DATE: December 5, 2017

EVENT: Managed Long-Term Services and Supports Meeting

Bob

>> DEPUTY SECRETARY BURNETT: Good morning, good more than everyone, I want you to know there's a room full of about 40 people here, that can hear how sick you are.

[laughter]

So -- maybe you could put -- good morning you'll be facilitating from afar since you're staying at home today, is that correct?

>> FRED HESS: Yes, I am.

>> DEPUTY SECRETARY BURNETT: You're here with Bob Thiel, Pam was not available either we'll get started on the meeting.

>> DEPUTY SECRETARY BURNETT: I'm going let Bob -- can you put yourself on mute when you're coughing.

That will be helpful I'll turn it over to Bob Thiel.

>> BOB THIEL: Good morning, we'll call the meeting to order.

We'll just run through attendance of committee members, please let us know if you're here by phone or in person we have some people here but we're going to run through the whole list any way.

Arsen Ustavev, Barbara Polzer, Blair Boroch.

>> **MALE SPEAKER:** Here.

>> **BOB THIEL:** Brenda Dare.

Denise Curry.

>> **FEMALE SPEAKER:**

>> **BOB THIEL:** Drew is represented by Ann Marie, McLaughlin.

Jack cane, James Fetzner, Jesse wilderlan.

>> DEPUTY SECRETARY BURNETT: Jesse on the phone?

No Jesse.

>> **BOB THIEL:** Juanita gray, Linda Litton.

>> **FEMALE SPEAKER:** Here.

>> **BOB THIEL:** Luba Somits, Pam is via here.

Ralph Trainer.

Ralph are you on the phone?

Ray Prushnok.

Richard Kovalesky? Steven Touzell.

>> **MALE SPEAKER:** Here.

>> **BOB THIEL:** Tanya Teglo, are you on the phone?

>> **FRED HESS:** She is on the phone.

They'll okay.

Thank you Terry Brennan, Theo Braddy.

>> **THEO:** Here.

>> DEPUTY SECRETARY BURNETT: Terry you're on the phone? Okay.

>> MALE SPEAKER: Yeah.

>> BOB THIEL: Theo is here, Veronica comfort.

>> FEMALE SPEAKER: Here.

>> BOB THIEL: William White.

Zachary Lewis.

That saw we'll now go through the Hughes keeping committee rules Marilyn gave me a list of rule ins you don't like the rules blame Marilyn.

[laughter]

Committee rules, everybody, of course, we're here to professional setting please use, professional language and respect everyone else's comments.

>> FEMALE SPEAKER: It's Tany Teglo, I'm here I had to join by another phone number because the free one wasn't working I had to join by cell but I'm here.

>> DEPUTY SECRETARY BURNETT: Great thank you.

>> BOB THIEL: Thank you.

Point of order, direct all comments to the chairman, wait until you're called on please keep your comment toss two minutes we'll try to keep this on tight as schedule as possible.

Meeting minutes, transcripts an meeting documents are posted on the Listserv at Listserv.dpw.state.pa.us, under MLTSS meeting minutes the

documents are posted within a few days of the meeting.

There's a captionist here is documenting the discussion so please, speak clearly and slowly.

Please turn off your cell phones.

When the meeting is over please clean up through throw away your trash, and wears public comments willing held at the end of the meeting the 2018 sub-MAAC meeting dates are available on the Department of Human Services web site we'll now review the emergency evacuation priors.

One note I was asked to, we have to make sure we keep the doors in the back with the fire exits, they're lanes they have to stay clear, if anyone is in those lanes please move out of those lanes.

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

If you require assistance to evacuate you must go to the safe area, located right outside of the main doors, of the honors Suite, OLTL staff will be in the safe area stay with you until you're told you may go back into the room or you're evacuated everyone must exit the building take all your be loanings with you do not separate cell phones do not try to use the elevators they will be lock down, we'll use stairwell is and 2, to exit the building for number one, exit the doors the left side near elevator.

Turn right, go down hallway by Walter town taken, one is on the left, for stairwell, exit honors suite on the right side of the remoter back doors.

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

For those exiting from the back door, exits turn left, then left again, stairwell two is ahead directly keep to the inside of the stairwell merge to outside turn left and walk down Dewbeerry Alley, to chestnut, turn left to Fourth Street and turn left to Blackberry and I hope everybody remembers those rules if something happens we'll be quizzed I'm sure we'll get onto the meeting minutes.

Cen is here with the OLTL updates.

[laughter]

>> DEPUTY SECRETARY BURNETT: Thanks Bob, welcome to our last MLTSS sub-MAAC before the launch of community HealthChoices.

Thank you for your support and input and rich ideas and, expertise all of which have contributed to the innovative and initiative called community HealthChoices we're at the Presipus of the launch 26 days away.

Which seems like some time but it really isn't, we only had 26 days, before we launch.

But I'm confident that the launch will be a success because of the years of the design and development work that we have done together.

And I really, really can't under score that enough I really

appreciate.

I'm also confident in the amazing team at OLTL and the Department of Human Services, who have worked so hard not only to learn this new work um, but to embrace it make their own to commit to an effective launch and successful future for community HealthChoices my team has been doing amazing thing with no new resources to effectively launch this program. And I'm very proud of them.

Many of you heard I'll no longer be with the department as of December 15th.

The secretary has decided to appoint Kevin Hancock to be the new deputy for OLTL and, I am sure that he will be a great leader for community HealthChoices going forward.

You all know him in his critical role as project manager for community HealthChoices so it will not be a difficult transition for either this committee or for my staff, the staff at OLTL and DHS.

I have spent the last 2 and a half years, working with Kevin and I am confident that the community HealthChoices will not only be a success,

I've given a lot of time myself to it, the past 2 years and close to ten months, to making community HealthChoices, a success I know it's going to be a success going forward.

So, after the last two and a half years of working with Kevin on community HealthChoices I'm sure that it will be a -- not only be a success but an important new delivery model for long-term care in the

Commonwealth and a new -- an important new model of stakeholder engagement across the nation.

In other states, I have -- who I visited and worked with, we have undertaken our stakeholder engagement in a very effective way that made it a much requirer program we brought in initiative questions did not hear about.

That we did not know about here, sitting in front from our purchase of the State, because of not the committee's work and advocates and stakeholders that have come through our doors to talk to us about what we're doing doing right and wrong.

Kevin is here with me, will be helping me with the presentation, you should join me at the front of the table because that is say transition meeting I want to move onto the updates Pat if you would, turn to our CH C presentation.

That's great.

Okay.

Michael if you could put on the presentation.

I'm going to go through a slide deck to bring everybody up to speed where we are community HealthChoices we will open it up for questions at the end of the meeting and, really, get your input through that.

Today's very important meeting too I think we have an opportunity I know we have an opportunity to talk with the 3 managed care organization that's are involved in community HealthChoices and this is -- you're

going hear some amazing things from them as they talk about service coordination, and their anticipation of, person centered service planning how they plan to implement that.

