The following printout was generated by realtime captioning, an accommodation for the deaf and hard of hearing. This unedited printout is not certified and cannot be used in any legal proceedings as an official transcript.

DATE: 8/2/17.

EVENT: MLTSS.

>> PAM: We will call this meeting to order.

Good morning, everybody. Why don't we start with introductions. Barbara, if you could start.

>> Barb Polzer, Liberty Community Connections.

>> Good morning. Veronica Comfort from PCOA.

>> Jim Fetzner, Comfort Care.

>> Carry Bach, Voices for independence sitting in for Tanya Teglo today.

>> Blair Boroch, United Healthcare.

>> Bill White AARP.

>> Denise Curry, Pennsylvania healthcare spokesperson.

>> Pam Mammarella.

>> Jen Burnett Office of Long-Term Living.

>> Fred Hess.

>> Steve Williamson Blair, senior services.

>> Estella Hyde, AARP.

>> Drew Nagele.

>> Theo Braddy, CIL-central PA.

>> Ray Prushnok.

>> Jesse Wilderman.

>> PAM: On the phone?

>> Tanya Teglo.

>> JEN: Hi, Tanya.

>> Ralph Trainer.

>> PAT: Brenda Dare, are you on the phone?

>> BRENDA: Yes, I am. Can you hear me?

>> PAM: Yes, good morning.

Anyone else registered from the committee?

>> PAT: No.

>> PAM: I will go over the housekeeping rules, then Fred will go over the emergency evacuation procedures.

First thing, I have been asked again, for the sake of our transcriber, if when we have a question or when we want to make a comment, each and every time we use our name first. Introduce yourselves and make a comment. It will make it easier for her to make an accurate recording of what we are doing here.

As always we want to exhibit the utmost of language and professionalism here at this committee.

Direct your comments to me. Wait to be called upon and, if you could keep your comments to two minutes, or shorter, that would be great.

The transcripts from this meeting are posted on the listserv that everybody has on their agenda. The captionist is documenting the discussion. Again, so please speak clearly. Please turn your cell phones off. Our public comments will be heard at the end of the meeting. We have 15 minutes for that. We will endeavor to ensure that we have that time today and now, Fred, if you could do the emergency evacuation procedures.

>> FRED: Run!!

No.

In the event of emergency or evacuation we will proceed to the

assembly area left of Zion Church, corner of 4th and Market.

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

OLTL staff will be in the safe area and stay with you until you are told to either go back or you have to be evacuated.

Everyone must exhibit the building!

Take all of your belongings with you. Do not operate your cell phones. Do not try to use the elevators. They won't work.

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

Stair 1: Exit Honor Suite main doors, left side of the elevator turn right and go down the hallway by the water fountain; stair 1 is on the level.

Stair 2: Exit here, right side of the room or back doors.

For those exiting side doors, turn left, stair 2 is right there.

For those who are exiting from the back door, turn left and left again and stair 2 is directly ahead.

Keep to the inside of the stairwell and merge to the left and walk down Dewberry Alley to Chestnut Street, corner of 4th Street, left on to Blackberry Street and Fourth to train station.

If you all can remember that, God bless you!

[LAUGHTER]

>> PAM: Now we will hear an update from Jen Burnett.

>> JEN: Good morning, everyone. I will start out recognizing we have a new Chair and new co-chair.

Fred Hess is co-chair and Pam Mammarella is our new chair for this committee.

Ralph Trainer, who has been a great leader for this committee since the beginning, has resigned as Chair, but he wants to remain a member. Our rules for the committee allow Ralph to remain in a membership.

He is remaining on the committee and is attending. Welcome, Ralph, as a member today!

We are still accepting nominations for this committee. We really -- we have two. Last month I did ask for some nominations for committee members and we have received two nominations. I would really embrace getting some additional nominations because we have a few other slots we need to fill.

I want to turn it over to Steve.

>> STEVE: My first term is up the 31st. I will not be reuping for second term due to other commitments. I want to do the committee justice.

P4A is how I was nominating I will nominate Steve from Philadelphia aging assuming all of the Is get dotted and Ts get crossed p.

>> JEN: Thank you, Steve.

I want to bring a few things to folks attention.

We held four provider summit meetings in western Pennsylvania. Two in Cranberry, one in Pittsburgh and one in Altoona.

We had over 1200 participants come to that, providers. Different provider type of agencies and different types of providers, actually. It was very well-attended. We got a lot of questions. Actually, we had 581 questions, to be exact. We are now organizing those questions and we will be putting them up on our website as FAQs once we organize them and have gone through them and vetted answers and all of that kind of stuff.

The primary objective of the summit was to educate providers on the basics of Community HealthChoices; that's for starters.

I can tell you, I did that presentation at the Summit. There were providers that I recognized and others that I didn't recognize that were nodding their heads and kind of moving along and understanding what was -- I was talking about, because I really did a basic CAC overview.

Then there were others that did not -- looked kind of deer in headlights. They hadn't heard about this. It was a good opportunity for us to educate providers about what has happened with Community HealthChoices in southwestern PA.

There were people from other parts of the state but primarily we are talking to providers in southwestern PA.

Your Center for Independent Living, Fred were there. They asked a couple questions.

The breakout sessions represented the different groupings of providers that participated in the sessions.

One was for nursing facilities, one for home and community-based service agencies -- that ran the gamut from home care, home health to home modification providers to PERS providers, DME all kind of service providers participated in that one; the third grouping was Area Agencies on Aging and service coordinators; fourth grouping was physical health providers.

Physical health providers was probably the least-attended, but some good information was shared with physical health providers. We got some ideas how to move forward and make sure physical health providers are aware of what is happening.

The last grouping was behavioral health providers; and that did run the gamut of behavioral health MCOs, providers of behavioral health, as well as the county agencies and our state regional office was also participating in that.

Fred, did you have a question?

>> FRED: Yeah, real quick one.

Do we have any idea how many providers are signed up for all three of the MCOs? Even a ballpark figure?

>> JEN: Randy is --

>> FRED: Don't run! I will run you down!

>> JEN: He will provide an update on the network and what we are finding out about the network.

I did hear feedback from the MCOs at the meeting that it was a great opportunity for them to reach providers that maybe they hadn't reached yet and they had -- they really worked hard on signing new providers up, getting their contracts in the hands of the providers. It was, I think, a time well-spent.

We had about 10 or 12 state staff that participated. Our DHS communications office was very much a part of it.

They really did all of the organizing of these events. It was really, I think, worthwhile.

We will definitely be repeating the same kinds of activities in the southeast in the coming months and then for the rest of the state as well.

I wanted to talk briefly about some technology changes for the MLTSS SubMAAC committee meetings, the actual committee meetings.

On July 27th a Community HealthChoices listserv email was sent out announcing beginning August 2nd, which is today the MLTSS SubMAAC meetings -- today's and thereafter, we will use technology that is similar to the technology that we use for the third Thursday webinar for these meetings.

The technology change really is to support the increased access that we need. We only have -- the other technology that we use prior to today limited participation to 100 on the toll-free access line. What that meant was, many people were being told when they tried to call in, Sorry, the lines are full. We cannot accept any more callers.

We have had well over 100 individuals register; that exceeded the amount of room that we had on the toll-free line. So as we get closer to the CHC implementation, we anticipate that more and more people will want to participate in these meetings remotely. What we did was, we moved to Go-To Webinar technology; that is what we are using today. It allows 500 individuals to participate in webinar and listen to the speakers instead of participating by webinar and dial in.

We are trying to push and steer people into using webinar technology, which is through their computer speaker system.

For individuals who cannot participate by webinar because we know there are people out there who cannot participate, take dial-in number is still available.

The number is no longer toll-free; however, recognizing that that could present an access issue to some of the people who want to participate, particularly those folks who are Medicaid recipients and may not be able to use a toll-free -- or a not-toll-free line we have a toll-free number that is available. We have a bridge number, which we will publish. I will not say it out loud here and a special PIN number just for these meetings.

The toll-free number is available but we want and encourage people to use the webinar technology.

We also encourage agencies, if your agency is participating, for you to have a place where staff can participate in the webinar together, as opposed to everybody sitting in their desk because it eats up the bandwidth as well.

If you experience any difficulties, use our MLTSS SubMAAC resource account, if you have questions.

All of these will go out in a follow-up email to the membership.

Readiness review.

I will talk briefly because Randy is going to dive a little bit deeper about readiness review.

We conduct ongoing weekly readiness review check-in meetings with the three managed care organizations and the readiness review teams. They are meeting on a regular basis MCOs and CHCOs have begun policies and procedure submissions to us in an online account that they have to submit information to us. We are also working on historical claims data for long-term services and supports on an ongoing basis.

We are looking at a number of staff and full-time equivalence as one of the proxies for network adequacy.

That is something that the MCOs will be discussing with providers as they come on board. The number of FTEs that agencies employ is going to be important to us.

We did hold an all-day session. I talked about it at the last meeting on July 10th with the quality bureau to really discuss the overall quality strategy and performance measures. We are going to have a presentation later in the morning on our quality strategy, as well as an update on the evaluation. Both of those will be covered in more detail; that was a well-attended with great participation at that meeting on July 10th.

July 11th we had a follow-up meeting with a slightly different focus. We continue to meet together with all three MCOs and have the individual meetings with MCOs to talk about different aspects of how we are moving forward with Community HealthChoices.

That was a second day on the 11th was sort of a training that we give to our providers. We provided that to the MCOs so that they would see what it is that we go through with our providers and we also recognize that we will continue to hold ongoing technical assistance meetings with the three MCOs.

With regards to communications -- Randy is going to go more into detail on network adequacy when he presents later.

Communications: We did send communications to ComCare waiver participants and service coordinators explaining Community HealthChoices and transition process. Some of you may have seen those letters.

We are also sending the initial touch flyer we reviewed a couple

meetings ago to all participants in the southwest this week; that's going out this week.

The flyer says Community HealthChoices is coming. It's just basic. Participants expect to be contacted by aging well. They will be assisted in transition and independent enrollment broker.

We also did mention LIFE in the script that we had that is associated with people calling in. There is an 800-number for individuals to call in, if they get the flyer and are confused about it in any way, we talk about LIFE. We have all of the other kinds of questions we anticipate people contacting us about on the 800-number; so that people at the call center have that information and know what to say if they get answers specific to waivers or LIFE or, "What do I do?"

We continue our outreach to communication providers with biweekly emails we send out to educate and classify the different areas of Community HealthChoices including things like billing, claims, health choices versus Community HealthChoices. We try to provide accurate information about Community HealthChoices to participants as well.

Those -- I have to say when I was out in western Pennsylvania at these four meetings last week, I asked for a call of hands for people who are signed up for our listserv. I am going to say a good two-thirds of people in the audience had not signed up for the listserv. We continue to put the information out there so that people are signing up.

If you have a newsletter that you put out, please make sure that people are getting that information. This really is for anybody that will be affected by Community HealthChoices to sign up for our listserv.

Our training contractor is developing a training for all service coordinators. It's an online training so that service coordinators can understand what is happening with Community HealthChoices. We anticipate that that training will be available mid-August. We are just reviewing it now. It should be ready by mid-August and putting it out to all of the service coordination entities.

We continue to encourage -- we would like to continue to encourage to sign up for the listserv it is easy and accessible right off of our Community HealthChoices homepage. There is a subscribe live link to sign right up. You just have to put in your email address, first and last name and that's about it; that's the information that is needed for DHS list.

The HCBS duals notice that we shared at the last meeting, I just wanted to give an update on that. This is an example of a notice that is going to go out to all southwest participants in mid- to

late-September. This is an official notice that includes appeal rights. We use HCBS duals for one population but we are trying to get all of the language regarding appeals and all of that kind of stuff correct and accurate woe will tweak the front end of it for different population we have HCBS duals but six or seven other categories of people that need to get the notice that informs them that Community HealthChoices coming and that they are going to need to sign up for an MCO. We would like them to do that by a certain date.

We sent two versions out after the July 7th meeting with a lot of feedback. We really appreciated all of the comments. It did help to kind of solidify some of the language, make it simpler and make it easier to understand.

The preferred version by the people who commented was the version with fact sheet we did send out two different versions one with and one without the fact sheet the version with fact sheet was the one that was more popular; that's the one we will go with.

>> PAM: Jen, can I ask you a question about that?

>> JEN: Sure.

>> PAM: Will we see the notice again before it goes to final and gets mailed?

>> JEN: I don't know. Somebody here from the communications team? Jill, do you know we will get that out?

