DATE: October 4, 2017

EVENT: Managed Long-Term Services and Supports Meeting

>> **PAM MAMARELLA:** Good morning everyone we're going get started.

>> We're having technical difficulties on the phone give us a moment.

>> **PAM MAMARELLA:** Good morning we'll call this meeting to order. And I want to start off by actually welcoming 3 new members, and as we then ask them to reintroduce themselves if they could tell us a little bit about themselves -- but today I want to welcome Linda Litton in the back to the left.

Hello Linda, fellow Philadelphian in the room.

Luba Somits.

And Steve to you Touzell, was on the phone,

welcome to the 3 and Linda, if you could start off introductions.

>> **FEMALE SPEAKER:** Hi.

My name is Linda Litton I am a former surgical nurse I live in the Philadelphia area and I am here in the role of a participant and I'm very glad to be here.

Thank you very very much.

>> **FEMALE SPEAKER:** Carrie Bach, voices for independence, I'm sitting in for Tanya.

>> **MALE SPEAKER:** Good morning Blair Boroch, united health care.

>> **MALE SPEAKER:** Good morning I'm Jack Kane, I'm more or less at large -- on the committee.

I one time did serve as council to DHS.

>> **PAM MAMARELLA:** Good morning I'm Pam Mamarella with new court land.

>> DEPUTY SECRETARY BURNETT: G Go od morning, Jen Burnett, office of long term.

>> **SPEAKER:** Good morning, Theresa Miller.

Department of services.

>> **FRED HESS:** Fred Hess.

>> **MALE SPEAKER:** Steve Touzell.

>> **FEMALE SPEAKER:** Estella Hyde council on aging and.

>> **MALE SPEAKER:** I'm drew Nagele from the brain association.

>> **MALE SPEAKER:** Thoe Brady.

>> **MALE SPEAKER:** Ray Prushnok.

UPMC.

>> **MALE SPEAKER:** Jesse wilderma n.

>> **FEMALE SPEAKER:** Luba Somitz, on.

>> **PAM MAMARELLA:** Good morning, I'm going to go over the

housekeeping.

>> DEPUTY SECRETARY BURNETT: A Anyone on the phone.

>> FEMALE SPEAKER: Can you hear me?

>> FRED HESS: I hear you Tanya.

>> DEPUTY SECRETARY BURNETT: We heard you.

Who else?

>> FEMALE SPEAKER: Okay.

Good.

Good.

>> MALE SPEAKER: Brenda Dare, Denise Curry.

>> DEPUTY SECRETARY BURNETT: A An yone else?

>> MALE SPEAKER: Terry Brennan.

>> MALE SPEAKER: Richard Kovalseky.

>> DEPUTY SECRETARY BURNETT: Okay.

Anyone else?

Okay.

Thank you.

>> PAM MAMARELLA: Thank you people on the phone and thanks Jen for that.

So, committee rules and then Fred if you'll go over the evacuation procedures.

As always, we would like to engage in the most, professional language that we can, with each other and keep respect for each other's opinions and comments.

As a point of order if you could direct your comments to me, wait until you're called on and then you keep your comments to two minutes if at all possible.

The transcripts for this meeting are posted on the Listserv which is also on your agenda.

We have our captionist here good morning.

As always -- please turn off your cell phones and at the endst meeting if you could clean up after yourselves, throw away any of your cups and your bottles et cetera.

We encourage as always for members to hear from their constituents and submit agenda items of any questions, comments or concerns as it relates to MLTSS and the ro roll out. And the public can submit agenda items when we want to hear as as many people as possible to a lever says I'm not going tread because I think that people, have it but if you go to OLTL it's littlessed there.

Now we'll have Fred go over the emergency evacuation procedures.

>> **FRED HESS:** Good morning everyone.

In event of emergency or evacuation we'll proceed to the assembly area to the left of the Zion church on the corner of fourth and market.

If you need safety answer, to evacuate, you'll have to go out here

to the safe area, located at the right outside of the main doors of the honor's Suite, OLTL will staff in the be in the safe area.

If you are evacuated everyone must exit the building.

Take all your belongings with you, do not operate your cell phones do not try to use the elevators they will not work.

We will use stare one and stare two, to exit the building stairs1, left side honor's Suite near elevator turn right and go down the hallway by the water fountain, one is on the left, for stairwell two, exit honors Suite through the back doors or the side doors if you enter out the back doors you take a left and another left, it will bring you to number 2.

If you're exiting out of this door over here take one left it will bring you to stairway two.

Keep to the inside of the stairwell and merge to the outside.

Turn left, and welcome down Dewberry Alle . to Chestnut Street, turn left to the corner of fourth street and left to Blackberry street, across Fourth Street to the train station we'll gather and do a head count.

>> **PAM MAMARELLA:** Sounds great.

I think good morning Arsen welcome.

I know Barbara intends to be here is going to be late.

So, I'm going turn it over to Jen.

>> DEPUTY SECRETARY BURNETT: O Ok ay.

Good morning everyone.

I do have a number of updates I would like to give today.

But before I do that I would like to -- welcome Teresa Miller our new secretary for the department of human services. And ask Teresa to say a few remarks to the group.

Spike speak good morning I'm Teresa Miller I'm really excited to, to be here.

I'm for getting now if I'm in the fifth or sixth week of the new job.

But it's going very fast. And -- one of the things I've been trying do as, as part of my initiatetion to DHS is really get out and, talk to as many stakeholders as I can, so, I think, a number of you in this room look very familiar I know I've had a chance to sit down with you, separately but, just wanted to have a chance to come say hello to this group.

The work that you're doing is really important and I wanted to be able to hear at least some of the discussion today -- I care a lot about what stakeholders think about what we're doing.

I think one of the things that going forward, I want to make sure our department is doing, is really collaborating not just, with our stakeholders but with other agencies as well I think this Governor has made it very clear that he wants all of the agencies to be working very well together.

But also, that we really are listening to stake holders and -- rail

I focusing on those that we serve.

I think that's one of the things when the Governor proposed the unification of the departments of health human services DDAP and aging one of the reason he's did that is because he was really focused on the experience of those that we serve and so I think, as we move forward with all of our work that is one of the areas I'm really focused on I know he is, sort of thinking about how do we make the experience of those we serve better how do we better serve Pennsylvanians I think part of his goal and unification was -- to really view the way we do business from the perspective of those that we serve, which I think is something that, should be intuitive that's the way we should be doing business but I think too often, we sort of, force those that interact with state agencies to understand how we do business and know where to go to get services and as I've been out talking to folks one of the things I've heard is, look if we've got a family member with a disability for example, or whatever it is we need from state government, we don't want to have to be PhDs in state government to know where to go to get services for people we love.

So I think from our standpoint we're going to be working very hard to even without unification and if unification doesn't happen it will be a little bit more difficult but I think we're really focused on what can we do to really make the experience of those we serve better.

So -- um, so I appreciate the opportunity to be here today, listen

to a little bit of the discussion and I know, I'll have the opportunity to sit down with a lot of you as I've been, going forward.

So thanks for the opportunity to be here thank you for all the work you're doing the important work you're doing giving us feedback as we do our work.

>> DEPUTY SECRETARY BURNETT: T Th ank you Teresa.

I -- I want to start out, by just reinforcing, something that Teresa started out with, which is we do, value our communication and our ability to be available to people who want, have questions for us, who have, concerns. And just as an example of that, in the last 24 hours, Tanya Teglow on the line, being represented by Carrie sent several emails I was in receipt of those emails, over her concerns about the -- about the communications, with the participants the people that are going to be affected, particularly in the southwest and how we are Miking those communications and she is feeling helpless in the dark as far as what is going on.

So today, what I'm going to do, as you all know you have been hearing this for the last 2 years, or more, we've been meeting, we are doing a lot of work in between these meetings a lot of work gets done in between these meetings.

It's a very fast paced amount of work and things are moving very quickly.

That includes working with our community HealthChoices managed care

organizations to build their networks to help them build their networks to understand how they're building their networks and, that information is all information that is sort of a cart before the horse thing, that information is, is information that is needed by the participants in order to make their decisions on which of the 3 MCOs they want to choose.

So what I'm going do is go over some talking points that I -- we put together, over the past couple of weeks based upon input that we've gotten from this committee and I'm hoping Tanya that answers some of the questions that you had.

If not we'll continue that conversation.

So we -- as I mentioned we're very committed to communicating and openness we do that through this meeting as well as through the third Thursday webinar we get invited to a heck of a lot of meetings last week I was in and out southwestern Pennsylvania with the Pennsylvania health care association meeting with a variety of nursing facilities.

It's first time I've actually attended that conference and it was really good experience for me just to be there and be immersed in the work that they all do.

But that is just one example of many meetings that I attend and, participate in, and provide information to.

We also are using multiple channels besides this we have the third Thursday webinar we have a very robust web site that is extremely active.

But I'm going to go through some of the other things that we're

planning in the coming wee weeks and months.

I'll start out with participant communications. And we sent out an informational flier in August to the people in the southwestern part of the State.

That information -- that informational flier was a heads up, hey community health choice asks coming please be paying attention to this.

You need to you'll need to pick a managed care organization.

We also are doing series of community meetings in the southwest we have 41 community meetings planned.

Fred Hess's agency is actually hosting one of them.

And in New Castle they're being held in every county in the southwest -- all 14 counties in the southwestern part of the state and, the flier on that went out on September 18th and the -- they're scheduled to begin mid October and run through mid November.

We have -- we plan to give more information on community HealthChoices on the LIFE program because the LIFE program is the alternative to community HealthChoices in the future of Office of Long Term Living services and we also want to emphasize the importance of these -- I want to emphasize the importance of these particular meetings are for participants.

We really are, hoping that participants get to these meetings and, not -- not providers advocates certainly are planning to attend, many participants are advocates.

So we really are trying not to have this as a provider event.

We've been doing a lot of provider events this is really to help participants understand, understand what is happening to them. And what they are going to need to do, once they get as they get, get involved in this.

People can register for a community meeting, it is on our web site, the registration form is on our web site.

But in addition to that, they can call an 800 number.

8133-735-4416 so that's another way that people can register for these community meetings.

We did send out notices last week we -- the first of our note -- actual official notices went out to the parenthesissants in the southwestern part of the State they informed participants that -- they will transitioning to community HealthChoices, in January they will need to select an MCO.

These notices also tell, potentially eligible participants they also may be eligible for the LIFE program and, also, we -- we are using those notices -- they have contained appeal rights.

If someone wants to appeal, this change in their service deliveries, availability they can do that.

At the end of this week we're going to be sending out preenrollment packets those are going out from the -- through the independent enrollment broker. And they will be mailed to all participants in the

southwestern part of the state.

I'm actually going send out the preenrollment packets to this committee, and it will be posted on our web site in the very near future if not today.

We're waiting for 508 compliance to be -- assured.

But we will -- I will send out the enrollment packets to this group so you can really, scrutinize.

Enrollment packets contain health plan comparison chart. And it also contains the added benefits each of the MCOs has it's own flavor of added benefits those are included in the preenrollment packets.

Information on how to get the -- the information, this information in other languages I believe there are 15 other languages we are making it available in.

The enrollment form and information on how to enroll, there's a brochure on how to enroll in a health plan.

Our toll free number and the web site, that the toll free number for enrollment as well as the web site, information on the community meetings that I just mentioned are going to be included in the preenrollment packets one more touch, we've already sent them out this is one more way, for us to get them in the hands of the participants. And we also are including in this enrollment packet information on this meeting as well as the MAAC meetings we're sending out information on what is the MAAC meeting and how to participate in it as well as how to participate in

this meeting.

And all of this information is going to be available on our web site.

But as I said we'll go ahead and send those out to all of you.

November 13th is the close of the pretransition period.

But southwest participants can enroll at any time, up until 1/1/2018, if participants don't select a health plan, they will get a follow-up call from the independent enrollment breaker.

And individuals who do not select a plan by November 13th will be assigned to a plan but they can change their plan at any time.

>> **FRED HESS:** I have a question.

If -- while we're going through that, while they're changing their plan, I'm just thinking -- if they don't pick -- get sent how are you going to determine who to -- to send that to -- which one, which insurance company they're going to get which MCO they're going to do --

>> DEPUTY SECRETARY BURNETT: How do we form them.

>> **FRED HESS:** How do you pick and choose --

>> DEPUTY SECRETARY BURNETT: A Au to assignment process.

With the HealthChoices auto assignment.

>> **FRED HESS:** Just computer does it.

>> DEPUTY SECRETARY BURNETT: Has to do with the PCP and just a various things I don't know Heather do you know the specifics of it.

>> **SPEAKER:** If they do not share any information with us like, who they D-SNP is, if they're in a nursing facility who their PCP is we not necessarily have that information.

It would go through the auto assignment process which first looks at is the family member in -- in the HealthChoices sister plan? Were they previously in a HealthChoices plan? Actually that's the one first.

So, if they are -- um, a non-dual, they're currently in HealthChoices, we would try to match them with a sister plan.

So if that anywhere AmeriHealth or PA health wellness we would match them with that same plan if not we would look at had they previously been in one of those plans within the last six months, but became dual eligible and left it, we look at other family members in one of those health plans and match them with that and after that, if we don't have any of those criteria, we would then, just go through a random auto assignment to the MCOs.

>> **FRED HESS:** Way it sounds to me because UPMC is prevalent down there the only choice is going to be UPMC, if the auto -- the auto is --

>> **SPEAKER:** The first couple hierarchy obviously UPMC because of their presence is --

>> **FRED HESS:** Yeah. There's no other presence in the southwest corner that much.

>> **SPEAKER:** Right.

If they were to contact us tell us -- oh I'm in this DSNP or this nursing facility we would use that, which is called our intelligent assignment we would go through that hierarchy, we would first look at what nursing facility they're in, whose network that is in, we would look at the DSNB if they're in a compatible DSNP to that, the next one would be I believe the PCP who their practitioner is and what they're in after that.

So we try to use the most information we have, to be able to make those intelligent assignments to participants.

>> **FRED HESS:** Sounds pretty much like it's going to be UPMC.

>> **SPEAKER:** Well I won't say that.

>> **FRED HESS:** You can't say that.

>> **SPEAKER:** You can say whatever you want.

>> **FRED HESS:** I can you can't.

[laughter]

Okay.

Thank you.

>> DEPUTY SECRETARY BURNETT: O Ok ay.

Participant call center I want to just -- is going to be operational through the -- through the enrollment period.

And, we are, asking people in the informational packet, they get the enrollment packet they get to call the information the independent

enrollment broker also if people do not receive an enrollment packet and if a -- for example, service coordinator finds out about it, they should encourage them to call the independent enrollment broker so they, enrollment packet can get sent out to them.

