DATE: 7/7/2017

EVENT: MLTSSS

>> PAM: Good morning, everyone. We are going to get started. Let's start with introductions.

>> Barb Polzer, liberty community connections.

>> Jim Fetzner.

>> Good morning. Carrie Bach, voices for independence. Sitting in for Tanya.

>> Good morning. Blair Boroch, united healthcare.

>> Jack Kane.

>> Pam Mammarella.

>> Jen Burnett from the Office of Long-Term Living.

>> Fred Hess with disability options network.

>> Steve Williamson, Blair senior services.

>> Drew Nagele from brain injury association.

>> Theo Braddy from CIL-CP.

>> Ray Prushnok.

>> Jesse Wilderman, SCIU healthcare.

>> PAM: The people on the phone, I understand we have Tanya on the phone. Tanya?

>> TANYA: Yes, I am here.

>> PAM: Thank you, Tanya.

>> This is Bill from AARP.

>> PAM: Thanks, Bill.

Anyone else on the phone from the committee? Pat?

>> PAT: Not that I know of.

>> PAM: Okay. I will go over the housekeeping rules right now.

As always, we want to use the high standard of language and professionalism as we always do here on the committee.

As a point of order, please direct your comments to me. Wait until you are called upon and keep your comments to two minutes, if at all possible.

Transcripts for these meetings are posted on our listserv, which is on your agenda.

I do want to, actually, request that the committee members submit more questions and comments and agenda items for this committee. It's been awhile since we heard from a lot of you.

If you could, perhaps, work constituencies.

Our captionist is here. Raise your hand. Good morning!

She is here documenting our meeting. Please speak slowly. I will ask everybody to introduce themselves before they start to speak.

For the sake of the telephone, speak up, as much as you possibly can.

I want to remind members to provide updated contact information when their information does change.

We have had instances where we have lost touch because of that. If your info changes, please submit that to Jen's office. If we could turn our cell phones off today -- I will do that myself.

Remember to clean up your area at the end of the meeting.

We will wait until the end to hear from the public, for public comments.

We will make every effort to make sure we have time in order to do that again.

Fred will go over our emergency evacuation procedures.

>> FRED: The emergency evacuation procedures are pretty -- they are set for me today. I have a PEMA FEMA meeting where we will do an exercise for emergency evacuations so -- in the event of an emergency or evacuation proceed to the assembly level to left of Zion church on the corner of Fourth and Market.

If you require assistance to evacuate, you must go to the safe area located right outside of the main doors of the honor suite.

OLTL staff will stay with you until you can go back in or until they get you out.

Everyone must exit the building.

Take your belongings with you. Do not operate your cell phones. Do not try to use the elevators. They will be locked down.

We will use stair 1 and 2 to exit building.

Stair 1, exit honor suite, left doors, left side of the elevator. Turn right. Go down the hallway by water fountain.

Stair 2, exit honor suite through side doors on the right side of the room. Exiting from the side door, turn left and stair 2 is directly in front of you.

Exiting the back doors turn left, left again and stair 2 is directly ahead.

Keep to the inside of the stairwell. Merge to the outside. Turn left. Walk down Dewberry Alley to Chestnut Street, turn left to the corner of Fourth Street, turn left to Blackberry Street and across Fourth Street to the train station.

>> PAM: Thank you, Fred.

I notice from the agenda we will start with Tracy Henry. Jen, do you want to tell us what this is a about?

>> JEN: There have been a number of questions about the hearing process and fair hearings, how we will be managing it in Community HealthChoices.

I have been reassuring the committee we have been working closely with the bureau of hearings and appeals they participate with us on weekly project team meetings. They have been keeping up to date with what is going on with Community HealthChoices.

I am not an expert on fair hearings and appeals. I invited the bureau of appeals director, Tracy, if you would join us.

>> JUDGE HENRY: Sure.

Good morning, how are you?

>> PAM: Good.

>> JUDGE HENRY: Good morning, everyone.

Once again, I am Tracy Henry, Department of Human Services, director for the bureau of hearings and appeals.

There were handouts associated with today. One was entitled elements and the PowerPoint will be projected for you.

Let's begin.

One of the things I wanted to do -- we are at slide 2 right now -- is give brief introductions and little bit of my background.

We will discuss the origins of recipient appeals. There was a medical assistance file rule that was issued by the federal government last year. I would like to cover some of the most applicable sections of that rule. BHA, as it's been stated, has been in the process of preparing for Community HealthChoices and wanted to share some of those things with you as well.

I also wanted to share some of the BHAA resources with you and identify what we have coined as our next steps in this process.

Prior to the presentation, I had asked Office of Long-Term Living to share the names of the committee members with me. I actually went out and did research on all of you through Google, and when I put my name in, nothing came up except bureau of hearing and appeals.

I felt I owed you a little bit about who I am.

I am from Philadelphia. Was public defender in Philadelphia for about 7 years.

I worked for a few years at a non-profit called Project Home. Went back to practicing law with the Commonwealth for 14 years and have been bureau director for 7 of those years.

Thank you once again for inviting me here today.

Slide 4.

One of the things we do, even when we train our judges -- I wanted to convey this to the committee and to members of the public who are attending -- that your right to a fair hearing is actually borne out of the United States Supreme Court called Goldberg versus Kelly.

In that, the case itself is good law.

It came down in 1970. It is the law of the land for all of the states in our union.

I wanted to share, just an excerpt of that case with you. It is contained on the slide. I wanted to highlight the words "due process" and define that for you.

Due process itself means that you are entitled to notice and an opportunity to be heard.

Slide 5.

Here is why it is important: It is the reason why we exist. Our bureau actually came into existence in 1976. It is the reason why you have a fair hearing. Not just because words are listed in your notice, but because it is law and we are required to do so.

In the interest of time, I created a document that, actually, outlines the elements of that case called -- what I am calling the Kelly elements.

Something that you can review at your own leisure and if you have time to look up the case, it would be interesting to read to see how it was born. This is the reason why you have a right to notice and a right to a fair hearing.

Slide 6.

It becomes relevant when we talk about Community HealthChoices because, as it has been stated earlier, we are working with the office of long-term living and administration in preparing for Community HealthChoices. One of the notices we will use is the transition notice. It has limited appeal rights. It's limited because based on the guidance of legal counsel and reality of the document it's not going to change benefits. It's just a notice to inform moving into Community HealthChoices the action will take place.

There will be some issues you can appeal. It will come down

to the issues where maybe you were not, necessarily, eligible for CHC. You are not yet 21, not receiving services in your home, or you are not receiving nursing home services or you are not receiving both Medicaid and Medicare. Those issues will be appealable.

They are also conducting level of care assessments. Those will contain and continue to contain your full appeal rights, as well as any reduction or termination of benefits.

You will still be afforded an opportunity to come before our bureau to challenge a decision made by the department as to whether or not you are entitled to the benefit.

And just as an FYI to you, upon request, our bureau will gladly review the notices before they are actually drafted and finalized. When BHA learns of a new program in the program office, sometimes we may ask to review the notes, just to ensure that due process and information that we think should be contained in the notice about your appeal rights are actually enumerated in those documents.

Slide 7.

Now I would like to move to what I have identified as medical assistance final rule. We are going to get into a few of those highlights. It becomes relevant, not just because of CHC, but because it involves medical assistance in general. This is something I feel that you should know.

Slide 8.

The final rule was published in November of 2016. There was an effective date of January 20th, 2017 -- now, I placed an asterisks next to that because contained in the final rule, depending upon the section, there were different effective dates.

It is applicable to eligibility, as it relates to notices and appeals processes; that is what makes it relevant to our appeal process. Once again, there are exceptions to the January 20th, 2017 date, which will come up later in the presentation.

Slide 9.

I wanted to highlight for you, some of the areas that are most relevant to our practice and to the work that you do as it relates to medical assistance eligibility.

Number one, we are now going to have to create an expedited

fair hearing process for eligible appeals.

Secondly, appellants will be permitted to make appeal requests by all modalities. By that, they mean all uses of modalities currently available to them for the application process.

We are also, in light of that, going to have to accept withdrawals through all modalities, and where there is an electronic withdrawal, we are now going to have to confirm receipt of that withdrawal.

Slide 10.

So one of the things I wanted to do for you, at least in my handout, is provide you with the actual language, so you wouldn't have to necessarily go in search of it.

On slide 10 you will see how modalities are defined.

You can receive request by telephone, in mail, in person, online or through other available electronic means such as text, fax, email.

Right now, the Commonwealth is in the process of creating the online and telephonic appeal request modalities.

Number 11.

This will impact, once again, medical assistance eligibility to include CHC, as well as benefits in services, the fee for service waivers. I am thinking, also, the non-CHC counties. We will obviously roll that out in phases.

Slide 12.

Contained on this slide is the section that relates to the withdrawals, as it relates to all modalities.

What I wanted to highlight here in this definition is that the agency will have to record the individual statement and telephone signature.

Slide 13.

The section continues on with withdrawals as it relates to how we now need to confirm that we received your withdrawal. If it's done in electronic means, this section is applicable. Once again for telephone, online or any other electronic withdrawals we receive.

Slide 14.

I wanted to give you a slight snapshot as to where we are in file rules of this section, I just mentioned.

Currently BHA has a withdrawal hotline. In some respects we were a little ahead of the government.

We implemented ours maybe 5-6 years ago; so that is already in place. It is initialed with the program office and the appellant on the phone, they can call them at any hour and withdraw an appeal.

What we have to do, however, in light of this regulation, is to come up with a policy and procedure on how to confirm our debt receipt.

With the online appeal process, once again, we are working with our IT department to not only create the opportunity for a citizen to make a request online, but also through the same technology, we are also hoping to confirm that. By that, I mean, confirm the withdrawal.

So at slide 15, I wanted to now highlight expedited appeals. This is new for us. The definition is very significant. It's laid out for you on slide 15. The highlight of the definition really falls to the fact that the agency makes the determination as to whether or not the request should be expedited.

If we find that the normal course of an appeal track, which right now for medical assistance appeals is 90 days, if we find that it could jeopardize an individual's life, health or ability to obtain, maintain or remain maximum function, if we find the 90 days would take too long, then we can put it on an expedited track.

Once again, the procedures for this not just within BHA, but also with BHA working with program offices, those meetings have been taking place. We are in the process of creating policy.

Slide 16.

We needed to have in light of this regulation internal discussions with the administration. Some of the decisions we felt should rest with at least the secretary.

Those decisions have been made and the discussions took place.

It was decided -- as I indicated in the earlier slide, per the regulation, it is the agency that makes the determination.

After discussions with executive staff, it was determined that BHA, will be making that determination; that no medical certifications would be required.

For those of you who are familiar with the medical appeals with the NCO appeals, you know that medical certification is required.

For eligibility, it is the policy of the department that no medical certification will be required.

There was also a request that we do a pilot; that we place the expedited appeal language in the notices; and that pilot is due to start in August of this year. They will be on the county assistance offices' notices.

Once again, I want to reiterate that we are currently still finalizing policies.

In the future, you will see the expedited appeals' language on the Community HealthChoices notices.

Slide 17.

So on slide 17, I just wanted to share with you some of the policy decisions we have made within BHA.

BHA is made you up of 4-regions. We have an administration region housed in Harrisburg. We decided we will centralize the determination, the expedited determination portion of the hearing.

We are thinking that this should be done in a two-prong process.

BHA determination is in form of hearing. We will centralize it with judges in Harrisburg. Their only role will be to decide whether or not it should be, in fact, expedited.

Once the decision is made, hearing regions -- whether western Pennsylvania, southeastern or Harrisburg area -- the judges housed in those locations, will then make the decision on what we term as hearing on the merits, which means whether or not the underlying decision made by the department was correct.

Once again, we will start the pilot in August. We will constantly review policy.

We needed to put something in writing so that we could train our staff and at least start.

Just know that those were our thoughts starting out right now.

On slide 18, I wanted to share with you some of the time lines.

When we discuss eligibility, expedited appeals, it means that we have 7 days to make a decision.

So it's when the appeal reaches the department, not necessarily BHA, which means we will have to work closely with the program offices to ensure that all appeals are forwarded to us timely. If it turns out that it should be an expedited matter, we have 7 days in which to render a decision.

If it involves benefits and services, we have 3 days.

Full implementation for the expedited appeals per the federal mandate, based on our discussions will counsel, office of general counsel that is, will be November of this year.

So we will pilot in August, but we are slated to go live in November.

Slide 19.