>> FRED: Say, Yes.

>> JILL: We can.

>> JILL: Yes, we will!

>> JEN: We will share a generic version. It is HCBS dual. Don't get confused it's the only population we are reaching out to. We are kind of tweaking it for each of o the different populations.

The comments that we received most of the comments were changes or additions to the language in the letter. That was the general gist of the kinds of comments that we received.

The letter really has just general information. You will be moved to Community HealthChoices. You will need to make a choice of your MCO, but you will be moved on January 1st, 2018.

What is Community HealthChoices?

What should I do next?

Those are the kinds of things we addressed in it.

Our legal department is now reviewing it. It could get tweaked further but I am hoping that by the end of the day, after meeting with the legal office, office of general council, that we have it closer to final. We will talk with the communications team about one more pass-around to this group.

I wanted to give an update on service definitions.

As of July 28th, all of the old employment service definitions have been removed from service plans that are in existence in our current system. The old employment service definitions will be closed this week. It took longer than expected because several providers needed to avoid billing so the service could be removed from the plan.

In other words, there was billing in flight. We needed to make sure we address that.

We are getting ready to really have these new services be in place.

Recent milestones: CMS did approve the 195(b)(c) waiver early last week. I guess it was two weeks ago.

The (b) authority allows us to implement mandatory managed care delivery system tore eligible beneficiaries. The (c) authority allows the provision of home and community--based services.

These services will be delivered through the managed care organizations.

CMS approved the independence waiver amendment on July 26th that adds residential rehabilitation services and structured dayhab which allows the ComCare participants to be trans missed to the independence waiver.

At this point we are on track for having the waivers in place for transitioning participants by January 1st. Prior to January 1st for ComCare, for example.

Upcoming events: The notice will be published in the Pennsylvania bulletin on -- or was on July 29th; is that correct, Virginia? Was it published for the four additional amendments?

>> VIRGINIA: That's correct.

>> JEN: Those four additional waiver amendments are out there.

One is pre-tenancy supports as part of service coordination.

The supports broker, which is going to be available for people who are in self-directed services, if they chose to have a support broker to help them sort of navigate what it means to be the employer of their own direct care worker, that service is getting added. Adjustments to unduplicated numbers and cost neutrality estimates.

That public comment period runs from July 29th through August 28th --

>> VIRGINIA: Actually, Jen, August 31st.

>> JEN: I had the wrong date on her. Got you!

>> VIRGINIA: That's okay. The information went out yesterday and everything is live on the website.

>> JEN: Everything is live and we put a notice yesterday. Please share it and take a look at it.

Just a couple other upcoming things that are going to be happening.

We will be working with Aging Well to do a series of meetings in southwestern PA for participants and we are looking for locations to hold those events around the region so that we are not just going to be in Pittsburgh but all over the region.

We are hoping to do about 20 of those events.

>> FRED: I have a big gym.

>> JEN: Fred has a big gym in New Castle, we will be using that. Communications team, make note!

We are also taking the baby steps that are going to be needed to make sure that we have coordination of Medicare. It is the MCOs that will provide service coordination as an administrative function. Those service coordinators will be required to do coordination with Medicare.

In order to do that, we are working on a number of different activities. We can certainly share some of those in future meetings here.

One is the Medicare/Medicaid data integration process that we are participating in with CMS and technical assistance we can have that project come and give an update where we are on that project.

We are also working to schedule -- as you know, we are requiring

each of the three MCOs to have a dual special needs plan. In addition to that, there are seven other dual special needs plan in Pennsylvania.

What we want to do is bring dual special needs plan to all of them who want to participate. The three new CHC MCOs to come together. We are scheduling a webinar for the end of August, hopefully, and we want to bring them together for a meeting in September. Those are some of the things we are trying to do to assure coordination between Medicaid and Medicare.

We are not a duals demonstration. This is not a PACE program, but we do recognize the need for us to coordinate with Medicare and have a number of different ideas about how we go about doing that.

We also have been in touch with the national committee for quality assurance, which is the NCQA, they do The accreditation for the managed care organizations. MCOs must have NCQA accreditation. We have been working with their leadership on different activities we want to do here in Pennsylvania.

One of the questions that people are asking us is, will the provider accreditation be standardized thing for all three MCOs as of January 31st, 2018? No. It is a goal we have to develop with MCO standardized provider credentialing.

NCQA has shown an interest in that activity so we will reach out -- we have been reaching out to them and scheduling meetings with them.

Another activity that I just wanted to mention is that the EVV notice is still -- electronic version verification is still out for public comment it will be closed on August 10th.

I encourage people who are interested getting comments on electronic verification to us. We are soliciting the use. By way of background, EVV is now required under the 21st century cures act, which went into effect, a federal law that went into effect on December 2013.

Section 2006 requires states to implement the use of EVV, electronic visit verification for Medicaid-funded personal care and home healthcare federal services.

We are now federally required to implement that. We are now -- one of the requirements under that law is solicit public input, which we are in the process of doing that.

The notice we put out is sim apply a request to provide input and there are a number of different ways that the input can be provided, but the way the EV -- the federal requirements for EVV -- there are a number

of different ways it can be implemented. The notice that we put out, actually, lays out.

>> FRED: I have heard three. One will be off the consumer's home phone number, off of a smart cell phone or they have got something where you can scan a card at the door and scan out.

>> JEN: There are a number of different ways. The way the law kind of lays it out, the services can be verified by the recipient's homelandline telephone, smart phone, buy metric recognition systems or fixed vet verification devices.

The EVV systems recently Pennsylvania home care association sponsored an event to bring EVV providers in so that the home care and home health providers would have a chance to kind of move around and get to know the different vendors. Janel, I am looking at you for a nod. Yes?

They held a techy Tuesday, I think they called it. All of their providers were exposed to various forms of EVV through that process.

I encourage people to get to know and learn more about EVV it will be coming to home care.

>> FRED: We are already implementing it.

>> JEN: That's great!

We are looking for feedback.

The other thing we I need to mention they must provide service, individual providing service, date of service, location of service delivery and the time the service begins and ends; those are all required under the 21st century cures act.

The notices, if you do have questions -- comments or questions on EVV -- your comments should be submitted to ra-evvnotice@pa.gov; that's the email to send your comments to.

Did you want me to read this?

>> FRED: Yes, there are some questions in there that I think need to be answered and it happens to do mostly with service coordination.

>> JEN: Okay. All right.

This comment comes from Tanya Teglo. You may have already seen her comments she commented about the one-page summary of service coordination under Community HealthChoices sent out by OLTL for comment.

Her comments are -- well, I will just read some of them.

While I think it provided a lot of good information explaining ow service coordinating agencies can become part of Community HealthChoices, one thing to be considered might be the document states service coordination entities have to be qualified but it does not recap what the qualifications are. The document also does not state if service coordinating agencies will still be used after continuity of care period is over. When will the public know who will be in charge of service coordination after continuity of care period? This has been a concern and will continue to be one.

To answer the last question, Who will be in charge of service coordination after continuity of care? The three MCOs. It will be an administrative function of the MCOs. They will be in charge of service coordination. That's that question.

It does not -- the document does not recap the qualifications. Can the document also does not state if they will be used after the continuity of care period.

We didn't include the qualifications. They have been out in the public domain for a couple years now. At least since the discussion document.

We are deposit want to confuse people. These documents we are putting out in the public, these one-pagers are really aimed at very, very simple information about what we are doing. It's really aimed at informing people at a very high level of what is going on.

People can certainly go to website after reading it. The website will be posted on there and learn more about how service coordination is going to be provided in the future under Community HealthChoices.

There is -- the agreement is out there. You can search. There is a search function for finding the word "service coordination" in the agreement. You can really read what the requirements are in the agreement.

We wanted to keep these very simple; so that is why we did not include those details.

Why one may be asking?

If the service coordinating agencies are expected to help with the transition over to Community HealthChoices, why would they want to do it if the service coordinating agencies know their contract could be expiring in a six-month time limit?

We can have the three MCOs today when talking about service coordination. All three are planning to have a hybrid model of service coordination and care coordination. Care coordination probably be in-house function focus odd physical health coordinating with physical health but service coordinator has a distinct and important role over long-term services and supports and coordinating with Medicare -- I already talked about that a little bit as well as coordinating with behavioral health.

There is a lot of input that we need those service coordinators -- service coordinator will also be responsible for the person-centered planning team process. They will need to be able to communicate with the different providers that the person may have. For example, their therapist, their MD, whoever it is that they are getting services from.

The service coordination is a much larger requirement than what is currently provided as service coordination.

The reason why they would want to contract with them is that they want -- if they want to continue to provide service coordination they would want to contract with them.

I will say that managed care organizations are going to be evaluating how well the service coordination is being provided and they will, you know, make sure that this service coordination is up to their standards for coordination of care. It is such an important service of managed care.

Does OLTL and the health and human services department think there will be a cooperative spirit in the transition process?

Yes, we are encouraging a cooperative spirit. This is one of the things that we really see happening. There was a lot of evidence of that last week during the four meetings we held throughout southwestern PA. We have already seen that agencies are trying to figure out what their new role is in working with the MCOs to do that.

What safeguards are in place to ensure under new CHC system worker profiles will not be lost, misplaced or not handed over in a timely fashion has happened in prior transition movements such as the one from 2012-2013?

We have made a decision to make sure that our case management systems are available to the MC Os throughout the transition period. I think that will ensure that valuable data does not get lost. Those are systems like SAMs, HCSIS and all of the different systems we have available.

Has anyone thought about what the safe guards should be?

Yes we thought a lot about that.

What incentive do service coordination agencies have to make sure the transition is handled properly if there is no guarantee of contract after first six-month time period.

They will have a contract for first six-month time period to hold accountable. The document makes sure the managed care organizations can do the proper monitoring and oversight through the contractual signature between service coordination and managed care organization.

>> FRED: Good. Good. Theo: I have a question on that. For me, I know in the past, when consumers switched, agencies are left.

>> THEO BRADDY: When they are left to provide information it doesn't always happen.

Can anything be done with the readiness review to ensure that after this move has ended and the service coordinator entity is not continuing to be part of the MCO, that that information is really smoothly shared with new service coordinating entity? It is a concern. I don't know whether if left to the MCOs and the service coordinating entity in regard to ending the relationship whether it will continue to be smooth.

>> JEN: We have requirements in our agreement with the MCOs.

>>JEN BURNETT: That show that they have to have a smooth transition in any transitions that they do. We will be holding them accountable through our monitoring. When we talk a little bit about some of the monitoring that we are going to do, one of them is launch monitoring which is that period of time between when we start on January 1st in the southwestern part of the state and into the next transition, which is July 1st, 2018, we are going to be monitoring a number of different activities, including this idea of transition. It's not just transitioning between service coordinator to service coordinator. It's transitioning to nursing to home, nursing facility to hospital.

All of the transitions are an important requirement we have for the MCOs.

They recognize how critical service coordination is. It is one of the underpinnings for managed care to have good service coordination. They must -- I mean, that is the bread and butter of what they do, to have good service coordination.

They will want to ensure -- Ray, did you want to make a comment?

>> RAY PRUSHNOK: One thing I think I can say consistent across the MCOs is we want to make sure that we are maintaining the satisfaction of our participants. We are there to serve them first. Any disruption is something we will all take very seriously and seek to avoid.

The question on the table, you know, we are very much committed to working with the service coordination network. We hope that through continuity of care that they feel that there is a relationship there and that they are working with us. It's not, you know -- in many ways, their collaboration with us is a big part of how we will evaluate where we will have the strongest and most sustainable relationships.

We hope that that's a fluid process where we work together.

>> THEO BRADDY: It is important. Speaking from experience, being caught in some sort of a loop and not having any control is one of the worst feelings a consumer can have. You just don't get any answers. You keep playing these cycle things, we lost this, this happened -- it is one of the worst feelings a person can have.

>>JEN BURNETT: I agree.

Theo, in our coordinate service coordination today, there are problems with it. It is not a perfect service coordination structure we have.

We provide it as a service not administrative function. Become administrative function gives us more control over what we can do.

There are bad actors out there today that are doing things that we hear complaints about on a daily basis we investigate complaints. Service coordinators going to local grocery store saying come over to my service coordination agency I will provide you 10 more hours of service.

Those kinds of things cannot be happening.

Theo, to your point, we recognize how important service coordination is. We want to make improvements to it, not make it less -- make there be less quality. We want to make improvements to it.