Access cards and the community HealthChoices MCO cards -- and participants will need to carry the access card with their community HealthChoices plan cards, in order to access other benefits outside of community HealthChoices for example, MATP.

Provider communication recap I want to talk about -- switching from participants to providers, a little bit about provider communications. And late halt we did send out the continuity of care provider fact sheet.

We did CHC -- we're doing a CHC 101 training for service coordinators and for nursing facilities in the southwest and that's going to be offered through webinars and online.

We are sending out bi weekly or every 3 weeks sending out fact sheets to community HealthChoices related topics and these topics really are identified, by the questions we're getting asked.

We put together -- informational resources for providers based on, questions that we're getting from providers, through either this committee meeting or through the MAAC meeting or through the webinars so a lot of ways we're getting questions.

So we use those questions to put together fact sheet.

The third Thursday webinars will continue on monthly basis during

the community health choice -- throughout the community HealthChoices it's a practice we've really adapted we're going to continue to make them available.

We find they're a good way of getting information from people, but also finding out what is going on, what are people concerned about.

We also are doing a lot of work to train our own staff that has been another priority of oth ours, moving from what we do, fee for service management day-to-day management for participants plans and moving to over sight of a -- over sight of managed care organizations, and looking at the quality of managed care organizations that's a different kind of work. And so we're doing a lot of training for staff, making sure that they're available.

That they know what is going on.

We did a CHC101 presentation to all staff that wanted to attend, we extend that had really following up on what Teresa was talking about we extended to the department of drug and alcohol program staff, Department of Aging staff as well as the Department of Health staff, in addition to our DHS staff.

So we held that.

We're also doing, webinars, and these webinars are based on a variety of different topics that we have heard about from the staff, what is going to happen to service coordinators? What is going to happen to nursing facilities? How does this work with physical

health -- those kinds of things.

With we held two of those, two in September, October 11th we'll do one on service coordination we'll do another one on home care and home health services home and community based services, we had it scheduled for earlier this week we had to reschedule it.

In terms of, um, IEB readiness we actually did -- readiness review process, with the independent enrollment broker.

Of the project plan for the independent enrollment broker has significantly redundancy built it, with call centers and the IEB, has the current provider network information, for each managed care organization.

And they will be able to provide that to participants who call in.

I will say that this is a very fluid changing information almost on a daily basis we're adding providers the MCOs can talk to you about this a little bit later.

But we are, so it's never really static and it changes.

And we'll be working with the IEB to make sure that information is updated.

On a regular basis.

Our readiness review go no go for communicating with participants was September 22nd with the go -- and that's when we decided we would start communicating with participants officially through our notice and that went out, the Department of Health, is -- network adequate

certification, is going to be supplied to us by the end of this week and , Randy and the MCOs are going to be talking giving an update on readiness review, later in today's meeting and so you'll be able to ask questions of more specific questions of him at that time.

We -- as I mentioned the provider networks are still being finalized but the independent enrollment broker will we'll have them and get them information that informs out to the general public within the next two weeks.

We have a -- this is switching to something community HealthChoices related but it's a little bit of a different activity which is that the people on the OBRA waiver have been, in the southwestern part of the state have been getting assessed for nursing facility clinical eligibility.

Prior to that, they had not gotten that assessment that level of care assessment.

But we decided to go ahead and assess them for level of care.

People who are -- nursing facility level of care will go into community HealthChoices and those who are not nursing facility clinically eligible are rather intermediate care facility -- for other related conditions and that they will stay in the OBRA waiver and the waiver will be smaller because of that.

We have completed -- we have 455 total in the OBRA waiver in the southwestern part of the State.

Of those, all of them have been completed except for 8.

And the 8 that have not been completed are because of a need -- the physician certification we're working with service coordinators in the southwestern part of the State to make sure that those physician certifications come in.

Talking about the behavioral health managed care organization enrollment, all new behave I can't rememberral health managed care organization, MCO enrollees will get member handbook information and so the people who are in the southwestern part of Pennsylvania who are either in the aging waiver or are in nursing facilities will get member handbook information about their behavioral health MCO.

Each county has one behavioral health MCO and those behavioral health MCOs will be sending out information to their new mem members as they get enrolled.

We are going to have presentation today, on the functional eligibility determination and update on the functional eligibility determination.

Dr. Steven Albert will be calling in for the meeting he'll be doing a presentation on the Medicaid research centers findings on the testing that they did, of the functional eligibility determination.

And we'll, present results of the testing that the time.

We have had a couple of questions from the last meeting on how we are planning to work with the MCOs on employment related activities and the housing initiative.

You will recall that one of the areas -- one of our goals in community HealthChoices is to promote program innovation. And two of the areas in program innovation that I was asked about was housing innovation and employment services innovation.

Those questions -- but you'll also recall we have two other areas that we asked for the MCOs to focus innovation.

One is to Miking improvements to the direct -- for the direct care work force and the fourth one was to for technology, using technology to innovate.

And we have some really good ideas on what that, what those things look like.

In terms of employment I'll just talk a little bit about that -- they have to pursue innovation around employment which includes, all the -- employment services that are now available through our waivers.

And the employment innovation needs to be person centered and includes -- employment related needs as part of the person centered planning process.

So all individuals who are going through the person centered planning process because they use long-term services and supports, will get questioned about employment asked about their employment goals if they have them, that kind of thing.

Also, we will be doing -- asking the community HealthChoices MCO toss do significant coordination with other employment services and

including nondepartment of human services employment services such as the services of the office of vocational rehabilitation to be connected with OVR.

We also will ask the MCOs to collect and publish data on competitive employment integrated outcomes the competitive and integrated employment outcomes we'll be asking them to collect and publish that information for us.

And we're asking the MCOs to provide services, that promote, or lead to securing or maintaining the competitive employment.

In terms of housing innovation -- while I'm on employment this is sort of an aside in terms of our building the employment OLTL working to build the employment capacity of the provider capacity in the employment space.

But our -- our employment specialist Ed Butler asked plea to share with you some information on the certified employment support professional exam. And we have dates for those exams coming up.

And the certified employment service assist people with disabilities, in finding and maintaining regular and community based employment.

So that -- the certified employment professional is one of the services we need in order to help the MCOs secure employment for individuals and we have one on -- I'll send out I'll have Marilyn send out the dates for this, but we're starting on October 17th

at university park we also have one in Clarion and one in Edinboro and Johnstown, also Marilyn will send out information to this group -- about the how to register for the exam this information, is up on our web site.

And going back to housing as you will recall I believe two meetings ago we did have Ben Laudermilch and our employment staff -- our housing staff come, Ben is sort of, he is the housing director for all of the department of human services but works closely with each deputy to each office.

So he works closely with my team that does, works on housing he works closely with the office of developmental programs team, works closely with the office of mental health and substance abuse services team.

But he has, come to this meeting a couple of times to talk about progress we're making in housing and that progress, is going to continue with the community HealthChoices MCOs.

We kicked that off, with a meeting with the community HealthChoices MCOs several weeks ago, maybe a month ago.

And Ben Laudermilch the housing director as well as his team and number of other housing resources that, Ben was able to bring to the meeting for example, the Pennsylvania housing alliance was at the meeting.

The Pennsylvania housing finance agency was at the meeting.

And several houser were at the meetings one of the outcomes of the

meeting was we decided in the coming months we're going to be doing a second meeting with each MCO individually so we can talk more specifically about the housing strategy and work with their housing director each MCO has someone that is identified to really work on housing.

So we'll be doing that as well.

In the coming months it might be a good idea once some of this -- we start to stand some of this up, and perhaps in half a year or so, we would want to have them, the MCOs come and talk about what they're doing around housing.

With that, we have that -- those are my updates I'm sorry it took more time than I wanted to.

But I would like to invite I guess I'll pass it back over to you Pam.

>> **PAM MAMARELLA:** Yes, does anyone have any questions for Jen?

>> **THEO:** I have one.

When the enrollment package be going out, do you have a time frame.

>> DEPUTY SECRETARY BURNETT: T Th ey're going out now.

>> **SPEAKER:** One of my questions --

>> DEPUTY SECRETARY BURNETT: H Ho ld on we have one in the room then we'll turn to you.

The question is Theo asked when the enrollment packets are going out they're going out this week, people are getting them you'll all see a copy of them.

>> DEPUTY SECRETARY BURNETT: Any other questions.

>> FRED HESS: Tany a --

>> PAM MAMARELLA: Okay.

>> SPEAKER: Okay.

One of the questions that I have regarding this whole process I just thought of it now, okay.

Let's say I'm a consumer I get my enrollment packet, a list of providers we still don't know, who they all are.

I see my list of providers I want to make phone calls to the providers to make sure they're the right doctors and medical team for me.

They say yeah, we're interested in maybe, taking you on as a patient it takes them a certain amount of time to even get your records transferred from another office, and everything you have to -- let's say you're a consumer you're looking you will this over, you have to make those phone calls to like four or five different doctor's offices, depending upon the amount of specialists and everything else you need.

As you go in through that process, what you have to -- you have to pick your MCO within like 2 months see that's part of what doesn't make any sense to me.

Like how can someone, have the time to make, that choice.

Based upon the scenario I've just given you, asking what MCA is

going to be best for them, because -- that consumer, looking at all that information, it is going to have to know how to do a lot of that leg work for themselves.

That's not going to come from an enrollment broker, that's not going to come from a service coordinator.

What are we doing about that part?

>> DEPUTY SECRETARY BURNETT: O Ok ay.

Thank you Tanya for your question.

I just want to reminder about the -- about the continuity of care period.

The MCOs must contract with your providers for the long-term services and supports providers for 180 days that gives you another half a year, to figure that out.

And in addition to that, using the HealthChoices standard is it 90 days.

>> SPEAKER: 60 days.

>> DEPUTY SECRETARY BURNETT: 60 days, for 2 months, the continuity of care period, requires the -- all 3 of the MCOs to contract with your providers that's what -- if they're willing and able to -- to contract, do you have anything else you want to say about that Heather?

>> DEPUTY SECRETARY BURNETT: H Ho ld on a second we have another comment.

>> **SPEAKER:** I would also say that particularly, for LTSS services, your service coordinator will help you through that process.

There isn't an expectation that you have to call every provider and find out who is going to be your provider and, that happens through your person centered planning process.

And your service coordinator will help you through that.

They also, you -- the MCOs also have care management staff who can hip you, when it comes to the physical health providers also.

>> **FEMALE SPEAKER:** And can I say something.

>> DEPUTY SECRETARY BURNETT: Ye p.

>> **FRED HESS:** Go ahead.

>> **SPEAKER:** You just said the service you just said that the service coordinator can help you with that process.

Your service coordinator is also going to be, someone that you're selecting in this whole MCO process.

And I thought before it was a conflict of interest for the service coordinators to do -- to help you choose an MCO.

>> DEPUTY SECRETARY BURNETT: The service coordinator, is also covered by the 180 day, continuity of care period Tanya you'll have the same service coordinator you have now for at least 180 days and the MC ons no matter which MCO you go with.

>> **FEMALE SPEAKER:** I mean, I understand that part.

But won't you also have to -- if you're saying, the present service coordinator testify during this process, helps them select an MCO don't you have to be concerned about that whole conflict of interest thing again?

>> DEPUTY SECRETARY BURNETT: No.

Service coordination is -- is an --

>> FEMALE SPEAKER: Service coordinator chooses the MCO they're going to tell them choose the MCO they are going to --

>> DEPUTY SECRETARY BURNETT: T Th ey will give you information on the providers like Heather said. And you're going to neighboring decision ultimately.

The service coordinators are -- are administrative function of the managedded care organization.

And so the managed care organization, must have service coordinators to coordinate the person centered service planning process to coordinate the -- the long-term services and supports with your physical health care and your behavioral health care.

>> FEMALE SPEAKER: And one other point that I wanted to bring up with this is, okay, if you have everybody still making their selections during that 6 month change over period how do they know, who all their providers are even going to be under like, the MCOs because we, as a subcommittee have a team that it -- has all that information, what I'm getting at is, we as a subcommittee, have not reviewed any of that yet,

to even, like, be able to give you any feedback on whether there's enough providers or, like, or anything.

But you're already asking consumers to make that choice right now.

I guess that's where I got kind of lost in this whole process.

Because I thought we would be seeing all that stuff including like individual policy from these MCOs with exactly how they were going to function before any of it got released to the public to have to make the choices.

I thought that's what the subcommittee was supposed to be all about.

>> DEPUTY SECRETARY BURNETT: The subcommittee -- the subcommittee has --

>> FEMALE SPEAKER: -- unless I'm wrong.

>> DEPUTY SECRETARY BURNETT: S Su bcommittee has provided us with invaluable, lots and lots of feedback on policies and things we're doing around this.

We -- as I mentioned earlier, the provider, the network adequacy process is what my team is doing with the 3 managed care organizations we're going to have a, a more in-depth presentation later in the meeting on what that looks like and they will be starting to talk about provider networks.

We are going to be publishing provider networks as I said these things are constantly changing.

They're growing.

And almost on a daily basis they're growing.

As the contracts come into the MCOs the MCOs that's their job.

The MC Os that talk -- that are going to be speaking today the 3 community HealthChoices MCOs can likely answer a little bit better your yes but they also are going to be posting their provider networks on their web sites.

We're going to be posting it on the IEB web site.

But again, it's a fluid thing it changes, going to be changing constantly.

But I think, that continuity of care period really gives you an opportunity to spend more time seeing whether or not that is the right MCO for you.

>> **FEMALE SPEAKER:** Okay.

Then maybe you just said it's going to be changing constantly.

So,.

>> DEPUTY SECRETARY BURNETT: G Gr owing.

>> **FEMALE SPEAKER:** Changing constantly you're still still in the continuity of care period, so you wait, to make your decision until like almost a month before the process ends, because it's constantly changing how can can someone be assured that their stuff is going to get processed and everything else in time, so they don't, loose services?

>> DEPUTY SECRETARY BURNETT: W We ll that's my goal.

Is that -- people do not loose any services, that's one of my essential priorities.

The other one is, that providers get paid in order for people to get services providers need to get paid we're doing a lot of testing right now, that's something we can talk about during readiness review, they can talk more about it in detail, we're testing all kinds of systems, we're making sure that claims are getting submitted and, they're getting processed.

A lot of our work has been -- is being done with regards to transferring information between systems to respond to some of the questions you asked earlier.

In terms of making sure your information is there.

And when -- what I said, the -- the network is changing it's growing.

It's -- they're adding providers in order to continue to grow their network.

So that's what I meant by that.

>> DEPUTY SECRETARY BURNETT: O Ok ay --

>> PAM MAMARELLA: Thank you Jen do we have another question from someone else we'll take a question from Ray and then, Ray do you still have a question or a comment? And then we'll go back to the phone someone else might have a question.

