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EVENT: MLTSS subcommittee meeting.

DATE: 2/1/17.

>> PAM: I am going to call this meeting to order.

Let's start by taking -- we have a phone issue. We will wait a minute.

Carry on, everybody.

[LAUGHTER]

>> Good morning, Barb Polzer, liberty community connections.

>> Veronica Comfort, PCOA.

>> Janel Gleason, from comfort caring sources.

>> Blair Boroch, united healthcare.

>> Good morning, Jack Kane.

>> Bill White MMOP.

>> Pam Mammarella.

>> Kevin Hancock, Office of Long-Term Living.

>> Fred Hess.

>> Drew Nagele, brain injury association.

>> Pam Auer in for Theo Braddy, Center for Independent Living Central PA.

>> Caren Caldwell in for Ray Prushnok, from UPMC health plan.

>> Jesse Wilderman.

>> PAM: Good morning, welcome everybody in the room. I will do roll call for anybody not in the room. Is Arsen there? Can you pronounce your last name for me?

Do we have Brenda Dare on the phone?

[NO RESPONSE]

Do we have Cassie on the phone?

[NO RESPONSE]

>> FRED: I will call Tanya too see if they can hear us.

>> PAM: Okay. So --

>> Arsen is on, Steve is on, Terry is on.

>> PAM: We can't hear them.

>> KEVIN: Is it possible they are muted.

>> PAT: I can hear them talking.

>> PAM: Can you ask us via web, if they can hear us?

>> PAT: I am --

>> PAM: As you can see, we are having technical difficulties this morning. There is a lot of energy in the room this morning, though!

>> PAT: There was!

>> FRED: They can hear each other but not hear us.

>> PAM: We will give it a minute to see if we can get people on the meeting hearing.

Brenda Dare are you on the phone? Can anybody on the phone hear?

>> FRED: No.

>> PAM: Fred, as she does that. I think we can go over the evacuation procedures so it only concerns the people in the room.

>> FRED: Right.

Emergency evacuation procedures. In the event of emergency or

evacuation, we will proceed to the assembly area to the left of the Zion church on the corner of 4th and Market.

If you require assistance to evacuate, like me, you must go to the safe area located right outside of the main doors of the honor suite. OLTL staff will stay in the safe area until you can go back into the suite or you are evacuated.

Everyone must evacuate the building. Take your belongings with you, and do is not operate cell phones. Do not try to use the elevators. They will be locked down and not work.

We will use stairwells 1 and 2 to exit the building.

For stair 1: Exit honor suite through main doors on the left side near the elevator. Turn right. Go down the hallway by water fountain.

Stair 2, exit Honor Suite through the back doors. From those exiting through side doors, turn left. It is directly in front of you.

For those existing back doors, turn left twice, and stair 2 is directly ahead.

Keep to the inside of the stairwell. Merge to outside.

Turn left own walk down Dewberry alley. Turn left at the corner of 4th Street, cross 4th Street to the train station.

In other words, run!!

[LAUGHTER]

>> PAM: I will remind everyone to engage in the utmost professional language with interacting with each other.

Point of order. Direct your comments directly to me.

Wait to be called on and try to keep your comments under 2 minutes.

Transcripts for the meeting documents are posted on the listserv. Everybody has that on the back of their agenda.

The captionist is documenting the discussion so please speak clearly, slowly and committee members please introduce yourself every time so that she can record your comments for the record.

Please turn your cell phones off. Clean up after yourself. Public comments will be heard at the end. We will make every effort to make sure we leave enough time to do that.

Ralph has already gone over the emergency evacuation procedures.

Pat, do we have phone communication?

>> FRED: Yes.

>> PAT: Yes.

>> PAM: Arsen?

[NO RESPONSE]

Brenda Dare?

>> FRED: Is anybody on the phone that can speak up?

(Voices heard).

>> PAM: Is Cassie on the phone?

[NO RESPONSE]

>> PAM: This is Catherine?

[NO RESPONSE]

>> PAM: Ralph?

He will be joining us later.

Steve Williamson.

Tanya?

>> TANYA: I am here.

>> PAM: Terry Brennan?

>> TERRY: I am here.

>> PAM: Anybody on the phone that I didn't call or I didn't hear respond?

>> Arsen Ustayev.

>> This is Stella Hyde.

>> PAM: Okay. Thank you. Anyone else?

[NO RESPONSE]

Okay. So let's begin. I will turn the meeting over to Kevin Hancock for the OLTL update.

>> KEVIN: Good morning everyone. I am getting over sinus infection if I lose my voice in the middle I will turn it over to Pam until I can get my voice back.

I will start with CHC updates and follow ups from previous meetings.

As all of you know on August 30th, 2016 we announced our three selected offers, Pennsylvania health and wellness, which is Pennsylvania subsidiary of [inaudible] corporation. UPMC.

If I tend to talk too fast be sure to slow me down; that is a bad habit of mine.

After we made the announcements, we went through a debriefing process with some of the offers who were not selected for the program. We completed those debriefings by the end of October and out of that process, we had four official protests.

Those protests were resolved by November 8th, 2016. The next step in the process who want to appeal the decision is to take their argument to Commonwealth Court. The first step of the two-step process in the Commonwealth Court is if any of the disappointed offers wanted to continue with the stay.

During this entire process period we have been in a stay, which means we are not allowed to communicate o to the selected offers.

The Commonwealth Court has to approve whether it stays valid.

The disappointed offers two of them request willed a stay to continue.

Of those two disappointed offer hearings, two of the hearings actually occurred the second of which occurred the second week of January and both of those hearings were found in favor by the Commonwealth.

Where it leaves us at this point, as I mentioned, there is a two-step process. There will be appeals that will still be heard by Commonwealth Court.

We are in a position now where we are able to engage with managed care organizations. We have not yet done that.

We are waiting for a green light from the Governor's Office, primarily due to the focus on the budget right now and other concerns,

some of which you have already heard.

We, as soon as we have the green light we will reach out to the managed care organizations and start scheduling meetings.

They will involve both technical assistance sessions and any questions they may have. Eventually we will go into agreement and rate negotiations.

Some more to come on that.

As also related to CHC and we already announced this in the prior meeting on December 15th, we announced that we were going to have to go forward with six-month delay for implementation of the southwest zone.

That implementation was moved from July 1st, 2017 to January 31st 2018. The reason was we didn't have enough time to let them develop networks and go through robust readiness review process in time allotted because we were not in a position to engage with them because of all of the procurement-related activities.

So what this means is, everything shifts a little bit Lehigh, capitol, northwest it will have July 1st, 2018 implementation date. The rest of the state will be on January 1st, 2019.

That's where we are at with CHC. I can go into some other agreement-related components, unless anybody has any questions?

>> FRED: Wait a minute, Kevin. We don't have a six-month hold. We are starting again in this July?

>> PAM: No. Southwest implementation date will be moved to January 2018, but everything shifts six months; that means the southeast will move out six months, July 1st, 2018.

>> FRED: Okay. Okay.

>> PAM: The next six months will not shift it keeps with the original date of --

January 1st, 2018 is southwest.

July 1st, 2018 southeast.

January 1st, 2019 --

>> JANEL: Kevin, I know it's still early for you to answer, with the talk at federal level, with block grant changes and possible changes to our waiver programs and the requirements for our waiver, do you

anticipate stumbling blocks with CMS approval?

>> KEVIN: We are planning for a significant amount of time to go through the approval process because of the new administration and comment on federal policy initiatives at this point.

Just to speak very generally, the person who has been proposed as the head of the centers for Medicare and Medicaid services, she was the director of the program in the state of Indiana is very much in favor of managed long-term services and supports services we don't anticipate any changes in Community HealthChoices with any proposed changes at the federal level at this point.

Who knows.

>> DREW: Yes. Just a follow-up to that, Kevin.

If there was a new block granting process, it would affect Medicaid waiver programs, is my understanding.

So are you saying that the intention would be to move forward with what is already planned, even if the state gets aid in a different way for Medicaid going forward.

>> KEVIN: At this point we are planning to go forward with the original plan to submit and that we will go through the process that is currently established.

If the federal government elects to go forward with a significant change with the way Medicaid services are authorized, Which includes a block grant that normally takes the norm of 1115 demonstration waiver, we will assume they would still want to go forward with these types of managed care initiatives.

At this point we are planning to go forward as-is.

Thank you, Drew.

>> Pam then Fred.

>> PAM A.: Maybe you will talk about readiness review more in your discussion, if not, I will ask my question now.

>> KEVIN: Why don't you ask your question now.

>> PAM A.: I am still wanting --

>> FRED: Do you want to do it?

>> PAM: Go ahead.

>> FRED: We had a pre-meeting on Monday, this is something we came up with. OLTL must determine whether selected MCOs are ready to start serving MLEs; that is readiness review.

There are several requirements the MCO must meet as part of the readiness review.

Of those requirements, probably the most important for consumers is the number, type, location of accessibility of service providers with whom the MCO will contract.

Now, this requirement is called network adequacy. Remember, that after initial six months, people enrolled in the MCOs will have to use providers in their MCO network.

Now that the Commonwealth Court has denied united healthcare request for stay, OLTL can move forward with readiness review, as you were saying, including network adequacy.

OLTL stated PA Department of Health, will make the final determination as to whether the MCOs have adequate networks of providers.

The Department of Health currently makes that determination for traditional HMOs. They have no experience or expertise in determining networks in non-medical providers such as providers of attendant care or services.

We heard previously OLTL and other subject matter expert from other offices within DHS will be meeting with the Department of Health to begin developing the standards of judging whether MCO has an adequate network of non-medical support providers.

The subject matter experts do not include individuals with disabilities not employed by DHS; however, when Pam Auer asked -- she has asked this at so many meetings it's ridiculous -- she asked whether consumers could see the proposed standards and comment on them, OLTL, Randy Nolan answered, "at this point in time, there is not a plan for consumers to access that".

Now, aren't consumers subject matter experts on the adequacy of networks of non-medical providers? Don't we have to seek services from these providers and suffer if we cannot provide providers to meet our needs.

Who will determine this?

>> KEVIN: There is nobody here -- Pam and I talked about this. One of the challenges we have with subject matter expertise in the long-term care services and I think -- you and I have talked about this as well, Fred, is we absolutely believe that consumers have to be part of the education process.