One of the things I wanted to share with you were the actual pilot counties. This was done at the request of our Secretary. He asked that we put together a pilot. The office of income maintenance identified those counties for you. There are 22 and they are enumerated on slide 19.

Once again, we would have 7 days for a decision.

Pilot counties in the western part of the state; however, York and Montgomery Counties are identified in the pilot as well.

Slide 20.

And lastly, at least as it relates to expedited appeals, I just wanted to do an overlap because I know that with Phase 1 of Community HealthChoices starting in the southwestern part of the state, perhaps maybe there would be a question how it would look with the expedited appeals process.

Where the counties are underlined they have CHC being implemented, as well as MA pilot.

I wanted to share that with you, in case you are dealing with

constituents, you would have some information as to why certain notices have the expedited appeal language and others do not.

Now we will talk about just a few things that BHAs had done to prepare for Community HealthChoices.

It was 60 slides now we are down to 35, which is my gift to you.

[LAUGHTER]

>> FRED: Thank you!

[LAUGHTER]

>> JUDGE HENRY: We are down to two issues on slide 22.

First, I wanted to share with you the BHA issue code committee work. It is possible you may not have heard of that. I want to share the significance of that committee work with you.

Also, just some research we have done as it relates to the MCO appeals.

At slide 23, one of the things I wanted to highlight is whenever a program office implements a new procedure, BHA is informed. We identify a numerical code for the appeals.

It's not just the program, but could be multiple types of appeals program.

The purpose of the codes are as follows.

First of all, for starters, we use them for scheduling slots. They help drive the length of the hearing when the appeal comes into the bureau.

In some instances, the case may require 15 minutes. In another, it may require an hour.

Scheduling letters. It is very important, because of the volume that we deal with in BHA. Last year we received over 94,000 appeals. We have to make sure that we set policies and procedures in place that are written so that our clerical staff can follow them.

The coding allows us to also to identify carbon copies on our scheduling letters.

We need to know who needs to be present for the hearing. Sometimes it's not just the appeal from the program office but another entity or agency that may have an interest with that appeal.

We work with the program offices in helping us to identify who should appear.

We also use our codes for our scheduling methods. Where the matters may only require 15 minutes we will put them in our group hearing process; however, if it's a protracted matter requiring 3 hours, we will carve that out. We identify those appeals by our codes.

Most significantly, in addition to what has been stated, we use the codes for recording. We note the number of appeals that come in. This is where, in working with the Office of Long-Term Living, we have been working to identify codes, in case there is a question as to the type of appeal issues that may be coming up for CHC.

As bureau director, I have the authority to move work across the state with my colleagues. So we use the codes as a means of regional assignments as well.

Slide 24.

It's been stated that CHC will model as much as possible health choices. With CHC being implemented, it will generate MCO appeals. We looked at our current MCO appeals' numbers for HealthChoices. I wanted to share that with you today.

We have a vendor that does our work in federal hearings and appeals. They provided this data to us.

In 2015 there were a little over 1000, 32 of which were expedited.

In 2016 a little over 900, 46 of which were expedited.

Next at slide 25, we will talk about some of the BHA resources. These are tools that we use to help facility hearings and appeals here in the Commonwealth.

On slide 26, you will see some of the things we will just mention briefly here. I want to share our regional map with you. I actually have enumerated in this power point our email and text accounts for your own information.

I also wanted to share with you we have videoconferencing

capabilities as well as a mediation unit we call the informal resolution unit.

So at slide 27, everyone in the Commonwealth utilizes this map, but it means something different depending upon who you are in the department.

For BHA it's regions. Program offices areas; CHC, it's used for phases.

I think health choices they use zones.

For BHA, we utilize it for our regions. It speaks for itself.

What I wanted to share with you is, in looking at the map, the work that is housed in the western part of the state, the central offices in Pittsburgh, our Erie office is a satellite office, the Harrisburg region, which is our central region, covers both Reading and some of the work in the northeastern region of the state. The south region office is located in our Philadelphia office.

Reading has a satellite office in the state office building.

At slide 28, I just wanted to highlight the significance of that map. It is my understanding that under CHC, potentially, there could be three IEB vendors.

It becomes relevant in our work because we have both telephone appeals and face-to-face appeals.

So when we spoke a little earlier about the issue code assignments, I explained to you that it is important for us to know who should be copied on our appeals. It's also important to know, for those who participate in forwarding our appeals to our bureau, where they should send them.

The example I wanted to share with you is that Montgomery County, of course, is located in the southeastern part of the state.

However, the telephone appeals are actually heard by the Pittsburgh judges.

So it would become very important for an IEB vendor or anyone else that will be charged with the responsibility of forwarding appeals to us, that we work with them so that they know exactly where to send them.

So we will train them. We have a liaison process.

One of my supervisors, who actually in the Pittsburgh office is liaison for maximus.

If there is a question or information needed we utilize liaisons.

We have written out -- there is no need for anyone to guess, we will forward to them what we call our regional assignment chart.

I did just want to highlight the significance, so any work the committee is doing or any of your constituents that potentially are participating in forwarding appeals, you cannot assume that because Phase 1 is rolling out, everything happening at that phase will take place in that part of the region for BHA; that's not necessarily true.

When Phase 2 rolls out in Montgomery County, that impacts my western staff.

Slide 29, once again, just enumerates all of our email accounts. They are active now. You can use them now at your leisure. It is a place you can submit any withdrawals you may have.

Slide 30, I wanted to highlight our videoconferencing, which is also in a phase, Phase 1 of 3.

Currently, it's been implemented for both our formal and provider appeals. We have videoconferencing equipment, both in Harrisburg, PAC and Philadelphia.

We are currently in the process of purchasing equipment for our Reading satellite office.

Sometime in the future, which is Phase 2, we hope to put videoconferencing into county assistance offices.

In the third phase, we hope to have the point of having monitors specifically in our judges' offices. Hopefully we can set up interface where recipients can look through a video monitor at their home and have a face-to-face hearing.

In slide 31, I just wanted to share with you our informal resolution unit. It's our mediation unit. This concept was actually borne out of the Affordable Care Act.

One thing we thought of doing as it relates to CHC is to potentially divert transitional notice appeals to this unit.

It's been our experience, sometimes -- especially when programs are new and sometimes just in general -- when individuals receive the appeal form, they just sign. We will send out a scheduling letter and then we will receive a call -- why? I didn't ask for an appeal. Why did you send this to me?

Sometimes even when we receive the appeal, there really is no issue. We try to carve out those cases. We are able to identify those through our issue codes.

We will set policy. We will offer people mediation. It's been our experience with verifications appeals that many of those cases do tend to settle.

Sometimes the issue was not necessarily whether you are entitled to the benefit or whether or not paperwork was received. Sometimes those details can be worked out.

Know that mediation is available to you. It does not put you in a position where you will lose your fair hearing.

We start the discussion with you knowing that you have the absolute right; however, if there is a chance the matter could settle. We will carve it out, because it creates more opportunities for the cases that actually have to go to hearing and creates more scheduling slots for us.

As a bureau, we have thought about, when I described earlier, the expedited termination hearing, we thought perhaps this unit could absorb that. We are not quite sure but it is something we are thinking about.

At slide 32, I wanted to move into some of the next steps.

On 33, I wanted to share with you that we continue to finalize all of our activities. Even with MA final rule, there are still steps to be taken. Meetings have been held but things are not finalized.

We continue to work with the department as it relates to Community HealthChoices both internally and with program offices.

We work with our IT unit with the system changes as they relate to the final rule.

We do plan to track incoming calls. We have receptionists in our regional offices. There is a CHC script that we requested that will be forwarded to us that we will share with staff. We are also

committed to communicating with administration and providing feedback, as much as we possibly can, in our role with CHC, as well as expedited appeals process.

We always review our scheduling policies, just so we can ensure timeliness and due process that is afforded to you.

Currently, at least at the time of this writing, we were about 98% timely.

We are now at the questions portions. I am not sure of the protocol.

>> PAM: I will open it up to the committee.

>> JUDGE HENRY: Please know I received one question in advance.

>> PAM: Why not start with that in advance? Thanks, Tracy.

>> JUDGE HENRY: This came from Ms. Tanya Teglo.

There were a few. I broke them out into three and will share them with you now.

It looks like she received in advance the due process elements document and had questions that came to mind.

So one of the first questions: If the person is considered financially destitute, how could they afford an attorney or would the state provide them with one?

The answer is, the Commonwealth does not provide legal counsel in administrative appeals; however, there are opportunities for individuals to secure counsel, hopefully at no charge to them, either through legal aid or through pro bono efforts.

I did a little research. I am not quite sure what the protocol is. If there is a question as to how to secure those resources, I can forward that to the committee.

>> PAM: Yes, if you can forward that to the committee, we will put it up on the listserv.

>> JUDGE HENRY: Okay. I know there is a written transcript. If I can squeeze in one vendor now, it's the Pennsylvania bar association. They have pro bono work and they provided a 1-800 number and website.

800-932-0311.

Their website is www.pabar.org.

It's a great place to start; however, there are local legal aid agencies as well.

Our second question was also, who is the impartial decision maker? It is my hope that we are the impartial decision makers.

[LAUGHTER]

We want to agree to be impartial, neutral, fair, unbiased; that would be the administrative law judges in the bureau of hearings and appeals.

Her third question: What would qualify them to be this impartial decision maker? They would have to have knowledge about the system, that is making them not so impartial.

For the record, I thought the questions were excellent. With that being said, let's agree that there is a difference between being impartial and being informed.

As we stated earlier, BHA works with program offices. We are here today because of Community HealthChoices. We are talking about the concept of what is to come.

When we talk about being impartial and making a decision, we are talking about your fair hearing; that's where the line is drawn.

BHA is completely separate from the program office work that is taking place in the Commonwealth. We have separate facilities. I mean, we have provisions in place. We don't communicate, believe it or not, through telephone. We use our legal assistance.

In fact, it's a little difficult to reach us sometimes. When questions come in, if anything, they come to me not our judges.

So everyone has roles and assignments in the bureau. The actual judges who are sitting down and making the decision, they are not in the meetings that I attend.

We also, once again, utilize a liaison process. Those are usually our supervisors who, if a question needs to be posed from a program office, we tell them the name of the person that they should then contact. It's usually a person who is not engaged in making the decision benefits during the course of the fair hearing.

We provide training to our judges.

Being impartial is not just because we are supposed to be it's an ethical responsibility as well.

We are trained on ethics and they are held to the ethics.

Every clerical person, believe it or not, is asked to sign a code of professionalism in our bureau. There is an ethical expectation. There is a legal expectation.

Just as a matter of practice, we know and understand, in order for us to render a decision in an impartial manner, we need to be separate from program offices. In addition to that, we ask that if we are contacted by an appellant, you also somehow make sure that any documents you send you send them to the program office of offices and vice versa.

We would like to think we are impartial. If there is issue or question, it can be brought to the attention of the regional managers or myself.

I believe that concluded her questions.

>> PAM: Thank you.

Any other questions from the committee? Fred?

>> FRED: Yeah, I got a couple right here.

If somebody is already receiving services and they are being told, you no longer get them, during the appeal process, do they still get their services?

>> JUDGE HENRY: Yes. They should be able to. There is usually a time limit and it is usually placed on the notice.

>> FRED: Okay.

Say, for instance, if somebody needs to be face-to-face, in person and has no way of transportation to that -- to one of the appeals offices, is there a way to set up transportation for them?

>> JUDGE HENRY: We don't set up transportation. What we do is offer you a telephone hearing.

>> FRED: Okay. For somebody with -- that is deaf or hard of hearing, what good is a telephone?

>> JUDGE HENRY: It works. We have to comply with ADA. We have a vendor that we work with, in the event an appellant has that need, we contact our vendor. If they have the equipment, I am assuming in their home, the vendor gives us a number and we are able to communicate with the individual --

>> FRED: If they don't have the equipment?

>> JUDGE HENRY: The only other recourse is to go to local county assistance office and have a hearing.

>> FRED: I am wondering because I want to make sure that everybody is covered with a disability.

>> JUDGE HENRY: Absolutely. If you ever find there is something you need, just communicate to us. Okay?

>> FRED: Okay. Wonderful.

>> PAM: Drew?

>> DREW: So, Ms. Henry, I commend you on the presentation. Thanks for keeping it short!

[LAUGHTER]

>> JUDGE HENRY: You are welcome.

>> DREW: I am impressed with the time frame you put out for the appeal process and possibility for video interface, I think that would also be another answer to Fred's question about how to help people who cannot get out.

