MLTSS SubMACC Meeting
May 3, 2017

>> PAM MAMARELLA: We're going to get started in a minute.

>> FRED HESS: Can we take our seats please?

>> FRED HESS: Good morning.

Good morning. We're about to get started here please.

>> PAM MAMARELLA: Let's call the meeting to order.

And we'll start with introductions.

Barbara, start us off.

>> FEMALE SPEAKER: Good morning Barb Polzer liberty community connections.

>> MALE SPEAKER: Jim Fetzer.

>> FEMALE SPEAKER: Tanya Teglo.

>> MALE SPEAKER: Blair Boroch united health cane.

>> MALE SPEAKER: Jack Kane.

>> WILLIAM WHITE: Bill White.

>> MALE SPEAKER: Russ McDade.

>> PAM MAMARELLA: Pam Mamarella from Cortland in Philadelphia.

>> KEVIN HANCOCK: Kevin Hancock.

>> FRED HESS: Fred Hess, Disabilities Options.

>> MALE SPEAKER: Steve Williams.

>> RAY PRUSHNOK: Ray Prushnok.

>> MALE SPEAKER: Jesse Williams.

>> PAM MAMARELLA: I'm going to call the names of the people we

believe are on the phone and for those who are, I don't call if you can let us know if you're there, so is Arsen on the phone?

[no reply]

>> PAM MAMARELLA: Brenda Dare.

>> FEMALE SPEAKER: Yes.

>> PAM MAMARELLA: Good morning.

Catherine Odom.

>> FEMALE SPEAKER: Good morning.

>> PAM MAMARELLA: Michael Pelicano?

Ralph, are you there?

>> MALE SPEAKER: Michael is here.

>> PAM MAMARELLA: Hello Ralph.

>> RALPH TRAINER: Good morning.

>> PAM MAMARELLA: Terry Brennan.

>> MALE SPEAKER: I'm here.

>> PAM MAMARELLA: Good morning, Theo Braddy.

>> THEO BRADDY: Good morning I'm here.

>> PAM MAMARELLA: Zachary Lewis?

>> MALE SPEAKER: I'm here.

>> PAM MAMARELLA: Thank you.

Do we have anyone else on the committee joining us on the phone?

>> MALE SPEAKER: Arsen Ustayev.

>> PAM MAMARELLA: Good morning.

Okay so with that we're going to ask Fred to go over our housekeeping

and committee rules.

>> FRED HESS: Good morning.

Committee rules are language -- be professional in here, we're supposed to be any way.

[laughter]

Point of order, direct comments to chairman, wait until called on and keep I didn't remember comments down to about 2 minutes.

Meeting minutes transcripts meeting documents are posted in the Listserv, at Listserv.dpw.state.pa.us under the MLTSS meeting minutes they are normally posted within a few days. A captionist is documenting the discussion so please -- speak clearly and slowly.

Cell phones, turn them off.

Or at least mute them.

Clean up -- so throw away your cups bottles wrappers we're not pigs in here.

Public comments will be heard at the end.

These are the emergency evacuation procedures in event of an emergency or evacuation we'll proceed to the assembly area to the left of the Zion church on corner fourth and market.

If you require assistance to evacuate, you must go to the safe area located right outside of the maindoors of the suite, OLTL staff will be in the safe area stay with you until you're told to go back in or everyone must exist the building take your belongs do not operate your cell phones don't try to use the elevators they won't work.

We'll use stair 1 and 2, two exit the building stair 1, exit the main doors on the left side near the elevator, turn right and go down the hallway, by the water fountain, stair 1 on the left.

For stair 2 exit through the side doors on the right side of the room, or the back doors.

For those exiting from the side doors, turn left and stair 2 is directly in front of you.

Everybody going out the back, you have to turn left and then turn left again you'll see stair 2 directly ahead.

Keep to the this side of the stair well and merge to the outside turn left, walk down Dewberry Alley to chestnut turn left to the corner of the fourth street, turn left to Blackberry cross Fourth Street to the train station we'll meet up do a head count.

>> PAM MAMARELLA: Thank you Fred.

So I'm going to turn the meeting over to Kevin Hancock who is filling in for Jen right now, Kevin?

>> KEVIN HANCOCK: Good morning, everyone.

I'm going to start with the office of long term updates related to the CAHPS survey tool I'm basically reading the update, I unfortunately wasn't able to attend the a April 5th, this update is to follow-up to some suggestions for the survey tool submitted by the Drew Nagele options for assuring cognitive accessibility have been developed for the CAHPS survey tool, that drew recommended long term lisk utilize all of the CAHPSS cognitive accessibility options and that includes survey by

phone, or in person, simplified response option and allow proxy responses to be very clear, we're definitely keeping these recommendations in consideration, and building them into the process.
And in addition, an individuals level of cognitive functioning should be assessed, in advance of the survey being administered, to determine whether or not think of the accessibility options should be utilized and a process must be included in contacting the agreement assure this, this is part of the way that we would be rolling out that survey tool.
Third, long term living should allocate sufficient resources for all the accessibility options to be exercised and last, drew requested that, long term living assure his concerns are being addressed there will be contractual policiesance procedures in place before the tool is implemented we're definitely taking all those into consideration.
So -- any questions about that? That I may or may not be able to answer?
Okay I'll move onto the community HealthChoices updates -- so I think it was mentioned in the last meeting that we have received full approval to move forward with the community HealthChoices and at this point we are, considered to be in full implementation mode.
The implementation kick off began on March 30th, with discussions with managed care organizations on what will be happening next.
Immediately after that, meetings were on April 6 we kicked off the ready any review process if you remember the readiness review process, it is the function that is required not only by the Department of Human

Services but also by, the centers for Medicare and Medicaid services to certify that the managed care organizations are meeting the terms of the agreement as agreed to, in the as agreed to the in proposal procurement and negotiation process.

That is right now, actively happening as well.

We have MCOs and long term living staff communicating on a daily basis about the levels have to be reviewed and in addition, many of you know this we also have participant consultants who are going to be helping us with this process and reviewing key areas of readiness review.

In addition there will be technical assistance sessions scheduled with the CHC and MCOs in regulars to readiness review the last is scheduled -- actually scheduled for tomorrow and that session they will be reviewing quality, provider files and enrollment and credentialing a lot of key areas where, information exchange takes place as part of the review process that will be discussed this more detail in that meeting.

In addition, Office of Long Term Living the Department of Health are currently, engaging, stakeholder input on monthly basis to develop LTSS network standards that's one of the key areas where we're having, participants support to help us with defining what is network adequacy from an LTSS perspective.

Since outside of the LIFE program, since LTSS will be new to managed care for a more global Medicaid program, those network standards need to be developed for the LTSS services specifically and, not only are we providers to the MCOs, but participants are going to be helping to find

how those -- what really is an adequate network how that is measured as part of the readiness review process.

MCOs, OLTL will be this discussion tore the definition of a long term provider.

That's a key component of certifying where any willing provider in the process -- I'm not going to define it because the discussion is under definition.

But it's important to determine when we talk about free choice of provider in a given network what is the difference not only between what is exists in the fee for service system and managed care how are we defining going forward and community HealthChoices as well.

Also there will be -- there was a specific kick off meeting that related specifically to the information systems that took place on April 12th, from this point forward, there will be sub meetings with information systems focusing specifically on file transfers data exchanges and requirements that are needed to be able to meet the information exchange between the department of human services, managed care organizations the independent enrollment broker and other entities involved in making sure that the individual will have the information they receive to be able to have enough -- to be able to enroll in CHC correctly and also to make sure that, that once that enrollment actually takes place that they are receiving information in a timely appropriate way.

And as mentioned we already are having the meeting tomorrow.

We'll focus heavily on quality as well as other topics and also defining key

actually introducing key performance measures and how they will have to be information exchange between the MCOs and the department of human services and making sure those measures are being received.

So a lot of information on a lot of activity.

Any questions on that, before I move on?

>> MALE SPEAKER: Hi --

>> KEVIN HANCOCK: Glad to see you in person.

>> MALE SPEAKER: Yes I've been a little busy but --

>> FEMALE SPEAKER: My question is about readiness review, as you know, probably, I'm on part of the readiness review committee one of my major concerns is the idea that the phase of readiness review is already up almost over.

I don't -- I don't feel comfortable with that because I mean we were asked, a few questions by OLTL but we're not even really going to get follow-up answer he's real good on what information we gave them to determine how things are going to play out.

Like based on the questions that they -- that you've already asked.

I think and I think I even heard Randy say this at the one of the meetings over the phone that readiness review is going to be a key component that we need to keep going throughout this process to make sure the MCOs and the consumers and everyone, are on the same page.

So the idea that this -- the idea that like, possibly the last meeting could be coming up is kind of scary it on me.

Because if it's already been stated that this is going to be a function that

we need to keep everything in check, even later on after everything gets started up, why would we want to end it?

>> KEVIN HANCOCK: Okay so I'm going respond to a couple of the comments you made.

You had made a comment that or statement that, a phase of readiness review is almost finished.

That to my knowledge is not true at this point.

We have just really begun the readiness review process.

Managed care organizations have received the tool they need to use to provide information in deliverables to us that is just getting started.

So no phase of readiness review is yet completed.

>> FEMALE SPEAKER: Okay.

I received an email last week where there was some concern that like the may 12th meeting might be the last conference call? I didn't know if that was going to be the end of consumer involvement on it or not?

>> KEVIN HANCOCK: No it's not.

>> FEMALE SPEAKER: I just want to make sure that keeps going because, that is something we're going to need throughout the start up process and way beyond.

If it's not there, how are you going to know what is working and what isn't, in like how our problems are going to get fixed.

>> KEVIN HANCOCK: To be clear may 12th is not the end of anything.

It may be a way that information, in the process is being documented I know one of the objectives is to make sure that we lock down a definition

for network adequacy for the LTSS providers we need to do that soon.
That will be an end of that, we need to have that soon we need to make sure it's communicated not only to the MCOs but it's been clear, with the Department of Health that's what they're going to be certifying as part of the process.
That has to get locked down, participants are involved in that.
But to be clear participant engagement through the readiness review process.
May not focus on one particular issue.
I can say with certainty you have to lock down the definition for network adequacy for long-term care providers for this program.
>> FEMALE SPEAKER: In that I understand.
But what I am still kind of confused on and maybe I'm just stupid or don't see it -- could be either one.
But how do we know like which MCOs are going to -- how do we know how they're going to function with these providers at this point?
That's what I don't understand.
How can you be making a determination on what is adequate if we're not -- we don't even know which providers are going to be in what areas yet.
>> KEVIN HANCOCK: I mean, you won't know.
Because they're voting out the networks right now, we don't know either.
We do know as part of LTSS network adequacy, that they have to know, at the very least what they have to do to be able to meet that requirements part of the process.

They're building out the networks right now.

We will not have a defined network with any of the MCOs, completed in the near future they're in the network development right now.

>> FEMALE SPEAKER: I'm following you.

I'm trying to.

But something, something in that process, just seems a little backwards. Because wouldn't you want to know, who your providers were and then then determine if it was going to be adequate enough to serve a population? It might just be the way I'm looking at it you know what I mean.

>> KEVIN HANCOCK: You're -- just, if you want me to be honest I think it is the way you're looking at it, you know who these providers are in your area but the first step in the process, is did he Tining what is LTSS provider, that meets the requirements for of the agreement. And also meets the requirements of the program.

And the Department of Health will use that to determine once the MCOs build out their networks if that network is adequate to meet the requirements of the participants.

So, they can't do that certification the Department of Health can't do that certification until that network is built out.

But the most important step in this process is to make sure we're very clear with the MCOs and with the Department of Health on our service definitions for LTSS services, on what providers are needed to meet those services and -- then, having them you know, build out a network of

those provider that's are providing the services.

>> FEMALE SPEAKER: When the providers are selected, is that another part of the process?

>> KEVIN HANCOCK: Yes.

>> FEMALE SPEAKER: Okay.

I think, what I was thinking was you would have to do the other one first just the way I had it in my head.

>> KEVIN HANCOCK: Yeah. Well, there's no doubt about the fact that the MCOs are talking to long-term care providers they have been for quite a long period of time.

There's no doubt about the fact that there's a general census what the LTSS provider and what LTSS services are we define them in the agreements they have been part of our waiver submissions.

But as attar of this process the part of the process that is important from a managed care perspective is the Department of Health is certifying network adequacies so we have to make sure the Department of Health and that's the participants voice in helping us to did that.

The Department of Health has a clear understanding what LTSS, network adequacy is for the LTSS services I mean you -- your voice has been contributing and your voice will continue to contribute to determining LTSS services and providers but the MCOs are still going to need time to build out that network.

The direction defining services and then identifying the building out the networks.

The last step in the process for the network itself is certifying network adequacy and we have to all those steps first your voice is going to be part of it throughout.

>> FEMALE SPEAKER: Okay.

>> PAM MAMARELLA: Fred has a question?

>> FRED HESS: Yeah. I have a quick question.

What's the -- is there a minimum number of providers that they have to have? Or, if so, what is that number?

>> KEVIN HANCOCK: Depends what is available in a Kevin area.

Minimum number of providers from my perspective will be enough for everybody to have a certain level of choice in a given area.

So, it really, really depends on how many providers in a given area and example would be say for example in a very rural area they may only have one or two nursing facilities.

You may not have an opportunity to have more than one or two nursing facilityless as part of the choice in the network really depends on the area.