>> **MALE SPEAKER:** I just wanted to comment briefly really to reinforce what Jen is saying it was one of the MCOs we're very far along in the network contracting process, as she says there are additions happening if there's a whole and community based provider out there, that is operating in the southwest we don't know about it, please stick your hand up we think we found everyone we're you know if we have not, we'll contract with you quickly.

And then, from you know just, in terms of access information the IEB is going to be really well prepared to answer any all these questions for more than two months now we've been exchanging -- we call the ops five report with the State that, details our network and, that's all very fluid so the IEB will have access to pharmacy, specialists PCPs home and community based providers so that, when you do have those detailed questions Tanya you'll be able to get that information and they're really the best objective source for you know, for comparing the plans.

Then, of course the service coordinators again, providing objective information as it's available to them they will have access to the directories, web directories all these resources will go along way to make sure it's transparent for the participant.

Also, um, thank you for your enthusiasm for that -- one thing I did want to make sure I said on the record is -- we have --

>> DEPUTY SECRETARY BURNETT: H Ho ld on Tanya.

>> **MALE SPEAKER:** We're a large MCO in the western part of the State we only serve 19 percent of the duals 80 percent of the duals in western Pennsylvania, are not with us so there is you know a -- you know a large population that is unconnected and really needs to be paying attention to what choices they have available.

>> **PAM MAMARELLA:** Thank you Ray.

Tanya do you have another comment or question?

>> **FEMALE SPEAKER:** Yes, I do.

Ray, I know you emailed me and emailed the subcommittee before about wanting consumers to review the documents which you said you had in October 1st deadline, documents never came.

And I don't know what you wanted -- because they never came.

So it's like, okay.

With this process, we're willing to review stuff, we're willing to read it and we're willing to give you, input but if there's nothing to give you input on, how can we do it.

>> DEPUTY SECRETARY BURNETT: Da nya we've gotten a lot of input you have reviewed documents this committee has reviewed a lot of documents.

>> **FEMALE SPEAKER:** No, no, no.

Ray knows what I'm talking about.

>> **MALE SPEAKER:** Yeah and if I may Tanya we reached out through the sub-MAAC to see if we could, arrange a meeting with the consumer representatives we commote pin down a date or location which was workable during September, we're still working to identify dates to do that, one of our contract requirements, and something we you know intended to do moving forward is have you know, participant review of materials make sure we're getting feedback making sure that, what we're communicating is effective and clear we still intend to do that I was trying to get that together in September unfortunately we could not pull that off.

Is that doesn't mean we're not still looking for an opportunity to review those documents with you.

>> **PAM MAMARELLA:** I hear that is a contract requirement also.

So right.

So all 3 MCOs will be doing the same thing.

Thank you Ray.

Was there someone else on the phone that had a question.

>> **FEMALE SPEAKER:** This is Brenda Dare.

I was just wondering if -- preenrollment packet, is there going to be any notice that tells participants how -- the provider network.

>> DEPUTY SECRETARY BURNETT: Y Ye ah. The -- the IEB will have a web site and the MCOs will be posting the provider networks.

>> **FEMALE SPEAKER:** That information will be included in the preenrollment packet.

>> DEPUTY SECRETARY BURNETT: Ye s.

>> **FEMALE SPEAKER:** Thank you.

>> **PAM MAMARELLA:** Thank you Richard.

>> **MALE SPEAKER:** My question is, discuss navigator on APRISE -- the MCOs.

>> **PAM MAMARELLA:** Richard, excuse me -- the.

>> **MALE SPEAKER:** MC Os provide application --

>> DEPUTY SECRETARY BURNETT: The question is, will the marks COs provide network navigation.

Is that the question?

>> **FRED HESS:** Yes.

>> DEPUTY SECRETARY BURNETT: MC Os will be able to provide information what is available in their network.

And we are still exploring the -- the requirement in the final -- the Medicaid managed care final rule that requires us to have beneficiary support system that is more robust than what is available in HealthChoices and we're still, exploring the the possibility of doing a procurement on that.

So but that is something -- that requirement doesn't take effect I believe until until next summer so we're still working on that.

We also are doing a lot of work with the APRISE program, APRISE counselors know about community HealthChoices we've done some training with them.

They -- their role is not, is not to -- advise on community HealthChoices their role is to give people information on the Medicare open enrollment process and they know where to point people if they have questions about community HealthChoices.

>> PAM MAMARELLA: Okay.

>> MALE SPEAKER: Thank you.

>> PAM MAMARELLA: Thank you Richard.

All right.

So thank you very much Jen and thank everyone for the rigorous discussion around some of the issues were grappling with, as we go into launch.

And with that said, we would like to hear from Wilmarie Gonzalez about launch indicators welcome mill Marie.

Marie.

>> WILMARIE GONZALEZ: Thank you.

>> DEPUTY SECRETARY BURNETT: Do you have to look at there?

>> WILMARIE GONZALEZ: I'm fine.

>> DEPUTY SECRETARY BURNETT: C Co me sit over here.

>> DEPUTY SECRETARY BURNETT: W Wi lmarie Gonzales.

>> **WILMARIE GONZALEZ:** Thank you.

Good morning everyone.

Happy October.

[laughter]

How exciting a lot of energy.

A lot of nervousness right.

Since we're getting close.

Oh, my gosh.

All right.

So -- um, okay.

So you know this has been a, maybe what a year and a half now of dialogue with regards to the quality and today, we're going to be really focused on launch indicators.

There's a lot of feedback we've gotten over a year and a half, has been how DHS really going to ensure that, community HealthChoices is actually you know, it's working?

Nothing is broken and, and -- there's no interruption of service.

Our ultimate goal for in particular for the launch indicators is making sure that we improve the quality of health care and long-term care services for all Pennsylvanians not only the folks that are receiving waiver services today and fee for service environment but also the dual eligibles we're going from 40,000 people that we're serving to

over 400,000 people in the 3 year span.

So, that's a lot of individuals that we are responsible for and we want to make sure we're doing it right.

We have had in the past year and a half talked a lot about our approach to designing quality should look like for community health services, we have had a lot of webinars and presentations at this forum and other types of forums we really have sort of beaten down what quality really looks like.

Right.

We have talked to a lot of states done a lot of national research we've gotten some really good consultants that have shared their experiences, in the area of quality and more importantly we know that there are no national LTSS measures across the State.

So a lot of the states who have been doing managed care, have been sort of trial and error for them, so we've taken best practices from them, we have heard from them some of the barriers and challenges that they have experienced.

In introducing managed care in their states so we want to make sure we are doing it right in Pennsylvania.

So measurement has been a key area for us, it's very new in the fee for service we really did not talk a lot about that.

We do have CMS assurances that we do meet, but when you look at long-term care services and supporting a managed care

environment, we really need to identify what those performance measures are going to really look like.

Measurement is going to be important for us as you know.

We can't improve what we don't measure, that's key and very important these are things at the national level, many of the states and a lot of organizations have talked about.

Transparency, has been key.

I talked a about it, this is not new, in in many of our conversations we've had, we talked about the fact that we want to make sure that we are transparent with the information we are receiving and collecting not only by the MCOs but by other entities that are helping us with the community HealthChoices.

So we want to be able to show how we measure, so measure can be acceptable.

Or not.

So we need to make sure we do that. And finally accountability.

We need to make sure again we want to make sure we're being accountable to what we're doing in the community health choice program.

Once we measure we can expect and track services that are being provided by our participants.

And it will give us an opportunity to make -- to make changes if we have to and so, really important.

Next slide.

So, Jen talked about it I know a lot of people are very nervous.

Our priority for community HealthChoices for the next 6 months.

We talk about continuity of care.

Two things.

Ensuring consumers get services and providers are getting paid.

If providers don't get paid, consumers aren't getting their services.

If consumers don't get services, guess what? You guys ain't getting paid those provider in the room, right.

It's important these are the two main things, priorities we need to make sure that community HealthChoices occurs when we start from day one and so, we have talked a lot about quality strategy, we have presented the quality strategy, we have provided a lot of details and the 11 components that make up the quality strategy for community HealthChoices we've had enormous amount of internal and external stakeholder engagement and dialogue and we've met with a lot of organizations and so -- I'm putting some content into this conversation, because I think it's really important for those of you who have not had an opportunity to hear me speak.

Right.

This is really important we've been talking about this for a very, very long time, so priorities during implementation and our DHS preparedness that's a big question, so what have we been doing so far to ensure that we are ready.

We -- the DHS, as a state we're ready for community HealthChoices.

And so you have heard about readiness review.

It's been ongoing.

We've had a lot of dialogues with the MCOs.

We've been meeting with them, weekly.

Weekly I mean not once a week but -- almost daily.

We have done an awful lot of stakeholder communication and finally, today what we're going to do is the launch indicators we're hoping that, when we walk you through the launch indicators, our hope is that you will be able to see the kinds of things that you, many of you have already identified and captured to ensure again, consumers get services, and, providers are getting paid. And so you know I move thed chair earlier for Paul who is not here you know he is my other -- my twin he is not here today he is on the phone he is going to -- provide us with some walk through on this, so -- next slide.

This slide really captures a lot of stuff that has been happening.

Again a lot of these things you have already heard.

Prelaunch this is what we're doing, right now. And prelunch there are four main things that are occurring.

We are identifying our primary aim what we're doing for each area.

Ensuring that we are identifying key activities that are supporting each of those areas.

And the kinds of tool that's we're utilizing, prior to -- and, more

importantly, at the end of the slide is about stakeholders.

We need to make sure that we're being responsive to the information you're providing.

So prelunch a lot of information both in on the web site and many of our presentations we talked about readiness review.

The kinds of things that we're doing is, we're doing system testing.

Not just OLTL but other organizations within DHS.

We're ensuring that we are reviewing baseline analysis, that's meaning we're looking at the data we have today good or bad we're looking at it right now to make sure, are we ready do we know the people we're serving today? So when we move over and get back to the MCOs they understand who they are.

When you talk about the types of tools, we have already talked a lot about the readiness review tool.

It's something we've adoptedded that already existed in our OMAP program offices for HealthChoices we've adoptedded that and I will go would not go into too much detail you've also heard a lot about the quality strategy.

I can -- I cannot express enough, how important it is if you had an opportunity to look at the 300 plus pages please just you know just take five minutes read the document.

It's huge.

But it's really critical it's really important it gives you kind of

a road map of the kinds of things we're going date of birth looking at.

And then finally all the communication we've been receiving from our stakeholders not just, at this forum but other forums as well and many meetings we've had.

January 1st, day one, launch.

It begins we're live.

The kinds of things that are going to be important critical, will be obviously continuity of care for 180 days so, some of the things that we're going to be doing which we already are doing now is -- ensuring that we have frequent meetings with the MCOs.

But it goes beyond just the MCOs.

It's the MCOs it's the IEB, is the information, also collecting --

>> **SPEAKER:** They're working on the elevator.

[Laughter]

>> **WILMARIE GONZALEZ:** Okay.

So -- I want to -- we want you to think about you know, when you think about community HealthChoices it is not just the MCOs.

There's a number of other entities that we're also going to be looking at.

We're going make sure that the evaluation plan at the Medicaid service rent center at the university of Pittsburgh that is -- we're on year two already that will continue during launch because they have done a whole lot -- they have done a lot of studies and evaluation, last year

when they -- when it started and so now we're in year two we've learned a lot from the information that they have collected and so that is helping us a lot.

Prior to launch.

The kinds of things we're going to talk about today, are launch indicators they're going to be key for us.

And, a lot of these indicators have already been shared with the MCOs. And so today we're going to walk you through that.

Really important to make sure is that we're also going to make sure we're analyzing the kinds of calls that we're getting in our hot line numbers, whether there's information, coming in from the provider hot line number or the participant hot line number.

Not only is the calls coming in in the participant hot line number for community HealthChoices but we also want to make sure that we're hearing also from the information that is coming in from our fee for service and participants.

Because we're still responsible for all of them as well.

And obviously really important, the MCOs are required to have participant advisory committees.

We're going to be looking that the, we'll be participating in that.

So -- that is going to continue that is going to be happening during launch.

There's going to be local advisory groups and again a lot of these

items, are things we've pulled out of the agreement and so that's, occurring.

Obviously, making sure that we are presenting the information that at the sub-MAAC and this type of forum and in other organizations as well.

Our goal will be to continue doing the third Thursday webinar depending upon the issues coming up which I'm sure there will be some issues.

So we want to make sure we're capturing them on third Thursday webinar and more importantly, if you have not had a chance to visit our -- the CHC web site there's an enormous amount of information on our web site.

A lot of information, good information, really gives you an idea of the amount of work that we have been doing, thus far in the past two years actually, because when we started out with the concept paper, two years ago, that's when I came to OLTL I mean Wow, two years later it's been a lot, a lot of information so -- so with regards to steady state, that is what we refer to as -- okay.

180 days have gone by. And we have moved onto continuity of care so now we're now in the phase we're looking at the data coming in, the encounter data, those kinds of things making sure we're collecting the data, for or evaluating or analyzing or improving we are improving systems, obviously making sure that the services

are being provided to our consumers a lot of these activities within each of these areas will continue we'll continue to have regular meetings with MCOs and other entities like the IEB, we are going to adopt the same thing that OMAP has with HealthChoices that is having quarterly meetings with the MCOs.

Looking at the data, reviewing the data.

Great you're doing wonderful or gee we've got some concerns.

So we're we're establishing protocols QRMs

you'll hear about that, later in January, sometime in January or February we'll have the QQRMs with the MCOs.

Other things we're going to be looking at is obviously, measuring outcome measures things like that. And ensuring that we continue to participate in the MCO participant advisory committees.

Next slide -- so, the question now becomes you know what are launch indicators.

These are the things that I think based upon our dialogue and our conversations we have had for quite awhile, here are some things we think are really important.

Remember, continuity services providers need to get paid consumers need to receive services.

Key data points, they're going to be provided during launch -- are things that we're going to focus on support, continuity of care, 3 areas.

Services -- for participants, which is number one.

Provider participation, making sure that they're getting services and the information transfer.

That is something I know I've heard, time and time again how do we make sure that the services and information, that exists today, will continue on in the MCOs have it, so we're making sure that we're focusing in that area.

I think the most important thing, why we have developed launch indicators as well is that the information we're collecting will help us, as close to realtime allow us to look at the data and respond quickly. And not wait until the data comes in later on, I think that's really important.

These launch indicators as I said, again I'll reiterate there's been a lot of internal and external stakeholder engagement, we've had conversations with you individually and as a group we've received a lot feedback by the MCOs when we first shared the launch indicators with the MCO he we thought, well, let's see what they say.