I really hope you can work that out.

>> JUDGE HENRY: It's our hope too.

>> DREW: My question is about people with cognitive impairment. For example, people with brain injury or people with dementia, who may not be able to give all of the facts accurately in a hearing and may need someone else present to help them give accurate facts.

So how would it be determined if someone could have someone else in the hearing with them, for example could an applicant ask for a family member or maybe their advocate might ask for a family to be present in the hearing.

>> JUDGE HENRY: Yes. In fact, it is set out in regulations.

You are entitled to have someone come in and facilitate that process for you.

Interesting question. It happened to me once. The individual did not have a representative. Based on my questions that I put to her, I could see that she was unable to fully participate. At that juncture, the program office representative was on the phone. I asked the representative to contact the family and see if we can help facilitate this.

I did not feel, ethically, I could proceed, if I understood that she did not understand what was happening.

>> DREW: I am glad to hear that. Thank you.

>> PAM: Any other questions from the committee? Jack?

>> JACK: Just a comment.

Good morning, Judge Henry.

>> JUDGE HENRY: Good morning.

>> JACK: I have some experience with the bureau of hearing and appeals. I want to affirm what Judge Henry said.

The administrative law judges comply with the highest ethical standards; 94,000 appeals a year is a staggering number. It's a huge caseload a year. The bureau handles all of those appeals expeditiously as they can. They do so in a very fair manner. I think when you read the opinions -- I must say, I don't always agree with some of the outcomes, but you can see in reading the opinions that the administrative law judges have done a very fine job in terms of looking at the facts, applying the law and coming to what they think is the right result.

Judge Henry, nice presentation today. Good luck with yet another challenge.

>> JUDGE HENRY: That volume that is coming. Thank you very much, Jack.

>> PAM: Thank you, Jack.

So we have a little bit more time allotted. I will ask the committee to support me in breaking protocol. We do have some questions from the public. Unless, Tracy, you will be here at the end of the meeting to answer them.

>> JUDGE HENRY: What would you like to do? We have time now, why don't we, as we are on this important topic, stay with it.

So Pat Brady.

>> PAT: I just sent you the first one.

>> PAM: Okay.

This is a question from Lovelle.

Tracy described the mechanics of a fair hearing and how long they typically take whether expedited or not. Could she briefly describe the parties involved and each of their rolls, administrator, law judge, consumer, state or MCO?

>> JUDGE HENRY: Okay. The actual fair hearing depends upon the type of hearing. So in our bureau we have recipient appeals, which would fall under the category of a person receiving benefits. We also have formal appeals. We will start with the recipient appeals.

Those by their very nature are informal. The room could be set up with tables and chairs. Typically, it is a representative from the program office, the administrative law judge and the recipient him or herself or their representative who is present.

We use digital recording. When that somehow is not working the way we need it to work, we will resort to tape recorders.

We keep a record of the entire hearing process recipient appeals are our highest volume.

Typically when the administrative law judge starts hearing they will do introductions; they ask the parties to state who they are, give their name, where they are affiliated and their title, if needed.

We confirm address and telephone numbers, this would be for both witnesses.

We then ask them to take an oath. If there is going to be testimony, we need that to be under oath.

Once again, this is all recorded.

Traditionally, we ask the program office to present their case. So if there is an issue that is before us, it is usually generated by a notice and the issue on appeal is limited to what is

enumerated and listed in the notice.

So we will confirm with both parties whether or not we are convening to address that issue.

The program office will introduce their testimony, witnesses, any documents that they may ask for our consideration in the record.

Then we will educate the appellants, informing them that they opportunity to pose questions and ask any questions they have on documents or exhibits that have been offered.

Once the program office has completed their case, it will then shift to the appellant. They have an opportunity then to do the same. They have the right to testify. They have the right not to testify.

They also can call witnesses. They can also present documents.

Once their case is offered, it is in -- an opportunity for the program office to conduct a cross examination, whether of the testimony or of the documents.

Sometimes when the documents are offered, they are challenged. There is what we call an objection.

The judges will have a role in making a decision as to whether or not those documents are something that could be considered.

At the outset, I make sure they have the Kelly outcome. Most of what I am telling you is presented. In that case, you have the right to bring in evidence, to testify, to ask questions, to have information forwarded to you from your case file.

Once the judge receives that information, the judge should be in a position to render a decision.

As it relates to the Supreme Court case, we can only make a decision, based on what is in the record.

This is where it goes back to that first question, where we ask, "How are you impartial?"

We cannot factor in how we feel, think, what we heard in the news, only based on what is in that record.

We, for the most part -- it will change a little bit with

expedited appeals, -- for the most part we do not make a decision on the bench. We are charged with the responsibility of receiving the evidence, gathering it up, and then we go back, literally to our offices; that's where we review the evidence and law and then write our decision.

Once the decision is written, we will then publish it to the parties and anyone else that needed to be carbon copied on that decision.

Those are pretty much the recipient appeals.

Our largest client is office of income maintenance. We receive of that 94,000 about 80% of those are from the office of income maintenance.

We also have formal appeals. They are not high in volume, nevertheless, they are just as significant to whomever wishes to seek an appeal.

The formal appeals, just from a legal perspective, you should know, fall just under a different set of regulations. There is a different process for those.

You still have a judge involved. Typically, you have a judge that may not be seated at a table but up on a bench. You may be in a courtroom more of a courtroom setting, where there is an actual witness stand.

We also record the hearing, but do it by way of a courtroom stenographer, similar to the stenographer here today.

Typically, in our formal appeals, we are dealing with not just a program office representative, but most likely an attorney in the county. It may be a county solicitor. In the department it may be an office of general counsel who is coming in to present on behalf of the program office.

Unlike the recipient appeals, in formal appeals, you are not permitted to bring in family member to represent you. You can represent yourself or if you have a representative, it should be someone who was a member of the bar.

The recipient appeals are usually appeals that are associated with, say, expungement hearings.

If you were applying for a job or coach little league, you have to fill out a child abuse clearance form.

Sometimes, depending on the person's circumstance they may find themself on the child line. They also have an opportunity to appeal the finding by the department; that would be a formal appeal that would come before our bureau.

As I mentioned before, we take our issues and we give them issue codes. We have formal issue codes that also dictate how the schedules are issued, who should appeal.

Depending on the nature of the formal appeal, it may take two hours, one day. Sometimes they can take 3 days.

As you can see, there is a much bigger distinction between formal appeal work and recipient appeal work.

In our formal appeal work, depending upon the issue, we will ask for exhibits. They tend to be much more detailed. Sometimes it requires testimony of a medical expert. We will have medical records, photographs, witness statements, multiple witnesses. Formal appeal work, especially if it's a child abuse case the child themselves may come to testify. It's very different than what you may see in recipient appeal.

I think in all cases, there is going to be a judge, there will be two parties. You will be in a courtroom setting. For the most part, I mean, some of the cases, technically, are open to the public but it doesn't happen that often in administrative law, because usually if something is generated, it is privately held to an individual. They may not want to publicize it.

Child abuse hearings, however, are absolutely closed and confidential.

Once again, in formal appeals, we will not rule from the bench.

Also you have the same advocacy process. As an advocate you can speak up for yourself, testify. You will be subject to cross examination, perhaps. I should say, in both instances, there are occasions where the judge may have questions for you.

I think that is pretty much it.

>> PAM: I think you covered it. We have time for one more question that came in from Kathy Cubit.

How often will CHC BHA reports be shared with the public? Will reason for appeals and resolutions be included?

>> JUDGE HENRY: I think in our discussions we talked about that. We have not finalized frequency but we discussed how that information will be shared.

There are, in my understanding, maybe a few ways in which appeals can be tracked.

We have the recipient nature appeal that we definitely track. Then because you are moving into managed care, managed care and appeals that we will track. It is also my understanding that managed care organizations should be able to track that information as well.

So what I think has to be finalized, both between bureau of hearing and appeals, is how it reaches you. Whether it's to OLTL and then to the public or perhaps rely more on the MCOs?

I think it still needs finalized, but there is no secret to the numbers.

>> PAM: Thank you, very much. Maybe, Jen, you can follow up on that when you give your OLTL talk?

We probably have time for one more question. Do we have anything else?

If not, let's thank Tracy Henry for being here today. Thank you so much, Judge Henry, as Jack taught us to call you, Judge Henry. Thank you very much.

>> JEN: I want to say thank you, Tracy, for a thorough and precise presentation. I think the members of the committee and the public learned a lot from your presentation and we appreciate your taking the time to put the presentation together and then come here and present on it.

I wanted to just acknowledge that Richard Kovalesky arrived. He is back in the corner over there.

Also, we have Denise Curry, who is here for Scott Rifkin, who is our member.

He has indicated his intention to resign. We have not yet received his resignation letter. When that happens, Denise will be taking over in that role. Welcome, Denise.

>> DENISE: Thank you.

>> JEN: Would you like to say a few words about where you

work and your interest in this?

>> DENISE: Yes.

My name is Denise Curry. I started off in the long-term care industry back in 1988 as a nursing assistant. I have been in the multi-facility type of role where I am managing more than one center for 14 years.

Just am glad to be here and assist in any way I can.

>> JEN: Great.

Denise will be representing the Pennsylvania healthcare association on the committee. Thank you, Denise.

So I am going to go into my presentation, an OLTL update. There is a lot to inform you about. I thought I would put it on to a slide deck and make sure it gets posted and that the committee members receive it.

I want to just start out with the waiver submissions and give you an update with where we are on those waiver submissions.

As you recall, we need to submit a 1915 (b) and 1915 (c) waiver.

The (b) authority gives us the authority to use monetary managed care to actually create a managed care system. It is -- when we submit it to CMS, it is submitted to the disabled elderly health programs group and center for Medicaid services. It is submitted to a different division. It's the division of managed care.

In the 1915 (c) authority gives us the opportunity to provide home and community-based services. Will those home and community-based services can be provided either through fee-for-service or managed care. This gives us -- it's considered by CMS to be a (b)(c) concurrent waiver.

I will talk a little bit about the procession of waiver submissions for your information so you understand what our office has to go through in order to submit these waivers.

CMS has no more than 90 calendar days to approve or deny a request for an initial application, waiver renewal or an amendment request or alternatively issue written request for additional information; that's a formal request for additional information which they call an RAI.

CMS attempts to resolve waiver applications through informal dialogue with the state and then informal dialogue can either happen through written -- actual written formal requests for information or conversations that we have through CMS on the phone.

The informal information requests or processes do not stop the 90-day clock I talked about in the last budget.

Generally speaking, CMS attempts to identify any serious issues within 60 days. We can address issues sooner than later and take care of them.

This is a big red flag. We are never going to approve this.

We do have the opportunity to take the waiver application off the clock and have done it in the past.

Once there are issues identified, the application gets resubmitted and the 90-day clock starts again.

We usually see informal requests for additional information within 5-6 weeks of our application that depends on the complexity of the application.

We submitted our (b)(c) concurrent waiver to CMS on April 28th. We received 20 informal requests for questions and 16 for 1915 (c).

This is a minimal amount of questions. We have had waivers with over 100 questions. This was good news when we saw these questions.

We did respond to 1915 (b) RAI earlier this week. We had a successful call with them yesterday. We met with CMS and went through all of the questions that they had. They accepted the majority of our answers on the informal RAI and indicated that they were pleased with the conversation that we had yesterday with them in terms of helping clarify the questions that still remained.

That is good news on the (b) side; that waiver looks like it is headed to approval by CMS.

The 1915 -- I said that already.

I will tell you on the 1915 (c) waiver, we have those back. We have received those as well. We have not sent them in to CMS yet for their approval because we are still reviewing our responses to them. Our legal counsel gets involved in reviewing those responses. Until they do their thorough review, we do not -- we cannot send it

back to CMS; that's headed back to CMS. Our goal is to get it back sometime early next week.

Some examples on the (c) application. I know the questions in this committee relate to the long-term services and supports. The kinds of questions that they asked us on the (c) side were a better description of the methodology for intermediate entity as well as for outreach enrollment entity.

They wanted to see more information on how we set rates for those things.

We also were asked for clarification on the role of the independent assessment entity.

They wanted to know more about community transition services. Those kinds of things were asked by CMS. We did our responses. They are still with legal counsel, but we should get them back in the very near future.

I wanted to also talk about -- so that's the CHC (b) (c) concurrent waiver.

We are in the process of submitting waiver amendments. As we move into Community HealthChoices, people will be moved off of waivers and into Community HealthChoices waiver.