>> FRED HESS: Just generalized on the area I do have five questions for you --

>> KEVIN HANCOCK: Are they related to the MCO questions.

>> KEVIN HANCOCK: Actually I'm not sure.

These are good okay.

>> PAM MAMARELLA: Okay.

So let's table that for now, until we can get through this I have a question

as it relates to readiness review.

You had mentioned there's a readiness review tool right now that the MCOs have, was that made public and have we seen that tool Kevin?

>> KEVIN HANCOCK: I don't think we made the tool public at this point. We, I guess has there been discussion at this point? I'm looking at Ratdy to be able to answer it.

>> AUDIENCE MEMBER: The decision is that's an internal tool between us and the MCOs it's not made public.

>> KEVIN HANCOCK: Just a really -- it's really --

>> PAM MAMARELLA: Basic tool.

>> KEVIN HANCOCK: Not basic it's pretty -- it's a technical tool that's probably part of the reason basically follows the policy of the requirements of the agreement however.

>> PAM MAMARELLA: Okay.

>> PAM MAMARELLA: Jack?

>> MALE SPEAKER: Is there a reason it shouldn't be shared?

>> KEVIN HANCOCK: Only reason, that we're basing it on it's a new program and it's quite possible through this process we just to be very clear, what we did was we adapt he had the tool that is used for the HealthChoices program included and put in our requirements as part of that tool.

The reason why we might hold back is because it might, the tool itself might evolve through this process, we may recognize some components we may need to add and for the term is I may say is change control, we

might add components -- we want to make sure we have a fair process with the MC Os at the same time we know we're a new ram we need a little bit of flexibility in the tool itself.

>> MALE SPEAKER: And I think the subcommittee understand the need for flexibility I think at the same time, the department has been almost from the outset very open and transparent in terms of this sharing documents I would encourage you to continue to do that and just as a follow-up, on readiness review the concept of any willing provider, how is that fitting in to -- can you talk a little bit about that, that has been an issue that was raised from the outset of the meeting as well with respect to any one provider being able to come that the network.

How is it -- how do you see OLTL, looking to manage that with the managed care.

>> KEVIN HANCOCK: We have with the continuity of care period that is built into the agreement, most providers for most services that will be for six month time frame.

That will be any entity, that is already an existing provider and also, on the existing service plan that is going to be transferring through.

When any willing provider in HealthChoices, applies to pharmacies, the pharmacy concept that is a very broad definition.

When we talk about any willing provider in community HealthChoices I don't think we're being as broad as that, except for during the continuity of care period.

However, we want managed care organizations to be able to manage

and control their own networks at the same time providing significant participant choice.

So there will be -- I mean, there will be a scope of time where people, where providers will be able to contract with managed care organizations through the process, but within the agreements, there's also provisions for managed care organizations to be able to manage and control recruitments and retainment in their own networks.

If you maybe ask a specific question about the specific providers it may be helpful for me to answer it.

>> MALE SPEAKER: I'm not talking about specific providers it's a general concept with respect to it I am aware there's the six month grace period so to speak after that, it becomes an issue what over sight the department have with respect to the MCOs to assure to be sure arbitrary decisions are not made with respect to network enrollment without specific facts I can't give you examples but it is I think, I'm just raising it to you as a concern I think it has been raised often, through the last several months, with respect to providers on home, consumers have relied for a long time, not continuing in the program.

So it's a concern.

>> KEVIN HANCOCK: I think I understand your question a little bit more I understand the concern as well.

The responsibility of the Department of Health and Human Services to ensure that minimum thresholds that the choice is maintained as part of this program.

In addition to that, we do have responsibility of the department of human services to also, ensure, not only our is some level of choice maintained but also some level of reasonable variety in providers also be available as part of the program.

I don't know how you define arbitrary.

But we if we believe there's network recruitments that some way is, arbitrary and is limiting choice for participants, in a way, we have the obligation to make sure that the MCOs are being more expansive when it comes to network development especially for this program, that's new especially tore the program there's an existing provider infrastructure that has to be transitioned as we go forward there's to question we have to have the responsibility for certifying for network accuracy through the process, participant choice is protected.

>> PAM MAMARELLA: Before I movie want to check there's no questions coming from the phone?

Okay.

Thanks Kevin.

>> KEVIN HANCOCK: Okay.

So -- then we'll move onto some updates for provider communication.

In April we started with our provider communication we sent out five specific mailings some are which are overlapping between providers and participants we sent documents related to OBRA, as people know, OBRA will continue after community HealthChoices goes live however, through this process, OBRA has a specific criteria for the way that people are

able to being assess the services through this process we're going through and going through a reassessment of the participants to make sure they're in the right program we sent out communication to providers about this coming our way to the service coordinators in the area agencies on age we'll be sending out letters to the participant in the never future to let them a separate process is going forward in this process will be going by the, CHC phases which means that the first set of letters that will be going out will be for the southwest participants for OBRA.

In addition we'll be sending out information to home care providers, specifically, in May and, we'll as I mentioned in May we will be mailing out letters to OBRA participants in the southwest regarding the LCD assessments in -- well, going through many of these please stop me and ask me if you have any questions.

Okay.

For June, we'll also be mailing letters to the OBRA participants not found to be nursing facility clinically eligible through the reassessment process and the nature of the letter will be that they will be staying in the OBRA program which is not changing.

The this July we'll be sending out the initial mailer for CHC participants we're calling it a mailer, it is a flier it's basically an introduction to community HealthChoices that community HealthChoices is going to be coming their way.

And -- it will provide a telephone number where people can call and ask questions.

During that same month, July we'll be hosting or -- out reach events taking place specifically for the what we call the healthy dual, people who are not nursing home clinically eligible this will let them know what is coming and what it means to them.

Nursing home facilities will begin CHC communication that same time and service coordinators will be getting that at the same time as well and, COMMCARE participants will be referring a notice, to on let them know that they will be moving to independence and the reason why, if you remember, is we're actually using what is the COMMCARE waiver we're repurposing to be the CHC waiver 1915C waiver for community HealthChoices, so everybody has to move to a different waiver and we have already changed independence to be able to accommodate the services they need.

That may not have existed with the independence prior to that change.

And then in August we'll continue the out reach efforts and just a point our partners in the process we've been in communication with aging well, and aging well has been part of the conversation to help us plan out these activities.

And in August, in addition to these out reach efforts, attendant care independence participants age 18-20 will be notified they will be moving to OBRA.

If you remember, the community HealthChoices is a program for people who are aged 21 and over.

So the people who are currently in waivers, that allow for people who are

18 through 20, are going to be receiving the notification they're going to be moving to OBRA because OBRA will be the waiver that is the -- will continue for populations outside of CHC unless, of course, they like to enroll into the LIFE program.

So that brings us up to August, September things start really start to ramp we start send the pretransition notices to the participants it will be much mother specific to the enrollment process for community HealthChoices. And October we'll continue pretransition notices if individuals weren't captured in the September mailing, the independent enrollment broker will be managing these pretransition activities continue with calls and other types of mailers to make sure people are given broad opportunity to be able to select their -- Yes, sir.

>> FRED HESS: Yeah Kevin will the member of the subcommittee be able to review and comment on the -- if so, and when.

>> KEVIN HANCOCK: It's my understanding they will and it's also my understanding since we know the date it will be developed very soon you can expect that you'll be receiving those participants will be receiving -- participant representatives will be receiving those mailings to be reviewed, within easily the next six weeks to two months.

>> FRED HESS: Are you going to email those to us or is it going to be here in this room I would like to have time to study it myself.

>> KEVIN HANCOCK: I do not know the answer to that question I will kick that back and reply to you.

It will either come most likely come before the next meeting.

So the next one.

>> FRED HESS: I'm hoping so we can review.

>> FEMALE SPEAKER: Kevin can they be emailed to us if we can't be in person?

>> KEVIN HANCOCK: So we can still, see and give you comments on the written documents?

>> KEVIN HANCOCK: To answer your question literally they absolutely can be emailed to you because they will be a document that some sort of a document.

I just want to make sure, that I am articulating correctly the process for the review so that I am not making other people who are involved in the review more directly have to adhere to what I'm saying.

[laughter]

>> FEMALE SPEAKER: Okay because like sometimes I won't be able to be here in person but it doesn't mean I can't edit something.

>> KEVIN HANCOCK: I will state this, this way Tanya, what you're asking for is completely reasonable.

>> FEMALE SPEAKER: Thank you.

>> KEVIN HANCOCK: You're welcome.

[laughter]

>> KEVIN HANCOCK: So I don't how that happens.

So the moving onto.

[laughter]

>> KEVIN HANCOCK: Moving onto, just the last part about the OBRA,

letter is going to be mailed to the participants participating in the zone 2 about the LCD assessment what that means is that, we have to begin there's going to be a lot of overlap especially in the fall between activities associated with southwest implementation and the ramp up for the southeast implementation there's a six month time period.

So we'll be talking a lot about the southeast this fall to be very clear because it's coming very soon and population in the southeast is four times as large actually as the southwest.

So we have to pay very close and rapid attention we'll be talking about readiness review in the fall for the southwest in great detail.

And in November, just to be clear that's when the transaction actually takes place some additional transition notices will go out and then we'll also be mailing some additional letters.

So it's going to be very active from this point forward when it comes to participant communication and provider communication any other questions about that before we move on.

>> PAM MAMARELLA: I have a couple of questions when you say in November we'll start the transition, what point in time do we actually ask a person to make a decision about which MCO or the LIFE ram.

>> KEVIN HANCOCK: Starts after the pretransition notice in September.

>> PAM MAMARELLA: September we're going to start to get an idea of where people are?

>> KEVIN HANCOCK: Yes.

>> PAM MAMARELLA: As far as what they want to do, so the once

months before that become more citial June you're to communicate --

>> KEVIN HANCOCK: What they need to do.

>> PAM MAMARELLA: They are ready to make that decision come in November.

>> KEVIN HANCOCK: This has been prescribed the mechanisms we'll use for that, will be the out reach activities for the healthy dual population and also service coordinators and nursing facilities will be asked to participate in the communication strategy for the participants who are receiving services either through home and community based services or through nursing facility services as well.

And just to be clear, throughout this process, it mentions it here they will continue to have out reach and communication to the LIFE programs as well as the LIFE participants they know how this is going to be he facting them, all the populations affected by the change will know how CHC is going to be effecting them and knowing where they're going to land.

Great question.

>> PAM MAMARELLA: Thank you.

>> KEVIN HANCOCK: Other questions?

>> PAM MAMARELLA: No.

That is it.

You covered all of them with one fail swoop.

>> KEVIN HANCOCK: Okay.

Great.

I just -- I always -- I'm sorry, to the transcriptionist I talk really fast I

apologize you're doing a great job.

Unless you're not understanding a single word I'm saying I wasn't looking at the screen.

[laughter]

>> FRED HESS: She is guessing.

>> MALE SPEAKER: It's been close.

[laughter]

>> KEVIN HANCOCK: Thanks Russ.

Okay.

Moving on -- to updates relating to aging well.

We had mentioned that aging will be our part there in process, hosting public education sessions and assisting participants in understanding CHC in a multitude of ways not the least of which is to provide education for service coordinators in the nursing facility staff on community HealthChoices.

Relating to MCO persons directed to OLTL we have a number of questions submitted for the MCOs and some of them will have to be responded by the department to be very clear.

But some of them will be responded to by the MCOs, little bit later in the presentation the MCOs are going to be presenting a little bit about who they are, and how they are going to be involved in this program.

And immediately after that, we'll go through some of those questions and the department will answer the questions, some of the questions that are relevant, more relevant to the program itself.

But the MCOs themselves will jointly be able to answer some of those questions relevant, if there's a need to get back to the group or to the committee that steps will be taken to make sure that happens actually we know the MCOs introduce themselves in the last meeting this meeting this will be the first time they are actually in a position to be able to present a little bit more detail about who they are, we're happy about that.
And last I think that we had committed Jill, is a director of provider supports she will be -- was to provide an update and follow-up about service definition we're doing a little bit more research on that topic shell be able to provide that information either through communication between now and the next meeting or at the latest at the next meeting.
With that that's my update, any questions -- more questions from me.
>> FRED HESS: Of course.
Okay now, what role are the consumers going to have in the quality plan, CHC quality plan.
>> KEVIN HANCOCK: I think that I'm looking for Wilmarie, that they have already Wilmarie Gonzalez please stand.
[laughter]
Wilmarie is going to be responsible for quality plan I think she is going to answer some of those questions when she does the presentation.
>> FRED HESS: Okay.
Now, OLTL issues RFPs for the independent enrollment broker.
When local financial management agencies transferred -- when we started Christian financial Fiasco and even with PPL, there were major

problems with -- bills not getting paid and tax not getting paid.

It is given to a different company or the independent enrollment broker contract is given to a new company, how does the OLLT plan, plan avoid the service interruption and payment interruption.

>> KEVIN HANCOCK: Great question.

I'll answer the financial management services question first and then, I'll go into more detail about the independent enrollment broker.

Financial management services we earlier this month we released a request for proposal and just this past week we had our preproposal conference with bidders it is very much a possibility that there could be a -- that's what the procurement process is for we have very strict requirements in the existing agreement with financial management with the financial management services entity to be able to provide transition activity we believe we built into the process now enough time for overlapping services between the two.

So, we have a lot of time to be able to test make sure that E some of the issues that are challenges that took place in the past will not happen again and we'll actually know early if there are problems.