You know, does it make sense?

Many of them said wow, these are great we'll be collecting this information, so if you want it, at a frequency that you want, we should be able to do that.

More importantly we have had almost 2 years, we've had internally, we have DHS and aging work group that not only has been looking at the quality strategy but also looking at the performance measures looking at

the launch indicators and really

looking at everything we've been doing.

Next slide.

Another question that has come up is why are launch indicators so

use useful?at the end of the day,

we're saying continuity of care is critical and important so there's no

interpretation of services for our participants, launch indicators is

really, ensuring that we're focusing on those kinds of things and when

you hear some of launch indicateddors

we'll walk you through that, I'm hoping that will answer some of the

questions I'm hoping it will make you more comforted of the things we're

looking at, once the community HealthChoices begins.

Next slide when you look at the launch indicateddors and here's a

new term, we've talked about this, but again this is very new because in

the fee for service environment, is just something we don't really talk

about, but, for managed care, we talk about domains or categories and so,

the four main things that we're going to be looking at during launch is

going to be, service continuity.

Service coordination continuity.

Provider participation and again these are all things that I've

already talked about and obviously information transfer. IIT systems they have to work.

The other thing is to -- that I'm going to invite Paul now to walk

us through each of these categories.

And again the goal will be to help you to better understand the kinds of things we're going to be looking at.

>> **PAUL SAUCIER:** Good morning, thank you I'm glad to be with you today the first category on the next slide service continuity.

Continuity indicators so we know, yes.

So we know that we want to ensure that people services don't stop and, so what are some things that we can look at, where the information will be available in the early days of the program.

So, I'm going to, go from left to right.

And the first one the first box you see is weekly enrollment and disenrollment of participants that seems pretty basic.

But we have to make sure everyone who has enrolled through the IEB, is actually showing up on an MCO's member list.

That is -- they're not getting lost in that process.

And no MCO knows on January 1, that they have a new member.

So looking at the weekly enrollment and disenrollment information.

Next one over, weekly enrollment and disenrollment of legacy waiver participants into the CHC waiver.

So, those of you who are in one of the existing waivers in the southwest today that is being transitioned to CHC, again it seems pretty obvious but checking to make sure that you are actually transferred from your existing waiver that you're using today to the new CHC waiver.

Participants with an HCBS interruption the first two weeks.

This is the box on the upper right.

So, this one is really important.

How would we know, whether or not you are experiencing continuity, so if you have a service plan that is in effect on December 31, it calls for having a personal care attendant come to your home on January 2nd, we want to know that actually occurred.

Whether or not the agency that you use is in the MCOs network continuity needs to be there.

So, um, the MCOs are going to reach out and contact all waiver participants, within the first two weeks of the program and then we'll report to the DHS on whether any of the people who are in waiver programs have experienced any interruption of service during that time.

Obviously if, when they have someone on the phone they discover there's a service interruption, then they will also be in a position to be able to mobilize the service very quickly.

So that's the key one.

Moving down to the second row, critical incidents will continue to be reported through DHS's enterprise system and so, that information will be available in realtime to the departments and so looking at those critical incidence are they higher than they have been in the past? You heard Wilmarie talk about you know, part of the readiness is looking at these numbers.

What do we expect to see in terms of incidents? Are those numbers going up? Is there variation across MCOs, does one MCO have far more critical incidents than another, if so, do some quick exploring to determine why.

Weekly participant complaints and grievances this is going to be new.

Because this is complaints grievances are not something that exist in the fee for service system.

So what are the types of compliance and grievance that's are coming in, in the early days and again is there variation across MCOs?

Weekly participant calls to the hot lines so -- the OLTL line that exists today will continue to exist but also, in recognition that there's -- generally a high volume of calls, days of the program, contracted lines, what is the volume what is the variation across MCOs.

And then, finally the early appeals that members may file, what is the volume of the appeals, what is the type will be particularly interesting if there are access related appeals you know, I believe I should be getting a service and the MCO denied that service, something to effect.

So moving to the next slide -- service coordination continuity indicators.

Again, Jen Burnett mentioned earlier that, service coordination is also, subject to continuity of care for the first six months.

And so first of all, again, it seems obvious that just making sure

that the participants who had a service coordinator on December 31, still have one on January 1, that is showing up in the MCO's system.

Weekly risk screens this is new.

MCOs are required to conduct risk screens on all members not just those with LTSS needs. And so weekly reports to sigh how they're progressing, how many risks have been conducted and what the results are.

And then, finally, weekly comprehensive needs assessments conducted.

So -- if a risk screening, indicates I mean you might be -- a so called healthy dual, living in the community not receiving many services but the risk screen indicates, that you probably have some unmet needs.

Then that would suggested -- that a comprehensive needs assessment needs to be conducted.

And, what are the results of that.

So, um -- so in this whole area, is your service coordination continuing if you -- um, if you had it in the past.

And, um, what is the risk screening and assessment activity looking like in the early days of the program?

Next slide.

Provider participation in indicators and Wilmarie mentioned provider don't get paid they're not likely to continue with the program.

So obviously that is a key indicator.

The first one is is how many claims came in to the MCO this week?

So the providers now need to submit their claims to the MCOs not to the promise system.

What is -- what is that looking like? I mean, we know that there's claims lag, we don't expect to see 100 percent of claims in the first week.

But how many providers did submit claims? And, does it look like a reasonable number?

If the number looks really low? Then why is that? Is it because -- providers are having trouble with the billing system and so on.

Moving to the right, weekly claims paid pending and rejected by the MCOs.

So, the first indicator is how many claims are coming in.

The second indicator is what has the MCO done to dispose of those claims? In other words, to address them one way or another.

Okay.

This claim is good, we paid it.

This one is still pending.

We have not had enough time or we have some questions about it.

And this claim has been rejected.

So again that will give DHS an early indication of -- if a lot of claims are being rejected, is that an indicator that providers need more help in figuring out the billing system, for example, so -- is there -- again early indicators how the claims processing is going.

In terms of how providers are -- might be vocalizing any concerns they have, looking at the weekly provider complaints to the MCO and asking the MCO to report on that.

But also providers will be able to use the hot line and so DHS will be monitoring those to see the number and the type of calls that are coming in and to see whether there's variation across MCOs in other words, if one MCO has you know 20 percent more than the others, that says there is something that needs to be explored.

Next slide.

So finally on information transfer and this gets pretty technical we really simplified these, there are actually more than two, it's the two most important areas for information transfer in terms of continuity of care.

First of all the selection process, that you all will be going through once you've made your selection through the IEB, is that information being transferred DHS and the MC Os in a timely way.

So IEB transmitted, was actually received by the MC Os? Does the MCOs list match the list the IEB believes they should have.

A lot of testing around that.

That will be a continuous process because even after this open enrollment period, people will able to choose the MCO they want, and people coming in continuously into the program as there are today, monitoring that information transfer making sure that basically the people don't get dropped in the virtual when

they're out there, as the information is being transferred from one party to another.

The second key area, for information transfer is, is functional eligibility determination so -- both in terms of people being referred for a FED assessment if they need one, if that referral actually makes it, to the FED entity, are they acting on it? But then also, once the functional eligibility determination entity does it's assessment does it's work is the outcome of that being successfully transferred to the parties that need to know?

So those are the major areas for -- that we've focused on for launch.

To summarize again, this is not meant to be all of the performance information that will be looked at over time.

But for the launch period, these are the ones we believe are critical to ensuring that, essentially, services do not stop they continue going for you on January 1. And the providers that are providing them, continue to get paid.

So with that I'll turn it back to Wilmarie to talk about next steps.

Argon gone oh, okay.

We have some questions.

We have some questions, and Paul is going to answer all of them.

[laughter]

>> **FRED HESS:** Paul it's on you.

>> **PAM MAMARELLA:** Theo do you want to start.

>> **THEO:** Thank you.

Following your scenario about December 31 and beginning January 1,

in regard to interruption of service let's say a home care agency or a consumer participant is not getting service on a

particular agency on January 1st, found themselves, service interrupted

how quickly then, can that home care agency become a provider or would

the participant have to choose another provider to that provider become

a provider.

Follow me?

>> **WILMARIE GONZALEZ:** So we're assuming this provider is not part

of -- not involved in any of the MCOs? We would hope they are.

>> **THEO:** Right.

>> **WILMARIE GONZALEZ:** You're saying perhaps they're not.

>> **THEO:** If they're not, how quickly can they become a provider or

-- would the participant be forcedded to choose another home care ocean

provider.

>> **WILMARIE GONZALEZ:** Very first thing that the consumer because

they do have rights I think the they vest finger they should do is

contact the MCO to make sure they're being -- that they're

connecting to the right people and then if that person the home care

agency is not part of that network we need to ensure that's occurring so

-- that consumer should be -- I know Ray is trying to respond I think if

that home and care agency is not connected to a network and they should

prior to, they should, we've been talking about it for over a year this

is not new news to people.

If they're not, sometimes that happens.

That participant should be able to pick up the phone.

And call the MCO.

The participant always, always knows they can contact DHS as well

the participant hot line number will continue to be available for those

for the consumers.

>> **THEO:** I understand that.

That's important to say.

But reality is -- that participants, don't have a home care aid, how

quickly is something -- in place.

That -- that consumer to get they're aid of choice or would they be

able to get someone else? That's my question.

>> **WILMARIE GONZALEZ:** They should have a right to continue using

that aid it's just how quickly, can the MCOs put them on their networks

so that -- that happens, rather quickly, so Ray I do know if you wanted to say something.

>> **MALE SPEAKER:** Thanks we've been thinking about this issue there's 3 things we want to say.

First we should begin receiving detailed data on participants and

their providers in late November the first step, for us is to make sure

that those provider organizations are in network and, validate those

members with -- the providers themselves.

So, that process will be a back and forth mostly through December.

It will be you know, but again that's how we're thinking about approaching this, so when we identify provider we'll confirearm with that provider okay is this your case load? We should be seeing if there's a provider that emerges that is out of network we're going to aggressively you know, contract and make sure we have them in for January.

In the case where there's someone who emerges after January 1, and their participant is in the participant is, being served by an attendant that is, from an out of network provider as long as that provider is a participating Medicaid provider of the promise ID we'll be able to pay them and come up with an out of network arrangement to until final contracting is finished we want those providers to continue you know providing services, in the case where that provider, drops off and is unable to fill those services that is where our contingency plan comes in, we identify back up provider within the network to get out there and provide services so -- something we've been thinking about you know, we all, are anticipating challenges.

>> **WILMARIE GONZALEZ:** Right.

>> **PAM MAMARELLA:** Before I wanted to move on I wanted to ask if the other two MCOs have any additional comment on that I think, that you're going to see a commonality on the approach, to ensure that people don't have an interruption in their service.

But, perhaps readiness if you have anything else to say the other marks COs can comment with that, drew?

>> **MALE SPEAKER:** Thanks Pam.

And -- this is really for Paul, since -- Wilmarie doesn't want to.

[laughter]

Field the questions.

[laughter]

But you flow that my concern is, mostly for people who have cognitive impairment, whether they be older adults or adults with acquired brain injury and I'm most concerned about the current enrollees making sure choice and, getting signed in, so it was good to hear Paul that you're going -- one of your things you're checking is just that.

I mean, you know, you're going with to check the current enrollees against who is enrolled I assume at every point from now until January 1.

But then, what are you going to do with that information?

So you know, you could call them up and you may or may not get them and they may or may understand why you're calling them.

And so I am wondering if it's appropriate, in those cases for their current service coordinator to assist them with the process?

Because they won't have chosen anyone yet they're still working with you know, they know their service coordinator.

They have a relationship with that person.

And is that appropriate and can it, can that happen?

>> **WILMARIE GONZALEZ:** Isn't that the expectation? Yeah. That is the expectation.

Thank you drew.

>> **MALE SPEAKER:** How will that happen.

>> **WILMARIE GONZALEZ:** Exactly how you said it, service coordinators -- is your concern for those consumers who have a service coordinating entity now, are you -- are you raising concerns come January 1 they may not have or they may not have selected their MCO?

>> **MALE SPEAKER:** Yes they may not have done the work you're expecting them to do because of their cognitive impairment, okay we don't want the disability to stand in the way, of them receiving services to which they're entitled.

>> **WILMARIE GONZALEZ:** Absolutel y.

Okay.

>> **MALE SPEAKER:** It would assume to me, that Paul's information, has to go to the service coordinator.

>> **WILMARIE GONZALEZ:** Uh-hum.

>> **MALE SPEAKER:** Is there a plan for that.

>> **WILMARIE GONZALEZ:** Well, remember with the continuity of care that means a service is not going to be interrupted.

So if an individual does not select their MCO they're going to be auto assigned.

>> **MALE SPEAKER:** Well that's just a disaster because that's -- you know, so what I'm saying -- gone gone I would not say a disaster drew, those are -- that's a little bit of a harsh word.

I would say that for the consumers that we are serving today, they have a service coordinating entity, for the past year we have been doing a lot of communication with them, to say -- community HealthChoices is coming.

You need to connect with the MCOs.

If you have participants that you're serving you need to be aware that community HealthChoices is coming.

There's going to be packet that is are coming out.

We've done a lot of public forums for service -- and providers,

so if the individual does not selected their MCO they're going to be auto enrolled come January 1, they say wait a minute.

January 2nd I don't want to be in this MCO I want to be in this company.

They will always have the opportunity to make a change.

>> **MALE SPEAKER:** Everything you described is great.

Gone gone now we're dealing with we can also talk about guardianship the guardians are going to be involved.

Family members and so --

>> **MALE SPEAKER:** I -- I'm not hearing the link, between the data, that you're being -- that you're collecting, and --

>> **WILMARIE GONZALEZ:** I'll have Paul answer.

>> **MALE SPEAKER:** The current service coordination system.

>> **WILMARIE GONZALEZ:** I failed at dance are answering drew.

[laughter]

>> **PAUL SAUCIER:** So drew I think I -- maybe I interpreted your question a little differently I will make I think you're asking in terms of calling participants to check for a service interruption, shouldn't their service coordinator be involved in that?

You know, the person might have dementia, not know whether they have a service interruption for example.

So first of all the MCOs have flexibility to do that outreach, in a number of different ways because we're -- DHS is expecting them I think, the non-is about 14,000 waiver folks in the southwest, so, that's a big volume to reach out and touch all those people in two weeks.

So I expect service coordinators will be deployed, in partnership with their MCOs to make some of those calls and report back to the MCO.

I expect that they will be intimately involved in that process.

But because the volume is large MC Os will probably use customer service reps they're in the room they can comment what they're thinking about I think it will be a combination of things. And then, let's say

it's a customer service rep who has called and the person says no, I haven't seen my aid in 3 days.