We had to submit waiver amendments to CMS and get approval for being able to do those transmissions of people from one waiver to another.

With ComCare it is becoming Community HealthChoices waiver; so that's the vehicle we used for sending in the CHC waiver into CMS.

ComCare will no longer be available to participants that are in CHC or outside of Community HealthChoices zone.

All participants in ComCare that are in the southwest zone, they will be transitioned to Community HealthChoices.

Those who are not in the southwest zone will be transitioned to the independence waiver.

Those changes will be made in the course of the coming months. We will be moving people from ComCare into the independence waiver.

The ComCare recipients will not be able to enroll into

Community HealthChoices until the zone becomes live or the phase becomes live. Again, the phases are January 1st, 2018 for southwest; July 1st, 2018 for the southeast five counties. The rest of the state, the other three health choices zones or as we call it, "our phase" is January 1st, 2019.

So people who are transitioning from ComCare to the independence waiver in Phase 2 and Phase 3 will get the same services that they received in the ComCare waiver in the independence waiver, because some of the amendments that we put into CMS, one of the amendments is to add services that were not on independence.

The independence waiver services as ComCare but it did not have two. We are in the process of asking for approval to add those.

>> FRED: [inaudible]

>> JEN: I knew you were going to ask that.

Fred asked what they are: Day habitation and residential habitation. They will be added to independence.

>> JEN: Aging independence care and independence.

Services will continue as-is in those waivers in fee-for-service waivers outside of the first phase until the phase is brought up, as I just mentioned, on those dates.

So all three people who are receiving services in all three of the aging, attendant care and independence waiver in southwest zone will be transitioned into Community HealthChoices.

The OBRA waiver is the only one we will continue as a fee-for-service waiver.

As Community HealthChoices is implemented in each zone, OBRA waiver participants aged 21 years and older will undergo a level of care determination to determine whether or not they are clinically eligible for nursing facilities.

Some people in OBRA will not be considered clinically eligible for nursing facilities. They will remain in OBRA.

Those clinically eligible will transition to Community HealthChoices.

We had begun those level of care determinations in the

southwestern zone. The 14 counties, people who live in those 14 counties are receiving Area Agencies on Aging are conducting level of care. We have been in dialogue with triple As about how those are going.

Talking next about communications, you probably heard we are doing four day-long educational conferences or summits in the southwestern zone. For southwestern zone providers.

Here are the dates and locations.

We had to close Cranberry because we were at capacity. We added a second session in Cranberry for July 22nd because there were a lot of people wanting to come there. It is a very popular place.

[LAUGHTER]

>> FRED: Very.

>> JEN: It is a good location, actually. It is at the intersection of two big thoroughfares.

The objectives -- this is what we will be doing. We will be doing Community HealthChoices basics and having an overview of what is Community health choices?

We have over 1,000 people registered for these sessions. We believe there will be people there who just don't know.

My experience is that when I go -- I went and spoke to people in the southeast in Philadelphia and also in Montgomery County at Villanova. In the last two weeks I went to those sessions and presented. There were people in there who just didn't know anything about what was going on with Community HealthChoices. It was their first exposure.

We will do a level-setting presentation of what is Community HealthChoices. People there, who are in this room or who are really paying a lot of attention, will have to sit through a presentation on the basics.

We will also do Community HealthChoices updates. We will provide a lot of information about what is going on in the latest and that will be part of that initial presentation.

And then, we will -- in the afternoon, after lunch, we will be having -- we will be breaking out into five breakout sessions.

We created five breakout sessions based on the provider types

in the Office of Long-Term Living system.

We have a session for nursing facilities. We have a session for home and Community-based services; that would include personal assistants service providers; that would include adult day providers; that would even include housers, who are housing people who receive waivers. They would want to come to that one.

In addition we have a session on service -- for service coordinators and Area Agencies on Aging.

We have a session for physical health. Physical health providers will also have a session and we have a session for behavioral health.

On the physical health sessions for providers, we are collaborating with the office of medical assistance programs on putting that session together. On the behavioral health side, we are collaborating with the office of mental health and substance abuse services to get them to help us figure out what should be in a presentation for them.

The next slide is the flyer, which has been updated to include that last, the July 22nd session in Cranberry. It went out a couple weeks ago and we just recently updated it.

All of three of the MCOs will have staff at these sessions. They are planning to be at each of the breakout sessions so there is a resource to those sessions.

The next slide is the slide of the flyer that you all gave us comments on. We got a lot of good feedback from -- at the last -- if you recall at the last meeting, we presented this flyer and we received some feedback on it through this committee. We got a lot of good feedback on it.

We made some adjustments to it.

It also includes the 800-number we will include and also translated it into Spanish.

We have decided to wait a few weeks. We were planning on putting this out this week. We were planning on sending it out Friday to participants, but we need to do some more work to make sure that providers in the southwestern part of the state are really ready for this, which would include putting together some training that we will make available to providers in the southwestern part of the state so that you are -- whether it's service coordinators or

people who work in nursing facilities that are affected by this, we are putting together training that will help them, the actual line staff, the people that interact with participants.

When this arise, it arrives in participant's mailbox, hopefully people around them will have enough information to say, Yes, pay attention to this. Be able to tell them where to turn, whether to call the 800-number or call the service coordinate entity.

Next slide, please.

This is a draft and this is also -- Tracy mentioned the notices. This is a draft notice that we have put together for home and Community-based service participants that are also duly eligible for Medicare and Medicaid.

We would like this committee to look at this draft and give us feedback on it.

This is just the front a page of the draft. It is several pages long. We have two versions of it, which we would like you to consider taking a look at. One that has a fact sheet and one that does not have a fact sheet.

We will make both of those available in their entirety, to this committee to give us feedback on it.

We are asking for email comments back to us through the MLTS SubMAAC at the resource account. We are looking for feedback by July 14th, if possible. Today is July 7th. That gives you a week to take a look another them.

These are the notices that will go out after they get the initial flyer, which we just talked about. The initial flyer has been put off for a few weeks. It will go out by the end of July, very beginning of August at the latest.

These dual notices are going out -- the actual notices will be put out in September, the first one.

The purpose of the notice is to really let people know that the delivery system is changing from fee-for-service to managed care and also give them their appeal rights, which Tracy just had us learn about.

The next thing I want to talk about is the -- some of the quality update work that we are doing.

We -- as you know, I talked about this. We told you where it was posted.

There is a statewide quality plan for managed care. This includes managed care that is delivered within the office of medical assistance programs, health choices program. It includes the office of mental health and substance abuse services, behavioral health choices program. It includes the CHIP program and it includes the ACAP, which is run by the office of developmental programs, the autism capitated program. It also includes OLTL's Community HealthChoices; it's a comprehensive statewide quality plan that states are now required to submit to CMS.

There were 14 commentators and over 200 comments that came into the statewide strategy plan.

We, the Office of Long-Term Living, received 12 of the 14 commentators were for us. It was for the Community HealthChoices program.

I will provide a more detailed summary of what those look like. We are just now delving into them. I did put a slide together that talks about some of the themes of those comments.

The first theme, which I heard a lot in this committee is to ensure that participants and providers have the mechanics in place to include an independent system or a beneficiary support system as defined under the managed care final rule.

Also, that participants and providers have a hotline number that they can readily access that's at the state level, and to continue communication as we have been doing here.

Another theme was to continue to promote stakeholder conversations across department of human services. You can hear -- and I think it was pretty evident with Tracy Henry's presentation, there is a lot of cross-office work happening around Community HealthChoices; so that the entire department is really engaged. It's a pretty large department. The entire department is aware of and understands what is happening with Community HealthChoices; that includes training that we do with other departments.

We have training specific for the office of income maintenance workers. We will have training specific for office of developmental services.

We are doing a lot of work to make sure that stakeholder engagement continues.

Across the MCOs, with providers, participants and advocates.

We continue to have a commitment to doing that.

We are also urged, through the quality strategy plan to continue to have program transparency, to report performance measures and outcomes to stakeholders.

This question was just asked in a previous presentation and we are committed to doing that. We just don't have any details yet. When we figure out what our process is going to look like for making sure you receive reports with what is going on with hearings and appeals, we will share it with the committee and get your input on it.

We also are doing transparency around consumer satisfaction, critical incidents and reports of abuse.

To incorporate pay for performance initiatives -- you will recall I talked about this before. As we roll out and launch Community HealthChoices, we want to get the program out to start. There will be bumps and hiccups in the process once we launch this. We recognize that. We want to work on those and really make sure that we have processes in place to address them.

Down the road, when the program is a little more mature, we will build in some pay-for-performance indicators, as well as value-based purchasing processes.

Right now, the office of medical assistance programs has been building those into health choices. You will recall that health choices is 20 years old. It's a very mature program. We are just too young to consider doing any of these more innovative approaches at this point.

Then monitoring the program.

Ensuring participant choice is another theme that we heard in the quality strategy program, as well as inclusion of diversity so that there was a number of suggestions around ethnicity, LGBT population and have translations available we are committed to doing all of that.

The next slide is about external quality review. The RFP was just recently released at the end of June. As we are required to have an external quality review organization, this is something that the state procures, it is a CMS requirement and the federal regulation where it is required is cited there.

The EQR will set forth parameters that states must follow when conducting the scerm external quality review the external quality review process actually gets done on the managed care organizations, as well as if we have pre-paid patient health plans.

So in RFP, which is out there for 45 days, we kind of laid out what our requirements would -- are going to be for our external quality review.

External quality review organization will help us with performance improvement plans.

We need to have PIPs in place that we are required to do. Some of the performance improvement plans I am considering right now, are performance improvement plan on coordination between Community HealthChoices and behavioral health choices plans. Coordination between those two MCOs.

As you will recall, behavioral health is carved out of Community HealthChoices, but we are still going to require coordination with behavioral health MCOs. So we will probably be working on a PIP that includes that coordination.

Another one that I am considering is the coordination between Medicare and Medicaid payments. The payments for Medicare and Medicaid. Coordination between those entities.

In Community HealthChoices, we have required that each of the MCOs have dual special need plans, but that doesn't mean participants who are duly eligible will use the dual special needs plan. They may decide to go for straight fee-for-service or choose different plan or Medicaid advantage plan. We don't know. We expect the CHC MCOs to coordinate with the provider or that other entity where Medicare is being provided. We might do a PIP on that; they are just some of my ideas.

Once the EQRO is finalized.

We could bring the EQRO to this committee. I think we probably will. Your recommendations for PIPs will be very welcomed.

Those are the dates where it is. It is RFP number 1015 and is up on the website for procurement. Solicitation deadline is August 25th of this year.

We are very excited when that got issued last week.

Next slide is update on evaluation plan.

The evaluation team with Richard -- which Richard Kovalesky is our representative on the evaluation team -- it includes the Medicaid research at the health policy institute at the University of Pittsburgh. It includes my staff as well as the Department of Aging staff. We have a number of -- also other parts of the department, office of medical assistance has people on it. So does -- there are a few other offices. I am not sure all of them. It was really opened up to all of the government that was interested in the evaluation.

I will say that our evaluator does continue to participate in both internal and external meetings. They attend meetings throughout the state.

The activities that are happening right now, in year 2 of our evaluation. As you will recall, we made it a 7-year evaluation. We moved into year 2 of the evaluation.

We brought University of Pittsburgh in to give a more detailed report several months ago. We will continue to bring them in to these meetings, as you request them to come and report on their update.

They are conducting key informant interviews and focus groups. The folks -- some of the focus groups were intended to help them develop the key informant and interview questions to give feedback on them.

They are also in the process of putting together a provider survey tool, which will be going out statewide to providers. We will be pilot testing that first before submitting it statewide. We are excited about that provider survey. They are doing a deep dive into administrative data right now.

There is a lot going on with that. We do have a preparation at the August 2nd meeting planned for the evaluation, to come in and do a little more detail on that. The plan is located on our Community HealthChoices website.

Additional updates.

Independent enrollment broker. We are, right now -- we have a procurement out there. We received proposals; however, we are in a stay right now on that procurement.

We are not doing anything with it. We have not unsealed the bids. We are waiting for the state to be released and finished.

The IEB extension, we did an extension to the current independent enrollment broker. The IEB implemented through that extension a new system at the end of May.

When I was down at Philadelphia and in -- actually not in Philadelphia but when I was in Villanova, I had people come up to me after the meeting and tell me the new system is working well. We are excited about that.

We are always looking for offers. It does offer improved opportunities for processing efficiency and reporting. There were some initial issues as it there always are with the implementation of something. You cannot expect to launch a new system and not have some kind of bugs. We have really smoothed those over.