>> THEO BRADDY: Thank you.

>>JEN BURNETT: In addition to Tanya's comments. There are more submitted by David Gates health law project.

What time is it?

>> FRED: Ten till.

>>JEN BURNETT: We will take care of these questions later. We are running behind I will turn it back over to you.

>> PAM: We are running a little behind not so much behind we won't have time in the end to do that. I want to take a moment to congratulate Jen and the department passing through waiver approval from CMS. Congratulations it was no small task to get it all the way through now you have another comment.

>>JEN BURNETT: This is related to needing input from you. I must have left it out or skipped over it. I'm sorry about that.

Attendant care waiver and independence waiver transition notices.

We have two slides to put up there. Sorry, guys. It outlines what these are. They are going to be sent out to participants. In attendant care outlining the Community HealthChoices roll-out and phase-in for participants aged 21 and older, independence waiver letter outlining Community HealthChoices roll-out and transition participants 21 years and older to the OBRA waiver -- is it 21 and younger?

>> VIRGINIA: Anybody younger than 21.

>>JEN BURNETT: Yes, this is somehow -- okay.

Age 18 to 21 in those two waivers will be getting a notice to move to OBRA it will remain open as a waiver. Those letters will come out for comment from you.

When we ran the data for age 18 to 21 in southwest PA, these letters will -- not a lot of people in those age ranges in our waivers we will send out specific letters for them so they understand what is going on with them.

We have the ComCare waiver letter in draft we will present it to the committee for review once available.

We want to get feedback on the other two waiver notices by August 10th. We will email it out to you after today.

>> FRED: Eight days.

>>JEN BURNETT: Yes, eight days. We have to keep moving on these things.

[LAUGHTER]

>>JEN BURNETT: That's all I had. Thank you, Pam.

>> CARRIE: My question is, have the agreements been finalized with each of the MCOs yet?

>>JEN BURNETT: No.

>> VERONICA COMFORT: Veronica Comfort. When will the Community HealthChoices waivers be posted on your website?

>> VIRGINIA: We plan to do it this week.

>>JEN BURNETT: Going up this week.

>> PAM: Thank you, Carrie.

>> CARRIE: This is from Tanya. She is asking about the state budget and how roll-out of CHC effects it.

>>JEN BURNETT: The budget bill went into effect as law without the Governor signing it a couple weeks ago. Right now the General Assembly is out on recess until August 13th with no movement on a revenue package or some other code things we have to do. There really is no update. There's been no movement.

We have also heard that although they have indicated they are going to come back an August 13th, they may not come back until September.

>> PAM: Thank you. Any other questions for Jen?

[NO RESPONSE]

Okay, we will move on to Wilmarie Gonzalez. She will talk to us today about quality strategy update.

>> WILMARIE: Hi. Good afternoon, everybody.

[NO RESPONSE]

You can do better than that.

>> AUDIENCE: Good morning!

>> WILMARIE: I wanted to make sure you are paying attention.

[LAUGHTER]

My comments will be centered around quality strategy. I want to take a moment, first of all, to thank many of you in the room who have

submitted comments. We receive comments from over 14 organizations, 200 comments -- over 200 comments.

Many of them were comments that were more clarifying comments/questions with regards to really the agreement that we are going to have between the state and the managed care organizations.

Next slide.

A lot of comments we got, again, like I said before, were more clarifying questions and many of the questions and the comments really related to what is already included in the drafted agreement on our CHC website.

For those of you who have not visited the website there is a lot of information regarding Community HealthChoices. I encourage you all to visit and look at the amount of information that we already have regarding the design of Community HealthChoices.

As many of you know, we have done a number of presentations and third Thursday webinars. We have done presentations here and other subcommittee meetings regarding the quality strategy that really impacts the Department of Human Services.

We are one of five program offices included in the quality strategy this year. We posted the quality strategy on May the 13th. It is a very detailed plan. This is our first time OLTL being part of the quality strategy.

The plan was posted for 30-day public comment period and we are in the midst of finalizing those comments.

Today we are going to give you a much more detailed information on what those were based on, on the 200 comments that we did receive.

Next slide.

I want to reiterate that the, again, many of the comments a lot of them were really questions. We will walk through -- I will walk you through some of the themes and you will realize many of the comments that we received can -- will be able to answer them as well.

One of the areas that came to us was in regards to participating provider support. Some of the comments focus on ensuring both participants are going to be served in Community HealthChoices as well as the providers that are going to be providing those services have clear channels for resolving problems and issues with the managed care organizations. So things like denial of services, protection of

participant's rights, rejection of claims from providers, et cetera, et cetera.

DHS will continue to maintain participant and provider hotline numbers. During launch, as Jen mentioned, we are planning on having early launch indicators. I am hoping that in the next MLTSS meeting we can provide you more details of what the launch indicators look like. We shared with the MCOs. We have had a lot of technical sessions with MCOs. A lot of that information has already been shared and vetted with the MCOs to gauge, not only their feedback but also tap into their experiences. Many of these managed care organizations already have experience in managing MLTSS programs.

Participants may file complaints with managed care organizations as they retain appeal rights. Again, a lot of the comments came from the commen Taters related to participant and provider supports.

Next slide.

Very key to the comments were ensuring stakeholder engagement continues. They expressed concerns that once Community HealthChoices is up and running, perhaps some of the public forums and things we already have in place for Community HealthChoices will sort dwindling down; that won't occur.

We have a commitment that stakeholder engagement will continue even beyond once community health choices is up and running we will continue MLTSS subcommittee meetings as well as participating in other subcommittee meetings as well as other public forums.

Each MCO is required to form participant advisory committees for each zone; that includes participants, providers, direct care workers, representative, advocates and other organizations representing the makeup of each of the networks.

The department will continue to hold groups and will continue to hold meetings as I mentioned before, information will continue to be posted on the Community HealthChoices website.

Another area that also came from the comments on transparency related not.

Some of the questions were, when will we be able to start seeing the quality data and information with regards to how CHC is operating.

We plan on presenting a score card not only in this committee but other forums we hope to share data and information as it becomes available.

Reports for the independent evaluation will continue. We have today Howard Degenholz at the research center we want to make sure that not only this committee but other subcommittees know what is happening with the seven-year plan. That will continue.

Obviously, to protect the participants' privacy, while we plan on developing a score card and sharing data, we do not plan on releasing raw data to the public; that was one specific comment that came in. More importantly, we want to make sure that we are protecting the privacy of each of the participants we are serving.

Next slide.

Another theme that came out of the comments was participant choice. As many of you know who have been working with us in submitting comments and design Community HealthChoices, our model has been person-centered. We want to make sure that we continue that. Our key goal for Community HealthChoices is to continue to expand participant choice. That is a commit we commitment we made on at the time of the concept paper and we continue to look at all of the design aspects.

Change in service coordinator. Again it is another area that we want to make sure participants know that they have a choice.

Some providers may chose not to participate p in Community HealthChoices established minimal rates to encourage participation.

Next slide.

This was another area that we receive a number of comments in the area of diversity and inclusion. Our commitment continues to be full support of full inclusion for all participants. We welcome specific strategies from not only all of you here today but also some of the folks that are participating via phone, in identifying specific strategies for ensuring full inclusion of all groups. The MCOs must monitor provider network for compliance with Americans with Disabilities Act and MCOs, it's part of their agreement as well, they must ensure that translation services are available to each of their participants and interpreter services upon request by the participants; that will continue.

A lot of these requests are included in the draft agreement.

Next slide.

There was a lot of engagement and movement in the performance measures area. When you look at the quality strategy, appendix N is -- Jen, someone is calling you.

There was a lot of energy around performance measures how do we make sure that managed care organizations are meeting all of its obligation?

I want to make sure that I really reiterate that the Community HealthChoices agreement provides a number of requirements. There are over 200 requirements. Some of those requirements are being met in different phases during readiness review each MCO must submit and you've already received information on our approach to readiness review and some of the requirements that we are expecting each of the MCOs to submit; so that will continue.

When you look at the performance measures, it goes beyond just the data. It also includes performance measures.

Right now, there were over 100 performance measures we listed on appendix N we grouped them three different areas like heed ition measures, national measures.

We also included some measures that were received by some of you that submitted it to us. We know at the national level there are no OLTSS measures. Many of them were submitted by many of you. We have included some of those.

I objecting interestingly enough we received comments from those comments.

Part of our performance measure included waiver assurances.

We need to ensure that CMS understands we have to meet assurances and how we will do that so a lot of the assurances were already listed in appendix N.

That was part of our application. We are happy to know that at least that part of the performance measures were approved through the CHC application.

As many of you know performance measures will change over time whereas this quality strategy is three-year quality strategy.

Because Community HealthChoices is so new we expect that by next year we will have more available information to provide to CMS.

So the way CMS asks when you submit a quality strategy, if there are no major changes, then that quality stays for years if there are significant changes for strategy CMS requires you to submit a new plan.

Our hope is for next year, we will be submitting an update the quality strategy for Community HealthChoices. Our hope will be between

now and next year, with the help of continuous dialogue with stakeholders will we will continue to perform not only performance measures but some other things that are coming through with regards to our readiness review.

Next slide.

The last -- this is the second part of the performance measures. I did mention about the readiness review and some of the things that are being met. The readiness review by the MCOs and a lot of the reports that are going to be required.

My hope is at an upcoming MLTSS meeting hopefully next month, maybe two months, we will be able to share with you what the launch indicators look like.

I just wanted to give you sort of an idea of the kinds of things that we are looking at during launch: Participants transitioning into Community HealthChoices; that's going to be key. While it's one area, there are a number of indicators below that.

Another area is service coordination and what that looks like. We want to make sure that we are looking at that starting day 1. Right?

Provider participation; that's really key and very important.

Above all, too, making sure information systems are working. If they don't work, participants are not getting services, providers are not getting paid. So -- again, we will be able to provide more details at an up coming meeting.

Next slide.

The last thing is that our plan is to revise strategy stakeholders submitted. Our hope is to update the quality strategy in the next couple weeks.

We will let this committee know when it is posted on the CHC website, as well as placing an executive summary as well of the various themes that we -- I just shared with you today.

Like I said before, the quality strategy is evolving. It will continue. When you look at the quality strategy we not openly talk about the three different major phases we are doing with Community HealthChoices, readiness review, steady state and early launch or launch indicators that I mentioned, but it's all of the different pieces.

We do provide you with more detail in the quality strategy. As always, I encourage you, if you have a moment to look at the 300-page

document, please go ahead and do that.

[LAUGHTER]

With that --

>> PAM: Theo, you have a question?

>> THEO BRADDY: I don't know whether you can answer this or not. You mentioned part of the quality assurance is ensuring that consumers have a source of service coordinators. So my question is, how would that be measured? How would it be done by the MCOs?

>> WILMARIE: My hope is at an upcoming meeting I will be able to share with you more details how we are actually planning on doing that.

Other questions?

[NO RESPONSE]

I get to present Howard? Fantastic!!

So Howard Degenholz is actually one part of the quality strategy; that's the evaluation plan. So Howard is here today from the Medicaid research center. He is going to provide an update on the activities that are occurring pre-community HealthChoices. So with that, Howard, you have to come up here because I had to come up here.

>> HOWARD: I don't have a printout of my slides.

>> FRED: You have to suffer like us and spin around.

>> HOWARD: It will be tricky. The last time I sat over there.

Trying to do everything paperless and do it all electronically. I can maybe follow alone on my own laptop if you give me a moment.

Thank you very much for the opportunity to be here and address the group.

Last time I had to be only on the telephone. So this time it's really a pleasure to be able to see everybody's faces and hopefully interact a little bit more directly.

What I am going to do, can you advance it?

I will give an overview of the evaluation plan and an update of where we are. I am just going to touch briefly on the participant and caregiver interview component of the study, the key informant interview

component of the study and then spend most of my time giving you some information that has come out of our administrative data analysis.

Most people who have been on this committee and heard me present before are familiar with the overall approach that we are planning. We are going to be conducting interviews with samples of participants and caregivers; that's starting this month in order to get a baseline before people get transitioned into the new program so we have a sense of their baseline, health status and -- yes, Fred?

>> FRED: How many people will be involved in this? Is it just random?

>> HOWARD: Good question.

So this will be a random sample of participants that will be selected randomly from different subgroups. Will you can see that on -- I think it is on the next slide.

What we -- nope, back up. Sorry.

What we will be doing is choosing a random sample of people from Phase I and Phase II area from urban communities and rural communities. Then we will sample people 21 to 589 receiving CHBS and 60 and older receiving HCBS and duals not receiving HCBS and a separate nursing home sample.