I would expect that the next call would be to the service coordinator to say what do you know about this? Can you get to the home? Can you check things out? And figure out what is going on?

Male well, thanks Paul that makes sense for after January 1, but what I was really trying to set up was a smoother scenario, for getting into and making a choice of the MCO, informed choice of the MCO.

And I was suggesting, that the data that you're collecting about enrollment, could be utilized in a dynamic way, to take advantage of the existing relationships that people already have currently with their current service coordinate you'res.

>> **SPEAKER:** So drew Kathy Godden with AmeriHealth Caritas, 100 percent correct.

So what -- what we're doing, I can't speak for the other MCOs, I would say that we're going out and we're meeting with these service coordinator entities, one-to-one, we're actually, looking at who are these high risk people, who do are the people that need this help in making this decision and ensuring that, if they're coming to my -- my plan, that -- we're ready, to help them day one and I know your concern is prior to day one.

But it's those relationships that we're building prior to.

Going out doing the one-to-one making them aware of the high risk

people that need the help ensuring they have all of the tools and all of the information to share with the legal guardian report representative and ensuring that the participant is choosing the MCO that has the providers that are in their network. And ensuring that MCO is offering all the services that particular person needs.

That's part of what we're doing right now.

And so we have a responsibility -- and ensuring that the service coordinators that's my role is -- service coordination, that they have all the tools, to understand what we do and how can we help them? So absolutely understand that.

>> **MALE SPEAKER:** You can only do that once the person chooses you, I'm concerned about the prechoice situation.

>> **PAM MAMARELLA:** Right I hear what you're saying drew and -- representing an aging network, where we have 70 percent of the people we serve have dementia -- it really does resinate to me I I think that, what we're saying specifically is that we need targeted communication directed at the service coordinators as it relates to assisting this population.

So that no one gets left behind.

And until they enroll with an MCO the MCOs are necessarily going to be be to help we have to targeted the existing network and the communication to that existing network to get that done.

And are we doing that?

>> **MALE SPEAKER:** That's my question Pam.

>> **PAM MAMARELLA:** Are we doing that?

[laughter]

>> **WILMARIE GONZALEZ:** How about -- this is something a follow-up I'll do with communication.

>> **PAM MAMARELLA:** Yes. Okay.

Okay.

>> **FRED HESS:** I have a quick we.

One quick question.

On the indicators when they start, when we start getting all the information in -- and we review them, I'm assuming that we're going to get to review all of the -- indicators that are coming in, although -- you know, this many problems and this many successes so on, we'll get that information, I assume.

>> **WILMARIE GONZALEZ:** I know you'll hold me accountable.

>> **FRED HESS:** Absolutely, yes. Oh, absolutely.

Okay.

What I need to know is -- is are we, going to be able to what kind of things can we do to help, with the problems and the issues with this, what can this committee do? What are we empowered to do?

>> **WILMARIE GONZALEZ:** I think that, as the data -- sorry.

I think once the data starts coming in and we start collecting them

and, start collecting aggregate data to make sure we identify either

trends by MCO, by region if there are things that we know for I know for a fact, we have communication in poor communication in

one area or not seeing a lot XYZ we should not only collect that

information present to the committee, be able to follow-up, the other

thing too is that it's not only just DHS collecting the information and

reviewing and analyzing, we're sitting along with the MCOs and talking

about that.

We should be able to hear present to all of you, some

dashboards on all, what is the data that we've been collecting and how

we have -- have we not only identified some of the challenges or core

trends, but how have we solved those issues, but also I'm hoping,

that on a positive note is that we can also recognize the good things

that are happening, go community HealthChoices as well.

>> **FRED HESS:** Absolutely.

>> **WILMARIE GONZALEZ:** That's the goal.

If we're identifying trends, and again these are the -- there is the

data that is coming in, weekly.

Then we want to make sure there are issues we don't want to wait too

long we want to be able to handle those, as soon as possible.

And then be able to present that to the group and then if I believe,

you know, Jen will be sitting at the meetings as well, as well as Kevin

and the executive QMT, from OLTL there are issues we need to escalate

bring to the second's office obviously to the committee members here,

definitely want to be able to do that as well.

>> DEPUTY SECRETARY BURNETT: So in other words, Fred we'll be giving you -- we'll be providing reports to the committee.

But, if you remember this slide right here, this slide, at the bottom has you and a role in all 3 phases, and -- your feedback is really going date of birth critical.

So if you are running into, I'm sure you will -- participant that is having some kind of an issue, we'll -- multiple venues for you to give that information to us.

>> FRED HESS: Okay.

What I'm really --

>> DEPUTY SECRETARY BURNETT: S St art with the MCO.

>> FRED HESS: What kind of power does this committee have? How can we, change -- just beside input we find a difficult situation, and, it is something that, you know you guys can't maybe get a handle on or something like that, are we empowered to make decisions over the MCO?

And this committee?

>> DEPUTY SECRETARY BURNETT: Y Yo u're empowered to make advice to the MAAC that's the roast committee.

>> FRED HESS: I wanted to clarify our role.

>> DEPUTY SECRETARY BURNETT: A Ad visory committee to the medical assistance advisory committee.

>> **FRED HESS:** I want do know where we are, in regards to the roll another and everything.

>> **PAM MAMARELLA:** Okay.

>> **FRED HESS:** Steve?

>> **PAM MAMARELLA:** We'll go to Steve first and then --

>> **MALE SPEAKER:** Just think the -- the points that drew is making really dove tail with what Tanya was talking about earlier and that is you know, how is this whole selection process going to take place.

And I'm just wondering, if it would be a value, to have someone from the IEB perhaps come and present specifically, what they will be doing and how that, how these matters will be handled and likely from OLTL will give an outline what will be expected the current service coordination entities in assisting consumers like this.

I think it's important to remember that, the plans are actively building out their network which includes the service coordination entities.

So the -- there will be a point in time, when the service coordination entities will be affiliated or at least, under perspective contract with the plans. And so, I think that's another element of this,

and so might be good to have you know a -- a clear understanding of what the expectations will be, of service coordination entities and all of this has to happen in a relatively very quick period of time.

And just to go back to Tanya's point with regard to knowing the

providers in advance, with older people at least they don't really have access to web sites and, computers and so forth.

And, what other media will be available to provide information on providers, with all 3 plans.

>> DEPUTY SECRETARY BURNETT: S Su re.

They will have to provide it whatever -- whatever mode the participant needs it to be provided in.

But I would say that my, my mother would take issue with your comment about them, older people not being -- into the modern age she has been on instagram.

>> MALE SPEAKER: Relatively speaking people don't have --

>> DEPUTY SECRETARY BURNETT: For four years.

Yeah.

>> WILMARIE GONZALEZ: Good feedback.

>> DEPUTY SECRETARY BURNETT: G Go od feedback we can have a presentation from the IEB at the next meeting and -- you want some more detail about the service coordinator's role going forward we can certainly do that.

>> AUDIENCE MEMBER: That may not happen until December.

>> DEPUTY SECRETARY BURNETT: We may have to shift some things around.

I think that's somewhat of a priority.

>> **WILMARIE GONZALEZ:** Otherwise you'll get a call from drew.

[laughter]

>> **MALE SPEAKER:** To the extent that -- the current service coordinators are contracted with the MCOs and, it is all smooth, that's great.

But, I mean, what my suggestion was about using the current service coordinators because they, have been working before they know that.

>> DEPUTY SECRETARY BURNETT: T Th at's why we're doing service coordination training we have an expectation that the service coordinators are going to be able to help, help people figure things out.

Kathy did you want to say something about -- how you would handle this?

>> **SPEAKER:** I think one of the things I wanted to talk to is the highest risk because that is really what our concern is, our most vulnerable because we know that, there are populations that can get this information and, they can, work with their service coordinator to understand, what their next step is.

But, it is truly our entities who are working hand in hand with the participants now, who can help us identify who those highest risks are, so we can start -- addressing what their needs are, what do they need to know I know we are, that's one of the things we're looking for is -- and this is after the enrollment part starts.

Is are then tightities to tell me, hey, I'm concerned because they

have an elderly caregiver and, um, maybe they're not able to identify if they have a problem with services.

Right.

So January 1, we spoke they didn't have services I want do know who the highest risk is, long before January is so we're ready to take action and ensure that nothing is missed.

So, so we are very much aware of what your concerns are and absolutely, need to identify that before this 1/1/18.

Okay.

>> DEPUTY SECRETARY BURNETT: O Ok ay.

>> **PAM MAMARELLA:** Thank you so -- I'm sorry.

Okay.

Two more questions then we'll need to move on, to -- we've tabled Listserv, with that said we're still going to fall behind schedule a little bit I know there's going to be some questions about the FED tool.

>> **MALE SPEAKER:** This came came in from Tanya it has to do with the information transfer between MCOs so when a participant decides that they want to change to a different MCO, can you talk about what system is in place to make sure that information is transferred for the participant between the MCOs and the time that you've specified that they will be switched over and if that doesn't occur, who do they contact? The new MCA the old MCO, OLTL.

>> DEPUTY SECRETARY BURNETT: Ray do you want to take that question that's a little more in the weeds than I exist.

>> MALE SPEAKER: Yes. So I think the -- the first thing is, sort of in context with -- MCO to MCO transfers it will follow the normal Medicaid dating rules if someone makes a change in the early part of the month, it will be active the first of following month later in the month, it will be the first -- the second you know, following month.

So rough live minimum you know a little more than two weeks to communicate and then maximum we're like you know, more like 6 weeks or so, for that communication.

The State has begun making strides for not just the CHC MC Os but for all of the DS narcses to have a expectation we're sharing service plans on the line DSNPs and as well as between plans as people make moves

we're anticipating that our service plans will be probably in the early staged exported to PDF and sent to plan contacts as original approach until we have more formal secure FTP transactions or something like that as we get further ahead.

At least early stages we think it will be more likely to send a PDF and have communication with the other other MCOs.

>> PAM MAMARELLA: Thank you Ray and Carrie and Tanya.

>> MALE SPEAKER: We all compete -- and, we are all on the same page in terms of realizing how important it is to the participants get the

MCOs that they want, I think we've all committed we'll make this happen and make the -- the switch happen flawlessly, so when it changes a change is made, their new plan will come in place whether it's supposed to.

>> DEPUTY SECRETARY BURNETT: J Ju st want to respond to one thing you said Norris you all complete you also are the building blocks of community HealthChoices and your success is critical to the success of community HealthChoices I just wanted to think of it that way rather than as competitors.

>> **MALE SPEAKER:** Friendly competition.

[laughter]

>> **PAM MAMARELLA:** I think we have one more question on the telephone --

>> **SPEAKER:** I sent you a text.

>> **PAM MAMARELLA:** I have a text of that question.

How will be the IEB contact residents regarding the selection of MCO plan.

>> DEPUTY SECRETARY BURNETT: N Nu rsing home residents will be getting that enrollment packet and -- they will need to make a choice of a choice of managed care organization if they don't, they will be auto assigned and that point an MCO will be in touch with them.

>> **PAM MAMARELLA:** Okay.

>> **MALE SPEAKER:** My question was -- I had -- I had thought I understood it to be there might be some follow-up prior to auto enrollment with nursing facility res denteds if they have not responded I was curious how that contact would be made.

From your answer now I'm assuming it's going to be if they don't, if they don't enroll on their own, then, the auto enrollment will take over.

>> DEPUTY SECRETARY BURNETT: T Th at's correct. And in the intelligent assignment process which is with the IEB the nursing facility is the top, priority -- in terms of the hierarchy of where the person goes.

So the nursing facility is in network that's the top priority.

But -- Denise your question is a good one and we are working as closely as can with the associations to figure some of these thing out because I think communication with the nursing facility residents is going going to be a tricky

one we'll have the nursing home facilities to help us with.

>> **PAM MAMARELLA:** Thank you Wilmarie and thank you Paul.

Lots more questions for you as we move forward.

But now I would like to -- I'm not sure how we're doing this Jen I think this say webinar?

Good morning Mike.

>> **MALE SPEAKER:** Good morning.

>> **MALE SPEAKER:** I'm turn this over to Mike Hale.

>> **MALE SPEAKER:** Thank you very much.

Good morning, still I guess.

Good morning everyone.

As everybody knows, awhile back we had decided that we wanted to change the LCD, the level of care determination to a functional eligibility determination tool.

We've been working on this tool for probably little over a year and a half, almost two years now I guess. And we had the opportunity to do some testing, with the University of Pittsburgh helped us develop the FED tool we did some testing this past summer.

It took little bit longer than we expected, than we had hoped for I guess.

But they also did the analysis of results and that sort of thing.

University of Pittsburgh Dr. Steve Albert is on the telephone.

And -- he is going to present the results ever the testing itself.

And some of the conclusions that he, his team drew from that. And then he will also be available for some questions after that.

So, with that -- I want to turn it over to doctoral best from university of Pittsburgh.

>> **MALE SPEAKER:** Okay.

Can everybody hear me?

>> **SPEAKER:** They can hear you now.

>> **MALE SPEAKER:** Okay.

Just checking -- thank you been listening in the last hour and a half or so, very impressed with the complexity of the challenge of pitch switching over and the questions are very good I think the committee is doing an excellent job of keeping everybody honest which is what we want to do I hope you'll, apply the same standards to what we've done here.

So I think some of you have been involved with our development of the FED for the functional eligibility determination and we had an opportunity to do a little bit of a test on it.

The instrument was developed, over time, came out of a long drawn effort involving video assessments of wide LCDs being conducted and also a review of 3 years worth of LCD assessments also a scan of other states determine eligibility, of long-term care services. And also, a need to harmonize eligibility determination with the use of the INTRA HC, for care management once a consumer starts receiving services in the new system.

So -- we had all of these things, to work with.

The basic idea was to see if we could do FED and LCD assessments on the same group of consumers.

Using different assessors and who had perhaps, different content with that consumer.

But at least the same consumer on the same day and that was our strategy just to see how well the FED and LCD correspond and if there

were any problems in the administration of the FED.

So that's what I'm going to talk about today.

We have samples of nearly 170 people which I'll explain in a minute.

And just to get it out front right away, because did might get lost in the whole presentation the FED and LCD agreed on NSDE determination about 70 percent of the time.

And that's an important number for us. And also, that about 70 percent of the assessments that have reviewed the LCD assessors decided were NFCE I wanted to come back get that out to show you over all where we stand on this.

If we can go to the next slide.

Remember the LCD, leads the judgment of the nursing home clinical eligibility to the assessor.

It's a subjective appraisal based upon the long interview or assessment that assessor does.

And we notice a number of problems, with the LCD which I think people have known for some time it's quite long it takes about 90 minutes.

It's not standardized to the extent that would be preferrable.