When you listen to them, I think you will reflect on that much of it is because of your own input into the way they plan to implement community HealthChoices we have an enrollment update I'll start with that, we have been undertaking our enrollment which means people are choosing either managed care plan and have chosen a managed care plan or, are or have been auto enrolled.

This PowerPoint will be available in our web site in a the next couple of days don't feel like you have to madly take notes it will be available to you electronically through our web site.

The first is APS that's advanced plan selection those are people who head had called in or went on the internet or actually, mailed in many mail ins for enrolling to community HealthChoices and as of the end last month, we have 43,294 people enrolled, people who have actually enrolled in making, made a choice you can see the break down of phone and mail enrollments are about equal.

The web enrollment is very low because the web is new and it evenly, opened up about 2 weeks ago.

Many have been had to go manually processed and then we also had DSNIP auto enrollments, or -- advanced plan selections for the dual special needs plans.

Auto assignment happened through transition weekend which was November 18th and 19th weekend before Thanksgiving.

We did hold a go no go call on Sunday and it was a go.

Because the transition had gone so well.

At this pint, 3 MCOs have their files they know who is enrolled and they are beginning to organize and are really clear up any data anomalies they may see and work with the department to see that they have everything squared way to know who is enrolled with them.

Our post enrollment activities started on November 27th last week.

When the IEB began sending out post enrollment packets.

And those post enrollment packets included the things that are listed up there.

If people made a plan selection themselves they got a confirmation.

If people were auto assigned they got information on who they were auto assigned to I do want to make a point the participants have until December 29th to make changes for the plan to be effective January 1st and after that, after that people can make plan selections any time during the month.

If they make their plan selection in the first half of the month it will be effective the first day of the next month.

These are Pennsylvania's normal date, called our dating rules.

We use them it's our client information system that assigns them.

But so people can make changes between the first and 15th that will

be effective on the first date of the following month.

If the changes are made, after the 16th, then, they will be

effective the first day of the following month.

So, that's how enrollment is going.

Communications, I want to start out by telling you that the Governor

will be in Pittsburgh on December 7th to kick off community

HealthChoices.

He will be at the Steven Foster center at 286 Main Street in

downtown Pittsburgh.

At 12:30, if any of you are in the vicinity or want to travel to

Pittsburgh please go and, listen to the Governor and secretary Miller second Osborne to talk about our plans

for community HealthChoices.

Next on communications I'm highlighting these so you know these

things are available on our web site.

Our web site is rich with information.

We have trainings for first of all overview training that takes

about 20 minutes to take.

If you have not looked at that overview and you're still confused

about what community HealthChoices is, please go on the web site and

watch that overview it's a very easy to follow and it really explains

the nuts and bolts what is happening with community health choice ins

you're a provider or, an advocate in the room and you want to get this

information out please send out, information on our web site where

information can be found, so people can be aware what is happening.

We also have a provider training on our web site that kind of lists all of the different component of that training.

We also have training for service coordinators and that training is teaches you service coordinators how to interact with the public about the health choice and service coordinator training just for service coordinators and their role as service coordinator ins community HealthChoices.

We also have training for nursing facility staff.

That is on our web site:those other trainings are before an hour long.

And they do come with the test at the end of it, so you can really test your knowledge and go back and review thing if you didn't, quite absorb the concept that is are laid forth. And those, trainings are also on our web site.

QAs, we have spent --

>> **FRED HESS:** This is Fred Hess -- someone send me the information on where the Governor is going to be when and send me an email.

>> DEPUTY SECRETARY BURNETT: We'll send it out to the whole community.

We'll send it out to the whole community.

>> **FRED HESS:** Thank you.

>> DEPUTY SECRETARY BURNETT: Confusing with the mic, QAs for providers this is a really important thing because we have gotten so many questions with all of the work that we've done.

Out in the community, spending a lot time almost 40 meetings in the southwest part of the State with participants, people who got that enrollment packet, they were also given a schedule of dates when they could go to a participant meeting, community meeting, to learn and to ask questions about community HealthChoices through that process we got lots of questions ourselves we could not answer.

So those were brought back to us and we wrote them down, we began to develop some FAQs we also have lots of questions during this committee meeting, we have lots of questions during the consumer sub-MAAC the general medical assistance advisory committee, the longterm services and supports MAAC the medical -- managed care MAAC and even sometimes the IMAAC the income maintenance MAACs a lot of MAACs we go to, we get lots and lots of questions what we decided to do memorialize some of those questions so we can point people back to, where the questions are answered.

These are out on our provider web page for on the community HealthChoices web site.

That's a listing of just some of the provider questions that we've answered, I will say each of those comes with anywhere with 15-40 questions.

Each of these items these are the buckets of questions come with a lot of questions an answers that go with them.

Another group of, provider questions, that we worked on, I also want to say for any one who is involved with the area agency on engage with the umbesmen around the State we did webinars we are getting ready to host a QA we have finished it, and submitted to the Department of Aging for their review.

And those will go on our web site very soon and participant questions, lots and lots of participant questions those also will be posted.

Readiness review, you're going to hear from the MCOs I'll not go into detail I wanted to just talk a little bit, because I've heard feedback, even very recently that the MCOs are not communicating with providers in the southwestern part of the State.

Or, providers don't know about MCO training.

So this is just a listing of all of the trainings conducted by our various managed care organizations for the managed care organizations I just listed the dates and where they, where they provided them and AmeriHealth Caritas, Pennsylvania Health & Wellness and UPMC, all 3 busy working with providers to make sure that they understand everything from how service coordination is going to work to how to bill, to practice billing all of those kinds of things are happening with providers.

Going to our launch update, Kevin do you want to take these slides.

>> **KEVIN HANCOCK:** Sure.

Good morning everyone.

Just go through these very quickly.

We continue with readiness review activities for community HealthChoices and the MCOs will talk about some of those activities which includes, finalization of the provider networks and also finalization of -- their infrastructure so support the roll out for the southwest for community HealthChoices that being said we are now transitioning into launch for the southwest for community HealthChoices as well. And what that involves is MCOs taking on activity that is associated with managing participant needs and services as well as department responsibility of overseeing those services are being met.

Throughout the launch the two focuses we have continued to articulate are ensuring there's no interruption of participant services as we transition to managed care on January 1st and also, related no interruption in provider payment we want to make sure that the system stays stable throughout the transition and the way we're do that is what is described we'll be having daily meetings with the MCOs and the daily meetings we'll talk about, issue that's are being identified through the discussion.

We'll also have launch meetings with DHS and other oversight stakeholders including the Department of Health if necessary.

Department of Aging of course will be involved in our launch meetings.

To make sure that we're addressing issues that have been identified as quickly as possible, and working with the MCO toss take corrective action.

We'll be having weekly meetings with stakeholders those include members of arrived Kas I community, members of our legal services community.

Et cetera to make sure that, any issues that they're hearing, are brought to our attention and we, develop develop a corrective action plan that addresses them right away.

Last we'll be speaking with the providers to make sure any issues coming through the provider associations, including their nursing facilities and including some of our other providers associations related to home and community based services those, those forums will provide an opportunity for the provider associations to talk about issues as well.

