about.
>> FRED HESS: I'm wondering how we'll fit in on this.
>> JENNIFER BURNETT: Richard once he had a chance to look at it, he will layout the buckets of work described in the applications that kind of thing.
>> FRED HESS: I want to know the difference is between, MCO1 and 2, if there's any differences, because if I've got, consumers coming up and saying you know how do I make this decision I want to be able to look at them, and go, okay.

What do you need?
If you need ABC, go with this, if you need ABDE go with this one.
>> JENNIFER BURNETT: We'll have that information but it's nowhere near to the point where we have it.
For example you have a consumer that comes up and says, you know my primary care physician is X and you want to be able to sigh well do you want to keep your primary care physician if that is important to you then you should go with this managed care organization or this managed care organization because they're in network that the kind of advice you're talking about.
>> FRED HESS: Yeah I got a question here from someone else too.
What guarantee is there, that there is no, or will be no conflict of interest for service providers how many choices will be there for consumers if the MCOs, have control of all the providers.
They're wondering if it's going to be a conflict of interest, at all.
>> JENNIFER BURNETT: No.
We won't -- our waiver applications will not get approved by the CMS if there's a conflict of interest so we have by virtue of having to get authority from CMS, we will not have conflict of interest.
>> FRED HESS: Okay.
>> JENNIFER BURNETT: Yeah. So we will keep in touch with what is going on with that process and Richard can certainly give us advice.
Have you already been through training?
>> SPEAKER: I've been through a little bit familiar with the consumers I know this week we're talking about independent enrollment brokers and the training will roll off shortly.
>> JENNIFER BURNETT: Okay.
Good.
Richard said he is somewhat familiar with it being on the consumer sub MAAC which has been doing this for a number of years and then, he also mentioned that the independent enrollment broker is one of the topics on the agenda.
There were questions about transparency and the MCO qualifications and experience in other states.

These questions, definitely got -- if you look at the questionnaire that the MCOs have filled out in order to make the application, many of those concerns are addressed in that questionnaire and they have to describe to us that's what we received already.
That's their description of that.
There where is also a request on MATP changes which is medical assistance transportation program.
Changes.
We didn't have time on this agenda, but for the next month's agenda we'll invite OMAP the staff person there Tyrone Williams and the deputy, to come and talk about the changes in the MATP program.
I also wanted to mention that CMS I believe it was last week or perhaps the week before issued its managed care regulation in final rule, very recently I think last week.
I wanted to talk about some of the final provisions that came through it's now actually a final rule that will be implemented over time.
And in fact, one of the provisions has a ten year window for being implemented.
So, it is a -- there is time.
There's like a whole time line for different time periods in which things are going to get implemented.
I wanted to highlight a couple that we were paying attention to.
We were concerned about the 14 day required fee for service window and they have eliminated that in the final rules.
That was something that we had recommended in our DHS recommendations to CMS they did relate that 14 day fee for service window.
CMS also heard from states concerns about directing supplemental payments in managed care and CMS did allow for certain payments to be directed by the State to the managed care organizations, those are payments made using value based payment model, payments made through initiatives, that improve -- reforms delivery, service delivery model.
And also payments, made through via performance improvement initiatives.
So we were definitely pleased to see that.

Another final provision is that, they finalized, this is one
we had made a recommendation on, so we were pleased with this,
but they finalized the State's authority to establish rate range
because the proposed regs had eliminated that provision.
They also, put in what they considered to be a more
rational IMD or institutions for mental disease policy and they
had proposed, they have monthly limit of 15 days of stays in an IMD
and much more detailed definitions of what in lieu of services
are, so we're going to be paying a lot of attention to that and
analyzing it.
This is really quick and dirty look at what was in the final
rule.
We're doing a ton of work really understanding what the
impact is going to be.
And we are in particular, at OLTL are looking for those
provisions related to managed long term services and supports.
They also put in some flexiblity around quality metric
development.
And they plan to issue sub regulatory guidance for states.
They had some changes in the grievance and appeals processes.
They have, what they did in the final regulations was they
finalized the 60-day time frame.
for beneficiaries to file a appeal and they clarified that
this, the point which that time frame starts and that actually
starts on the date of the adverse determination notice that, the
notice that was sent to the beneficiary.
The actual notice gets sent and that clock starts.
>> RALPH TRAINER: Can I ask.?
In that notice, do they let the consumers know their services
continue?
>> JENNIFER BURNETT: Yes we would like to know that.
Yeah.
I don't know that the regulations specifies that I didn't
get into that detail, but we as a state can do that.
The regulations specifies the time frames within which the MCO,
the managed care organization or other types of health plans
that are authorized under the rule which include actually PIPS, PAPS
and CHIP program, prepaid patient health plans --
>> FRED HESS: Say that real fast ten times.
[laughter]

>> JENNIFER BURNETT: They actually, specified that.
And then they codified the guidance this is an area we are really interested in because we actually used the guidance that CMS, has had on its web site for several years now, 3 years. Around developing managed long term services and supports.
If you recall, the discussion document that we issued, that was actually based on and we used that guidance as a framework for developing that discussion guidance if you take our discussion guide, our discussion document and, CMS's guidance on MLTSS you can really kind of map it almost.
So we use what.
But we're pleased to see they went into the final Reg.
I wanted to give a quick update on the nursing home transition webinar that we had a couple of weeks ago.
And Ginny Rogers is here our bureau director she can fill in any details I don't get into or answer any questions I'm not able to.
In an effort to reenergized the NHT program, we have been doing a lot of work behind the scenes to make improvements in the program and we held a webinar recently, because we're going to be issuing some guidance out to states, bulletin out to providers related to it.
So we had surveyed during this time where we're, kind of trying to figure out how to make improvements we surveyed stakeholders for their recommendations on enhancing the department's nursing home transition program.
Someone have a cell phone ringing.
>> SPEAKER: It's your attendants Ralph.
I think.
We have a question.
>> FRED HESS: Can you -- try it now.?
People record of the webinar been re --
>> FEMALE SPEAKER: The bulletin relessed in the NHT webinar been released yet?
>> JENNIFER BURNETT: No it hasn't.
>> FEMALE SPEAKER: I remember during that webinar that it was -- the commentary was exposed to expire May fifth there will be time for public comment once that bulletin is released.?
>> JENNIFER BURNETT: That is the comment period, may fifth is the --

>> GINNY ROGERS: After it goes out, we'll have to expand that.
>> SPEAKER: That's what I was concerned about.
>> JENNIFER BURNETT: We'll be issuing it and giving a time period for public comment.
>> SPEAKER: Okay.
Thank you.
>> FRED HESS: We have a question from Tanya, can you ask whether or not there's data on the MCOs bidding on these contracts how successful they have been and serving disabled population so far?
>> JENNIFER BURNETT: I'm sure there is data I don't have it. But once you see that press release that lists it out you can do some research and take a look at that.
So we held a webinar.
We issued a survey this past winter and got a lot of data from the survey.
We used the survey in this webinar, to kind of describe what recommendations are being made.
From the survey we had the number of recommendations that were made and, so these are some of the change that's we're making.
We're expand willing the network of NHT partners to assist individuals to transition out of nursing homes into community living.
And I have to tell you, when we look at our, this is a place where we do a lot of data, the State has a lot of data, when we look at the state county by county we have some counties that are doing very, very little nursing home transition.
We really want to make sure that we have providers that are available.
We're also told by certain providers that they're not interested in nursing home transition.
We definitely see some pockets where there's a tremendous imbalance and NHT is not getting used.
Fred do you have a question.
>> FRED HESS: Seeing how the Center of Independent Living now have a fifth core service which is transition doesn't just mean, nursing home transition.?
It also means, stands for transition from high school to work.

High school to college, college to work.
Can we utilize the CILs also for transition from where we are now, into the -- well, number one, we can utilize them for the nursing home transition most definitely.
Can we use the Center of Independent Living to get everybody onto the managed care?
>> JENNIFER BURNETT: Well that's going to be the role of the independent enrollment broker I'm going to talk about right now. They are going to be the actual official choice counselors and enrollers into managed care, into the managed care plan. They will have access to the system that we will use and they will be the independent enrollment entity will be doing that.
>> FRED HESS: Working closely with the CILs.
>> JENNIFER BURNETT: They will be working closely, across the State.
>> FRED HESS: We're the best option to get the word out to the services to people on disability the.
>> JENNIFER BURNETT: We're using a all hands on deck to get the word out.
We're aware people are not going to know about it.
And so we are going to be doing a lot of work to kind of, jump start that and get that going, starting this summer.
We don't want to go too early, Ginny can talk about the notices, the official notices are going to start, in advance of those official notices we want to be getting the word out.
We're doing that through our partnership with health funders, you've been participating in the one -- in the southwest PA which is convened by the Jewish health care foundation.
We continue to do whatever we can to really get the word out.
You'll be hearing a lot more about that in the coming months.
>> FRED HESS: I've had --
>> JENNIFER BURNETT: Coming weeks.
>> FRED HESS: I have a lot of consumers when I tell you we're going to managed care, they have no clue what it is, none.
>> JENNIFER BURNETT: We'll have scripts and you know, descriptions and brochures, all that kind of stuff, this summer.
>> FRED HESS: Okay.
>> RALPH TRAINER: Question.
>> FEMALE SPEAKER: If a cell is doing NHT work are there going to be qualifications for the workers performing that task.

>> JENNIFER BURNETT: I don't know Ginny.
>> GINNY ROGERS: Current CILs providing the service, will continue.
To provide the service, nursing home transition.
So if you have service coordinators, is your CIL a service coordination agency?
No.
Okay.
>> SPEAKER: I'm not a CIL.
>> GINNY ROGERS: So CILs are current agencies providing transition will continue with that?
>> SPEAKER: There's no requirements for the people to do the transitions.
>> GINNY ROGERS: Right.
Outside of what is already what they already are.
If there are requirements already in the guidelines for example about what qualifications NHT coordinators have to have
>> SPEAKER: And then if there's an SC entity who is going to do NHT work we would need to meet the qualifications of a service coordinator.
>> GINNY ROGERS: That's correct.
>> JENNIFER BURNETT: So the question was about whether or not there are qualifications for people doing NHT work.
And Ginny described we will have service coordination qualifications and I have to say, having been around at the early days of NHT when CMS initially issued back in 1999, when they were still called HICFA, nursing home transition grant I was the project America for the grant, I will tell you the qualifications for doing NHT is much more intense work than service coordination is.
Service coordination is very hard work I know that.
But it's got a different skill set.
It has a skill set around housing and around knowing about community resources that are, you know, are able to bring.
So it's a little bit of a different skill set.
But we're going to be making sure that, people are qualified we're going to be doing training that will be required as any service coordination entities come in.
So I wanted to talk a little bit about that.
When I say expanding network of NHT partners we actually have

had since last year, nursing home transition as part of our waiver and so we will be issues guidance on that, that's what the bulletin describes and, that will will include, we don't think that, service coordinators right out the bat can be doing NHT we'll be offering and requiring training for them.
We are also -- we have increased our staff to assist community partners.
We have five new NHT staff to really help with this.
We're creating more efficient billing systems, increase provider payments with successful outcomes, imimproving communication and, we're streamlining eligibility process for home and community based services.
Since 2006, NHT has helped over 14,000 people to move from nursing facilities in to the community we believe it's a valuable tool that's why we built it into community health choices we do not want to lose our network of people who know how to do NHT.
We're going to have work group updates, later today.
But I wanted two now, I guess I open it for up for questions before we turn over to the conversation about service coordination.
Fred?
>> FRED HESS: I have a list here of 8 questions.
We had a meeting earlier on Monday, with couple members of the MLTSS and other people.
Question number one, what can O on LTL tell us about the capacity and expertise of MAXIMUS to respond to the questions from the CHC enrollees we understand they have done it in other states one of their plans to staff on PA specific programs and processes.
>> JENNIFER BURNETT: We actually have a big chunk of time to cover that.
It's on the agenda from 10:50, to 11:30, we have a big chunk of time --
>> FRED HESS: Most of are these are MAXIMUS.?
>> JENNIFER BURNETT: We have a whole presentation on the independent enrollment entity.
Okay.
>> FRED HESS: I'll wait for that.
>> JENNIFER BURNETT: Okay.