We notice accessors skip around, complete some section after they leave.

It doesn't have the good guidance and standard administration as we would have preferred I think.

There's a special problem with the cognitive assessment, the SLUMSs assessment is long and required not completed often at the end of the day when you're looking at the LCD it's hard to know if the missing data on the SLMs is the decision made by the assessor or refusal by the consumer or -- if it was just skipped, very hard to notify.

And finally, the current LCD requires that the assessor attribute disabilities to specific medical conditions or physiologic systems which is very difficult even clinicians would have trouble doing this, we reviewed 80,000 LCDs the first time LCD for consumers over 3 years.

And noticed that, there was a mismatch between disability in cardinal areas essential to Pennsylvania's NFCE definition and the assessors over all rating of NFCE status it went in both directions.

We found about 15 percent of consumers that at least on the LC did not report any disability in the five key domains and nonetheless were considered an NFCE, there were some consumer that's were not designated FCE.

Part of that is I think the assessors are taking a larger global perspective it's very hard too justify or know what it means if we don't have a stable relation between these five cardinal indicators of disability and NFCE determination.

If we can go do the next slide.

The FED attempt toss remedy some of these things in the following ways -- we're using, items from the inter I health care tool, the

standardizeddized tool.

[Inter-RAI]

Made sense to use for eligibility determination as well.

In developing over the last year and a half community stakeholders to take a look at it, OLTL has reviewed it.

The FED basically assesses these five cardinal NFCE domains, using interAI agency problems and score.

The five that you see are activities of daily living toileting cognition and mobility and eating you'll see in a minute, toileting cognition and mobility and eating are the key domains because we learn from the university of Michigan folk when's they came and trained our assessors, that it's very, very rare, to have an ADL problem, if you rapidly change that -- toileting cognition mobility eating problems have ADL problems often it's -- many cases the toileting and cognition and mobility and eating are the key domains.

And also, that the big difference between the FED and LCD, is not occasion for the a assessor to make this global rating of NFCE.

Rather NFCE comes out of the level of disability in these five cardinal domains.

And so, people are scored across a number of questions that, tap each domain on a level of need or a level of support.

So they could have maximum support in toileting or some support in toileting or no support in toileting and, we do the same with all

of the other dough plains, we come up with a scheme, by which we combine

profiles of disability, assign people to those profiles and then, see

how they match up against LCD assessor determined and NFCE.

That's what we tried to do.

This is a test.

We would not expect 100 percent accordance as I said we have

different assessors using different tools and the assessor doing the LCD

may know that consumer more than the FED assessor but we thought it would be valuable to do the head to

head comparison of the two tools to see how they work.

Let me stop for one minute now in case there's a question -- because

the next thing I want do is go to the actual FED test.

>> **FRED HESS:** No one?

Okay.

>> **MALE SPEAKER:** I see no hands.

>> **PAM MAMARELLA:** Keep moving.

Thank you.

>> **MALE SPEAKER:** We're okay.

Okay.

Let's go to the next slide then.

So we did the FED test in May June and July just a couple of months

ago.

We had the FED and LCD raters -- work with the same consumers on the

same day, to see how well the two instruments correspond in the

assignment in FCE and also, disability in each of these five domains.

Ten AAA counties were very gracious to do this for us.

We had separate FED and LC ratings with consumers on the same day.

That is, we had different assessors, the FED assessors showed up first, did the assessment and left and then the LCD assessor came in later, I think about the 7 percent of the assessments were done on the same day, a couple of counties had a little trouble did it within 3 days.

So different assessors from the same agencies, conducted each assessment to prevent contamination in the ratings it was a very strong test.

It was a very strong test of their performance.

The FED assessors were trained they reviewed all all of the online training materials plus they spent a day, with inperson training with an Inter RAI staff member and they were contacted in advance and agreed do the dual assessment and were very grateful for their participation.

Next slide please.

Okay.

So the counties were selected to cover really the span of Pennsylvania.

They included rural and urban counties also they varied in this variation ever the size of the agencies and their consumer populations.

We aimed for 200 consumers split evenly between under age 60 and

over 60.

So each of the 10 agencies were supposed to recruit 20 people.

For the beta attester, 10 under age 60, 10 overage 60, in fact the counties were able to complete 168 consumer assessments, and one third of the people were under age 60.

7 of the ten completed the full complement but 3 were unable to do did and the counties sent us linked deidentified LCD and FED forms so they came in, encrypted they came in FedExed they came in various forms we enderred and cleaned the data and when necessary we recontacted the local sites, to clarify missing values or incomplete forms.

It was a lot of work but we ended up with a very good data set to analyze these data.

So let me move right along to show you some background again about the participants in the study.

Next slide.

These were the ten counties that participated and you can see that I mentioned 7 out of the 10 were able to do the 20 assessments we had a little more trouble in a airplane I Snyder union and Wayne, more rural counties and -- but they tried the best they could.

If you go to the next slide -- these were features of the consumers about 64 percent were female.

I already mentioned a little under a third were under age 6 on, nearly everyone was English speaker.

84 percent were white and if you look at the -- lower two rows you can see residential status, the vast majority of people lived in a private home apartment or a room. And then about at the time percent lived in long-term care facilities.

One sort of another. And we have a smatttering of people in other settings most people lived with a nonrelative that was about 32 percent.

And good chunk of people lived alone, about 27 percent.

Okay.

So let me stop here for one second any question on the sample or the broad approach?

>> **MALE SPEAKER:** Doing a terrific job.

>> **PAM MAMARELLA:** I have a question I think would speak to the broad approach.

So I worked with my colleagues who have a lot of experience working with the senior population whose average age for services nursing facility is closer to 80 than 6 60, the thing they were concerned about, this is casting such a wide net we wanted to know if you considered the clinical complexity of the very senior population such as those in the LIFE program if in fact did this tool take into consideration the preventive services they needed as they age? The cognitive needs as they continue to increase and if we could know how this tool accounts for that older senior population.

>> **SPEAKER:** Okay.

It's good question, it's a complicated question.

Remember, this is just an eligibility determination tool.

Most of the detail I think you're looking for will come from the care management side. And the whole InterRAI service assessment and the service plans that come out of this, this is a much more simpler effort here -- really at the end of the day, we want to know if someone meets Pennsylvania's NFCE requirements, and is eligible.

So that's really what this tool is designed to do.

Now, by that same token we have very complicated questions on cognition and applied domains I mentioned they will capture functional need and disability.

And, one thing we know from the interRAI tool and the long experiences, clinical conditions have a final common pathway, expressed in disability.

And in these cardinal areas. And in fact, some times, the functional disability is the driver for services much more than the clinical conditions.

But you know at the end of the day, assessor doing the FED has a fairly good idea of cognition, very good idea of mobility, very good idea of ADL competencies, eating toileting.

I think all that comes out very strong in the FED I hope you've been

able to see the tool, and the guidance that assessors have in making a rating.

While I'm talking about full support, partial support or no support support, in fact the raters have 8 different levels of needs of support they have to decide between, and each one of them is operationallized very well.

So I think we do quite well I think you'll see in a minute, when I get to it, that the disability profiles of the old and less than 650 population, are quite similar it turns out.

So hang on that to that, see if your concerns are addressed and you can come back to it.

>> **PAM MAMARELLA:** Sounds good.

>> **SPEAKER:** Unless there's something I would like to move onto the key next slide if possible.

Why don't we go onto that.

Some of you may have seen a table like this, the first go around.

Based upon, over 80,000 LCDs.

This one is based on 160.

Because, of those 168, in 8 cases the LCD assessor did not make an NFCE determination.

Basically got a 1650 of the, matched FED LCD assessments that were done in the date test.

And remember, the FED does not assign, an NFCE.

What it assigns is, people to different levels of disability. And in our algorithm we have identified 11 levels of disability.

Based on what we think a is closest to the Pennsylvania NFCE definition and also, based on the way that other states, do this.

And so this, this is pretty much the approach that Oregon uses for example, and other states have adopted more or less va variants the same thing.

As I mentioned we have the five cardinal dimensions the key things are the four of the toileting eating mobility and cognition, there are multiple items for most of these domains.

Pander's already said, quite a range of ability or disability that the assessor can assign in those items and then we aggregate the those items to come up with a level of need for help in a particular domain.

So, maximum disability in this system, is someone who needs full support in toileting and full support for eating full support with mobility and full support in cognition.

Cognitive tasks.

That would be the most severely disabled profile and in our beta test, 12 people, met this criteria, or 7.5 percent of the sample.

That's from the FED and now on the LCD side, 100 percent of the people in this group, all 12 of them, were assigned, an NFCE by the LCD assessor.

You see how it works? We're giving the distribution across the

sample, across these 11 disability levels, and we're also giving you of those people, the proportion of them that the LCD assessor, ad and the FCE status.

If you start to go down you see level 11 is the least disabled and that those people needed no help, in any of those five domains.

No support.

And in fact, there are only five people in the beta test sample, who reported no need for any help in those five domains.

3.1 percent of the sample.

But one of them, was assigned NFCE status by the LCD assessor, one out of 5 is 20 percent that's where that comes from at the very bottom.

So this is the kind of thing we're interested in.

If you run your eye down the LCD NFCE column you can see as people are less disabled the LCD assessors were less likely to assign NFCE.

So it starts with 100 percent and goes down.

As you get down to level 11.

Note also, that some of the profiles are very fair no one was in level 2 of the beta test, no one was in level 10 and some people, they're very few people in levels a and 6.

That's just a function of how small the sample was.

Vast bulk of people are in level 3 or 4 or level 7 and 8.

Let me also say something about ABL we measure by reports in need

for help in 3 areas, bathing personal grooming and upper and body -- upper and lower body dressings.

[ADL]

Actually four domains most of the people in 1-5 and 6, have a ADL disability.

And at least some extent.

Probably full in most cases.

But we don't need that criterion for assigning people to these most severe disability levels.

We're only going pay attention to the other four, these are all mutually exclusive, if you don't meet level one, you're going to meet one of the levels below level one, 2-6, one of the levels actually of less severe disability.

Now I drew the red line between level 6 and 7.

We have a statistical procedure, which allows us to figure out on what cut point in these 11 disability levels would maximize agreement between the FED and the LCD on NFCE.

And it turns out, that one if we group 1-6 and compare them to 7-11, that gives us the closest correspondence, between the FED and the LCD on NFCE determination.

And I think you can see why if you look at levels 1-6, in all of those levels over two thirds of the people, were assigned to NFCE.

If you go below, if you go from level 7 above you can see that is

much -- much smaller proportion are assigned NFCE.

So you know, based upon purely statistical criterion the cut point

for NFCE on the FED will be 1-6, NFCE obviously.

But level 7 and 8 you can see there's substantial proportion of

people, assigned NFCE by the LCD assessor, these are people that have

partial support, in any two of the four domains, or paragraphals in the -- that's different level, 1-6 levels

they are people that need at least some help with one or two of the

four key domains of toileting eating mobility and cognition.

And that's what comes out of the FED that's the report that the

assessor ticks on the form and that's what we entered into the

computer then we have, computer code, which trolls across these

domains and assigns people to one of these levels.

That's what we mean by algorithm.

You can see there are very few people with ADL disability who don't

also have disability in these other areas.

In fact there are only, 2 people, in the sample.

>> **PAM MAMARELLA:** So Drew you have a question?

>> **MALE SPEAKER:** I do do, doctoral best, I was drawn for the

result for level 7 and 8.

[dr. Albert]

I appreciate your explanation there's still disa ability there, it's

less and it may not meet the criteria of NFCE I know most states do

require some impairment in 3 domains.

So you know what you're suggesting makes sense.

I am wondering if you know, we go through all of this, and because, the tool is actually showing you know a pretty high end in level 7 and 8 whether that information, should not be then used to match those people up to other resources or other ways to meet their needs even if they're not going to meet the NFCE criteria for CHC.

>> **MALE SPEAKER:** Yeah. Very good point. And I think you may be onto something here.

This is group with intermediate disability and maybe some other services would be appropriate.

Or maybe we need to go in and see what else is the LCD assessor looking at that made them think, 5 percent of those people in level 7 were NFCE.

But by the strictly -- based upon these five key dough plains, you know, they are not as disabled as people as levels 1-6 certainly.

>> **PAM MAMARELLA:** Right if I could piggy back on that Ray I see your hand go up.

Again, my concern would be what drew's concern is -- and I like your option number 2, I would, I am very curious to understand why it is that a human being sat in front of someone and so often determined that this person was in need of more help in order to be able to savely live out in the community.

And, um, and as I read more detail on this I understand that often

the cognitive ability piece of the LCD was not filled out so my concern would be I know that the determine's concern would be, we don't want to get this piece wrong because what follows is how a care plan gets built out underneath the level of care need.

And how could it be more than half in level 7 have been deemed nursing facility eligible is there something we're missing in the analysis of the comparative tools?

And ray? Yeah.

>> **MALE SPEAKER:** I think --

>> **PAM MAMARELLA:** Do you have an answer?

>> **MALE SPEAKER:** We're dealing with small numbers we're talking about 9 out of these 18 people.

You know it is definitely small numbers so -- just keep that in mind.

>> **PAM MAMARELLA:** Ray you wanted to add something.

>> **MALE SPEAKER:** Dr. Albert, this is is ray Prushnok this a very helpful analysis, my question is around interrater reliability across the tools were you able to tease out where you see the variation, the LCD said, NFCE but the FED did not, was that because you know -- the LCD had rated cognition, but the FED did not you know was there alignment across assessmentses where the FED picked up a deficit and ADL or limitation and cognition, but the LCD, you know was there disagreement across the instruments I guess or the -- the assessors themselves.

>> **MALE SPEAKER:** Yeah I know exactly what you mean, we did those

analysis I'll show them to you in a vehicle.

It is -- you know the on the whole the answer is, the level of concordance is roughly the same it's not driven by someone eliminates.

They agree about 3 quarters of the time on NFCI, and then we have another quarter where the FED and FCE, the LCD did not, and vice versa.

It wasn't -- it was not as if any one domain pushed things one way or the other.

With one caveat we don't think the LCD gave us reliable information on could in addition we were not able to pull out a good indicateddor of needs for support in cognitive activities from the LCD just the reasons I mention before, too much missing data and not clear why data is missing.

>> **SPEAKER:** Brenda has a question.

>> **PAM MAMARELLA:** Brenda Dare has a question.

Brenda do you want to ask your question?

>> **FEMALE SPEAKER:** It was answeredded it was about whether cognition was equally considered in each test.

>> **MALE SPEAKER:** It was.

>> **PAM MAMARELLA:** Thank you.

>> **FEMALE SPEAKER:** Yes.

>> **MALE SPEAKER:** Okay let me push on then I know time is -- moving

on.

