DATE: 7/6/16
EVENT: MLTSS subcommittee meeting

>> RALPH: Hello. We will get to you in a second. We will do role equally now and start with Barb pols diser.
>> Barb liberty community connections.
>> Daryl Andress Bayada home healthcare.
>> Blare bore of course, united healthcare.
>> Bill ARRB.
>> Bob Theil here for Pam Mammarella.
>> Kevin Hancock Office of Long-Term Living.
>> Ralph Trainer.
>> Fred Hess, disability options network.
>> Drew Nagele, brain injury association.
>> Pam your in for Theo Braddy, CIL of central pap.
>> Rap Prushnok UPC PA.
>> Jesse willedderman.
>> Zachary Lewis disabled in action, filling in forecastcy Holdsworth. (on the

phone is [inaudible])
>> Stella AARP.
>> Mary Maloney HHA exchange.
>> RALPH: Anybody else, please
>> Arsen you stie yef from Sarah care.
>> RALPH: Anybody else?
[NO RESPONSE]
>> Tanya is here.
Let's go over housekeeping disutility Is.
When you speak, be professional. Try to limit your comments to two minutes.
Try to be professional in your language, please. For the meeting minutes, they
are going to be -- they are usually posted a few days after this meeting on the
state's listserv. We have a captioner here documenting discussions. Turn off
your cell phones. Clean up your area when you leave, picking up any empty

cups, bottles, et cetera.
We will take public comment at the end of the meeting. For the emergency procedures evacuation, in the event of an emergency, everyone must get out
of here. Exit the building.
If you require assistance, stay. Take belongs, don't operate cell phones. Do not
try elevators they will be block locked down. Use stair 1 or 2 to exit the building. Stair 1 is located through the main doors and located on the left side
near the elevator. Turn right and go down the hallway by the water fountain.
Again, stair 11 is on the left. Stair 2 is out the left side of the building or near
back doors.
For those exiting side doors, turn left. Stair 2 will be directly in front of you.
Again, for those exiting from back doors, turn left. Then turn left again and stair 2 is directly ahead.
Keep to the inside of stairwell and merge to the outside. Once you are down
the stairs, turn left and walk down to Dewwberry alley to chest nut Street, turn left go to blackberry Street and cross to train station.
Or proceed to assembly area to left side of Zion church located at 4th and market.
With that being said, I would like to introduce Kevin Hancock to do the OLTL
updates. Thank you.
>> KEVIN: Thank you, Ralph. Georgia goodman is going to be kind enough
to walk through PowerPoint slide for people participating on the subMAAC feel free to ask questions.
I will be updating community health choice activities since we had a change in our time frame and what it means for the southwest zone.
I will also be providing update on independent enrollment broker.
For those involved in home and community-based services and also with the
long-term care services in general, we have had a few changes with the way
that we are managing the independent enrollment broker services indirectly relevant to community health qhoises. I thought we would give an update

where we are on progress with transition leave ourselves with transition make
them specific to Community HealthChoices as well.
Starting with the roll-out itself, managed long-term services and supports rollout
usually has about five phases to it.
This sort of indicates the first two phases.
Are people on the phone able to hear my presentation?
>> I can hear.
>> Kevin, I can hear well.
>> Tanya: Some of the other ones were sort on the microphone. I am not sure why.
>> KEVIN: We will make sure we are mindful, Tanya. Thank you for bringing it to my attention.
I will try not to talk too loudly.
The first two phases involves program design and procurement and plan selection.
Program design is really how we are framing out the program, what we are trying to have it accomplish and what we would -- what input we receive from
stakeholder engagement process for the requirements of the program and what would be included in the procurement vehicle.
Program design for Community HealthChoices really began when it was announced by the Governor and the -- in the late winter of 2015 really started
ramping up in June of 2015 with publication of discussion document in six listening sessions around the state continued with publication of our concept
paper in September of 2015 and then the additional publications of a draft RFP and draft agreements in November/December 2015.
Through all of the time period and through all of the program developments we did a lot of academic-level research on activities happening with other states on managed long-term services and supports.
We listened to stakeholders about the areas they were most concerned about
and areas of opportunity to be able to improve long-term services and supports system through managed care appointment structure.
Through it, we received anywhere from -- I would say more than 4,000 different/separate comments from individuals giving us ideas on how they

wanted the program rolled out and what was folded into what was published
and ended up being the RFP and draft agreement.
So program design was completed effectively on March 2nd when we publish
RFP/draft agreements.
The procurement plan selection is where we are now. If you see the green arrow on your screen; that's an indication we are a little bit past where the air
eis now. We are in active proposal review and plan selection. We received 14
proposals on May 2nd 2016 and those proposals have been reviewed and going through the scoring process and that will continue for several more weeks. We continue to hope the selected authors will be selected in mid- to late-July and go forward from that point; that's where we are now.
Moving on --
>> Fried: Once it's scored, will we have say-so on anything or not? When will we finally get to see the contracts.
>> KEVIN: Final contract?
>> FRED: During the process of negotiations, will we be involved, is the committee going to be involved in the negotiations at all?
>> KEVIN: No and yes is the way I have to answer it. It's a procurement process. We are under strict legal guidelines on what we can and can't do in
including people.
The procurement process itself cannot be as public a process as some of the
prior discussions about contract contents; that's the reason why we put so much effort up front in making sure stakeholders had input up front.
Once we enter into contract negotiations for the protection of the interests associated with the negotiation, I mean, that does have to be -- it has to be a
closed process that's why we have to go through the blackout period as well.
>> FRED: Okay.
>> KEVIN: That being said, if there's anything in particular -- I know you have read and know you, personally, have seen all of the content we have had
in the draft agreements. We have, based on some concerns raised by stakeholders on some of the content of the draft agreement we published in

March, we published addendums. If there's anything in particular in the contract you want to have revisited at this point, just make sure you send it our way.
They are not final agreements until the contract is signed. So they are still draft and we are still working with draft agreements right now.
So this committee, in this process, still has an opportunity for input and content of the final agreement.
This being said, it has -- we have to move to a final agreement eventually, something the plans will sign. It also has to be priced.
Any type of additional content we have to make sure that it's captured as quickly as possible.
An additional point -- you made the point just to me 10 minutes ago -- we recognize in a roll-out there will be -- we recognize that there are issues we may not have recognized and areas of opportunity for change after the rollout
take place.
So throughout the roll-out of Community HealthChoices and probably forever,
we will look for opportunities to modify the agreement to make sure that the program is making changes that make sense for the program.
>> FRED: Will that be on a year-to-year business, with the length of the contract or throughout the contract.
>> KEVIN: The plan now is year-to-year basis; that's the way health choices
works now. We are following the pattern. Great question. Thank you for asking.
>> Brenda: I --
>> KEVIN: I just wanted to make sure the microphone was close to the phone. Go ahead, Brenda.
Brenda, are you still there?
>> Brenda: I accidentally hit mute.
I really want to Mick sure independent beneficiary support moves forward we
have input on the language. I think a group of consumers will get together and formulate a strongly-worded recommendation on that so that we have some input on that. Be expecting that in the near future frism.
>> KEVIN: I am not sure what the beneficiary support is -- just kidding!!! [LAUGHTER]
Just as a matter of background, Brenda, in the managed care final role, which

was published last month, there was a component to the managed care role --
part of the federal regulations package that talked about beneficiary supports
services and requirements.
We are going to -- we are still waiting for and probably going to need some guidance from CMS and what the scope should be for that role and that independent role -- that being said, you can absolutely and. We are actually counting on this and other MACC subcommittees to contribute to the process
for what we are going to use to frame out the role.
>> Tanya: Can you say that on the listserv when actually seeking an engagement so the comment doesn't get lost in the cloud somewhere.
>> KEVIN: Absolutely. Great idea. I also suggest you not wait for that process. If you have particular thoughts you would want to include right now
or if you have a consortium of people who have people with comments or thoughts on how it should be framed out. Don't wait.
>> Jen: I am interested in having the committee and will recommend -- here
in southwest we had a meeting with the Jewish -- Bill who holds a contract spoke to us about how it works, I think it would be beneficial for this committee (Brenda) if we could work on getting here.
>> KEVIN: I think that's a fantastic idea. If you could send me his contact information.
>> Brenda: I will do that. **>> DREW:** Kevin, will there be a process where the department shares which of the 14 proposals you are pursuing draft agreements with?
>> KEVIN: Are you asking when we publish the names of selected offers specifically?
>> DREW: Yes. Uh-huh.
>> KEVIN: Well, you could expect us to follow the way that it was released with health choices. We will publish the names of selected offers. We hope to
do it mid- to late-July. The names will be released, yes.
>> DREW: Yes.
>> FRED: I have a follow-up to that. Will it say which zone each has?
>> KEVIN: Absolutely. Any other questions?
[NO RESPONSE]

Great. As mentioned, we are in the active procurement and planning process,
which means we can ask -- we are still in the blackout period no specifics on
the contract itself. We are prohibited from answering specific questions on the
process but when we move on from that we will move into the remaining three phases of the roll-out; that's where the -- as all of you know in this room, the decision was made by the secretary to extend the time frame for the
roll-out of Community HealthChoices specifically in southwest zone from January 2017 to July 2017.
We appreciate the time although we were working full steam ahead to be able
to meet the June 2017 time frame, the additional time allows us to build into the -- two of the remaining three phases.
The first of which is readiness review. We have a requirement -- it's a contract
standard of practice to conduct readiness review process for a program this large but it is also a CMS requirement we meet the standard as well.
They have stringent guidelines they want us to meet and we have stringent guidelines of our own to make sure they meet what they propose to do and what the requirements are for the program for the participant's safety, health
and preferences. It's really important that readiness review is conducted.
What it requires is to go through all -- to the minute detail all of the specific contract requirements and to make sure that each of the selected offerers are
capable and able to meet all of the requirements to the highest degree possible.
Throughout the process, they are -- they are going to be monitored through --
to make -- that they are meeting the assurances that we require and also to demonstrate to us that they are fully ready to be able to go live in the southwest, for example, to be able to be alive and available on July 1st, 2017.
We will have in this process what we call a go-/no-go date. In that date it will
basically certify the plans are ready to move forward with the implementation

of contracts or not.
If they are not, then we would either have to work with them or take serious consideration whether they are ready to go live on the first day.
It's a process that's been in place with health choices -- physical health choices
all managed care organizations pretty much since the advent of managed care
and we will definitely be following best practices. The additional time gives us
more time to do readiness review. We were planning to do thorough readiness review process and have more time to be even more thorough.
In addition to the readiness review process, there will be an implementation time period. There will be overlaps between implementation and readiness review. Implementation involves outreach to participants to let them know that this change is going forward, ongoing communication -- our communications team is here. They will be talking about that in much more detail in a little bit. The implementation period is communication to participants that this change is going through, extensive education for participants and for providers to let them know what this change actually means. Ongoing communication with managed care organizations to talk about implication and significant work -- I'm sorry. For the people who are on
the phone. If you don't mind hitting mute we are getting feedback or background noise, we would appreciate it very much.
We will also be working extensively with independent enrollment broker through the implementation period will also have a very significant role as well.
The implementation is to make sure that participants are receiving the services that are currently under their plan, they have an opportunity to be able to select a managed care organization of their choice and that's -- they have all of the information they need to know what this transition means.
It's also important for providers as well to be part of this communication process and to receive as much education as possible and what the change
means as well.
Implementation is critical.
For both of these there will be a period for each of the zones. There will be readiness review for the southwest first, southeast, the Lehigh capital area, northwest and northeast each zone has readiness review period and each zone has its own implementation.