Now the independent enrollment broker is moving smoothly and back to its rates that are within our contract requirements for things like abandonment rates, call wait time and that kind of thing.

Our expectation is that the process and application experience will see significant and ongoing improvement in the coming weeks and months.

We are past the hiccups that happened at the launch, the end of May, through the month of June. As they have gotten into their stride, all of the agents are now really fully versed in using the new system. We would expect to see significant improvements in the coming weeks and months.

>> FRED: Good. Because I have had nothing but complaints about the IEB.

>> JEN: The new system?

>> FRED: Yeah, all of the providers and everything that have come to me, the service coordinator entities being signed on, they continually are having long 30- to 40-minute waits on the phone. They are not getting responses back.

I did tell them to file with you guys and let you know this so you should have that in your records.

>> JEN: I don't know how long ago that was. There were complaints about it for the first three to four weeks in the month of June. We are back to our normal wait times, which it is within the contract language.

We acknowledge there were some bumps and long wait times. We realize that. Once we started finding out about them, we jumped into action with the IEB and we really had a very quick response from them, but it wasn't until about 2 to 3 weeks in June that we started hearing that there were problems; that's part of why it went a whole month with the complaints.

We are back to our normal wait times and to our normal abandonment rate and even less than it. We did have a problem in the launch. It's been corrected.

It was particularly a problem with nursing home transition. I heard there were a lot of problems with nursing home transition. We fixed that.

>> STEVE: I know there is a stay for the IEB but can you tell us how many people submitted a proposal?

>> JEN: No.

>> STEVE: Thank you.

[LAUGHTER]

>> FRED: Short and sweet!

[LAUGHTER]

>> JEN: The next slide is about the financial eligibility determination tool. We are in the process of testing it right now.

We had, as of June 30th with 10 counties participating in the testing. As of June 30th, 175 of the 200 that were required for the testing have been completed. We have extended the testing period because we want to get the full 200 in.

We are going to be training all of the Area Agency on Aging assessors in September. Our implementation is targeted for November.

The 10 counties involved in the testing new functional eligibility determination tool are Perry, Warren, Forest, Erie, Snyder, Montgomery, Blair, Huntington, Fulton and Blaine.

The system is being tested right now.

Your slide said financial eligibility.

>> JEN: The slide should say functional eligibility. I did

review these and I didn't see that. Sorry about that.

>> JEN: Nothing is changing in financial eligibility. It is remaining the same.

The next slide is about encounter data. Drew asked a question at the last meeting about what our plans are for using encounter data.

The people in OMAP who are going to be teaching us to use encounter data are coming to our next meeting and talk to us about what they do with encounter data. They were not available in the short turn-around time to put together their presentation.

It is used for a lot of things, as you can see here. It is defined as medical service or product received by a member from a provider; that's how we define it.

It indicates what services or products have been provided to an MCO member; so it also includes by which provider.

Our CHC MCOs will submit pseudo claim providing all pertinent information on their claims.

We will test encounter data with MCOs to be sure they are able to submit claims; that it's working; also submit encounter data.

The data will be stored in our data warehouse. We will have analysts that pour through it and give us reports on it.

You can see, it can be used for rate development, monitoring of the MCO contract requirements, data analysis, fraud and abuse, long-term services and supports quality studies. We use it for a lot of different things.

From contract monitoring perspective, encounters will be used to ensure the contract requirements of timeliness and accuracy encounters are met.

We will be looking at that in our monitoring and using it very closely.

That is just general information about encounter data. You might as well not ask me any questions. I likely will not be able to answer them and will wait for experts to come to the next meeting, if that's okay with all of you. Just save me the embarrassment.

>> FRED: For now!

>> JEN: That's right.

Committee membership is the next thing I want to go through and talk about. We do have some people who have resigned. Scott Rifkin being one of them. We have not received his formal resignation at this point.

Here is some general information.

When we first established the MLTS SubMAAC they were staggered with appointments of either a two- or three-year term.

On August 31st, the two-year term will expire.

The reason we staggered it was so we wouldn't have an expiration of every single member and potential for full turnover of the membership at any given meeting.

We have two- and three-year terms.

Those people who were on a three-year term after that they will be on a two-year term. Then it is every other year your membership will expire.

So members who are appointed due to non-full term resignation may be considered for a second two-year term.

If you came, for example, I think James came mid-term. You would be considered for a second full, two-year term.

This is all in accordance with the medical assistance advisory committee bylaws. We follow their bylaws and operating guidelines.

Here is the status, the different statuses of the membership.

People whose membership is expiring at the end of August, the end of this August, can be considered for a second two-year term.

Those members recommended to continue for a second year term were sent an email in June explaining the term is coming to an end and ask if they wanted to continue for a second term.

There are people who wish to continue. If they just need to confirm that you just need to confirm your desire to continue. We will ask you to submit an updated resume.

If you do not want to continue, you need to send your resignation to the Chair of the committee and the deputy secretary of Office of Long-Term Living; that can be done through an email.

If the term is ending and no second -- if a member is not recommended for second term, the member will receive a letter thanking them for serving as a member of the committee.

We have some resignations, as I mentioned.

The one slot is for -- these slots that are on these next steps, we are going to accept nominations for the committee. We are inviting you and the members of the public to submit nominations for new members.

If the membership is an association, you will recall the Secretary had me create a committee that included half agency or association member representatives and half participant representatives.

Right now there are five slots open, not including the one that we have already replaced with Scott Rifkin because of the recommendation.

We have three slots for under 60 consumers. We have a resignation by Jennifer Howell. We have a resignation by Cassie James. Who is the third one?

>> MARILYN: Cassie has not sent hers in yet.

>> JEN: She indicated she wants to.

>> MARILYN: The rest are just terming out.

>> JEN: Okay.

We have one slot for over 60 consumer and one slot for Area Agency on Aging because Steve indicated he is resigning as well.

So we are accepting those nominations. Once we select, we will get appointment letters.

I did speak to Ralph Trainer, who is in surgery. He wished to convey to the committee it has been an honor for him to serve as the Chair. At this point, he is resigning as the Chair because he just can't -- he points out and said to me he has not been able to fully participate. He feels as a member of a committee or a Chair of a committee, that he really needs to be able to give it his all and be here in person.

He is resigning as Chair.

I have -- I will be appointing a new Chair and Vice Chair. You will hear about that. I will make the announcement in the next week or so.

I just wanted to let folks know, he has been really -- felt this was one of the best committees he's ever been part of. If you know Ralph, you know he has been a member of a lot of committees. He's been around the block and back.

He was on the committee that first started the statewide independence living councils steering committee for their biannual meeting, power through knowledge, as Theo was as well, starting in 1993. He has been doing a lot of committees and is very active.

He was very pleased to be that. We will be sending him a letter, once we receive his resignation. We will go forward from there and figure out who will Chair and be Vice Chair.

With that, I have a question page. I know I have questions.

>> FRED: Yes!

>> PAM: Fred, the Chair recognizes you.

>> FRED: Imagine I have questions. Yes.

Has anybody considered having a town hall or anything for consumers themselves starting in January that have questions or before January? Like similar to what you are doing with the providers but have it strictly for consumers, after we put out the initial letters and everything? Has anybody considered that? If not, I need to.

>> JEN: We have considered that. You will hear about it in the coming months. Like the provider meetings we will do things for consumers.

>> FRED: Wonderful!

>> DREW: Imagine I have a question!

Thanks for the update on the FED pilot. I see the timetable on that is really tight. I want to be sure that we get feedback about those consumers that we recommended be re-evaluated who had cognitive impairment and see how the new tool does on them.

>> JEN: Yes. That's on our radar. The University of

Pittsburgh has the list. We will be looking at them.

>> DREW: Great!

Another question is, update on clinical assessment tool and where we are at with that?

The reason I ask is, some of the MCOs are looking at alternate payment methods. I am wondering if the clinical assessment tool will afford tiers for need determination.

>> JEN: I don't know the answer to that. I will take it back.

>> DREW: Thank you.

Also, I wanted to just ask you a question about what the IEB being in stay means?

>> JEN: It means we have had a challenge, a vendor has challenged us. We have to go through a legal process to get it released. They have challenged us under first right of refusal or something like that.

Jack, did you know the actual term for it? A vendor that believes it had the first right of refusal.

>> JACK: For the contract?

>> JEN: Yes. It's under stay.

>> JACK: If someone filed a protest, it's an automatic stay. It's an interesting protest but, yes --

[LAUGHTER]

>> DREW: I know I asked you this time --

>> JEN: Just to finish, our counsel submitted response to protest and they have 15 days to respond to it.

>> DREW: Okay.

I asked you this last time, since then better reconciliation of care act has come out. I am wondering if the department has looked at the implication of that Senate bill for the agency program.

>> JEN: Not specifically for CHC but Medicaid at large. The

entire Medicaid program is at risk now. It's gone beyond us. The Governor and Senator Casey actually submitted a letter to the Senate about it.

So, yes.

They listed out all of the things that will happen to Pennsylvanians because of it. Yes, we are very much -- we are moving forward on Community HealthChoices; that's not going backwards. What will happen is that BCRA, if it goes into effect, people will lose services.

>> FRED: Uh-huh! A lot!

>> DREW: Thank you.

>> PAM: Thank you, Drew.

Jack?

>> JACK: Jen, are the MCO contracts finalized? Are they through the signatory process?

>> JEN: No, they are not. The grant agreements are not. They are not contracts, they are grant agreements.

I always call them contracts when you talk externally, people want to know what it is. It is like a contract but it is --

>> JACK: There is some debate about that --

>> JEN: And don't debate it with me.

>> JACK: Questions with CMS and answers that will go back, at some point and I am assuming when the approved waiver, once the waiver is approved, you will release the waiver and then questions and answers will be released along with the waiver?

>> JEN: Virginia, do we typically post the Q&A that we go through with CMS?

>> VIRGINIA: We never have in the past. It doesn't mean we can't visit it.

>> JEN: We will consider it.

>> JACK: ODP has done it with their waivers. Just for your information.

>> JEN: Sure. Thank you.

>> PAM: Jen, I have a question, actually.

Going back to the IEB and the fact that you now -- no, not the IEB, the notices that are going out, there is a phone number now. Can you tell us who will be answering the telephone and what kind of training they will get to be up to speed, to answers questions about MLTSS? In addition, what kind of training they will get for the program?

>> JEN: It's a call center vendor the state uses who will answer the 800-number. It's a large averment. They will get significant training and will have scripts.

>> PAM: Thank you.

Any other questions for Jen from the committee?

[NO RESPONSE]

Okay. Thank you. It was quite long and comprehensive.

There is a lot going on.

Next on our agenda is Randy Nolen and William Wiegmann. I hope I am pronouncing it correctly.

They will talk to us about the readiness review update.

>> RANDY: Good morning. Good afternoon -- I don't even know where we are at here. It's close to both.

I am Randy Nolen with the Office of Long-Term Living. Part of my responsibility or major responsibility right now is overseeing ratings and review process.

I just want to stop in today and give you overview update of where we are at.

Bill works with the Department of Health under the managed care unit. Responsibility and working relationship with them is that they will review the provider network provision that comes in from MCOs.

I give you update and lead-in with things we are doing with provider networking and how we are trying to get things into place with that. Bill will talk about the process from his perspective and what DOH has to do.

So just some updates with where we are at on readiness review. We have revised our readiness review tool based on the latest draft of the agreement with the MCOs; that's the agreement that we got a lot of feedback on both internally through our legal department also comments from MCOs and other stakeholders within the department.

So we had some revisions we had to make to the actual tool itself that the MCOs have to follow.

We sent the revised tool out to them last week with also a copy of our worksheet tool that listed the changes we made so that they are prepared to start providing us with information; that was sent out to them last week.

All three MCOs submitted us a time line of when they will be submitting their policies and procedures.

We are also working on time lines. We are going to do onsite visits with them.

In general, all three of the MCOs will be submitting their policies and procedures, starting next week until the end of the month they will be downloaded, uploaded, whatever the term is, into docushare for staff to start reviewing the documents.

We are working through that process.

We are also working through what we call the park process. There are things that need prior authorization review program some of the policies centered around medically-related things and pharmacy need to be prior authorized before the MCOs can provide those services.

There is a process that goes through that. We are working through not only getting policies and procedures and clarifying things with MCOs, but we are also working internally to set up some staffing to assist with that review process, that staff will be under the quality management bureau. We are working through that part of the process to get staffing involved to start reviewing that.