>> FRED HESS: When we jumped to the question, it was like bam instantly that's why everything was so chaotic yeah I'm glad we're stretching it this time.

>> KEVIN HANCOCK: Lessons learned from past experience.

So the independent enrollment broker -- I'm sorry.

>> THEO: I have a question, when you have a chance Kevin.

Can.

>> KEVIN HANCOCK: Theo.

>> THEO BRADDY: I have a question when you're finished.

>> KEVIN HANCOCK: Related to financial management services might be a good time to answer it.

>> THEO BRADDY: Yes. It's RFP focused on statewide or going to be consistent with the managed care.

>> KEVIN HANCOCK: We have two lots in the RFP one lot I think is for for ODP specifically for services and we do have a statewide lot for OLTL related services.

So, it will be --

>> THEO BRADDY: It is statewide?

>> KEVIN HANCOCK: It is statewide.

There is a differentiation in the RFP itself between community HealthChoices and the legacy fee for program, that will have to continue. So we have requirements for both in the program.

Or in the RFP.

>> THEO BRADDY: So -- how is -- one more question.

>> KEVIN HANCOCK: Sure.

>> THEO BRADDY: How is the how is choice consumer choice, which is statewide.

>> KEVIN HANCOCK: For financial management services entity? Is that what you're asking?

>> THEO BRADDY: Yes.

>> KEVIN HANCOCK: Participant choice.

Participants have choice in their participant directed worker, consumer directed worker as we used to call it.

That choice will always be maintained that choice will be maintained, both in the fee for service program as well as in community HealthChoices.

So, there will be no change there.

With the State widen at this timity, since the State wide entity is going to be responsible for all of the overlapping services for financial management services the State wide entity in that administrative function will only be one entity so the participants will not be able to select the financial management entity, they will be able to select their participant directed worker.

>> KEVIN HANCOCK: Did that answer your question Theoo?

>> PAM MAMARELLA: We have Brenda.

>> KEVIN HANCOCK: Hello Brenda.

>> FEMALE SPEAKER: Theo's question about choice got to my answer I would like to make a comment I would like to see as we move forward a better process for consumers to register, Complaints with our, about the financial management service, and I would like it to be if possible, there's a second available if someone really has a problem with who the FMS is I think that while it's more important to have choice over who our workers are, and the model service we use, I think some choice with financial management services, is not unreasonable.

>> KEVIN HANCOCK: Duly noted and just in the planning process we took into consideration the -- we took into consideration what it would mean to offer, offer one offer for management services one thing I have to say is that while, there might be -- we are going to do everything we can, in perpetuity to protect participant's choice for their worker and the model of service as you mentioned Brenda, but -- there is an administrative burden meaning a cost associated with having multiple vendors providing financial management services we want to make sure those dollars are spent on services rather than administrative functions of the program.

>> FEMALE SPEAKER: I can appreciate that I just hope that means we're going to be very diligent in how that financial services provider is going to be provided since we'll not have choice.

They are more responsive to consumer needs than they have in the past.

>> THEO BRADDY: I agree with what she just said --

>> KEVIN HANCOCK: The expectation of the department you'll continue to hold us accounts on that, we always appreciate your input.

So we are also open to recommendations to make sure that we can always improve our over sight.

>> FEMALE SPEAKER: Thank you.

>> KEVIN HANCOCK: Hello James.

>> MALE SPEAKER: Just a good question, is there any discussion about additional registration or credentialing for direct care workers under CHC or enrolling with an MPI number.

>> KEVIN HANCOCK: There is discussion that's in the RFP itself.

>> MALE SPEAKER: Okay.

>> KEVIN HANCOCK: They will go through one of the requirements is that the financial management service entity will be required to as part of their registration process for the direct care workers they have to go through the Federal registry process for the national provider okayedor.

>> MALE SPEAKER: Would the direct care workers on the agency model side have to do the same? Or that will be strictly for consumer directed model.

>> KEVIN HANCOCK: Thinking it should be equal for both.

>> MALE SPEAKER: Okay.

>> KEVIN HANCOCK: Okay.

>> PAM MAMARELLA: Do we have anymore questions for Kevin?

Okay.

So thank you very much Kevin.

>> FRED HESS: Oh, I do --

>> PAM MAMARELLA: One more Fred we're trying to make sure we have time for the MCOs.

>> KEVIN HANCOCK: Sure I had to give a quick update to complete Fred's question about the independent enrollment broker --

>> PAM MAMARELLA: Quickly as possible.

>> KEVIN HANCOCK: So we released independent enrollment broker RFP April 7th we had an April preproposal conference we published questions from that proposal conference I believe today.

And proposals for that, RFP are due in late may.

The object for this independent enrollment broker we have just to be very clear we have 3 lots which means we can have 3 separate vendors for independent enrollment broker I think just, providing clarity on that, that is the way that the RFP has been structured.

The 3 lots, are by the phases of CHC not, by the zones but by the phases.

So the first lot is, for the southwest.

The second lot is for the southeast. And the third lot is for the remainder of the State.

And all three of those lots have responsibilities not only for continuing enrollment in the legacy fee for service program but also, pretransition activities and ongoing enrollment for community HealthChoices.

That is -- a lot of responsibility and there will be a lot of land off overlap between the existing agreement currently held by Maximus and the roll out for the independent enrollment broker by lots, for the new agreement.

I wanted to let you know. And we talked about transition activities right though, it's based upon the time line we're hoping to have anywhere from 4-6 months overlapping activity through the transition between the new vendor or vendors that may be identified through this procurement process, and the existing vendor.

>> FRED HESS: Okay I'll have more questions for you afterwards.

>> KEVIN HANCOCK: Sounds good.

>> PAM MAMARELLA: Okay thank you Kevin, thank you Fred.

Next on our agenda is Wilmarie Gonzalez and Paul Saucier to talk about the quality plan I'll ask them to keep to our time line allowing MCOs to come up by 11:15, if possible.

>> WILMARIE GONZALEZ: Good morning.

Good morning, everyone.

I'm Paul Saucier, this is Wilmarie Gonzalzez,.

[laughter]

I'll try to make my comments brief.

Is that -- it's up, okay.

Good.

So I'll go through this very fast you know for the past year we've talked a lot about quality and there were a number of third Thursday webinars presentations here at the subcommittee as well as a number of discussions and engagement with various associations we've heard a lot about concerns about quality and so we have time and time again have committed that we were going to be apart of the quality plan for DHS with regards to community HealthChoices and so wanted to make sure we walk through really quickly, what the quality plan actually looks like.

Keep in mind that what the quality strategy plan accomplishes two things -- one is to monitor the services provided to participants, the other is improving the over all quality of the actual program.

Last week OMAP rented the quality plan at the MAAC meeting and they gave a very over all view of the quality plan they announced that the draft of the plan is available now on the DHS web site under HealthChoices

plan, so it's there, it's available.

Next slide.

As many of you know the HealthChoices program is a mature program in Pennsylvania for community HealthChoices many of the processes and policies and things that have been in existing in HealthChoices we've adopted for community HealthChoices which makes sense.

CMS requires that every state has a quality strategy plan.

So obviously for Pennsylvania community HealthChoices wanted to be apart of that.

It is a technical development that's a requirement by CMS.

It is where CMS wants to make sure that states are following high quality and efficient health care for participants, receiving services in the managed care environment.

The quality strategy is a requirement by CMS it is, we're required to update it, every 3 years unless significant change needs to occur.

So, today what we want to do is give very high level overview of what the 200 page document actually looks like.

I know.

Next page.

So the quality strategy is being updated mainly for 3 different reasons.

Mainly for today's discussion we're really going to focus on community HealthChoices it's introducing and including community HealthChoices within the plan.

So, for today, we're going to walk you through rather quickly, many of the

sections within the plan.

Next slide.

And again, we where focusing on community HealthChoices today, so, community HealthChoices, as many of you know is a new initiative that will be used managed care organizations to coordinate physical health and long-term care services and sort for older adults, persons with physical disabilities this Pennsylvania and those individual whose are duly eligible for both Medicare and Medicaid.

Next slide.

More importantly, as many of you know we have been you know reiterate we have been very transparent in sharing of all of the different things that we have been doing to design community HealthChoices, with always the ultimate goal in ensuring that we are focused on the five main goals for community health choice so they are listed on this slide.

Just to make sure that we are all sort on the same page what we're trying to do, with the quality plan in the community HealthChoices portion of the plan.

Next slide.

Starting on page 54 the plan, like I said it's over 200 pages there are a number of Appendces supporting the document starting on page 54, community HealthChoices OLTL basically describes the background of OLTL we are responsible for community HealthChoices, CMS wants to know you know, where is community HealthChoices? How are we operating? Administering and providing oversight.

We provide an over all background of OLTL.

We also provide CMS with a history of HealthChoices from the beginning concept paper to the draft RFP, to the draft agreement and so we give not only that we also identify the goals of the plan, we list designated zones for community HealthChoices.

We also share the implementation time lines and phases. And so again, they want to know, what are we doing with community health choice once we go live?

Very important I know many of you are are very interested is making sure that we are defining how we are monitoring and ensuring that MCOs are meeting compliance and are meeting performance measures so we identified at our very, very high level the various activities that we have already put in place for readiness review, as many of you know, there are layers and phases of prior to go live date.

You all know that Randy Nolenz, if you have any questions, Randy is over there.

He is the lead for readiness review.

We talk over all, what we're doing with readiness review so that MCOs are meeting all the requirements up until go live date.

We do mention about launch monitoring we have already touched on that in previous meetings where we talk about early launch we'll talk little bit more about that.

We also give a brief description of the steady state ongoing, what do we do once community HealthChoices goes live? And so once readiness

review is complete, what are we doing with regards to ensuring that MCOs are meeting all the requirements within the contract?

And then lastly, and again you have heard a lot of updates through all of the various communications and vehicles used is the independent evaluation.

As many of you know we have already reported the Medicaid research center at the university of Pitt is the organization leading that charge.

Next slide.

And then, I don't want to miss out on mentioning external quality review it is a CMS requirement.

If you're operating a haddinged care program, you must have an EQR.

The EQR role is required under CMS and there are a listed validating performance measure and counter data and interaction between the MCOs it replace the claims we receive in the fee for service environment this is all very high level.

But for I'm going to turn this over to Paul now Paul will walk us through 3 critical pieces of the plan which are the Appendices Paul will one us through what the key ones are to support the community HealthChoices.

>> PAUL SAUCIER: Thank you Wilmarie.

So next slide.

So we'll go to appendix M.

Okay.

Good.

So it is a big document high level document one way that OLTL was able

to include some detail in it was through use of Appendices we encourage you to look at them there are a lot of Appendices in the documents, 3 that specifically relate to CHC and so appendix M is the first one we draw your attention to.

It describes 16 standards that the CHC/MCOs have to meet in their quality management and utilization management program.

So if you want to know what they're required to do and have, in those areas, take a look at appendix M.

It mirrors language that is in their agreements so these are standards that they have to meet both to demonstrate for launch and then, ongoing.

Just to give you air flavor of what it includes, but it includes a lot more than this, it talks about a comprehensive annual quality management plan that they have to submit and keep updated and evaluate from year to year.

It describes the minimum infrastructure they have to have, in terms of leadership staff information systems that would enable them to monitor quality.

They have to have written QM and UM policies in place.

They have to have mechanisms for health row motion and for monitoring and treating chronic conditions which implies they have to know what chronic conditions are in the membership for example.

They have to be able to show how they're going to promote coordination across the board.

So a lot of dual eligibles in this program, how do they coordinate with

Medicare? How do they coordinate with the behavioral health management organizations and so on.

They also have to provide their participant rights and responsibilities statements which have to meet state standards and show how they're going to employ that to every member and also to their provider network.

So that gives you appendix M is the sort of the core meat of what they are required to do.

Going to appendix N.

You've seen pieces of this before.

This is what many people have shown interest in and it is the performance measures that will be used in the program over time.

So there are 3 broad categories, national measures which we have talked about before, these are nationally validated measures that are broad use across the country they are preferred by Pennsylvania and many states because you can compare to other states and other programs.

So HEDUS is a set of measures adult measures.

The CMS adult core measures are largely derived from HEDUS but with a little bit of variation.

The CMS nursing facility measures and then, 3 different CAHPSS tools, Kevin mentioned the CAHPSS HCBS which will actually survey people receiving waiver services every year in addition to that, they will eastbound a CAHPS nursing home survey and a CAHPS healthth plan survey for all members and then, finally there will be OLTL is starting to receive performance information that DSNPS are submitting to CMS that

is going to be submitted as well there's not a lot of detail on what those measures are in the appendix because they're all maintained by national organizations, so, what we provided is the links to the measure U.S. can go through and get as much details as you want they are maintain and the State measures are what we would really like some feedback on. These are areas in mostly OLTSS where there are not many, or any nationally validated measures, so states are having to create their own. Pennsylvania has looked extensively what other states have done in is proposing a bunch of measures many of which have been adopted by other states and some of which are very specific to Pennsylvania so do take a look at these, my recommendation is that if you're trying to figure out where to spend your time look at the state measures and give us some feedback on those, that will be very helpful.

These are going to cover most of your LTSS services, how they're provided, the balance between community services and nursing home services, the service coordination measures et cetera I think people will be particularly interested in those.

Then finally the third category we're calling launch indicators they're not necessarily, measures, because technically they might not have a enumerator and denominator, those are really critical for program launch. Before we have -- so the national measures for example those measures are done once a year.