Specially between southwest and southeast -- yes, sir?
>> FRED: Who all will be involved in the readiness review?
>> KEVIN: The readiness review process?
>> FRED: Yeah.
>> KEVIN: Primarily Commonwealth staff. Are you asking that the committee has a role?
>> FRED: Or does anybody with -- that's getting these services, are they going to have anything to do with this at all?
>> KEVIN: This committee is going to be a recipient of the reports for readiness review as will the MACC. The role you will have, when we report out the activities -- basically it's an audit process. We will be reporting back on
the process on -- to this committee and this committee will have ample opportunity to be able to comment on raised issues or concerns with this process. Absolutely.
And just to add to that a little bit, so program participants will have a lot of opportunity to hear how the process is going. Providers will also have an engagement as well.
Since they are part of the education process for free implementation and for
readiness review and that there are standards associated with determining network adequacy, providers will be very much part of the conversation as well.
>> Brenda: Yes, I do have a question. I want to second Fred's comment that
we need an active role in the readiness review process. We learned from the
people from Massachusetts and Ohio at the last meeting here in the southwest
that consumer engagement overall is very violatal to the readiness review process.
The other thing I want to add is to make sure that you're looking at data management systems and transfer of data management to OLTL's current data
management system to any data management system be accepted and -- [inaudible] -- that's identified as a big issue in Massachusetts and Ohio. Critical information got lost during data transfer and there were people who fell through the cracks and lost services.
So I think even just as important as provider network adequacy and other

things, infrastructure needs to be critical part of the review and it meshes well
with what you are handing off from to their network.
>> KEVIN: Thank you, Brenda. I will comment on both points. We absolutely
need there has to be robust review as well as implementation. Obviously there
will be a lot of opportunity for when we talk about implementation itself, there will be a lot of opportunity for participants to be involved in review communication and actually helping us frame it out and craft it.
From data management perspective, I couldn't agree more that that's a risk.
An area just to illustrate with an example, we have a continuity of care build into comurcht health choices. The couldn't fewity care for people with home and community-based services will be based on the service plan that would either be in the SAMS platform or HCSIS platform.
We would have to have assurances to make sure that the managed care organizations selected offers would not only have access to that information
but be able to interpret that information in a way that is meaningful to them to be able to manage that continuity of care process.
We recognize it is not only a miss being but it's also a key component of continuity of care. I couldn't agree with you more. Thank you for the question.
>> As a follow-up is there any chance that members of this committee if not the dmt as a hole could sit down and talk to them about readiness and ask questions about what our concerns are rather than having to go through you?
Is there any chance to sit down with them directly?
>> KEVIN: So I think there will be an opportunity for participants to have that type of conversation. With where it gets tricky where you have a relationship a participant provider relationship. We are going to have -- we have to figure out how to manage that.
If you are participate of a network and you work for a provider, for example, there might be a perception of a conflict of interest. Just putting it out there. We have to figure that one out.
>> I think that all of us that are consumer members of this committee that work for any potential provider would be more than willing to submit to any kind of conflict-free or conflict of interest disclosure you may develop in order

to participate in that process.
>> KEVIN: I think you appreciate the complexity of that issue that keeps coming up. We have to figure it out. Probably the way that we would navigate
it would be to use participants in this process who don't have direct engagement with a provider that might be part of one of the managed care organization networks; that's just a thought off the top of my head.
A lot more to come on that obviously.
I think Drew had a question?
>> DREW: Yes. Could you comment in this roll-out plan, how the new service definitions that are expected to be approved for CHC will come into play, say, for independence and OBRA, which will be operating in the background during this roll-out period?
>> KEVIN: What would be an example of one of the services you would be asking about specifically?
>> DREW: All of the service definitions that are proposed to change.
>> KEVIN: So we have service definition changes that went into what was the draft Community HealthChoices waiver; that's correct.
If they -- the same service definitions, if they are continuing into independence and OBRA and the attendance care waiver, for example, we would have to send waiver revisions to CMS with those service definitions as
well.
I think in some cases the definitions will go through a waiver process; that would be applicable.
What I am assuming, Drew, what you are saying is what would happen in independence waiver in non-CHC zone, would the services be applicable?
The way they would be is we have to go through a waiver amendment process
and if CMS approved it and it is similar to waivers that will continue it the other regions, they would be part of the program; does that make sense?
>> DREW: What I am trying to get at is, when they will become operational and be used in both CHC and sort of the background waivers that are operating until it's fully rolled out.
>> KEVIN: To answer when will CHC and other waivers go into effect; is that what you are asking?
>> DREW: I assumed CHC will go into effect according to this timetable you
have on the screen.
>> KEVIN: July 1st.

>> DREW: Well, yes. July 1st 17 for southwest.
>> DREW: You will use OBRA for attendant care. Will new service definitions go into effect for those waivers at that time I want too know the timing of new service definition.
>> KEVIN: I look to Elaine to answer.
>> ELAINE: The current waivers are -- right now we are submitting amendments to CMS to add some services the employment services. As CHC
rolls out in each area it rolls out, it will only have the CHC waivers and the OBRA waiver, which will stay in existence thoughts, you know, CHC roll-out.
We are not including that in the CHC waiver.
In terms of independence, independence will exist until --
>> KEVIN: Why don't we move to the map to make it a little bit easier.
>> ELAINE: Comcast will be the vehicle for CHC. So as people are -- its level
of care nursing facility clinically eligible.
We are going to amend the independence waiver and add residential has been
I will takings and structured day so that individuals that need those services as CHC is rolled out can have those services. Does that make sense? It's very
confusing.
>> DREW: What about the voc for the waiting time for it to cascade across the state. The new voc services will they be added to --
>> KEVIN: Vocational services?
>> ELAINE: The employment services are being amended into the aging, attendant care, independence and OBRA waivers, yes.
>> Drew. So when do you expect that will go into effect?
>> ELAINE: That should go into effect in October.
>> DREW: Of which year?
>> Elaine: This year.
>> DREW: It's complicated.
>> KEVIN: We are using different waivers for the zones through the CHC roll-out. It's complicated.
>> RALPH: Drew, thank you for drilling it down.
>> KEVIN: The next phase is steady stage operationallization. Steady state will be implemented by zone.
We are expecting it by the time southeast goes live January 1st, 2018 we will

still be in implementation phase for southwest we will not move into steadystate of southwest until the calendar year of 2018.
That's what we are shooting for for the five phases but you will see overlap as
we roll through them.
Going back to the map. These are the dates for Community HealthChoices loll-out blue for southwest, January 1st 2018 which was the original roll-out date for southeast five counties.
For the people on the phone, please mute your phone and unmute when you
have questions, that would be helpful. Thank you.
For remainder of the state light blue for the north best which is orange and for the northeast which is the green it will be January 1st 2019; that's the original timetable and are looking for from this time forward.
Moving on, these are some of the priorities we are focusing on through extended time line. Brenda already mentioned information systems and it's always significant concern for us. We have an opportunity to be able to expand and augment system requirements through this process. It gives more
time for the assurance and development of network adequacy for selected offers and also for reviewing entities and put into the Department of Health and us to ensure network adequacy as well.
It presents more time for member and material services developments and I
believe our communications team will be going to some detail in a little bit.
We will have more time through readiness review process for stakeholder communication which involves as mentioned participants and caregivers, providers and the public at large on what Community HealthChoices will include and what the implementation means for current program participants.
It also helps pretty significantly -- I don't want to minimize this. It will help with the Department of Human Services and Office of Long-Term Living build
out our capacity to be able to shift focus away from home and communitybased
waivers, nursing home facility services to be able to move towards managed care operations oversight rule, which is a significant change for an
organization that has been doing this type of work for a long time.