We will be working with pharmacy folks and the office and with some medical directors in reviewing those policies. We are putting those processes into place.

I mean, that is kind of the major thing that we are working on right now, besides providing technical assistance training

sessions to the MCOs over the last couple weeks we have had a number of sessions. Some of them centered around IT, whether it was the 834 report, assessing on HCSIS and EIM, how the system works and how they should be utilizing it.

We have an upcoming session Monday with quality management, talking about quality reports, to talk about all of the quality measures that we will be going through.

There will be discussions from a number of staff within the bureau to talk about quality, including Dr. Kelly and Dr. Williams, our medical directors. Also Dr. Levine talking about quality things related to opioids and areas like that.

So we are working through the quality piece of it; that's on Monday. A full day on Monday. A full day on Tuesday we will be going over educational and training things. We will educate MCOs on the training we provide to new providers, to SCs; that session is on Tuesday.

We have some other sessions in the works. There is a session on encounter data that is the beginning of August. That will be provided. We have talked internally of setting up other sessions to talk about policy-related issues, probably BPI-related issues. There will be other things set up as we provide technical assistance to MCOs and working through that part of the process.

Our goal for onsites is probably mid- to end of August to go on site with MCOs.

We will have a list of things we will monitor on site, interviewing staff, looking into their call center. Our IT folks from BDCM will be monitoring and looking at their IT systems and their capabilities to do billing, their capabilities of downloading different things that need to be done from the department's perspective.

We are kind of working through that whole process; that's where our emphasis has been over the last month working through this stuff, answering a lot of Q&As that come in from the MCOs regarding clarifications with the agreement language and with the program itself. We continue to work through that process also.

We are also continuing to have weekly meetings with the MCOs. Each one of them has a slotted time each week. We have an hour and a half set for those meetings. Sometimes they last longer or shorter, depending on the topics we need to cover. They are still done on a weekly basis, plus the project leads talking with MCOs on

a daily basis; so that's overview of readiness review and where we are going at right now.

One of the biggest pieces we are working on is provider network and being able to define provider network advocacy.

On the physical health side, obviously it's a little bit easier, the contract has parameters in regards to time, distance, monitoring travel for providers. Some of the provider types we can certainly tell where the MCOs are at as far as getting contracts with these providers.

Things like we know how many nursing facilities are in the southwest region.

We know how many hospitals are in the southwest region.

We are able to take a look at some of the data based on that.

The difficulty that we have is identifying what adequacy is for LTSS providers.

We are doing a couple of things in relations to that.

We are running some internal data based on historical claim information to come up with an idea of how much services have been provided.

We did that about a month ago in working with the committee with Pennsylvania health law project and a number of consumers. We ran the data in regards to past workers in the southwest. Came up with the total number of units being utilized, converted to hours, we took a look at the number of consumers that were in the southwest. Did math with that. Divided this, applied that, came up with general idea on average how many hours are used a day.

Based on that, we are able to kind of calculate the number of potential workers needed to provide those amount of services.

We will do that with a whole list of other services also.

Our analytics staff is working on that right now. They will be running numbers on service coordination, on RN/LPN services, different types of services that have been through for.

Once we have the information, we will do calculations and say, in general, the expectation that we need this amount of providers out there by provider type to be able to adequately provide the services.

What that will do is allow the MCOs to have numbers, so that they know what to look for as far as building network out. It will provide numbers to work with and provide to the Department of Health as they take a look at determining network adequacy looking at LTSS providers and adequacy is somewhat different for Department of Health. They are used to looking at physical health side. This will assist us in working back and forth with them also as they take a look at network adequacy.

We are requiring MCOs submit a report on a regular basis. Regular basis is usually when I ask for it. The last report I got from them was this past week regarding where they are at, regarding contracting with providers by provider type.

This will allow us to work with MCOs and say, Look, we need to ramp up and see where we are at or at this time we think you are meeting the criteria. Moving forward I will probably over the asking for the report monthly or maybe even every two weeks depending on where we are at and being able to identify the short comings that each of the MCOs have in the area.

So we are working through that type of data collection also. With them. Hopefully, as I collect the data, we will be able to provide you a better update where we are at percentage and numbers wise.

The problem on the LTSS side, like I said, is identifying what the denominator has to be so we know, are we at a certain percentage or have enough providers starting up. Once we get the information over the next week or so, we will be able to put some of that into place.

I will be able to say, at this point, we have this amount of providers under contract. We are working through that process with the MCOs.

One of the other things that we are doing with that, before I turn it over to Bill, here, is in general, when DOH takes a look at provider network adequacy, they have a spreadsheet that health choices MCOs would fill out that lists who the provider was, where they were providing services at and what their specialty was.

We worked with Bill. He did a lot of revisions to address LTSS population. We sent the spreadsheet out to the MCOs so they have it. It's a spreadsheet we are asking them to collect data on and send to me as I need it. It's also the final spreadsheet that needs submitted to the Department of Health.

We added things under that spreadsheet to assist us in identifying areas of need or numbers that we need.

Primarily, what we did was on the LTSS services, we asked them to identify the county the provider is in and also the county that the provider serves or counties that the provider serves.

One of the biggest asks and changes we made to the form was to ask certain entities number and types of workers that they have or staff that they have.

So we are asking a provider to provide information that says, all right. I provide these services. I provide past services. We are asking, how many workers do you have?

I am an agency that provides RN and LPN services, home health services. How many workers do you have?

We are asking those types of questions to providers. There has been feedback from powers not sure why we are asking the question. We will put out clarifying communication to them. I have to work with provider relations with Jill, hopefully finalize that today so providers know we are asking for the information as a step towards determining what we need for network adequacy.

It may look like MCO A has 10 and B has 5. You may say A is twice ahead of B in what they are doing.

In reality, the 10 agencies that A has may only have 500 workers and the 5 agencies that B has may have 1500 workers.

In reality, B seems to be in better shape. To know that information, we have to get the information and know what the providers and how many they have in each individual type.

We are working through that. If you hear from providers that they are asking about that, again, we will send a clarifying information out to them. Basically, the department is asking for the information through the MCOs to help us determine network adequacy.

Those are some of the things we are working towards on the LTSS side to come up with our parameters for network adequacy.

So what I will do, I will turn it over to Bill so he can discuss his process and what they do at DOH.

>> THEO: Before you move on, are you seeing any weak areas or needs based on where you are at right now?

>> RANDY: I think the weak areas are identifying the LTSS providers and making sure that we have an adequate number of PASSs, FSCs.

On the medical side, I am not seeing any trend. I mean, we have some issues with providers that come back and forth. Some providers may only want to sign up with one MCO. Some providers may not want to sign up with somebody because they don't want to change the IT or billing system. We are running into issues like that.

Nothing as far as significant weakness at this point in time.

>> THEO: Thank you.

>> PAM: Richard, do you have a question?

>> RICHARD: No, I will defer at this time. No, I do not.

>> BILL: Hi, I am Bill Wiegmann with the department of managed care, bureau of health.

We have a long history of working with DHS on provider networks.

We go back many years working jointly with them on Medicaid zones, behavioral health zones.

We are happy and very comfortable to be in the position now working on this particular roll out and looking at these networks.

As you are probably aware, we look at them in similar ways but also somewhat different ways.

We come at it through the lens of our managed care time/distance rearview mirror requirements in the regulations.

The advantage is, you have two different agencies looking at a network slightly different ways and that should benefit the member in the long run. They should end up with a better network product at the end of this process.

We are comfortable looking at physical health, behavioral health, pharmacy. They are the types of providers we look at. It's the 25 to 30 new types that we don't have the experience in.

Our approach is going to be, first we will run it through the requirements of managed care regs for time and distance. We will see if that works, if that makes sense.

Our fallback position may be just reasonable questions to the health plans of, Walk us through this. How will this work with these providers for this type of service in these counties?

Try to look at -- we will try to look at it from the members' perspective. If I am a member, how do I get these services?

If a provider doesn't exist in a county, our normal response to that is, where do people normally go for that? Do they normally go out of county? How is that service obtained? We will also be going along that path.

Initially, this will work well. We have two agencies looking at the network.

Down the road, if there are questions or concerns, again as to the benefit of the member or the provider, they can go to Randy or come to us. Either agency is perfectly equipped to solve it. If we need to, we can also join forces; that's a huge advantage sometimes too.

So at this point we are ready and prepared to start looking to networks. When they come in we will have continuing dialogues with Randy and his staff, with the plans and their folks in provider areas as we have questions on the network. We believe this should roll out smoothly.

If there are any questions for me, I will be happy to answer them.

>> FRED: I have a quick one. Can you give us an example of 25-30 new providers that you are unaware of or have not worked with before?

>> BILL: Sure. I have a couple here. This isn't the modified spreadsheet. Things dealing with architectural modification, employment benefits and skills, nutritionists, pest control.

There are a number of these that are just beyond our normal.

>> FRED: Yeah, thank you. I just wanted some kind of idea of what it was like. As long as it is not durable medical equipment and things like that. That was what was making me sweat a little bit.

>> BILL: Some of these are mobile. Time and distance doesn't apply if the person can't come to your home now are they

available? Do they have enough staff? If they get three calls for one day, can they get three different trucks out there?

>> FRED: Right.

>> CARRIE: I do have a comment from Tanya and a question.

She would like to know when consumers will be asked about the readiness review. It was her understanding that she would be part of a smaller committee to work on this. She has not been contacted since May, which was before her surgery.

She is still interested. She would like to know at what point and what type of topics will consumers be contacted for this process?

>> RANDY: We had a consumer group we are working with with David Gates, Tanya was on the committee. There were three or four other individuals on the committee also.

I think our last meeting was at the end of May that we last met.

>> FRED: Yeah.

>> RANDY: At that point in time we put direction in place leading to the process of trying to collect historical data in regards to amount of services being provide the.

Once we get that information back, then I will schedule another meeting with that committee.

At this point in time, I haven't scheduled anything for the month of June, one, because I don't have anything really to talk with them about, because I wanted to collect the data.

So my hope is that I have the data and then once we get through some of the stuff carrying over into the next couple weeks is to reconvene the committee end of July or beginning of August to talk about the data that came through and talk about the parameters that we will provide to DOH. Yeah, we will continue with that.

>> BLAIR: Follow-up question from that, separate in work adequacy there were similar -- participant involvement and readiness review for other areas.

Had there been any decisions made yet about how participants may be included in aspects of readiness review? a couple suggestions or ideas I had based on launches in other states we have

done regardless of requirement with participants is looking at submitted training materials, getting their comments on how staff are trained or what constitutes a care plan or what things might be missing. They are a couple ideas to consider.

>> RANDY: I don't think we made any decisions yet I terribly of what we may send through the committee for review.

Certainly education and training will be one of them.

We did have some discussions with education and training. One of the things we asked the MCOs was to include consumers in that process; that is a little tricky. It is hard for the MCOs to reach out to the consumers right now because of the process and the fact that they have to wait to enroll individuals; that's a tricky slope to be on.

Certainly, I think, some of the policies and procedures that come in, it may be related to that to share through the committee here.

>> BLAIR: Great. Thanks.

>> Jim Fetzner. Just a quick question. I was wondering what point the lack of contract with MCOs will impact your ability to do readiness review?

>> RANDY: We have a go, no-go set of December 30th.

There are a number of big-ticket numbers that need to be in place by the MCOs at that point in time. The ability to pay providers is one. The second is the ability to provide services.

That means they can upload the care plans of those individuals and have the provider network in place to provide those services.

So that is the goal that we are looking at.

Why I am looking at and going to be requesting information from them every two weeks in regards to their provider network and this is not just a network that they are working with but they actually have contracts with to do CHC work is so that we can get to the point over time to know that we are comfortable with the network that they have set up I don't want to wait until September 20th to figure out that they don't have network adequacy.

We will know that beforehand and work with them to build them up.

>> JIM: A quick follow-up to that. Aren't there components of their infrastructure, vendor contract or particular type of provider contracts they will not be able to set up until they have a finalized contract.

As we move down, September 30th isn't that far away if they don't finalize the contract until the end of August will they have time to put services in place?

>> RANDY: Having a final agreement in place, yes, it is important. There is no doubt about that. There are things that they can move forward with. There are provider contracts that they will utilize between them and the providers they have all been submitted, reviewed and approved. They are moving forward with contracting and building the network.

Some of these things are going on at this point in time. We are moving forward with that.

>> PAM: Any more questions from the committee?