>> FRED: How many? A hundred?

>> HOWARD: About 800 in each group. It is a quite big sample. The sample size was selected we will be following the same people over a three-year period. We expect that over three years there will be attrition. People will either move away, lose eligibility, some people will pass away. We want to make sure by the end of the three-year period, in each of those groups, we still have a minimum number of people in order to draw valid conclusions from the data collection.

What we will be doing for our data collection from successes, we are working with OLTL to identify participants and draw that random sample. We will be sending letters out to individuals that we have selected to participate. That letter says something along the lines of, you have been selected for the opportunity to be a participant in this study to provide information about healthcare and services that you receive.

It will be followed up with a telephone call from a person from our staff.

>> FRED: Okay. What happens if 100 people say, No, I don't want to do this. Do we find another 100.

>> HOWARD: Sure. That's how it works. We have a team experienced in doing that kind of survey. We will be selecting enough people so that we can accommodate, you know, a fairly typical rate of refusal.

We always hope that 100% of the people that we reach out to will agree to participate.

>> FRED: It never happens.

>> HOWARD: It never happens. In this case we figure around 50% we conducted pilot testing in Allegheny County area for the past couple months. We think 50% is a pretty good estimate. We think it will be better once we start sending out the notification letter that I was just telling you about.

So just to touch on a couple other points related to this. The primary data collection will be on the telephone with people although some individuals will prefer to have an in-person interview and we are ready to accommodate that. We will have interpreter service available for people -- if English is not their primary language, we have some Spanish language interviewers. If we have other people with preferred language they like to communicate in, we will have interpreters available to do that.

The last thing --

>> FRED: Including people that are visually impaired or both visually and hearing impaired?

>> HOWARD: Let me come back to that quick. The next component of the study way toking into that, as we talk to local agencies provider advocacy groups, AAAs, et cetera, we are giving them about this component of the study, the in-person, to reinforce the importance of what we are doing. If they get questions from clients/consumers why am I getting information from research center the people we are reaching out to will have answers. We have been doing research regarding that.

>> HOWARD: One thing we discovered in pilot testing, which wasn't a surprise. We anticipated it. There are some people for whom communicating on the telephone is not preferred way of communicating either for hearing or other issues. In those situations we are prepared to do interviews in the home. This is also typical, we think, when -- we experienced this also in pilot testing. Some people we sample and identify as living in the community are, actually, living in some type of shared quarters, whether it is assistive living, personal care home,

group home of some sort. In those cases, there might be only one telephone for the entire place or if they have a roommate, they might prefer to have that interview in person, rather than have to go to a telephone. So we are prepared to go into people's homes for that.

>> FRED: Okay.

>> HOWARD: And as people on this committee should be familiar, we discussed early on incorporating nursing home residents into this participant part of the study, our plan is to recruit nursing facilities and random sample of nursing facilities and sample of residents from each of those sampled facilities. We will be doing that in the -- essentially in the downtime between the telephone interviews that I was just describing. It will be later in 2017.

>> FRED: Okay.

>> HOWARD: Let's go to the next component of intervention for update on key informant interviews.

I put on the left side of the panel is list of different stakeholder groups we have been in touch with over the past 6 to 12 months.

On the right are examples of stakeholder groups we queued up in the coming weeks and months. The overall design of this component of the study is to interview representatives of stakeholder groups during the pre-period what we call pre-implementation or planning period. Then we will be going back to -- that's primarily in the Phase I region although we talked to some providers in Phase II and Phase III and providers currently servicing multiple regions of the state.

Starting a new year we will be continuing to interview providers in the Phase I region as they are in active implementation stage and also ramping up our interviews with providers in the Phase II region as they get into active planning phase of getting ready for the roll-out in that part of the state.

Likewise, in the following year.

Let's go -- I will not read the whole list. Let's go to the next slide.

So just some very high-level observations from some of the interviews. Just bear in mind they are observations that were from interviews conducted prior to the recent provider summits that Jen Burnett mentioned earlier during her comments; that refers to the second bullet point.

We talked to AAAs and found some AAAs are mixed in their anticipation for what will happen with Community HealthChoices. The main impact should be obvious, having to do with service coordination and there is uncertainty with regards to what they can expect in terms of service coordination with managed care organizations. Some of them are enthusiastic and planning for this, anticipating this by investing in tools for improving quality and getting ready for quality management and risk sharing.

Others are expressing more trepidation and uncertainty with regard to how the contracts will be unrolling with managed care organizations. Similar to the comments that Jen made earlier.

With regard to providers, again, providers report varying levels of contact with managed care organizations. Some have heard from all three. Many have heard from only one. Many have heard from none at all. A lot of uncertainty as to when things would be starting, what they can expect in terms of rates, what they can expect in terms of payments and providers.

Some are generally aware of what is happening. A lot know only what they have read in the newspaper and are asking us what we know and can share with them; that's not our role as independent evaluator. We can only direct them back to the websites and information sheets.

The last point was providers expressed some concern about not knowing what to tell their clients because they don't have a lot of information yet.

>> FRED: Right.

>> HOWARD: Now, that was all prior to provider summits taking place last week. My understanding from the observers there was that managed care organizations had information tables at each of those events. There was an opportunity for providers that had not engaged with MCOs to start to make those connections and set up the necessary paperwork to be part of provider networks.

In general, at this stage, still a lot of uncertainty in terms of what is going on.

Next slide.

The next slides are preliminary data that we have been putting together for the component of the study that we have referred to administrative data analysis. This it is very important. We dedicated a lot of our resources at Medicaid research center into this component of the evaluation.

What we have been doing so far over the past 6 to 12 months is analyzing data from the years 2013 to 2015 and then as data becomes available, we will be updating that to include 2016 and 2017. That reflects, what we consider the baseline or historical period. The pre-CHC patterns of of care.

This is very important to have good analysis of the patterns of care in the time period before CHC goes into effect so that we can see what is changing and where is it changing?

So if we see a change starting on January 1 or July 1 of 2018, we need to be able to put it into context is it part of long-term trend going on? Is it variability that we would expect to see random noise that is always kicking around in the system or is that a true signal that is a result of this change in policy?

What I want to share with you is just general background data that we collected that we think is interesting and indicative of what is going on.

This is just a sample of the many different measures that we have been putting together.

Just as background, what we have done is, wherever possible, we have been using measures that we are taking from the scientific order policy or research literature that are proven and validated for these populations.

>> FRED: What is gray literature?

>> HOWARD: Good point.

We use the term to describe technical reports and documents that are not or have not appeared in scientific journals but are disseminated typically through the internet.

For example, a report that comes out of an organization like research triangle institute where they have done a lot of research on a particular topic and their reports are publically available but they are not through -- they are not published in a scientific journal.

>> FRED: Okay.

>> HOWARD: That's what we refer to as "gray literature".

So and then the general goal, I will just be showing you some samples of this is to select measures that identify broad measures of issues and outcomes affected by CHC.

Let's go to the next slide.

So I already mentioned this. What I will do on the next few slides is review some date that we have put together on several major top level rebalancing rebalancing, chronic conditions hospitalizations, behavioral health.

Next slide.

I have a bunch of slides and only seven minutes. I will try to move quickly but would be happy to come back for questions.

One thing to point out and this should be familiar from my earlier comments that in all of these analyses, we identified several different subpopulations of interest. In addition to the make or groupings of individuals 21-59 and 60 plus we identified people with severe mental illness it has come up through conversations in this group and also DHS staff as we shared our work with the evaluation work group.

Next slide.

Okay. So this is a slide showing nursing home population in the state, all ages. The bottom line shows the HCBS population, the waiver programs that are affected by CHC.

You can see the growth in the two populations. I'm sorry you can see the growth in the HCBS population and it's approaching the sort of long-stay in nurse willing home population but it's not quite there.

When we talk about rebalancing, the of the of then-Stated goal oven-stated goal it is philosophical that people should have the choice but practical in terms of the dollars spent and number of people served.

In states and state programs that have been working on rebalancing for a long time, you often see this curve where HCBS is on par or higher than nursing home population. This is one of the things we will be tracking.

Next.

In the next few slides are statistics on chronic conditions in the target populations. So the interesting thing here without getting hung up in the details this is the prevalence of diabetes.

You can see one interesting thing is that what we are showing here is duals versus non-dual in the different colored blue bars. I hope people can see that.

You can see that with the 60-plus HCBS you have a big difference

between the duals and the non-duals in terms of the diabetes rate.

As you would expect, the older populations have a higher rate of diabetes. Let's keep moving.

Hypertension and ischemic heart disease.

The numbers speak for themselves. These are chronic diseases often associated with aging.

Again, these are presented by way of background. They are not factors that we anticipate that CHC would modify, but these set the stage against which CHC is operating.

Let's keep moving.

So now we are going to talk a little bit about the prevalence of severe mental illness. It is very important because it gets to the question about coordination between the CHC managed care organizations and the existing behavioral health managed care plans that are still in place in the state with the expectation with CHC is improved coordination between physical health and behavioral health services.

So in conversations with OLTL, we have asked, well, okay, who should -- where should we be looking to see evidence of improved coordination? Our first cut at this was to pull a definition of people with severe mental illness and you can see at the top that that is defined as people with schizophrenia, bipolar disorder or major depressive disorders. This is defined based on diagnoses in the previous 12-month period coming out of scientific literature and CMS indicators for these populations.

What you can see is, for each of the different populations, you could see that the prevalence of severe mental illness varies; that it's fairly high in the dual eligible, which is kind of what you would expect in that population. It's also high in the 21 to 59 population. And then the next thing that we looked at was the receipt of case management services. So now just to be clear, this is case management service that is provided under behavioral health. It is different from service coordination. It is different from care coordination that might be done by a physical health plan. It is a specific service.

Again, also this groups together several accreditations of intensity of case management services for the purposes of just identifying the prevalence of receiving any case management service.

This should be taken cautionly because having a diagnosis of a severe mental illness does not mean you should be having some level of

case management, but we would think that case management services would be targeted to people with these severe conditions.

Now, one of the things that has come up as we shared the data internally with OLTL is the recommendation we also identify people with substance abuse disorders. This is one of the places that we will be going with this particular analysis to identify that as another important subgroup for whom coordination between physical and behavioral health is important. We will be looking for evidence of improvement along that boundary. And also recognizing people with severe mental illness also have concurrent substance abuse problems.

Let's keep moving.

So the big ticket items for physical health services is acute hospitalizations. On this chart we show the rates of acute care hospitalizations at Jena cute hospitals.

You can just see how the rates vary across the different subpopulations.

The next slide gets into a definition that comes from the policy research literature and the grey literature -- thank you, Fred -- identifying potentially avoidable hospitalizations.

These are hospitalizations where good, ambulatory care should reduce the risk of an acute hospitalization.

We have identified these conditions and this is one of the things that we will be tracking to see evidence of improved quality of care and improved care coordination as CHC rolls out.

Turn to the next slide.

You can see that there is some variability in terms of hospitalizations. The bottom chart shows hospitalizations that are potentially avoidable.

You can see that the older adults, both in the home and community-based and nursing home, as many as 40% are potentially avoidable.

You can think about this as showing, what is the room for improvement in terms of hospitalizations in the populations that will be served by the CHC managed care organizations?

>> FRED: [inaudible]

>> HOWARD: Yes.

Keep going.

Same approach with regard to ED visits. Not all ED visits are inappropriate but it is often looked to as an indicator for opportunities for improvements in the system. Again, if people are receiving primary care or have improved access to primary care, then they won't need -- then they can avoid some ED visits.

Again, just to be clear, these are ED visits that don't lead to a hospitalization. We know that many people who are -- typically when people are admitted to the hospital they come through the ED. So when you look at this indicator, it is ED visits that some fraction of which probably could have been handled in a primary care setting or prevented with better primary care.

Next?

Let's keep going. I already shared that.

Now, turning to HCBS services and then I will be wrapping up. Two minutes.

One of the things we did was look at the claims for HCBS services. This just shows the standard list of services covered under current waiver programs and percentage of consumers using the services. I think this is just the 60-plus waiver.

Yeah.

One of the things to note -- this will come up over the years as we share data with you guys. One of the things we do as we look at the waiver of consumers we will typically restrict our analysis to consume everies that have one or more -- in other words, people are eligible for a waiver but don't use waiver services in six-month or even a twelve-month period.