If there is a real gap with the Department of Health in understanding adequacy for long-term care services, especially for home and community-based services, it's something that they have not been part of certifying as being part of managed care organization up to this point, then there absolutely is an opportunity for that type of education. There would be a lot of value for that to be coming from consumers.

We have to make sure that we manage the relationship between a lot of our subject matter experts, many of whom are in the room right now, are maybe consumers of long-term care services or work or are affiliated with providers with the certification of the network adequacy certification process.

We have to figure out we will take advantage of that type of education, how to manage the risk between people who would be subjected from a providers perspective to actual certification and the actual service and accessing the actual service itself.

So what that means is, we are open to having certainly having this conversation not only with the Department of Health, but also with consumers who will be able to add value to the education process within the Department of Health and us and how -- it would be conducted.

It's important for us to make sure that we separate the role of an individual who might be working for a provider and otherwise be part of the certification for network adequacy.

>> FRED: We don't want a conflict of interest. The perfect person to know how it is to live in home and community-based services is a person who do it.

>> KEVIN: Absolutely.

There are other components to network is adequacy, like time and distance and also financial viability. There are a lot of different components to network adequacy that we look at as part of our review as well as the Department of Health looks at as well.

>> FRED: Is there any way that this committee can see what the questions would be for the readiness review, see what they have -- not what the answers are, just what the questions are?

>> KEVIN: I think we are.

>> PAM A.: We need to be -- to be clear, it's not just educating them. We need to be part of developing the standards. We need to be at the table. Nothing about us without us.

If you have a home care agency or whomever helping you develop the standards --

>> KEVIN: Yes, I get conflict-free. It's when you say "we", that is what I am worried about.

>> PAM A.: I do not work for an agency that is a home-care provider. Everything is separated out.

I get your concerns.

There are people out there.

It has to be part of the standards from the very beginning.

Education can be -- you know, we can tell them anything we want and it won't mean a darn thing, do whatever you want.

If we are at the table, say, No! We told you this. This is where we are coming from in developing the standards; that's key.

>> KEVIN: We agree in principle. We just have to figure out a way to execute it in a way that protects the integrity of the process.

>> PAM A.: What I heard the answer is, yes, it's not if it's how will we get it done; is that right? I think it's a pretty good outcome.

>> KEVIN: We will take back the execution and reach out to members of this committee to look for suggestions on how they can contribute.

>> TANYA: I have a comment.

>> PAT: Brenda has a question also.

>> PAM: Understood. Brenda, Tanya and William, I understand you have a comment or question.

>> KEVIN: Before you give your comment, do you mind if I reply more thoroughly to Pam's response, and will turn it right back over to you?

>> TANYA: I just wanted you to know.

>> KEVIN: The brain injury association has provided a lot of

different ways to make sure that we are including concerns about -- that the special circumstances of the population.

We may present some of the ways they -- just I am calling out to Drew a little bit because it's been helpful, calling out ways that they have presented information to us; that might be helpful for us in the readiness review process.

There are a lot of ways that I think we will be able to address your requests, Pam. I think that we will be able to find a good middle ground.

>> KEVIN: Tanya? Comment? Question?

>> TANYA: Yeah. One thing I wanted to bring up has to do with the employment piece of things.

Recently I have been offered a job. I am having issues finding all of the income criteria for what is state and what is federal and everything else for funding to see, like, where my job would put me incomewise and everything.

One of the things, I think, that needs to be done in this whole process, because we are following through with the Employment First initiative, is to somehow be able to get the information for housing formulas and SNAP benefit formulas to consumers who need them with the right kind of answers, when they go to get these jobs.

Right now, there they are not easily available the organizations that are supposed to know how to help you with this only know one piece of the puzzle and not the full puzzle right now.

Can we do something either as a subcommittee or as part of Governor Wolf's OLTL Employment First initiative readily available so they know what they are looking at in terms of their benefits and services, when they become employed, so they don't have to get the job first, and wonder how it will affect things. So they can -- almost a side-by-side process.

Right now, that is not being done easily.

>> KEVIN: Tanya, just in general, I couldn't agree more with your comment about making sure information is available to people, especially people seeking employment services and knowing what the impact of this employment will have on your eligibility and access to services that are provided by some of these programs that are either funded by Medicaid or otherwise.

It's part of the Employment First initiative to make sure that information is made available to them. We would love continuous feedback on how to make that better.

>> TANYA: Right now I am working with three or four different entities to try to solve a simple conundrum. It's not easy. All it is is, like, an example: One office might know the SSI formula but they don't know formulas for HUD housing and how it affects rent.

Whether you call your HUD counselor, they will tell you, well, we can't tell you, until you get your first pay stub; that doesn't help the person know how the employment is going to affect our future or what kind of salary they need to ask for to be able to compensate for missing part of their benefits and then trying to be able to keep their services and everything else.

It's a mess!

What we need to do is simply, like, make a little booklet for consumers that are seeking employment so that they know all of the formulas will in advance.

When they get the numbers, they can plug them in for themselves, easily do the math, see where they will end up, know what the guidelines are for different waivers and different programs.

>> KEVIN: Thank you, Tanya. Drew, do you have a follow-up for that?

>> DREW: Thank you, I do.

I just want to reinforce Tanya's point. This has been mentioned for people who have brain injury as being a very intricate and involved process understanding what their benefits are as they consider taking on work and it's -- I want to make the point that it needs to be an integrated process. It can't be that you go to agency A to get your employment benefits counseling and go to agency B to get your supported employment services.

It's not just sitting down with an employment benefits counselor and looking it up in a book. It's an interactive process, iterative process.

If you pursue a certain kind of employment and it's paying you a certain amount of money, it could very well affect your benefits and make you ineligible for the waiver.

You have to know that.

You have to go into it with your eyes opened.

Then you would go back and you might say, well, that's not really the best choice for me and I need to look for a different kind of work. You can't -- it needs to be integrated process. It can't be fragmented.

We don't want the managed long-term services and supports to disintegrate people's services. We have made this point to Jennifer. She didn't see anything wrong with going to agency A to get benefits counseling and going to agency B to get your supported employment.

I just really want to establish; that would be a problem!

>> PAM: Thank you.

>> TANYA: That's exactly what I am trying to say. Thank you for explaining that a little more clearly.

>> PAM: We have another question from Steve Wilkinson and --

>> It's actually Brenda.

>> PAM: I'm sorry. We have a question from Brenda.

>> BRENDA: Hello. Is it any better now?

>> KEVIN: That's perfect.

>> BRENDA: I have a comment first that has to do with the process for non-medical providers.

I think one of the things you could encourage non-medical providers to do now before formal readiness review happens, is some sort of consumer satisfaction survey.

I think how well they are actually serving consumers needs to be an important factor that MCOs are aware of.

It cannot just be self--- [inaudible]

We definitely need some kind of quality satisfaction form to go along with that.

It's one way consumers can give input to feel more of the process.

My question is -- I don't think anybody else has mentioned this today. Last week the governor announced the realignment of the Department of Human Services with the Department of Health. How do we think that will affect staffing and will it have any effect on

implementation of Community HealthChoices?

>> KEVIN: Well, thank you, Brenda for that question.

[LAUGHTER]

Why do I always have to answer these questions? Why is Jen always taking vacation?

[LAUGHTER]

>> PAM: She times it well.

>> KEVIN: When it comes to Community HealthChoices, there will be no changes. They are a full partner going forward with this consolidation we have been working holistically with the Department of Aging on the implement aches of this program.

In that sense it will not be an interruption.

In terms of consolidation with the Department of Health, however, it actually might be a net positive. The Department of Health -- office of long-term living and Department of Human Services we all have good relationship with Department of Health.

When you look for opportunities for organizational integration you can actually improve how these large initiatives can be administered and implemented.

From my perspective and perspective of Community HealthChoices, it could only be a net positive in the way that it is rolled out.

>> KEVIN: William.

>> BRENDA: Thank you.

>> BILL: Bill White, AARP. I want to emphasize community services with the aging network. There is a lot of expertise and experience out there. When looking for experts, as you mentioned, you are working with them, but there is a lot of positive experience out there.

>> KEVIN: When we talk about having subject matter expertise, especially people receiving services in the community for either long-term care or otherwise, absolutely the aging network and participants who are receiving services in the aging nets work have to be part of the conversation. They are largest part of population of Community HealthChoices and need to have a voice Sean seat at the table. Thank you. Thank you, Bill.

>> PAM: Any more questions before we proceed?

[NO RESPONSE]

>> PAM A.: Can I ask about navigators?

I want to know what is up with the navigator process? We hear halfway that it's part of the person-center the counseling. We have never heard any formal agreement with that. It goes along with what Brenda was talking about, tan Tanya and Drew having one system working with all of those key parts.

Is that what person-centered counseling will be.

>> KEVIN: Whenever you mention navigators to me, I want to classify the management final role requirement for the beneficiary support specialist function in a managed care program?

>> PAM A.: Helping people figure out which managed care they will choose based on Medicare/Medicaid.

If it's the same thing; that's what I am asking.

We asked from the very beginning, how will people be supported and educated in choosing their provider and what would work best for them?

>> KEVIN: So we -- there has been a lot of conversations about this. The object of the Department of Human Services and Department of Aging is to look for a holistic solution that meets all of the regulatory requirements, while at the same time has the best service component for the roll-out of this program.

One thing we do know is that our requirements for a managed long-term services and supports program is that we actually have augmented requirements. We have to do a little bit more than what would normally be required in the health choices program.

So we know that we have to do a little customization. The thinking right now is still looking for a solution that would meet the requirements of all of managed care, at least conceptually, while at the same time meeting the requirements for Community HealthChoices.

So it's not final yet, to be perfectly honest, but we are talking about it and planning for it. We recognize what the need would be.

We actually learned through the independent enrollment implementation from aging waiver, we learned how important that function has been and how much we can, actually, can gain from it and how much it could help people navigate through the process.

We know what it needs to be. We just -- you know what the entity will be and what it will look like is really the question at this point. There are a lot of different ways -- the states are talking about doing it differently. They are talking about IRBs, independent enrollment broker, existing services if they want to take legalistic focus using agencies within their states for supporting people through grievance and appeals process.

You know, there are a lot of different ways we can approach it.

>> PAM: Just to remind, Kevin, when a member asks a question, if you can repeat the question for the people on the phone? Thank you.