[NO RESPONSE]

Pat, anybody on the phone from the committee?

>> PAT: No.

>> PAM: Okay.

All right. Thank you very much, William and Randy.

We are going to extend readiness review and hear from our MCOs, have an MCO perspective.

I don't have names on the agenda. I assume Ray you will do UPMC.

>> JEN: Patty Wright from AmeriHealth Caritas.

>> RANDY: Well, Josh is here and Norris from Pennsylvania health and wellness.

>> PAM: If you could join us. Let's start with you, Josh.

>> PATTY: Hi, my name is Patty Wright. My background is in social work. I am currently the administrator for Community HealthChoices for AmeriHealth Caritas statewide.

In the future maybe we can reverse so AmeriHealth isn't

always first.

>> Fred. Alphabetically.

>> PAM: We will put names in the hat next time.

[LAUGHTER]

>> PATTY: Thanks, it's hard going first. I am used to being in the back with W for last name.

AmeriHealth has been a partner in Pennsylvania for more than 20 years. Many of you may have already been part of our family as either member or provider under health choices in either AmeriHealth Caritas or keystone first based on where you live or where you provide services in the state.

We are very excited to be part of Community HealthChoices. My whole team, Cathy, Tiffany, Chris, Jen that do direct oversight of Community HealthChoices, you have had the opportunity to meet them in other venues, in addition to that, we have a full team back at our Philadelphia office, our Harrisburg office and now our Pittsburgh office. All of those are individuals that are helping to support our core staff for Community HealthChoices. Will.

Readiness review.

All right. You are all excited about readiness review.

We have been through many successful readiness review in Pennsylvania through health choices.

We understand and acknowledge while there are similarities of health choices and Community HealthChoices, we have also heard from all of you as well as OLTL about the differences.

We have been preparing for Community HealthChoices for over a year and a half. While we have been preparing our policies and providers to demonstrate how we can meet our contractual requirement requirements we have been working diligently to work and prepare our staff for Community HealthChoices.

We have a readiness review team that is specific to Community HealthChoices in Pennsylvania. We meet minimum weekly as a full team and we also have functional area teams that meet on an ongoing basis.

Over a year and a half we have been holding listening sessions with consumers, caregivers and providers throughout the

state.

In addition we have been attending all of the subcommittee meetings, meet-and-greet sessions and all of the OLTL sessions as well as the technical assistance sessions our team is incorporating all of the feedback, comments and suggestions from all of the venues into preparing for readiness review.

When it comes to providers, we are working with all of the current providers to obtain contracts to ensure that all participants can continue to receive their services as we transition to Community HealthChoices.

We are working with the department to determine access standards, to make sure that the network has complete adequacy.

We are also working with providers to understand their concerns and to help them identify potential service gaps and to brainstorm for ideas for out-of-the-box providing services to participants where you are and when you need them.

We are committed to providing provider panel that offers you choice.

We are also committed to provider partnership; that's really the core of what we do.

As we meet with providers we want to reinforce their value to you, as well as your value to us.

They are the ones interacting with you on a daily basis. We want to have an open communication with all of the providers between the providers, their staff that are in your homes providing services, as well as our service coordinators and case managers.

We will be working with providers and associations on how we can provide support and education on topics that they have been identifying that will help them better serve you.

For many of you, you get services and supports from informal support systems, caregivers, individuals that are non-professionals and for some of them, this is emotional, it's a tough thing to do. We want to be able to provide them with as many resources and tools as possible.

We are also working closely with MCOs and OLTL to create a credentialing process. All MCOs have commitment to making it as uniform and painless as possible.

We will be incorporating all of the quality indicators into our program as we develop them with Wilmary and the team.

Kathy Gordon, myself and the rest of the team are meeting with all of the departments and staff from senior leadership to direct-facing staff to help them understand you, the participant, and how we can best meet your needs, help you achieve the goals you set and live in a setting that you chose.

>> FRED: Ha!

>> PATTY: We are, Fred. Honestly.

There is a lot of anxiety about the process and change. We are committed to gaining your trust. CHC is about you.

We are preparing for a readiness review to demonstrate how to prepare our team, how to coordinate care, your service plan for physical health, behavioral health, LTSS, with the other MCOs both physical and behavioral health, with our DSNP partners as well as Medicare.

We are also working closely with Community and housing resources we know are vital to your goal of independence.

>> FRED: Yeah, I got a question on how involved you are with consumers right at the moment.

>> PATTY: I was actually getting ready to type an email with Randy. We have been working with an organization at a request to see if we can have consumers work with us to develop our training plan.

I mean, even when you just look at the difference between consumers that may be calling in to our contact or consumer sales right now about health choices, individuals in Community HealthChoices, number one, they have different needs. Also, just making the phone call is a different challenge for some.

We want to make sure our our staff is equipped when saying I can give you phone number to Dr. So-and-so, they may have to wait a little bit, allow the person to get a pen or even have someone else take the information for them, how they write down the information. Even just speech patterns, they have to listen a little differently.

We really want them to be equipped as possible and get to know the consumers; that's why we are going to be asking, if we can include individuals from some of the CILs to be able to help us

develop the programs.

>> FRED: The best source of information for all of the little details that goes into a person's life with a disability is the person with a disability. Guaranteed.

>> PATTY: Exactly.

>> FRED: One more quick question. I have tried to ask this almost every single meeting that we possibly can. I need to know what you have already planned or if you have planned anything to do with the service coordination entity.

Are you going to continue using the ones that are in existence now? Hire your own? A combination of both? Hire those on to your staff? Do we have any plans as of yet?

>> PATTY: I can talk a little bit about that. Pam, when we put the names in the hat, stick mine at the bottom. Glue me to the bottom of the hat.

>> FRED: You love answering my questions! I know!

>> PATTY: Now I know how Jen feels.

[LAUGHTER]

>> PATTY: I know all of the MCOs are committed even though it's contractually, we are all committed to working with the service coordinators for the continuity of care period.

I can speak for AmeriHealth, we are developing an evaluation tool that will help us, that we will share with service coordination entities. They will also be involved in helping us develop our evaluation tool.

>> FRED: Oh, good!

>> PATTY: That way we will be able to use the evaluation tool through those six-month periods to determine which agencies we can and cannot continue with. We will do some direct hire.

Part of that is the reason -- Kathy has years of experience in developing service coordination case management teams. We understand that there are going to be some participants that have deeper behavioral health needs or even chronic conditions, physical health needs, that may be outside of the skillset of some service coordinators.

We will hire some direct service care coordinators that may be licensed or have specialties in certain areas, whether brain injury, behavioral health, et cetera that can supplement the team.

We are looking at a hybrid model. How hybrid it is, we will determine as we go through the six-month continuity of care zone.

>> FRED: That's the best answer I have heard so far.

>> PAM: Let's hear from Ray and Josh on that issue also.

>> RAY: Sure.

I think I can say we have a similar view as Patty. Our intent is to have a hybrid model.

The first thing that is important to understand is that the CHC program will require more service coordination than the current model today. The care planning component and connection with healthcare services, there is also additional requirements for nursing facilities.

There will be demands on the system for us to hire internally. We are also looking very closely at partnerships.

I think that we all recognize that there is some variability in the system today. I don't know where that variability is. I have met with many service coordination entities. Some have been very impressive, more impressive than others.

At the same time, it's hard to know until you get into the trenches with those organizations as we head into continuity to have a definitive answer to say, Look. Here is where the quality is, and we will make our investment.

Our accountability is to the consumer and we need to meet their needs in the program. We share this commitment and are looking at what we can learn from continuity.

Six months is not a long time. You don't get a lot of claims data.

It is a unique opportunity Pennsylvania built in the six-month period.

>> FRED: One of my biggest concerns is that there are a lot of fly-by-nights out there. It doesn't take much. One person has to get a degree and hire anybody he wants off of the street, basically.

That will not happen after this, is it? They will all have to be 100%, college educated, in the specific field of service coordination for you guys?

>> RAY: We don't have a set standard that I think I can share today in terms of what we look for for the capacity organization. You know, the requirements of the contract have been changed since the RFP and the draft that is out there; those qualifications we are looking at in having in our staff.

Again, I think that you are right, we are looking for organizations that, as you said, are not fly-by-night; that have competencies; that have the same shared focus on quality.

>> FRED: If you have bad service coordination, it is the people with disabilities that will suffer the most. It is something I really needed to know. A lot of people wanted to know. Thanks.

>> JOSH: Good afternoon this is Josh Shoop, from Pennsylvania health and wellness.

Our approach is similar. Just like everyone here, our focus is to put the best interest and needs of the participants first and foremost. We are going to continue to do what we have been doing which is making sure we have been leveraging the provider Community and provider network to make sure that we fully understand the needs. What is good today. What could be improved upon.

We want to use the continuity of care period to make sure that we listen and learn and oversee.

Our responsibility is to make sure that the participants are cared for. Before that is happening and quality service coordination is provided. We want to add value to that rather than simply supplant them.

>> FRED: Here is another question: If we are having a bad experience with our particular service coordinator, they are doing a lousy job for us, who do we complain to? Is it you? OLTL? What can be done about it as far as that goes?

>> JOSH: I can only speak for Pennsylvania health and wellness. We want to know immediately if there are any services that are not meeting the needs or quality or satisfaction levels. We want to know directly and immediately so that we can properly address the situation and, certainly, we will make sure that we notify OLTL as needed.

>> FRED: Awesome!

>> PATTY: Fred, for AmeriHealth, we will have an advocate you can call. One thing we did hear when we were actually at AIM when they had a listening session for us, one of the participants shared a concern about having a concern about their service coordinator, it's hard for them to issue the complaint to their service coordinator because they are concerned it could impact their service plan.

>> FRED: Exactly! Absolutely!

>> PATTY: We took it back. In our model we are building in an advocate that would not be your service coordinator so that the participants could be able to reach out to them without it impacting the service plan.

>> FRED: Nice!

>> PATTY: Also, under our model at AmeriHealth, we will have ride-alongs. Supervisors will be doing ride-alongs. It was coordinators as additional support to make sure that they are understanding the tool. Plus, it's the best way to know the participants. You will get to know them. You will have their contact information as well. We will also have it set up through contact center for you to be able to call in there as well.

>> FRED: Excellent!

>> PAM: Patty, did you have anything to add to readiness review or should we will pass to Josh?

>> PATTY: I am ready to pass to Josh.

>> PAM: Thanks very much.

>> JOSH: Thanks, Patty, for always going first!

[LAUGHTER]

A couple things. As we have said before and will continue to say, our main objective at go-live is participants get services and providers get paid.

Everything that we do every single day is measure it against those core objectives.

We are empowering our teams to say that if they are working on anything that doesn't advance those two goals, they should not be

doing it.

Within that, there are three core areas that we are focused on. First and foremost is network. Randy spent a lot of time explaining that. We have the vast majority of our resources focused on building our network and making sure that it is not just adequate but more than adequate for readiness review.

Second is our systems. We want to make sure that we are able to certainly communicate effectively with OLTL, our file fees. We want to make sure that our systems, that employers and end users' access are as simple as possible. This is going to be enough change for everyone. So challenges logging into 12 different systems doesn't help. So we are doing everything we can to make it as simple as possible.

In the third area is hiring key staff. We have found so far lots of very qualified individuals who have already joined the team. The vast majority of our staffing or hiring will happen in the third quarter. So far that's on track.

Back to network. I cannot stress enough, you know, that is where our focus is. Right now we are processing several hundred contracts every day to make sure that every provider that is currently providing services and certainly wants to participate in the program has the information they need, has the contract from us. We have a call center set up. We have field staff available and we want to make sure that we are answering questions, we are helping providers understand the process. Managed care contracts are not the -- they are certainly not pleasure reading. We want to make sure that everyone understands exactly what they are signing and we are getting those in as quickly as possible.

I will just end by saying, we certainly appreciate feedback and support. The sooner we get provider contracts in, the sooner we can begin testing to make sure that we can pay claims.

We are targeting to begin that probably late August. So we really encourage providers and anyone who can influence providers to please return those contracts as quickly as possible.

>> FRED: I think I can do that!

>> PAM: Thank you, Josh. Ray?

>> RAY: First I want to thank Randy Nolen and his team for leadership of this process. It's been great to have the personal attention. When he said we are in touch daily, we really are. Our

readiness team has done a great job answering questions where they can. Where they need to get clarity, we have had great success in getting those things back in writing. It's a great collaboration.

The state, as you've seen through the public processes that they have had to date, that's continuing behind the scenes with each of us.