We don't consider those people to be active users even if they are in the eligibility in the denominator.

For analytic purposes, we will typically drop those people. Let's move to the next slide.

One of the things we did was focused in on person will attendant services. I didn't say it but it's at the top of the list after service coordination. It's the most common service. It is what we think of when we think of HCBS services.

What we did was calculated the hours per person, per day.

Now, this will combine both 2159 and 60-plus and it's an average.

What we are showing here -- I'm sorry. This has 2159 in a separate line than the 60-plus. My mistake.

What you can see is a trend over 2013, 2014, 2015 period where the average hours per day seems to trend upward.

Let's go to the next slide.

The next thing we did was looked at this just for 2015 where we broke it out breathe by the face, the CHC for different age groups you can see there is regional variation.

And then also the regional variation seems to be pronounced with the older adults.

Next slide.

I will wrap up.

So what I have shared with you is some analysis of administrative date that we have been conducting in preparation for the, you know, the data we will have over the next several years.

We will be updating these reports they go first to OLTL as they are cleared we can share them for publically.

As I said at the beginning, we will be starting the baseline or pre-rollout interviews with individuals in the Phase I region and Phase III will be the comparison group.

We are also continuing with key informant interviews.

Last slide. Do I have a minute for questions?

>> PAM: Sure. Committee, any questions for Howard?

[NO RESPONSE]

I actually have a question.

Some of the data that you showed us, of course, the question, Why?

It's not your job to determine why we are seeing a rise in the number of hours of home care that people are getting or to try to analyze or gather more data around that to try to understand. It's sheerly to share the data?

>> HOWARD: That's a really good question!

One of the things that we are doing is to understand what is going on currently and in the period before CHC starts so that if we see, let's say, rises in the number of hours in a person per day, the question is, Well, is that really due to changes that the MCOs are making or was that a trend that was already existing?

A large part of what we are doing here is looking at what are the trends in the data so that we don't make a -- we don't erroneously attribute any changes to -- any apparent changes to the effect of the policy. Does that make sense?

>> PAM: Okay.

>> HOWARD: Now, one of the things we will be doing is looking into those data marks more carefully.

We want to restrict that to people who are continuously in controlled, for example, as opposed to people new on the program or who die during a particular year, because you would expect that newer people might have lower letters of acuity. People that die during a given year might have a higher level of need. We need to control for some of those things which might explain it.

That one is interesting. That trend does seem to be there in the data.

>> PAM: Okay.

So if there are no furnishing questions, than thank you very much.

>> PAT: Pam, Brenda has a question.

>> PAM: Do I have that?

>> PAT: No, she said she has a question.

>> PAM: Brenda, your question?

>> BRENDA DARE: Can you hear me?

I was concerned about the emergency room data. It is actually more of a comment than question. I just wanted to note that a lot of times that happens because doctors in a given person's network may only have six visits available that day and sometimes we are told to go to the emergency room. I know urgent cares are not physical accessible. If I try to go there as an alternative to emergency room visit, I am also told, we can't treat you. You need to go to the emergency room.

I think that is just a point worth noting because there is an opportunity for improvement there, but it's not just in utilization. It is in improving access to facilities.

>> HOWARD: Thank you very much, Brenda; that's exactly why we are tracking that.

From these data, we can track the rate at which people are going to the emergency department, the underlying mechanism, the reason why, that's something we will be getting at by interviewing consumers and interviewing primary care doctors and also interviewing the plans to find out, Well, did they make changes?

>> BRENDA DARE: I also recommend you definitely include same-day urgent care centers in that pool and not just primary care doctors.

>> HOWARD: That's point. Thank you. That's a good point thank you.

>> PAM: Any other questions?

[NO RESPONSE]

Thank you very much, Howard.

>> HOWARD: Thank you.

>> PAM: So Edward Budler is going to talk to us about benefits counseling.

>> EDWARD BUTLER: Good morning.

I'm here to speak to you about benefits counseling and give you an overview.

So the most recent things that have happened in benefits counseling: On October the 27 am the Office of Long-Term Living issued a memorandum to inform all service coordinators and providers that the present work incentive planning and assistance WIPA SSA-certified organizations had the capability and capacity to begin to do benefits counseling.

We had provided this information in our original employment and employment-related services bulletin as a non-waiver funded service; however, it also is a waiver-funded service under our new service definitions.

That being said, there presently are three certified WIPAs in Pennsylvania. They would be AHEAD, keystone, goodwill and disability

rights of Pennsylvania.

They are the three certified by SSA and have a contract through Virginia Commonwealth with the Social Security Administration. All 67 counties in Pennsylvania are covered by these three SSA-certified WIPAs.

Benefits counseling exists in all 67 counties for benefits counseling under SSA; that being said, the other development is, presently the Office of Long-Term Living in collaboration with the office of developmental programs is drafting an agreement with Virginia Commonwealth University to get the SSA certification for benefits counseling training to Pennsylvania, to begin training additional benefits counselors.

Now, within those SSA certified benefits counselors in Pennsylvania, you have two groups of individuals or certified workforce incentive counselors. Those that are under the SSA contract for AHEAD and keystone Goodwill there are other SSA-certified not under the contract, they are free to provide those services under the present waiver services.

Now, that being said, with benefits counseling, and the SSA certified providers, those SSA certified providers are providing beneficiaries under the new WIPA service model.

So, for example, those WIPAs will receive referrals from the help line, the ticket to work help line.

They have specific criteria for how they will handle it and a very detailed time frame on how they are going to be responsive to those individuals seeking benefits counseling through the ticket to work help line.

For the sake of time, I will not get into great detail with those.

In addition to the ticket to work help line, SSA has prioritized beneficiaries under this new service model. In particular, veterans transition-aged youth and other under-served populations are considered a high priority for this WIPA outreach and services.

In the priority group number 1, it's individuals who are currently working or engaged in self-employment and have both a need and interest in receiving individualized work incentive planning and assistance.

Then it goes on to talk about those beneficiaries. One thing that I would invite you to do is go to ticket to work website to become familiar with that free program.

I would look at the trial work experience period, because that plays into the benefits counseling. I would also invite you to look the the guide lines for substantial gainful activity regarding employment.

That being said, the second priority are beneficiaries who are actively pursuing employment or self-employment who are interested in receiving work-related benefits counseling; that group would include beneficiaries with the clear employment goal who are conducted an active or regular job search or beneficiaries with clear employment goals who have taken active steps to achieve that goal.

Then within this priority group, beneficiaries with the most urgent needs would include beneficiaries with one or more job offers pending requiring WIPA services to make employment decision, beneficiaries who are actively using work incentive to support work preparation efforts and require assistance in managing or resolving issues.

Beneficiaries with employment or self-employment goal requiring purchase of items or services that would be appropriate for the candidate for work incentive development; then, finally, beneficiaries who are engaged in education or training programs that will be completed within a year.

Within each of these two priority groups, they also list those individuals who are considered less of a priority within the first two priority groups that I have mentioned.

That being said for employment-related services in Pennsylvania, right now we have 32 providers, 18 providers that have met the credentialing and 14 that are on corrective action. Those that are on corrective action are there until they can get the certification so that we can ensure a seamless transition for our participants from the two old employment service definitions to the five new employment-related service definitions.

To that end, OLTL has been actively out and recruiting more providers to provide those employment and employment-related services. We have also been establishing sites for the CESP exam to get the credentialing so that the providers on corrective action can move to become full-fledged providers and we can continue to build capacity to provide these services to waiver participants.

That's the crux of benefits counseling.

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

>> DREW NAGELE: I do.

Ed, I appreciate that OLTL feels the three entities will cover this.

We submitted comments in the past that sometimes the process of providing benefits counseling is an iterative process. It's not a once-and-done kind of thing. It needs to be done through the course of job development, job placement and job coaching so that as a job is obtained, the individual can work through the impact of getting the job and the salary on their benefit situation.

It's not always the kind of thing that can be done by telephone, either. Several providers have attempted to get their own people certified under the VCU program to be benefits certified and have been blocked out of the program because they have been told that the priority goes to the WIPA sites.

Will your agreement that you are entering into with ECU allow for other providers in Pennsylvania to become benefits certified.

>> ED BUTLER: Our benefits presently is with legal now. the premises on which it is built is to bring the availability of benefits counseling to widen the scope of benefits counselors overall in Pennsylvania.

It would be SSA certified. We are holding to that guideline because we believe individuals who are receiving benefits have worked hard. When they are getting information regarding benefits counseling, we want it to be in line with what Social Security Administration is prescribing.

Our benefits counselors will have the SSA certification, but will not be as appropriative as those benefits counselors that are presently with the existing WIPAs now and will have more flexibility now in delivery of service as our waivers define between fits counseling.

And when I mentioned about all 67 counties being covered by benefits counselors, it is not to say we feel we have many enough benefits counselors. We are still striving to identify additional certified benefits counselors. We are happy to find that AHEAD and other SSA certified not restricted under the priorities imposed by Social Security and VCU for the existing WIPAs.

All of those things you mentioned entailing the involvement of benefits counseling, yes, it is very involved and it encompasses many aspects of employment and employment-related services.

>> DREW NAGELE: My question is still, How can this be opened up to other entities that are interested in providing that service?

>> ED BUTLER: Our agreement will be the first step. Prior to this agreement with the office of developmental programs, we had engaged in numerous conversations with Virginia Commonwealth to try to get that training opened up or to try to get more of that training more readily available than the states in which they were offering or just being a one-time offer Pennsylvania; however, their contract with Social Security is very appropriative.

I can tell you that Virginia Commonwealth is presently working on a curriculum that will be identical to SSAs, but is going to be just offered by their University, but they want it both ways. They want to keep the SSA contract, and they also want to provide the benefits counseling from their University. We have been monitoring with them all along, but it's been a very slow process on their part. We are doing our best to open it up to try to accommodate as many individuals that would be interested in benefits counseling as we can. This is a push, the starting point at building the capacity.

>> DREW NAGELE: I am still not getting the answer to, How other entities would get their staff certified if they wished to.

>> ED BUTLER: It would be through the availability of what we are able to bring to Pennsylvania or if Virginia Commonwealth gets their curriculum approved; that will open it up or if SSA changes their requirements, sir.

>> DREW NAGELE: Can you give us some time lines on this?

>> ED BUTLER: We were not able to obtain time lines except agreement with ODP we are trying to push it through as expeditiously as possible.

>> JEN: Drew OLTL and department are equipped to see people with disabilities get employment.

We know that benefits counseling and the concern about benefits is always a concern for people with disabilities.

What we are doing is attempting to work with VCU to bring the training here. It would not necessarily have to be for people who are WIPA approved, the three entities that Ed is talking about, to broaden the amount of providers we have by providing the training.

We don't know how long it will take. It is with legal right now. Once done with legal, we have to continue to work. It has been a long and drawn out -- we have had numerous phone calls with VCU to get them to budge and help us bring the training to Pennsylvania.

If we are successful in getting the training to Pennsylvania, it will be offered beyond just the WIPA providers.

>> DREW NAGELE: Great. Thank you.

>> JEN: I hope that answers your question.

>> PAM: Fred, you have a question?

>> FRED HESS: Is this cross-disability?

>> ED BUTLER: Yes.

>> FRED HESS: Is OVR involved?

>> ED BUTLER: Yes.

>> PAM: Carrie, you have a question?

>> CARRIE: This is a Tanya question. I will try to summarize it.

I believe she is speaking on behalf of people with physical disabilities but it -- her questions do extend across the spectrum.

For people who may be able to work, their concern is not entering the workforce and will I succeed there? It's more a concern of survival. They need to know what that threshold is when they negotiate the work contract.

>> PAM: Can you speak into the microphone?

>> CARRIE: They need to know the financial threshold to know that they can survive. They need to know that they will still qualify for the income-based programs or they have to make enough income to make up for the services that they provide.

So she is wondering, is there a worksheet with these formulas on it that is currently available for both state and federal programs?

>> ED BUTLER: There is no worksheet for each of the programs; however, OLTL has been offering webinars on each of the individual programs to heighten the awareness of the service coordinators, our participants and providers regarding programs like medical assistance for workers with disabilities. The benefits counseling. Housing and the subsidized rental assistance. An individual who will be segueing toward sweat competitive integrated employment needs to look at the entire picture or entire package in their decisionmaking process.

That's why OLTL is submitted to the SSA certified benefits

counseling program. We recognize how much an individual went through to get those benefits obviously at the end of the day, we recognize the value of work in a person's life. We want to be able to make the best possible decision for themselves.