>> KEVIN: Absolutely.

I want to give update on the grievance and appeals process. This was discussed in the last meeting.

So the department of human services is developing a process for grievances and appeals that meets the new requirements for the managed care final role, at the same time is aligned with the managed care programs covered by the regulations; that would include health choices, Community HealthChoices and CHIP program.

While we are going through this, we don't have we know what the requirements are. What we are challenged by is that we have state legislation through Act 68 that has a framework as well.

We know that the federal laws and regulations preempts state requirements, but we also know that we have this established grievance and appeals process that has been in place with Community HealthChoices for 20 years and has worked very well.

We want to meet the requirements of the legislation while at the same time keeping what is best about our program.

What we plan to do through these vehicles using subMAAC and other vehicles is to present to these committees what we are proposing to do, so the way the whole flow would work.

The plan would be to present this in the next meeting, in March 2017.

We will give you a presentation of what we are proposing to do to meet the requirements. Then we will ask for your feedback.

>> PAM A.: I will stop after this. This is a big issue for me.

Is there any way, if possible, if you have something in advance of

the meeting, it really helps to be prepared in advance to know what to ask.

>> KEVIN: Absolutely. We cannot promise. With we will handle this two ways if we can get it to you in advance we will make sure we do. If we cannot get it to you in advance we will ask for follow-up comments in writing or otherwise that you can return back to us. We would discuss it at some future date. Thank you.

That's grievance and appeals process. If there is no more questions about that, just jumping over to a related topic, we are going to continue to have a lot of opportunities for review and stakeholder engagement.

Most specifically with communication that will be going out to potential Community HealthChoices participants in the very near future.

Some of the documents we will be asking for comment and review include draft participant communication, draft provided communication and as I already mentioned, language associated with grievance and appeals process.

This is a list that is certainly not all inclusive. We will probably have many more types of comments.

The point of mentioning this is, we have already talked about this before. Just to ready you for a request for a fair amount of review in the very near future there will be a lot of requests to be able to review this document. The documentation, make sure it's meeting revision of the objectives of the communication; also that it makes sense for your knowledge of the audience, including the participants and providers.

A lot more to come on that.

Just -- I think that -- I will skip the next point but I gist wanted to make sure to give quick update on enrollment broker.

We will be releasing new request for proposal for independent enrollment broker. We hope it to be this month.

I'm sorry. There are no operators available to service your request.

We hope to release the RFP in 2017 a lot more to come on that.

When we release it, we will do a blurb that goes out on listserv to announce that it's been published.

With that, are there any more questions for me.

>> PAM A.: Since you are talking about independent enrollment broker, what is happening? We still have people that are not getting the word about who to contact if you are having trouble. You know, people are still, like, not getting through -- when they call that line. Just some different things that are still happening.

I am wondering where -- we didn't get numbers. Jen said she would send them out to it. Maybe I am not on the email list.

>> KEVIN: We will report that through long-term care subMAAC. We want to focus the community on Community HealthChoices where the new RFP will be most significantly relevant. All of the requests will be in the long-term care subMAAC in the next couple weeks.

We have specific bylaws for what this subMAAC is supposed to be focused on. We are also reporting this information to the consumer subMAAC.

Jen and I are both reporting it in the long-term care subMAAC. Since they are focused on ongoing activities, it makes sense to report out there.

There are still case-by-case issues for independent enrollment broker.

We also know that it's getting a lot better. It's certainly a lot better than it was last summer. Certainly the data is better. The volume of enrollments in December for aging waiver, for example, were frightenly high. A lot of that they were cleaning up a lot of backlog cases, but we hit a record in December 20 -- we are back in January and the call center performance has been less than I would have liked to have seen but it's certainly a standard improvement over the history over the last 6-8 months.

There are always case-by-case issues we see.

Volume of complaints is going down significantly, but we still have individual complaints. A lot of it has to do with people with special circumstances trying to figure out how to get through the process.

If you hear of any of those special cases, Pam or anybody else, make sure that you are sending them to the Office of Long-Term Living.

If you want to send them directly to me, please do so. We will research them and make sure they are correct.

>> PAM A.: This is a key piece, isn't it? This is how people get

into the process. Knowing how it is working and working out the kinks if they are being worked out is important to see how it fits in the process.

>> PAM: Pam asked why we wouldn't be reporting out the same information for the current contract for the independent enrollment broker with this committee compared to the way we are doing it with long-term care subMAAC and consumer subMAAC?

The reason is Community HealthChoices will be covered under a different contract; that's the contract we are planning to post this month in February.

Where comments from this committee will be most helpful and they have been helpful are specifically -- we received a lot of comments from representatives of this committee and this audience for how we would craft the independent enrollment broker RFP; that's where those comments have been helpful and we will certainly answer any questions you have.

We are not going to plan to report out active program data on the independent enrollment broker for this committee, just because it's not part of the charter. The charter really is Community HealthChoices. We have a managed long-term care and supports services.

The consumer subMAAC and other subMAACs have been very vigilant keeping after this issue and provided a lot of suggestions in a solution in the managed long-term care contract.

>> PAM: Any more questions for Kevin?

[NO RESPONSE]

We will hold public comments until the end.

Okay, so thank you very much, Kevin.

We will turn the meeting over to Dr. Dale Adair and Ellen DiDomenico. They will talk to us about certified community behavioral health centers.

>> DR. ADAIR: Good morning, everyone.

Thank you for the opportunity to come speak to this group around the certified community behavioral health clinics, which I will now probably continue to say CCBHC, since I defined it.

I am Dale Adair, the medical director for mental health substance abuse services.

Ellen is within the secretary's office and does a lot of work with us at OMHSAS. She does in particular a lot of work with me.

Anyone who -- I don't know that anybody is in the room or on the phone that has seen me present, one of the things I always do in any of my presentations I always have a cartoon.

The reason for that is as a psychiatrist, and as a physician in general, humor, to me, is very important for the soul.

I always try to start off with some sense of humor. I have a million of these.

For those of you on the phone, it's a gentleman who is being weighed. He says to the nurse weighing him "I hope you are taking into account I have an enormous ego".

That doesn't particularly apply to me, though.

[LAUGHTER]

What I would like to do is give you a little background. I will try to keep you on your schedule so I hope to be done by a quarter after 11.

I will give you a brief history of CCBHC.

2014, Congress enacted a law called protecting access to Medicare Act. Signed into effect by President Obama.

It allowed the secretary of health and human services to develop criteria to establish the certified community -- at the time of the law, they were actually referring to it as certified community mental health centers.

SAMSHA and CMS has had some forms where they got community consumer and other input and, actually, changed some of this. Then came up with the criteria.

So they are now referred to as community certified behavioral health clinics.

In order to be one, a clinic had to have been established by April of 2014, which is when this went into, the act went into law.

All states, all 50 states had the opportunity to apply for a planning grant, which we did. We were in October of 2015 were awarded a planning grant. We were one of 24 states that received the award.

We received a little shy of $900,000 to do a 1-year planning on how

PA would establish following the criteria that had been established by the feds, how we would go about establishing these clinics.

The clinics really have to serve three populations, three target populations.

One is individuals with serious mental illness, children with emotional disturbance.

Individuals with substance use disorder.

There is a special emphasis then on veterans, making sure that veterans are served.

We establish a steering committee made up of a number of different inter-governmental agencies in a whole host of stakeholders, with family members, et cetera, on it.

Our steering committee was really geared -- there was 51% of either consumers or family members on our steering committee.

So over the past year, we looked at all of the criteria that the feds had established. We had originally put out a request for letters of interest to see how many clinics in the state were interested in being part of this, if we were awarded.

And we originally had 75 clinics that were interested.

Now, when we looked at the data, we believe that there is something like 300 clinics that could potentially qualify for it.

There were 75 initially interested, and through the planning process, it whittle down as people became more aware of what is required to become a certified behavioral health clinic.

We had 16 clinics which actually applied. We began working with them and helping them to meet the criteria.

In the end, we ended up with 10. So in October, October 30th of last year, we submitted an application to SAMSHA to become 1 of 8 demonstration states.

The demonstration is a two-year demonstration where we put all of the planning into action, we get to test out a number of things.

When you talk to folks at community behavioral health centers, one of the things administrators talk about are the things they want to do but can't afford to do, but then they take a loss on it.

The CCBHCs established a new payment structure for the mental health clinics. It's what is called a prospective payment system.

Those of you who are familiar with thoroughly-qualified health centers, it's similar to how they are paid.

It takes into account the actual cost.

There is also a big focus on evidence-based practices. So what we did was vetted a number of evidence-based practices through stakeholder involvement through the clinics going around the state talking to a number of different people.

We came up with a list of evidence-based practices that we believe will help better serve individuals who are experiencing the challenges that I told you are the target population.

That was all part of our application that SAMSHA accepted.

These are the ten clinics.

>> ELLEN: I was trying to keep up with your rambles.

>> DALE: I talk on this all of the time and don't keep to a thing, but for purposes of your knowledge, these are the certified clinics. They are kind of spread throughout the state.

One of the requirements for any state that elected to become a demonstration state was that you had to have a minimum of two clinics and at least one had to be a a rural area.

You know, we are very fortunate, Pennsylvania is a very diverse state and if you follow the definition established by the center for rural PA, which we did, out of 67 Counties the center identifies 48 are rural.

We have, I think, 4 of the 10 counties represented are considered rural.

If we look at the other 7 states that are involved with this, most states only decided to put forth 2 clinics.

To my knowledge, there is only one state doing more clinics than we are is Missouri. Missouri is in a unique situation because a few years ago, they moved all of their community health Centers to health homes. They have 28. They have decided to make all of their health homes, behavioral health health homes into community -- certified community behavioral health clinics.

This is a list of at the time counties. Go to the next slide.

These are the goals of the CCBHC program; that's to provide a complete scope of services.

There is actually a list, I believe it is in these slides, that actually talks about the 9 core services that they have to provide; that will improve the availability to access participation in the services that are all new criteria.

We have to demonstrate the ability to expand behavioral health services while improving quality.

All of this focuses on improving access; that's why focus is on evidence-based practices.

This is the prospective payment system I talked about.

We had couple options, PPS-1 is a daily operate and PPS-2 is more of a monthly rate.