So if you recall, at the last meeting there was a motion regarding service coordination and it was after the meeting had ended, so we tabled it, to this meeting so I've set aside a little bit of time, see how much time we have yet.
Yes do.
Okay.
We have about 15 or 20 minutes to talk about this and I'm going to open it up by talking about what is actually in the RFP and the draft agreement language.
So first of all, CHC managed care organization, must provide service coordinators and service coordinator supervisors have the following qualifications -- service coordinators must be RN or bachelor's degree in social O, psychology or other related field and at least 3 years of experience in social service or health care related setting except that service coordinators hired before, prior to the CHC zone start date must have the qualifications and standards proposed by the CHCMCOs approved by the department.
>> FRED HESS: Everybody is getting grandfathered in, already now and -- anyone in the future will have to have the --
>> JENNIFER BURNETT: Yeah. I would not use the term grandfathered but we have to approve it and so, we are, in agreement we have a service coordination network out there, that has the qualifications based upon our regulations.
>> FRED HESS: Okay.
>> JENNIFER BURNETT: So service coordinator supervisors must be an RN or PA licensed social worker or PA licensed mental health professional with at least 3 years of relevant experience except service coordinator supervisors hired prior to the start date have a master's degree but not a license, must obtain a license within their first year of the agreement and must have the qualifications an standards proposed by the CHCMCOs approved by the department.
So with that I will, open it up because, last time there was some discussion about it we didn't really get into.
>> THEO BRADDY: Well, I said this from the beginning. The first part of these meetings, reiterate it -- as much as I appreciate what DHS the department has done to listen to consumers, I need to formally go on the record and say that what they have done with the service coordination, I completely

disagree with.
I feel it's more important I stated this in the beginning, we need to have someone that I know, understands the service coordination needs for a person with a disability like myself versus those with higher credentials and I truly believe, that the department, did not listen to the consumers in this area.
And I would like to formally go on the record with that.
>> JENNIFER BURNETT: Thank you.
>> SPEAKER: I have a question about the license within one year, the license.
What are the license standards again?
Just eligible to be a service coordinator, have to be licensed and --
>> JENNIFER BURNETT: Ginny do you want to answer it.?
>> GINNY ROGERS: I don't have it in front me, it's what you read.
>> JENNIFER BURNETT: Licensed within the first year of agreement, must have qualifications in standards proposed by the CHCMCOs proposed by the department.
>> SPEAKER: Licensed in what did he mains, you mentioned licensed clinical social workers.?
And --
>> JENNIFER BURNETT: RN and PA licensed social worker or license mental health professional.
>> SPEAKER: Okay.
Because there's a lot of licenses that fall under each occupation it supports.
That is just a question I had, thank you.
Push buffer okay.
>> SPEAKER: I agree with Theo I support his comment.
Also the concern about the licensing is, you're not going to be able to get a license within a year.
Working full-time, holding a job, raising a family.
It's not going to be achievable.
And at what cost?
Who is going to bar kept the cost of it -- heightened requirements.
>> JENNIFER BURNETT: Ginny?
>> GINNY ROGERS: I think that, one of the ways we've dealt with that is by adding the language about OLTL reviewing what the

MCOs are going to propose and looking at that, so I fully expect there will be some back and forth so that we can evaluate the credentialing of the MCO, for example, is going to propose and the current field of service coordinators and service coordinator supervisors that change was an attempt to get at the existing field of folks so we're not having inan quad amount of people available to do this work.
>> JENNIFER BURNETT: Barb, we'll look into the length of time we anticipate those types of license take and we'll take that into consideration.
>> SPEAKER: I think it is a two year program at a minimum. And I guess Pennsylvania, some states don't require you to have your masters.
That's another thing.
There's very few supervisors in the field today, that have a masters.
So, you're asking them to get a masters and then get licensed and have that done within a year?
That's not going to work.
>> JENNIFER BURNETT: I have to tell you barb I've had numerous providers come through my door and spoke to them over the course of the last year since I've been here, one year now, who have told me absolutely they have that requirement for a supervisors qualification that's an expectization.?
Other service service coordination entities that do feel that's an important credential.
>> SPEAKER: That's an interesting statement only because of the survey that PAPCPA did of their members and, based upon their results, the majority of the supervisors would be out of jobs.
>> JENNIFER BURNETT: I guess, there must be a lot service coordination entities in Pennsylvania, that are not part of PAPCA I've had at least ten come through my door talking about the credentials of their supervisors saying they have a master as degree, they feel that's an important callification.
I don't, I don't know how broad PAPCA's membership is, we have over 120 service coordination entities now in the State. So there's probably others that don't you know, that are not part of that coalition.
All right.

Anything else?
>> RALPH TRAINER: We'll have --
>> SPEAKER: I have a question.
>> RALPH TRAINER: Zach.
>> SPEAKER: Forgive me for not completing understanding but like, is that like the -- the end all be all for that.
Is that it?
The final ruling on that?
>> JENNIFER BURNETT: Is that what?
>> SPEAKER: Is that it, as far as like the final ruling on that?
As far as -- the provider licenses?
>> JENNIFER BURNETT: I think if you reflect what Ginny just said the provision is really, the bottom line is the CHC MCOs, MCOs proposed to us, have submitted to us what they think these people, the service coordination entities should be credentialed adds what kind of credentials they should have.
We will, we at OLTL are going to go through and evaluate that, that's what this process over the month of May is to evaluate and understand that.
So it's going to be a give and take, this is not the final, final.
It's a give and take between the MCOs what they have, what they come to us recommending, and I will say there are MCOs from out-of-state that don't have, that have a tremendous amount of experience in other states doing managed long term services and supports.
This is a new area for us and we're really taking a close look what they have, what they're recommending and what they're proposing to do.
What they're proposing to do around service coordination w you have to remember that service coordination along with chronic disease management, are two of the really key fundmental aspects of managed care.
And so, it's an important function within a managed care environment, that they have strong service coordination.
>> SPEAKER: I mean I just say, with that, we have some concern about this as well.
Just in terms of the potential for disruption and you know given that there's, so much change happening and we, I think we

understand that service coordination, having a strong service coordination element is really, really critical to the success of the system and I mean, and we support that any effort to improve that.
Just want to make sure that it's done in away that isn't disruptive to the thing that are working so to speak and so, I guess, it would be helpful to understand and, maybe, the department has looked at this so what would the, I mean, do we have the numbers on how many people would not qualify and how many people this would impact?
Could we have a sense of if there are alternatives and apologize if this has been discussed at previous meetings we also have a sense of, what any of the potential I know none of them have been selected yet but any of the potential managed care organizations who are thinking about in terms of their alternative proposals like, how they would deal with the issue, to make sure there isn't some mass you know, exodus or mass you know, effort to try to up scale everybody, without the capacity to do that.
>> JENNIFER BURNETT: I as I said I think service coordination is really, bread and butter to managed care.
Service and care card nation if you will.
And, it is certainly behooves managed care organizations to not have any kind of disruption that will effect consumers adversely which effects their bottom line.
They want to keep people as integrated into the community, as healthy you know, managing their chronic conditions they have.
Those are all things they want to do.
And a service coordinator is critical for that work.
So I can't imagine.
As far as the number of people this would effect I mean we have the continuity of
care limit.
We don't have any number -- do you have any sense?
>> GINNY ROGERS: We have not surveyed as a whole all the service coordination agencies we have received feedback from the PAPCA we did survey their members.
But we don't have that broad compiletion of
information yet.
Also that meeting something we want to do going forward is to

survey all the medications.
>> RALPH TRAINER: Barbara.
>> SPEAKER: To piggy back on this gentleman's comment description, disrupttion the consumer from Tennessee last month he made a profound statement, his care coordinator was part of his family I urge that we sincerely do whatever we can do to preserve the existing relationship that currently exists with the consumers and service coordinators and their managers.
>> JENNIFER BURNETT: I would say, would totally agree with that I've heard it, when we were doing the meet and greets with managed care organizations that, if these service coordinator is a good fit for the consumer, why would we want to disrupt it, we heard those questions.
So they recognized, that there's a value in that relationship especially for long term -- on the long term services and supports side.
You know we're really taking a hard look at that I totally agree with you, it's important part his life.
I did have a question from one of our members on the phone which is can independent living centers be independent enrollment brokers?
And no they cannot.
They cannot be independent enrollment brokers.
We'll be procuring one independent enrollment broker for the State, which is how we do it in health choices.
>> SPEAKER: Cassie wanted to be on record to also say that, she feels the heightened academic credentialing is unfair to many potential workers with disabilities and other Pennsylvanians that might loose their employment opportunities, because of these licenses.?
There are many dedicated workers that will be denied these jobs and she wanted to be on the record to say that she in the disabilitied community and other providers think it's unfair.
>> JENNIFER BURNETT: Thank you Cassie.
>> THEO BRADDY: One other comment, are there any plans to revisit this down the road and really see if in fact the higher credentialing is working versus you know, the use of more experienced people with disabilities?
>> JENNIFER BURNETT: Yeah. I mean this is built into our evaluation.

Our evaluation is looking at all aspects of community health choices and, the implementation.
So, it is both a short term kind of, taking a look at and understanding what is happening as we roll out into the southwest so we can make improvements in the southeast.
We're going to be doing that.
Service coordination sure is one of the credential aspects of what we're going to be doing with the community health choices.
So we'll be taking very close look at it and I also want to point out, although we have evaluation on the evaluation study design and update on the study design for 12:00 today, so we can get into more of that, but, we definitely are going to be looking at it closely paying a lot of attention to, particularly with what Jessie Wilderman said the disruption that's something we want to avoid.
Okay.
>> RALPH TRAINER: Okay.
We'll have discussion now on the enrollment.
With Ginny Rogers, Amy and Caryn Swartz.
Do we have another question?
>> FRED HESS: Yeah.
Tanya, said can we talk to any -- hang on.
Can we talk to any current service coordinators that are under an MCO system to hear what the positives and draw backs are?
>> JENNIFER BURNETT: We could maybe bring, see if we can find one or two to bring to the next meeting if that would help.
>> FRED HESS: Will that work Tanya?
>> JENNIFER BURNETT: Are you on mute?
Is she on mute.
>> FRED HESS: She can hear us.
She said that will work.
Okay.
She is a little slow.
>> JENNIFER BURNETT: We have some speakers here.
We're going to move out of your way here.
>> SPEAKER: Could you do a general reminder to speak up if you could repeat the questions so on the folks on the phone can hear.?
>> JENNIFER BURNETT: Try to speak up we'll try to remember to repeat the question when questions get asked.

>> FRED HESS: I'll try to speak up louder.
>> JENNIFER BURNETT: We have four speakers to talk to us about the enrollment process for Pennsylvania.
Ginny Rogers bureau director for participant operations OLTL,
Amy high who is the contract manager for our contract with the IEB , which is the independent enrollmenter and two people from MAXIMUS Caryn Swartz, from MAXIMUS and barber to talk about what we're doing with -- in the independent enrollment program in the process.
Oa
>> GINNY ROGERS: Thank you everybody, we're going to have barber start first we had a lot of interest how enrollment is going to work in the future a lot of questions about our current contractor MAXIMUS and one of the things that we thought would be a really good way to talk about this is to actually have them come in and talk about the work they're doing on enrollment around the country and I'm going Barbara start, vice president of health services at MAXIMUS.
>> SPEAKER: That's right.
>> GINNY ROGERS: And Caryn Swartz who is the program manager for the current independent enrollment broker that is currently operating and Amy high from my staff who is a contract manager, who is working on the operational part of MAXIMUS in our current process and then I'll talk about up coming, some of the CHC related enrollment things to look forward to.?
So -- I'll have Barbara go ahead.
>> SPEAKER: Is someone going to work the slides?
Okay.
Okay.
Next slide.
Thank you very much for giving me the opportunity to speak today.
I am the market lead for long term services and supports.
And in that capacity, I have the opportunity to work with states across the country on the design and implementation of managed care, long term services wand supports and in our assessment programs.
So today, next slide, just very quickly, I'm going to give you a very quick overview of MAXIMUS I'm going to go through that, very, very quickly.

I'm then going to focus more the experience in Medicaid long term services and supports we'll talk a little bit what we're doing in the Pennsylvania IAB program and then, just a real quick summary of the other things that we're doing in Pennsylvania.
Next slide please.
Next.
Just very, very quickly we have been in business for over 40 years.
We have 16,000 employees world wide.
Our focus has always been on human and health services.
We are the largest independent benefit review organization performing appeals for medical parts AC and D.
We are independent under the balanced budget act any enrollment broker must be independent that means we have absolutely no financial or any other type of relationship with managed care plans or with any providers in the States in which we're enrollment broker.
Next slide please.
A very quick overview.
We touch on one out of two Medicaid managed care consumers in the U.S.
We have worked with 9 of the 11 financial alignment demonstrations for dual eligibles.
I'll get into more detail in a little bit about what that entails.
But we work very extensively with folks that are participating both in Medicare and in Medicaid.
In our program in the united kingdom, we have done 8,000 assessments in the past 12 months.
We, as you can see, we focus on out reach, eligibility enrollment, customer contact centers.
Next slide please.
Just a quick overview, we have extensive experience in doing enrollment broker, determining eligibility, particularly in long-term care, out reach and education.
I'll get in a this in much greater detail.
Conflict free independent assessment, conflict free independent contact centers.
Next slide please.
We are the enrollment broker in 18 states.

And in the district of Columbia, again, the dual eligibles in 9 states.
We provide all of the services above very similar to the work that we'll be be doing in Pennsylvania.
Next slide.
One of the things we're most proud of at MAXIMUS is our center for health literacy.
This center specializes in providing materials for low literate and culturally diverse populations.
We use the center for health literacy to develop all of our materials, we use them to develop our web sites.
And, we do extensive usability and community testing.
We have multiple entities that do translation services.
We do want to call adaptive translations which means that it is not just translating word-for-word but we adapt the translation to ensure that the information is understandable in the native language for non-English speaking participants.
I want to focus just very quickly on our very extensive experience with Medicare.
We do a huge number of Medicare appeals and because of our experience with Medicare appeals, we have a very great depth of knowledge about Medicare policies, procedures and how the managed care plans, implement the Medicare programs.
Next slide please.
So the first slide here is really giving you an overview of our experience serving the elderly and persons with disabilities.
I'll drill down but I just want to you know begin by saying we've had the privilege of working in Pennsylvania since 2010.
We worked for the independent enrollment broker.
In New York State and I'll give more details in a moment, we provide the conflict free evaluation and enrollment center where we do intakes assessments and we focus on enrolling elderly and persons with disabilities into long term services and supports we are now taking over the intellectually disabled population as well.
In our SSA, social security administration, ticket to work program we assist persons with disabilities identify and prepare for employment.
Again, we have extensive experience with dual eligibles in the demonstration projects from CMS.