>> JEN: I would encourage people going to work but are concerned about losing benefits like housing and rental assistance, that they seriously consider opening an ABLE account. We had the ABLE -- the treasury department here to talk about it. It is a really good tool for people to be able to save money without having if affect their benefits.

I think that that is sort of a lifeline for people with disabilities. Not just people with developmental disabilities but all disabilities. It's pretty broad the way that treasury has defined it to open one of those ABLE accounts. It gives an opportunity for that very concern.

>> CARRIE: Can I have a follow-up to your question?

>> PAM: Sure.

>> CARRIE: Are there formulary sheets for individuals to figure out where the threshold is.

>> ED BUTLER: I am not sure what the protocol is the counselors use. I have participated in some of the webinars where they try to heighten the awareness for participants and service coordinators when they provide benefits counseling.

>> FRED HESS: I know one thing. I work. I am still dual-eligible and still receiving SSD. My financial threshold is I am not allowed to make anything over $1,170 per month gross. If you are blind or vision impaired you are able to make a little bit more, but that's the threshold that I know about.

>> PAM: Okay. We have a question on the phone from Ben did a, if you want to put the mic down. Brenda, you have a question?

>> BRENDA DARE: I do. I ask this question every time employment and waiver services are mentioned in the same breath it is for OLTL and for Ed.

How committed are we to keeping Act 150 open? How soon can the transition be for folks who no longer qualify for HCDS who need access to home and community-based services to maintain their employability.

>> JEN: We are committed to Act 150 we think it is an important program for people who are able to work but don't qualify for Medicaid.

Yes, you have our commitment.

>> PAM: Thank you, Jen.

>> BRENDA DARE: How soon do we think the transition is able -- for people who hit the threshold -- [inaudible] -- are we working to close that gap?

>> JEN: I am not aware of any gap. If you have specific instances, just let us know.

>> BRENDA DARE: Okay.

>> PAM: Thank you, Brenda.

Does the committee have any further questions?

[NO RESPONSE]

Thank you, very much, Ed.

>> ED BUTLER : Thank you.

>> PAM: You did it in time. Very impressive.

>> FRED HESS: With five minutes to spare!

>> PAM: We will hear from Randy Nolan and MCO providers about a provider network update.

AmeriHeath.

>> RAY PRUSHNOK: I am leading the implementation effort for UPMC.

>> SUSY KREISKOTT: I am from PA health and wellness, vice president of legislative and governmental affairs with me I am Susie Prescott contracting network development for Pennsylvania health and wellness.

>> Steve Orndorff from AmeriHeath I am director of provider network.

>> PAM: Thank you, we will turn it over to Randy.

>> RANDY: Good afternoon. We are actually after 12.

I am just going to give you an update and turn over to the MCOs. The update is pretty similar you probably heard before -- actually, Fred, do you want to do the update for me?

>> FRED HESS: No, thank you.

>> RANDY: I thought I would give you a chance.

Just a little of what we have been doing over the last month.

We were out southwest doing shows. The week before that I was in Mexico I might have missed a few things. I know it is such a hardship for me.

What we have been looking at over the last month is continuing to meet with the MCOs on a regular basis, continue to provide a lot of technical assistance trainings with them not openly with all three MCOs but with them as they run into issues we have done trainings surrounded around behavioral health skep air Yohes we continue to work with nursing home facilities. We are providing encounter data session next week with all three of the MCOs.

I feel like Kevin when I do stuff like that!

[LAUGHTER]

>> FRED HESS: Take a deep breath!

>> RANDY: The following week we will do a session regarding financial reporting requirements in the EFRM system that is used to submit financial reports. We are working up and finalizing a lot of the templates that the MCOs need to do the reporting to us on.

We are sending those out to the MCOs on a weekly basis. We will be having a webinar closer to the end of August to go over those.

We are working right now with the MCOs also to set up the on site date reviews so we can spend some time-out there with them from the readiness review perspective. We will be looking at kind of their set up, call center set up, staffing. We will be interviewing staff. We have a list we will go over with them.

The bureau of datas and claims management. We will be handling everything IT systems related and working with the MCOs to make sure that they are up to speed with that.

The MCOs continue to have -- is it weekly or biweekly calls with the bureau of data claims management?

>> RAY PRUSHNOK: Biweekly.

>> RANDY: That handles everything IT related.

We are continuing with that type of stuff.

We are also in the process now, the MCOs are uploading deliverables, policies and procedures to us. We are working with the readiness review time e team and monitoring and submitting comments back to MC Os on things we feel are corrected or admissional information is needed. We are going through that process right now.

The other big thing we are working on, obviously part of the biggest concern we have is network adequacy piece. We continue to work with DOH. They are working onsetting time lines on when they inspect stuff to be submitted to them for review. Hopefully we will get the time lines out this week to the MC Os so they know what they are looking at.

I think we are looking at submission by the first week in September, which will allow DOH time to review stuff. It will also allow three to four weeks for MCOs to continue finalizing contracts that they have in process so that we can look at their network advocacy by the end of the month.

in assisting with network adequacy we are working with internal analytics staff that are running a lot of information and data regarding services that we have provided on the LTSS side both for 2015 and 2016. We are taking a look at that. Basically we are taking a look at the number of services that we provided, the number of consumers or participants that we have in the area and then trying to come up with an idea, this is the amount of services on average that each consumer gets, how do we translate that to the number of staff that is needed?

We continue working with the MCOs, when they are doing their provider networks, that they are asking providers, LTSS providers for the number of staff and the type of staff that they have, so we know how many pass workers or home health qorkers or RNs out there we are trying to do that to match those numbers up so that we are able to allow DOH to have a good get I./parameter of the amount of staff needed out there.

We are continuing to work with that. It is a process we started as we worked with the consumer group and David Gates at Pennsylvania health law project. We haven't met in a month or so because we are running the data. Once we get everything situated, I will reconvene that committee to walk through it also.

That's kind of where we are at structural willy right now working with readiness review.

The MCOs I have requested it's been about every three weeks a full update on where they are at on their provider networks, including

numbers and actual listing who the providers are so that we can see where they are at.

The next report is due Friday of this week and I know the MCOs are working on that. I have had the conversation with them about that so we expect to see where we are at in regards to that and I will be sharing that with DOH and throughout who needs to see that information.

So that's kind of the process of where we are at right now in regards to moving forward with network adequacy. Real quick, I want to talk about the meetings last week and then we will come to Drew's question.

We had four meetings last week out in southwest. I thought they went extremely well. I worked with Judy Patrick and did the nursing facility breakout sessions in the afternoon. They were well-attended. There is a lot of questions and issues surrounding nursing facility-related services. We talked a lot about coordination of services with the service coordinators from the MCOs assisting nursing facilities and being another partner in the process with them.

A lot of discussion around rates and things like that on the nursing facility side. I think all in all over the four days, the nursing facilities were represented of the population that is out there. I think we are moving forward in regards to discussions and contracts with them. I think the sessions themselves went very well out there. The travel was a nightmare back and forth but the sessions are very good.

Drew?

>> DREW: Thanks, Randy.

Regarding network adequacy it has been reviewed that they are asking questions of providers about numbers of staff and various types of service provided.

For one service RES-HD they won't tell you capacity it is the number of beds. It is also true for that service that a person in southwest may wish to receive their service in central or southeast region or vice versa and so by only focusing on contracting with southwest providers at this point, the MCOs will not be able to establish network adequacy for that service.

I wonder if you can help them with that? Address that in some way?

>> RANDY: It's certainly a good comment that we will discuss with them when looking at the number of beds instead of the number of

individuals.

As far as the provider types or the provider services that they want that are out of the zone, that is something we will have to discuss because that will be, you know, if they are living in Allegheny County but they want their service in Dauphin County, it is certainly something we will have to take a look at and how we will work it out.

Technically, they are not in the CHC zone. They will get their services through fee for services if they are getting them out of the area. Once we go statewide, then we have to look at that and how it is handled.

>> PAM: Do we have any other questions from Randy from the committee before we turn it over to our friends from the MCOs?

Theo?

>> THEO BRADDY: This is Theo.

This is a general comment which I have been saying for a while and sense I have the ears of all of the three MCOs here.

I would just like to continue to draw their attention to this as it is getting closer to roll-out to do whatever you can to ensure that this does not become a medical type model; and that this is too important for our long-term supports and services to focus on quality of life and not become something that is overly shadowed by a medical model mentality.

>> PAM: Thank you, Theo. Well-said!

Pat, anyone on the phone that has questions for Randy?

>> PAT: We do not.

>> PAM: We will start with you today, Ray.

Before you start, if you can be -- as many specifics and not just generalities is what we are looking for at this point.

>> RAY PRUSHNOK: Sure, sure.

So from -- I think the first thing I will say is Randy and Jen mentioned earlier today the provider summits last week I think in our eyes were a great success.

I would proximate well over 1,000 participants over the course of four days. It was a great opportunity for us to have individual conversations and have an opportunity to put faces to names and, you

know, also one reassuring piece that, you know, we saw was there were very few providers who hadn't heard from us in some way. It validated the outreach that our network teams have been doing.

In terms of our network efforts, we I think are perhaps a little different than the other MCOs due to our presence with many other lines of business, be it commercial, Medicare, health choices in western Pennsylvania.

So for our fiscal health network, we have sent provider amendments to providers that we already have existing contracts with.

Typically it is opt-out process and coming in the tail end of that. I am happy to report that we have not received a single opt-out to date. We have had questions, many conversations.

Within that same vein, as it pertains to LTSS, we have all of the nursing facilities operating in the southwest zone who are Medicaid providers in our network presently. So that scenario, again, we are having conversations with nursing facilities around rates, around the contract, around expectations with billing but those are all areas where we are confident that we have a strong baseline to build from.

In terms of home and community-based providers, we have -- it's approximately 150 contracts executed with home and community-based providers in the southwest zone. For specifics and from what I understand is we are basically over 80% of the contracts that we have sent have come back executed. We feel like we are far along.

My biggest concerns, frankly, and I think for folks in the audience or on the phone, if you have not heard from us, if you have not reached out to our CHC providers at upmc.edu email box presentations on the website, it is in a lot of different places through the CHC homepage. Please reach out to us.

We have tried our best to identify providers through the state's provider files, meetings like last week -- again, there were bordering county offices because they may not be within the confines of the southwest zone where we concentrated our energy.

I spoke to folks like Drew, what needs to happen? Do we need a contract? Maybe not if the person is moving out of the zone but how to we make sure we have coverage?

If you have not heard from us, reach out to us and we will work through that.

I think some of the areas where we know additional effort is for

providers who may not participate in Medicaid presently and have a provider ID. Making sure that we are building a stronger pest irradication network, for instance. We are worried there are home mod providers that are downstream and haven't gotten into Medicaid to date. I think those are some areas where, for organizations in contact with those other providers, to help us in this effort of educating; that there is a lot more that we all can be doing.

One other thing I guess I will close with, in response, I think, to Theo's comment, at UPMC we are known, we are part of an integrated delivery system for having strong medical services, but that doesn't mean that we are, you know, building this on an independent living model. We are committed to working with the Centers for Independent Living and existing infrastructure to make sure that it is a reality. We are putting people first and making sure that we are supporting them in their goals, not necessarily the goals of their physician; that doesn't mean that we will not make strong physical health services available to every participant. If they are in need of better connections to frption, as Brenda mentioned earlier, we worked with our providers today to make sure that they have office hours available to our members. I believe -- I hope to prove in the near future we are doing better than some of the numbers that Dr. Degenholz showed. I think managed care will improve upon as we go into the system. Thanks.

>> Pam. Thank you. Fred?

>> FRED HESS: This is for all three of you.

Do you know what your "extras" will be? For instance, gym memberships, OTC medications/drugs? Anything?

What extra do you have above and beyond the contract?

>> RAY PRUSHNOK: I do have an idea but I, unfortunately, Kevin and Jen don't know what my idea is, so we are not at liberty to share that until we have final approval on that. We have a pack aiming that made it through -- it will get through our help of executive management tomorrow to send through.

>> FRED HESS: Can you get it to the members as soon as possible?

>> JEN: We will.

>> PAM: Kevin is going to answer that question.

>> Kevin: We have to answer is for the department we have a requirement that managed care organizations have to have our "extras" as you call them we call them value-added or expanded services before

talked about publicly.