I listened to our financial folks who are experts in that part of it. The decision with our consulters where Mercer is going with PPS-1. What we heard from other states who decided to utilize PPS-2, they dropped out. It was too heavy of a lift to get done.

With PPS-1 rate, we have the -- the state has the option of providing a bonus to clinics, who are able to meet certain performance measures. The performance measures are established by the feds, there are 6 of them.

The first year of this 2-year grant we said we would keep it at the 6. The 10 clinics, if they are able to meet the performance measures, we establish a baseline then we are looking for incremental improvement, they will be able to earn bonus money to help then improve things at the clinic.

This is something that is unique and different than we have done before and the clinics are fairly excited about the opportunity.

These are the core services. The first four on top of the list, crisis services, screening assessment, diagnosis, patient-centered treatment planning, outpatient, mental health and substance abuse have to be delivered directly by the clinics.

The other 5 can be delivered by the clinics, but can also be delivered through what the -- what is referred to as designated care organizations or DCOs.

If they establish a contractual relationship with a DCO to provide a service they cannot provide, the DCO has to meet the same stringent criteria.

They have to provide the information as service-provided, et cetera, to the clinic, which then bills us.

We then give the payment to the clinic, which then they have a contractual arrangement, they have negotiated rates within DCOs, they then will pay the DCO.

The clinic is responsible for all of it.

It covers screening, treatment planning.

There are a couple important things, but the things I will touch upon are, number one, there is a big focus on integrated care, which has been what the department talks about.

It fits nicely. We want to ensure that the whole person is cared for. Not --

>> FRED: The bonuses they are getting, is that if they can get so many people out and get more people enrolled -- is that going to affect their mental health issues?

>> Dr. Adair: No.

I don't have a copy of the performance measures.

One of the performance measures is around suicide and suicide risk.

We know in PA as across the country, we have some concerns and challenges with suicides.

>> FRED: Especially among Vets.

>> Dr. Adair: Vets and we are working with department of military affairs. You have pockets. An example, too, is you have pockets -- you folks may not know -- there is a group of young folks between the ages of 10-14 that we have seen a dramatic increase in suicides.

So the focus is really to, in these areas, to try and make changes. Try to improve things. They can't automatically get money.

They have to -- again, we are collecting the data to show where the numbers are at as far as these particular measures.

And then, as they show improve, incremental improvement, they will

be able to earn a certain percentage of the money.

If they do everything that we are asking, then they can earn all of the money that's certainly what we are hoping is that in the end, they will reach the maximum.

>> FRED: Okay.

>> DR. ADAIR: The other thing I did not say and I should have at the beginning, is that the expectations that these clinic treat the entire age span.

I mentioned serious emotional disturbance within children but they will be treating from children to basically infant -- I was going to say birth but -- on through older age.

Anyone can present to these clinics and receive treatment.

These are evidence-based practices that we have put forth. It is an aggressive and ambitious list of evidence-based practices.

One of the things that clinics will frequently complain about is the training. For all of these practices, individuals working is there have to be trained to deliver the practices and their skills have to be maintained.

The PPS allows them, as part of their cost reports to build in the training so there is a way that the training expenses are ended up paid for under this.

Again, we are looking to see an increased number of individuals that are trained in evidence-based practices providing the treatment to improve the outcomes.

So this is a two-year demonstration, which originally SAMSHA said that they were announcing in December -- and they did. They informed -- I received a letter -- actually, I got a call from them December 31st saying we were one of the states.

They originally said, once they announced the implementation of the states was supposed to be in January. Any of you who ever put anything together, from the time of an announcement to the implementing, it's really difficult to do it in a matter of a couple weeks.

SAMSHA was open to comments and changed it. They gave all states the ability to have some flexibility.

They told us we had the choice. We could start in January or we could start at the latest, July.

So it would be no surprise to any of you in the room or on the phone, that our choice, we start July 1st. So I pushed it out as long as we could, because there is still a lot of work to do.

There is a lot of work for the 10 clinics to do. There is a lot of work for us as the -- for openly is a's DHS to do to make sure that we can collect the data that we are supposed to collect for the feds, as well as we are going to do an evals on behalf of the state to look at the results as we go along.

The feds are doing an independent evaluation at the conclusion of the two years.

Then they have a report that is due to Congress in the year 2021.

2021, for me, is, you know, for our purposes, is kind of a delayed -- it's not timely enough for us to make some decisions.

What I believe will end up happening on a federal level will be that when the report goes to Congress, there will be a couple potential outcomes:

One would be this is a great success. People are getting treatment, doing much better with recovery, et cetera, et cetera and then the recommendation of Congress will be: This should extend, not just to the demonstration states, it should be the way that mental healthcare is practiced across the country.

One would be that the data is kind of equivocal. They are really not sure what it means.

In that case, what I think they will do is extend the demonstration.

The last one, I think, is if the data says, you know what? This was an abysmal failure! What were we thinking to do this?

In looking at this and in looking at the way this is supposed to roll out, I do not believe it were to be the case but if it were, what they would say is, we are scraping this. We need to think of something else.

A lot of people are very, very excited about this. This is really the first significant change in the provision of mental health community care since the 60s when JFK established community health centers.

It's been a long-time coming. There is a lot of excitement about it.

The legislators that were involved with this refer to it as a game

changer.

We are very ecstatic and happy to be one of the states selected to demonstrate the effectiveness of this approach.

>> PAM: We have a question from Brenda Dare on the phone and I want to announce Ralph has joined the meeting.

>> BRENDA: I work for an organization that served Washington, Greene and Fayette County. They are not on your list of 10 clinics. I was wondering what the service area of the Pittsburgh clinic would be and whether or not there are plans for mobile outreach to the outlying counties?

We have a very, very substantial problem with the opioid epidemic down here.

There is a lack of services, particularly for people with physical disabilities.

I was just wondering if you had any plans to address that gap?

>> DR. ADAIR: Very good point. I heard you say to repeat the question since it's on the phone do I have to repeat the question?

>> PAM: It would be good to repeat the question.

>> DR. ADAIR: The question essentially is would the clinic be able to expand where their service area is and tied in the opioid epidemic, which is on everyone's mind.

Is that a fair summation of what you asked?

>> BRENDA: Yes.

Initially, it was, what is the service area of the Pittsburgh mercy clinic? Are you --

>> DR. ADAIR: Specifically around Pittsburgh, what is the service area?

The service area for that particular clinic does not extend down into Washington or the other counties.

>> FRED: Then it's strictly for Allegheny County only?

>> DR. ADAIR: Let me finish her question.

Sorry.

The clinics cannot refuse an individual who presents to them. Okay? Regardless of residence or ability to pay; however, the feds had some things around the service area, if you would, and with the -- there were complications with the managed care. This is all rolling through health choices. Behavioral health choices. There are complications in it.

Essentially, if I lived in Washington County, and I presented to Pittsburgh Mercy, they would not refuse me.

>> ELLEN: Maybe I can describe it in a little bit broader context.

This is a demonstration. Obviously ten out of what we are -- 10 out of potentially 300 clinics in Pennsylvania is a nice start.

It gives us an understanding of what it will take to do this in a much more integrated way.

This is not the end. It's the beginning.

The fact that we have 10 clinics that were able to meet the criteria to be certified at the front end is really just that; the starting point.

The clinics, in general, probably came to the conversation with a service area that they generally provided services into.

They are certainly open to other individuals from other places, but it is probably not likely that individuals or a lot of individuals from, say, Washington County would be going to the location to receive services, where the services would be provided from a clinic that is in Allegheny County.

Over time --

>> BRENDA: [inaudible] that's correct because transportation is a huge barrier in our area.

>> ELLEN: Certainly one of the barriers within the services location is making sure that individuals can make the appointments and get the right services at the right time.

Clearly, the point of the demonstration is really to learn what it would look like to expand this kind of what we believe would be a really significant improvement in quality of services to a much more universal look at how behavioral health services are done within Pennsylvania.

So, you know, sort of -- while it doesn't deal with the specific question of what about Washington County, today.

Certainly from the opioid epidemic and centers of excellence and other things, a bigger picture of strategy looking at those bigger issues.

>> BRENDA: Thank you.

>> DR. ADAIR: I think one of the things you will see over time, this is the direction community behavioral health will going. I think you will see more about PA pushing some of the concepts out.

Again, this -- as Ellen pointed out, the demonstration is really learning how it, actually, would play out and work.

It will end up being a gradual process beyond the 10 clinics.

Did I answer you?

>> RALPH: Yes, we did.

>> PAM: We have to wrap in a few minutes.

>> DR. ADAIR: I think I covered what was on the slides, not the in order, actually.

>> PAM: We appreciate that, actually.

Any final questions?

[NO RESPONSE]

Pam, you have a question? We will have to keep this very short right now.

>> PAM A.: I am curious about the targeted management part.

At the CILs, who we work with we have trouble getting case management they may get administrative level but they are not getting the roll follow-up they need to live successfully in the community.

What is that a targeted case management in this? Will that help those individuals?

>> ELLEN: I want to address that from a couple different perspectives. We believe a part of good, quality care is the ability to provide the care coordination aspect; that often comes from a targeted case manager.

In the demonstration, the terminology is a little bit broader than what it is that it might look like in Pennsylvania's Medicaid state plan

for targeted case management.

Again, under the demonstration, we have more broad ability to define those things.

We see a couple things that we think will provide the support that I think you are asking about; that both the ability of targeted case management for individuals who meet the criteria of that, but also a really expanded role of peer.

We are looking at how peer support services are provided in Pennsylvania, what is currently in our state plan and how it could look in a much, much broader way.

Looking at clinics expanding those supports and connections for individuals through -- I heard the term navigate, sort of a similar kind of look looking at peers not only from the perspective of peers who support serious mental illness and of transition-aged youth, individuals who are family members. Thinking about family, peer, thinking about peers for substance abuse, disorder, certified recovery specialist or other forms of peers.

Looking really at the role of targeted case management and peers to really meet some of the gaps and services identified at the local cline I believe.

It doesn't mean every local clinic has targeted management services every local -- will have peer services how they define those and how they put those within the larger scheme of their services are really dependent on what they have identified in the local community in that they serve. Their geographic area that they serve and what are the needs of the individuals and what do they need to do to meet those needs better?

>> PAM: Thank you.

First of all, congratulation on the award it's remarkable. We look forward to hearing about the early success of this initiative.