And we work extensively, in the united kingdom doing disability assessments foreperson was disabilities.
So as the chart shows, some of our experience working with these target populations.
So I'm going to turn it now to our friend from Pennsylvania, do you want to talk a little bit about what we're doing in Pe Pennsylvania
>> CARYN SWARTZ: This next slide is a brief overview of the work that the independent enrollment broker has been doing in Pennsylvania since 2010.
So we have a good solid 5.5 years now of experience.
Some of the things that I wanted to make sure we pointed out is we're actually working with the nursing home transition population since that is a service that is covered under waiver we are coordinating and making referrals for those services.
That's part of our standard procedure for anyone that we do see in a nursing facility or any kind of transition at the time of the begin of waiver services.
We do employee a number of field employees.
They actually work out of their homes and they are scattered across the State so we can easily and quickly dispatch these brokers to do in-home visits.
And assessments and make sure that we are doing those timely.
We actually have very, very little turn over in those staff.
It's something that the group that we have employed now is just it's a great job they really enjoy doing these face-to-face visits and, having this interaction.
They also, these field workers are also heavily involved in the transition.
Nursing home trance significances they kind of case manage those cases as well, through the process as we know that, those are sometimes lengthy procedures and there are a lot of pieces that need to be addressed.
There's a couple of stats here at the bottom, so -- we do have a call center here in Harrisburg it's a central location where all of our calls come in and that's where someone who is in the enrollment process can call to check the status of their application that's also where we, take most of our referrals in.
We do now have also a web site and email services available

so that we have multiple avenues for people to make referrals.
And, the total number there 26, over 26,000 completed enrollments since December of 2010.
>> SPEAKER: Okay I would like to now talk a little bit more next slide please about our New York conflict free evaluation and enroll center.
It is something that we are doing in-depth assessments of individuals who are elderly and individuals with disabilities.
We're doing automated scheduling.
We're doing evaluation using all registered nurses to do those assessments.
We're working with the State and doing the determination of eligibility for services.
We're doing a great deal in terms of educating this population about their managed care options and then, we're handing them off to the service coordinators to perform the plan nive care.
Also in New York, next slide please I want to focus on this because our New York Medicaid choice enrollment broker has been doing voluntarily managed long term services and supports since 2006, ten years and we have been doing the New York State has transitioned to the mandatory program in 2012.
What is important hear is that I know that the advocates have some concern about our training.
We have trained counselors to do this enrollment.
The programs that we are enrolling into, include Medicaid manage long term services and supports.
Medicaid -- I'm sorry, it should be Medicare advantage program, advantage plus.
Which is, putting someone in a plan that has both Medicare and Medicaid plan so they get services from both of those plans.
We work with the PACE program across all of New York State.
And, in the integrated dual demonstration we are helping people choose to participate in the specialized integrated programs.
>> SPEAKER: In setting this up in New York, how did you train people in MAXIMUS to -- what kind of training was provided to them?

>> SPEAKER: Okay it was about a four week training program.
And it involved both the enrollment brokers and the
assessment folks.
They were trained on all aspects of policy.
They were trained on all of the choices on how to you know,
what are the differences among the individual plans.
How the plans differed.
How they can help people make choices that were best for them.
We had training on the actual, in this project we're doing
assessments and we're doing the choice counseling.
It's all kind of part of a single flow.
So we're going at it, so we have that assessment information
that helps us to be able to provide choice counseling.
So there is an extensive training program.
It is both computer based and it is face-to-face.
And then we have an extensive quality assurance program in
which people actually go out to the homes and sit with the people
who are doing the assessments we record 100% of the
calls we do quality assurance after the fact.
>> SPEAKER: That's what I was going to say, are there post
testing and --
>> SPEAKER: Yep.
We have a very extensive quality assurance program that looks
at, not only the assessments and the outcome of the assessments but also,
looks at all of the
telephone calls that we get in the call center.
>> THEO BRADDY: Does your training include working with
people with diverse disabilities.?
>> SPEAKER: Yes we have a special part of the training is of
course on, sensitivity training for working with people with
disabilities.
We have some training that is involving the whole idea of
different cultural norms, in terms of how that affects
health care and ensuring that people have sufficient capabilities
to work with populations that you know have different feelings
about the health care system than you know, we might in this
particular environment.
>> THEO BRADDY: I also have to ask you people who are
deaf-blind since they can't be here.
Do your staff know to work with people who are deaf-blind

>> SPEAKER: We work extensively, we do the assessment for persons with disabilities, so we of course work extensively with people who are blind and people with a range of physical disabilities and that is incorporated into our training.
It's specific you know, specific capabilities that have to be provided.
>> THEO BRADDY: Okay.
>> SPEAKER: Anything else?
>> SPEAKER: Yes.
Maybe you can repeat this question.
There was a question from Cassie James on how many individuals in your company have disabilities and how many have decision-making power?
>> SPEAKER: Um, I think, I'm going to talk to Karen in terms of --
>> SPEAKER: Can you repeat the question.?
>> SPEAKER: I cannot tell you the -- statistic I can get back to you.
>> FRED HESS: Do you need to repeat the question?
>> JENNIFER BURNETT: Repeat the question.
>> FRED HESS: What was it again?
>> SPEAKER: The question was, how many individuals in their company have disabilities and how many have decision-making power?
>> FRED HESS: The question is how many people in your company do have disabilities and of those people, how many of them have decision-making power,s basically.
>> SPEAKER: Correct.
>> SPEAKER: Okay.
Swap war on Pennsylvania I can speak only for the Pennsylvania project.
I don't have the exact current status but we are generally somewhere between 30 and 35 percent of staff with a self-described disability.
I'm not sure about the decision-making power that's not something that we have --
>> FRED HESS: Anything in upper management that you know off --
>> CARYN SWARTZ: Absolutely yeah. Our field supervisors, I know of at least one, that is -- one of the four.
So 25%.

I have to think about others in upper management
>> SPEAKER: I can check with you are on human resources committee I can get a company wide.
>> FRED HESS: Please do.
>> SPEAKER: I'm sorry I don't have that statistic.
>> FRED HESS: You can get it out to Jennifer she can get it out the Listserv.
>> SPEAKER: This is Brenda dairy would like to make a comment, I'm very excited to see you're so invested to make sure people are properly trained as a new system online I have to say that the current person centered, conflict free choice counseling that is offered during the enrollment process, is thoroughly lacking.?
I've been part of several different MAXIMUS appoints enrolled on the waivers as well as people who are, participating in nursing home transitions and when it comes time for them to make the choice of service coordinators and service providers, there's very little offered in terms of information when they ask questions of the current IEP.
>> CARYN SWARTZ: I would love to have a further conversation with you about what kind of information you feel would be helpful. You know obviously we have to remain completely unbiased in offering information but I certainly like to have further conversation.
>> SPEAKER: I will be willing to do that.
>> CARYN SWARTZ: Okay.
Great.
>> SPEAKER: Okay.
>> SPEAKER: Any other questions.
>> SPEAKER: Actually two questions.
One when will your slides be available?
>> SPEAKER: Yeah we can make them available.
>> JENNIFER BURNETT: We'll post them.
>> FRED HESS: The question was, are you're slides going available anywhere where anyone can get to them.
If so where and when.
>> JENNIFER BURNETT: We post everything to the CHC web site on, the MLTSS sub MAAC web site, any slides that are presented at these meetings in the next few days will be posted to the MLTSS sub MAAC web site that's access from the CHC web

site.
>> FRED HESS: From Tan yA, clarify -- clarify whether or not MAXIMUS is solely going to be working as the enrollment broker.
Meaning, they are just going to be responsible for disseminating information and not influencing people's decisions.
>> SPEAKER: That is a very important part of our training.
We are an independent broker, we are not permitted in any way to influence people, we can explain the differences between the plans, we can talk about how one plan has certain characteristics that another plan may not.
We never say to someone you need to pick this plan or this plan to be better for your people.
It's totally based on we answer questions it is a totally unbiased approach.
By law.
But it does bring up something that I think is very important I do want to mention.
In our New York managed care long term services and supports we work with over 10 community organizations across New York State who are our partners in terms of helping us get out the message, in terms of referring people, in terms of assisting us to reach this population.
Another example, we have been doing the star plus program which is the Medicaid managed care program.
In Texas since 1978 that's been a very long roll out.
It started in certain parts of the State and over the course of this very long period of time has rolled out statewide.
In that program we have contracts, with area agencies on aging and with other community entities across the State of Texas again to help us get the word out, to help us with out reach, that kind of thing.
So we have a very long history of working with community groups.
>> FRED HESS: I have a list of questions, I'm going pass these down.
We have some of the members of the MLTSS subcommittee here and, concerned consumers out there, usually get together on a Monday before this meeting and, come up with some questions and these are the questions.

What can -- I guess I'm going to ask you --
>> JENNIFER BURNETT: Fred before we go to questions can we finish the presentation.
>> FRED HESS: Sorry.
>> SPEAKER: Okay.
I'm sorry next slide please.
So these are the States in which we're working in the duals demonstration in those programs that there are integrated care plans in which the individuals have to receive both Medicare and Medicaid from this integrated program.
And, we help, it is a totally voluntary program.
Because we have 9 of the 11 demonstrations we have a monthly work group, in which we participate with all of the state people and the MAXIMUS star plus people, and CMS to talk about best practices to share ideas to talk about communication.
We are just in the process right now of doing individual interviews with all of our internal projects and their state clients to find out you know, what lessons we have learned.
How we can improve the program, what we can do two make things better in terms of the call center in terms of the materials and in terms of the data integration and in terms of the communication strategies.
And, we will be developing a report on the, on that for CMS.
So we have had a lot of lessons.
We have learned a great deal about working with this population.
Last slide, okay.
Just a quick overview as you can see.
We do a lot of work in Pennsylvania.
We're very dedicated to this state.
The independent enrollment broker, we also work as your Medicaid enrollment broker for the non-long term services and supports population.
The non- -- magi population, we worked on your healthy PA the Medicaid expense effort.
Both to enroll people in the private coverage option and then to roll that back and move the additional one.
MAXIMUS just acquired a small company that specializes in working with the intellectually development tally disabled

populations and that population and that company is currently the broker to perform the waiver assessments for the IDD population.
We also have a max Federal, or Federal division has a facility in Pennsylvania that does all of the appeals work for the Federally facilitated exchanges and the State based exchanges across the country.
So as you can see we have extensive extensive experiences.
>> JENNIFER BURNETT: We want to go through the presentation.
>> GINNY ROGERS: These questions can be answered as we continue through the presentation anything that can't we'll go back to those at the end.
>> FRED HESS: That's why I gave you a copy you can check them off as you go.
>> GINNY ROGERS: I didn't know, are you talking Caryn.
>> CARYN SWARTZ: Amy and I are going to go to together.
>> AMY HIGH: I'm the contract manager for the independent enrollment broker and office of long term living, I am going to, I would asked to speak on the current operational process for the enrollment broker as many of you know, we did enter into an emergency procurement beginning March 1, of 20106, so just wanted to go through the current enrollment process as it is -- as of March 1.
>> GINNY ROGERS: Can you talk louder.?
>> AMY HIGH: I'm sorry.
If you can't hear me please let me know.
I will try to speak up.
Next slide please.
Just to highlight, the function of the independent enrollment broker is to coordinate the enrollment and eligibility process for home and community based waiver programs and the Act 150 program.
That includes the coordinating the clinical eligibility determination which is determined by the level of care determination completed by the area agency on aging and the physician's certification received by the individuals physician.
The second piece of eligibility is program eligibility that's confirming the individual looking to enroll meets the target criteria of the waiver they're looking to enroll.

The example of that would be our independence waiver, requires an individual have a physical disability that causes 3 functional limitations.
And the third piece of eligibility is the financial eligibility, which is determined by the county assistance office.
The role of the independent enrollment broker is coordinate that process, to achieve enrollment for individuals into our program.
Next slide please.
The process begins currently when the applicant contacts the independent enrollment broker for individuals that are currently enrolled in the medical assistance already.
MAXIMUS, the IEB starts the process as soon as application is requested.
For individuals that are not enrolled in the medical assistance program when they contact the IEB, the process would begin when MAXIMUS receives the PA600L or the MA application.
This is available now, through the compass web site an individual can apply online, which will alert MAXIMUS to proceed.
In addition, on MAXIMUS's web site, the PAIEB.com, that form can also be down loaded if the individual is able or has the ability to access or at the request of the applicant a form can be mailed.
When the -- as soon as the application starts the first step in the process is the IEB, will request a level of care assessment be completed by the area agency on aging and at the same time the physician certification form is provided to the individual's physician.
That is the physician is identified, by the applicant at the time they contact the IEB.
So both of those happen as soon as the application begins.
Next slide please.
Upon receipt of the clinical eligibility determination from the level of care assessment and the physician certification, if the individual meet -TS the clinical eligibility criteria, the IEB schedules the home visit.
At that home visit, they complete a needs assessment, and, information on the programs to determine which program would best meet the individual's needs.
And they also provide information on service coordination

providers, in the area in which the individual resides.
For them to choose.
Once the home visit is complete, and the program in which the individual will be looking to enroll in is confirmed they send the IEB will send information to the county assistance office for those familiar, the 1768 form to -- for the, to notify the county assistance office, to proceed with financial eligibility determination.
And when the eligibility is confirmed by the county assistance office, the enrollment is considered complete.
And the information is enrollment packet and the service plan record, whether it be SAMS or HIXUS is transferred to the service coordination agency.
So that is, an overview of our current -- the current process.
Next slide please.
This slide highlights the changes and process improvements we made effective March 1.
The beginning March 1, the requirement for enrollment changed to 60 days.
So from the time an application starts when a determination is made the requirement is 60 days.
The aging waiver, has also been included in the IEB enrollment process.
So effective April 1, MAXIMUS we began accepting applications for individuals enrolling in to the aging waiver program.
Other enhancements include touch points or required contacts that the IEB has with the applicants as they go through the process.
As they, as each step is this the process is achieved they contact and let the individual know where they are in the process.
If information has not been received they follow-up to move that process along or offer another form if necessary.
They also, for individuals in the enrolling through the NHT program there's a requirement they follow-up every 15 days.
Bullet four is the reorganization of steps as I said the application now begins as soon as, an individual contacts the IEB and requests an application.
We, there is no longer, it compress he's so the individual only has two visits now instead of 3.