So the point of all this is, is daily or frequent communication to make sure issues are being developed.

We have already covered how we're approaching the launch.

Going through prelaunch, launch and steady states.

We have a number of key variables we'll be using to measure the effectiveness of the launch.

To identify, any trends for particular issues I think you've seen

this slide before.

So we'll move onto what are the launch indicators, we have also talked about there, as well before, for -- in prior meetings.

We will focus on these key data points, through out to identify trends and build opportunities there may be some systemic issues with the community HealthChoices that may require a broader change our focus is to identify issues that effect participants services and identifying any risk of participant service interruption. And also, risk for provider payment.

And a lot of that will be -- we will hear, we will take any type of information we hear whether it's anecdotal or otherwise we use that as a way to identify and build out corrective action.

Hey Barb?

>> **FEMALE SPEAKER:** Hey Kevin.

In addressing the services to the participants I know we've got a launch indicator that looks at ensuring there's no interruption of services, what are we going to do to ensure or to monitor reduction in services?

Knowing that is the most feared aspect of CHC for consumer ins.

>> **KEVIN HANCOCK:** Thank you for the question.

To make a formal statement on this issue we know that this is a fear.

And throughout the continuity of care period for people receiving

home and community based services I'll just focus on home and community based services, their service plan the requirement during the continuity of care period is the service plan has to stay intact.

So the level of services that were approved, and were in place on January 1st, 2018 for the southwest for example, those services will have to stay intact unless the participant and the service coordinator with the CHC MCO have a discussion that those services would either need to be reallocated there will able discussion with the participant.

But the requirement is to make sure those services will remain intact.

After the continuity of care period, that's when the department will have responsibility to continuously pay attention to the way that the managed care organizations are managing the service plans for participants in home and community based services if we see a trend in reduction of services, we will go to the managed care organizations and have them justify not only the trend but in many cases individual cases that may reflect what, may indeed reflect what the participant, what should be part of a person centered planning process, but may reflect otherwise and it's the department's responsibility to make sure that, participants are receiving the services they need, and working with the managed care organizations to make sure that, they're following the requirements they have, for the person centered planning process to make sure that, the participants their caregivers and person centered planning

team are building out a service plan that reflects what the participant requires to be able too remain in the community, does that answer your does that answer your question.

>> DEPUTY SECRETARY BURNETT: Let me restraight that, we don't need a launch indicator it's required they continue with the same service plan, no reductions during the couldn't knewtive care period we didn't develop a lunch indicator based on service reductions.

We will be watching it though, to make sure that they live up what they're required to do and, agreement they have with us, grant agreement they have with us.

However, in the future, once we're past the launch and we're getting into steady state, these looking at service reductions is going to be something that we monitor very closely.

That we work with the MCOs to oversee and address and there will be reductions I'm sure I've heard participants say I don't need, as many hours as I have, this person sits and watches TV all day long, that case they may, be -- maybe, it's justified.

The managed care organizations, cannot, reduce service those a point where, people start to disenroll, they have an incentive to keep people happy with the services they're getting.

They also, have a an interest in keeping people living in their own home not having to go into a more expensive institutional setting either nursing facility or even a hospital and acute setting.

So -- service personal assistant services is a critical service and they know this. And it's very well outlined in the requirements of the contract with them.

So I hope that, helps to facilitate a more of an answer.

Together.

Kevin and I together.

>> **BOB THIEL:** Brenda on the phone has a question as well.

>> **FEMALE SPEAKER:** Actually now I have two questions.

[laughter]

This is about the, weekly meetings with stakeholders you mentioned.

During launch phase -- where will those meetings occur and how will participants have the ability to attend.

>> **KEVIN HANCOCK:** Hello Brenda -- I'm sorry, go ahead.

>> **FEMALE SPEAKER:** Require an invitation or open to any participants who have concerns.

>> **KEVIN HANCOCK:** So conference calls and, open for working through the advocacy community to build out a list of participants.

More than welcome.

One point we definitely want to have participants from a wide array of advocacy communities but we want to make sure that we have, the participants there will be a vehicle for providers to also have an opportunity to be able to engage in these stakeholder sessions.

But we want to make sure that the stakeholder, stakeholder calls and

conference calls are participant focused.

So that's, that's going to be the key but, but -- would love to have as much of a wide array of participation as possible.

>> **FEMALE SPEAKER:** Right.

Please get that information out as soon as possible we'll start publicizing it.

My second question has to do with, reductions in service and, review once the continuity of care period has ended one point this committee put forward that every reduction in service, was going to be reviewed by the State.

Is that still the case?

Or are participants going to of have request it needs to be reviewed individually?

>> **KEVIN HANCOCK:** So, there -- the department will be looking at reductions in services.

We will look for, like just to make a blanket statement about looking at every case, we will -- I'll state it this way, Brenda, we'll endeavor to look at every okay, we'll be looking at trends definitely.

>> **FEMALE SPEAKER:** Okay.

Will people have the ability to use those stakeholder calls to have you look at those cases individually.

>> **KEVIN HANCOCK:** Absolutely.

People thank you.

>> **MALE SPEAKER:** I didn't know you were going to take questions Kevin you mentioned you'll be reaching out to provider associations to get feedback from the large forward, how do you do that for service coordination in as much as far as I know there's not an association for service coordination entities and also wanted to double back too Jen's report on the enrollment, I'm not sure that we got a number on how many people were auto enrolled and, also --

>> **KEVIN HANCOCK:** We'll be up -- we have presentation that will focus on that.

>> **MALE SPEAKER:** Will that give us a break out by age, whether people were auto enrolled or self enrolled.

>> **KEVIN HANCOCK:** Broken down by age, primarily on participant selection we don't have the auto enrolled at this point we can get that.

>> **MALE SPEAKER:** Just concerned if there's any you know trend there, in terms of, you know, especially with regard to older adults whether or not they have been able to, their disproportionally represented in the auto enrolled.

>> **KEVIN HANCOCK:** We'll show the data look forward to the questions to see what else we can present in the future.

Now your first question for service coordinators reminder that we consider service coordination and administrative function of the managed care organizations whether they are, directly employed by the managed

care organizations or subcontractors they are, an administrative amount of the managed care organizations so -- during the during this process, the transition the voice that they have in this process is, through the managed care organizations themselves, because they are representing the managed care organizations in their work.

>> **MALE SPEAKER:** During the continuity --

>> **FRED HESS:** Sorry I'll wait.

>> **MALE SPEAKER:** During the continuity period in terms of the loose will you be looking for feedback for service coordination in any way.

>> **KEVIN HANCOCK:** I think that, we'll be open to suggestions.

>> DEPUTY SECRETARY BURNETT: I think we also, although there's not a service coordination entity association, we, Steve all the time, see with all the time entities have associations that have service coordination as members.

RCPA is one of them.

V4A is one of them.

Pennsylvania provider coalition is one of them.