We don't want to wait a year to figure out if this program is going well right?

So the launch indicators are going to be mostly weekly data points that OLTL can use to assess whether this program is operating the way it should. And, with a very strong focus on continuity of care so our people are continuing to get services during the launch? And are providers continuing to participate and be paid for those services?

So those will be of interest as well.

That pretty much takes care of the measures and then finally, moving onto the third appendix O.

This is a a compiletion a give you a flavor the MCOs are going to be submitting dozens and dozens of reports I don't want to give people the wrong impression these are the only things that MCOs are submitting.

But this appendix focuses on access reports.

Reports related to access of services which is critical it gives you a flavor what those are.

For example, monthly provider files there was a long discussion earlier today about how will state will know if the network continues to be adequate.

The State will get files every month on the provider networks so they will be able to detect changes see whether, the number of providers is declining and so on.

And counter data, is what replaces claims in the system and, that will be come understanding monthly as well.

So the State will know every service that is provided, every month.

And, again, can compare that to what was provided in the fee for service

to see if certain services are going up or down.

Complaints and grievances with participants in those that may be related to access people complaining about not getting the services that they want.

And then finally, denial log which is, MCOs are going to have to report to the State every time they deny a service.

So that again the State can monitor whether you know are those denials appropriate? They very will may be, if they're not appropriate the State will be able to further investigate that.

A lot of information for you all to look at.

And we're really looking forward to any input and feedback that you have.

>> WILMARIE GONZALEZ: The last slide thank you Paul the last slide that we have is really the time line that I just wanted to go over.

Right now, as I mentioned before, a draft plan is available on the web site that we provided a link for for easy access.

OMAP is receiving comments on the draft plan.

We are planning on doing participating in the may 18th Thursday Thursday webinar we'll continue to have the conversation and continue to talk about the quality plan.

Particularly the CHC portion.

There will be -- our goal will be to publish on the PA bulletin some time this month we're hoping crossing our fingers we'll be able to post the draft plan on PA bulletin for a 30 day comment period that's coming in the meantime I want to encourage you all just like Paul said is, if you have an

opportunity review the plan and, remember this plan is to monitor the services for participants, and improving the over all quality of the program.

One of the things we want to do, besides the webinar that is coming up we want to continue to do stakeholder engagement.

Something at these meetings and comments we heard through the webinars we have heard many clear many of you want to be apart of the conversation.

Not just sending you know a plan out getting a comment making sure we're engaged.

We're planning on having a meeting on the southwest, to do that stakeholder engagement.

We will be posting information on the CHC web site as well as the detailed information on our email notices on the Listserv we're also planning in the month of -- end of May early June in the southwest, to do also some more stakeholder meetings as well.

So more to come on that. And I think, I have two minutes.

>> PAM MAMARELLA: That was brilliant actually.

Thank you very much.

Do we have some questions, Jack and then, Tanya.

>> MALE SPEAKER: First of all very well done. And I look forward to reading all the Appendices, could you go back to page 5 on the your slide presentation?

>> WILMARIE GONZALEZ: Program goals.

>> MALE SPEAKER: This is just more of a comment if you look at the last point increase the efficiency of health care by reducing preventable admissions those are obviously worthy goals.

I just want to urge the department that in looking to assure access in quality, in terms of -- looking at all of the responsibilities on the MCOs which of course, will go down to the providers as well, there is a responsibility to assure the provider payments align with quality and access.

So I just urge the department to in negotiating the contracts it is not going to be hands off going forward.

Because all of that aligns.

You can't expect access and quality without looking at what are the payments? They really all do align I just urge the department to keep that in mind.

>> WILMARIE GONZALEZ: Thank you.

>> PAM MAMARELLA: Tanya?

>> FEMALE SPEAKER: Yeah. My question has to do with like over all functionality and how the MCO system is going to work.

When you mentioned something about like denial of a service from the MCO.

Right now my understanding of how things work is this -- it's okay if your insurance denies you let's say a piece of equipment, or something you might have a way to be able to get that same piece of equipment through your waiver services without necessarily using your Medicaid insurance

or you can get it, through services my way eventually if you're on that particular waiver.

My question it's been this way since the beginning, and it still remains is if the MCO is controlling all parts of this, where does that differ.

Where does that differentiation, come in so the consumer can still ultimately get what they need?

>> PAUL SAUCIER: I think I guess the way I would respond to that is, the MCO is going to be administering parts of the system that the department delegates to it, right. And ultimately for the consumer the fall back is the appeals process.

So if you have just exhausted, complained to the MC occasioner they don't agree you ultimately have access to the fair hearing process and that's how you would ultimately get back to the State with your concern.

>> FEMALE SPEAKER: I get that part of it.

But right now, there's a differentiation, Damn word --

>> PAM MAMARELLA: We got you.

>> FEMALE SPEAKER: Differentiation, between waiver money, and, your insurance money.

If there is -- is there still going to be a differentiation in the funding for the consumer to still be able to make a choice with equipment or a certain service if it's needed?

>> KEVIN HANCOCK: Are you talking about services my way Tanya?

>> FEMALE SPEAKER: Yes. Partially but there's also like, like -- home lines for example I don't think right now, you go through your insurance

company to get home Mod made.

How like -- how are all those functions going to be carried out.

>> PAM MAMARELLA: Kevin do you want to come to the microphone.

>> FEMALE SPEAKER: It might -- it might not actually be a quality question specifically.

It's a question that I've been trying to get, answers for over a year now.

>> KEVIN HANCOCK: Okay.

So to make sure I understand the question Tanya you're asking how will services be managed in CHC like home modifications or even budget control transportation et cetera how they're managed in the fee for service the biggest difference there's a lot of -- right now, we have a service plan in the fee for service system, that is added by your service coordinator or depending upon the type of services you receive. And those services are approved by -- through the review process by the departments. And then when claims are submitted for the services then the claims would be paid.

If they're not approved, you would of an opportunity to be able to appeal that decision.

It's considered to be an adverse decision.

You'll be able to challenge whether that decision was appropriate or not.

Managed care the process is pretty similar except the difference is that, in the beginning of the process, instead of just having a service plan that delineates the services or identifies the services that you're supposed to be receiving, there's a person centered planning process that the MCOs

are going to be conducting, the person centered service planning process is going to establish on your service plan or your person centered service plan what services you agree and your team agrees, that is required to be able to manage your care requirements.

And, the managed care plan will be responsible to once that service plan is identified to be able to pay for those services to pay for the services that are agreed to in that person's services plan.

The biggest difference between the two systems number one, there's a lot more in managed care, because it's just a better feature of managed care compared to fee for service.

Managed care there's a lot more participant engagement in the way that service plan is designed and than what you would see right now.

Because there are a lot of like -- the participant is a key and central voice in the way that service plan is defined in many ways the participant is leading that process.

The other consideration is that, the managed care organizations have a different -- have a much more direct relationship with the network of service providers that are actually providing those services.

So the managed care organization not like fee for service, where the providers are enrolling directly with the department to be able to provide the services or the Medicaid program, there are also the providers have to enroll in and be qualified by a managed care organization and the managed care organization in controlling that network and in doing quality over sight and utilization review with those providers they have a

more of an opportunity for more improved quality over sight.

So the process itself will work in many ways the same but the two points that are really different are the person centered process and the over sight the managed care organizations have over that network.

Those services are still eligible the program has still home modifications we didn't take any services out of the community HealthChoices all those services are still available.

It's just the way that those services are planned for and delivered by the provider network is different.

>> FEMALE SPEAKER: In that, that's what I'm concerned about is what -- how is it going to all function? What is the functionality of it going to be?

And how much time are consumers going to be given to learn the functionality of a completely new process before they just have to choose which MCO they're going with without knowing all the information up front.

>> KEVIN HANCOCK: Great question the reason we have the education and out reach process we talked about prior to going live by phase with CHC that's one part of it.

The other part of our allowing participants time to understand how the process is working is through this continuity of care period we have six months after the go live for most services or you know, minimum for all services where participants will have six months to adjust to the new flow for how those services are going to be approved in managed care that's

the reason why we didn't, the six month continuity of care period.

>> FEMALE SPEAKER: Don't kill me that brings up one more question.

[laughter]

Who is going to -- like I understand that the service coordinator, service coordination agencies, that we have now, are still going to be in effect for another six months.

But who is really helping the participants figure out, the functionality of the new system if it's not going to be the same service coordinators and everything that they previously have had.

Because no matter when you start this process or how you start it there's still going to be a need for an incredible learning curve in there.

>> KEVIN HANCOCK: Sure the service coordinator for the continuity care process will be part of it.

The service coordinators will be receiving significant training.

We talked about aging well providing that training to service coordinators.

Service coordinators will be familiar with community HealthChoices by the time each of the phases goes live.

So service coordinators will know what community HealthChoices is and how it's going to work for participants.

In addition to service coordinators, the managed care organizations themselves will have a responsibility to be able to make sure that, that any questions participants may have and how this changes is going to be effecting are answered and, we will, as the department as the Office of Long Term Living continue to have that responsibility as well.

>> FEMALE SPEAKER: Good I'm just hoping that everybody sitting here at the table and in the audience understands just how big of an undertaking that part is actually going to be it's not going to be something you're going to be able to get, consumers or even service coordinators or MCOs to fully understand the significance of everything playing all together in one like round sphere is how I'm envisioning an MCO working is going to take a long time to be able to build a solid trunk a solid concrete service plan for an individual consumer and for them to fully understand how to function in this new system and that's why, okay, I understand things are moving along maybe as fast as they can.

I don't know.

But the sooner, you can get the information about the providers, the information about the types of MCOs about the types of services about the types of service coordination out there to the consumer, the better off, everybody is going to be.

Because -- I'm just.

>> KEVIN HANCOCK: We agree very strongly.

>> FEMALE SPEAKER: I'm afraid what you're going to have is one heck of a mess if this stuff isn't done in a right type of time line to give everybody even you guys enough time to make a necessary adjustments.

>> PAM MAMARELLA: Thank you Tanya --

>> FEMALE SPEAKER: You're very welcome.

>> PAM MAMARELLA: William do you have a question.

>> MALE SPEAKER: Bill white from AARP I'm sure it's tucked in the 200

pages or some other paperwork somewhere -- I have not heard any mention of licensure certification, independent accreditation because all of those things are very, very important for quality indicators.

And you don't want to send one of my constituents to a nursing home which has a provisional license, for example at least that would be my assumption.

So gist keep that in mind that there's all these other accreditation and licensing organizations that are really good indicators of quality.

Thank you.

>> WILMARIE GONZALEZ: Thank you Mr. White.

>> PAM MAMARELLA: Thank you.

Okay.

>> MALE SPEAKER: Sorry can I jump I appreciate all the work has been done on this.

And -- I brought it up before the work force indicators I'm not sure if they're -- I mean, if you didn't have time to go through the wholly would be interestedded to learn more about that because few reasons one is obviously that along with what Jack was saying alignment with access, alignment and the quality of the work force has a huge impact on achieving that goal. And, then also you know, part of the advocates to build the case for the need to have adequate rates to you know providers. We need the data.

And you know we have some of it now not enough of it I am hoping through this process we can be able to build out the data that will help us

to continue to build a strong case about the need to have adequate rates for the work force.

>> PAUL SAUCIER: I would point out there's a place holder I think, you'll see in the appendix folder for work fors measures theres no detail we've been working on work force measures definitely.

>> MALE SPEAKER: Okay.

Thank you.

>> PAM MAMARELLA: Thank you.

Okay so without further ado, Kevin are you going to join us back in the front again?

>> PAM MAMARELLA: Okay we'll hear from our 3 MCOs.

And I think for sake of space, we have some microphones along this row, they can come to those microphones next to Ray.

Okay Kevin just asked me if we had an order for the MC works to come up?

>> KEVIN HANCOCK: Did you have a conversation prior?

>> PAM MAMARELLA: Are you from -- AmeriHealth --

[laughter]

>> PAM MAMARELLA: There you go.

Okay.

We'll do the alphabet cat why don't we start with by having introduce themselves and then we'll start with AmeriHealth after that, I've asked Kevin to help facilitate this portion of our meeting today.

>> KEVIN HANCOCK: We'll start with introductions.

>> MALE SPEAKER: Chris Barret AmeriHealth Caritas.

>> FEMALE SPEAKER: Tiffany Earl, manager LTSS.

>> FEMALE SPEAKER: Sharon Alexander, the president of the center of cleans.

>> RAY PRUSHNOK: Ray Prushnok, UPMC health plan my role is the associate vice president leading the product and operations business side for the community HealthChoices,.

>> KEVIN HANCOCK: Also a member of the committee you have not noticed before.

[laughter]

>> MALE SPEAKER: Jacqueline Smith clinical operations for UPMC.

>> JOSHUA SLOOP: Joshua sloop.

Pennsylvania Health and Wellness I'm president and responsible for the program.

>> KEVIN HANCOCK: Thanks, so I guess AmeriHealth Caritas we'll start with your presentation.

>> FEMALE SPEAKER: Sure.

Thank you good morning.

Still.

And I'm Sharon and, I appreciate we all appreciate I'm sure the opportunity to be here and you know the good work that the department has done in getting us to this point. And certainly appreciate the real incredible valuable feedback that we're hearing from consumers and stakeholders. And we hope that we can have that really rich dialogue as

we head towards implementation of this initiative throughout the State.