So the process is less c cumbersome.
The IEB has a web site, which is with effective March 1.
And this provides information in regards to the eligibility and enrollment process.
It also can -- individuals can make referrals through the web site, access the PA600L and in it, there will be additional enhancements moving forward the physician certification form is going to be added to the web site NHT coordinators or individuals can go on the web site to get that norm and also, an individual will be able to log on and check the status of their application online.
And then, as we spoke about earlier and Ginny will speak to the strengthening of the requirements and working with the NHT program.
>> GINNY ROGERS: We have a question right back here.
>> SPEAKER: Yes, I have a question and a suggestion.
As far as when you guys have like your monthly me meetings.
My suggestion as far as by having advocates at those meetings to tell you guys what is happening on the ground level.
Because like, you gave examples like you can follow the pro Yes, sir online.
But a lot of people, a lot of people poor people do not have access to the internet.
So like how would you explain that, how would you explain that process to someone who can't go online to see where their process is?
And do you guys have like advocates there so that way you know you can see what is going on on the ground level as well
>> AMY HIGH: I'll let Caryn speak to that the online tracking is one option to check where they are in the process.
>> CARYN SWARTZ: We do operate a call center, here in Harrisburg.
It's a toll free number, anyone can call and check the status of our application.
That's what we always had.
We were having some of our applicants saying they would like another option another way to check the status so we've offered this as alternative.
We feel will be -- we realize it doesn't reach everybody now

we have, have a number of options available.
>> THEO BRADDY: Can I have a question quick.?
Is there any monitoring with the 60 days?
If so, are they independently associated with failing to do it in 60 days.
>> CARYN SWARTZ: Yes and yes.
[laughter]
>> THEO BRADDY: Good answer.
>> CARYN SWARTZ: It's heavily monitored and penalties associated.
>> SPEAKER: 60 days is new.
>> CARYN SWARTZ: Used to be 90.
>> SPEAKER: What percentage of cases were following above the 90 --
>> CARYN SWARTZ: We were measuring 90 the average number of days for completing applications prior to March 1 was 66.
So I can't tell you exactly what the percentage is, I do have the average.
>> SPEAKER: Given there's multiple steps in the enrollment process and entities have hand the AAAs, the enrollment program, other interim time turn around time requirements in terms of the steps being within and can you elaborate what those turn around requirements are for different steps of the process.
>> CARYN SWARTZ: I can speak for the ones on the IEB maybe Amy or Ginny can address those questions at 30 days we need to have completed the clinical pieces and make the program determination so that information can be relayed to the county assistance office.
So that's one other kind of benchmark for us as well.
>> AMY HIGH: The, the area agencies on aging have a time frame of 15 days to complete the devil of care determination.
We work closely with the Department of Aging to Monday those time frames as well, to meet the 60 days, I'm sorry.
I'll repeat myself, I wasn't speaking loudly enough.
The area agencies on aging benchmark time frame is 15 days for the completetion of a level of care determination.
We work with the Department of Aging to monitor those time frames a as well and the county assistance office, requires 45 days before the review of the financial eligibility determination that -- let me say -- that piece, that is also, a requirement.

>> SPEAKER: Thank you.
>> RALPH TRAINER: Two other questions.
>> SPEAKER: If an individual has applied to the waiver under the new 60 day requirement and, is found to be not eligible due to level of care, what is the process that they would go through to request a review or an appeal of that decision?
What are the time frames involved with that?
>> AMY HIGH: For anyone that is determined ineligible they get a notice of decision which includes the right to appeal.
And they file an appeal and that is returned to the IEB.
And then coordinated with the hearing and appeals to schedule a hearing.
I don't have specific information on scheduling the hearings prehearing conferences are also scheduled if additional information is presented with the appeals.
So -- we do prehearing c conferences as well we would look at it if there's a change.
If it can be resolved prior to a hearing.
>> SPEAKER: So just to clarify, is the notice that is given a written notice?
Aim yes.
>> AMY HIGH: Yeah.
>> SPEAKER: When is the notice written.?
>> AMY HIGH: As soon as the determination is made, currently for -- for the current application if the LCD indicates an individual is NFI, or nursing home facility ineligible, a notice would be issued within --
>> CARYN SWARTZ: I want to add for a calf we would wait for a physician certification is, there are programs, NFI, with certain other factors involved.
So we would wait until both of those documents have been received and then, immediately, the notice would be issued.
>> SPEAKER: Is there a timetable for the physician's S to be received?
>> CARYN SWARTZ: It needs to be received within 30 days of the begin of the application.
If is received after that, we'll continue to process.
>> SPEAKER: How long do people have, once they have received the written notice to appeal the decision?
>> CARYN SWARTZ: An applicant has 30 days.

From the date of the notice.
They have 30 days to submit their appeal.
>> GINNY ROGERS: Most recently, the question was how long does the person have to appeal once they receive the notice that is 30 days.
The question before that, was how long do we have for the physician certification to be received?
Obviously, it's especially helpful if it comes right away.
But we, wait for up to 30 days before the application proceed s through the process.
>> CARYN SWARTZ: We have several reminders built into our system if we have not received it.
>> SPEAKER: Is that 30 plus 30, equal the 60?
>> GINNY ROGERS: It's not an exact match.
Because we have to leave the county assistance office at least 45 days, we have it --
>> CARYN SWARTZ: Are you saying about the appeal 30 days tacked on?
>> SPEAKER: Well I'm just confused now as to what the 60 day requirement actually is.
>> GINNY ROGERS: To complete the eligibility process for enrollment, within 60 days.
That includes all of the tasks that Amy has reviewed in her presentation.
>> SPEAKER: But not the physician certification.
>> GINNY ROGERS: It includes the physician --
>> CARYN SWARTZ: It happens simultaneously.
>> THEO BRADDY: What if -- that is held up?
That doctor, that causes you to go over the 60 days.
>> CARYN SWARTZ: If we have not received it within 30 days we'll close that application and send the applicant a notice.
So their application is missing information that as soon as that document would be received we can jump start a new application for them using any current documentation we have on hand and move as far along in the process as we can.
>> THEO BRADDY: 630 days starts over again?
>> CARYN SWARTZ: 60 days would start over again, once the application is closed it's closed we would start fresh we would bring over any relevant documentation from the prior initiated application.

>> SPEAKER: I'm sorry, just to follow-up on that previous, so if the applicant feels there is information, that is relevant that has not been reflected, would a new visit be made to the home?
Swap war potentially.
If there's been a change in condition.
>> SPEAKER: Well or something was missed in the initial interview?
>> GINNY ROGERS: I think the people always havest opportunity if for whatever reason, there's an assessment and there's information that was missed or not available at the time when they bring that forward the person can be reevaluated based on whatever information is there.
Part of Amy's unit we work with people who are going through the appeal process, they're doing prehearing conferences.
That actually does happen where the information comes forward and that potentially can change a decision in terms of enrollment.
So that does happen.
I just wanted -- I do want to move on I wanted to talk about CHC enrollment, but, someone else had a question I think Ray -- go ahead.
>> SPEAKER: Is there a document that states all the time frames for consumers to know their rights?
>> CARYN SWARTZ: The time frames to submit their appeal.
>> SPEAKER: Is there like -- a document for them to like you know, on the web site --
>> CARYN SWARTZ: Absolutely on our web site -- just paieb.com there's a button there that is takes you to a page which is the steps to apply for waiver services.
We have worked really hard to make that a concise but informative document but it describes each of the steps that haily talked about and the time frames for completing them.
So that's something we handout at all of our meeting and put it on our web site and mailings, to help everyone understand the process.
>> SPEAKER: If you're found ineligible are there other resources --
>> SPEAKER: Can you please repeat the question?
>> CARYN SWARTZ: I'm sorry the question is, was there a document that people can refer to, they understand the process

and the time frames?
I mentioned that that's a form that we put together and is also available on our web site.
And then, the second question was -- can you repeat the last question
>> SPEAKER: If they're found ineligible do you provide other resources.
>> CARYN SWARTZ: Are there other resources provided to the applicant if they are found ineligible, we do counseling with applicant for other potential resources they may be eligible for, we can't determine the he will gentleman gentleman built for the services we do give them a listing that's actually another thing that we're adding to phase 2 of our web site, which is coming mid May.
There will also be a -- a listing of additional resources there.
Again realize not everyone doesn't have web site access, we provide that at our home visits as well and, in the mailing packets.
>> GINNY ROGERS: So I just wanted to say we do have a couple of questions that came in on the phone.
But I would like to proceed with the presentation and then maybe we can circle back.
Some of these are additional calls, additional questions about process.
The other thing I wanted to say was we had -- the 90 day was, the 90 day enrollment process originally was from a settlement, agreement that we have worked very diligently to address.
So what now with the 60 day process we think we're going to have enrollments completed
within 60 days with all the streamline we've done and all of the feedback that we have received from stakeholders around the State in many meetings such as this.
So all of that information has come forward to help us, we think, create a better process.
So moving on.
We can leave that one up.
I wanted, we organized this today, so that you can kind of understand the existing or current process how it may relate now to what is going to happen for community health choices in the

future.
And I wanted to talk about the transition that is going to occur starting in August through December.
And then, basically the ongoing enrollment process.
So, if you can move to the next slide.
So this is just to illustrate for you for the up coming few months, these are things that you've heard about before.
This has to do with the waivers, the current configuration of waivers, OBRA, COMMCARE independence waiver and aging is in the middle part of that, on the, other slide where it says CHC zone, it includes OBRA and then the CHC waiver.
From other meetings you know the COMM care waiver is being changed into the CHC waiver.
All of the individuals who are in COMM care in the South Western zone will go and be transitioned to the CHC waiver.
And individuals who are in the COMM care waiver in other parts of the State are going to go into the independence waiver.
So some of the work that is currently under way, Virginia Brownie, I believe talked about in the amendments, there are changes in the independence waiver to pick up additional services available in COMM care so that individuals in COMM care can be served appropriately in the independence waiver.
In your non-CHC zones, the OBRA waiver, independence and attendant care and aging will continue to operate until we have the State wide roll out.
At the end of the statewide roll out there will be the CHC waiver.
The OBRA waiver and then, I just put in Act 150 will continue as well.
That is a state funded program.
So this is a visual to just kind of, give you that information.
In addition, just because I'm sure we've talked about this as well, the OBRA waiver participants, are going to be receiving assessments level of care determinations, they -- those who end up being nursing facility clinically eligible, will move to community health choices.
Those individuals who are not nursing facility clinically

eligibility will remain and be observed in OBRA.
In addition, individuals from the, who are 18 to 20 in the other waiver programs will be transitioned into the OBRA waiver.
Because community health choices begins at 21.
That is a very fast, there are a lot of activities associated with this work.
One, we are going to be working with the AAAs to get those assessments under way for the OBRA waiver.
There's, pretransition letters that will be going out.
The notices, will be coming out probably towards the end of August September range that will be introducing people in the southwest to community health choices.
There will be follow-up letters, that will be occurring as people make choices with the MC Os and in a little bit I'll talk about some of the additional requirements we're going to have for the independent enrollment broker.
You can go to the next slide.
>> SPEAKER: Ginny can we have that slide that will be very helpful.?
>> GINNY ROGERS: Yes this will be part of --
>> JENNIFER BURNETT: We'll post everything.
I also wants to point out that the CHC waiver is out for public comment right now.
You can take a look at that and we really would appreciate your feedback on it.
>> GINNY ROGERS: The next slide is the CHC, this is for ongoing enrollment, for individuals who are looking for long term services and supports.
So, those individuals will contact -- first of all I want to say this is a no wrong door process.
Someone is presenting at another entity they will then be eventually referred to the independent enrollment broker.
They can still present in other places.
We have processes in place for that.
But this shows that the participants or applicants will contact the independent enrollment broker.
The broker will help the participants apply for long term services and supports.
That process is not going to be, too much different from what Amy described in the current process.