It's really hearten to hear about the amount of work that went into the planning for this, that you will take the extra time to make sure when implementation starts, you are ready to go.

Congratulations, thank you very much for that.

>> FRED: I have one real quick question. What is the time line on this? Do you think that everything will be set and able to go on and expand?

>> DR. AZAIR: Let's see what the results are.

>> RALPH: Rough time line?

>> DR. ADAIR: I am hopeful there will be things within the two years we can push out.

At the end of -- so we start July 1st, '17 and June 30th, '19 is which the two-year demonstration is over we will work with a group of folks and looking at what our outcomes are.

Then a large part of it will be what we see as outcomes.

I don't want to push out anything that the outcomes say I shouldn't push out.

>> RALPH: Right. Right. Exactly.

Like 2019-2020?

>> DR. ADAIR: Somewhere before 2020, I believe we will be able to say these are the things that we want to go strongly forward with and we will have to then lay out a plan on how to do it.

Just like we planned to get to this point in time, to be responsible, we have to plan then on how to push it out.

>> RALPH: Thank you. That answered my question. Thank you.

>> PAM: Thank you very much. Let's give him a round of applause.

[APPLAUSE]

>> PAM: Next up is Paul Saucier and Marjorie Faish.

>> MARJORIE: Good morning, everyone. My name is Marjorie Faish. I am with the Office of Long-Term Living.

Paul and I want that talk to you about -- related to Medicaid and Medicare.

Paul will talk to you about coordination under CHC with Medicare. I will speak to you about coordination with Medicaid under the DSNPs.

Paul?

>> PAUL: Thank you, Marjorie, thank you everyone. It's nice to be here.

Talking about this topic, which we addressed this group once before on coordination for dual eligibles.

First of all, why are we even talking about coordination for dual eligibles?

You can skip, Georgia, to the chart.

You have seen a version of this before. It's been updated. Just a reminder to everybody that 95% of the people who will be enrolled in CHC will be duly eligible. They will have both Medicaid and Medicare.

We think about this in MLTSS program, which it certainly is, we need to keep our eye on the large group of dually eligible, who don't use LTSS.

So of all of the expected participants in the program, only 5%, the small wedge at the top, have Medicaid only, the other dually eligible and subset of them, 28% have LTSS and dually eligible and 67% dually eligible without LTSS.

Going to the next slide, dually eligible people will have three different options or scenarios that they can choose in terms of how they receive their Medicare services.

As you all know, the Medicaid portion is required for everyone. Everyone in the top row will be in a CHC, Community HealthChoices MCO. A choice of three.

Then what people choose to do with their Medicare will continue to be an option for them. They will continue to have the same options they have today with the addition of one new option, the first option on this chart.

Option 1 is the one that we think will provide the greatest ease of coordination of Medicaid and Medicare.

The CHC plans are all required as of January 1 next year to offer a companion dual-eligible special needs plan for Medicare.

So once you have made your choice, of which CHC MCO, you will have the option from that company taking their related Medicare product; so that's option 1.

Because it will all be within the same company, although it there will be technically 2 different products, this ought to provide the greatest ease of coordination.

Option 2 is to choose your CHC MCO, then choose an unrelated

Medicare managed care option.

Now, why would somebody do that? Probably in smoaft cases because they are already using that Medicare managed care option and don't want to change it. It's working well for them, but it's not associated with the CHC MCO, but they want to stick with what they have got. They will have the option to do that.

By the way, they can change the Medicare choice every 30 days. It's not an irreversible choice if you want to go away and try something else.

Option 2 is a little more challenging for the CHC MCOs to coordinate because they have to interface with another unrelated company, but there is still an expectation and requirement that they reach out and coordinate those Medicare services; 37, choose CHC MCO but stick with fee-for-service, traditional Medicare many people have today and may want to keep.

Again, still an expectation on the part of the CHC MCO that they reach out and coordinate.

In this case, it would be with the individual Medicare providers who are operating a fee-for-service.

The CHC contract --

>> PAM: Paul, before you move forward, I represent the Life program. We are all always struggling with the fact that government talks about three options, when quite frankly there is a fourth option.

We will formally ask, again, that rather than remove us from the education and documents that you remember to include the Life program in these documents.

We are targeted specifically to the dual eligible, an integrated product and really believe we she be there when trying to educate the public as to where you are.

>> PAUL: Thank you for that reminder, Pam.

The people who are in Life today will stay in Life unless they actively choose to change.

>> PAM: They can choose.

>> DREW: Do the current 3 CHC MCOs currently have a medicare DSNP program available?

>> KEVIN: I can answer that.

>> PAUL: The three.

>> KEVIN: It's our understanding and may not be the most up-to-date information the 2 of the 3 selected offers do have active dual special needs plans in Pennsylvania.

A third was recently licensed as dual special needs plan in Pennsylvania.

We are not sure at this point what the growth is of the network.

We are hearing it secondhand because we have not been able to engage them directly at this point; that's our current understanding. That's what we understood through the proposals.

>> DREW: Thank you, Kevin.

In order to interest people in option number 1, it would be good to know what those plans are so that people can start researching them and understanding what it means for them in terms of if they have to change providers and so forth.

I take it, you don't want people to choose option 2, because that would be the hardest to coordinate care.

>> PAUL: I think in terms of programmatic --

>> Excuse me. Can you please remember to repeat the questions?

>> PAUL: Sure. The question was, it would be helpful for consumers to know what the companion DSNP options are of the 3 CHC MCOs and the presumption that option 1 is the preferred option.

From a perspective of coordination of Medicare, option 1 should be the easiest one for the CHC plans to coordinate Medicare.

So it's preferred from that perspective. At the end of the day, it's up to the Medicare beneficiary which one they want to choose.

In terms of giving people information about the companion DSNP, it's -- there is not going to be information about that for a little while, because the plans -- Medicare Advantage plans are working right now on what they are offering in 2018. There is a whole CMS process for that.

The call letter comes out at this time of year. They will respond and by July they will have all of their application materials in to CMS for the 2018 year.

In the second half of the year, there ought to be specific information about what those offering are.

>> DREW: Thank you.

>> PAUL: Okay. Moving on to the next slide, there are coordination requirements or facilitating features in a couple different contracts.

I will talk about the CHC contract. Marjorie will talk in a minute about the Medicare or MPA contract.

We are coming at it from both directions.

So the Medicare facilities in the CHC contract -- this is not all of them but the major ones -- there is a general requirement: The CHC plans need to coordinate all services for their members and there is specific reference to and mention of Medicare as one of those types of services.

So there is a general expectation that the plans will coordinate Medicare even though they are not required to.

Person-centered planning. There is language in the section for those people who have an LTSS person-centered plan; that that plan must address how Medicare services will be coordinated.

So, again, the person-centered plan must reference and talk about how Medicare will be coordinated.

Coordination of Part D, prescription drugs for dual eligibles. Obviously Medicare pays most prescription drug costs.

Again, the CHC MCO must coordinate all prescription drugs needed, including those paid for by part D and there is specific language in the contract about that.

Then, final letter, prohibition on balanced billing. I mean, there is a legal prohibition again balanced billing but discussed in the contract to make clear that dually eligible members may not receive balanced bills or be asked by the providers to pay cost sharing on their Medicare because it's a Medicaid obligation.

Those are some of the highlights of the coordination requirements in the CHC contract.

I want to just share with you information about one other initiative DHS has going on related to this. Then I will pass it over to Marjorie.

So for duals, as we have been discussing, the primary payer for many

providers, doctors, specialists, hospitals, rehabilitation, therapies, et cetera is Medicare.

So how will DHS know how all of those services are being coordinated with Medicaid? Obviously, you have to have Medicare data in order to know what is happening on the Medicare side.

So DHS is participating in and offering CMS called Medicare Medicaid, CMS contractor is MIS systems who have been heavily engaged with the state.

In the past, DHS has requested and received historical data, historical data from CMS, old data that is interesting to look at for many reasons, research and otherwise.

Going forward, through this initiative, DHS will be receiving much more current Medicaid data. It's called COBA data, which is not important except people may refer to it as that so you may know what they are talking about.

DHS will be receiving data that will be 3, 4, 6 weeks old. Very current.

They will be able to look, almost in realtime, at what is happening on the Medicare side of the ledger for dual-eligibles.

This will also be data used in the evaluation and other purposes.

>> Does this include -- only fee for.

>> PAUL: The question is, the data that the state is receiving through the MMDI project is does it include Medicare managed care data? It does not. It's fee-for-service Medicare; that's one big piece.

If we go back to the models -- yeah, so -- this third option 3 for option 3 group, will have the fee-for-service data to know what is going on.

Marjorie will talk in a minute about the reporting requirements for DSNs, which is new, which addresses what is going on for other groups. Not all but most.

There will be Medicare managed care data coming in. Marjorie will discuss that.

With that, unless there are other questions about this, I will turn it over to Marjorie.

>> PAM: Do we have any other questions?

[NO RESPONSE]

Okay. Thank you.

>> MARJORIE: As I said previously, I want to talk about coordination in 2017 with the contract.

So everyone is on the same page I want to go over what MIPPA stands for is Medicaid/Medicare improvements for patients and providers. It is to enhance Medicare and Medicaid coordination between dual eligibles.

When we say DSNPs; that's one type of a special needs plan. So that's a DSNP, the contract is between the DSNPs and the state Medicaid agency in that state.

The 2017 MIPPA contract in Pennsylvania was enhance coordination to improve quality of care through that enhancement of coordination.

I pulled highlights out of the 2017 contract; that's what I want to speak to you about today.

The first thing I want to talk to you about is the expectation for the DSNPs to coordinate all types of services with Medicaid providers.

You've heard us talk at different points, there have been different presentations made. A companion DSNP is a DSNP with aligned -- and non-companion DSNP.

Whether you are aligned or not aligned, we expect you to work with all of the MCs is that are Medicaid providers and also expect you to work with Medicaid providers that are within the traditional fee-for-service system.

The other piece of information that is on this slide, hopefully it's the slide that is above me -- it is --

I think this is really important. I wanted to talk about this because it addresses service caps. Although that -- service caps is an important issue, the other thing I really like about there is, you've heard Kevin and Jen talk many times about transparency with the whole CHC implementation.

This is a perfect example of public facing. We put a document out on the website. We asked for public comments. We got public comments. We looked at them. We went back and said, you know, we want to put this into the MIPPA and we did.