There is a public document that is going to be developed. We will make sure that this committee sees it before shared publicly. That document will be used to educate participants on what the extras, as you called them, actually are; that will be made available. We will make sure that the --

>> FRED: One of the reasons it is important especially to us as a Center for Independent Living is to be able to inform our consumers so that they can make an informed choice that is going to make it better for them; that way they can pick the MCO that is going to be the best for them and the extras, as I call them, will be things we want to put out there.

For me, I wouldn't need a gym. Somebody that has an over-the-counter medication, absolutely that would be to my benefit.

>> KEVIN: I understand and support what you are doing completely. I want to make sure that they are thoroughly vetted. I appreciate for what you are doing. Thank you for doing it, actually.

>> FRED HESS: Okay.

>> PAM: Thank you, Carrie.

>> CARRIE: To add to that comment, I feel it necessary to bring up the fact that these policies and procedures have not been approved yet. You are asking for the MCOs to build a network of providers who have no idea what they are supposed to do and we are at a four-month point.

So they are writing policies and procedures but providers also need to write policies and procedures to implement this program.

It's a trickle-down effect.

I am asking and encouraging that we speed this process along so that the details can be given to the providers. If the providers fail and we have six months to succeed but ultimately who is affected in the end? It's our participants. It doesn't just come down to the fact that maybe they don't get to go to the mall someday. When you are talking about home and community-based services for some people it means they don't get to get out of bed that day if we fail as a provider because we were not notified in enough time to do what we had to do.

For example, with home modifications, transportation, there is a lot of rumors flying around because there is nothing in writing yet about these policies and procedures. Do these people need to have their

own PROMISe ID? I don't know. Perhaps we can get an answer to that right now. I know that we provide home mods. We certify that all of our contractors meet the requirements. There is a rumor out there that they all need to have a PROMISe ID. We have hundreds of contractors that we need to get ready in four months if that is the case.

>> JEN: It's not a rumor we put out a policy.

>> KEVIN: I am speaking from the department I will answer the question now.

They have to be providers it is not a rumor. We have been pretty transparent about that.

>> JEN: We have a policy.

>> We put out listserv communication on it.

>> CARRIE: As the program is right now, they are not the contractors with the MCO. We would be.

>> KEVIN: If they are performing the service for managed care organizations in Community HealthChoices and having contract with Community HealthChoices they have to be MA enrolled providers that includes transportation providers as well as home modification providers as well.

>> CARRIE: Last question on this. So our network of contractors that we use for home modifications each need to have an individual contract with the MCOs?

>> KEVIN: I am -- I can answer globally yes. I think we would probably want to talk through the specifics we are happy to answer your questions. I know, Carrie you are not shy to send emails. We are happy to answer them.

>> CARRIE: We want to do a good job.

>> KEVIN: We appreciate that.

>> PAM: I think it is fair to hear from the other MCOs to hear from everyone and then go to questions at this point. So Barbara, does that work for you or is there something? Yes? Okay.

AmeriHeath Caritas.

>> First off I am a stand in for Chris B. who was called for --

>> FRED HESS: I'm sorry. Can you get closer to the mic? We

cannot hear you.

>> I am stand-in for Chris, who was called for jury duty and selected for a jury. I have garnered all of the information that I can get to give you. Steve Orndorff. I am the director of the physical health side. Chris is director of MLTSS side. We work together but separately. I have some information on his side for the LTSS providers and then the physical health side.

We are still enrolling physicians. To echo the meetings last week, they were wonderful. We made a lot of contacts. Our phone lines and emails are very busy getting requests in, getting questions in and we are responding back to those.

On the physical health side/hospitals, just last week we received the Conemaugh Hospital agreement so that brings us the four hospitals associated with that that leaves one opening of Armstrong Hospital who has promised us a contract when he gets to it. We are waiting on their contract.

They are gathering physician information and credentialing information to be submitted to us.

The PCPs, specialist, ancillary providers, we continue to close the gaps, reviewing those against both the DOH and the LTSS requirements. This past week we closed six more gaps in the specialists for the physical health side. Those continue to get closed.

What we are finding with that is, as we contracted, there were some physicians who did not do an LTSS addendum so we are getting that addendum brought in; that will complete those.

For LTSS side, agreements have been mailed to everybody that we had an address for, same as UPMC was doing. We are contracting with all willing providers that call in, talk with us. We are reaching back out doing follow-up calls for the contracts that have been mailed trying to get them back in the door, answering any questions they may have and working with providers to update PROMISe. There is a situation, I guess, that we are running into. The provider completes the application and says they provide these ten services, when we go into the PROMISe system, they in fact have a PROMISe ID for two of the ten services or for two of the ten addresses that they put on the promise system.

We are working with these providers to get promise updated to include all of their specialties and services and addresses to list them in our recruitment effort.

We have the dedicated mailbox for CHC for questions or get a

contract mailed, to return a contract and once the contracts are returned, they go through our scrubbing process and get into credentialing quickly as possible.

Our turnaround time is about two days to get them into credentialing.

It fluctuates with the volume.

From the provider summits last week, my physical side of the house, while we didn't have an overabundance for attending the breakout session for physical house, we did receive a lot of positive feedback that the sessions were helpful. It certainly helped them understand what this whole thing is about, that they have heard about. We answer their questions.

We will schedule with specialists once we get through the readiness review.

With that, we will be scheduling with the LTSS folks separately looking at modes of orientation, meaning seminar platform, looking at obviously in office. Some of them that are larger organizations may want one specific presentation just for their organization. We will certainly do that as well as we will be looking at webinars for those who maybe can attend at one of the dates and times that we have, they can do it at their leisure. We will have that available to them to watch.

The only other thing I have is our full network is getting ready to be submitted for Friday. It's in the final scrub and it's improving.

>> FRED HESS: I have UPMC.edu for information page. If you said your page I miss it had.

>> I didn't. It is CHCproviders@ameriHeathcaritas.com.

That too is all over our literature, documentation and website.

>> JEN: Fred, we will send all three out to the membership again.

>> Pam. Thank you, very much.

>> Thank you.

>> PAM: That leaves us PHW.

>> Good afternoon. I am Norris Benns, the vice president of legislative government affairs. A long history of working with DHS. I worked with many of you over the years. Happy to be here today along

with my colleague, Susy Kereiskott, on behalf of Pennsylvania health and wellness.

Next slide.

I want to start by explaining why we were here. Some of you may have heard me say this. I'm sorry about the mic. Since I have a microphone, I want to say it again. -- largest provider of MLTSS services in the country. With one goal in mind improving the health of the community one person at a time.

In Pennsylvania that means that PA health and wellness is focused on ensuring that Pennsylvanians get services and providers get paid.

Here is what we will do and the idea bubbles here are in no order of significance with the exception of participant being at the center of the slide.

To achieve our goal of participants of getting services and providers getting paid, we have locally-supported services to work with providers to answer their questions. We have training we will do for claims submissions and billing. We will have quality measures in place and trainings for providers in other areas that interest providers.

We have local provider service reps to meet directly with providers in offices to answer questions. We are going to conduct ongoing training in in-person and webinars to help providers along.

You can keep it at this slide. Somehow the slides got mixed up.

The next idea bubble, again, the bubbles are in no order of significance except that participant is at the center here. We have been hard at work in Pennsylvania for the last three years building relationships and creating partnerships with key stakeholders who will help us achieve goals of making sure that participants get services and that providers get paid and that they get paid quickly and accurately.

Now, some of the highlights we have done so far, we have contracted with all major health systems and hospitals. We have contracts with key physical health providers. We have contracted all LTSS providers. Some of them we have actually contacted up to six times. If you sort of feel you are being stalked a little bit, it's Susie's fault, not mine!

>> FRED HESS: Throwing you under the bus!

>> Yes, a little bit!

I wanted to use this opportunity to encourage any participants who are here or listening that over the coming weeks if you have a chance to

talk to your providers, encourage them to take to us and sign up to ensure that you continue to get the services of your choice from the providers of your choice.

So in conclusion, I just want to reiterate that we need participants help to talk to their providers so that they can sign up with us. As I said before, I really want to be consistent here, if you have any issues or problems, they are Josh L.'s fault not mine. I say it in all sincerity because he's not here today.

[LAUGHTER]

I really want to thank you again for the opportunity to talk to you about some of the things that we are talking at PA health and wellness.

Susie, anything you want to add?

>> SUSY: PA health and wellness. We owe him the same report you will see our numbers jump significantly. Summit was helpful a lot of opportunity to people who may or may not have heard our name maybe got a call from us, was not sure what it was a about. Our phones and emails and faxes are sort of going wild these last few days to get the conference in place.

Every LTSS provider has been reached. Sometimes as Norris was saying up so six times to respond to us and get a contract back to us.

There are a section of folks still looking at the contracts questions on rates, questions on language. Those will still be coming forward in the next couple weeks. It will not be on the list with Randy on Friday but will be coming to him shortly.

Again, we encourage everybody to find us. We have contracts available for you. We passed them out at the summits. We can email them to folks.

Any willing provider, we want you all. Thank you.

>> PAM: Thank you very much.

Barbara, do you want to start with your question?

>> NORRIS: Sorry, if you can go to the next slide?

>> PAM: Are we good? One more slide.

>> SUSY: The last slide shows our information and email address for people to use and get ahold of us (information@pahealthwellness.com.

>> BRENDA DARE: I want to.

>> BARBARA POLZER: I want to continue the conversation about the concern for not only the smaller providers, family members, neighbors, whatever, who are providing transportation to adult day centers or whatever and the difficulty we will have getting them to sign up as an MA provider. The application is quite detailed and I don't know that they are going to be able to do that.

Also, who will be reaching out to big e priors like SEPTA who -- I know we have over 1,000 consumers who are currently getting that service. If SEPTA doesn't want to be an MA provider then what?

>> JEN: They will.

>> CARRIE: Or if they don't know they don't have to.

>> Whose responsibility is it to reach out to them?

>> KEVIN: The managed care organizations have the Respondent of building out their networks. We recognize, at the same time, that there will be unique providers and unique provider types that might require some special handle. Transportation has been a point of discussion in the development of this. We will work with managed care organizations to be able to address particular issues. We will also work with particular provider conditions to see what we need to figure out regarding flexibility.

We are very much aware of SEPTA as a particular circumstance. We have a little bit of time with SEPTA, a little bit, but we recognize that that might require a special conversation with SEPTA and the department and the managed care organizations to address some of their concerns.

>> BARBARA POLZER: Thank you, I appreciate that. Especially the smaller or individual ones I would hate to see the consumers stay in their homes because they don't have that service available anymore.

>> KEVIN: We agree, obviously. We know the MCOs agree as well.

>> PAM: Any other questions or comments? There is a question or comment from Brenda.

>> BRENDA DARE: Sorry. I didn't hit mute.

Early on in the PA health and wellness presentation you mentioned you have contracts with all of the major hospitals. Does that mean you intend to offer physical health access across all of the major health networks in our region?

>> SUSY: The answer is, Yes.

>> BRENDA DARE: Thank you.

>> FRED HESS: Is that all, Brenda?

>> BRENDA DARE: Yes.

>> PAM: Does the committee have any other questions? Carrie.

>> CARRIE: This is a Tanya question received by text.

Tanya would like to know if the committee members will be privy to what the service coordination safe guards will be when the CHC transition take place?

>> JEN: I don't really understand the question.

>> CARRIE: I think she is going back to the conversation that was handed over to you and you had indicated that, Yes, there are safe guards in place. I think she is wondering what they are.

>> JEN: It's in the agreement and also the proposals that MCOs came forward with that describe what those safe guards are.

I also -- ultimately we will be publishing those things. Correct?

>> JEN: We will have operations memos and documents and we also will have operations manual all of those will be in the public domain.

I also just want to mention this because of the question from Brenda. I just want to remind everybody that the adult benefit package is in Community HealthChoices. So there are some individuals who might be on one of our waivers who have the adult benefit package through fee-for-service or through a managed care organization in health choices. They will have to make that decision about a Community HealthChoices for the adult benefit package.

>> PAM: Thank you.

Okay. So we, actually, are five minutes early to open it up to public comment. We are going to start with some questions that came in through the phone. The first question is from Q. Blake Williams.

Why are state licensed personal care homes larger than eight beds prohibited in participating in waiver. It looks like, Jen, more you.

What provisions are being put in place to help SSI residents living in large state-licensed personal care homes pay for the services they

receive from the home and why are residents who chose to live in large state-licensed personal care homes being denied access to the ComCare waiver?

Would you be willing to come to stated licensed personal care homes larger than eight beds to speak to residents and here why they choose larger homes?