We are also recognizing that we will have to run dual systems for a long time
as well. The additional time will help us to build out the capacity to meet those objectives.
That is some of what we are focusing on through the extended time line. And then talking about priorities over time, and you will continue to hear us repeat this pretty frequently. When we talk about launch and implementation,
these are our key focuses. We are going to focus on no interruption or disruption of participant services; that is key; that's the reason why we have extended continuity of care service, which is a focus of readiness review process to have assurances that there will be no interruption or disruption of
services for participants.
Next in line is to make sure the providers continue to get paid. We -- lesson learned from other types of managed care roll-outs -- I appreciate Brenda's comments made earlier, but information systems and claims processing systems can sometimes be a challenge in this type of roll-out. We have a lot of
opportunity to be able to make sure that these assurances for providers getting paid are met and that we can validate that.
>> FRED: I got a quick one, here. Are the MCOs required to contract with community-based long-term services and providers? Are they obligated to? Request they just pick and chose who they want and half the people will get
laid out, no work --
>> KEVIN: You always ask the simplest questions, Fred.
[LAUGHTER]
They have the opportunity to build the network. That being said, the managed care organizations will be looking for experience, specially in longterm
services and supports.
The question is, do they have a requirement in the contract or an obligation? I
will answer the question first. At this point, requirement is not something I would use to characterize how they are going to be contracting with longterm
services and sports providers.
Obligation is a little different because not only are participants already receiving services from long-term care providers but they also have most

experience in providerring services.
As managed care organizations buildup network, we may not call it necessarily requirements, but we would say that it would be a smart business
practice to contract with those entities.
>> FRED: Is that the same with service coordination?
>> KEVIN: If you remember in the contract itself --
>> FRED: They can make their own or sub it out or whatever they want, but
is there anything in there -- I know during continuity period, they have to keep all of the service coordinators there.
>> KEVIN: That's also correct for six months.
>> FRED: The biggest concern now, because the requirements that they -- everybody is going to have to have, there will be a lot of the service coordination that is just not going to be able to fit it in. It's going to be a huge
disruption. Do you guys have any plan for when the first six months is over to
pick up the slack of all of the SCs that will be gone?
>> KEVIN: Managed care organizations were given the opportunity to propose how they wanted to approach service coordination because we are in
blackout period I am not able to articulate how they proposed they would be
approaching that role.
That being said, it's anded that they will do an environmental scan and see how service coordination is currently being performed. It's also -- it would be
expected that they are going to look for opportunities to be able to make sure
that that particular role is successful because really, this program is build on
the concept of the person-centered plan, participant engagement and the significant role of the service coordinator; so that's a big way of telling you that smart business practices will have that looking at how things -- looking for the best of current approach and also looking for opportunities for improvement and building from there.
>> FRED: Is there anything in there -- I'm sorry. One more. Is there anything

in there about retention of direct care workers. This should have been asked
by him but that's all right.
Can they start getting rid of our attendants for fun? Not during the six months
but after that?
>> KEVIN: The participant direction is a requirement in the contract so participants, if they are hiring -- are involved in the hiring of their caregivers, it's really participant -- if the participant is involved in participation direction, the participant-directed model, as part of the delivery of their personal care services, they want to hire their own personal attendant --
>> FRED: What if they are under agency model?
>> KEVIN: It's a little bit -- I mean -- an agency model -- I think participant, agency as well as service coordinator, that's a person-specific question. I think
that -- in a lot of cases the agency also has a voice in that process, as well as
the service coordinator, managed care organization.
So if they are in agency model, the participant will have a voice in the selection of their attendants, but in the agency model, it is a little different. It is now. The agency has a voice in the attendants that are available for those
services right now.
>> FRED: There are a lot of attendant care programs out there that -- I don't
know how to say this -- there are a lot of them -- like where I get my services.
Once we go over say they decide to lower rates, you will lose a lot of attendants.
We need some kind of guarantee for the retention of attendants.
>> KEVIN: There is no --
>> FRED: They could still be fired but --
>> KEVIN: I am not going to speak -- we don't know if managed care organizations will lower rates.
>> PAM: There is a follow-up to what Fred was saying, con summer directed
employees have people with criminal records. I agree with Fred. If there is a
way to protect consumers who have their own attendants how can they gairch

tea retention under participant directed if it goes against MCO's policies, the
requirements for attendants -- we talked about it a long time if the person has
a criminal record but you're consumer employed you continue to keep them you can keep them. Is there anything that will protect the consumers they have the same rights in employing.
>> KEVIN: We didn't have any new permissions or provisions in the draft agreement. You read it. We didn't add any new provisions that would prevent
anything you are describing at this point. If there is something specific you are
worried about in this process that you can point to, it would be helpful for us to react to it.
There was no vision in this process, Pam, that would change the relationship
between the participant and their attendant.
>> ELAINE: Pam, it's also in the waivers that, you know, the same conditions
for participant direction as it is currently; so that's not in jeopardy.
>> Tanya: Yes, I do. I just didn't know what the appropriate time was to chime in.
Right now with the new fiscal year starting, under the current system there is
all kinds of problems with workers being able to submit their time cards and us being able to approve them.
Can we do something so, like, in the future under the new system, that something is implemented so, like, the service plans and all of this and authorization have to be in by a certain date before the new fiscal year starts?
Nothing gets delayed in processing? Can that implemented somewhere?
>> KEVIN: You are talking about issues with the current system? Is that with
financial management services provider and the way that --
>> Dania: Either the financial management services or, like, something somewhere authorizations have not come in now OLTL to them because, like,
I tried to submit time cards the other day, just like I was supposed to for deadline and, like, my workers couldn't submit anything. I couldn't approve anything because it was saying no thoorgs granted.

About I talked to the service coordinator, he was telling me that everything I need to was in the system but he was waiting for authorization from OLTL. What I am wondering is, when we know a new year is going to start, can there be something done to make sure that all of the paperwork for everyone
is done prior to fiscal year so there is no delay in processing paperwork?
>> GINNY: What you are describing has to do with reauthorization for folks under 60 going through HCSIS system.
>> Tan yamplet. I am pointing out it is a problem in the process and if we can do something to make it work better in the in the future, so this stuff doesn't happen anymore.
>> GINNY: I totally agree with you. The system is clunky indeed. Anything we can do in terms of changes in the future, I think we will want to proceed with that. Thanks, Tanya.
>> Tanya: You're welcome.
>> KEVIN: In the interest of time, thanks to Tanya, Fred and Brenda and everybody and Drew forasking your questions, I will jump quickly into the independent enrollment broker update. This is specific to the community home and community-based services independent broker role. It's relevant to
the Community HealthChoices because we will have a retirement to have independent enrollment broker for Community HealthChoices program. It's an
area we are monitoring. We are receiving a lot of great suggestions and feedback. It's an area we plan to build on for Community HealthChoices as well.
Just as a matter of background on April 1 fort, 23016 independent enrollment
broker took over services for aging waiver. They were providing enrollment services for home and community-based waivers and prior to April 1st, the Area Agencies on Aging we are performing enrollments for the aging waiver.
Independent enrollment broker took over the role. There have been real challenges in that transition, not the least of which has been some confusion
as to who is doing what in this process from a -- an eligibility perspective. Siches that time we have taken a lot of steps to make sure that steps are made
for agencies including Area Agencies on Aging and independent enrollment broker itself to make sure the most important focus in this process the

participants' enrollment is processed as timely and quickly as possible.
We continue to address some challenges. The challenges -- the focus of the
challenges often seem to shift once we have a particular problem started and
begin to see the ongoing issues of some of the other problems that have been
created.
We have made some successes. We were having some significant call center
issues with the independent enrollment process, as of July 1st, they seem to
be more under control at this point. The independent enrollment broker on
July 1st their average speed to answer calls was 7 minutes; that's compared to
a time period a month before their average speed to answer was 142 seconds,
which is pretty lengthy period of time. There were times some participants
were required to wait more than 15 minutes to be able to receive a call or talk
to a customer service representative.
I will go through these statistics and come back to you, Pam.
We have also been able -- we had significant issue with abandonment rates
which was technical more than anything else with IEB. They were able to
reduce it from an average that exceeded 5 minutes which was a standard July
1st the rate was 1.6 secondses.
They are current with completing call backs on time.
When it comes to actual processing, including application referral processing,
they are also current as well. They currently have 5,421 applications in process.
Our ongoing focus with this issue will continue to be customer services
representative training.
To address a lot of call center issues they brought on new people. The new
people that are involved in this process, they have had training, but we are
recognizing some gaps. We are having the independent enrollment broker fill

the gaps as quickly as possible. We are beginning to see some improvement
but there is always room for improvement there as well.
They are planning on integrating response system to support an individual's
opportunity to be able to answer questions without having to go through the whole process of waiting for customer services represent representative.
It is used standardly in dual centers and it does end up having to save a lot of
time and trouble for callers when calling in and asking for status.
>> RALPH: Really? Music?
>> Kevin: There is background music. If you could mute your phone that would be appreciated.
Lastly, we continue to focus on service levels.
[LAUGHTER] **>> FRED:** I think somebody put us on hold.
>> RALPH: These are the days of your lives.
[LAUGHTER]
>> KEVIN: People are bored, I guess, with the call center data.
We will look for opportunities for improvement.
With that, I will turn to Pam and I think we had a question as well.
>> So does Brenda.
>> PAM: The question I wanted to ask first was about the wait time. Are they are there still times give name and number we will get back to you; is that the part of the referral processing time or --
>> KEVIN: No. I just turned myself off.
No, no, they can -- they have the opportunity to be able to not have to wait for
customer service representative and leave message and have somebody call
them back if they want to wait for customer service representative one should
be able to answer their call.
>> PAM: Some of -- some people I have heard when they left their name and
number it was a very long time --
>> KEVIN: Recognizing that was a problem, I noted here that they are completing their call backs in one business day now, but you are absolutely right. I am going back to prior to June 9th, there were smr situations where people were waiting up to 4 or 5 days; that was unacceptable; that has been

addressed.
>> PAM: What do you mean by service levels?
>> KEVIN: Service levels across the board call-center related activity, making
sure the responses are received in an appropriate amount of time. Service levels also represents the amount of time it actually takes to process applications and go through the application process as quickly as possible. In my opinion is making sure participants calling are treated with dignity and
respect and be sure they are receiving accurate information when calling; that
is the most important part of service levels. I will be very blunt. It is an area that we are really focusing on heavily to make sure it is something not left behind.
>> PAM: Can I ask one more thing?
>> KEVIN: Absolutely.
>> PAM: I've experienced this with another consumer. They call, get the paperwork sent to them. The form gets to the doctor and they don't have a clue how to fill the paperwork out. Then they call the IEB for help and they are not knowing what to do and being told when they call, well, we can't call out. They don't have the ability. Who is helping them? What is happening?
>>: Kevin: That is a challenge. I am assuming, Pam, you are talking about the completion of 600-uneligibility form?
>> PAM: [NODDED HEAD]
>> KEVIN: With aging waiver specifically -- in my opinion it's always been an issue with under-60-waivers. The CILs and support agencies have engaginged in helping people through that process and some AAAs, most of
them have viewed it as part of the enrollment process as well.
the way that the independent enrollment broker's role has been designed, they don't have the capacity to be able to perform that level of support to the
degree that you and I are like and are used to. It is rolling it into the comment
Brenda made earlier about the benefit support role as well.
We are recognizing this as a challenge. We are also recognizing how complicated the financial eligibility process is to be able to access our services;
that being said. We want help.