So just a little bit because I know we're a little bit behind on time so I'm going to -- it we can go it the next slide.

I'll give you a brief overview about AmeriHealth for those who may not know who we are.

Very, very quickly, we have been in the managed Medicaid business for over 30 years.

Our roots were actually as part of a faith based ministry work out of the west Philadelphia area in collaboration with the sisters of Mercy where we saw early on this those times vulnerable populations not getting access to care and that was sort of the early origins of the health plan and the work we do with vulnerable under served populations.

We have since grown over the decade.

5.7 million members in 16 states.

In the district of couple bee a, we can go to the next slide.

Our our mission is to help people get care, stay well.

And build healthy communities.

We have over 6,000 associates.

The majority are in and around Pennsylvania.

But as I said we do have other lines of business in other states and we obviously employee plenty of individuals in those states.

Go to the next slide.

Our footprint to give a visual for those of you it shows where we do have our presence.

Primarily in the eastern half of the States and we -- some of the work that we do out in the western portion of the states is really associated with our pharmacy business.

You can go to the next slide.

And to that point, we are able to offer an integrated care approach through some of our sister companies that are associated with AmeriHealth behavioral health organization, our pharmacy business, many of you probably know of Peror care we serve 250 to hundred 3,000 individuals in Pennsylvania, through our organization will and will be coordinating the work with our sister company and the others, in the Commonwealth to serve individuals who have behavioral health issues.

We also have NCQA accreditation of the organization.

Our pharmacy company as well, provides not only foundational PVM services, pharmacy benefit management services but also specialty services as well.

And they're based in Philadelphia and we do serve many clients outside of the Commonwealth as well.

The next slide.

What's really relevant to this experience here though is the work that we do right now in LTSS and with individuals who are duly eligible. We operate DSNPS here in Pennsylvania right now, primarily in the southeast portion of the State.

They do serve individuals with both Medicare and Medicaid needs in advance of this effort, we have been coordinating our work with the AAA

community here in the Philadelphia area.

I look to my colleagues from the AAA network.

So we're kind have been honing some of our practices in advance of the roll out of this program to see how best to provide a better continuity of care and coordination of those individuals.

We also serve individuals through our financial alignment demonstration programs in two states, Michigan, South Carolina where again, we serve individuals who are both Medicare and Medicaid eligible and the LTSS services are part of that service package.

So we're accountable really for understanding what the individual's needs are and providing all the services and supports they need.

To meet those needs.

So the next slide.

This just shows the work that we have done in speaking of the quality aspects and the maintaining excellence on certain of the NCQA is one way to sort of show the good work that happens this health plans.

We have reached those accreditations standards for our health plans we have achieved multicultural health designation which is a very nice recognition we have.

We're also a early adopter for the NCQA LTSS standards as well.

We're commencing work on that front.

The next slide -- the next slide after that.

The point I want to make here and I think this is to what Kevin and I appreciated the comments that were made about real our model care and

our person centered approach.

You know, this -- these programs and, we know this work from some of our experience in the other states, we have a very high touch model of care.

We build trusted relationships with our members.

They are very -- intimate, they're intimate, integral. And they make a difference in the person's life.

And that sort of foundation to what we do makes all the difference in the world.

We you know, we assess individuals needs we have an understanding what their priorities, what their priorities are, what their priorities and their goals are, that's what sets the planning process.

And those are the things that we capture we work with not only the individual but also their family if they so choose.

We work really hard, we train our care managers we work with community based organizations to ensure that those values are here too I think that what really drives it is you know, ensuring individuals have what they need so they can maintain their independence in their homes and in their communities.

Next slide.

We talk quite a bit about the provider community today and, we have Chris here to answer any questions, but we wanted to acknowledge the really important relationship that we intend to have with our particularly LTSS network that we're looking to develop obviously in the southwest

and in the rest of the State.

We have dedicated teams who will work hand in hand with providers who we understand have -- this is all new to folks.

And to make sure that claims are paid accurately and timely.

We understand that that's you know this is going to be a new process.

So we are investing in the people and in the processes and the effort to make sure that those issues are addressed up front.

We'll have you know, statewide meetings be available in person we'll have forums all kinds of things we can certainly discuss we wanted to just really emphasize the -- we have certainly recognized the provider communities is an important partner.

Next slide. And we have other mechanisms to communicate with us through our email addresses and we have one set up that's here on the slide deck that you can take note of.

And then finally on the last slide are our key contacts Patty Wright, who is on the phone with us today, not here on site she is, overseeing our day-to-day operations in the team she a great colleague and we're thrilled to have her and Chris will be talking more about the provider and Tiffany can help us answer any of the service coordination care manager questions as they thank you.

>> KEVIN HANCOCK: We'll move in view of time to UPMC.

>> RAY PRUSHNOK: All right.

Hello everybody -- all right.

To start things off, just a little bit about UPMC I'll dive into our approach to

community HealthChoices.

And first we are head quartered in Pittsburgh Pennsylvania we're part of UPMC which is the integrated delivery system.

We have over 30 hospitals and 5,000 physicians as part of our parent entity and UPMC health plan we have about 3 million members across workers compensation, commercial insurance, about 400,000 HealthChoices Medicaid members and we serve almost 170,000 people with Medicare. And within that Medicare population we serve about 24,000 individuals who are dual eligible.

And that will be you know, I think in the very exciting way, integrated in with long-term services and supports that provide great opportunities for the MCOs as well as participants this the program to better coordinate care and drive outcomes.

So now to the next slide with the over all goals that the Commonwealth put forward I don't need to run through the goals specifically.

But one of the areas that we want to highlight in terms of the RFP response and general approach to the community HealthChoices program refers around our innovative community relationships to enhance relationships for community living as we have worked over the course of the last you know decade or more in DSNP we through that have built very close relationships with some of the service coordinators that operate in our market today have begun significant amounts of coordination across the Medicare services and aligning those with long-term services and supports.

And we really hope to expand that as a strong community partner.
We also are very proud of our quality record in the dual eligible space. We are one of, very few four star DSNP's that say stand alone DSNP contract we've been able to achieve that in part of because of our coordination with providers, some with our own provider system where we have within able to experiment with a lot of value based payments that start with quality, so working with our provider network to reach quality goals and hoping to extend those practices and new ways to LTSS.
And additionally, to the integration of physical health and behavioral health as a part of UPMC health plans division we're a failated with community care behavioral health which is the largest behavioral health MCO in Pennsylvania covering many counties across the Commonwealth, and through that we have proudly had many cooperative efforts in including what we call connected care, where we have been able to set up consents with the measurements on the DSNP and Medicare side and being able to share information that help us better coordinate care cross the systems and lastly, our we're very proud of the analytics program and you know our diversity of clinical programs.
So next slide.
In terms of the service coordination model, the bottom part those are really the steps that are part of the program today and really you know some of the new pieces around the comprehensive needs assessment, it's really about helping people to live independently and have their

optimal quality of life. And doing that in a very person centered way.

We intend to integrate our technology across our on physical health and LTSS health platforms to really use that to identify opportunities to better coordinate services across the system.

And again, with the goal of providing services in the least restrictive and cost effective setting.

Next slide please.

In terms of our model and our differentiators that we, we are looking forward to implementing through this program, again, our expertise as a Pennsylvania plan, looking to really leverage the service coordination of provider networks that, exist in Pennsylvania today, we see, Pennsylvania is different than many other places in the investment that the Commonwealth has made over the years.

So working with many of those organizations and looking to further enhance quality.

Also, leveraging our SNP experience in Pennsylvania. And looking to leverage what we have learned as an integrated delivery and financing system.

We have extended those principles most of our DSNP members have a BCB that's not a UPMC physician but most of those members are still part of different quality relationships that we're excitedly looking to extend to the home and community based and long-term care space.

And in terms of coordinating our needs with partners and looking again for performance and value and, having partners that represent the

diversity of our participants, and addressing social determinants looking for housing, supporting unpaid caregivers and connecting participants with community resources.

Next slide please.

And in terms of our network approach, we're currently building our capacity.

All of us were in the process of I'm sure meeting our CMS deadlines as well for Medicare networks in recent weeks and looking to again expand current partnerships and expanding our relationships to identify high quality providers, providing technical assistance around quality issues, looking to support electronic Vise verification and training.

One major theme that appears throughout the draft agreement and the requirements is around accessibility that extends not just, to access to providers, and network adequacy but making sure that our providers are held to a higher standard and truly accessible to our participants looking at ways where we cannen senttivize our network to help us meet those needs.

Looking to again scale relationships and payment models to promote quality.

And our quality focus really will begin with contracting and looking for the high quality, lowest cost providers looking to move the principles to home and community based services.

Next slide please.

And in terms of participant feedback, we are looking at having 3 different

types of advisory committees and possibly you know a fourth around caregivers around provider participant and health education advisory committees.

And looking to private implementation having some focus group he's with some of our current members and doing some out reach, around making sure that our materials are you know ready for the go live and they're meeting our individual member's needs. And in terms of how we use that feedback and how we use some of the advisory structures today, we have a core team where we bring that information back in terms of reporting, share that across other departments importantly with folk that's are interacting with most closely with our providers and participants directly and ultimately to impact our quality improvement strategies.

Next slide.

And just to bring it you know, together again our model we are really looking to transform LTSS and have integration of medical care with social supports and looking to build upon partnerships and working with community organizations to address the barriers many of the participants of the program face and again, with all of this aimed at helping to keep people independent and help them return to integrated community settings.

And finally on our last slide, just wanted to include next slide please -- some contact information.

There's my phone number and email also our providers email box which has been on some of the fliers that OLTL has been distributing CHC

providers@upmc and also general inquiries you can reach out to the CHC@UPMC account that's all I have for now.

Thank you.

>> KEVIN HANCOCK: Thank you -- and with that we'll move over to Pennsylvania Health and Wellness.

>> JOSHUA SLOOP: Okay thank you good morning again.

Appreciate the opportunity to be here.

Slide two please.

And briefly, go over a little bit about who we are, how we're approaching the implementation.

Our experience. And also, how we would hope to continue to engage stakeholders.

Next slide.

So first of all we are locally head quartered we're just across the river in Camp Hill that's our office we also have offices here in Pennsylvania and Pittsburgh and Philadelphia.

Even though we are local we are backed by a national company, over 30,000 employees we currently over 11 million members and two international markets, next slide.

Here is really the core of what we're focused on now, with all of the work that needs to happen, with implementation.

We want to make sure that in that we accomplish two things.

Members get services and providers get paid.

That's why we're all here.

So everything we do, is and will be measured against those two metrics. Our members being taken care of, are they getting what they need when they need it? And are the providers who are serving them well each day, being supported and paid for correctly and timely.

Next slide.

Once we can assure and prove that members are getting services and providers get paid, then we move into other areas which are obviously critical.

Like quality and, transitions.

And as Jack mentioned earlier, aligning quality incentives is important. That takes time.

It takes work and we're going to need input from all of the stakeholders to make sure that we're focused on the right quality metrics that the payments are aligned and, it works so we'll be through the implementation period, working with and looking for key providers who are interested in working on quality and making sure that we set up those incentives appropriately.

Next slide.

Little bit about our experience -- even though we operate in 23 states, we currently serve 7 states for LTSS.

And a little over 200,000 members are receiving LTSS through our organization.

Which makes us the largest LTSS provider in the country.

So while we have experience, we don't know everything.

And we have never done this in Pennsylvania.

As CHC is new to all of us.

So we're going to be looking forward to working with all of the stakeholders to make sure that we make the Pennsylvania program successful.

And we firmly believe that health care is local. And what works in other states may not necessarily work in Pennsylvania.

And what works in Harrisburg or Pittsburgh or Philadelphia may not be one in the same.

So we want to make sure that we're focused on Pennsylvania and also the individual markets here as we partner with the local groups.

Next slide.

It's one thing for me to tell you how wonderful we are.

It's more important what our providers and our members say about us.

And so each day, you can see on the screen here we receive input from our markets for people that have been helped.

And that is our goal.

We measure our success, based upon the feedback we receive from our members and the care management support services service coordination, support services that we deploy each day.

And surprisingly the comments are actually not surprisingly, most people are not commenting how well our system is run or how great our processes are.

They talk about our service coordination.

They talk about our care managers and the people that help them and the people that talk to them on a daily basis and they endless amounts of phone calls on their behalf that's what really matters.

So yes we're focused on process.

Yes we're focused on claim system and care management systems.

But those are only there to support the people.

And so that's our focus as we go forward.

Next slide.

Next slide please.

Finally, we look to engage everyone in the community providers, consumers advocacy groups we're all in this together, how we will make this successful.

This is not a once and done process.

We don't collect information once and check a box.

This happens every day.

Good feedback, bad feedback we know we'll have challenges.

The way we resolve those is by working together.

We strive to listen.

We look to be held accountable to do that and we take that information we make sure everyone in our organization is aware of what is really happening in the field.

Because sometimes what we think is going on, may not actually be a reality the way we know that is by hearing from people like yourselves -- of what is going on and what our reality is.

And then we look to continue that process.

Okay.

I'll turn it back to you Kevin.

>> KEVIN HANCOCK: Thank you Josh.

So committee members submitted to Office of Long Term Living a series of questions, to pose to the MCOs the reason why, we decided to take this approach is to sort of make sure that all questions are, being addressed but at the same time, make sure that we're being considerate of the limited time we have involved.