This was from one of the stakeholders in the room today.

I just want to throw that out there and let you know that we value your comments.

Service caps. What are we talking about, here?

We want the DSNPs to be aware when there are service limits under Medicare to make providers aware.

Once the service caps are hitting either items -- they can be sent out and implicate the process to get Medicaid approval, whether through prior authorization or whatever it needs to be?

Obviously, the reason for that is, we don't want gaps in services for the consumer.

I talked a little bit about our expectations related to coordination with Medicaid providers, but we also have the same expectation on the Medicare side.

So, you know, we all understand about networks and in and out of networks some requirements are in-network but providers out of network.

As you heard Paul talk earlier, Medicare is like Medicaid, people can choose to get services through traditional fee for service under Medicaid also.

We want coordination on both sides.

The next thing I want to talk to you about in terms of the DSNP contract is some service coordination requirements we put in.

The DSNPs will be able to determine if service coordinators are necessary for the members. They will do that based on whatever assessment that they set up. It has to be based on the member's health needs.

You know, there was a presentation at Dale just did on behavioral health.

One of the components is coordinating care not only between the physical health side, which is CHC, but also the behavioral health side.

Some of the things that we would like to see communicated or planned and unplanned admissions, whether they be two nursing homes or hospitals and some of the other things are identified health concerns that may am could up in the initial assessment, so that there is communication back and forth between Medicare and Medicaid side.

The next thing I want to talk to you about is continuity of care.

You've probably heard this come up previously in different presentations. Also, it's been in place for a long time on the physical health MCO side.

There has always been a medical assistance policy related to continuity of care.

You heard Kevin and Jen related to CHC moving forward. There is also continuity of care built into the MIPPA contract.

Specifically, it's DSNP for whatever reason terminates contract with CMS.

They add and delete counties throughout the year or moving from one year to another, and then it's also possible because there is freedom of choice and individual member might choose to leave one DSNP and join another DSNP.

Under all of the circumstances there is expectation by the department that there will be continuity of care. This relates to prior authorization of services, et cetera.

The next thing I want to talk about is, as I said previously, you know, we call these things companion DSNPs and non-companion DSNPs.

Most of the contract applies to both of those types of DSNPs.

Because a companion DSNP is with an aligned CHC MCO there is an opportunity for enhanced coordination just based on organizational structure.

So consequently, we have enhanced expectations through the MIPPA contract, through the coordination of what that would look like.

What does that mean, though?

We are looking at things like integrated screenings, needs assessments, and service coordinate nation.

Our expectation is that there is one service coordinator for both sides, Medicare and Medicaid.

And then because that is our expectation, what does that mean? That means that that service coordinator should be able to see both the Medicare and Medicaid side, claims, eligibility and service planning.

The next slide, I wanted to put the reporting requirements in the center of the slide because that is the overall theme.

The reason why we tried to beef up the MIPPA contract this year is because we are, you know, being driven by quality. Everybody is.

We also want to enhance coordination.

So what are some of the things -- like, if you think of this as a cog or bicycle tire, what kind of things lead into the hub? You think of the hub as the quality.

What do we need to look at and address?

The first thing is DSNP's non-renew articles, termination and service area reductions. We talked about that a little bit ago in terms of continuity of care.

Another thing is DSNP's chronic improvement and quality improvement programs.

You might be aware of these from the perspective that they are called SPs and QPs. If you hear that term beare talking about that.

The other thing we want DSNPs to report is quality reports they already send to CMS or national committee for quality assurance things like HEDIS measures, if you ever heard of that; that's kind of what we are looking at.

We also want to look at Medicare encounter data and Medicare grievances and appeals. Lastly, DSNP monthly enrollment and disenrollments.

I'm sure everybody has digested that very well.

[LAUGHTER]

Where do we want to go from here? What are the next steps?

We want to incorporate coordination requirements into CHC program monitoring. We desire to develop baseline profile with the integrated data that Paul talked about earlier between Medicare and Medicaid.

We also want to engage DSNPs to fulfill the new reporting requirements that are in the contract for this year and, you know, hopefully we will be going forward.

The very last page of the slide, it's just a link to the 2017MIPPA contract, in case you all wanted to go out and read something tonight before you fall asleep. It's only 33 pages long. Very well-versed in it. Have some popcorn with it; that's my only advice.

[LAUGHTER]

The last thing is, if you have questions, specific to the MIPPA contract, there's an RA box you can send in your questions to.

I think I am supposed to say -- should I ask? Are there any questions?

[LAUGHTER]

See, I was hoping not to have to ask that.

[LAUGHTER]

So.

>> PAM: On the phone, Pat any questions?

Pam has a question.

>> PAM A.: The PowerPoint is on the website?

>> PAM: Yes. Everything is always linked.

The MIPPA contract, all of the requirements in that will be up and running as CHC gets delivered? Begins to get delivered?

>> Marjorie: The economic takings, because it's a heavy lift. We understand that. We try to build language into the contracts that acknowledges that, you know, these are the goals and this is where we want to move to but it's also a collaborative effort between department and D-SNPs.

>> PAUL: They are in place today.

>> Marjorie: Right. Paul just mentioned to me, he said, you know, they are in place. This is the contract that is in place.

It's also working and it's working through some of the technology areas also.

>> PAM: Okay. Thank you -- any other questions? Blair you have a question?

>> Blair: Either you Marjorie or Paul.

What do you envision will be allowable or shared in the scenario where the D life SNP is not a companion plan to a Community HealthChoices but managed care D-SNP. Do you feel data will be able to

be shared in both directions? Community HealthChoices to D-SNP and vice versa? How do you feel it would be useful in ensuring that all coordination of care is optimal for those members?

>> Marjorie. I think that is an excellent question.

I think there is some dialogue related to that internally that we are having specifically related to the FEI project going on right now with the integrated data, but that is something to keep in mind going forward.

I don't think -- we haven't worked up to what that answer is at this point, but definitely dialogue around it.

>> PAUL: I guess, what I would add, that's why I think models 2 and 3 are more complex and take more effort.

In model 1, if you choose that model, I will be agreeing to share information back and forth.

Whereas, with model 2 or model 3, the CHC plan has to approach the Medicare advantage plan. They will have to do releases of information. There are more transactions, essentially, so it's more complicated.

>> I am not expert on HIPAA. I think there is a lot of opportunity but it funds or sounds like there is a lot of hurdles to be able to share the which was.

>> PAUL: At the end of the day the beneficiary will have to agree on release of information. It's a big step you have to take.

>> PAM: We are not ready for public questions, yet. David.

Paul, Marjorie, are you going to be here for public comments?

>> PAUL: Yeah.

>> PAM: If you can hold off for public comments.

We have more than ample time today for public comments knowing in the past we have not left enough time.

We will have at least a half hour to do that.

If there are no more questions from the committee, then thank you very much.

[APPLAUSE]

Next we will hear about data reports from Kim Mankey.

>> KIMBERLY: I can say good-noon everybody. It's not afternoon it's not morning it's good-noon to you

I timed it just perfectly.

Good-noon to you will!

[LAUGHTER]

>> It's the little things. See?

>> KIMBERLY: Thank you for asking me to come. My name is Kim Mankey. I work in the OLTL quality bureau

In my division we do program development, innovation, metrics and analytics

I have an IT background project management and things like that. I am a double-nerd threat. I have data and IT.

The first thing I does was I went and looked at the purpose you don't have this committee to see what would I want to hear if I was them to is drive towards their purpose?

Whenever I read your purpose it says to review and advise MAC on policy administration for CHC.

I thought, What would I like to know data wise if I was on this committee?

That's why I chose these agenda items.

What data will look like in CHC.

What measures we have in place or will have in place?

The quality strategy plan measures, which I will go over. I got permission to share a deeper dive than you've seen before; that's something new for you.

What is available and of course, next steps.

The thing I thought you would be interested in is, like, how the general data will flow in my -- in our shop here at DHS. Sort of like what data will be available directly to us.

Like I said, I am an IT person. I colored different colors of

boxes.  They are different systems data is housed in.

I thought it would be interesting.

This is a very high-level view of it now.

IEB begins application and kicks off FED.  It leaves me.  What is that?  Functionable eligibility.  Thank you very much.

I have said acronyms so long that I don't know what it stands for.

(Music.)

>> Somebody put us on hold.  I will mute everyone.)

>> KIM:  I think we are on hold.

The next system the data will flow through is the assessment system, which we are allowed to say is we are working on that right now, getting a PO in order.

I want to manage your expectations at the same time as informing you.

The green is not even started in development yet.  As far as that IT system that is going to house this data, it's still coming and being built.

Also, then after the assessments are done, the two types of assessments, then we will see that again in our CIS system in DHS.

Just to also let you know and manage expectations the fields we will be using in SIS system we are not testing those until November.

It's being built now.  I will see it.  Us, personally, will see it in November whenever we do some testing.

The encounter data, which you have heard before -- you know, OMAP already using encounter data of course, but our encounter date is a is in our billing system as the last step.

From soup to nuts we have the person applies and the all the way to having a service and being billed.

I wanted to show you that as a flow.

Just talking more about the future of, like, whenever you start to see me more often, whenever I start to come to meeting, all of the time like I do for the LTSS subMAAC, it it will probably not happen until,

you know, a lot of this data is fulfilled.

I will talk more later about what is currently available.

I wanted to let you know about -- a lot of this data can be used for trends analysis. I wanted to just warn you been what kind of a trends analysis is.

You don't want to go from one box to another compare them from one period of time it's different sets of people.

Whenever you do a trends analysis, you do one box at a time.

In November they will this many apps, this many December, January and that kind of thing; so that's probably -- I am just thinking future, here -- what you would see for trends analysis.

>> DREW: Are you taking questions?

>> PAM: Did you want to hold them until the end?

>> It's a very brief question. It's a noon question.

On that diagram are you saying that OLTL will or DHS will still be getting encounter data under CHC?

>> KIM: Right now we get what we call claims data. We get the fee-for-service claims data. It will turn into in CHC encounter data.

>> You will still require that and do something with it?

>> KIM: Yeah. Kevin, do you want to answer that?

>> PAT: Can you repeat the question, please?

>> KEVIN: Drew asked the question whether or not you need encounter data?

>> I thought you were getting out of the business and handing it over to MCOs. Why would you get encounter data?