What would this committee or stakeholders recommend we do in being able
to address what could be a pretty significant gap in services.
>> PAM: My comment is, what we have been asking for from the beginning is navigator from start to finish. Honestly you say CILs do it. We do it because
there is not another option out there, but when we do it, from the time we help them know how to apply and go through the process until they are receiving services and are unhappy with it, that's what we already do.
In my opinion, that could be part of the navigator system.
>> KEVIN: Understood. How do we -- I am putting it back on you because we do need help in being able to figure out how to address this problem -- how do we unfold it into what is the managed care final requirements and Community HealthChoices and meeting the immediate need. You don't have
to answer the question right now. The Department of Human Services.
>> PAM: We can help be part of it.
>> KEVIN: Zachary Lewis. My question is when will the programs be more centralized to Pennsylvania. As a consumer from Philadelphia my personal experience is that they suck. So we already addressed there are issues there
but I want to be able to talk to somebody and see them face-to-face or go to
an office when things aren't, you know, there. As far as I know I am still calling Boston and even when you look on their website and get the phone number for the area that I am localized in. I will call the number and they will
say, no, this is not the phone number you want. Hang up and call this place.
>> KEVIN: Are you talking about financial management services vendor or independent enrollment broker? The financial services vendor is out of Massachusetts. The indent eastbound rollment broker is in Pennsylvania.
>> Zachary: I'm sorry. I meant financial.
>> KEVIN: I can answer that question. We are planning with new procurement financial management services to require a bricks and mortar in
each zone. We are recognizing what you are describing as an issue and we are
requiring more engagement in the next iteration of procurement for financial management services.

We are addressing the problem you brought to us and thank you for it. Drew?
>> DREW: I am wondering if the 5400 application in process is increase from previous that would reflect applicants from aging waiver? Do you know
what it was before and how many of the 5400 are aging applicantants.
>> KEVIN: I will give you estimates off the top of my head. I have been looking at the data every day.
So about 2400 of those applications are the aging waiver. The aging waiver is
our largest waiver it makes sense that the majority of those applications are aging waiver applications.
It's not really an increase over volumes that we have seen in the past except
for the fact that in general our home and community-based waivers are seeing
increases in the level of enrollment.
Well, we are paying attention to the length of time that it actually goes through the process. We have standards that we are -- we must meet and we
also have goals that we are focused on achieving and what we are going to continue to focus on and what we are worried about to be perfectly honest is
that it won't take too long in that process.
>> DREW: I don't flow whether maximus has the ability to flex their workforce in response to that increase. I don't know how their contract is structured.
>> KEVIN: They do and they have.
The volumes -- the call volumes and processing volumes that they have been
seeing, the flex change that you just described; that's the way that we have addressed it. They train more and put in place more customer service representatives to address the issue.
The process itself, though, is -- the independent enrollment broker is only in charge of part of the process.
So they still -- the financial elogyibility is still determined by the County assistance office. There is still level of care determination that continues to be
managed by the AAA and services communication process that helps clinical

elimination I believe for the programs.
All of these processes independent broker but we have to monitor the whole
process to make sure it doesn't take too long.
>> DREW: I bet they don't have the ability to flex up like maximus does.
>> KEVIN: I shout out to AAAs they have been consistent. Always variability
about multiple agencies. They have always stepped up when needed to when
it comes to level of care determination.
Physician certification is an area that has to be managed a little bit, but did is
something that we focus on as well.
In some cases, physicians are not always -- incentives are not always in place
for physicians to move through that process very quickly but it is something that is -- it's managed fairly heavily and it has engagement --
>> Brenda: Maximus might be doing bad on duty a benchmarks but on the ground things are a lot better for consumers in the southwest we have people
get incorrect information from their IEDs, we have incorrect information being sent to the county assistance office. It has been a real mess I have to say, regarding the level of care determination, now that it's happening earlier
in the process, I think it's being handled sloppily.
I am helping a consumer advocate who is clearly somebody who is will be eligible for benefits. In the end of things. Right now has had to appeal level of
care determination twice and his denials come within three days of his visit; that's clearly not enough time to look at medical records and make informed
decision.
There are real on-going problems that have to do with all of the parts and pieces. I just want to let you know that meeting the data benchmarks isn't really making things better for a lot of consumers who are in the process.
>> KEVIN: Brenda. Thank you for the comment. I agree when I mentioned service levels earlier what you are describing, incorrect information and making sure people are treated with dignity and respect is something we are
monitoring.

It's something we are working with pretty frequently. We talk with them on a daily basis and we do much more intensive discussions with the independent
enrollment broker on a weekly basis and bring the cases to them to make sure
it's built into training module. We want to make sure it gets better. It is an area we continue to worry about.
>> BRENDA: I have to reiterate I don't think having level of care determination early in the process is overall helpful to people who are brand
new to this process.
I think that perhaps the influx of new people that the Area Agencies on Aging
are dealing with are taxing them to a level that you are not aware of but on the ground, people are -- people that we know should be eligible for services
are being denied without any explanation and I can't discuss too much in specifics, but it's fairly shocking in a couple cases I know of right now. I would
really strongly urge you to address that part of it as well.
>> KEVIN: Thank you for the feedback, Brenda. If you could email me one or two cases you don't have to give me names or participation identification information, if you could email me a couple cases, we will work with the association for the Area Agencies on Aging to research it and see what we could do to make that work better as well.
>> BRENDA: Okay. I will get that to you.
I need to speak with a couple of the advocates involved to get more details. I
will get it to you in a couple days.
>> KEVIN: Thank you. I know you have my mail address.
Any other questions?
[NO RESPONSE]
That's my presentation. I will turn it back over to Ralph.
>> RALPH: Consumer communication I don't know these folks personally. It's Heather Hallman and Kathaleen Gillis.
>> THE SPEAKER: Good morning, everyone. So I am Heather haul man from the Department of Human Services secretary's office. Kate Gillis is the press secretary. Don't call her Kathaleen,.
We are passing out two documents we have created. I am trusting you will pay attention to us and not read the documents right now. We are trusting

you. Please don't, you know, ruin our trust.
[LAUGHTER]
So this is going to be hard because I can't see -- all right. So we have been working hard on developing communications. We meet on at-least-weekly basis to talk about how to communicate. There are a lot of people to communicate to. We are trying to figure out the best way to comiewb indicate
with everybody.
We are hoping today you can help us provide feedback on how we should communicate and also what needs to be communicated.
I think there is is -- this is a heavy topic for some, particularly when we start talking about which waiver goes when, where, how, how that impacts everybody.
We have to figure out how to dmiewn indicate this to individuals in the best way possible.
We need your help dining this.
First, who do we need to communicate to? First we need to dmiewn indicate
to the general public. We also need to communicate to participatants this is a
huge change for them. We want them to feel as comfortable as possible going
into this situation.
We also need to communicate to providers for physical health providers it's not as of a change because many of them already participate in health choices.
When it comes to long-term care providers, this is going to be a big change for
them. We need to make sure that they are fully aware of how this will work and feel comfortable going into this new system.
Finally, we need to make sure that our staff know exactly what is going on. We have consistent messages to everybody; and that we are up and running
and able to make everything work from day 1.
First, how will we do general public outreach? We already started some of this. We are utilizing our website a lot. Everything is available on our website.
We kept all of the concept paper, discussion documents, RFP, everything is
going up on our website. We have FAQs. We want to utilize that in the best

way possible so that everybody has the same consistent information available
at all times.
We are also utilizing press releases, we got a lot of good press around this. We
are utilizing email blasts. We have a large stakeholder list. If you are not on any of our distribution lists, make sure you sign up for them so that you can be unto date on everything that is going on with DHS.
We also utilize social media. Twitter, Facebook, we are trying to get this out there as much as possible so people are aware of what is going on.
We are developing a CHC-101 training.
This will be a video. We had a lot of success with this when we did health choices expansion. We were able to put together a video that is very tells everybody the basic need what they need to know average person on what CHC is.
We are also developing publication. You have two of them right now. We developed a fact sheet. We actually worked with health law project. They utilized consumers from the consumer hub. They turned it quickly for us for you today.
We have to start at the basics of what scrp HC is. It is a low-level fact sheet we
hope people will understand.
We also created an acronym list. In state government there is nothing better
than creating a new acronym tolts.
We wanted to make sure people knew what the acronym meant and a glossary of the terms. These are living documents. They are final right now but if you come up with something that we are missing, let us know and we will be happy to add that on to there so that we can make sure that everybody
has the information that they need.
We also -- yes?
>> Zachary: As far as reaching out to everyone, like, even in this day and age a lot of people do not have internet.
How are you actually reaching out to those consumers?
>> THE SPEAKER: We will talk about participants next. This is general public, what is going to be out there. I will get to participants in a minute. Okay? All right?
So we also have our FAQs up there. We will develop something about how to

apply. We still need to vet that one through.
We also need to know what needs to be out there what information do you need?
I think we realized a little more information on what this means for the waiver we will develop fact sheets on this.
Any otherredies you have, please share with us.
Next we have a video. The video is just been developed. You guys are the first
ones to see it other than secretary Dallas. He got a preview of it.
It is not captioned.
>> Not yet but it will be. It's not in his final, final stages.
>> THE SPEAKER: We would like input from you guys. There are a couple changes we would like to make to it. We want you to give us input. It is lowlevel
of what does CHC mean.
(Video.)
>> Healthcare can be complicated. Maybe you have more one provider. Maybe you are covered by more than one insurance.
Wouldn't it be nice if there was someone to help coordinate it all? That's why
Pennsylvania is starting Community HealthChoices.
If you have both Medicare and Medicaid or receive long-term supports through Medicaid because you need help with activities such as bathing, eating or dressing, you will be covered by Community HealthChoices.
Community HealthChoices will coordinate your healthcare coverage to improve the quality of your healthcare experience.
We will serve more people in communities rather than in facilities giving them
the opportunity to work, spend more time with their families and experience an overall better quality of life.
Community HealthChoices will roll out in phases across Pennsylvania, starting
with southwest in 2017, southeast in 2018 and the remaining of the state 2019.
This will affect more than 420,000 Pennsylvanians. Are you one of them?
Here are four things you need to know:
One, there is nothing you need to do until DHS contacts you. We will reach out and help you make informed choices about the future of your care.
Two, no health coverage will be immediately impacted.
Three, all beneficiaries will be informed about transitioning to community