>> JEN: It's really a waiver question not a CHC question. That waiver change went into effect a while ago.

>> VIRGINIA: 2011.

>> JEN: 2011.

The waiver change actually does a good job of aligning us with the 2014 CMS regulation around home and community-based settings. Personal care homes do not qualify for home and as home and community-based set beings. That waiver -- the ComCare waiver change has been in effect for six years now. We made the change because we knew through their NPRN which is the notice of proposed rulemaking the work that CMS was doing leading up to the final rule that went into effect in 2014 we saw the writing on the wall back as far as 2007, 2006 when we started with the NPRNMs around a qualified setting.

>> PAM: If I understand what you said, Jen this is CMS regulation that we are following right now?

>> JEN: It is. We made the change 2011 because we knew it was moving in that direction. We were very strongly approached by CMS regional office and central office over the course of four or five years leading up to 2011 to make this change.

>> PAM: Thank you.

We have a question from Jennifer Poole. Comment: The number of hospitallation in slides is extreme. If proper, skilled home health, where education can be provided, would be ordered, the hospitalizations could be decreased. Insurance could cover the cost, hopefully decreased hospitalizations could be the goal of MCOs that would include skilled care. Worth a try!

>> JEN: It's part of why we are moving to Community HealthChoices. I don't know if any of the MCOs want to comment on that? I would agree with that.

>> NORRIS: I hate to speak for my colleagues, but I think we are all in agreement with that.

>> PAM: There was a lot of non-verbals and head shaking coming from MCOs for the record.

>> FRED HESS: I was going to say they can't hear your heads shake on the phone.

>> RAY PRUSHNOK: This is Rhode Island from UPMC our numbers are different we hope to improve there is a big opportunity for managed care to work with improvement and health outcomes.

>> PAM: Speaking from health provider LIFE provider, they were shocking statistics.

Being in managed care organization, I know that we can help with that for sure.

This is from Brian Stever relating to health policy surveys how will residents be notified they will be selected? Sent to them directly in nursing home to their attention or sent to nursing home itself to attention of nursing home administrator?

>> JEN: Howard, can you respond to that one?

>> HOWARD: I'm sorry, I was having a sidebar.

>> PAM: How will we communicate with people in nursing home? Will it go to them directly or to NHA in nursing home, the surveys.

>> HOWARD: Really good question. I will address that in the way we generally do that kind of research. We usually work with the nursing home administrator. We ask them for a current census.

>> PAM: For people on the phone, can you lean into the mic more?

>> HOWARD: We work with the director of nursing or administrator. We will ask them to give us a current census, names of people and room numbers. Then we work from that list to take a random sample. Then our interviewer will, basically, knock on resident's door, ask for permission to enter, et cetera.

We ask the administrator and staff to identify only people who are in isolation due to infection or who are known to be violent or non-communicative; otherwise, we attempt interviews with everybody present.

We typically do ask them to inform residents that will be in the facility doing this, but we want to avoid a situation where nursing home administrators or staff are picking and choosing the people who would be approached for interview views because it biases the sample.

>> PAM: Thank you.

We have one more question from the phone from Aaron. Ray this is for you.

Will UPMC allow in-network access to Allegheny health network affiliated providers or just hospital and facility UPMC homes?

>> RAY PRUSHNOK: Currently for Medicare products Allegheny health facilities are not in network but West Penn is in. At this point we are not looking to expand our hospital network. We have current practices for Medicaid and Medicare.

>> PAM: Thank you.

We will open this up to the public.

>> FRED HESS: Michelle, you have a comment? They are getting you a mic.

>> MICHELLE: Okay. My name is Michelle. I come with Fred. I have been receiving services for about ten years. I have a question. One thing that really bothers me and another thing I am just curious about.

First, what I am wondering is, why aren't our aids -- they dent have to be certified in CPR anymore. It bothers me. I get attendant services because I have heart disease, COPD and average right. If something goes wrong with me and my attendants don't know how to do CPR it is a big issue. They know how to dial 9-1-1 but I have a serious heart problem it may not be enough time.

To follow that up, what I want to know is, is there any plans to ever -- for attendants to become certified home health aids again? I know there was -- we tried it out once and everybody really liked it. Then it kind of the funding got cut for it.

>> PAM: Jen, do you want to take that?

>> JEN: I will have to research it. I don't -- I have no idea. I don't -- I hear the question. I don't know any of the history of what you are talking about that they used to be certified in CPR. We will take a look at it and see what we can -- and make come back at the next meeting and have a response. I just don't know enough about the issue to respond to it.

>> FRED HESS: Anything else, Michelle?

>> MICHELLE: No.

>> PAM: Thank you, Michelle.

>> DREW NAGELE: I wanted to cycle back I think you were talking about the OBRA waiver 18-20 years olds there were only a few folks on the attendant care waiver that may qualify.

>> JEN: Independent.

>> DREW NAGELE: In terms of future people that may qualify for that or brain injury association would be interested in having details about when it would be available and how people would get those services.

Do you know that yet?

>> JEN: It's going to be available for people 18 to 20 per several conversations in this committee.

>> I do when?

>> JEN: Starting whenever we transition people into OBRA, the people in that waiver. Sometime this fall. I don't have an exact date. Virginia do you?

>> VIRGINIA: I guess I am a little confused about the question because until the OBRA waiver and the independence waiver and attendant care waiver go away, those waivers will continue to serve individuals 18 to 21. It's only when CHC is coming to the region that those individuals that are under the age of 21 will be transitioned to OBRA.

For example, if there was an individual age 19, who needed services that are offered in the independence waiver and they were eligible for independence they could continue -- or they could be enrolled in the independence waiver and then would only be transitioned to OBRA once CHC comes to that zone.

Does that help? Does it answer your question?

>> DREW NAGELE: It does.

When would independence be available, including the new services?

>> VIRGINIA: October 1st of this year.

>> DREW NAGELE: Thank you.

>> FRED HESS: Anything else, Drew?

>> DREW NAGELE: No, that's it.

>> FRED HESS: Anybody else have comments or questions?

>> I'd like to go back to the questions about what I call the ancillary providers. We talked about transportation. My particular concern is with home mods. Since my wife is actually received them through the aging waiver.

I understand now the contractors would have to have -- would have to be enrolled in MA. I am concerned, though, will there have to be a direct contract between each of the contractors -- for example, in our case, we had three different contractors in our home to do the home mods.

Each of those would have to have a separate contract with the Community HealthChoices MCO and each of those would have to be enrolled in PROMISe and each would have to bill separately? That's not how the world works in contracting. Okay?

We would never be able to figure out through different contractors to do this job. I mean, it just can't function that way.

>> KEVIN: So Kevin Hancock from Office of Long-Term Living.

To answer your question, Mr. Gate, the expectation is general contractor would be enrolled in the Medicaid program. It is true that you have individual subcontractors for a general contractor for a particular project that may be performing certain services like electrical work or whatever work that would be intended to be needed to complete the project.

There is an expectation and it's meant to be able to make sure that we have assurances that services that are prayed for for medical program and overseen by managed care organization have some connection to Medicaid provider oversight.

The general contractor would have to be enrolled in Medicaid. The MCOs would be contracting directly with the general contractor.

>> Well, then that raises the question of how do we, as participants, find the general contractors?

Quite frankly, right now, most folks work through organizations shriek CILs who have people who know the contractors who do this very specialized type of work.

We had a whole roll-in shower put in. It's not the kind of thing you just look on a website --ed.

>> FRED HESS: It needs to be done by ADA certified --

>> Someone -- how do we connect with those folks.

>> KEVIN: The managed care organizations -- this is Kevin Hancock long-term living trying to follow familiar's rule about announcing the name.

They have the responsibility for identifying the services for their participants even ensuring that those services are provided by a contracted entity regardless of what they are.

For home modifications, it would be the responsibility of the MCOs and their service coordinate ators and service coordination role to be able to provide the services and make sure that they are identified for the participants.

It's not the participants themselves, the participants themselves have help.

I thought they had help with CILs and service coordination agencies the managed coordination agencies provide umbrella services it is their requirements and based on the way they propose to execute those roles they will embrace it.

>> Just last thing I will say, that does certainly raise issues around network adequacy for those kinds of services. Now you are not looking at a CIL to say, we can provide contractors for these home mods the MCO has to show contracts with a bunch of general contractors; that adds an extra layer in terms of determining network adequacy. It's not a question but a statement that it's going to take a deeper dive to determine network adequacy when you have to look at a whole bunch of contracts with individual general contractors.

>> KEVIN: It's a consideration is for network adequacy.

>> Thanks.

>> FRED HESS: Barbara, you have a question?

>> BARBARA POLZER: Maybe they cannot answer but MCOs do you have providers for these types of services lined up? Do you have the challenge in finding them?

>> RAY PRUSHNOK: I don't have numbers on home mod contractors in front of me today. I will say that -- to David's point and you're general out look on this, I think we are hoping to partner with organizations like the CILs and other providers of home mods to help in a brokerage of these things.

That doesn't take away our requirement that each of the downstream

-- is a Medicaid provider.

That is where working with liberty resources and other organizations that are closer to these general contractors is critical to us. You flagging these organizations, connecting them with us and helping us make sure that we are supporting they will and getting Medicaid identification applications through.

>> BARBARA POLZER: Thank you.

>> SUSY: We are following the same process we were approached at the summits by several contractors or those vendors of those types of service so we have a direct relationship in addition.

>> DENISE CURRY: Denise Curry from Pennsylvania health coordination this is in general from all services. Is there a required crosswalk that is currently knowledgeable about what providers are available to the participants, no matter where they are living currently so that we know that network adequacy is being achieved?

No matter if you are at home, if you are in a small personal care, if you are in a nursing facility that what is currently provided is part of what the MCOs are working towards?

>> KEVIN: Just to make sure I am understanding your question, you are wanting to know how the individual MCOs are documenting their secured networks and how is that going to be presented to CHC participants so they know who they can access and whether or not it is an adequate choice for participants.

>> DENISE CURRY: It is at current stat he is and beyond.

>> KEVIN: I can't speak to the last question but I can speak to the rest. Think the enrollment process for Community HealthChoices, the pre-enrollment process for the transition and ongoing enrollments, that information on existing provider networks will be part of what the independent enrollment broker will be communicating to program participants and program participants can use that information to be able to identify which of the managed care organizations has a network that best represents their needs and their requirements ?rks that will be -- it's definitely going to be made available in a very Broadway to participants and applicants as they go through the enrollment process.

>> DENISE CURRY: A follow-up: Is there a minimum expectation for the different --

>> KEVIN: Yes. Randy, I wasn't sure if you would want to speak to that a little more generally.

Working with stakeholders including Mr. Gates for LTSS providers as well as physical health providers there have been standards determined for what network adequacy actually means.

The most significant part of readiness review, especially when determining provider network adequacy is that the Department of Health and also the Department of Human Services, Office of Long-Term Living will be working together to certify that the three MCOs are ready, day 1, by zone and phase to be able to provide adequate provider choices for their participants.

>> BLAIR BOROCH: -- by the Commonwealth do waiver participants with the network submits by the MCOs to see if there is a significant volume of providers delivering services to participants towed that have not enrolled with the MCOs with additional analysis that would address the specific question that was asked.

>> KEVIN: Speaking generally, that would be something we -- as part of the assessment we would look at the as-is provider and measure it against the level of network advocacy available with managed care organizations.

Randy?

>> RANDY: As a quick wrap-up for the whole thing there are standards that you will see across the board in any MCO. The problem is standards on LTSS side there is nothing nationally. We looked at CMS. I think we are creating more of a parameter standard than any other program or state has by looking at the services we provide over the last couple years and the number of participants and trying to come up with the number of needed providers based on that.

Most other states are saying, you need to have choice. You need to list two providers we know on the LTSS side it's not a good enough standard.

I think we are looking at that.

One thing health will look at and we will look at with he will hath, when the networks are submitted we will certainly look at and health with will have a list of our provider files. There will be cross-checking and we will try to deal with that at that point also identify anybody who hasn't submitted and maybe why.

>> KEVIN: I think Fred is trying to cut you off Randy.

>> FRED HESS: We are over!

Okay. Our next meeting is September 6th, right here, same bat time and same bat channel.

Meeting is adjourned.

(Meeting concluded at 1:06 p.m.)

The following printout was generated by realtime captioning, an accommodation for the deaf and hard of hearing. This unedited printout is not certified and cannot be used in any legal proceedings as an official transcript.