So --

>> **FEMALE SPEAKER:** I have a question if you have a moment.

>> **MALE SPEAKER:** Good for it,.

>> **FEMALE SPEAKER:** I'm a little concerned about something, the perimeters seems like we used to do this test only had to do with like physical perimeters of what the person could not physically do.

Did anyone take into account, if it's a care determinant has -- I might be confusedded what it is, if it's a level of care determinant, did anyone take into consideration like another category.

That like, okay.

This person, is going need help with going to appointments this person is going to need help, getting out into the community.

Did all that get taken into other than just -- the physical part of it?

Because if -- we're missing the boat on like how a person becomes a full person, with the physical disability.

You understand my concern?

>> **MALE SPEAKER:** Yeah. That's a good question.

I answered it two ways you know, we do have the measures of cognition, mobility.

Which will -- speak to what you're asking about can someone get out or can someone follow-up on an appointment we get some of that

information in the ratings about mobility and cognition.

We even had an cognition categories of mental health indicators, behavioral symptoms that may be relevant we get it there.

Understand also that the -- NFCE, definition, Pennsylvania uses is a little restrictive, it is -- you know, basic functions that people need to savely live at home.

That would be that -- that they could not, they have nursing home level of need, that would prevent them from living at home.

That's really, what it is centers on.

So it doesn't include cooking it doesn't include socialization.

It is things like these.

>> FEMALE SPEAKER: Well I think, I'm just saying I think with the program that I'm hoping, we're trying to develop those other -- those other measures and standards ought to be looked this is no longer just about care.

It is it's only going to be about everything.

>> DEPUTY SECRETARY BURNETT: Can I respond to the comment this is only a determination of clinical eligibility for nursing facility level of care that is all.

In addition to that, the person -- the individual the participant will go through, a whole service person centered service planning process, with the service coordinator.

To determine things like you're talking about, Tanya whether or not

they're going to need help getting into the community.

Whether or not they need help with you know finding employment or staying employed.

Those kinds of things, happen with the MCO.

Not with this clinical eligibility determination.

It is just getting the clinical eligibility determination necessary to determine whether or not they get long term services and supports that's all this is.

So you're talking about is further down the road, going through a service plan.

Service planning process.

>> **MALE SPEAKER:** Okay.

Let's move on then.

Unless there's something else.

Go to the next slide.

We are able to compute a measure of agreement, between the FED and LCD, we have a couple indicators one of them is sensitivity, if the LCD assessor said NFCE on the consumer the FED also say NFCE, if we use the level 1-6 I already identified, we get that kind of agreement in about 83 percent of the cases.

So the -- the LCD assessor said NFC, the FED said NFCE, 83 percent of the time.

That's the most important number because the key foreseening and eligibility, is call case to case, someone who needs services gets the

service or is identified as someone who needs services.

Lower other on specificity.

That's the LCD assessor said it was not NFCE it was NFI did the FED agree with that? And they're we're only about 54 percent, legallier on specificity over all, you'll see in a second that among older people it's much better.

But this is what we find.

We have a number called Kappa which allow us us to see how well they agree controlling for chance agreement and anything above .4 is considered good we're a little under on that one.

Some of that is a function of the smaller sample size.

But over all, I would say this is a pretty good test when you think that we have -- two assessors, using two different instruments, and yet we find, pretty good concord answer we not expect 10 percent in any measure there's also a trade off, between sense fist and specificity in if one goes up the other has to go down, if people are interested in that I can explain that, but -- that may be, beyond our scope today.

>> **PAM MAMARELLA:** Dr. Albert we have another question from drew.

>> **MALE SPEAKER:** I'm concerned about the difference between sensitivity and low kappa in the under 60 group it's quite significant I mean that kappa is very very low.

>> **MALE SPEAKER:** We're going to the next slide, right.

Two slides ahead, hang on one second we'll get there.

>> **PAM MAMARELLA:** Thank you.

>> **MALE SPEAKER:** Anything else?

Let's go to the next slide I think I need to explain I'll try to do it simply, one question on the FED whether it would work equally well in under 60 and over 60 and I think that's what drew's question is referring to as well.

One way to look at it is -- you know, do you get the same disability profiles in people under age 60 and people ever age 60, that's what is shown in the Histogram.

The X axis is 1-11.

On those levels of disability, that the FED proseses and -- the bottom panel is people under age 60 and the upper panel is people, overage 60.

And don't worry about the sidesst bars because we just have more people in the top panel which are people overage 60.

The more important thing to see is that, it really is the same distribution that -- most older people, are in levels 3 and 4. And most younger people, are in levels 3 and 4. And we have another blip around 7 or 8 we find the same thing in old and young and then we also find that level one is highly represented in the two groups.

So I would say that the disability profile that comes out of the FED

are pretty much the same in people under age 60 and people overage 60, that's reassuring to me as an investigator that this measure looks like it works, reasonably well, in both age groups.

If you go to the next slide, we can come back to drew's question.

And there now, what we've done here is calculate, sensitivity and specificity for the two different age groups.

Now the first thing to noted is, the first two columns there, so -- you can see that in fact the FED is little more likely to assign an FCE over all, than the LCD.

So in the people under age 60, by FED computation, 77 percent were eligible.

And by the LCD, only 75.5 percent were eligible.

Likewise, for the overage 60, so the FED is a little more liberal in assigning NFCE status.

The sensitivity and specificity differ a little bit.

This is a concern, and drew has drawn our attention to it already.

It looks like, the FED is -- the correspondence between FED and LCD is higher over all in the people overage 60.

I think that reflects there's more hetereogeneity, in disability or sources of disability in the young sample that's why we have a lower specificity.

However, the sensitivities are not that far apart.

It is 78 percent, in the under 60 and 83 percent in the over 60s

that's the number I would pay more attention to.

And the low specificity, in the under 60s is a concern

that's why we have the low kap pa score it speaks to the fact there's

more hetroGeneity in the under 60 group, you're right to draw attention,

you want to anything you want to add.

>> **MALE SPEAKER:** Wonder if there's any correction go that? I mean

you know, the needs of the people in the under 60 group might be

significantly different. And I don't know whether, it's possible to

look at you knee, including level 7 and 8 in the under 60 group or some

you know, some correction to make this improved.

>> **MALE SPEAKER:** You know what would happy can tell you if we

included level 7 and 8 in NFCE we would bump up the sensitivity to

nearly 100 percent in both groups.

But you would, you might actually lower the specificity it's just a

feature of these statistics.

As you're increasing the -- as you widen your net you'll bring in

people who the -- the LCD assessors did not think were not NFCE as well.

So that's why I say it's a tough statistic often.

More important number is the sensitivity.

>> **MALE SPEAKER:** Well, it is impressive that the FED does

identify, more.

Than the LCD.

I'm just wondering if we can look at this over time as well, not --

I mean I don't know what your contract is with the department, but I mine, if this is something that can be looked at you know in a larger sample I think it will be even more telling going forward.

>> DEPUTY SECRETARY BURNETT: I think that's a really good question.

>> MALE SPEAKER: I agree with you, we need to monitor this I hope we can do that.

>> DEPUTY SECRETARY BURNETT: T Th at's a good idea.

Drew and I -- I don't think this is not just a once and done we'll be, collecting data on it and analyzing it as we go.

>> MALE SPEAKER: Also remember Drew you know kappa is a very stringent test it's pretty hard to get a high number on that thing.

>> MALE SPEAKER: Yeah. But you're -- your other ones look good, even the 3.7 I would accept.

>> MALE SPEAKER: Okay.

Let's go to the next one which speaks to ray's question earlier.

Next slide -- so we did look a little bit at total agreement and sensitivity, and specificity, by the five domains.

Recognizing that we left cognition out because we did not really feel the LCD gave us a clear guidance on who had need for full support or partial support or no support in cognition.

So the total agreement column is the first column.

That's you know -- all of those, the proportion of people who had a exact match on NFCE or NFI status that shows you how much, the

instruments agree total.

The sensitivity and specificity are the more complicated calculation.

You can see that you know some domains were a little better than others.

Eating seems to be a tough one on sensitivity.

And as I mentioned, to others before I think that's partly driven by we have very few questions about eating.

It would be better to have more questions on eating in my mind.

But we don't have that option, in the InterRAI tool.

We're pretty good mobility is nearly 100 percent on sensitivities people know it, people know mobility disability when they see it.

But specificity is a lot lower.

I guess, people have some trouble on making some ratings on that at least, relative to the LCD assessor.

ADL on the other hand, very, very high agreement.

Those questions worked very, very well I think I would, see these as -- not as important as the total, at the bot there, but just to show you there's no single domain that seems to be driving disa agreement or discordance they all, had their strengths and weaknesses in assessment.

>> **FRED HESS:** I have -- one quick question.

How come on cognition we have absolutely nothing, did you just not run it or were there no participants? Or -- what?

>> **MALE SPEAKER:** On cognition.

>> **FRED HESS:** Yes.

>> **MALE SPEAKER:** Yep.

Yeah. I think the problem -- that we face is, the LCD, assessors majority did not do the SLUMS, we don't have the formal cognitive assessment and, the current LCD questions we tried to look at them carely, we didn't feel confident in knowing if skipped information, meant that the assessor didn't do it or that the consumer refused doing it.

Or, the assessor just decided to make a judgment on his or her own we didn't feel we had enough confidence on what level of cognitive disability those people had.

So that's why we left that out.

>> **FRED HESS:** Okay I was just wondering because it's going to be hard and difficult to get that from non-any way with the cognition problem.

>> **MALE SPEAKER:** The FED is better on that, because their the assessors forced to do the particular performance assessment about memory, and about sequencing of tasks. And looks at the behavioral systems there at least we know what we have, we could not do a head to head comparison on this domain we didn't think we had clear LCD information.

>> **FRED HESS:** Thanks.

>> **PAM MAMARELLA:** Drew?

>> **MALE SPEAKER:** Even though you can't --

>> **MALE SPEAKER:** Let me keep going. Okay.

>> **MALE SPEAKER:** Even though you can't compare, the cognition on the -- LCD on the FED can you tell us how the FED fired on cognition? Since we put so much energy in it.

>> **MALE SPEAKER:** You mean the distribution on cognition? You mean how many people were in support, full support or some support or particular items number of behavioral sy symptoms stuff like that.

>> **MALE SPEAKER:** I don't know we wanted to make sure we we spent a lot of time on making sure the FED had all of these items I want to make sure you feel they're sensitivity and picking anything up?

>> **MALE SPEAKER:** Yeah. Okay.

We -- I didn't present that here but of course we have that data. If you go back to the big table you'll get a sense that would not show you cognition I can provide that if people are interested in.

>> **FRED HESS:** Yeah.

>> **MALE SPEAKER:** I think we are.

>> **FRED HESS:** Oh, yeah.

>> **PAM MAMARELLA:** Okay.

Jen can you make sure we get that.

>> **MALE SPEAKER:** If you do want that gran ulayerity we have it.

>> **PAM MAMARELLA:** Now we'll need to wrap because, we have to -- we want to hear from the MCOs also.

I just heard they will supply us with the information Andrew needs to ask one more thing.

>> **MALE SPEAKER:** I'm sorry I did have a question about the procedure --

>> **MALE SPEAKER:** We can go to the next slide --

>> DEPUTY SECRETARY BURNETT: W We 're running out of time.

>> **MALE SPEAKER:** I had a question about the -- the proxies, was that procedure utilized here because we discussed that the first couple of items would signal, whether there was a need for a proxy I didn't hear anything about that, in yesterday's presentation.

>> **MALE SPEAKER:** No the proxy reports incorporatedded into these ratings if the assessor, had to talk to a proxy on some item that would be reflected in the rating.

>> **MALE SPEAKER:** Were there any proxies in the 160 ratings.

>> **MALE SPEAKER:** That I don't know for sure.

But I think we probably could retrieve that, if need be.

>> **MALE SPEAKER:** I would like know that.

>> **PAM MAMARELLA:** Thank you and now, Doctor, Albert your conclusion.

>> **MALE SPEAKER:** Very quickly I realize we're pressed for time.

We the FED is practical and feasible it takes only 20 minutes very little -- in this assessment, no missing data.

It is certainly was he infective for illicitting the cognitive status which has been a challenge with the LCD the FED and LCD were

highly concordant with the severe level of the data built, based upon this data we can make a recommendation, on the purely statistics basis levels 1-6 correspond quite well to the LCD and NFCE subjective rating.

That's based upon statistical criteria.

Going to the next slide one last thing -- we recognize, that comparing the FED to the LCD is not ideal bottles the best we can do.

Really would be nice some day to have independent geriatric specialist rating pim using that as the gold standard but we didn't have the opportunity.

So -- thank you to all if I can -- provide further data perhaps on the cognition to the FED or whatever else just let me next.

>> **PAM MAMARELLA:** Thank you, Doctor Albert we appreciate it.

Jen I guess the only question I do have though, is -- has it been decided, level 6 or --

>> DEPUTY SECRETARY BURNETT: No.

>> **PAM MAMARELLA:** Office is still in process as to where that is going to be cut off.

Thank you.

Okay.

We'll need to move on, at this point.

So that we can hear from our CHC MCOs but anyone who has further questions, as it relates too this, encourage them to submit through the Listserv so we can be sure to get them answered.

Okay.

Now let's -- welcome Randy Noel an.

>> **RANDY NOLEN:** Hello.

Thank you.

Pleasure to be back.

Since we're -- on a time constraint here I'm going to give a real quick overview.

Of where we're at, with ready ins review I'll turn it over to the 3 MCOs.

We know there's a lot of issues a lot of stuff going on, primary work in the last month has been on, building provider network with the MCOs and, building the IT systems. And we weeked with our bureau data and claims management they're working on the IT related systems they continue to work through any minor bugs, but we've been Anne too do a lot of test case and in regards to the ops file, provider network files a lot of that work has been done.

With the testing on billing a the ability for 3 MCOs to bill, so -- the IT component, with the systems and stuff everything is looking good.

As far as other areas and readiness review, where we're at with the policies and procedures right now, approval wise, UPMC we've approved 72.87 percent of the policies and procedures.

AmeriHealth 72.3 percent and Pennsylvania Health & Wellness, 79.6 percent.

And we're -- we have a number of policies and procedures we're

reviewing now some of them are, contingent on other things.

Some of them are contingent getting the hearings and appeals stuff information in.

So we continue to work through that, so there's a number of policies that are pending right now so we have that information done.

So we should be in pretty good shape with that.

>> **PAM MAMARELLA:** Rand . can I interrupt ask the people to mute their phones please.

>> **SPEAKER:** We're going to do did for them.

>> **PAM MAMARELLA:** Thank you.