There's a number of association that's we deal with, we're meeting with them next week, PAPC next week there's associations that we've been having ongoing dialogues those associations we'll stay in touch with. with for the -- for the roll out, so down the road, where they're not involved, with as an administrative function of the MCOs they can still stay involved.

>> **FRED HESS:** Jen, that's Fred Hess, that's twice I've heard the people, are getting auto enrolled.

I know a few people, that are going auto enroll and they have not received notices what are these notices coming out? I heard earlier you said they were already out.

But they're not.

>> **KEVIN HANCOCK:** Fred this is Kevin the post enrollment packet started they started to be mailed last week, but they will be staggering the way they're mailed because, we want to make sure that in the mailing process, that we're not mailing them all out at the same time it's a way to manage the volume.

They're going out throughout this week and, looking at, Chris and Jeanie to verify they're going out next week.

>> **AUDIENCE MEMBER:** Should be finish bid the end of this week.

>> **KEVIN HANCOCK:** Jeanie verified they should be out by the end of this week.

If you hear someone who has not received one by the middle of next week it will be great if you could reach out to me and we'll definitely follow-up to see if something went wrong with the mailing.

>> **FRED HESS:** Will do.

>> **BOB THIEL:** Could we like Kevin get through his presentation we'll do questions make sense to everybody just kind of dish know we

start a little late to stay on schedule.

>> **THEO:** I got -- get this out.

For the record.

Kevin, Jennifer, again I've been around long enough to know what I fear tends to happen.

And I fear that those reduction of hours is going to happen.

When they do who can we call?

As a participant?

>> **KEVIN HANCOCK:** So just to be clear, Theo I'm quite sure you will always reach out to us we appreciate that, very much.

We need to know about those experiences if there is some sort of a system problem or a problem with individual MCOs, that -- that is not reflecting the preferences and the needs of participants when it comes to the development of their service plan we need to know that.

That being said, on an individual basis, we do have managed care has mechanism built out that a laws for complaints, for grievances and for appeals.

And, we do that process, does have to be recognized that process does have to be followed because, it will allow the participant a voice in addressing disagreements with the managed care organizations. And that process, also allows the ability to be able to document the case on behalf of the participants so that if it goes through an appeals process they will, they will have enough information that they can reflect why

they think the decision on the part of the managed care organization was not made appropriately or to their appropriate benefit or we have a complaint grievances and appeals process, has to be followed through this -- but, if we're recognizing a systemic problem we'll look for this committee to help us and we're also looking for feedback from the stakeholder community across the board to make sure we knee if that's taken place so once again corrective action can be put in place quickly as possible we covered, launch indicator domains and cat guys et cetera, focusing on service coordination and continuity, provider participation information transfers et cetera and I think at this point, Je next do you want to take over with coordinated care.

Do we want to ask anymore launch questions before we move onto the next section?

>> DEPUTY SECRETARY BURNETT: We're running behind time I'll go through very quickly how we're hoping to promote coordinated care for Pennsylvania's dual eligibles.

So, as you know community HealthChoices is not just MLTSS but it's also, an opportunity to better coordinate care for people who have not entered, long-term services and supports they are not nursing facility clinically eligible they are not getting personal assistance, they're getting health care.

And, they are getting health care through Medicare and Medicaid.

So, they are considered to be duly eligible for Medicare and

Medicaid, 94 percent of the people are going to be affected by community HealthChoices are dual eligibles people who are duly eligible. And so I want to just share with you some of the ways that we are, envisioning and working towards good coordination between Medicare and Medicaid.

I would just step back and say we have an example of a very integrated so integrating Medicare and Medicaid, Pennsylvania has a rich history of integrated care with our LIFE program, the LIFE program has been in existence they just celebrated their 20th year that is a, actually a statutory opportunity for kind of coordination between Medicare and Medicaid we don't have that in community health choice that's authority to coordinate but we're working very hard to make sure that we are looking at every opportunity for coordination.

One of them is to really work with the dual special needs plans.

There are 10 dual special needs plans in Pennsylvania.

That is kind of unusual most states don't have that many special needs plans these are Medicare advantage plans you might hear about them as, if you are a dual or, if you know duals your parents might have known about them or your grandparents.

But these are Medicare managed care organizations and they, the duals are, the DSNPS are specific for people duly enrolled.

You'll require you'll recall in the design of community HealthChoices we did require each of the community HealthChoices managed care organizations, to have a dual special needs plan so each one of

them, has a dual special needs plan which is aligned.

In addition to those 3 special needs plans there are 7 others.

My staff has been working very hard, to coordinate with those dual special needs plans.

We have really worked with them, we first held a webinar back in August with the dual special needs plans.

We've been communicating with dual special needs plans threw a 3 way agreement that's been in existence since I think 2008, called the MIPPA, MIPPA act.

And it allows, gives us the authority to have a 3 way contract between us, the department Medicare which is CMS and the plan the dual plan.

So that 3 way agreement gives us some language around requirements

and, this past year we've really beefed up this meaning IPPA agreement to assure we have some coordination and communication and I say communication I mean real communication, between the plans.

So if you think about it, you have individuals, dual people are dual , get Medicare, prime may it please health care is through Medicare.

If there are duals in long-term services and supports their primary long-term services and supports is through Medicaid.

The two don't speak to each other that is something we're going to, we heap to overcome and really work on, in the coming years in terms of promoting the coordination between the two insurers.

We held a webinar in August and since August we've held two

face-to-face meetings with the dual special needs plans.

One of them was just I think it was, last Friday.

It was last week.

And one of the things we're learning from those meetings is, the duals special needs plans really are interested in figuring out how to help make the coordination better.

Because they realize the health outcomes for their participants especially people who are in long-term services and supports is dependent upon the Medicaid payment for long-term services and supports that coordination is, really important for them.

We did spend a lot of time, with the dual special needs plans these are all day meetings one last Friday was all day. And we have brought before them information from the, integrated care resource center, from the mathematical policy research and the MPR is a big research institute does a lot of work at the Federal level on, dual integration the center for health care strategies was another presentation that we had for them to really help them think through what their communication between each other, what kind of agreement they're going to have, between each other all of those kinds of things. And then in the last meeting last week we did have a presentation from the E-health partner which is -- now with the Department of Human Services, but that was really a presentation on Pennsylvania's progress, in whole arena health exchange. Talking with the DNPS really gives me hope,

that is one possible for people in community HealthChoices some people are duly eligible, don't haven't joined a DSNP in original Medicare.

Some of them are in a regular immediate care advantage there are other kinds of places where, Medicare touches the folks and one of the things that we are have been doing for the past year and a half is participating in the MMDI or the Medicare Medicaid data integration at some point probably next spring after the launch and we've gotten some some of the glitches worked out with the launch of community HealthChoices, I hope that you will invite the MMD

I folks to understand what they're doing.

It's a Medicare Medicare initiative, it's an initiative, that the State is participating offered by the center for Medicare and Medicaid services CMS which is our Federal partner, under the Medicaid innovation accelerator program so Medicaid innovation accelerator program has all different kinds of initiatives that they have undertaken but this one, called MMDI, Medicare Medicaid data integration is one of the more exciting ones we've been involved in, the State has been involved in several of them this lists a few of the things, that -- that are happening with the MMDI project.