>> KEVIN: Quality assurance. We will collect encounter data to make sure that we are -- our managed care organizations are meeting terms of agreement. It's standard practice with manage willed care and the way that the state agencies are -- whether they use managed care as part of a delivery for the Medicare Medicaid services.

>> DREW: What will you do with it?

>> VIRGINIA: I can answer part of that.

Hi, I am Virginia Brown. Drew asked what we will do with the encounter data?

For at least part of what we will do with it is for 1915 (c) waiver, we still need to report to CMS costs for demonstrate cost neutrality.

The data we receive from those encounter claims will be used for that purpose, as well as the purposes that Kevin just outlined.

>> KEVIN: Rate setting, on and on.

To continue with what Virginia was saying, our agreement for Community HealthChoices will largely be built on collection of encounter data it's essential.

>> DREW: I understand. It doesn't get you out of the business.

>> KEVIN: We are in the business of oversight of our business; that's what we are doing.

The difference is we will not be paying claims. We will oversee from quality and grievance assurance perspective, agreement of services.

>> DREW: Thank you.

>> KIM: Thank you.

This is, I wanted to then start to talk to you about what you would care about, again, in the future to achieve your purpose.

I was thinking, since I am in the bureau of quality, I think that a lot of the qualities measures and the quality strategic plan that is coming out, will be your bread and butter as far as to oversight and things like that.

You have seen this before. This is sort of just -- I will not read all of these things to you.

This was in the December 15th Third Thursday Webinar, I believe it's been presented here. But now, I will show you something new.

The quality strategic plan. Here is the national measures. I just have the head categories, because -- please pay attention to the little draft sign.

This has not been released yet. Here are the major things we will look at for national measures. The HEDIS measures and CAHPS assessment.

I love surveys. They are my favorite. You speak to people and get a lot from those which is why they are national measures because they are used often.

The MCH adult core measures, CMS nursing facility measures.

You had a fantastic presentation from Marjorie and Paul about the Medicare, the D-SNP measures.

The state measures are high-level category sections.

Please look for this, coming soon!

It will probably be an appendix -- I will not tell you what appendix because we are not sure -- for you to look at, when you hear quality strategic plan has been released for public comment, that's when you could look through and see the actual details of the measures.

I like to tell my team, whenever you think of measures, please think in your head, does this help me monitor the MCO and is this actionable?

If I collect the data, can I do something about it?

Is it for monitoring and is it actionable?

So the state measures that we have so far of the categories are plants, denials, appeals, grievances.

The LTSS community based service measures, service coordination and care coordination.

Of course, nursing facility admissions/discharges; CHC waiver assurances in my next slide you will like.

The program launch, is also a smaller set of measures. I will go over it at the end, the order you will see the data rolling across to you all.

Waiver assurances. If you want to read, like, if you really want to read the numerator and denominator of these measures.

What happened? Nope. Nope. Go back.

How is this out of order.

I have no idea how that happened. I have proof that was not the order.

>> GEORGIA: Blame it on me. Sorry.

>> KIM: No, sorry about that, Georgia.

The waiver assurances -- this is online. If you want to see the numerator and denominator of all of these numbers under each section, you will go to the CHC waiver, the draft waiver and go under performance measures link and click on it.

This big PDF comes up with all of the intricate little details of the measures.

I think that this overview gives you the affect that we are hitting things at all angles that we can.

Waiver assurances cover administrative authority, which is contract compliance. The level of care; that's the functional eligibility and application stuff.

The qualified providers will like the certifications and things like that, those measures.

Service plan -- person-centered is in there over and over again.

Health and welfare is instances and surveys. The financial authority. That's rates and payments.

I'm sorry. I will just say the header. What CHC data is available now?

The historical data summary is out there. It has been out there. It's slightly dated. So I put a link to that web page. It shows all of the data that we put out whenever we prosecute, actually, asking for people -- asking for MCOs to bid.

So we gave them a general idea. There was a lot of data. As you manage the MCOs want to know who they are dealing with. There is a wealth of information there.

I have also -- it is great. I want to point out the word "estimated" to manage expectation.

As you saw in the flow diagram a lot of the IT stuff is not in the systems now for me to give you pinpoint accuracy of how many people are in our systems in our population.

However, we have worked diligently with our IT system guys, who I just love.

What we have come down to is trying to get the estimated population using all of the codes that are currently available to us. You should

see the spreadsheet of all of the codes that have to -- that we have to do just to put them into the buckets.

So this is what we have now. We have it as fresh as a snapshot data of 6/1/2016.

I took this information off of the IEB RFP, which was also information put out whenever they were soliciting for the IEB comments.

Next steps, please.

Document measures. We are going to keep on working on the measures. We are going to, hopefully very soon, talk to the MCs.

Of course, your input we love!

We want to develop and test the IT systems holding the data.

And then it kind of goes in this kind of flow. So the vision is the disposal of these times, readiness review, anything that Randy wants us to create -- to do his readiness review measures. There are launch measures we already mentioned.

There will be some monitoring, whenever people are getting started measures and steady state measures and a lot of the quality measures I mentioned before.

After everything is hunky-dory we will do innovation and special studies; that's kind of what happens to data, the lifecycle.

That's all I have. Drew?

>> DREW: Could you go back to the types of data slide, please?

Kimberly, I know you're excited about the data; that's great.

[LAUGHTER]

I think we still have not dealt with the fact that the CAHPS data will not be accurate for folks who are interviewed by the phone who have a cognitive impairment, which could include people with brain injury and dementia.

We still have not worked out a proxy arrangement for that data.

So it's not going to be clean data unless we work that out.

I don't know where that is at. We raised it last time. We still need a process for that.

>> KEVIN: I can speak to that, Kim.

Drew, thank you for the comment. We recognize that. We will continue to work with you. This isn't the only gap. We know when we are delving into long-term quality measures that are associated with overseeing managed care a lot is fairly new and with he have a lot of opportunity for growth.

We know that -- look for opportunities to expand in this area as well.

As the body of knowledge and the measures become more mature, I think we will able to address some of those gaps; thank you for the comment.

>> KIM: We want everybody --

>> DREW: I know what you want.

>> KIM: I want it all.

>> PAM: Any other questions?

[NO RESPONSE]

Any on the phone, Pat?

[NO RESPONSE]

Thank you very much for your report.

>> KIM: Thank you.

[APPLAUSE]

>> PAM: There is a public question. We will start with the public question. I am happy to say that we allotted 45 minutes for public questions today so hopefully -- well, somebody just said oh, no! I hope we will be happy at the end of the session. Pat, let's start with that question.

>> PAT: On slide 7, does item D, nursing facility admission and discharge apply also in hospital admissions?

>> KIM: I do not believe so. The question was, does the nursing if a silt --

>> PAT: On slide 7, nursing facility admission discharge apply also in hospital admissions?

>> KIM: The question was, does nursing facility admission and discharge on federal measures apply to hospital and it does not.

>> KEVIN: Not directly.

>> PAM: In what way does it indirectly?

>> KEVIN: Indirectly, I would answer -- it's my understanding that since a lot of the nursing facility admissions and discharges are associated with hospitals admissions or discharges, there is sometimes a way that they capture that relationship.

So that would be one way that it might be captured.

>> KIM: Wherever you come from.

>> KEVIN: I am too a data nerd.

>> PAM: It's good to have a lot of data nerds in the room.

David, did you have a question? Do you still have your question?

>> DAVID: This has to do with the coordination between the Medicare and Medicaid and in particular the issue of the dual eligible special needs plans.

So there has been a lot of volatility in the whole managed care market with plans dropping counties, plans getting out entirely.

However, the requirement as you stated was that the Community HealthChoices plans will have to, in a year, have an aligned D-SNP plan. All plans are decided for statewide.

Does that freeze them into maintaining a D-SNP plan statewide for the entire length of their contract?

>> KEVIN: I will answer that question, if that's all right.

To be perfectly honest, the summation is, yes.

>> PAM: Kevin, can you rachet the question?

>> PAM: Sure. David asked whether or not if the selected offers, once their agreements are finalized, they have the requirement that they have to have an aligned dual special needs program within the year that the execution of the agreement whether or not they will be locked into that requirement throughout the length of their agreement -- we are calling it an agreement. I keep messing it up myself.

The answer to that would be, yes, it's an agreement requirement.

>> DAVID: Thanks.

>> PAM: Any other question?

>> Lester Bennett with [inaudible] supports coordination.

This is about the D-SNP plan. All right. I think it's Ms. Marjorie. I am kind of confused. The coordination of service -- coordination of, in there you said something about there being a deciding if the service coordinator would be needed. Am I understanding that correctly?

>> Marjorie: Yeah. What I was saying is that there is -- the D-SNP is going to have the ability to determine whether or not service coordination is needed. Specifically for their members but it's based on the health member's needs.

>> Lester: So --

>> KEVIN: Can I just add to that?

So if a person -- service coordination is a requirement for people who are in need for Community HealthChoices. A person will have a service coordinator if they are in need of long-term services and supports or if their condition also requires it as well.

I am not sure if your question was about Community HealthChoices or dual special needs plan.

The expectation is that the Community HealthChoices managed care organization is going to coordinate with the dual special needs plan for service coordination regardless of the types of services received in the dual special needs plan.

If they happen to have a care manager or a service coordinator in the dual special needs plan,that will probably help facilitate that coordination.

Expectations on the Community HealthChoices sides; is that that service coordinator will be coordinating those as much as ifs they are long-term services and sports eligible.

>> Lester: I just heard that someone besides the consumer will be making a decision whether or not they needed a service coordinator; that's what I thought I heard. I was just asking for clarification.

>> KEVIN: Well, just to be clear, is your question -- I will repeat

the question by asking it again. Is your question whether or not a person who is in need of long-term services and supports do they get a service coordinator or not?

>> Lester: Yeah.

>> KEVIN: They have the opportunity to choose and have some say as to who their service coordinator will be in the Community HealthChoices program although it is an administrative function of the organizations.

They will have a service coordinator.

>> Lester: Regardless of whoever provides it?

>> KEVIN: That is correct.

>> Lester: Okay. Thank you.

>> KEVIN: Any other public comments or questions?

>> RALPH: You mean to tell me we have this time -- okay. Here we go.