So the way approach this, I'll read the question I'll randomly select an MCO to answer it first and then ask the other MCOs to -- to chime in.

>> PAM MAMARELLA: See if you can beat the question from -- answer from the person before.

[laughter]

>> KEVIN HANCOCK: I would have actually made this into a game show if I was more creative this morning.

[laughter]

>> KEVIN HANCOCK: So with that, the topic of the first two questions, am be the advisory committee which is requirement in the agreements.

And just also a note some of these questions have to be answered by the department.

So I'll be answering some of these questions.

Even if they proposed to the MCOs the department has to answer them you'll know, which they will be questions I'm answering.

So starting with the advisory committees what responsibility would a participant advisory committee have, and will concerns and suggestions be considered and will consumers receive incentives to participate as a committee member I'll defer this question to AmeriHealth Caritas.

>> MALE SPEAKER: AmeriHealth Caritas the advisory committees that we're looking to implement is participant advisory committee, number one is which will include our providers, participants as well, community stakeholders. And any of the family members or support group that participants need to participate or want to participate in these committees.

The committees as they evolve, will look at certain specific areas of interest and concern or topics that really are important to the individuals within that committee.

At that point.

So some of the lessons learned from from previous committees is that we're exploring opportunities of having multiple committees because if there's a different benefit package among individuals maybe someone doesn't have LTSS services having them in the same committee with individuals that do, that tends to take the focus away from, what truly, should be discussed at the meeting, you have individuals worried about, they have this and I don't.

So we have learned that over time, it makes sense sometimes to separate and have two different committees to address and have meaningful discussions surrounding the certain topics for those

individuals community well dual individuals will have different needs and, concerns than someone that is in a nursing facility or -- those are some of the things we've learned.

And we may look to implement as we move forward.

As far as taking feedback from the committees there have been several that come back through our organization here as well as past experience, one of the items that we discovered through committee meetings was barriers to obtaining labs and obtaining care, transportation someone would not go out to go to the laboratory came back was discussed.

One of the -- they worked through a contract agreement, to provide mobile Phlembotomy they can send someone to the home to do the lab draws to make sure the person was receiving the care they needed.

Another item, that was learned in the past is, individuals may not feel comfortable during the assessment sharing freely their concerns or issues that they feel some other people can over here.

So the care managers service coordination was implemented was a white noise so that, the conversation would remain private.

So that they would not have to be concerned over someone overhearing some of the things that might be going on, it was strictly confident between the service coordinator and care manager and the participant.

Incentives for joining and participating in our committees, that is something that we will obviously have to have.

As we said before, any incentives we're exploring that at the time there's nothing set in stone for that.

>> KEVIN HANCOCK: So clarification of that question would be, an example of an incentive will transportation be provided to the --

>> MALE SPEAKER: Transportation definitely will be something we would coordinate.

And, to ensure that we have participation, we don't want that to be a barrier to someone.

We will also be holding these committees in community settings, you know we'll be reaching out to our provider partners to see if you know, such as adult day care, you know, if they have a room or something that is more convenient for individuals to get to, so we will be going through and working together and trying to make this as easy as possible for everyone attend and participate we understand there's going to be some challenges where someone will have to participate via phone.

But we found that, face-to-face interaction has been the best for dialogue and feedback so that's where we're going to as we implement the committees.

>> TERESA CARAWAY: Thank you.

Do either of the two MCOs to add.

>> RAY PRUSHNOK: We would echo many of the same points in terms of the role of the board the boards is to make sure we really know what is happening and, to help us develop, improvements whether it's to benefits or network or processes that we perceive might be working and our services but really are not working on the ground for the participant.

And that I think we share the same you know basic outline in terms of,

making sure we're getting out to community settings and providing transportation and in terms of incentives like gift cards unthose are things we would work with the partner to make sure that is permissible.

>> KEVIN HANCOCK: Okay.

>> JOSHUA SLOOP: For Pennsylvania Health and Wellness very similar structure certainly the committees are critical, to the program success and, really serve as a formal mechanism to vet the informal feedback we receive on a daily basis.

>> KEVIN HANCOCK: Thank you.

I think we're going to make sure we get a chance to go through the all the question would be it okay if we held the questions to the end.

>> PAM MAMARELLA: Yes we'll need to hold the questions until the end.

>> KEVIN HANCOCK: We have a lot of questions so the next question relates specifically to durable medical equipments.

The question is what policies will be established for durable medical equipment providers? And this question will go to Pennsylvania health and wellness.

>> JOSHUA SLOOP: Well, first and foremost we're all providers.

Any willing providers we will look to contract with.

As far as policy and procedures and we will make sure we adhere to Medicare and Medicaid coverage policies and apply those accordingly.

>> KEVIN HANCOCK: Great and do any other MCOs have anything to add?

>> MALE SPEAKER: We'll continue to build upon the relationships that we have currently existing but with the DME providers expand that upon to make sure there's coverage.

The policies obviously, need to be submitted and approved through the readiness review and that will include all of our information there.

>> KEVIN HANCOCK: Okay.

Great so the next question actually is a question for the departments will the MCOs use any other fiscal agents in the agreement the MCOs have the requirements to use the fiscal agent contracted with the department of human services.

So, that is outside of their control.

So we'll move onto the next question regarding MCO relationships.

Would you explain your viewpoints on consumer care?

What can the MLTSS sub Maac do to ensure a smooth transition I'll send this question to UPMC.

>> RAY PRUSHNOK: It is -- this is one of those questions I wasn't really sure what was being asked to be honest.

But in terms of I don't think I know enough about the other MCOs model those explain our specific differences.

Consumer care is at the center of what we need to do through the program and extending some of the practice that's, we already embrace in our current program in preLTSS.

>> KEVIN HANCOCK: Sure a way to clarify the question, would be how would you highlight your model of care? What components of your model

care would you want to highlight, have an opportunity to highlight?

>> FEMALE SPEAKER: To highlight our model of care I would highlight the fact that we're on the ground face-to-face within the member's homes so pretty much everything we're doing is done in a person centered fashion.

I don't think that would be really any different than the other models but, that's how we figure we would differentiate ourselves today.

>> AUDIENCE MEMBER: Kevin can I remind the speakers to pull the mic close to speak clearly and loudly to those on the phone.

Thank you.

>> KEVIN HANCOCK: Thank you Pat.

>> KEVIN HANCOCK: For the people didn't hear we were asking the speakers to make sure that when you're answering the questions speak into the microphone and seek clearly because of the people participating on the phone.

Do any of the other MCOs they want to add or highlight at the moment?

>> JOSHUA SLOOP: Just for add Pennsylvania health and wellness I agree that, the person centered approach will likely, look very similar across the MCOs, as far as the question about how this group can help, I think, two things.

One is, the more information we can have and understand now, what is working and what challenges may be that will help us as we built the implementation and then certainly January 1 and beyond, ongoing feedback will be vital so we can make appropriate adjustments.

>> KEVIN HANCOCK: Okay.

>> FEMALE SPEAKER: In terms of the AmeriHealth Caritas I echo the sentiments from the other MCOs would encourage.

>> PAM MAMARELLA: Can we bring the Mic closer.

>> FEMALE SPEAKER: I thought it was pretty close I'm sorry.

Like I said I would echo the statements from the other MCOs, participant feedback is critical.

And as Sharon mentioned earlier we are high touch we'll be face-to-face meeting with the participants and, we look at the participants holistically and so we really want to draw in the folks that are important to the participant and that may look different for everybody but it is, our goal and our service coordinators role to understand who those people are. And, that they are, they are there to support them and work collaboratively.

>> KEVIN HANCOCK: Thank you.

Related question relating to MCO relationships, what will the MC Os, what would be the MCOs a roach or your approach to coordinating services and care with the behavioral health managed care organizations I'm going to actually send to AmeriHealth Caritas, if you would not mind describing your approach with behavior will health managed care organizations.

>> FEMALE SPEAKER: So currently we work with the MCOs we extend our relationship with CHC currently, what we do and, I said we'll extend is having them be apart of our care team.

Our structure and our model for CHC includes having a BH liaison as a

part of our team.

So if needs arise, that BH liaison will have the direct contact with the BH MCO and, we'll draw them in and hopefully to coordinate those services as seamlessly as possible.

And.

>> PAM MAMARELLA: I'm going to ask you to bring your Mic in closer for the people on the phone you can pull it in.

>> FEMALE SPEAKER: I feel like I'm top of it I will use my outside voice I think that again it's about that coordination we'll draw currently what we do extend that to make sure we're meeting the needs and I'll repeat it again, in case I wasn't heard.

Is that we'll have a BH liaison that works closely with our service coordinators ensuring that there is seamless communication and -- there was another piece of that question that I may have missed.

But again, it is about the coordination and as I mentioned holistically working with the participating and making sure we're sharing the information.

Collaboration, behavior health services is really important over all because behavioral health issues can effect physical health and also with coordinating physical health needs and medication you know so we look to take all of that into consideration. And really strive to you know have a great working relationship and pulling them in so that information is shared.

>> KEVIN HANCOCK: Thank you.

Do either of the MCOs have something to add specifically with the coordination with behavioral health coordination and behavioral health services.

>> FEMALE SPEAKER: I would add that, UPMC currently today, we have a behave I can't rememberral health MCO we're working with, so they're at the table with us as we're building our models so that we're all inclusive everything that needs to happen from a BH perspective.

>> KEVIN HANCOCK: Thank you.

>> JOSHUA SLOOP: For Pennsylvania Health and Wellness, we would just add that we would look to identify as best as we can, potential needs during the assessment process. And during the ongoing touch once and then we'll look toe behavioral MCO as subject matter experts are apart of care money planning team question.

The next question is for the Office of Long Term Living.

Specifically, what will the relationship be, between the MCOs and the Office of Long Term Living in the future?

And it goes on once the MCOs take over it will be end of OLTL.

[laughter]

I can say -- so -- the Office of Long Term Living will continue.

Obviously with unification of the departments there will be changes in the scope of what our long term living services but that has absolutely nothing to do with community HealthChoices or the relationship with the MCOs.

The Office of Long Term Living has responsibility of the agreement over

sight with managed care organizations and that responsibility will only become that much more important as this program moves forward.

So the role of the long term living function the currently is medicalled by the Office of Long Term Living with partner with Department of Aging will be agreement over sight.

Very clear.

It will not go away regardless how the role evolves and the Department of Health and human services unification.

So moving on.

Also, relating to MCO relationships, what can the MLTSS committee further do to ensure a smooth transition and relationships with the MCOs?

And I would actually give this to Pennsylvania health and wellness.

And then, ask the other MCOs to chime in.

>> JOSHUA SLOOP: I I this it's very similar to the earlier question and response.

The more information that we have, the more that we can understand what is working today, what the challenges are, that will help us better prepare and organize as we hire the teams we build build and configure our systems.

We really need the input from this committee.

>> KEVIN HANCOCK: Thank you.

Do any of the other MCOs have anything to add?

>> MALE SPEAKER: Just that, continued coordination and feedback

continual feedback is not as someone mentioned before it's not a one time and done process.

It is going to be evolving we'll need continual feedback and collaboration between all of us.

>> RAY PRUSHNOK: I mean the committee has been valuable with individuals with very different perspectives being able to share what is working or not within the system we'll look to continually hear that voice also, ongoing way after launch what each of our MC Os is have you hadly doing we should be be improving upon, this is, accountable structure that we, are glad to be apart of and look forward to hearing more from you as we move ahead.

Thanks.

>> KEVIN HANCOCK: Thank you.

The next question, relates to plans and policies. And specifically will the MCOs send their plans policies and documents to OLTL in the MLTSS sub-MAAC for final review and commenting.

The department will answer this in part and I'll turn to the MCOs if any of them have anything to add.

As part of the readiness review process and also ongoing agreement over sight, the MCOs have the responsibility to send their policies and most of the documents for review and approval.

So that's part of the existing readiness review process as well as for ongoing agreement monitoring and over sight.

So that in itself is part of the agreement as part of the responsibilities.

As for the MLTSS sub-MAAC the sub-MAAC will be asked on many occasions to review policies and documents and most specifically the documents and policies that will be -- this is also true with the consumers of the sub-MAACs will be touching participants, so if there's a communication or a policy document that has some sort of impact with participants, may not be the document itself but the concept may be shared with the MLTSS sub-MAAC for feedback and also for input.
That's the response and, I'm not sure if the MCOs have anything to add.
Okay.
So that is sort of an agreement requirements.
Moving onto questions relating to providers.
First, will the MCOs cover out of network providers? And specifically will participants have access to clinics? On the cutting edge of medical care research and using an example of Johns Hopkins, and will MCOs begin limiting their options for the first six months or negotiated with providers the general question relates to out of network provider access and examples are cutting edge providers and what would happen after the continuity of care period?
And Fred mentioned second opinions would be also consideration I would turn that question over to UPMC first thank you.
>> RAY PRUSHNOK: Well, first during the continuity of course, any one provider will be in network generally speaking we'll be looking to have the providers in network we're working in an ongoing way and we hope that he out of network type arrangements are rare. And that we're you know,

in close coordination with our network in general.

>> KEVIN HANCOCK: Any other statements?

>> PAM MAMARELLA: Center of license like Johns Hopkins can you speak to that.