We have a contractor from CMS that is on staff teaching our staff, how to use almost realtime Medicare data.

We're trying to figure out what we use that for in terms of, working with the community HealthChoices managed care organizations.

But this is something, we're building right now.

And, I think that sometime next spring or early summer we'll be a good time to invite the people involved in the project to come to present on it it's really really exciting.

We're one of six states participating in the MMDI project.

And the goal of the project is to improve care coordination far Medicare, Medicaid those dual eligible participants.

So as I mentioned, hopefully there will be a future product.

The third area I want to talk about is our coordination the first slide was how we're coordinating.

We have to coordinate with behavioral health you'll recall early on in the discussions around community HealthChoices we issued, what we called a discussion document back in June of 2015.

We did listening sessions around the State.

We also had a lot of input we submitted published a public notice. And we got lots and lots of input on that discussion document. And as a result, we ended up carving out behavioral health the feedback that we got is that we already have a robust behavioral health managed care network throughout the State. And we need to depend upon them.

So we have been working between the community HealthChoices MCOs and the behavioral health MCOs and the counties on the behavioral health side the counties are involved in the behavioral health system we brought them together to really work on what how we're going coordinate

between community HealthChoices and behavioral HealthChoices.

We're also working at the state level with our partner and the office of mental health and substance abuse services to really assure coordination and they have been a great partner in figuring out what we put into our contract and what they put into their contracts to make sure coordination occurs.

So we will work with OMHSAS to monitor the progress of that collaboration, communication et cetera.

But, I want you to be assured a lot of work has been done.

I know there was a meeting yesterday on the behavioral health and CH C coordination.

I'm going to put up the resource page for you.

But again, we have all of this information on, will be posted on our web site.

And with that, I don't know what do you think boob, kind of a kind of running behind do you want to open up for questions at the end or --

>> **BOB THIEL:** We can take a few questions we have, several other presentations to get through.

So if anyone has one or two questions we'll take them now.

>> **MALE SPEAKER:** Blair Boroch united health care -- I can hold this question -- third party liability section in that agenda topic are you going to be talking at all about coordination of benefits for the community HealthChoices plan as secondary to the DSNP plan or is that

not part of that discussion?

>> DEPUTY SECRETARY BURNETT: We have third party liability to come in talk about it, hello Amy.

Do you have an answer to that question?

>> **AUDIENCE MEMBER:** I mean we talk we're going to be talking -- sorry.

We're going to be talking about order of payors where, um, if they have commercial and private insurance that's the first payor, if they have Medicare they're the secondary and then, Medicaid is third.

I mean we're going to be talking like that, I'm not sure what specific --

>> **MALE SPEAKER:** Sure my specific question came from some of our staff that are working with Medicare members.

The question was when the provider with the DSNP provider is non-Par with their community HealthChoices plan I read somewhere there's a requirement that the community HealthChoices plan has to cover that Medicare cost share.

Even if the provider is not Par with them I wanted to confirm if that's accurate and second as part of readiness review, those plans are ready would also pertain to behavioral health MCOs too,

because Medicare does cover behavioral health.

>> **KEVIN HANCOCK:** Blair, the specific CHC requirement is the participants cannot be balance billed for costs that are overages from

the Medicare coverage.

We can share with the committee what the specific language is, when it relates to the relationship of payment between Medicare and Medicaid that might actually inform future discussion you might have an opportunity to ask more specific questions about the language, is that all right.

>> **MALE SPEAKER:** Yeah I think what I read was something published with law project.

The provide everies are informed they're not allowed to balance bill, the member for the Medicare cost sharing and sometimes, it still happens if they're Medicaid claim is not paid even though they're not allowed to do that, that causes trouble for the member, one of the things I wanted to confirm is just will they get paid by the community HealthChoices plan for that Medicare cost share? If they're not PAr is there a requirement I know Delaware did that for example.

>> **KEVIN HANCOCK:** So the answer to that question is, it depends, it's probably we share the language with the contract language with the health law project.

If that it's detailed.

So, probably would be, helpful is a specific topic on a future agenda we're happy to go into a deep dive of what the requirements are, it is a really good question it will be important for providers and for participants to go out and hear how it's going to work.

>> **MALE SPEAKER:** Okay thank you.

>> **KEVIN HANCOCK:** Sure.

>> **BOB THIEL:** Okay we're going to move on the to the next agenda.

>> **FEMALE SPEAKER:** We have some questions from the community.

>> **BOB THIEL:** We have other presentations.

>> **FEMALE SPEAKER:** We want to be ask questions about the specific topic.

>> **BOB THIEL:** Kevin and Jen are not going anywhere we want to make it through we will have public comments there always the email address.

>> **FEMALE SPEAKER:** Never happens.

We need to ask questions now, while it's current and develop.

>> DEPUTY SECRETARY BURNETT: Pam we'll take questions at the end we'll stay late if we have to.

Okay.

>> **FEMALE SPEAKER:** These guys have trains to make, people have trains.

>> **BOB THIEL:** One of the agenda items is a few on here so we want to make sure we get through them.

Okay.

>> **THEO:** I would -- I would -- I would agree with them.

I understand agendas, as well as anyone else -- I really do.

Since we got consumers here, let's hear them.

>> **BOB THIEL:** Kevin just said he will take a few questions.

>> **KEVIN HANCOCK:** 3 questions.

>> **PAM AUER:** One of first questions the biggest concern a lot us have we've been hearing a lot of rumors and questions a lot of things happening we know that a lot of people know what happened in Iowa, our biggest concern what Theo was saying before, about service plans.

You know, I don't feel like we really got answers on if service plans are cut whether it is, in the -- continuity of care or if it's after the continuity of care.

Directly, who are we talking to? You know, talking to the MCOs, you're talking to the people who are running the show.

Our consumers don't know what they don't know.

They don't know who to contact.

I guess, I want to know, who directly are we going, what are we going to do how do you ensure, you'll not be cut what is the language that is going show the services will not be cut without a reasonable what is the reasonableness, what is the criteria for cutting what is the State giving the MCOs, as criteria to cut services or allowable cut services.

What is that? What is the service coordinators being trained? How are they being trained?

Is that happening? What when is that happening? There's so many questions.

I'm not the only person here with these questions I'm --

>> **AUDIENCE MEMBER:** Yeah.

>> **PAM AUER:** I'm asking them for everybody else.

What is happening with the cut you know we heard a rumor everybody has heard the big rumor I'm sure about one of the MCOs teaching the service coordinators to cut the service plans I will just be blunt.

So what is happening? Is that really a reality?

>> **KEVIN HANCOCK:** No.

>> **PAM AUER:** That's why we're here.

You were you were how are they being trained, to look at service plans and evaluate when someone should be cut?

How is that happening?

>> **KEVIN HANCOCK:** So later in the presentation we're going to be going through the comprehensive needs assessment all 3 of the MCOs will be going through the details how they're planning to build out their person centered plans it's a fair question I think that what we need, to do is in this session is, to talk about we need to talk about the grievance and appeals process as well.