health dhoises.
Four, there will be no gap in coverage.
Community HealthChoices. Providing health, independence and making it easier for Pennsylvanians to live in their communities.
Brought to you by ghof nor Tom Wolf, Department of Human Services and the
Pennsylvania Department of Aging.
For more about Community HealthChoices go to www.dhs.pa.gov.
>> THE SPEAKER: What do you think? Very high-level meant for general public to understand what Community HealthChoices is, they have an idea --
>> Tbren did a: This is Brenda Dare. I think you need to say, If you are currently on a waiver. I think it's not clear for folks who don't know the system that it's going to impact everybody who receives services hearing that
they may think well, if I am somebody who needs help, I will get help under this program.
Do other people agree with that?
>> PAM: Yes. Can.
>> THE SPEAKER: You believe the word -- my concern with that is the average person doesn't know what a waiver is. That's why we talked about long-term services and supports if you need assistance with certain activities;
that's our thought behind that.
>> Brenda: -- by saying if you need or if you receive they may not understand that that encompasses people who are already involved in the system. I think if you say, someone who is paid through Medicaid; that might
thinkinger more recognition.
>> THE SPEAKER: Thank you for that input. We will look at that.
>> RALPH: I would ask that the age group that is affected by this be highlighted more so throughout the video. Some folks looking at it may not realize it starts at a particular age and goes to a particular age.
>> THE SPEAKER: So add something about 21 and over?
>> Drew. So it's certainly very catchy and appealing. How would you intend to use the video? What are your plans for the use of it?
>> THE SPEAKER: We will be able to utilize this on our website. We can work with provider organizations to actually in the waiting rooms, have it playing at doctors' offices, the federally-qualified health centers. We will be able to utilize this and put it out there. Any organization that would like to

share it, we would be happy to allow them to do that too.
>> DREW: Public service announcements, how long is the video?
>> THE SPEAKER: Two minutes and two seconds, I believe. We are limited
somewhat in the money that -- we really -- we will talk a little later about how
to do direct outreach to participants. We want to utilize our dollars there so that we actually get those participants who are currently involved and do the
direct outreach.
>> FRED: I think you need a phone number on there. Like what was mentioned earlier, there is a lot of people out there that do not have computers. They do -- they will not be able to go www.gov.
I have been doing an autism lot of work with the Jewish healthcare foundation in Pittsburgh. We have been working on how to communicate with all of the consumers out there. Get ahold of us, people know what is going on with that they have been going on with that. Georgia's been down is
there.
Contact the Jewish healthcare organization has a ton of suggestions. We brainstormed for a couple months now. We have fantastic ideas up there.
>> THE SPEAKER: Great. Thank you.
>> RALPH: I would also recommend closed captioning on this. I think you spoke a little bit about that.
>> PAM: Open caption.
>> BRENDA: I would prefer open caption not closed that way everybody can
see it. If you are somebody who has trouble hearing but doesn't want to use it
on your television or doesn't want to use the feature on whatever system you
are views i viewing it on. Open caption is much more readily accessible.
>> PAM: I just wanted to agree with brend did a earlier on about some of the language.
When you talk to people who don't know anything about it. They don't know -
- you have to explain long-term services and supports.
My only question at the end it says coverage won't end.
People on the program will think that is insurance and maybe coverage or services because they see it as services not necessarily medical.

>> THE SPEAKER: That is one part we are changing a little bit and will have
different language. I believe it says services, but I will make sure that it does.
>> Pome: Most of the people on the program know it as waivers. Long-term
services and supports won't know what that is but I liked the way you explained it.
>> Bill White from AARP. It's a difficult process to communicate. Itch think you realize that. One thing I would recommend besides having it in different languages, obviously Spanish and what have you, is to try to use the aging network -- I am talking about existing networks of communications.
More importantly is actually get real people somewhere and show them the video to see if they have any idea what you are talking about.
We are all experts on this. You understand maybe managed care. You maybe
understand Medicaid but not Medicare and what is the connection? Actually
do a live test on it.
I think you will find out that there is a lot more confusion than you would ever believe.
The computers is a good point. A lot of the elderly don'tize computers but their children or neighbors might use computers.
The standard way to communicate isn't as effective as in a normal marketing
campaign.
>> THE SPEAKER: I think there was one more question in the back and get
on how to communicate to participants because we absolutely realize that everybody does not have access to the internet.
>> My comment is that it seems to be address being individual that uses you.
If you have more than one coverage. You don't need to do anything until contacted.
At the end you go off the rails and use jargon even speak to someone else and
say, beneficiaries will be whatever or whatever.
If you could be consistent and say you -- whatever that message is at the end.

I don't think people realize they are a beneficiary. They don't know what that
means. Speak directly to the person again for that final message.
>> THE SPEAKER: Thank you.
Let's move on next to participants.
We will actually be developing marketing materials for participants. We will utilize focus groups to ensure that those messages White said. You are absolutely right. We know certain terms that not everybody else does we will
utilize mark marketing materials that will be easy to understand, as easy as possible because as we said it is a complicated system.
We will be utilizing marketing materials and we will begin direct outreach in January. The extension of the time line has allowed us to really I object crease
the amount of out reach that we can do for participants and will have a full six months in which we can talk about what is going on.
We will be utilizing outreach organizers who will be holding -- doing direct mail to participants. They will also be doing events where people can come and actually ask questions, find out what is going on and will actually be able
to have those hands on activities where people can start to really understand
having specific questions answered about what this really means for them.
Then starting in March we will do what we call the 90-day pre-transition letter which I argue is not 90 but it is 120 but it is what we are calling it.
In March we will do an initial letter. We have a lot of flexibility in this letter. We have a complicated system in which the notices are generated but because
of the way that this letter is, we will have a lot of flexibility. We are actually going to bring this letter to the communications group that was developed through this subMACC so that we can talk about what is in that letter. We want to make sure that it targets the visits and they understand what it means
to them and what they need to do.
We will bring it to the communications group so that we are can really talk about, you know, make sure that people have a full understanding.
At this point, when they have that 90-day pre-transition letter, they should have had outreach to them. Ideally the majority of them will have an understanding that this is coming. Now they understand what they need to do.

After we send our letter, our enrollment broker who is currently maximus will
send out an enrollment packet. That packet will talk about which MCOs are available in their area. It will talk about what the networks are and give them
more information to make informed decisions. At that point, as we said, they
would have had quite a bit of outreach to them to make sure they feel comfortable with that.
Maximus will be able to help them make those decisions as they go forward.
And because not everybody -- you know, we have growth in our waivers, we
will -- 60 days prior to transition, we will send out the same letter to those new participants and 30 days we will also send out.
We are making sure that everybody gets the pre-transition letter as easily as
possible.
The enrollment packets will also go out in March. Maximus will also follow up
with additional letters and phone calls to people who don't select a plan.
We want everybody to select their plan. We want them to have their choice in
what their services are.
If they don't select a plan, after all of our outreach, they will be, as you know,
automatically enrolled in a plan. They can change it at any time. We want to
make sure that as many people as possible, we would love to see 100% of people select MCO prior to going live.
Our official notices will be mailed in May. These we don't have as much flexibility because of the way the computer system is designed. We will have
standard notices that to me don't -- are not English. To me they are very confusing. We are working as hard as we can. We will also work with the communications group to make sure that that language is as easy as possible.
We will have the ability to do because of extending the time line we will have

a CHC fact sheet. Not the same one as you have here but more in-depth. If all
of the other communication forms they didn't understand we want one more chance to see how this impacts them.
We will be able to do that.
Any questions on participants?
>> DREW: So for a subset of participants, possibly those who have brain injury or those who have dementia served under the aging waiver, there is an
issue of cognitive accessibility. When you are sending them a letter, they may
or may not be able to understand what the letter is about, even if it is a wellwritten
letter.
What are your plans for providing the information in a way that is cognitively
accessible?
>> THE SPEAKER: Great point. We will include powers of attorneys so family members helping them will get the letter also.
If there is anything that we can do to make it easier, let us know.
>> DREW: We would be happy to.
>> Brenda: I'm sorry. Go ahead.
>> DREW: I would just say the brain injury association and, I'm sure, the Alzheimer association would be happy to review what you are planning to write to them from the perspective of cognitive accessibility.
>> THE SPEAKER: Great point. I will make sure -- I don't know exactly who
is on the communication subgroup of this group but make sure they are involved in that process.
>> DREW: I guess I would ask, how systematic do you have the power of attorney or a family member that you would also be sending the letter too? In
terms of people with brain injury it is often the case that they do not have a guardian or power of attorney but they have a family member helping them.
>> THE SPEAKER: I cannot answer that question specifically for you. We have had those conversations. I don't know -- Georgia was involved a little bit
with those. I don't know if you remember how that process works, but it does

have to do with who Getz the notices for an individual when we print regular
notices any other notice it would go to those same individuals.
That's a great point. If there's other ways you can come up with how we can
communicate that or utilizing their provider network, we are happy to have those conversations.
People that are already served there may be people helping them through provider network.
I don't know if we get into any difficulties with confidentiality or how you could handle that, but it needs to go to the people who are helping them.
>> THE SPEAKER: Right. Good point.
>> Brenda: I think that one of the ways you can enhance what Drew is talking about but also address another concern that I have, I think every notice should have a phone number to call and hear an audio recording of that notice.
The reason that is so important, particularly in the rural area if you are in the
southwest, we have a lot of people with disabilities who are a little bit older or were educated in school that didn't meet their needs who have low literacy
skills. They are very proud and ashamed to admit that.
They are not going to o come to people, if they are not already connected to a
CIL or support agency like us.
If they have a phone number to call and hear a recording, at least they will know what questions to ask somebody that they know who might be able to help them.
>> THE SPEAKER: Great suggestion. Thank you.
>> RALPH: Pam and then the lady there.
>> PAM: Just one suggestion, it may already exist but to go to what Drew was sailing about other people who help the individual. IEB used to ask, is there someone else I can contact if I can't get ahold of you. Maybe just in whatever paperwork that goes along with consumers. If the consumer says, I
handle it myself. If someone says, no, this person helps me and they could be
listed. Maybe it won't be a confidentiality thing however you write it up.
>> THE SPEAKER: Whenever it comes to the official notices when we send