>> On Friday the Commonwealth announced had announced about the four agencies, DHS, Department of Human Services, Aging health Carl and drug and alcohol being combined into one health and human services agency.

A couple questions, will it affect MLTSS and if so, how?

>> KEVIN: Do you want me to answer them as you go through?

>> JEFF: Yes.

>> KEVIN: Jeff asked the question whether or not the proposed consolidation will affect Community HealthChoices? The answer to that question is, No. We are going forward with Community HealthChoices.

As I mentioned earlier, one of the agency lings that has been proposed in the consolidation along with the Department of Human Services is the Pennsylvania Department of Aging. They have been a full partner Community HealthChoices all along.

The Department of Health has been consulted about Community HealthChoices and proposed consolidation might help with the addressing of network adequacy and other test requirements that are under the current jurisdiction of the Department of Health.

>> JEFF: My second question is also related to that: Do we know how CMS, Centers for Medicare and Medicaid, view this?

They tend to want to talk to one lead agency and not two, as I think we have seen, folks have dealt with issues in the office of development 85 programs that one decision maker -- I am kind of curious how that is viewed or may be viewed with them.

>> KEVIN: The second question was, whether or not this consolidation of agencies would have an impact on the way -- I will just paraphrase it a little bit -- the way CMS would view our programs and our submission of waivers, for example, and how that, what potentially impacts the overall communication in the way that CMS would be approving our waivers; just assuming that is related to what you are asking.

>> JEFF: Right.

>> KEVIN: It's impossible to say how the current CMS will react to -- because it's under new administration. We are waiting for guidance from them how they will interpret certain approaches.

I can speak from experience that Medicaid's -- or CMS's concerns with states and with the Commonwealth really, they want to be able to communicate with sun single state agency.

When you have a consolidation, you will have one single state agency.

From their perspective they wouldn't look at it as being a difference.

Honestly, it's a speculation. I cannot speak for them. This being said, they are part of the Department of Health and human services as well at the federal level. So they probably will have an understanding of what is being proposed.

>> JEFF: I was thinking of that, not just in terms of Medicaid waivers but with the department of you aging, the older --

Do we know how many other states have done something similar to this type of proposal where you did a consolidation like what the Governor has proposed?

>> KEVIN: Jeff asked: How many other states have done this type of consolidation? I can honestly say I don't know how many other states have done this type of consolidation. I do know of states that have done this consolidation.

An example is Texas. If you remember, we had -- Pennsylvania asked their equivalent to the -- our Secretary for the Department of Human Services speak in a couple different occasions about their experience

with MLTSS. They were part of the consolidated agency.

They -- it's -- he characterized it as a successful organizational change. I honestly can't answer the question how many other states have done this.

>> JEFF: Thank you.

>> KEVIN: Sure.

>> PAM: Do we have any other questions?

>> PAT: I have one more but need my glasses it's long.

This is from Pam Wahls.

Can you describe what is involved in the coordination required by the MIPPA agreement? What specifically must D-SNP do and is it spelled out anywhere? How will department monitor compliance and what steps can be taken if they don't comply.

>> KEVIN: Marjorie, do you want to fill in the details for the MIPPA agreement?

>> Marjorie: Sure. I apologize. Can you just read me parts of that question and then I will answer?

>> PAT: You may want to repeat them to be heard. First is what is involved in the coordination required by the MIPPA agreement?

>> KEVIN: PAT asked, what is involved in the coordination required for the MIPPA agreement. I am repeating so that the people will be able to hear the question.

>> Marjorie: There are multiple requirements within the MIPPA agreement related to coordination. The slides that I presented and I spoke on actually have the citations that refer right back to the MIPPA contract.

I would just encourage the person to look at those slides and then go back and there is a link on the resource page that talks about the -- it goes directly to the MIPPA contract. We have know they are extensive but could you provide me one or two examples coordination requirements? If not we will ask people to just reference the agreement and make sure it is published as part of the minutes to this meeting?

>> Marjorie: Sure. Some of the things I apologize just going back to reiterate some of the slides related to continuity of care, related to service caps between Medicare and Medicaid, related to service

coordination, related to enhanced service coordination with companion D-SNPs one service coordinator that coordinates both Medicare and Medicaid services and it has access to both Medicare and Medicaid data in terms of both assessments eligibility and also claims data. Is that good?

>> PAT: I think a follow-up question is, what exactly does the plan have to do in terms of coordination?

>> KEVIN: And, to repeat Pat's question, what does the special needs plan have to do to coordinate services between -- I think between the Medicare and Medicaid program? Are there requirements that -- if there is a hospitalization as an example in helping them coordinate the transition from the inpatient setting into home care, short-term, nursing home stay, other services?

>> Marjorie: Just specifically, to follow up on what Pat just said, what I presented today was highlights I pulled out there was a section transition between hospitals and nursing homes for example, the expectation of care coordination having integrated systems will having specific time frames will for D-SNPs to report.

Hospital or nursing home within the D-SNP network, having specific time frames that they need to report at admission or discharge.

>>: PAT: I think the second question -- that was all around the first question. I know you love this, Marjorie.

[LAUGHTER]

The second question is, how will the department monitor explains and what steps can the department take if a D-SNP does not comply?

>> Marjorie: I actually do like this question.

[LAUGHTER]

>> PAT: Kevin, could you repeat?

>> KEVIN: The second part of the question as Pat stated is what authority does the -- I am paraphrasing: What authority does the Department of Human Services have with the MIPPA agreement in enforcing the requirements will of the MIPPA contract?

>> Marjorie: Right. The first part I want to address is I think there was an aspect to it in terms of monitoring.

With submission of the different -- with the requirement of the different reporting elements within a MIPPA contract, we will have data

to look at and analyze.

As Kim said earlier, there is no point -- I personally feel this too -- there is no point of getting data unless it is actionable and you are going to do something with it; that's part of it. Being able to look at data we have not necessarily looked at in the past and being able to do something with that analysis.

In terms of specific things, you know, I think that's where the department reaches back out, just like there's going to be relationships and monitoring on the CHC side. I foresee that on D-SNP side.

We have had relationships since the MIPPA contract was in place, before I even got here. Those are continued. I just want to throw a shout-out for all of the D-SNPs, they have been great to work with and I appreciate that.

If there is a problem, having dialogue and go back.

In terms of, I think what the person is saying, well, where is the stick? The stick is, this in order to operate in any state, a D-SNP is required to have a MIPPA contract in place. It's a federal requirement from CMS.

On the other hand, states are not required to just give out MIPPA contracts; that would be the stick.

Obviously, then you wouldn't be able to do business.

>> PAM: Yes, Marjorie. Can you go now?

[LAUGHTER]

>> PAM A.: Maybe it's not you, but in listening to that presentation, I had a hard time taking it in. I am learning a little more as it goes along.

I am wondering what the time line would be for starting to educate people on this stuff before they have to start picking. What is the time frame for educating people and the time frame for navigators or whatever they will do. I know it's not set yet.

It's going to take a lot to get people prepared for this.

>> KEVIN: You are talking about enroll plenty in the adult special needs plan?

>> PAM A.: Uh-huh.

>> KEVIN: Enrollment in adults special needs plan for Community HealthChoices participation is voluntary. They don't have a time frame they don't have to be enrolled in adults special needs plan.

>> PAM A.: They need to know that too.

>> KEVIN: True.

The time frame will be throughout the implementation of community health choices as well as after community health choices active in a given zone; that's always been the communication.

That information is currently available by may be available through apprise counselor who provide information on dual special needs programs all of the time.

They are, by far, the most well-versed in providing information on the Medicare product Medicare benefits and how they all could be coordinated with Medicaid program as well.

In addition, there is no question about the fact that other entities, including the independent enrollment broker, person-centered counselors, et cetera, will all have to be very clear on what the CHC requirements are for this coordination and what are the options for Community HealthChoices participants as they enter into the program.

Speaking generally, I think we believe in community -- with Community HealthChoices. It's going to be better for the participants. I think Paul made his point clear. It will be better for coordination of services to have people enrolled in an aligned dual special needs plan.

There is no question about real opportunities for coordination for participants, but I mean, it's very much their choice.

So I agree with you, they will need to know that that's absolutely something that we can't mandate as part of the program. I think Paul wants to add something.

>> PAUL: So one thing I want to add this is necessary on learned from financial alignment stated which some of you track dual eligible.

In those demonstrations there was a special provision to allow for passive enrollment on the Medicare side.

Meaning you are assumed to be in for you your Medicare and actively get out.

The early results of that were a lot of confusion.

So Pennsylvania deliberately chose not to do passive enrollment.

Which means if you don't get educated or know what your choices are, your default is that your Medicare will stay exactly the same.

The consequence of not enough education will be no change as opposed to being enrolled in something that you don't know about and then having consequences from that.

I think it's a real positive design feature of CHC.

>> Marjorie: Are I want to add something to that too, Pam.

Internally, whether we send out an RFP there is a work group to develop -- to develop the RFP. Part of the IEB process, you know, the recommendation was made that people from the Department of Aging be involved from the perspective of counselors, benefit counselors so that they could speak exactly to what you are talking about, the relationship between D-SNPs and CHC.

Also, there is language within the MIPPA contract with D-SNPs sharing information with the IEBs and, you know, they have to stay neutral. At least they can provide the information.

>> PAM: Any other questions from the group?

>> Lester: Lester Bennett again. One thing I can say, I have personally dealt with two D-SNPs for two different consumers, their care managers. One thing I want people to realize this will be a good thing for our consumers. It will be great because we are -- there will be so much conversation on how we can get the best quality services for that person in the community.

I am going through an issue right now where I don't have to ask the state to pay for an OT and assessment because this person has a D-SNP program that she is getting services through already.

They have a cap on what they will pay for, but they are willing to pay for OT assessment.

Things like that, that I am seeing at the ground level, I know this is all messy and everything, I do see a long-term plan that I think, overall for our consumers will be better.

I think what Pam is wanting to say is, because it is so important, to have a D-SNP, I think more and more education we provide to our consumers to allow them to make that decision the better off we will be.

Thank you.

>> PAM: Thank you, Lester.

With no further questions, we are adjourned. Thank you very much.

>> FRED: In the future we will have time opening at the end for further comments so those who are not here today have been wanting to ask questions, come on in the next time and you will have a chance to answer and ask questions and get answers.

(Meeting concluded at 12:44 p.m.)