Participants always have the ability to be able to -- to, submit a, if their service plan, if their service plan or services are not developed in away they think is appropriate to their needs or preferences, they always have the opportunity to submit a a grievance.

We will make sure that participants will have understand what they

need to do to be able to go through that process.

>> **PAM AUER:** So the service coordinator is going to be trained the way they were supposed to be, way back when, to teach people the their rights how to peel, how do we know that's going to happen with the new managed care system? They know that, that -- how to do the fair hearing, they know, they know that you know, if you don't get in within the ten days, hours don't freeze.

But who can review it in the meantime because we know that the, the -- hearings can take a long time processes for that, people go without services what happens when people go without service these die.

We want, we want moor answers.

We want more answers to -- you know, yes.

All of the consumers all of the reviews will happen.

And then they will happen by this person, this is who they contact we want to be able to give that out.

>> **KEVIN HANCOCK:** Getting two tracks of questions you can correct me if I'm wrong you want to understand how the service plans are developed and, what would -- in any way, create a potential risk that a participant services may be reduced which is something you know, which -- part of the discussion we would have for the comprehensive needs assessment and the person centered planning process, MCOs will talk about that today.

The other part, correct me if I'm wrong, what are the

participants's rightness this process, if they do believe their service plans have not been developed to reflect their needs.

>> **PAM AUER:** We shouldn't have to get do that point, but yes.

>> **KEVIN HANCOCK:** There will -- the reality is, there will always points of disagreement.

Between any type of service system and the participants themselves. And, the -- relief for that disagreement is the, the -- grievance and appeals process.

That will always occur, that occurs, I think, the opportunity with managed care is to quote you Pam, we have more opportunity to make sure we have more partners involved in making sure that the service coordinators will -- we have great service coordinator ins our current fee for service system.

But -- it's just hasn't been as even as we would like we have an opportunity with managed care to make sure that all service coordinators are held to the same standard of communicating with participants what their right also in this process we have regulated and so strongly articulated processes in place able to address point where is there are true disagreements with managed care organizations an the participants that is the grievance and appeals process.

We -- we owe you a presentation on the grievance and appeals process in detail we are committing to do that.

>> **AUDIENCE MEMBER:** Excuse me most of the stuff you present is it in electronic like most of the stuff everybody has --

>> **KEVIN HANCOCK:** Yeah.

>> **MALE SPEAKER:** My other question say if your whole system goes down, how can you all ensure these consumers these -- people that are sitting behind me if your system goes down, if something goes wrong, nothing will get messed up so they go back and say well, okay, system went down, we can pull your stuff up this way, how do you ensure this is going to be -- the system goes down you can go back and fix their stuff.

>> **KEVIN HANCOCK:** Unrelated question, but good question.

The managed care organizations are held to two different standards the first is, they have significant requirements for what we call disaster recovery.

Which means if there's ever a situation where the system goes down or there's some other type of disaster, they have to have, redundancy or back ups in place to be able to recover that information.

>> **MALE SPEAKER:** What are those back -P ups when the system goes down.

>> **KEVIN HANCOCK:** We can certainly, well, they're all kinds of different back ups that could be used by, managed care organizations to be able to provide that process, if -- if it's a desire for a future meeting to talk about continuity of operations.

We can certainly do that.

But they all have to have them in place, as part of our readiness review we certify that the disaster recovery systems are in place we've already done that.

And, and -- we are comfortable with the managed care organizations, all 3 of the managed care organizations ability to be able to maintain operations in event there's some sort of a disaster or some sort of a issue that would cause a threat to the information that relates to the participant services.

>> **MALE SPEAKER:** I have a question, how well are you all training like, Pam said how are you well are you training the service coordinators what steps are you taking to training these people -- what we need.

That's what I'm -- that's --

>> **KEVIN HANCOCK:** This is the third question, just -- the managed care organizations will have an opportunity to be able to answer that question in their presentation, which, is really going to be the focus of their presentation.

>> **PAM AUER:** Will they address about Iowa, if something happened like in Iowa with a Emeri health, how Pennsylvania is going to be protected.

>> **KEVIN HANCOCK:** Pennsylvania's roll out long-term services and is very different than Iowa we have said this publically many, many times -- we didn't bank savings in the program we recognized the fact during

the build out of a program we weren't requiring the managed care organization touses save money, and/or budget.

Iowa has taken a different approach.

We have always look at lessons learned from other states but, Pennsylvania's approach has been really to build out the better service system for long-term services and supports and to address the five goals that we have always already mentioned.

Focus on community based services, focus on service coordination, including Medicare and behavioral health services focusing on innovation, focusing on efficiency and effectiveness and I always forget the last one, and focusing on quality.

[laughter]

You have a right to laugh.

[laughter]

Quality.

Focusing on quality.

Which is the most important one, and some way, some cases but -- that we've never talked about budget savings.

That's different from the Iowa experience and the Kansas experience.

That is our commitment.

>> **PAM AUER:** And Texas.

>> **BOB THIEL:** We'll move on to the next stoppic.

You can email RA-PWCHC@pa.gov we'll move onto third party liability

with Amy Heckman, please turn off your mic s thank you.

>> **AUDIENCE MEMBER:** Just remember a lot our people don't have access I don't know where your getting these numbers from.

May be the family member, or may be a counselor.

May not be the actual person.

That's my problem, because -- I work with a lot of people that are just.

[inaudible]

You are putting out you know the acronyms how are the consumers going to know what you're saying.

I'm forever using foul language I'm a consumer that just came -- just came out of the hospital.

Almost lost her life 3 times.

I don't want to be put back in the nursing home.

Nor would I like -- please take into consideration.

That you have on the paper, may not be the actual consumer.

They may be a counselor for consumer or a family member.

>> DEPUTY SECRETARY BURNETT: Michelle we really appreciate what you just talked about -- talk to --

>> **AUDIENCE MEMBER:** I will end up in a nursing home if you do this wrong.

>> DEPUTY SECRETARY BURNETT: I know that you all are in the south eastern roll out which we have another year for the southeast we'll

begin the same process we've gone through in the southwest Kevin will be involved in working with you hearing your input

Michelle I think it's really important after your experience in the hospital, to really, help give us feedback and help us understand, what worked what didn't work.

So that we can make sure that there's good communication.

Our all those enrollments packets post enrollment packets they are people are able to read them, someone is available to help them understand what they say.

>> **AUDIENCE MEMBER:** Changes need to be made you need to go through the -- the process to get things repaired.

Who is going to help you get through the process.

We don't have these resources.

>> DEPUTY SECRETARY BURNETT: Something we have not talked about -- here in today's meeting we've talked about in plenty of other meetings is the requirement for beneficiary support system.

That is something we're working towards building it's required in the Federal managed care Medicaid managed care regulation is to have a beneficialry support system.

So, you'll be hearing more about that, the requirement doesn't go into place, until the midful next year it's something we're working on --

>> **AUDIENCE MEMBER:** That is not going to happen.