out a lot of rules that the person has to give us permission to send those letters through that process, but we can find out if there are ways to simplify that process.
>> Joan Bradberry with suspense Pennsylvania -- I would be remiss if I didn't
say anything even though we participate in communications work group and
certainly our providers have been involved throughout the process.
A couple comments:
One is on the sheet that you does hand out the references to life program. Appreciate that. Definitely do not take that for granted.
Would love to amend the definition a little bit so it's clearer for folks.
Also, in termses of the navigators would love to offer LIFE providers would love to help with navigation with folks in the community they have the ability to connect with folks even when they receive calls from folks interested even
if there isn't a LIFE program available they provide the counseling for lack of a
better term to really help folks in the community figure out who they need to go and speak to. I would love to offer that they are part of that process and help with the communication of that information.
Then also, of course, with all of the letters, making sure that it is very clear that folks who are currently enrolled in the LIFE program do not need to make a change if they do not want to make a change.
In all of the letters that go out, 90, 60, 30 days that folks know, if you are enrolled in LIFE you don't have to change it you have the opportunity to if you would like to but you certainly don't need to. Thank you.
>> THE SPEAKER: I want to point out that LIFE is something we need to regularly put into that because we do recognize that this is a great option for
many people we don't want them to think that it's going away.
Also, it's an opportunity for people to learn more about LIFE at this point.
>> I appreciate that. I struggled with the video. Certainly you are trying to educate people on a brand new program.
When there are opportunities to make sure that folks know about LIFE as an
option is equally as important.
>> As time goes on also we have the opportunity to create more in-depth videos that will tackle that. This is for Joe Smith in Mechanicsburg who has never had interaction with this. We will take all of that into consideration

when we develop more in-depth material.
>> FRED: What about people with vision impairments how will they see the letter.
>> THE SPEAKER: Great point. If you have suggestions -- you know, you are
the disperts, here. So if you can give us suggestions. I think, you know, -- I really would love to know what your suggestions are for that.
>> FRED: Usually anybody with vision impairment has something to do with
the lighthouse for the blind, blind association things like that. Find out everything you can about those programs. Utilize your centers for independent living. United lies -- even doctors' offices have notices in the doctors' offices. Definitely inform doctors about this because that way they can suggest it to people.
I notice that this just says participants. Is there anything involved with nonparticipants
that do not know what services and supports are?
>> THE SPEAKER: General public is outreach to general public. People who
are not participants.
When you say non-participants other than are you talking about family members?
>> FRED: I am taking about someone who doesn't know about long-term supports. I have run into people and said, hey, how are you doing? Brought them in and talked to them. They said, you have what? I can get help? Oh, Wow! How will you reach them?
>> THE SPEAKER: Part of that is having this gin outreach that we are doing
is going to increase the awareness that these peoples are available to the community. We are doing programs to providers ideally if it is connected to primary care physician -- next we will talk about how we outreach to providers; that will increase their awareness also to programs that are available. Okay?
So let's move on to providers.
So when we did the health choices expansion and we learned a lot about how
to communicate qait to providers. Providers didn't attend webinars. They didn't want to do a lot of those trainings.
We really need he had to get more information to the staff that actually do the work. You know? Not the executives. We needed to get down lower.

We will need to be developing a lot of fact sheets. These materials are available at all times. They are available on our website. On the intranet so that people can really start to see and have it on a daily basis and at any moment I have a question about this pertaining to transition. I have a question about promise -- they will be able to reference those materials. So we learned a lot before from that. We will developing those materials in a
similar fashion.
Also, we will be holding trainings.
One thing, as I said earlier, physical health providers already are very fume with how health choices works.
Our long-term offices support providers are not as familiar with managed care. We will really be doing targeted outreach to providers. We will include physical health providers but we will also really be targeting long-term services supports and providers. They feel comfortable and know exactly how
managed care works and how they should be working with managed care organizations.
We will do very intensive outreach and trainings in those communities but also be doing webinars so that people are available to do that at any time.
We also recognize that while we are rolling out in the southwest in 2017, that
providers go beyond just one region. We will be making sure that we get those outlying counties also so that we can get that full reach.
We also work with provider organizations. We have a lot of success with that.
We will be developing training materials they can do on their own. We will also ask that we come to their events or partner with us to do outreach so that
we can really make sure that we are getting all of those providers.
We are will also be doing email blasts and social media like we are for the general public because a lot of the providers do have more of that -- more interest neat capabilities and realize not everybody does.
We will utilize as many different options a possible.
Finally, staff and contractors. So we need to make sure that our staff know what is going on. We need to be developing as I said earlier a DHS-101 we will provide to all staff in Department of Human Services and Department of Aging.
We will also do more intense training for staff impacted by this. Our staff and

office of income maintenance who process the applications we will also be working with long-term living staff so they know how it works and how it impacts their jobs.
We will be working with our office of mental health and substance abuse services. This is a change for them when it comes to the aging waiver now being involved in behavioral health services.
We will also be working with office of medical assistance programs so that they know what CLC is.
We also will have to work with our contractors. Maximus, all of our call Center staff, the AA aches, all of those contractors that work with our participants on a regular basis will make sure that they are wall-trained so that they know what is going on and have consistent messages from us and
from their employers.
We will develop call discripts so when anybody calls any telephone number at
DHS or PDA they know how to direct anybody or answer easier questions so
that people are not bounced around to 9 different places and understand what is really going on.
We will be doing email blasts to our staff as we do on a regular basis so that
they know what is going on. We want all of our staff, even in Children and Youth to understand what community health choices is. These programs impact everybody.
Comments?
>> Jesse: Two quick comments. Contractors thinking about fiscal management participant directed, obviously there are about 20,000 participant-directed direct-care workers that will want to understand what is going on, how the transition impacts them.
The those folks are also providers. They may not be provider organizations in
the same way that, you know, home care agency or some other kind of provider is, but -- we need to think about, carefully, how we also make sure that they know what is going on. They not be left out of the engage ment so to speak.
One way to do that is to engage with direct care worker organization that work with them and collaborate with them and figure out how to bring them up to speed on all of the details of the changes going on.
>> THE SPEAKER: Thank you.

Any other comments?
[NO RESPONSE]
We need you at the table for this. Any feedback you can provide we really appreciate it particularly what it confusing to find out a better way to communicate it.
>> BOB: Next we have review of evaluation plan and quality strategy with Wilmarie Gonzalez.
>> THE SPEAKER: I almost feel like singing. It's such a great microphone. How is everyone doing?
[NO RESPONSE]
Yeah? It's nice to see a lot of familiar faces.
My name is Wilmarie gone discal as, part of Office of Long-Term Living. Today we will give you a global perspective of where we are in our groach of
evaluating and evaluating quality strategy for Community HealthChoices. I feel like I am really loud.
Next slide. Because I am aging I have to put my glasses on because I cannot
read.
All right. So there are so many moving parts for Community HealthChoices. Most important, what we need to realize as we talk about evaluation and quality strategy for CHC is we are moving from fee-for-service environment to
managed dare. There are three main things we need to think about when we
talk about evaluation and we talk about quality strategy:
Consumers will access services very differently in MLTS system.
Long-term care services support services and providers will receive payment
differently.
Medicare eligibility will flow differently through the system than it does today.
One of the key important things again that we also want to make sure that we
understand and recognize is that we want to continual what we have been doing, to be transparent and engage with consumers and providers throughout the state.
Next slide.
We have done a number of research on how other states have implemented

their MLTSS system. We have also been using our experiences and best practices here in our Commonwealth with regard to how health dhoises are operating. We have experts in the field helping us as well.
Paul, are you on the line?
>> PAUL: Yep, I am here.
>> Wilmarie: Thank God! He has been great help in just doing a lot of the research and helping us along the way. He has, as you all know, you've heard
him before, he has done presentations here at this committee but he has been
helping us working through all of this.
Obviously, with any quality and with any new program, there are federal requirements.
It's really important to note that we have to follow federal requirements and meet federal requirements.
So I won't get too much into it.
Very important to note as well is that the national committee for quality assurances has right now initialed a project to pilot standards for LTSS system; that is something we are recognizing and are including as we continue to design what our quality design looks like for CHC.
More importantly, when you think of the Commonwealth in this state and what we have been doing is, part of our quality strategy has been the feedback we have received or heard from MCOs, provider advocates and consumers via public forums comments received from our various published
documents and we have already regarding Community HealthChoices.
So the three phases when you think of quality for Pennsylvania, we are looking at readiness review. This is a pre-community HealthChoices. One of
the approaches we will be using so before Community HealthChoices, we are
going through a process called readiness review and will talk about it in more
detail. You have early implementation go-live date first phase one, two and three. Obviously the steady state which you heard before, the on-going monitoring of Community HealthChoices.
This is really a global picture when you think about how we are going to be evaluating and monitoring Community HealthChoices.
The goal of this chart is real j to give you a picture of how this is going to