>> **RANDY NOLEN:** Okay.

That's good we're getting some feedback there.

We continue to provide technical assistance training we had a session yesterday that talked about the DME program, event program and nursing home trance significance and, also, a number of policy related issues.

Training in the next couple of weeks coming up will be on hearings and grievance and appeals item plateds and some other templates that were finalizing for the MCOs.

We have a training scheduled for the 18th on FMS and we're working onsetting a training up between the behavioral health MCOs and CHC MCOs continue to provide training and continue to have weekly calls with the MCOs we're working through a lot of the policies at that point in time,

getting them resolved.

As far as network -- there's been submissions every week over the last couple of weeks to the Department of Health.

I spoke to my counterpart Department of Health on Monday, he believes that, on the LTSS side provider wise all the networks are adequate on the physical health side we have some issues with specialties out there.

Which we run into normally.

And some of the counties and the -- MCOs are continuing to work on that, we'll talk about that, themselves today.

And on the nursing facility side we do have some ongoing issues that we're working through as far as the rate setting mechanisms and payment mechanisms for the nursing facilities.

The MCOs have made this their priority over the last couple of weeks.

They all have, well over 50 percent of the nursing facilities on board. And are working through the contracting process with the rest of them. And in anticipation over the next couple of weeks is that, they will have well over, 90 percent of those facilities on bo board.

I wanted to ask the MCO toss speak more specifically about the numbers they have in the network at this point in time what they're doing moving forward as far as getting ready, hiring staff for the participant hot lines as far as moving into that direction.

Also like them to talk a little bit about, what they're doing

training session wise for the providers and provider handbook. And then we'll -- we've been back and forth with the provider handbook trying to get that finalized we should have that out, I like the 3 MCOs to talk more about that.

So as far as Randiness review that's where we're at right now and I'm going to turn over to the MCOs I have a -- 3 sided coin I'll flip here to see who goes first.

[laughter]

>> **FRED HESS:** Rock paper scissors.

>> **RANDY NOLEN:** I'm liking at AmeriHealth Caritas I'll let's them go first.

Chris?

>> **MALE SPEAKER:** I think that was a strategic move by PA health wellness.

[laughter]

-- thank you so, just a little bit about you're provider network.

For -- in the southwests zone that's our focus, we're still talking about providers statewide we do have over 40 hospitals contracted in the southwest zone we have UPMC and algain I health systems they're both in our network that's been a concern from others, if they had either pick one or the other so both of those health systems in our network.

From a PCP perspective we have over 2500PCPs throughout the 14 counties participating with us, individuals would be able to choose

from.

Specialists there's over 7,000, closer to 8,000, over 7700.

So -- it's a very, robust network.

And as Rndy said we have over half of the, nursing facilities contracted, we are in discussions with some of the other larger ones.

Finalizing contract language -- um, rates working through that, just to make sure that serve good to go, one of the key pieces for some of the facilities is -- they want to see that provider manual up front.

Before they will sign on that.

So we actually, we had a meeting right before this, this OLTL as part of our weekly meetings we did discuss a couple of the -- two additional lines we need to work through, to make sure that everything is good to go.

So -- I think that's coming along and should be, we should have that finalized, very soon.

For Randy mentioned about the LTSS home and community based providers, we are continuing the contract, Ray said it earlier if someone is out there, that is not contracted with us, and we're still looking to build that network.

We're not looking to shut down a network or, close out any specialties at this point.

We're looking to build that.

This is you know, and we've said it before but, this is a partnership between us providers and the department the participants and the committee as we start to you know roll this program out and have that it's -- in all of our best interest to work together and so we're not looking to did he doctor any providers from joining our network we're looking to continue and expand on that.

>> **FRED HESS:** Pam -- one question.

I have got a question real quick.

What about nonmedical providers say like Center of Independent Living, house cleaning -- you know, pest control things like that.

>> **MALE SPEAKER:** Those are all follow that all falls under the LTSS kind of spectrum from a provider home and community based provider yes.

So -- we have, over 190 agencies that have been entities have that signed agreements with us at there point.

That render, all of those services we actually have two pest eradication providers that, are going through the MA enrollment process right now they're working on getting that, enrolled so they can finalize their contracting credentialing with us so we are --

>> **FRED HESS:** So they're -- two --

>> **PAM MAMARELLA:** I think we need to hold our questions until the end and give all 3 MCOs an opportunity to present because we are -- dangerously close to going over we can't.

>> **MALE SPEAKER:** Just to kind of address that, so those are two brand new providers that are outside of the -- of the, so -- we're not isolated to focusing on providers that are existing MA providers we're going outside of, providers that are currently enrolled, talking to them and saying hey, you want it to join the network, or can you -- you know, are you able to meet the requirements, to enroll under OLTL.

Through the MA program? And help them through that process and direct them in that way, as well we're looking to expand and build our networks make it as robust as possible hopefully have additional providers that may not have been an option previously.

For the participants.

As far as, provider training goes, we are, targeting November through December.

As the initial phase of training.

We're -- it's going to be, robust training as far as the policies procedures of the health plan how they're going to have to work with us the billing process how that is going to work from beige a -- community based provider as well as skilled nursing facilities as Randy mentioned we're having a lot conversations there but quality is going to be a key focus.

There's a number of areas that we're going to to presented to the providers it's going to be ongoing process for education.

I know I mentioned November December, but once we go live it is

still going to be, continued education.

For the providers.

We do have just kind of -- we are, we have 3 out of our four account execx hired they live in the community, we have a fourth candidate we're working, we feel comfortable with so it's -- we're making progress there, so they will have that dedicated individual to reach out to as we move forward and as they have specific questions.

So it -- again it's, we're hand in hand with the providers as we move through this.

It's not someone sitting over here we're not communicating with.

And, the service coordination entities we are, Cathy's team is actually working with them and will be working together with them on the training the expectations from the MCOs in our agreements we do outline the requirements, from our agreement.

That it says here's what is covered under the service coordination so they're fully aware what the expectations are.

But, the training tools and resources sorry Kathy I stole your line that will be provided to those, entities so that, they are -- on board how we're going operate and be able to help, provide services to the participants.

>> **FEMALE SPEAKER:** So, um, I know --

>> **PAM MAMARELLA:** I'm going to incompetenter correct we have ten minutes left.

So Randy I'm going to ask potentially we move to the next CHC MCO so we can hear from everybody irrigate full you'll be back at the next ML took SS meeting so we can continue.

>> **RANDY NOLEN:** Okay.

So move over to PHW.

>> **MALE SPEAKER:** Good afternoon I'm Norris Bends vice president of government affairs I have suesy Prescott, vice president of the network development on our call center our call center is operational.

We've hired 3 fourth of our staff in the process of, getting the call center operational and our staff, there has -- has taken, 50,000 test calls and we, call center is up and ready to go.

As far as staffing is concerned, we continue to move forward.

We continue to move forward with our staffing plan feel we're right on schedule with the people that we need to have on board.

As far as readiness review we had our readiness review on

September 12th and we have not gotten our report card yet from the State all the feedback we received back so far has been pretty positive.

As far as readiness is concerned, positive comments and feedback on systems and operational readiness we're ready to move forward towards implementation.

As far as our network is concerned.

Our network build is continuous work in progress.

But we believe, we meat, we have -- an adequate network from a Department of Health stand point, standpoint, we have -- every major, hospital system in our network as well as, Armstrong and Washington hospital.

And as far as training is concerned, we plan to -- the bulk of that in November and December, we actually are talking to the home care association today, to give them some really detailed information about how, our billing process works.

And I have a meeting, right after this, meeting to discuss some additional training for nursing home facilities.

>> **FEMALE SPEAKER:** So -- um, again, it's a work in progress we continue to add providers every day.

I just got 3 texts about additional provider that's would like to join our network.

It's -- as Chris said, every day, Ray will tell you the same thing we're providing networks to make sure we've got enough to take care of the participants if we discover at any point in time there's a provider out there, that we have not identified, that would, is currently providing care, we can do a single case agreement which is a fairly immediate process there's no disruption in services.

>> **MALE SPEAKER:** Only other thing that can I add we have done extensive claims processing, and contingency plans we realize the

significance and importance of making sure the providers get paid and accurately and timely. And use this as a shameless plug if you're a provider you have not heard from us, please -- reach out to either Susan or me we'll be happy to work with you and try to get you on board.

And that happy to take any questions -- just request that you -- reserve all your difficult questions for my esteemed colleges at UPMC and AmeriHealth.

[laughter]

>> **MALE SPEAKER:** So you know -- similar similar report, our physical health network we have 45 hospitals in the same vein of, we do include you know saint Vincent, Forbes, Jefferson, many of the hospitals are in network for the CHC and Medicaid lines of business, we have about 3500 PCPs we look at, you know some of the things in it is different in terms of provider locations like PAS providers have 908 service locations which is how we're reporting that to -- to DHS and to Department of Health.

You know, 40 adult day cares we have amended contracts with 156 nursing facilities with half those returning signed rate sheets we're going through the final stage was a large group with all of our nursing facilities.

We're making great progress we're you know, the end stages of having what we see as a very robust network that we'll be able to deal with our membership in terms of readiness as Randy pointed out we're over 7

on percent for approvals and we're near very near 100 percent for our initial submissions and we're back and forth on all those documents.

It's very very well.

Some of you don't see in this form, dozens of people behind Randy and minute each of the MCOs are working through lited rally thousands of pages of documents an very robust effort and they deserve a lot credit for the average the State is putting into it, holding us accountable we know.

It's been a very strong process.

We will have six events we're planning.

For later this month and in through November I believe announcement is going out this week, if it hasn't already for those times and locations for providers to look out for that.

We will also be doing joint events with the other MCOs with HHH, as well as the nursing home facility association there will be a lot different events that the organizations will be doing, collective live, to make sure that we're you know, being mindful of all the time commitments for the provider community as we go into the fall. And lastly, in terms of, you know, call center and, our preparedness we made a decision to merge our DSNP and CHC call center operations we're currently staffed up and begun training all of our staff will be cross trained so they can, handle all of the coordination of benefits issues

as they emerge between CHC and Medicare.

And you know the also, trained in the new benefits as well as the -- you know areas like protective services and the types of supportive services we'll offer and we have all of our positions posted I think we're, um, at least 70 percent there, in terms of having our staff levels hit.

So we're raring to go open enrollment is around the corner it's a very exciting you know, moment for all of us and, you know we're -- we're excited for the next few months to come.

>> **FRED HESS:** Thank you Ray do we have any questions from the committee?

Yeah.

>> **MALE SPEAKER:** I have a question for the, community health choices plan but Ray eluded to the earlier the coordination with the DSNPT and coming forward I want to comment on the September 20 the OLTL hosted to bring together the plans and DSNPT and God a future presentation on the topic it was a very productive collaborative meeting we found there was a lot of great information sharing on best practices and ensure seemless coordination between the two, I I've been getting participant feedback on some of those discussions -- would be really helpful as well from all stakeholder wasn't to address we address that topic future meeting after we get through the -- the immediate 1/1 go live.

>> DEPUTY SECRETARY BURNETT: T Th ank you for that, Blair.

I also attended that meeting and found that it could be really, a very interesting meeting and, one in which, there's a really a lot thinking going on, in Pennsylvania's DSNP community.

Around how -- how the DSNPs will coordinate and collaborate with the CHC MCOs that's very exciting to me I think having this committee learn a little bit more about that would be -- good for you and also getting your input what we're doing, would also be, good for us.

So thank you.

>> **FRED HESS:** Anymore questions from the committee?

Do we have anything from the audience?

Nope.

>> **SPEAKER:** I have a whole bunch.

>> **FRED HESS:** Okay.

Go ahead.

>> **SPEAKER:** All right.

>> **FRED HESS:** I was wondering.

>> **SPEAKER:** I don't flow how many how much time --

>> **FRED HESS:** Five minutes.

>> **SPEAKER:** Okay.

First question is -- will service coordinators be able to view the FED questions as they are presented by the reviewers?

>> DEPUTY SECRETARY BURNETT: I don't really follow that question.

>> SPEAKER: Sounds like a ray question to me.

[laughter]

>> SPEAKER: I don't know if this was a follow-up from the FED presentation from the presenters --

>> DEPUTY SECRETARY BURNETT: Y Ye ah. Maybe -- the person sent that in could -- make a little more clear and send to Pat we'll try to address did in a future meeting.

>> SPEAKER: Came next question -- from Lester why is MAXIMUS still doing people in the enrollment enrolling people in the OBRA people in the southwest region.

>> DEPUTY SECRETARY BURNETT: B Be cause the OBRA waiver is still open.

>> SPEAKER: And -- the next question, from Lester will the training for service coordinators happen with regards to CHC service needs to be provided to consumer those help unbiased evaluation of the MCOs for the consumers.

>> DEPUTY SECRETARY BURNETT: I have the same question. And it's a question that is a priority of mine, it's going to be something I'm going to look into, this afternoon I wish I could have the answer for you today I know that the training has been reviewed by certain staff, I just don't know what the, how they're going to deploy it I think they're

putting it on some learning management essential does anyone know.

>> **MALE SPEAKER:** I know a little bit more.

Yeah.

So.

>> **FEMALE SPEAKER:** Service coordinator training has been reviewed, and -- it is my understanding that it is going date of birth deployed on the learning center web site that will go out through the Listserv and the nursing facility training also I think we're finalizing on comments so those changes need to be made that's also going to be put on the web site and distribute loud the Listserv I don't have a date on that.

But we can give to Pat to give out to the group.

>> DEPUTY SECRETARY BURNETT: O Ok ay we'll do that.

>> **SPEAKER:** Okay okay.

Next question -- is, from service coordinator also, we have been instructing our service coordinators to refer participants to the IEB for information on each MCO provider network.

Are you suggesting that the service coordinators do otherwise?

>> DEPUTY SECRETARY BURNETT: No.

The IEB is going -- it does have the information on the networks for each MCO.

>> **FRED HESS:** Pat we have time for one more question.

>> **SPEAKER:** What is the cut off for registration for each of the 41

community meetings in the southwest?

Does registration close a certain number of days prior to each scheduled event or based upon capacity?

>> SPEAKER: Capacity.

>> DEPUTY SECRETARY BURNETT: B Ba sed upon capacity I don't know if there's a deadline Rebecca, is there?

>> FEMALE SPEAKER: Not that I'm aware of.

>> DEPUTY SECRETARY BURNETT: T Th ere's no deadline but based upon capacity we'll be closing them.

>> SPEAKER: We'll email the rest of the questions to you all.

>> FRED HESS: Right.

Okay.

Our next meeting will be here November 1, same bat time, same bat place.

>> DEPUTY SECRETARY BURNETT: T Th anks everybody.

[meeting concluded]