>> DEPUTY SECRETARY BURNETT: It will help with the roll out of the south eastern part.

>> AUDIENCE MEMBER: Doesn't platter where I'm from.

I'm always going around the State doing other things for other people.

I made this in Philadelphia.

I go all over.

>> DEPUTY SECRETARY BURNETT: And Michelle, that's great.

You're inputted and support for people to make sure their voices are heard has been an incredible help to us here at the state.

We spent a lot of time, have spent a lot of time and continue to spend a lot of time in the southwest, Kevin will continue to do that that's where we're starting community HealthChoices.

We have, many, many organizations helping us.

From the Pennsylvania health law project to the Pennsylvania health access network to the Centers for Independent Living in the southwestern part of the state.

To the area agencies on aging in the southwestern part of the State.

One of our co-chairs Fred Hess is from disability options network, which is one of the southwest certainties for independent living but they're all, involved in helping us.

So we're committed to continuing that kind of process, as we move

across the State.

So thank you for your input.

>> **AUDIENCE MEMBER:** How are you go out if you don't even have the mechanics together to even roll this program out.

>> DEPUTY SECRETARY BURNETT: I'm sorry, can you repeat your question.

>> **AUDIENCE MEMBER:** How are you going to roll this out, and you all you just said you don't have everything together to roll it out, you don't even have a really all the logistics of really what the consumers need.

>> DEPUTY SECRETARY BURNETT: We do, we do --

>> **AUDIENCE MEMBER:** How the question is, how.

If you all had it, show me, if you have it, don't show it by no graph on the computer screen.

Physically show the information because, I'm a consumer she is say consumer, everybody in this room, is a consumer.

Show it by graph, you're not showing the numbers, of what the consumers need, what what we, you say you're offering you're talking about your service coordinators, they don't even know the consumers.

Some of them don't even know the consumers what the consumer.

>> **KEVIN HANCOCK:** That's a problem.

>> **AUDIENCE MEMBER:** That's like you have to have the consumers don't know, the service coordinators don't know the consumer jump

through loopholes to get to the consumer wants.

>> DEPUTY SECRETARY BURNETT: Can I just.

>> AUDIENCE MEMBER: You're trying to roll this out, it sounds like what you're giving us back it sounds like you don't even have it together you're trying to force it to get rolled out whether you work on it, two years ago, 3 years ago, four years ago, you don't have all the information, to roll this stuff out and you keep trying to push it.

Why?

>> DEPUTY SECRETARY BURNETT: I would agree with you, what you just described, was what we want to change.

You described the existing system where service coordinators are not necessarily doing the job they need to be doing.

>> AUDIENCE MEMBER: That's a boldface lie.

That's a lie right there, because --

>> DEPUTY SECRETARY BURNETT: That's what you just said.

>> AUDIENCE MEMBER: That's what you just said.

>> AUDIENCE MEMBER: What they're doing right now is rolling out for the southwestern part of Pennsylvania.

Philly is going to come next south eastern --

>> AUDIENCE MEMBER: It's not going to work in Philly.

>> AUDIENCE MEMBER: It is, because it's everything is a learning process, and as they go --

>> AUDIENCE MEMBER: You got to be --

>> **BOB THIEL:** Excuse me, can I get attention we have to get through the agenda, there's a part where the MCO also going to be up to talk, can we please move through the agenda public comment section at the end.

We'll move onto the next item thank you.

>> **AMY HECKMAN:** Good morning.

>> DEPUTY SECRETARY BURNETT: Hold on, one of our members wants to talk.

>> **FEMALE SPEAKER:** Well, guys if you want more control over your care, you want to be more in control of your services, check out services my way, sit down with your service coordinators make them show it to you.

Make them know that you want to use, if you want more independence, that's the way to go.

Because if I'm speaking out of turn tell me I'm getting angry when I hear people yelling and screaming.

>> DEPUTY SECRETARY BURNETT: Thank you.

Thank you Tanya, I we are going -- Tanya is one of you're members from Erie Pennsylvania, she has offered to do a presentation on services my way which has a complete consumer controlled model where you have -- you have control over, your budget.

Tanya is going to be doing a presentation in a future MLTSS sub MACC meeting sometimes next string we fleeted to get moved on the agenda we're behind I would like to be.

>> **FEMALE SPEAKER:** I'm just trying to help thanks so much.

>> **AMY HECKMAN:** Good morning my name is Amy Heckman I'm a manager in the division of third party liability.

We're located in the Bureau of program integrity within the Department of Human Services.

I was asked this morning to give you an overview what we do in TPL so that's what the next physalia and presentation will go over some of the activity wees do at TPL.

The term TPL, is when another entity such as Medicare or private insurance is responsible financially for participants health care.

The rules for that fall under the Social Security act section 1902.

Where we're to take all reasonable measures to ascertain the legal liability of third parties including private insurance to pay for care and services available.

The purpose of TPL, is to recover Medicare assistance dollars paid when other resources are now known and from settlements and certain Casualty and probate cases we're also to avoid medical assistance payment ifs other insurance resources are available.

Because many he had call assistance is the payor of last resort by Federal law.

In the next few slides we will discuss how we recover TPL and how we handle the term cost avoidance.

We have several delivery systems for Medicaid recipients as you know

we have a fee for service population and that is when providers build directly to the Department of Human Services and we also have Medicaid managed care, which is our HealthChoices program and then, in January, we'll be now community HealthChoices.

I'm going to be explaining how we handle things in the fee for service world but the, managed care organizations will have similar processes, set up within their systems.

When a participant has Medicare and other health insurance or coverage, each type of coverage is called a payor.

When there's more than one payor is when coordination of benefit rules decide which one pays first.

The primary payor pays what it owes on the bills first and then it goes to the secondary payor et cetera.

In a situation where a person has a commercial or private insurance and also Medicare and Medicaid, the commercial insurance pays primary, then it goes to the Medicare and then, Medicaid will be tertiary meaning third.

The dual eligible population are individuals as Jen mentioned earlier who have both Medicare and Medicaid.

This population is currently in fee for service, but will be moving to community HealthChoices in January.

There's approximately numbers I had around 450,000 dual eligibles Kevin do you have a similar number on that?

>> **KEVIN HANCOCK:** Statewide?

>> **AMY HECKMAN:** 450,000?

>> **KEVIN HANCOCK:** We have been using the total number roughly 420,000.

Your 450 could include, those individual whose have some of their premiums paid by the Medicaid program, which may not be the same.

So -- thanks.

>> **AMY HECKMAN:** Okay.

Those are, those are the dual eligibles now I'm going talk a little bit about cost avoidance which it's a term that is used when we know in advance, that you have other insurance.

That a participant has other insurance.

TPL we have a vendor, that works for us that has looks for insurance, they get insurance files, eligibility files from insurance carriers and they look to see if any of our participants have other insurance.

And then we store that information in our client information system.

So we also as a department, have data exchanges with the Social Security Administration and CMS, which gives us Medicare data.