A lot of this work continued from the time the RFP was submitted. We each were taking steps knowing that this is such a big lift. It's been many months in the process, thinking back to last May when we all submitted our proposals.

Network development, of course, is central for us. We are spending a great deal of time working with home and community-based providers. We have had calls with, you know, organizations like the Pennsylvania home care association working on scheduling. Similar ones to review the contract terms with nursing home associations and others that are -- service coordinators that are in the process of being scheduled.

Quality in building out our infrastructure has been a priority. Again, as mentioned, thinking through what data we will need for evaluation and tools for transparency as we go into the continuity of care period and looking to have an open dialogue as we go into the new program.

As I mentioned the readiness program, we have daily emails, our weekly calls where we go through specific issues.

A lot of our work -- a lot of this readiness review process is pretty mundane, if you think about the policies and procedures that we are all reviewing and rewriting and, you know, making sure that the language is consistent with the vision that we are putting forward.

I think we can all say that we are reading hundreds of pages of these types of things and that's a big part of what is entailed in readiness review.

We are also building out infrastructure, whether it's processes or expanding what our different teams do, whether it's new things like critical incident reporting for LTSS or fraud, waste and abuse in areas that we already have.

There are other things through readiness that are a little more strategic. The state has set goals for us around workforce, housing, employment. There are things like IT getting our systems

ready to pay claims, integrating service coordination system and then adding to what Patty and Josh said, recruitment and back up our perspective team.

A big part is culture change. We recruited one team member away from UPMC disability resource center with a focus on making sure all aspects of company understand how it is culturally different.

To respond to the question around consumer involvement, I think we are also in limbo. We want to be mindful of the state's process. As we go through this, we don't want to be influencing choice in any way, but we also want to be responsive. As mailings start to go out, we are looking for state's guidance and approval on how we appropriately engage consumers without going too far in that area.

Of course, as you all know, we are all having to need to be very present. You know, there is a lot of moving parts. We are all spending a lot of time on the road, whether it is for organizations that are convening meetings, like the Jewish healthcare foundation in Pittsburgh or first hospital in southeastern PA.

DHS held a lot of meetings for us on configuration of systems, quality, service coordination, all of these things.

We are also spending a great deal of time planning for the provider sessions for July 24th through 27th.

That is my overview for what all is happening in readiness and what that means for us.

>> PAM: Thank you, Ray.

Does the committee have any questions for the MCOs regarding readiness review or while they are here are there any other issues that need to be addressed with them?

>> CARRIE: Carrie Bach.

I have several questions from Tanya. As you know, she wraps several into one question.

This is for the MCOs. She would like to know to date if there is anything that you would do to improve upon Pennsylvania's readiness review process having been through other reviews in the past.

If there is any information, data, questions or concerns that

you are waiting for from the Commonwealth in order to move forward and be ready to go for a January 1st implementation date.

>> PAM: Let's start with Ray this time.

>> RAY: I must say, at first with the timing of a lot of these things around contract, it started out slow and we are in full rush. More time is good for a project this large. I want to echo what I said that Randy and the team have been very responsive and been great partners as we go through it. It is a very big lift.

In terms of changing the process, I think really, there is not much to do just inevitability of time lines and what we are all trying to do. It feels a little hairy at times, but I think we are very confident we will get there and have a successful program.

>> JOSH: This is Josh from Pennsylvania health and wellness. I would agree with Ray. Not just because our customers are here in the room with us, but it has been a very collaborative process and we have done many readiness reviews in other states. Some are better than others.

Honestly, Pennsylvania is right at the very top of the list. When we have questions, we get immediate responses. We get guidance and support.

Really, we couldn't ask for more.

>> PATTY: And this is Patty.

I would just echo that. I think the thing that LTSS' readiness review is still new, as the states move to it more and more, I think the thing that has been so impressive, really, has been just the communication and open dialogue.

OLTL has spent a lot of time with DHS understanding their process for health choices.

Even just the collaboration here today about with OLTL and DOH.

The concern is, if we present a network, a spreadsheet, will DOH also recognize some of the challenges? Whether it is both or employment, will we be judged differently from one venue or another?

I think we all share the same thing wanting consistency. Most importantly, I think the department is committed to a successful implementation that benefits the participants, as well as the providers.

>> CARRIE: Thank you, I know it is a loaded question. Tanya is committed to wanting this to go smoothly. She would like the committee to know of concerns.

There is one more she has. It has to do with the network. Is there a specific deadline in mind? This might be a question for the department, to have provider materials sent out to participants to have an opportunity to review and make their selections before the implementation date. Will the committee have an opportunity to see those materials are before they go out?

>> PATTY: I think Tanya trying to make sure she gets an opportunity to see the provider directly, provider manual?

>> CARRIE: That's my understanding of what she is referencing, yes.

>> PATTY: I think it is standard. All of the MCOs have to provide a provider directory manual; that is part of readiness review, as well as participant handbook. All of that is outlined through the final rule.

Then, once, through IEV, it is my understanding that each MCO will be able to present information, then the IEB team will be able to share that with a participant so that they have as much information as possible to allow them to choose the MCO. Then when they do, we will send new member packets, which will also include almost the same information as well as ID cards.

>> PAM: I think we were looking for a time line on that from the department to ensure that there is enough time for people to see that and make educated decisions about it.

I'm sure it is rather circular as it relates to the grant awards being signed, et cetera.

Do we have a sense of that, Randy or Jen?

>> RANDY: I think some of the time line we are looking at, obviously we are working on participant handbook right now, internally, to come up with a template. By final rule the state has to do that. We are working on that part of the process for the participant handbook.

As far as the provider handbook and network that can be put out there and provided by the MCOs -- we do realize that people need to know who is in your network before they make a decision and what MCO to sign up with.

The goal with provider network is to have everything done and finalized because it is part of the decision of go/no-go date at the end of December.

At that point in time each MCO should know who their provider network is and should be able to have it online so people can research it.

As letters come out to participants in October and November about the fact that it is time to make a choice with an MCO, we will have information in those mailings that go out to them that lead them to who they call, where they look for the information on the MCO's website and stuff like that. We will provide that information to them.

The bottom line is, we have to have the whole network stuff done by the end of September to be ready for the go/no-go date to for participants to review on the website to make a choice in October or November.

>> PAM: Thank you.

>> FRED: Thank you.

>> PAM: Do we have any more questions?

If not, we will ask Jen to come back and move to the public comment section.

I think the MCOs maybe should stay here for that in case there are questions for them.

>> FRED: Yep!

>> PAM: I know we have questions that came through the phone. I will start with that.

This is a long one. This is from Lavelle Miller-Wilson for you, Jen. Jen, will IEB extensions continue in southwest zone because of the stay?

What happens when CHC MCO meets adequacy in some areas and not all. I will stop there and let you answer those two because it keeps going on.

>> JEN: The IEB extension isn't until the end of December for the entire state. The stay is going to put us in a place we may have to further extend that, but we have not made decisions about that.

>> PAM: The second one was, What happens when the CHC MCO meets adequacy in some areas and not in all?

>> JEN: Randy, can you respond to that?

>> RANDY: Part of what happens is, we review adequacy. Department of Health will identify areas that they feel the MCO hasn't met criteria. They will work back and forth with the MCOs and with us to discuss that and figure out why around what needs to be done.

For instance, say there is a certain provider they don't have in Green and Westmoreland County. DOH will discuss it with them. What are your plans for providing those types of services in that county? MCO has to respond back they are working on contracts or respond that they have a provider in another county, but they cover the questioned counties.

It will be a back-and-forth between everybody to handle those situations.

>> PAM: Okay. Same question to each of the CHC MCOs. Since consumer will have a choice they can exercise any time about which of the three to join, what makes your CHC MCO unique?

Put another way, how is your approach different from the other two? Are there any particular approaches you can share?

>> PATTY: I am not sure we can all answer that right here. I think one of the things we will be able to do, the information that we have to present to the IEB, each MCO will have an opportunity to list their basic services, as well as any value-add services or enhanced benefits or if we have special case management programs for, you know, certain chronic diseases, asthma, et cetera. Then we would have the opportunity to be able to list that, then that would be available for the participants to review.

I think the other way that each MCO has an opportunity to be able to share what may make us unique is when we do our face-to-face visits, either with consumers or with providers and in the community, you know, we will host, come greet us and meet us and talk about who we are and what may make us the same and what makes us a little different.

>> This is Norris from Pennsylvania health and wellness. I will take this question.

I think as Patty mentioned, it is early to distinguish what

makes us different from other MCOs. We are all committed to quality services. The big difference is we are the largest provider of MLTSS services in the nation; I think that that is really what will distinguish us from our competitors.

>> PATTY: We have been here over 20 years.

[LAUGHTER]

>> PAM: We are off to the races.

>> RAY: And I wish I knew how they were distinguishing themselves; that would help us in our planning -- [LAUGHTER] -- in terms of being a Pennsylvania company part of integrated delivery system.

We look forward to bringing our different collaborations and experience, especially in serving dual-eligibles and medicated to bear in this new program.

>> PAM: I will ask one more question and then excuse myself and turn it over to Fred.

This is from Kathy. Does the new process include addressing losing documentation? We are still hearing complaints, especially as related to the physician certification form.

>> JEN: Yes, it does. It includes losing documentation; that was a big fix that we asked for. If you are having issues get them to me, and I will address them immediately.

>> PAM: You can come up and ask your questions. Thank you, committee.

>> My name is Lester Bennett. I am with supports coordination. One thing I want to ask our MCOs is about the database. We will have three different ones. Correct?

Will there be some type of baseline is there information that will transfer between each one.

If I am a consumer with PA health and wellness and there is certain information that should be transferred over to all three of them.

>> PATTY: Well, we will be using the state-mandated tools. One of them will make consistency in that area.

Lester, if you are asking if you are with MCO A and switch

and go to MCO B, would we exchange information? Yes, we would. Part of the agreement requires us. We will develop a type of participant profile.

Let's just say you chose to move from MCO A to B, you are scheduled to have a surgery the following month. You are involved in behavioral health. You already have certain services set up, part of the profile we will share A to B will contain that information.

>> LESTER: That second part is what I was looking for. The first part is, right now as a service coordinated entity on aging waiver we provide information directly through a SAMs data base.

And then there is HCSIS. Are we all using same thing or do you all have three different ways to talk to us?

>> PATTY: Each MCO has their own system.

>> JEN: The information will all be the same.

>> LESTER: The information is the same.

>> JEN: The requirement is they use the home care suite of questions. So it will be the same kinds of information that is getting collected for case management.

>> LESTER: If you are service coordinating into -- we will be all over the state. We are going to want a contract with all three. We will have three different databases that we have to learn; that's what I want to make sure, guaranteed.

>> PATTY: Yes. Each MCO has their own system.

The information we collect is pretty standard.

I don't know that you will be collecting different information. I think it may be how it is placed in each system that might be a little bit different.

One of the things the MCOs -- we have already talked to Jen and Randy and the team -- on day one, you are providing service coordination as you have been as we lead up to implementation you are providing service coordination.

We don't want to be burdensome by having three different MCOs come in at three different times for training and education. One of the things that we have talked about together, as well as with the department is, How do we coordinate with entities? We will all

collect EIM system. We will all be using it may be unique to MCO. In OLTL they are committed to making it as painless as possible. We want to be very respectful of your time you have a service to provide during the go-

>> RAY: The other thing I will mention is we will be providing existing plans from HCSIS and SAMs and be able to log into those systems and use the information through continuity.

This will all not be so abrupt.

>> JOSH: Pennsylvania health and wellness is very similar to what you heard.

>> LESTER: I wanted to make sure.

Jennifer, I got a notice from a consumer just recently that was going through the IEB program. She basically was told from maximus to contact us to see if she had already -- they are telling people to contact service provider if they have been staffed when we don't have paperwork.

When we get -- as things change I would love to have a 1, 2, 3 this is how we will be evaluating you to see if you are eligible. I understand we are doing function. I understand we are doing financial. When we got -- yes. I mean, meaning to certify that you are eligible for the waiver.

The Office of Long-Term Living makes the final decision. In that process, maximus is basically saying, I have done my job. We will send out 162.

>> JEN: You have a very specific question about a specific situation. Rather than talking about it in this committee, let's take it offline and figure it out.

>> LESTER: Got you.

>> FRED: Any other questions out in the audience?

[NO RESPONSE]

>> FRED: Our next meeting is the second of next month. We are done.

(Meeting concluded at 12:57 p.m.)

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