For people that are looking for those long term services and supports they're still going it need you know the clinical level of care determinations, the financial eligibility all of the things that Amy described.
So this is just further detailing scheduling that information.
Helping the person complete the Medicaid application if it's still needed.
That information will go to the county assistance office.
And often times people are already in Medicaid or have medical assistance so sometimes the applicant will actually -- the CAM will potentially refer the person to the IEB.
To complete the -- the information needed for the long term service he's and supports.
Did I see a question?
Not yet.
Okay.
So the next slide -- so when this applicant meets with the enrollment broker the broker is going to present the MCO options, for that applicants zone.
They will be talking about health care, long term service, MC O providers in each network and hipping with the choice counseling.
All applicants also, are going to be offered the choice of community health choices or the LIFe program, if the participant chooses LIFE the enrollment broker is going make a referral to the program.
And then the LIFE program will out reach to the applicant.
All CHC participants are also going to be notified annually, of their choice of MCO plans and other the life program I just wanted to make sure that people knew that, LIFE continues to be an option for participants as we move forward.
If people, if the applicants do not make a solution before eligibility is completely finalized, an MCO will be auto assigned.
An individual may do that, may change their MCO at any time.
And then, coverage with the MCO begins the day following the date the individual is determined eligible.
And, I think this is actually very positive thing.
Because, once the MCO takes that person then they could implement the needs assessments and the service planning, almost

immediately.
So there will be some time frames we're going to build
times we're calling them NFI population.
The NFI population.
They must be financially eligible, the county assistance
office has a role in that.
Once the person applies, in the county assistance office,
this is next slide -- we'll let the person know if they qualify
and then, the person will need to work with the independent
enrollment broker to choose which MCO they want to provide
coverage.
The IEB will send
information to the individual.
Information about selecting an MCO, asking the person to make
a choice and get back to them.
And then if the person does not make a selection they will be
auto assigned within 30 days.
Obviously the same thing if the person wants to make a
different choice they can make a different choice any time.
And then, enrollment broker will send the follow-up letter
letting the person know the date the MCO coverage will begin.
So moving onto the next slide, I put this under
recommendations because we have heard a lot from folks about how
to improve this process and some things I think in addition that
have not worked so well.
So, we wanted to look at ways that, as we move forward with
new tasks what can we potentially include to streamline it make
it better.
So, some of the things that just to let you know we are
making changes to the existing contact with the IEB.
Some of these tasks include the following -- we're going to
be -- they're going to expand operations to be responsive to
participants calling about plan choices.
So that will be you know, the 800 numbers and other ways that
will be able to provide people to contact the enrollment entity.
They can talk about the MCO plans and what is available.
They will be required to send notices to participants the pretransition
notices and then additional follow-up notices, assisting the
person to make a choice.
And once the person has made the decision and that

information has been collected they will no longer need to continue to follow-up with the letters.
There will be development of a web site portal, so that all of those options will be displayed for the person and then the person will potentially be able to go in and make changes to their plans if they desire.
We're talking about referrals to alternate service providers. There's been questions and requests of us to have at the end of the potentially, several day process, that in someone for whatever reason is not eligible at the end of the process, is there another entity to refer them to?
We're talking about a kind of like, we're using the terms more hand offs we're going to describe and, get referrals to other entities in some cases, it may be that APPRISE counselors if someone has questions about Medicare, how that works for them. It could be back to the AAAs or the CILs depends what that person is looking for and what their needs are.
Also, there's a numerous IT requirements that we're in the process of working onto ensure that the plan selections and other information is captures and of course sent to the CAO and to the MCOs and that data and information is shared so this whole process will work.
I know this was really quick I know that we also have a lot of questions for folk -- that folks have about the process.
And in terms of timing -- cording to 12.
Yeah.
How much time do we have to wait.
>> RALPH TRAINER: Let Fred address the questions he has and -- we'll see if we have time.
>> JENNIFER BURNETT: We paneled your questions.
>> FRED HESS: Let's run through quickly and real briefly. Make a real simple answer to it.
Well, we're -- what OLTL can the tell about the capacity of MAXIMUS.
You've done a very good job, you gave us a scope of the sports and applications of maximum, deliver under the emergency procurement, number 3, how will and MAXIMUS communicate with the participants good job on that.
What time limit -TS for processing applications you did a good job for that.

With the IEBs role, interrelate to the entity which will be making clinical eligibility determinations.
>> GINNY ROGERS: It will be similar to today.
The clinical eligibility determinations are completed by AAAs.
And the independent enrollment broker has a, referral process, or -- so that, information is referred and the assessments come back.
It will be very similar to that in the future
>> FRED HESS: Okay I know that you guys are going to have your contact information out there, but one of the questions is, if for some reason we can't get, if you can't get in contact with -- let me rephrase it, who should consumers contact if MAXIMUS IE is not responsive or if they have complaints?
>> GINNY ROGERS: Okay.
We definitely want to be responsive about customer service.
We have a participant help line.
And I would certainly direct folks and also, I'm sure that's operated in my area and then, those calls would be given to Amy and her team to work on.
With the IEB.
>> FRED HESS: How will MAXIMUS handle questions about the Medicare enrollment?
What medical -- training will they receive?
MAXIMUS be required to have a written agreement with the APPRISE regarding referrals of applicants to APPRISE for advise regarding Medicare
>> GINNY ROGERS: I don't, we don't think there's going to be a need for written agreement, we're going to be having conversations with APPRISE and talking about, what the roles are going to be in the future and how, these potential warm hand offs may work both for the IEB and for APPRISE.
>> SPEAKER: Can I say something really quickly.?
We worked very closely with, for example, 1800 Medicare, dual eligibles we have a process in which a referral process, because very often, in the dual projects people call 1800 Medicare.
So we actually exchange information with the Medicare system.
We have extensive training on Medicare.
We work very closely in other states I don't know how it's going to work in Pennsylvania.
>> FRED HESS: That's what we're concerned about is here in PA.

Max muzzle be required to have agreements or arrangements with other agencies that currently counsel older adults and persons with disabilities such as AAAs and Centers for Independent Living
>> GINNY ROGERS: I do think we're going to further develop those kind of relationships in terms of, written agreements I think that, there's -- we need to discuss that and think about what that is going to look like.
As Jen said earlier it's going to be all hands on deck I think that, we cannot under estimate the
value of the existing agencies, you'll definitely hear more as we proceed.
>> FRED HESS: There are a couple of recommendations.? Readiness contact review, each CACMCO will undergo readiness review should MAXIMUS IEB, readiness contract review will ensure MAXIMUS has adequate capacity and realistic plan to train staff and meet the increased number of individuals under CHC. What contingency plans will they have to handle days times when the volume of calls are higher than normal, what are PH specific training materials and qualifications of trainers I know you'll not be able to answer that right away.
But it will be nice to have something that we can hear of next month on that one.
>> GINNY ROGERS: Okay.
>> FRED HESS: Regardless of the number of the staff of MAXIMUS, has available in other states, it needs to present a plan to train staff including those will be out-of-state, and the complexities of PA's home and community based services available under the CHAC it should be review the by OLTL staff and the consumers before the contract is finalized that's very important because PA is a different animal than most other states applicanten rowy liaison, MAXIMUS should designate one or more staff to be the point of contact for any applicant enrollee who is having problems with the enroll amment process cannot be resolved by max misplus customer service staff, that liaison should compile data, on the number and type of issues faced by applicants and enrollees and that data should be shared with the MLTSS subcommittee.
3 MAXIMUS, IE should provide evidence of an agreement or agreements with APPRISE to deal with the referrals regarding

Medicare issues and with the community organizations, like centers for independent living, on home and community based services and nursing home transition issues.
That's very important to the consumers in this state.
We are included in everything.
Four, max misshould submit quarterly reports on the performance, based on measures in the contract, and, such other measures as OLTL, may later request based upon recommendations in the MLTSS subcommittee, those reports should be made public, performance measures should include at a minimum, average time between the initial contact and each step of enrollment process in which MAXIMUS, is involved as well as the applicants are denied, IE over income or failed to provide complete financial verification.
>> JENNIFER BURNETT: Okay.
Well, thank you Fred for those recommendations.
We will take them under consideration and, I thank you MAXIMUS and also my staff for coming and presenting on the independent enrollment process in Pennsylvania.
It's evolving process as you have just heard.
But this is actually, this all this talk about APPRISE is a good segway to invite Darlene Sam son from the Department of Aging to come up and talk about the APPRISE program and -- to give us an update, we're doing a lot of work with the APPRISE program, to figure out what that connection is between, all the entities and APPRISE.
>> DARLENE SAMPSON: I think it's still morning, good morning.
I would like to start by first saying I'm really pleased to be here today to share information with you about the APPRISE program and all the work that we do to assist Medicare beneficiaries but I also want to take some time as well to tell you about some of the things we have been doing and working collaboratively with the office of long term living to prepare for CHC because there's going to be a lot of transition for the beneficiaries we serve we want to make sure that we're, our program is well positioned to continue to work with the beneficiaries throughout the transition.
Next slide.
Thank you.
So I think I'll start with giving you some background and a

quick overview on what the APPRISE program is since I know that there's probably, varying levels of familiar clarity with what APPRISE is.
The APPRISE program is very important to first understand that this program is part of a national network of programs across the country.
The APPRISE program is built into Federal statute and so, each state, across the country, actually, operates in the APPRISE program.
And we're here to provide assistance to Medicare beneficiaries.
Several years back when CMS was experiencing changes to the Medicare program in terms of the advent of the Medicare advantage plans, they quickly recognized that there was a need to be able to assist beneficiaries and understanding how to make the decisions around choices.
So this program came into existence.
We are largely funded by Federal, the Federal dollars that come into the State to operate the program.
We do, here in Pennsylvania, have a state allocation but most of our funding comes through our Federal grant.
And the Pennsylvania Department of Aging which is where I work is the grantee for APPRISE funding and we then, allocate those dollars to local area agencies on aging administer the program at the local level.
So we have staff in every area agency on aging, most of the area agencies, some of our area agencies on aging serve more than one county.
But in all of our areas I meant to say, there are every area on aging but not every county.
We have staff in the area agencies on aging that work with a group of volunteers, within their communities to ensure the beneficiaries receive APPRISE services and right now, we have over 700 volunteers assisting us throughout the State.
Our program is currently, serving about 200,000 of the 2.
5 million Medicare beneficiaries in Pennsylvania.
So APPRISE work can really be categorized, under 3 broad areas.
We do health insurance counseling.
That's our primary role is to assist Medicare beneficiaries we assist them in understanding how Medicare works.

There are a lot of rules and that apply to the coverage and, it can be very confusing.
Like any other insurance.
Medicare is confusing.
So, we help beneficiaries understand how those rules apply to their coverage.
We also conduct a great deal of community education with various groups in communities all across the State.
Our APPRISE counselors work with a whole host of groups, businesses, they will work with hospitals, they will work pharmacies wherever we know where -- a connection with beneficiaries will go and form partners and, utilize those partnerships to help educate the community about Medicare.
And we do a lot of out reach because we need to make people a ware of our services.
We have 2.5 million Medicare beneficiaries in Pennsylvania, a lot of beneficiaries that still do not know a program of this type is available.
And it's interesting when people find out, they're just amazed they can go somewhere and get questions to, about their Medicare answered.
So we have to do a lot of out reach.
Sometimes our out reach is very targeted.
We receive I mentioned that we receive a Federal grant, to administer the APPRISE program.
We also receive a separate Federal grant for the sole purpose of doing out reach, doing intense out reach to locate low income beneficiaries so we can inform them of public health programs is that they may be able to, they might be eligible for, like the Medicare savings programs which is our programs under the Medicaid program and the low income subsidiary which is a program that will assist beneficiaries with the out-of-pocket cost related to prescription drug coverage.
Who seeks out watch prize coverage, it includes individuals over the age of 65.
It's interesting a lot of people think Medicare is strictly for people over 65.
But there are other groups that also, receive Medicare benefits.

Individuals under 65, who have certain disabilities.
And anyone, any person of any age with instage renal disease qualifies for Medicare.
The Medicare population well the 65, those that are 65 and over are obviously the largest group that served by APPRISE and are the largest group within the Medicare program.
And they're entitled to Medicare because of their work history.
When we work we pay, we actually pay into the Medicare our social security
fund, you saw the FICA
Federal income contribution act.
That's money going into the social security fund and it also pays for your Medicare.
So when a person is over 65, their work history determines whether or not they're eligible for Medicare.
But then there's a separate group that also qualifies and those are individuals, under 65 and they qualify based upon their disability status.
But our program also does a lot of, provides a lot of assistance to caregivers and anyone, basically that is calling behalf of a Medicare beneficiary and they are there -- they're trying to help them resolve issues with their Medicare.
We help those individuals as well.
Now, this slide illustrates the various ways in which the APPRISE program, provides assistance to beneficiaries.
First and foremost it's important to note the counseling that we provide is unbiased and personalized.
So one of the reasons why APPRISE counselors are so trusted by beneficiaries is because they know that we are neutral, that we don't receive any compensation for the counseling work we do.
So they come to APPRISE because they know that the information that they're going to get is accurate and it's going to be unbiased.
But we also help them, again, understand Medicare rules, we interpret those rules for them.
And we explain it to them in plain language, language they can understand.
Counselors also help Medicare beneficiaries understand how different other insurances coordinate with Medicare.

Sometimes Medicare is going to pay first.
Sometimes Medicare will pay second.
Sometimes Medicare won't pay at all.
And there are all types of insurances that people have that work with their Medicare and we have to help them understand how those insurances work with Medicare.
For instance, if a person has Medicare and say, tri care for life which is military health care for retirees and their families, Medicare is generally the first payor and then Tricare for life is second.
But sometimes tri care for life will pay for a service that Medicare doesn't pay for.
And vice versa.
Medicare may pay for something that Tric care doesn't pay for.
We have to be able to explain when they present those insurances to us how those insurances work.
Medicare APPRISE also extends to as I said helping beneficiaries enroll in programs.
Like the low income subsidiary program and Medicare savings program.
And a large part of our work is helping them enroll into plans.
So that's critical as part of this discussion about CHC because a lot of people are wondering what is going to happen with Medicare and enrollment into Medicare programs.
APPRISE counselors will continue to play that role of assisting Medicare beneficiaries enrolling them into Medicare advantage plans.
And beneficiaries also turn to APPRISE for help with filing for appeals.
Our counselors are trained on the appeal process in Medicare and, will help beneficiaries prepare to file appeals and help them go through that appeal process.
So you can see there's a lot we do, in terms of the kind of assistance we provide to the beneficiaries.
Now, I included this slide because I wanted to give you a sense of all of the different types of considerations related to coverage that beneficiary might be confronted with.
So if you take for instance, part A, and then, one other thing I would like to note this is not an all inclusive list.