work or we plan on looking at how we managing Community HealthChoices.
I talked about the three faces. You've heard in a number of presentations by
the University of Pittsburgh on the independent program evaluation the University of Pittsburgh has already undergone. You've heard a lot of that information. It is ongoing. 23 you notice in the four circles, the independent program evaluation is sort of on the side, but it is a cycle.
Part of those arrows to visually get you to start thinking about what we plan on doing with regards to first get ready, know and understand what are the critical things we need to look at at the very beginning when Community HealthChoices goes lies u live. What are the things we need to look for when
doing the ongoing monitoring of Community HealthChoices.
Obviously, overall, in long-term range, how was Community HealthChoices actually working for Pennsylvania?
This graph is an evaluation and source of information with regards to quality.
The goal will be to supplement all of the data analysis that the department is
analyzing that is getting directly from planned and other resources.
When you think of this, you think of things like the data that is coming from the various resources, the various IT systems, there are a number of them. You've heard of EIM system, the IEB and various might be vendors we will be
looking at.
Obviously, more importantly, coordinating pong among all of the Office of Long-Term Living bureaus. Finance, policy and quality and participant operations. Other program offices within DHS.
Readiness review. MCOs must pass a readiness test before they can enroll anyone. When we use the word test, we wanted to -- we were trying to find a
word that can best explain what we want to make sure the MCOs are ready to
help the correspond assumers that are going to be community health choices.
The goal will be to make sure that the team is looking at provider network capacity. We want to make sure that service coordination capacity is available; that the IT systems are actually working.
Whether you look at IT systems the data that the MCOs are collecting,

submitting to us, making sure that we are collecting the data and understand
the data.
Obviously, ensuring that the MCOs and other vendors are following follosses
and procedures and more foreignly readiness identifies priorities to monitor on steady state.
Early implementation monitoring.
When you think of day 1, this is the most we think is important. Again, this is
based on our research, some of our conversation with other states. Obviously
our experts.
Consumers need to get services. Providers need to get paid. How we do that
is, the plan is to have an early implementation monitoring strategy to -- the kinds of things we will do is daily contacts with MCOs, enrollment consumer system, monitoring services and claims coming in.
Monitoring complaints and grievances receiving from the community in large
consumers, MC Os and IT convenient ors and short-term implementation reports from the University of Pittsburgh.
Ongoing monitoring of quality and performance. Ongoing monitoring some activities we will look at again it is not an inclusive list but we will review MCO data and reports. We will make sure that we are going on onsite monitoring visit. There will be two-prong: Virtual, the actual data live and then also the onsite, it is a-to-face where we will talk not only to MCOs but other vendors that are participating in Community HealthChoices.
One federal requirement, we must have external quality review entity. It is violatal and important the data that the MCOs will submit through us must go
through EQR entity that will validate and analyze the data coming in; that helps us monitor and analyze how the MCOs are doing.
More importantly, too, you have quality measures, you have the med okayed
HEDIS also tellth care environmentness data and information set. It is a tool
used by to help measure performance on care and services.
In Pennsylvania, we are in the midst of finalizing our MLTSS measures that are specific to Pennsylvania, what we think is important to us.

We also want to be able to hear from consumers receiving services from Community HealthChoices.
From those of you who are involved in long-term care services and supports,
the CAP is a national organization that designed surveys that are tested and
validated to ensure that where we are getting that feedback from consumers.
We, in Pennsylvania, want to make sure that we are using CAP's various survey.
The CAHPS survey and HCBS experience survey which is certification pending.
Hopefully when that is done we will be able to share what that looks like.
Measuring the date that we will be receiving.
The other important thing for ongoing monitoring is that we can identify areas of improvements, weak areas and use data to increase special initiatives
and things we want to recognize too that what things are actually working well for us and be able to acknowledge that.
We can also access things going on by region there is a number of data sources and a number of data comes into OLTL. The question is how do we
use that data and analyze a and how do we react. Some of the things that we
can do with the data that we are receiving.
I think more importantly, too, when you think of that diagram that I talked about earlier, between early implementation and ongoing monitoring, I think what will be critical from one phase to another is that continuity of care. We need to make sure that that is one of the areas that's on our radar; that's important.
We already talked about the independent program evaluation, which the University of Pittsburgh is conducting. You've heard from the doctor who gave
extensive presentations in former meetings.
This is just sort of highlighting some of the things that they are doing with the
plan. Does H clp BS expand? Does service coordination improve? Do quality
of life and quality of care improve? Does innovation increase in housing, employment and technology? You know the evaluation plan is in draft form.

It is out on our DHS website.
We are waiting for comments from the community at large the comment period ends July 8th.
Our next steps, again, I hope that we were able to give you sort of a global perspective of what we are doing. There is a lot of details in between all of the
various areas that we are working.
When you talk about readiness review, there are a number of key areas that
the team is going to be looking for. You've got the early implementation, more
details to come on that. We are still working on that to make sure we get is this right.
We talked about the external quality review organization, the EQR, which is critical to the data the MCOs are collecting and subpoenaing through them to
us. So we can follow up with the committee and talk in more detail of what that looks like.
We definitely can share with you some of the comments we have received from the community at large with regards to the evaluation plan that the University has put out for comment.
Our next step is really to make sure that we design a -- an effective and good
and clear-quality strategy for the quality.
Our plan is to publish public comments later this fall.
This quality strategy is a strategy for all Medicaid managed care programs. It
will include, you know, not only Community HealthChoices but health choices
and CHIP.
I don't have anything else. I am hoping if anybody has any comments, I am happy to hear them. Any feedback? You guys are an energetic bunch!
[LAUGHTER]
>> Brenda: I have a question about whether or not -- not through continuity of care period in phase one before phase 2 rolls out in southeast. Are you at
all worried about not having feedback from phase 1 participants to work out any bugs?
>> THE SPEAKER: We are hoping that that will not be the case.
[LAUGHTER]

The intent today was to really give you a global perspective of the things that
we want to do with regards to evaluation and quality strategy. You know, the
devil is in the details. Right?
With the various cycles or phases, if you will, there is a lot of activity and moving pieces in each one of them.
When you think of readiness review, I will tell you that there is an enormous amount of checklists that the teams are going to be looking at to make sure that the MCOs are ready for live on July 1st.
On July 1st, there is a number of details in what we want to do on what we think is important for early implementation. So July 1 fort, which will be day 1. We will do this on a regular cycle. Phase 1, phase 2, phase 3, ongoing.
Think of the graph that I shared with you. First of all, it was colorful and I thought it was frit cool. Second of all, when you think, how is DHS going to do this?
Think of the four major cycles you are looking at.
The question that I would ask is, gee, I like the pictures. The colors are really
nice, but what can I get more details on really what the readiness review looks like. Can I get more details on when does readiness review end and when does early implementation monitoring begin?
I sort of gave you a flavor of July 1st for early implementation.
Then you have ongoing monitoring; that whole cycle continues, neighs 1, phase 23, phase 3.
Each phase or cycle helps each phase strengthen so by the time phase 2 comes
in, we hope that some of those wrinkles have been wfn phase 1 for the time fables.
>> BRENDA: The cycles does not concern you at this point?
>> THE SPEAKER: No, Brenda.
>> RALPH: She also had her fingers crossed too.
[LAUGHTER]
>> Drew: Hi, Wilmarie.
>> THE SPEAKER: Oh, my favorite guy!
>> DREW: I just had a yes about state- defined MLTSS measures. What you
went over is health measures we are more interested in long-term supports and services measures. We would like to know what you are thinking about and would like to give you feedback.

>> THE SPEAKER: We welcome the feedback. We are still in the pro excess
of finalizing those. As you all know, we have not publicized the managed care
organizations that will be operating Community HealthChoices. We are still in
the midst of reviewing the plans, at the same time we are finalizing MLTSS measures for Pennsylvania.
If you have any ideas, by all means, I know you have my phone number and
have my e-mail address, send them to me.
>> DREW: I am thinking of the other folks around the table there might be population-specific measures that may need to be considered certainly something different for dementia crowd and brain injury and for physical disability.
>> Jesse with healthcare. Building on the comment and ongoing monitoring and quality performance, wondering if there is any consideration adding workforce metrix, accessibility of services, for community living and so on depends on having accessibility and available and qualified workforce and one
that sticks around, retention.
So I. Just wondering if it's an outcome or met lick that would be considered added into this program? When the RFPs, particularly there was a focus on workforce and workforce innovation and whether it would be something you consider looking at. Are we making progress on improving the workforce expanding workforce and making sure key element of community living is available for people.
>> THE SPEAKER: Absolutely. Thank you.
>> One other question on quality measures. Is it your plan to share those as
overall public strategy in the fall or are you intending to share those measures
before then?
>> THE SPEAKER: I think if we announce MCOs and if we have a clear quality strategy that we can publicize in the fall I cannot understand why we couldn't provide those and get feedback.
Our goal will be when we publicize -- I'm sorry quality strategy plan is to also
engage Os who have experience. Pennsylvania should be looking at X, Y and Z

as well.
We will throw you a bone. The goal is that you will come back and say here are other things.
>> You will wait until the fall to share those measures or do you plan on sharing it -- is it part of overall quality strategy or do you plan on sharing them before then or are you going to wait until you share over all quality strategy?
>> THE SPEAKER: It's a good question and something I need to follow up with. I am glad you guys have interest.
>> FRED: Does state incentivize home and community-based services? What
do they do to get the MCOs to put out the 85% that the federal requirement requires?
>> THE SPEAKER: We are working with CMS. Other states have been doing
the P for P, the PAY for performance. It is something we are definitely interested in.
I think with everything we are working on in trying to, you know, start up Community HealthChoices is something definitely we want to do.
I don't think it is going to happen on day 1 but it is on our radar to consider and include in our plan and our for example.
>> FRED: It's been mentioned in the room 95% wants to be in home or community-based services instead of institutional one.
How are we trying to incentivize this with MCOs because they may consider it
more expensive.
>> THE SPEAKER: Good point. Thank you. That's it? It's all you have for me?
>> RALPH: That's it you you are done. Thank you very much for your work.
>> THE SPEAKER: Thank you.
>> RALPH: Any work group Chairs that have a report? I personally am not aware of any myself.
[NO RESPONSE]
With that being said, it's unprecedented, but we will open the floor for public comment.
>> Before you start, Steve Williamson is on the phone and has a question from one of the earlier presentations.
>> RALPH: Steve, can you please address the committee?
>> Steve. Yeah. How is everybody doing? Sorry I was a little late getting on today.