>> RAY PRUSHNOK: Johns Hopkins is not in our Medicare network for instance, they're a high quality facilities like UPMC like in western Pennsylvania we work with, we're always looking to make sure we have a network meets the needs of our consumers part of this is you know, driving value and volume to providers that each of us are working with, but we're competing on this as well, to the extent that one of us has a network provider that one of us doesn't those are areas where we are going to be paying attention to make sure that we're not losing members for those types of reasons.

>> JOSHUA SLOOP: For Pennsylvania health and wellness, certainly we prefer the providers being contracted that way we can develop a strong work relationship working relationship out of network will be reviewed by our medical team by a case by case basis we have a responsibility to care for our member's needs and provide what they need within guidelines so -- those are on individual basis.

As far as limiting the network after six months, our focus is not going to be reducing our network our focus is going to be on establishing a quality network.

And so we're going to be looking for providers who want to go above and beyond just providing basic services establishing quality arrangements

and if that leads to limiting the network that would be really at the provider's choice not Pennsylvania health and wellness.

>> MALE SPEAKER: I would like to actually second the notion there that we're not looking to limit networks.

It's all about building quality as we move forward.

Looking at value based agreements as we start to receive additional data from different provider types.

We'll be looking to implement and create quality tools so that we create transparency among the providers to say, here's what the real expectations are.

In order to provide those quality services.

There are certain requirements that we have to adhere to, that will be passed down to providers that are quality driven.

That we will need to be receiving information back from certain providers.

So this will be in an evolving process as well.

We'll be as transparent as possible so that everybody is aware on the same playing field.

>> KEVIN HANCOCK: Thank you.

So the next question also relates to providers specifically, well MCOs assure that provider payments are sufficient to enlist or contract with enough providers so so care and services are available.

With that question I'll be turning it over to AmeriHealth Caritas first.

>> MALE SPEAKER: Obviously provider reimbursement and payments is not something that we generally speak to in a large forum that is

usually discussed in a one-to-one setting.

There are going to be some requirements on provider reimbursements as far as floor level goes from, as we work through our agreements with the department.

But as of right now, we'll be looking to include any willing provider and in our network and as we move forward and work through the quality metrics and working with providers that will obviously increase our potential opportunity to for certain providers to receive higher reimbursements.

>> KEVIN HANCOCK: Thank you.

>> JOSHUA SLOOP: For Pennsylvania health and wellness, certain hi provider rates and provider agreements are between the organization and individual providers.

Generally speaking though we firmly believe that, adequate rates are critical for the program's success and so if the concern is does Pennsylvania Health and Wellness intend to negotiate heavily and drastically reduce provider rates that is not the intent nor the goal.

>> KEVIN HANCOCK: Okay.

Great.

So we'll move on then to service coordination.

And the first question which would be going to Pennsylvania health and wellness, will be will service coordinators be contracted with outside agencies or the MCOs provide service coordination.

Just speaking generally as an agreement requirement service

coordination is an administrative function of the MCOs.

So when the MCOs are answering these question we impose this requirement on the MC works.

So when the MCOs are answering this requirement they will be answering on the way they plan to a etch pro the requirements.

So I'll turn it over to Pennsylvania health and wellness.

>> JOSHUA SLOOP: Simple answer is we'll have both, certainly for the continuity period, we'll be contracting with any and all service coordination entities similar to the other providers.

We'll be focus and quality and for and foremost the number one priority are the members and are they getting what they need when and how they need it? And so to the extent that service coordination agencies are doing that, then we look forward to a partnership.

>> KEVIN HANCOCK: Thank you.

>> FEMALE SPEAKER: For UPMC our goal is to do a hybrid model between using internal service coordinators and external service coordinators balancing on the continuity of care period as we work with the external service coordinators.

>> FEMALE SPEAKER: And I'll just state for AmeriHealth Caritas our approach will be to have a shared model, service coordination internally as well as using external service coordination entities, with the focus on training and quality ensuring that the participants needs are getting met in the way where we intend to holistically looking at all of their needs.

>> KEVIN HANCOCK: Thank you.

So the next question also relates to service coordination will be given to UPMC specifically, does UPMC, have a dispute resolution process that may exist between service coordinators and participants as part of your model?

>> FEMALE SPEAKER: Yes we do.

The service coordinators are oriented to the fact that an individual can change or request a different service coordinator as they feel that they need.

We will have a dispute resolution process with managers and supervisors when there's an issue between the service coordinators.

And the members.

>> KEVIN HANCOCK: Any other MCOs want to say something about that mem.

>> FEMALE SPEAKER: AmeriHealth Caritas I want to echo the same statement as -- other speaker and, would just say we encourage it.

Because, we know that at times when service coordinators need to be changed, it could be for a larger purpose and, could be also helping other participants that do not speak up so again we do have will have a process in place, as well.

>> FRED HESS: Real quick.

Will consumers have a choice of the service coordinator or one will be appointed and that is.

>> FEMALE SPEAKER: Consumers have a choice of service coordinator, absolutely.

>> KEVIN HANCOCK: That's in the requirement of the agreement as well.

Participant choice and service coordinator a is something that we require in the MCOs and all 3 of the MCOs have presented creative ways to make sure that choice is maintained.

So, Jack I if you want to respond from that perspective that's fine.

Okay.

We'll move onto specific questions relating to services. And this first question, on services would go to AmeriHealth Caritas, specifically, how do the MCOs plan on handling the functions that handle all the functions that the new amendments to the service model and plan for taking them on, for example, the employment first initiative.

Another way of asking the question, would be how will MCOs adjust to new amendments to service models, like helping participants who are interested in receiving employment to be able to obtain employment.

>> FEMALE SPEAKER: So again, as you're hearing the theme it's certainly driven through our service planning care planning process, with the individual, the individual is, identifying the need to you know, one of their goals and priorities is employment, that we are actually going to be having employment coordinators as a part of our care team as well so those individuals if that goal is the priority for that consumer that you though we would have that resource available to assist the care team assist the individual to identify opportunities and help to implement.

That's just one example.

>> KEVIN HANCOCK: Great.

Thank you.

Either of the MCOs have anything to add.

>> JOSHUA SLOOP: I would add in addition to for Pennsylvania health and wellness in addition to the care team identifying participants needs and goals we would look to partner with community experts to help provide guidance and opportunities.

>> KEVIN HANCOCK: Thank you.

>> MALE SPEAKER: Exactly I was going to add we are currently, in discussion with community agencies to move that forward from an employment standpoint and, organizations that evolves starting with the care plan.

>> KEVIN HANCOCK: Great.

>> RAY PRUSHNOK: This as much an effort on having that internal expertise to support our service coordinators around employment or network challenge as we work with the Commonwealth to make sure there's adequate capacity whether it's job searches or pest eradication or other services in the program.

>> KEVIN HANCOCK: Great.

Okay.

I would agree.

So then, moving onto the second question on services and this will be going to Pennsylvania Health and Wellness, how does Pennsylvania Health and Wellness plan to operate services my way.

>> JOSHUA SLOOP: Well thank you for that question w.

[laughter]

>> FRED HESS: Nice being put on the spot.

>> KEVIN HANCOCK: I'll remind you services my way, this season existing service that exists in the waiver that's allows for the individual participants to have budget authority over a lot of the way that their services are defined.

And we do have a this requirement in community HealthChoices as well.

>> JOSHUA SLOOP: This is an area where we do operate similar models and other markets and so we'll look to Borrow what works well in those areas we want to fully understand how services my way works today what is working well.

What the challenges are.

Put those together and then this is an area certainly, we'll look to the Commonwealth for input and feedback and as been asked earlier, this is something we want to bring to the committee for input.

>> KEVIN HANCOCK: Thank you.

>> FEMALE SPEAKER: From UPMC, what we currently know today, that service utilization is pretty small.

So, what our goal would be is to expand the utilization of those services ongoing.

>> FEMALE SPEAKER: Only thing I would add to that is that we would also look to have aggressive monitoring to make sure that once selected it is a good fit and making sure that all of the participants needs continue

to be met in the way that the participant needs them to be fulfilled.

>> KEVIN HANCOCK: Thank you.

Okay.

Next question also relates to services, specifically, relating to physical therapy.

Will the MCOs allow participants to either go to a physical therapy on a continuous basis or will they provide membership or other types of alternatives to be able to meet the requirements associated with physical therapy.

That would allow for choice for the participants? And examples would be services like activity services like silver sneakers that exist in some parts of the State in Pennsylvania.

All of which are intended to maintain over all physical health for participants this question is going to UPMC.

>> RAY PRUSHNOK: The second part of the question we do offer Gym benefit for physical therapy it is offered in a continuous way within the waivers today and those guidelines will be followed, that's really an individual decision as part of the service plan process what is it's really going to take to support that person in staying independent.

>> KEVIN HANCOCK: Thank you anything to add?

Okay.

Next question also related to services most of the questions just to be very clear, were service related and, there should be no surprise with that.

I'm going to read this question verbatim -- and, this question will be going to AmeriHealth Caritas, will the MCOs have help consumers to become independent with their care or do they want to have them become independent on a uniform system.

The question is how well will the individuality of the participant be addressed.

>> FEMALE SPEAKER: We want participants to be as independent as they're able to be.

That being said, that's based on what the participant tells us their goals are.

How their care plan is developed.

So what we do is work with the participants to meet their goals.

We have to understand what independence means to them not what we think it is.

We rally look for the participant to guide and lead us and we are in place or the vehicle to help them to meet their, to heat their goals and so at the end, looking at what independence means to them and with that, there's not a uniform system, we have processes in place to help participants who reached their goal in terms of services and supports and you know, utilizing care teams and such but, again, not a prescribed system so to speak to say this is what you have to do.

It's driven by the participant and it's really individualized no two participants are alike.

So to answer the last part of that question, again it is individually based to

meet that participant's needs.

>> KEVIN HANCOCK: Thank you.

>> JOSHUA SLOOP: For Pennsylvania Health and Wellness I would just add that, our goal is to support and not sub plant we want to make sure during the assessment process and ongoing we're listening to the participants and understanding their needs and making sure we know what their goals are, not our goals. And then it's our responsibility to support those within the perimeters that we have to work with.

>> FEMALE SPEAKER: I think when you put it all together, and everything that was said, it is still person centered our goal is to individual goals and to wrap it around the individual centered concept.

>> KEVIN HANCOCK: Thank you.

Next service question, how do the MCOs plan to helping individuals with hearing impairment or hearing impaired this will go to Pennsylvania health and wellness.

>> JOSHUA SLOOP: We intend to have benefits aligned with hearing needs to support that.

And then, also, as a part of the care planning process, service coordination bringing in care teams they will identify needs and opportunities and try to bring in support services.

>> KEVIN HANCOCK: Thank you.

Anything to add?

>> FRED HESS: Would you cover hearing aids?

>> RAY PRUSHNOK: We currently offer hearing aids in our DSNP

platform, I can't speak to you know within the Medicaid side of the program at this point.

>> KEVIN HANCOCK: That comment came from UPMC.

>> FEMALE SPEAKER: We would echo that as well.

>> KEVIN HANCOCK: Okay.

So moving on related question for UPMC, how will the MCO handle vision and dental benefits.

>> RAY PRUSHNOK: It's a similar answer, that these are benefits that are currently you know, supplemental benefits in our Medicare duals program and we have not made decisions how those benefits will wrap around with enhancements with the required Medicaid platform.

>> FEMALE SPEAKER: And we agree, with that and we just add we're in that process right now because we're preparing our bid work on Medicare DSNP side for submission.

So that will be unfolding I'm certain through the fall.

>> JOSHUA SLOOP: Similar status with Pennsylvania health and wellness.

>> KEVIN HANCOCK: Thank you.

So this is a general question, that we'll be going to AmeriHealth Caritas, how will the MCOs provide better services than the current system?

>> FEMALE SPEAKER: Can we start with an A so we take that question first.

So to answer that, I would say that, you know, through the continuity of care period, that gives us a great opportunity to begin building

relationships, with the participants, understanding the services that they, currently have in place.

What is working for them, what is not working.

And looking to have a baseline to then measure how things can improve and, how we can maybe more effectively contractor realign what the participant is receiving or maybe increase that.

But again, it begins during that, excuse me, during that period.

We will also use satisfaction survey schools CAHPS will eventually roll out we'll look for feedback in that way as well.

But, again most important is aligning what services that participant needs making sure that they are giving those services and then, doing continuous follow-up, to ensure that their needs are being met and addressed timely, and appropriately, by the providers.

And having that relationship, with providers as well, and, the potentially offering training and understanding the population being served you know in away that would increase how services are delivered.

>> FEMALE SPEAKER: I would just add that, our experience in the other -- in our other communities point us that consumers typically are not shy so we hear from them. And they let us know when things are not going well, when things are not going well, but when things from a service perspective that's valuable feedback we can act upon and you know, the relationship they have with their care manager and their service coordinator you know helps to Foster that feedback.

That's very important.

>> JOSHUA SLOOP: For Pennsylvania Health and Wellness, it is not necessarily better services but rather better coordination of the services that exist today for the most part providers are providing good services, the specifically when it comes to coordinating benefits between Medicare and Medicaid that's where we intend to provide value.

>> FEMALE SPEAKER: UPMC I would really add it's about the coordination of services. And the other opportunity is that we have is to have, valued adD benefits so things that are above beyond what the Medicaid benefit service level is today.

Incorporating those into our population.

>> KEVIN HANCOCK: I would add, we have to remember in community HealthChoices nearly 95 percent of the people in our people are are duly eligible for medicine cared and Medicaid.