These are just some of the issues that come to us from, you know E with beneficiaries present to the program.
Some of the issues they're presenting with.
And how we have to help them work through some of these issues.
So, for instance, part A.
There's cost sharing generally in all parts of Medicare.
But, if a beneficiary for example, has only Medicare, original Medicare no other form of insurance, then there's some significant cost sharing they may incur.
Like the part A deductible going into the hospital.
There's a large deductible that a beneficiary would be responsible for.
So we have to help them understand how those you know, that cost sharing will apply in those situations.
There's rules about how hospital stay will link to them being able to access skilled nursing facility care, if they need that following a hospital stay.
There's also, a misconception that Medicare pays for nursing facilities custodial care in fact Medicare really only covers skilled nursing facility care.
And beneficiaries also need to understand how medi gap coverage it is secondary insurance coverage to Medicare.
And some folks opt to have that sort of arrangement for their Medicare, Medicare plus supplemental insurance.
In addition to talking to them about Medicare advantage plans we also have to be knowledgeable about medi gap how supplemental insurance works.
Then there's a whole host of other considerations that relate to other areas of Medicare part A, part B, part D.
Issues like, if a person has -- they exceed a certain income threshold, then, an additional amount is tagged onto their premiums and we refer to that as the ERMA, income related monthly adjusted amount counselors.
All right.
I would like to transition more specifically about the issues that we deal with when we're dealing with the dual population.
As you can see here on the slide, some issues that are unique to this population that we often assist them with.
For instance, Medicare cost sharing.

When a person is dual, there's a certain protections in place for them that they are not balanced billed.
So a provider when they have something that has both Medicare and Medicaid they know they're not supposed to be sending bills to that individual.
Because those two insurances are supposed to suffice for the payment.
So we do a lot of educating with our beneficiaries about those types of protections.
Medicare beneficiaries, are becoming dual, you know, every day.
I mean, people are becoming new to Medicare.
So when there's Medicare status changes, when they're becoming a dual and they're also going to be receiving Medicaid, we have to help them understand how coverage might change a little bit and what they need to do related to that.
Medicare and Medicaid sounds so much alike and often times Medicare beneficiaries are confused so we have to explain to them how those two insurances are different.
How to use their Medicare and Medicaid card when they're going to providers.
Our counselors also do a lot of work helping beneficiaries navigate service systems and working with plans and in fact the Federal government has a system in place where our counselors receive what is called a unique identification number.
So that they're able to speak on behalf of a beneficiary directly with a plan if there's an issue that comes up.
There's a lot of different ways that we assist duals.
This slide I just wanted to give you some idea of some of the things that have been going on more recently in terms of our work with the office of long term living.
To prepare for CHC.
I know that there were a number of questions that came up from the members of the committee regarding the APPRISE program and how, what role the APPRISE program will play in the new program CHC.
We've been engaged in discussions with the long term, the office of long term living.
I want you to know that first.
And we are trying to identify ways in which we need to

prepare our own network for what is coming down the pike with this transition for the beneficiaries.
So for starters we, through the help of office of long term living we've been able to convene calls, at least a call with, we've had several other calls with other states but, we've convened a call, with states, to talk about their experiences, their SHIP program, the national name for programs like APPRISE. It stands for state health insurance assistance program.
We have actually had conversations with other SHIPs across the country to find out what their experiences have been with implementing integrated care programs and -- so, we're we're trying to gather our information so we can better prepare ourselves.
The staff, at the state level, myself and the State wide APPRISE coordinator, we sit on work groups that are convened by the office of long term living so that we can provide input on, issues that we think are going to be important to the APPRISE program and important to the beneficiaries we serve.
We have reviewed the documents I have received the concept document, the RFP we are as information is coming out, APPRISE program is there, participating as well.
We participated on a webinar where we did some training with stakeholders and some of you may have been on that training where we did some basic 101 Medicare training so people can have a better sense of, what -- how the Medicare program works and some of the issues that counselors are, some of the issues that, beneficiaries deal with and using Medicare benefits.
You were on that, Okay.
I hope it was helpful
>> FRED HESS: Yeah. Absolutely.
>> DARLENE SAMPSON: Okay.
Good.
We have our OLTL staff has presented at our most recent APPRISE conference which we held last year.
And, I'm sorry.
Last month, last month, in State College and, they gave our network an overview of what the CHC program is, and you know, what all the plans around CHC and just to make them understand how this program is going to work as we're preparing to counsel beneficiaries on CHC.

We have conference calls being scheduled for the zone 1 local APPRISE programs because just like readiness reviews have to be done with the plans and I heard someone ask earlier about readiness review with IEB, IEE, we're also, looking at readiness for APPRISE and what we need to do to sure up our programs at least for now and in that first zone so that they're ready to assist beneficiaries.
We're reviewing what additional training our network is going to need.
So that they're also ready.
And, we're identifying communication and referral processes, someone brought that up earlier.
You know, what will the referral look like between the IEE or IEB and APPRISE, we're in the discussion with office of long term living around that you can rest assured that there will be some sort of referral process that will occur between us because as I said earlier, there are a lot of things that are going on, on a daily basis in the lives of our beneficiaries with their coverages we've got to be ready to discuss those needs as CHC rolls out.
Finally I just wanted to summarize by talking, just giving you some facts about the program in terms of why we're so positioned to be of assistance during this process.
APPRISE is a trusted resource.
A lot of people come to APPRISE when they have questions with their insurances.
Sometimes it's not Medicare they're questioning they will just call U.S. because they know we know insurance.
We're a trusted resource in the community.
Our counselors are trained in all areas of Medicare and they're trained on other insurances.
We have to be because we have to how Medicare, those other insurances coordinate with Medicare.
Our services are available through out the eastbound tire state and APPRISE understands Medicare beneficiaries receive coverage in both services.
We're familiar with the fee for service system and we're also familiar with the managed care system.
So we are positioned to help folks.
APPRISE works in partnership with numerous community

organizations.
And, we have experience working with the population.
So that concludes my presentation and, at this time I'll
entertain any questions
>> RALPH TRAINER: Any members have any questions for Darlene?
>> SPEAKER: Hi there --
>> SPEAKER: I have a question or -- you if like assistance
with the committee to help ensure your staff is in the southwest
region already I would certainly be willing to get together with
you and maybe get together --
>> DARLENE SAMPSON: Okay.
Who are you may I ask?
>> SPEAKER: I'm Brenda Dare.
Yes.
>> RALPH TRAINER: We'll make sure she gets your information
Brenda.
>> DARLENE SAMPSON: Thank you for the offer.
Thank you.
>> SPEAKER: You're welcome.
>> SPEAKER: I'll say first thank you.
As a plan representative, APPRISE is incredibly helpful it's
the first place our community out reach staff go in the new
county and it's incredible resource for advising beneficiaries.
We, you know, every day, find someone who is paying too much
whether it's part B premiums, they don't have LIS they don't
realize they're a dual APPRISE is their go to resource.
I think my question is around AEP the annual election period
around Medicare is incredibly busy for APPRISE.
This is a new program with new notifications that are going
to be going to I think, I'm most worried about in this
circumstance are the unconnected duals.
They are not in long term services and supports they don't
have a service coordinator.
They may not know they're a dual.
They will start receiving notices in a new way that increase
your call volume and create a lot of concerns.
What additional capacity is APPRISE planning to add on and,
how will you go about that understanding?
>> DARLENE SAMPSON: And Ray we have the same concerns and
that's part of what we're going to be having discussions with our

programs in that region to talk about how we're going to be prepared for that.
What we need to do with our local programs to be prepared.
We are looking at issues around volunteer support -- we're looking at issues around sharing resources between counties, to assist beneficiaries as they call.
Now fortunately, at this point we -- our role we don't see changing that much, in terms of what we currently do with assisting beneficiaries and particularly assisting the dual population.
So, I envision a lot what we're going to be doing initially will be to make referrals to the IEB and just doing a lot of educating beneficiaries about what is the CHC is helping to answer questions, that they may have regarding the notices that they're going to be receiving.
And we had conversations with the office of long term living about ensuring that APPRISE counselors have access to those notices in advance, so that when we do have individuals calling us, we are familiar with what the notices say and we'll know exactly what we need to say, and share or information we need to share with them to sort of ease their anxiety around it.
So yes we're preparing, we're looking at all those issues and we're going to be making whatever preparations we need to address that.
>> RALPH TRAINER: Thank you very much.
>> DARLENE SAMPSON: This yes has a question.
>> SPEAKER: Hello.
I've been a consumer for 15-16 years I've never even heard of you guys before I'm dual eligible.
And what do you do as far as like out reach, like.
Where would I find that information?
Because you know I'm a part of a CIL, I've never heard of you guys?
>> DARLENE SAMPSON: We actually do work --
>> SPEAKER: Could you please repeat the question.?
>> DARLENE SAMPSON: The gentleman said that he has never heard of the APPRISE program and he is -- you said you're part of a CIL.
>> SPEAKER: Part of a CIL a consumer.
>> DARLENE SAMPSON: A consumer is just surprised he has

never heard of APPRISE program, where would he go for information about APPRISE we have a toll free number for starts that -- you can call, if you have questions and you need any assistance from the APPRISE program.
But there's also information on the Department of Aging's web site about the APPRISE program.
And our local agencies, the AAAs you can contact any AAA and access an APPRISE staff person there or volunteer for help.
>> JENNIFER BURNETT: Let me also say that I have seen APPRISE at a lot of health fairs.
The local agencies make sure they're connected with opportunities for doing out reach.
One of Darlene's slides had one of those health fair booths on it.
So they do try to get, do as much out reach as possible.
I would in your case, you're in Philadelphia contact the Philadelphia corporation for aging get hooked up with their APPRISE program.
They are looking for volunteers across the State
[laughter]
>> DARLENE SAMPSON: Please share with other people that you know that could use our services because you know, we're doing everything we possibly can to get the word out because as I said you've just confirmed it, there's still a lot of people that don't know.
>> THEO BRADDY: Are you reaching to centers you know --
>> DARLENE SAMPSON: We do,.
>> THEO BRADDY: He would not be connected to aging.
>> DARLENE SAMPSON: We do lot of work with through the MIPA out reach, our out reach to low income subsidy, low income beneficiaries around the subsidiary program, we do a lot of collaborative work with the CILs and other organizations, that make up the LINK partners across the State, which the CILs are one of those partners so, through those partnerships we ask our partners to safety us and make the community aware of the services that we offer.
>> JENNIFER BURNETT: I'm sure Darlene would be glad to come to talk to a PCIL meeting do out reach to the CILs to improve the awareness.
>> DARLENE SAMPSON: Absolutely.

>> JENNIFER BURNETT: That's why we're doing this today.
I think, Ralph we're running out of time so --
>> RALPH TRAINER: Thank you very much.
>> JENNIFER BURNETT: Thanks so much.
>> RALPH TRAINER: Thank you.
Now, if we may hear from professor
Degenholtz on his CHC evaluation.
Thank you.
>> HOWARD DEGENHOLTZ: Thank you I'm feeling a lot better today.
Than I was the last time I addressed everybody.
So, while she puts up the slides, as you might recall, so first of all thank you for inviting me to come back to speak to the group and, really was, very fruitful the last time I was here and I look forward to sharing some more details of the evaluation plans.
You can go to the next slide.
And, what I'm going to do today is I was asked to come back and talk about the methodology.
There's a lot of different paths we're going to be doing under the evaluation.
So what I'm going to do, today, I was going to say this morning but I'm going to do today is focus on one specific part of the evaluation plan then I expect over the next few months and years, have an opportunity to come back and, provide insight into the components
>> FRED HESS: Can you hear him back there.?
>> AUDIENCE MEMBER: No.
>> HOWARD DEGENHOLTZ: I'll speak up the part I want to talk about today is the focus groups with participants and caregivers just to reiterate the over all goals of evaluation are to assess whether a community health choices is achieve being the Stated objective, rebalancing long term services and supports, towards community settings, and improving service coordination, and enhancing quality and accountability, advancing innovation, increasing efficiency and effectiveness, can I have the next slide.
So there are four major components to the evaluation.
Focus groups which I'm going to talk about in a moment.
Interviews with the participants and caregivers, key

interviews with key informants and stakeholders.
And analysis of administrative data.
Can you turn to the next slide?
And then -- Okay.
Click one more time.
Thank you.
No too far.
So, the role of the focus groups I'm going to talk about two ways that we're using focus group in evaluation plan.
The first is part of our planning process for the evaluation, and, what we're learning what we expect to learn through the process groups is, ways to improve what we are doing in the evaluation itself.
And then, secondarily, we're using focus groups as part of the data collection effort, over the period of the CHC implementation period itself.
Is there a question?
>> FRED HESS: Someone have a question on the known?
[no reply]
>> FRED HESS: Brenda?
Doctor doctor what we call the preimplementation period is 2016.
We're planning to conducts some focus groups.
Early this year and we're actually in the process of setting up those groups as we speak.
And then in 2017, 2018 and 2019, we'll be doing a small focus group, small round of focus groups each year of the program to collect data on early implementation experience.
Turn to the next slide.
Okay.
This is a little bit wordy.
So what I call the preimplementation focus group as I said the purpose of this is on understand, the perspective of current program participants.
And the real goal here is, for us, as the researchers, to understand how do people interact with the current services in their daily lives so that when we go out to collect research data, interviews with participants on a larger scale, we are asking the right questions.
So that's the main reason why we're doing focus groups early