>> RALPH: We are good. You will be penalized later.
[LAUGHTER]
>> STEVE: A couple quick questions.
The first question has to do with the maximus is there an option where folks can talk to a live person as part of that process?
>> Kevin: Can everybody hear me?
So integrative voice response -- it's sort of leads people to the way that their
calls would be resolved. It allows them to hear a status of their application without having to talk to a person or gives them the option to talk to a live person.
Yes, it gives them that option.
>> STEVE: Again, I guess as a secondary comment more so than a question.
I think I heard it expressed so I probably am reiterating.
I guess there is a concern the level the documents are written at in terms of appropriate reading level and those dined of things. I just ask that we are asking examination of the level they are written at and write them at a level that is sufficiently for folks to be able to act on.
>> KEVIN: Communication people who presented earlier left but we will make sure that they do receive that comment and we agree with it. We want
to make sure that all of the documents are accessible in whatever way they need to be accessible. Thank you.
>> Brenda: I don't know of you heard me earlier. I recommended every one
of those notices have a phone number somewhere someone can call in and
hear an audio recording if there is no --
>> STEVE: Part of it is we write stuff in jargon that we are all used to. The folks are not used to that stuff.
Also, a lot of stuff is being developed by high-educated professional people and a lot of folks in our audiences have not will those opportunities in their lives. We are asking that we keep -- [inaudible]
>> Brend did a: Right. Right.
>> KEVIN: Steve, we agree we want to make sure that the -- whatever documentses that are released, whatever communication that goes out on Community HealthChoices is fully comprehensible to whoever receives it. We
will work really hard on that. As Heather haul man asked this committee we

will ask for your help to meet that standard.
>> STEVE: Thank you.
>> PAM: I may have missed this is the navigator system going to go out for bid or is it just going to go to aging like the other pilot programs?
>> KEVIN: Wow!
>> PAM: We have been doing it a lot time it would be great opportunity --
>> KEVIN: It's not decided at this point.
We recognize what is required of managed care final role is going to be -- it's
going to apply to health choices, Community HealthChoices, potentially -- LIFE program has their own set of regulations it is more broadly applicable than just Community HealthChoices and just even the fee-for-service programs.
We recognize that that requirement has to be met by multiple parts of the Department of Human Services.
From our perspective, we want -- it's always a goal of ours to make sure that
people have access to the same opportunities, regardless of which part of our
population or which program they participate in.
So obviously, to be able to meet that standard, sometimes it makes more sense to procure another role.
That being said it's not decided. As I mentioned earlier. We are looking for help to be able to figure out how to be able to address that.
>> PAM: When will you know? How long will you have to come up with something and make a decision on it?
>> KEVIN: We recognize the need is an immediate need. We do not have to
be in compliance with the managed care financial role until July 1st, 2018 is.
Obviously we are recognizing that the need is an expressed need that has to
be addressed. We want to be able to look for an opportunity to be able to address that beforehand.
We want to get it right. At the same time we want to address it pretty quickly.
>> RALPH: It would be very nice to get that ASAP for a lot of with reasons members around here understand.
>> KEVIN: I think we agree it is something needed in the current system it is

not something that would be directly related to Community HealthChoices.
>> Ralph: Thank you. Zach?
>> Zach: As much as for Kevin and I guess the whole group. As far as coercion when it comes to Pennsylvania independent enrollment supports coordinator agency for consumers to go to, what type of actions do you guys
take when that happens? I don't know if you even know if it has come up but
it's evident. It's out there. What kind of actions will you take against that.
>> KEVIN: To be clear an independent enrollment broker cannot steer individual to service coordination entity. It is a violation of their contract. If you ever hear of anything like that, please make sure that the Department of
Human Services knows about it.
The role of the independent enrollment broker is to present the choice without any conflicts of interest or without any coercion as you stated.
The reason why we went in this direction is to make sure there are no appearances of conflict of interest. If you hear of anything like that, any type
of coercion, let us know that.
Contact the Department of Human Services. Make sure it is made aware to us
because that's unacceptable.
>> Zach: Okay.
>> JEFF: Two quick questions. One is on cry den shalling for supports coordinators to NHT. Has anything been decided on that at this point.
>> KEVIN: Can you give more background to your question. Do you mean in
Community HealthChoices first of all?
>> JEFF: Yes.
>> KEVIN: When you talk about credentialing are you talking about education for the service coordinators in the program or are you talking about
specific requirements that the role would need to fill to be able to perform that role for community health choices?
>> JEFF: A little bit of both if you have it.
>> KEVIN: So the requirement -- we have requirements for nursing home transition in the draft agreement. We also have -- I believe we have requirements in -- I think Patty could April, this. I believe there are requirements in some of the waivers that were submitted.

>> Patty: I believe the details of NHT are still in process at this point.
>> KEVIN: We have high-level requirements for nursing home transition in the draft agreement and high-level concept of nursing home transition in our
waivers, both of which would be sort of the authoritative sources.
Highly related to service coordinators will have to understand what the requirements understand being. I think it is the expectation for the managed
care organizations to be able to make sure that their service coordinators are
familiar with nursing home transition.
That being said, are you leading to a certain direction? Are you looking for a
certain credential would would be required for nursing home transition?
>> JEFF: No. Not at this point.
>> KEVIN: Do you mind if I ask why you are asking the question?
>> JEFF: Someone from one of the centers had asked me about trying to get
an answer from OLTL on this.
>> KEVIN: Okay.
>> JEFF: We can have a separate follow-up.
>> KEVIN: That would be great. If there is an opportunity or a suggestion out of this we would love to hear it.
>> JEFF: The second question, I think you may have answered it, as far as the MCOs are participating in Community HealthChoices, when will the MCOs
be announced? Do we know yet?
>> KEVIN: I mentioned it earlier and am happy to repeat it. The expectation
is that it will be announced mid- to late-July.
>> JEFF: So the end of the month.
>> KEVIN: Yes.
>> Hi, everyone.
>> Lester Bennett can Casey Ball support coordination.
I hope everyone had a Joyceous holiday.
We talked earlier about the issues with maximus. I had some questions, some
advice is needed. Georgia I sent you an email -- you didn't get it? I will be choicing you down.

Is it 45 days between start and process -- start of the application until service
coordinating entities get information from them independent enrollment broker.
>> KEVIN: The entire process?
>> Lester: Yes, start to finish.
>> KEVIN: Multiple steps are involved in that process. There is the referral process, level of care assessmentment to determine that someone is clinically
eligible for long-term services and supports. There is the financial eligibility process that determines people are financially eligible not only for Medicaid but Medicaid long-term services and supports.
Regulations, federal regulations require that to be completed within 90 days but we have a goal where we are striving to complete it within -- at a maximum 60 days.
>> Lester: Who makes the final decision if that waiver is approved? Will it be maximus or Office of Long-Term Living.
>> KEVIN: By federal regulations they will be made by the department of services as Medicaid state agency. I'm sorry. I sounded like I was testifying in
front of Congress but it is the right answer.
[LAUGHTER]
>> Lester. There is a lot of misinformation a lot of letters are isn't out saying contact for starting services especially with the aging population. I am getting
phone calls I am able to check maximus. I see that they are still looking for financial eligible. We call maximus and we are getting different answers. We
are saying, um, some consumers are being able to prove they have -- whatever
is in SAMS saying they haven't been able to prove that they actually have it and these things are being lost.
I am kind of worried because at the end of the day who gets the documentation that is going out during the application to start the services, such as, like, the MA-51. I am getting, again, phone calls to go out and start services. I am not really sure I should be starting services if one -- it says the
waiver is approved in the system, but it says it was approved by maximus it will say June 9th this was approved by maximus.
I have not got ebb paperwork but consumer is calling p.

For example, it may be a POA paperwork. I don't want to get wrong information from someone to make decisions in a person-centered manner. We are supposed to be person-centered and you need to know who to be listened to.
If we don't have all of the proper documentation, we are, basically, allowing these people to not get any services because we don't know if we should or should not be going out to start services.
This has been going as you, Mr. Hancock has pointed out it's been going on
since April the 1st.
>> KEVIN: A lot of good points you raised. The general answer is that maximus should be able to give status of the application and where it is at in
the process. There have been cases that I am aware of where I notice -- a notice was sent out to participants prior to them actually finishing the elogyibility process.
Through the corrective measures we talked about through maximus and improved training and processing, mistakes do get made but there were a lot
of mistakes being made in that process. We were recognizing that. The corrective action that we have required is to take preventive 34EZs me you are you're to not let that happen again.
If somebody received misinformation through the mail about eligibility process and referring them to their service coordinator to start service coordinate -- it should be stopped or minimized.
If you have case where's you hear it happening, especially if they haven't in the last couple of days, please let us know. Let long-term living know and we
will address them with the indent enrollment right away.
The worst case scenario maximus should be able to provide the status of the
application. If it's clear that participants receiving misinformation, contact us.
We should be able to provide that information.
>> Lester: I have been trying. I've been trying to figure out what to do. The biasic question is, should we be going out to get services started for individuals that I could go see in SAMS that says it's been approved on June
the 9th. Yet, I haven't gotten any information from the Office of Long-Term

Living or maximus to basically say who this person is. I know this person has
chosen our agency saying, where are you at, you should have been here a long time ago.
>> KEVIN: If you don't receive information, if you don't receive information that shows this person is enrolled with receiving service coordination in your
agency, you have to verify that.
If the participant is reaching out to you and choosing you, if you don't have the documentation you would normally use to trigger starting services, you have to verify that.
>> Lester: I call maximus?
>> Lester: They say, you know what, we will send that information to you via email I give them emails they say we will send it to you in 24 to 48 hours
and that's been three, four days and still waiting for information.
>> KEVIN: It's too long. When we get the cases we will take them to maximum and keep on hunting them to improve the process.
>> Lester: That is what I am trying to do. Make sure the plans are being approved and stuff. There are plans that are still under 60 that are still saying
they need to be approved.
I think that's all I need from you. Let me check again.
I will chase you down, Mr. Hancock! Thank you, everyone.
>> Ralph: Thank you.
Any comments on the phone?
[NO RESPONSE]
Any comments from the audience?
[NO RESPONSE]
Okay. All of that being said, I call the meeting to order. Everybody have a great week.
Meeting concluded at 11:33 a.m.)
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