Opportunities for coordination are part of the design of the program it's good to hear all 3 are building this as part of their service model.

Next question which is much more specific -- the last question, will be for Pennsylvania Health and Wellness, they seem to randomly be getting the specific questions.

Are you planning to cut hours after six months continuity of care runs out in June.

[laughter]

This is random.

>> JOSHUA SLOOP: Thank you Kevin.

[laughter]

I appreciate that question.

You know our goal is not to cut services.

Our goal and our mission is to make sure that participants have what they need to support their well being and that they have what necessary need to support their goals within the perimeters the program design and benefits we will make sure that we carry that out.

>> FEMALE SPEAKER: UPMC our goal is to actually identify unmet need and add to services if they, if that exists.

And it's really at the end of the six month period just to evaluate and reassess.

>> KEVIN HANCOCK: Thank you.

Great.

>> KEVIN HANCOCK: The next question for UPMC, generally, how will you handle conflicts of interest. And specifically, when conflicts of interest arise, will the participants health care come first?

>> RAY PRUSHNOK: In terms of conflicts of interest you know we are going to be very careful to watch you know our network if we have providers that are involved in different aspects of care, that maybe in conflict, that's about having the right types of monitoring and inest work.

Over sight.

In terms of sorry I'm looking for the question here.

The -- in terms of the over sight of that, I mean, it is going to come back to our service coordinators who are closest to the consumer and making sure that, the delivery is appropriate and that the person needs are being

met being able to address that with the providers.

And that point we do have, provider, complaint grievances procedures they will be internally being investigating to make sure that provider is a good fit for our network.

>> KEVIN HANCOCK: Thank you.

Anything?

Okay.

>> KEVIN HANCOCK: The next will be for AmeriHealth Caritas, how this actually, I haven't directed read -- all 3 MCOs should answer this question, how will each of the CC MCOs coordinate coverage for your Medicare with dual eligibles, to who chose not to align in the DSNP plan that will be for people in the Medicare advantage plan or the people who stay in the traditional fee for service Medicare program.

So --

>> FEMALE SPEAKER: Great.

So we would be looking to extend our -- I'm sorry I'm getting closer so we would be looking to extend our relationships that we have, already, and we would be looking to identify points of contact with the other DSNP plans or other organizations so we can continue to work and find the best method of communication, so that services can be coordinated appropriately and timely.

So that, so that the -- it's seamless so we look to establish consents in place following the guidelines that were already put forth by the department in the MIPPA agreement you know we would be looking to

share information to best meet the needs of the participant and work collaboratively with the other MCOs.

>> KEVIN HANCOCK: Okay.

Just to add is there anything more than you would be able to say about the traditional Medicare program in coordination with the traditional Medicare program.

>> FEMALE SPEAKER: I'm sorry I neglected to put that piece in there. But yes for the traditional fee for service, you know, part of that one would be making sure that our staff have a solid understanding of the services that are in place, who those providers are and reaching out, to those participants, to take the lead on coordinating those services finding out exactly what is currently in place identifying any unmet needs and gaps and again taking the lead to ensure that all of their their needs are addressed.

>> KEVIN HANCOCK: Thank you.

>> FEMALE SPEAKER: I think there's two different ways that this will have to happen in.

The individual with a managed care organization, it's aligning with that haddinged care organization and their care managers or their service coordinator whatever function they have, for the member that is in the fee for service world kind of to your question Kevin, it is being advocate for them our service coordinator has to be the Medicare advocate for them as well getting things that they need from that perspective.

>> KEVIN HANCOCK: Thank you.

>> JOSHUA SLOOP: For Pennsylvania Health and Wellness, very similar approach we're going to need to work with everyone in the community.

Even if they are technically a competitor the participant needs are first and foremost and our responsibility is to make sure that they're getting what they need regardless of the responsible funding party.

So, we'll you know, similar to working with the behavioral MCOs we'll be reaching out to the other organizations and companies.

I think the value though we will bring as the CHC MCO we'll be taking on the work that is currently being done by participants by their caregivers, we'll now absorb that work.

>> KEVIN HANCOCK: Thank you.

Next question, once again very specific question for Pennsylvania health and wellness -- what are the plans for providing nursing home transition services.

>> JOSHUA SLOOP: Clearly nursing home transitions are vital and important for individuals who are able to and want to transition to the community.

First and foremost we want to work with the existing agencies that are doing that work today.

We want to you know understand from them what is working, what is not working how can we partner with them, we certainly don't want to be duplicative we want to support what is happening in the opportunity.

Second to that, and really, in parallel not second, we value relationships

with nursing homes.

And the only way that nursing home transitions are successful is with the support of nursing homes.

So, we in no way intend to work on transitions in a vacuum it has to be a complete partnership with the nursing homes with the participants with the caregivers and, the community agencies that will then support them once they move.

>> KEVIN HANCOCK: Okay thank you.

The next question is also, specific and this will be to UPMC, how will you provide nonmedical transportation.

Just for the audience the differentiate nonmedical transportation there's emergency medical transportation, nonemergency medical transportation and nonmedical transportation, nonemergency medical transportation is usually provided by the medical assistance transportation program which would be coordinated through the MCOs.

Nonmedical transportation currently in the fee for service system is service that will be offered through home and community -- certain home community based waivers.

>> RAY PRUSHNOK: In terms of the provide are network we, first around medical transportation are looking to rely on existing contracts that we have, with a variety of medical transportation providers that you know, are diverse from everything from cabs to wheelchair vans to across the board ambulance rides where where appropriate.

We also exploring opportunitieses to the Ubers and Lyfts seeing ways we

can see the gap in the availability of the transportation providers to meet existing needs and seeing this expanded, as a challenge looking to make sure we have, as many options in our network as possible.

>> KEVIN HANCOCK: Thank you.

>> MALE SPEAKER: AmeriHealth Caritas is exploring the same opportunities with some of our medical provider transportation provide we ares.

But also, engaging other transportation providers for the nonmedical services, part of the discussion is also are including EDD to possibly track realtime some of the driver services to make sure that the individuals are receiving getting picked up on time being transported to their appointments those are some of the items that we're looking at as we roll out this benefit and look to appropriate provider for these services.

>> KEVIN HANCOCK: Thank you.

So we have two questions remaining and then I'll turn it back over to Pam.

General question -- I think this one is going to AmeriHealth Caritas.

Do you foresee any problems in transitioning these services to a managed care platform in Pennsylvania? And if yes, how would you correct it or manage for those problems?

>> MALE SPEAKER: It is more -- I don't foresee problems.

What we talked about recurrent team, training and education for the service coordinators for any of the community agencies that we're working with.

As any barriers or items may arise that may be unique to a specific geographic region, communicate that back to us we'll work together to resolve those and you know, all suggestions on the table is, where we look at it, it's not being as out of bounds it's what can we do to make sure the individuals are receiving the services they need.

>> KEVIN HANCOCK: Thank you anything to add.

>> JOSHUA SLOOP: For Pennsylvania Health and Wellness we are concerned and we'll be focused on making sure we fully understand the existing care plans in order for the continuity of care period to be successful and for participants to continue to get what they have today, in the same manner, we're going to need to know the details of those care plans so we're going to be focused on making sure we know what those are.

We have the details they're completely loaded into our system.

Our service coordinators either internal or partnered service coordination agencies are communicating effectively so on day one there's no interruption.

>> KEVIN HANCOCK: Thank you.

>> RAY PRUSHNOK: There's I think in terms of, problems that we see I think, the same vein there is a lot of variability this Pennsylvania whether it is due to the resources in that community or options that are you know, available and I think each MCO is going to be bringing a different degree of standardization to their approach and looking to be fair so that, the level of service, someone doesn't receive is an accident of geography

and, additionally, there are challenges around work force and housing that we'll all collectively work to address those are problems that are new. But hopefully collectively we'll be able to make big improvements that will help the rebalancing of our system and provide more community options.

>> KEVIN HANCOCK: Thank you.

And last question -- also specific and I think this is has to go to actually this one goes to Pennsylvania heal health and wellness.

[laughter?.

>> JOSHUA SLOOP: 3 for 3.

[laughter]

>> KEVIN HANCOCK: It's pretty specific as well.

It worked out this way.

What are the elements of your housing strategy as you move to ensure people who can move to ensure that people will be able to access and be able to served in the community.

And related question, what way do you envision working with housing provider?

>> JOSHUA SLOOP: Similar response as earlier we look to work with existing community agencies and experts some here in the room we have already met with.

We want to make sure we understand the current barriers the challenges and the current capacity, which apparently is very little.

So we actually, have just hired a housing expert someone from Pennsylvania who has been in the housing space for very long time has a

good understanding.

We have pilot programs that we have operated in other states.

That have seen levels of success, we would like to bring here and try.

I think to some degree, there will be pilot rams that we want to use.

So I think, to a large extent, it's going to take a lot of involvement from the community.

We have ideas we would like to bring we need to make sure they fit here, certainly housing is going to be critical to support transitions. And -- even diversions.

>> KEVIN HANCOCK: Thank you.

>> FEMALE SPEAKER: We would just add that, you know, this -- this is a problem that's been decades long, so this is where really working with the community partners and in collaboration among the MCO is going to be critical to try jointly develop, innovations and solutions also going to bring some of our own ideas to the table as well.

We will be a partner at the table to to help tackle this issue.

>> KEVIN HANCOCK: Thank you.

>> RAY PRUSHNOK: One thing I would add that has not been mentioned bunch of this starts with keeping people in the home they're in today making sure that we're investing in home modifications making sure that we're not increasing the need for accessible housing in the community and then of course working with housing authorities in those local, those types of local partnerships where they may have accessible stock that is being used by individuals that may not have those needs

and helping to work with them around realignment and working locally with organizations that are developing housing options so that we can you know have places to go for nursing home transitions that really housing is the only barrier.

>> KEVIN HANCOCK: Thank you.

So that was the last of the questions that we captured from the committee.

I want to thank the committee for providing those are very thoughtful questions and forever the participants from the managed care organizations for providing thoughtful responses to those questions.

Obviously this is the first opportunity the committee has had the opportunity to ask these questions.

So, we expect more will be coming your way and our way and we will some time in the future with the committee's permission having an opportunity to answer these types of questions again.

>> PAM MAMARELLA: Yes.

So thank you very much, and thank you Kevin for facilitating that really important portion of this committee meeting.

We have 6 minutes left, so I'm going to ask the committee do we have questions that we want to ask right now, do we want to open it up to the public that have come to also ask questions I hear a committee member, yes.

>> FEMALE SPEAKER: My question is, how many are how do you -- how will you handle the differences in the needs between, the adult

population, that you serve, and senior citizens.

Anyone can answer it,.

>> FEMALE SPEAKER: So you know again it is starts with who the individual is dealing with an older individual, you know, take the time to understand what their concerns are, what the problems are.

What their needs are that comes out through the initial assessment.

But also through our ongoing contacts with the individual and their family.

And, you know, our interventions our support, service plans, are all customized to what nodose those needs be.

If we're working with a younger individual who perhaps, wants to you know, have active employment, versus an older adult who wants to volunteer you know, those needs, will drive, that will drive the support and the priorities we work on with that consumer and that family.

>> FEMALE SPEAKER: I'm talking mostly about senior citizens who are home bound and who need care in their home.

Not looking for employment.

>> FEMALE SPEAKER: Yes, sure.

That is just an example, to show that you know, that we would deal with that.

Yeah. .

I mean for individuals who have needs no matter what their age is, we have individuals who are younger who are home bound as well so, really it's their needs that are driving how we would support them, if an individual, is not able to leave their home you know we would customize

our support to you know to support those needs to be more suitably see what we can do to help advance that person integrating into the community.

>> PAM MAMARELLA: Jesse and Fred.

>> MALE SPEAKER: Just quickly for -- this is sort of I guess a question a bit for the managed care organizations a bit for the Commonwealth, but -- in the past, historically, rates have notes accounted, the rates provider agencies have been made, that's the direct -- to provide living wages over time coverage, and health insurance particularly for in the home and community based sector as we look to expand the opportunity for community living and expand the opportunities for home and community based services, trying to figure out what kind of strategies or plans do the managed care organizations envision that would begin to take into account the need for improving the work force innovating in the work force and reducing turn over so that one of the ways to drive quality in the community living system.

>> RAY PRUSHNOK: This is another problem that is years in the making that will take time for us to all address.

I think, the first part it does come back to rates I think we all acknowledge that, there haven't been increases in recent years in some of the rate categories it's really, important for us to address that to make sure for the same reasons you noted we don't have turn over we don't, you know, have a work force that is unstable, which then results in our members, you know being unnecessarily institutionalized we're still in the process of

you know, determining what our rates are I don't think this will happen on one fail swoop the goal is we identify providers that are helping us reach the quality metrics the quality is looking to have higher standards for all of us in CHC agreement in helping with the career ladders and development of the work force I'm excite today see what comes of that.

>> PAM MAMARELLA: Fred?

>> FRED HESS: Okay.

I am waiting for verification.

What are the plans of each of you guys to provide nursing home transition services?

>> KEVIN HANCOCK: They answered that question.

>> FRED HESS: They did.

Okay.

Never mind.

>> PAM MAMARELLA: They were going to work with the existing structure first go build out there through, which really brings us to -- 1:00, so -- all is left is to thank you again for attending today and I know that we'll be seeing you again soon.

So that we can have a lot more follow-up questions so meeting adjourned thank you everybody.

[meeting concluded 12:59]