in this preimplementation period.
The topics for the focus groups, have to do with satisfaction with the services people are receiving.
Care coordination, quality of life, quality of care, independence, person centered care.
I didn't put it up there, it could go on forever we want to touch on community integration as a topic under that quality of life topic.
And importantly for us, how do these concepts various I across the different groups that are going to be involved in community health choices and also, what is the language that people use in talking about their programs?
So we have just heard a very long, really excellent discussion of Medicare and the ins and outs of Medicare I know normal people don't talk about it that way.
So it's important for me and my research team to meet people where they are and speak the language that people are going to understand because if we're talking about if we talk about these things and we don't use language we don't understand what people are telling us, then we're going to miss the mark in our data collection.
>> FRED HESS: I got a quick question.
When you're doing focus groups, okay, is it going to be a regional, right?
And just the people from that particular region are going to be the focus group for that region?
Or are you going to have someone from the Philadelphia area trying to figure out what is going on in PA.
Do
>> HOWARD DEGENHOLTZ: Are we having focus groups regionally, I'll get to in a couple of slides.?
Because we're doing these early in 2016, they're not going to be specifically about community health choices per se.
And the major public education campaigns have not got going yet we're asking people, about their -- the care end services that they receive in their daily lives today under the current program because what we're trying to determine in the evaluation, is, how does the change to community health choices impact the care and services people receive.
I said a couple of times, the results of the focus groups

will be used to design the interviews we are going to be conducting on an ongoing basis, and -- we can talk about that, component in the study at a later date.
Thank you.
So on an annual basis, one of the tasks that we have been given by OLTL is to conduct focus groups in a timely way so that we can find, we can find out what is going on from the perspective of consumers early in that implementation year.
So that means in South Western Pennsylvania and early 2017, southeastern Pennsylvania in early 2018.
And then, in the balance of the State in early 2019.
With the goal of using the reason to use focus groups is to complement the other data collection approaches that we'll be taking key informant interview and stake holder interyou views and structured questionnaires.
Focus groups give you a different flavor.
The group dynamic produces different answers to questions and helps us triangulate on what is going on for people and what is their experience.
The purpose for doing early in the year, is to provide that feedback to OLTL early enough so that, if a course correction is required they can take that under advisement, and it provides OLTL with another source of information that is coming independent, coming from a university that is collecting this data, independently of OLTL and independently of any of the agencies that are involved, and gives them another look at what is going on out in the communities.
The people that are being impacted by this program.
So go back -- I just want to make sure I covered everything.
Okay.
Next slide.
>> FRED HESS: Who is going to be involved in these -- are there going to be consumers.?
>> HOWARD DEGENHOLTZ: This came out too small it's like an eye test for me to read.
[laughter]
So -- so how are we going to do this.
Our general approach will be to work through community organizations to recruit participants.
Also to find locations to hold the meetings, distribute

fliers with the opportunity to opt in to the chance to be in a focus group.
Typically, a focus group will have 8-10 people in any one session.
I find that we found that if you have fewer than 6 it's hard to get the conversation going.
Because there isn't enough diversity of experience.
But about, if you have more than 10 to 12 then it's hard for everybody to have a chance to express themselves.
Our general approach to recruitment, will be a flier that has a telephone number and email and that will go to research staff person who will ask a few screening questions, just to confirm that the individual is eligible to be in a group find out, what their availability is in terms of time, what their needs are, in terms of transportation communication preferences.
And then, we'll have to call them back to schedule them into a session.
We'll be getting a whole bunch of phone calls we'll find out the availability and we'll try to put them into groups based upon their location so forth.
>> FRED HESS: Inperson meeting.
>> HOWARD DEGENHOLTZ: Inperson meetings I suppose you know it is possible we could engage someone who is unable to travel, but there's something about the inperson contact that is really valuable.
That's our rational for identifying community organizations to have these meetings out in the community at a community centers senior centers, and -- so on.
If we, we've learned through lots of experience that the University of Pittsburgh main campus where I'm based is, particularly difficult to get to to park and to navigate.
It's expensive to park.
And it's confusing it puts a huge burden on people.
So we don't do that.
Worst case scenario we go to Penera and another restaurant we can throw a nice meal on top of that makes a nice experience.
Let's see.
We engage in professional focus group moderator.
And, we have a moderator that bilingual in English and Spanish.

We identify other language preferences or
communication needs we'll work with that through interpretation
interpreter services and so forth.
Representation and geographic location.
So we're planning to have a focus group, we're planning to
have a group of people that are under age 60, LTSS users, group
of people who are over 60, that are LTSS users and a group of,
what is sometimes calledded the well duals, who are not LTSS
users, a group of people who are currently caregivers, who are
program participants, and then, we're also planning to conduct
these groups in both urban areas and more rural adjacent areas
and in Spanish language so the major language that we have
identified.
The -- just let me finish one point I'm happy to take your
question.
During the preimplementation period we'll conduct the periods
in the South Western Pennsylvania region then in 2017, we'll have
a smaller series of groups in South Western Pennsylvania, 2018
we'll have groups in Philly, 2019, to be determined, we'll have
to figure out the best location to have that, those groups we may
do in the capitol region also and then for our goal is for each
of those demographic groups to have an urban and rural group.
So younger people in urban areas and younger people in a
suburban rural adjacent community.
>> WILLIAM WHITE: I'm being a little picky but your board
representation you have under age 60 and over 60.
Which means you'll miss out on anyone age 60
[laughter]
>> HOWARD DEGENHOLTZ: Sorry.
Yes.
Yeah. 60 and older.
Yes thank you.
Thank you.
Thank you for pointing that out.
And then I think the last point on this slide is, our
approach to guaranteeing privacy and confidentiality when these,
with these groups we recruit people, we use the first name and
last initial basis only.
And we're very careful on the recordings and transcripts to
not to identify anyone by their full name.

So if we don't collect that information, at the outset, then it's not in the transcript or in the documentation to have inadvertent release of that information.
And so typically, we know who is coming, we do a sign up sheet.
Have to have their telephone number or email address to contact them.
We keep that information separately, from the transcripts and the data, so the people come they, show up.
They sign in, then that entry form can just get shredded there's no connection between their phone number and their presence in the group.
Participating in the group does not go to OLTL or any other agency.
So the only people that know that an individual participated in the group is the research staff we don't even know, we won't even have full contact information for those people.
Next slide.
>> FRED HESS: Can I make a suggestion.?
>> HOWARD DEGENHOLTZ: That's all I have.
Leg leg I'm really sure, make sure whoever you pick is not a member of the DHS is not a member of the MLTSS affiliated with anything they will have a biased opinion.
>> HOWARD DEGENHOLTZ: You say pick, you mean -- leg leg when you choose someone, yeah. For these committees make sure they're not involved with MLTSS, DHS you know, with -- you know, center for -- anything, that would have -- any kind of bias.
>> HOWARD DEGENHOLTZ: Very good point that's a standard screening question, well, do you or any other member of your household, currently work for an advertising company or, you know, not advertising.
>> FRED HESS: I know what you mean.
>> SPEAKER: Yes, will you guys be doing focused groups after six months, like -- after six months like when the transition period ends next year.
>> HOWARD DEGENHOLTZ: So the --
>> SPEAKER: Can you please repeat the question.?
>> HOWARD DEGENHOLTZ: Yes, I will.
The question is whether we will have focus groups pardon me.

Later in the year and I assume you're refer to go 2017?
After the continuity of care period has ended.
So our my answer to that is no that's not our plan for a very important reason.
We are -- the focus groups are a complement to other data collection strategies.
So we will have planned for telephone interviews with a random sample of participants that will take place after the continuity of care period ends.
So in July 2017 we'll be doing telephone interviews with a representative sample of consumers and, we expect to capture a lot of information about their experience in July, August, September of 2017.
So that's our, that's going to be our window into understanding the continuity of care experience and we'll also be doing stake holder interviews, throughout the year, so we -- that will include some consumers also.
So, our focus groups where we're doing a approximately 12 groups of 10 people each that's in the early part of the year.
And then our stake holder interviews, where we're going to have I believe, about 10-15 longer interviews with consumers throughout the year, those -- some of those will be in the second half of the year.
And then we'll also have the structured interviews in the second half of the year.
Then also, again in the personal interviews in the home in the fall of 2017.
So the purpose for, just to reiterate, the -- what we're using, in 2017 our use of the focus groups is early, early information about the program.
And we want to conduct them early so that we can get our report to OLTL quickly.
So that they can take action.
>> SPEAKER: Isn't it like after, after that six months that's when the consumers will have experienced change, like?
>> HOWARD DEGENHOLTZ: Yes.
That's absolutely right.
But, our -- it's late in the year to turn that information around to OLTL.
So we have other methods for capturing the experience

of the change.
>> JENNIFER BURNETT: The experience of change is direct contact with the consumers, the focus the focus groups is to gain information in order to be able to do those interviews exceptablely.
>> HOWARD DEGENHOLTZ: Also it will tell us, when we're talking to them in January and February, we're going to find out what they're anticipating for the change and that helps us plan those telephone calls.
So, those telephone calls that is going to be a much larger sample of people and that's going to get us a lot of information about what is going on out there.
At a much, in a much more systematic way.
Focus groups get a small number of people, to give you rich in-depth information.
And it is a complement to broader representative interviews.
>> RALPH TRAINER: Okay.
I appreciate your presentation and we look forward to your information thank you.
>> HOWARD DEGENHOLTZ: Thank you very much.
>> RALPH TRAINER: For this group here today, I know Richard is here we have subcommittee reports I would ask that, we table that for now so we have more opportunity for the public to provide comment and if you do have reports, please submit it to us we'll make sure we get online.
All right.
If I may can I open the floor for public comment as well as committee member comments?
You have to be kidding me?
[laughter]
>> SPEAKER: Just sent you something from Cassie.
Sent to Jessica.
>> JENNIFER BURNETT: I don't have any phone.
They took my phone to do an upgrade I'm without email here.
>> RALPH TRAINER: We have it?
>> JENNIFER BURNETT: Okay.
There are concerns about creating a computer system to determine level of care it seems very impersonal and there have been problems with this in other states, a functional assessment must be person centered.

We do intend to have a person centered functional clinical eligibility determination we are working with the subcommittee number of people in this room are members of that subcommittee.
And they are meeting this afternoon.
So it's not, I would not say it's a computer system but we are going to be using algorithm and then some clinical judgment by OLTL staff.
>> SPEAKER: Jennifer, can I speak to that --
>> JENNIFER BURNETT: Can I finish we're very interested in several things in this change to the clinical eligibility determination.?
For one thing, we're interested in compressing the amount of time that it takes currently the process is about 2-3 hours, it's very long process.
We're interested in getting it to be under an hour long process.
That's one thing.
The second thing is, our interest in consistency across the State.
Currently, there is not a lot of consistency we see that in the data.
So we are interested in creating a consistent process.
So, we do have a committee that's been working on it, we're going to be doing starting our testing of the clinical eligibility determination.
But I will tell you the clinical eligibility determination process is not necessarily although it will effect people coming into CHC for long term services and supports, it's really just to support OLTL's broader systems.
So our fee for service system will use the new clinical eligibility determination while we're running a concurrent managed care system in the southwest onto the southeast and to the rest of the State.
It sort of stands it's an independent of CHC per se.
It's not a CHC activity.
So Richard do you have a question?
>> SPEAKER: Just about some various limitations of using a algorithm system.
And some weaknesses that were pointed out.

People find being found eligible and ineligible, advocates from other states not picking up on functional cognitive impairments or various types of populations and how OLTL will would address that
>> JENNIFER BURNETT: Okay.
So Richard brought up the point I guess there's been some research being done in other states, who use the interI product which is the set of questions that we're looking at for our clinical eligibility determination and also, concerns advocates have that the it is just not working very well in those states.
I would say that, we are -- the other piece that I didn't mention is that, we're really looking at this as simply the clinical eligibility determination.
Not the comprehensive needs assessment.
Comprehensive needs assessment happens later in the game.
Doesn't happen, at the onset so this is just to determine someone clinically eligible to get long term services and supports.
Those other states you're talking about, have a sort of a combined process, which we're not going to have.
We're going to have, at the other end, we'll have a clinical, so the clinical eligibility determination the financial eligibility determination, the this happened enrollment broker helping people make their choices about what they want, where they want to go.
And then, at the other end comprehensive needs assessment, gets done on the individual once they're found eligible.
>> SPEAKER: Good.
Okay.
>> JENNIFER BURNETT: You're welcome.
>> SPEAKER: Can I ask --
>> FRED HESS: Tanya has two.
First one is, we I tried to get this out earlier.
Will people have to reapply if they are already enrolled in the program or will they just be sent a form asking them to choose an MCO and everything will be carried over.
>> JENNIFER BURNETT: They will not have to reapply, they're already in our system they will simply have to make a choice.
The documents they receive in the mail and the information,

that we give out in advance, in terms of, doing community out reach, and we've heard a lot about that today, it will lead people to having to make a choice of managed care.
The only thing they will have to do is technically enroll in the managed care --
>> FRED HESS: Second one is, can you ask if the subcommittee would be willing to create something think tank time so the members could have time to discuss what they heard at the previous meeting amongst themselves, so we can make sure the system is fool proof somewhat.?
That's kind of Tanya that's what we do on Monday, before the meeting.
We get together and have phone conversation on the Monday of the week of the meeting.
And we discuss things.
I'll get you the number if you want to join in on that.
>> JENNIFER BURNETT: Okay.
Great.
All right built in.
>> FRED HESS: We already got it.
>> SPEAKER: A question from Steve Williams what languages are materials available I think this is the question for MAXIMUS.?
When does MAXIMUS use automated calls?
How many times is MAXIMUS asked with when reaching out to consumers before they move on.
Any of that -- resonate. Couple questions one, what different languages or how many different languages are currently available for folk that's are going to be working with your team?
>> CARYN SWARTZ: Currently they're available in English. However, we do have an option we have the center for health literacy that is one of the things they can offer as a service if other languages are requested.
>> SPEAKER: The answer is center for health clitoris class is helping when other languages will requested.
The question other question, do you ever use automated or robo calls swap war we have automated dialer.
Do you want me stand closer.
>> JENNIFER BURNETT: Yeah please stand closer.
>> CARYN SWARTZ: This is caryn, so we do use automated dialer, for certain touch points along the process.

We do in certain circumstances, the dialer will first give a brief message allow the person on the receiving end of the call, to choose an option to speak with a live agent.
There are a couple of kind of we call them blast messages where we're just providing information to the applicant such as we're still missing a document on your application and we would give the specifics in that
question.
>> JENNIFER BURNETT: This was brought to my attention in a meeting with the Pennsylvania association of area agencies on aging on Monday.
We are in a transition for the aging waiver going from the 52 AAs to the independent enrollment broker doing the enrollment as Amy mentioned that we began on April 1 we're getting feedback. We are going to address that feedback and, address issues that are coming to our attention.
For example, seniors not knowing what these robo calls are in a bi weekly meeting with area agencies on aging, MAXIMUS and my staff, that are -- have just been established that is starting next week.
And so, we will be addressing concerns, like if you have a concern about the robo calls at those bi weekly meetings.
>> CARYN SWARTZ: There was a third qu question.
>> SPEAKER: How many times does MAXIMUS test with reaching out to consumers before they move on?
How many times do you --
>> CARYN SWARTZ: It kind of depends upon the progression of the application we reach out multiple times if there's missing information things like that.
But from a high level and for every application so we would have a communication with the applicant when they are initiating their application.
We would also reach out to them then if, so the aging office would be reaching out to them to complete their LCD, hopefully the physician is also reaching out to them to gather information if needed to complete their form.
The next step would be that we would contact the applicant and schedule our in-home face-to-face visit.
Following that, once the program determination is made, we are contacting the applicant to let them know about that and that

their information is then being forwarded to the county assistance office.
And then, there's always a final notice.
So whether there's an approval or a denial there's a notice issued to the applicant.
>> SPEAKER: Just in case Steve's question was about CHC, there will be the series of 90, 60 and 30 day notices, in writing, that will be sent out.
Just want to mention that in case that's the question.
>> RALPH TRAINER: Drew?
>> SPEAKER: Well, to just add to Richard's comment about the ability of the tool to pick up on things like people with cognitive impairment may not be totally aware of all the areas that they have problems with, we have been talking in this national group with the other states that are having problems with that tool and the authors of the uniter I, university of Michigan are saying that the ability of the tool, to be sensitive in areas where there's cognitive impairment is totally dependent upon using the training as it is written by the inter eye authors.
So they have tested the tool and they feel it is sensitive if the tool is used exactly as they have --
>> JENNIFER BURNETT: We're going to be doing extensive training using their sanctioned training in order to be able to get that at that.
>> SPEAKER: Brings up another question about training and the manual how the manual will be used and how it will be used both internally at MAXIMUS and other training manuals.
>> JENNIFER BURNETT: We are going to be training all of the assessors once we are, we'll have to train them in order to do testing of the tool.
We'll be conducting testing this summer and then, down the road if we made any changes we'll retrain and make sure they get extensive training and we're planning to use the training that the university of Michigan has sanctioned.
>> SPEAKER: Well, that's good to hear.
But we would like to recommend that we, when someone is trained, that they, there are some pilot cases that they are given to see whether or not with that training, they are able to pick up on people with cognitive impairment.

>> JENNIFER BURNETT: Okay.
>> SPEAKER: From this just speaking to the work group that's specific around the CED work group that OLTL has been gathering that meets this afternoon, not a plug but meets this afternoon, specifically, we have been talking about a lot of those things because there's so much concern and there's so much riding on the folks that are the assessors understanding how to give the assessment.
And I would just piggy back on that kind of what has been a little reassuring about the fact that it is a tool that is "Automated" is the fact that based off the training of asking the questions, that goes a long with the tool itself, there's no room for interpretation.
Of those questions and answers.
And, part of that question and answer process isn't just a straight sitting there based upon how you ask the question but it's also observation which is something that we have been drilling in the group constantly talking about you can't just ask a question you have to be talking about the other environmental factors and what else is going on.
>> SPEAKER: Right.
That does require the training, the people who are doing it, to be assessors, not interviewers, which was different than what we were told in the meeting last time.
>> SPEAKER: Okay.
Absolutely.
That's consistent with what I've heard from the work group.
>> SPEAKER: Okay.
>> SPEAKER: The other thing I want to mention about that I'm sorry, that Richard you also mentioned too is part of the questions that we've been reviewing and the work group for this CED tool, was talking about existing diagnosis.
So that, if there is a case where someone is unable to that it's obvious, that they would be nursing facility clinically eligibility, based off pre-existing
condition, they would not be subject to the evaluation process.
That will be included in the tool as well.
>> RALPH TRAINER: Thank you I have Zach I have Pam and then barb.
>> SPEAKER: I have a question -- you laid it out,

for MAXIMUS.
They're saying that you know, they have been through the assessment process.
It's been past 90 days and, they're frustrated.
Like what do do they do, they turned in all their forms all their financial information all the, doctor's information it's been past 90 days they have been waiting you know, what do they do?
>> JENNIFER BURNETT: Ginny do you want to?
>> SPEAKER: Can you repeat the question?
>> JENNIFER BURNETT: Zach asked a question, if it's been past 90 days the consume every feels like they have already supplied all the information, and they have not heard back it's past 90 days.
So, Caryn, do you want to address that.
>> CARYN SWARTZ: There's a little bit of information.
So there's a form that is given to every applicant that gives them appeal rights.
If their application process, takes longer than 90 days.
However, we do have to consider the pieces in the puzzle I think sometimes what is maybe confusing is, we may be started a process then ended it, like we talked about earlier because there was missing information and that information comes in later and we start another application for them e
The other thing to consider also, is that, even after all of the information has been submitted, there is a lot of processing that needs to happen in addition to that.
So I would suggest your question is what do they do?
I would suggest that they call the contact center for MAXIMUS for the IEB.
And ask what the status of their application is.
And then, based on that information, they may need to take further action.
If we have not received the information back from the county assistance office, we can provide the applicant with the phone number or even transforeto that county assistance office to follow-up there we don't have advisablity into what their process is.
That's where I would start, call the contact center, what's the hold up?

Where's my application?
Why haven't I received any notice.
The other potential thing is we sent out mailing to the applicant they were returned for some reason or another.
I mean, really a number of things that could contribute to that.
>> RALPH TRAINER: Okay.
>> JENNIFER BURNETT: Do you want to say something.?
>> GINNY ROGERS: I agree with Caryn you certainly should start, with the IEB and the contact center but, we are well aware this is a complex process and can be hard to understand.
So I would say, if people would like to call the customer help line we do have staff that will contact MAXIMUS we'll help to work through any barriers that we're experiencing.
>> JENNIFER BURNETT: So the participant help line is OLTL help line we get a lot of calls on that.
In order to make sure that you guys have access to that number, as well as the contact center number, we'll make that available in our transcript.
We'll add to the transcript.
>> RALPH TRAINER: Okay Pam?
>> SPEAKER: I have a quick question.
The question is, the former way you used to do IEB, the consumers got some real hands on assistance filling out the MA forms, calling the -- getting the foremans to the doctor or following up and, a lot of consumers need that.
What happens in this new process if someone needs that assistance, what should they do?
>> CARYN SWARTZ: So there are some ways that the IIEB is offering, there's online and paper application, if someone has questions about specific information, that needs to be entered on the form itself, they can call the contact center we can provide them support over the phone.?
We also, when we get to do our in-home visit if they have received a mittsing information letter from the county assistance office we will go through with it, at that time make sure understand and putting together the documentation they understand the importance of returning that information, timely.
With the physician certification we actually are doing a lot of follow-up and prodding.

It is definitely an area that we will continue to look at.
We realize that that's a piece of information that is often missing from these applications
>> AUDIENCE MEMBER: You're following up with the doctor.
>> CARYN SWARTZ: We are, we're doing both actually.
We're sending reminder letters to the doctor.
We're actually making a call to the doctor we're actually calling the applicant as well and letting them know the information is still missing.
>> RALPH TRAINER: Great.
Okay.
Barbara
>> SPEAKER: One other question, what kind of assistance does MAXIMUS provide in acquiring that missing information?
>> CARYN SWARTZ: Well, we're --
>> SPEAKER: Does it result in being enrolled missing the test?
>> CARYN SWARTZ: We have to have the physician complete the form.
So we're making as I said several phone calls and several mailings or faxing to the doctor's office.
>> JENNIFER BURNETT: Getting the physician certification is really critical one that we need help with, actually.
I mean MAXIMUS is doing everything they can do --
>> SPEAKER: Become's problem.
>> CARYN SWARTZ: Absolutely.
We agree.
We're trying to, we have been talking about -- creative solutioning for this.
And any kinds of options
>> JENNIFER BURNETT: Including to the Pennsylvania Medical Society and getting with some of the, physician groups in the State.
>> SPEAKER: Pennsylvania eliminate the requirement?
>> JENNIFER BURNETT: No.
Because the requirement is the basically the medical authority for getting into the waiver.
So then once you're in the waiver, you don't need to go back to the physician to get DME approved.
To get you know, we don't -- it's the ticket to get into the

authority.
Some other states don't have the physician authority.
But then in managed care they do a lot of extra checking they have to do a lot of extra checking for people to get into long term services and supports.
So -- we're continuing to use it.
>> SPEAKER: Could that be put into the comprehensive part of the assessment?
Instead of at the screening part?
>> JENNIFER BURNETT: No because it is the clinical determination, that we use.
So we're -- we are now aware that there's a big problem with the physician certification and we're really going to do a lot of work to try to physicians more aware of it and, there's some people on the MAAC that are helping me with this and making those communications.
There's actually been a suggestion that you pay physicians to fill it out, fill out the form when we do our financial analysis of that I don't know if we can -- you know, maybe someone can lobby the legislature for that one.
>> RALPH TRAINER: Barbara do you have a question?
>> SPEAKER: Which assessment tool is going to be used to determine whether a current OBRA waiver participant is in a --
>> SPEAKER: Can you please the request?
>> JENNIFER BURNETT: Which assessment tool is going to be used to determine whether or not OBRA waiver is NFI or FCE.?
>> GINNY ROGERS: Current process the level of determination is currently used.
>> SPEAKER: Do this assessment for the OBRA waiver consumers to determine whether they can go into independence or not?
>> GINNY ROGERS: Yes.
>> SPEAKER: So it's --
>> GINNY ROGERS: Using the LCD.
>> SPEAKER: Level of care.
>> JENNIFER BURNETT: Level of care --
>> SPEAKER: Not the new one.
>> JENNIFER BURNETT: It's not done yet we have to take time to really test it and make sure it's what Pennsylvania really wants.
>> RALPH TRAINER: Someone in the back row raised their hand.

>> SPEAKER: I was going to ask you thinking at all about managed care, possibility of eliminating the doctor form, in managed care.
>> JENNIFER BURNETT: No.
No.
>> SPEAKER: The question is whether we'll be eliminating the form.
>> JENNIFER BURNETT: It is required, in Pennsylvania, for getting into long term services and supports.
Not managed care.
So it will continue to be a requirement for getting into long term services and supports.
I mean we don't want to have to get a physician authorization every time, a service plan changes or every time some additional services are authorized maybe, maybe they have they're looking at physical therapy we don't want to go back to a physician every time those changes are made in a comprehensive needs assessment or service plan.
So the physician certification, authorizes LTSS in bulk for the service coordinator now to be the official authorizing person you know, creating the care plan, the service plan.
So that's really the, why we're keeping it.
>> SPEAKER: Some of the things I've heard Dr. Williams OLTL physician is something as simple as making the form look important so rather than it just being a fax that would shoot out at a doctor's office that, they -- it's just one more piece of paper they don't have to time to deal with in that moment it would actually say something, across the top this is coming from the State, and this authorizes, Medicaid services or, whatever.
So I know that's, something that, they have been talking about at least as it relates to the CED work group we've been talking about
>> JENNIFER BURNETT: I want to say the physician certification in Pennsylvania is the in the State statute for nursing facility level of care.
Which, my staff person who is listening in, over the forum building because we told people to stay back there because, this room was, we anticipated this room to get too full thank you Jen.
>> RALPH TRAINER: One more we'll conclude.

>> SPEAKER: You just said there was a penalty for after like the 90 days, after 60 days, if you don't complete the application process, what is t that.
>> CARYN SWARTZ: I don't know off the top of my head.
>> GINNY ROGERS: This is Ginny it's a percentage of cost, off the invoice.
So in the percentages range based on the -- the performance measures whether they're hitting them.
>> JENNIFER BURNETT: Built into the contract with the IEB.
>> GINNY ROGERS: I have one clarification earlier when we were talking about nursing home transition, I said that the bulletin, it's been clarified it
has gone out, it went out on April 22 and May 6 is the date to get comments back.?
So, I just wanted to make sure I don't know if we're still on Brenda, but, that, that information is out.
>> JENNIFER BURNETT: If you need us to guide you to it just get in touch.
>> RALPH TRAINER: Okay.
With that being said, I want to thank members of the --
>> JENNIFER BURNETT: Before I break up I do want to make the announcement I talked about a -- there will be a press release that lists all of the managed care companies that submitted community health choices applications to us.
There are 14 applications that have come in.
So, it's the biggest amount of applications for managed care that has ever come in 234 this state.
[laughter]
>> RALPH TRAINER: With that, meeting adjourned thank you.
Those on the phone thank you very much.
[meeting concluded at 1:04]