So our Medicaid MCOs and our county assistance offices, provide us with TPL insurance information that they may gather through interactions with our Medicaid population.

We rely on our data exchanges to give us the majority of our TPL

information, because sometimes participants may be reluctant to indicate that they have other insurance because they, sometimes, feel that it may effect their eligibility which it does not.

All that happens is like I mentioned the order of payors we go through that order, and then, that's when our coordination of benefit rules kick in.

In the fee for service population, if there's TPL insurance and a claim is submitted without first billing the other insurance, the claim is denied and the provider is instructed to bill the other insurance.

Providers are to indicate through their building processes, that they either received a payment or a denial by the private insurance before Medicaid would pay.

In cost avoidance dollars for health related insurance, in fiscal year 16-17, we cost avoided 311 million-dollars.

In the managed care contracts it states that they must attempt to avoid initial payment of climbs whenever possible, so they also will have rules built into the systems to utilize TPL information.

Currently, um, our current numbers, have a approximately 12 percent of medical assistance recipients have private or commercial insurance and about 16 percent of our Medicaid recipients have Medicare.

We have what we call health insurance premium payment program also within the Department of Human Services.

That is a program that is operated in a -- it comes into play when

situations where an individual has employer group health insurance and it may be cost effective for the department to pay the premium.

If it is cost effective the individual is enrolled in our HIP program that insurance becomes primary insurance.

As of November of this year we had 29,450 individuals enrolled in our HIPP program.

And in fiscal year 16-17 the HIPP program cost avoided $97 million.

Now, I'm going talk a little bit about -- the ways we recover.

In October the Governor gave a press release announcing a record number of 6,980,000,000 in recoveries and cost avoidance this number was reflection of activity -TS within the Bureau of program integrity, TPL,

itself, accounted for 580 million of this number, of which, 408 million was cost avoided and 172 million was recovered.

Now, we're going to talk about how we recover money in TP lashings.

Casualty recoveries accounted for 55 million in fiscal year 16-17.

Listed are just a few examples of the types of cases we encountered.

If a participant is in an accident, a slip and fall, an auto insurance auto accident or medical malpractice and there would be a lawsuit filed, then, TP lashings establishes a claim against any potential settlement that may happen for expenditures that we paid out on the behalf.

So if, when the settlement, whenever it is settled then TPL recovers

the MA expended dollars.

The State recovery program, is another way we recover money in TPL the State recovery program, is for participants 55 and older they have received nursing home a services or home and community based services upon the death of the participant, a claim is filed upon their state for these payments.

If a -- um, if there's more question about state recovery because there's a lot involved with that, there's more information on DHS's web site under DHS.pa.gov, and you can search on a statery cover I.

Out there on the web site, you will find a state recovery regulations, our brochure and some frequently asked questions.

The last thing I want to talk about is the health insurance recoveries, we found there's other insurance, estate recovers we paid the claim we find out, through our vendor that they have the other insurance.

Our vendor takes these paid claims in our system, and they utilize a database and they have contracts with over 1,000 insurance carriers and they bump up and match up against that, to see during the date of service if there's other insurance.

They build the insurance carriers to recover that money we had paid.

They accounted in fiscal year 16-17 for 68 million.

So you know, while I know, this was just a high level view of the

activities in TPL if there's any

questions do you want to keep to the end.

>> **BOB THIEL:** Anyone have any questions for Amy regarding her

presentation?

Nope.

Okay.

All right thank you.

We'll move onto the next item the CHC MCO comprehensive needs

assessment.

Mike Hale and Wilmarie Gonzales.

>> **KEVIN HANCOCK:** The order of presentation we'll have FEI

presented -- okay.

Great.

>> **MICHAEL HALE:** I need a couple of chairs.

Good morning everyone I know Jen and Kevin were talking about having

the -- the 3 MCOs, is it up?

We're good.

Having the 3 MCAs, talk about service plan development.

One of the things that, one of the tools they're going to be using

is something that we've been talking about, several meetings, over the

last year or so.

That is, the what was known as interAI heme care tool, FE systems

which Pam McCoy pants and we have another representative here, helping

us Pennsylvania develop a Pennsylvania specific brand for interRAI HC, that will suit our needs and the MCOs needs when community HealthChoices goes into effect.

I've asked, I think, the order of presentation will serve us if we have FEI systems talk about the interRIHC we're calling the Pennsylvania assessment system, will you tell them discuss, and talk about how that was being developed, and how it being implemented. And then, I think the 3 MCOs can talk about service plan development, in the use of the tool, within the a objective of the developing service plans.

So, with that I'll turn it over to Pam Mccoy, with FEI systems.

>> **FEMALE SPEAKER:** Okay.

Hi good morning everyone.

Next slide, please.

We at FEI are here to really support the Commonwealth of Pennsylvania in their community HealthChoices initiative.

And as such Pennsylvania assessment system and that's what it is.

It basically will serve to help, assess the residence of Pennsylvania in understanding understanding what they're needs are for services across the State.

Next slide.

Next slide please.

Initially, when an applicant applies for services, within the Commonwealth, they will be assessed at a very high level to determine

what their eligibility their clinical eligibility is.

And there has been a tool that was developed to serve this need called the functional eligibility determination tool.

This is the first assessment that will be -- that will be used to assess clinical needs of an individual.

The result of this assessment, is that someone will be deemed either nursing facility clinically eligible or nursing facility ineligibility.

So we're going to talk about the nursing facility clinically eligible path.

Next slide.

Okay.

Once a person is determined to be nursing facility clinically eligible, the MAXIMUS independent enrollment broker will continue on and do additional eligibility processing for that individual.

And that will -- that will include you know financial determinations and other eligibility that they will go through.

Immunol going to address maximum's eligible process here today.

Once a person is, determined to be eligible, and then they will be -- they will be -- served with another instrument called the interRAI HC the interRAIHC please next slide please.

You can go on, through a couple of, these are too detailed so next slide.

Next slide.

Okay.

Next slide.

Okay, here we go.

Thank you.

So the inter-RI HC is an assessment tool that will determine needs assessments.

So, once a person has been determined clinically eligible we need to really kind of understand based on their clinical eligibility and their clinical needs what services, could they be needing as a result of this.

So the interRAI HC is an instrument that will allow most eligibility determination to guide that subsequent care and service planning.

Okay.

Next slide.

Next slide.

Next slide.

Okay.

Next slide.

Okay.

Thank you.

So interRAI assessments are done, as soon as someone is determined nursing facility clinically eligible.

So that assessment will be done by the MCAs that each participant has selected to be associated with.

So the interRAI HC from a best practices perspective is done initially upon enrollment it's updated on a yearly basis.

And that yearly update, will indicate whether the participants needs remain constant or whether they're changed.

There's also another assessment that can be done on an as needed basis.

So if a -- if a participant has a significant change in status, and the MCO determines that an interRAI assessment is needed again too really assess what their changed needs are, they can exercise that instrument at that time as well.

Okay.

Next slide.

Okay.

Next slide.

And I think -- Mike, from a -- this is a good time to turn it over to the MCOs to talk about how they're using the interRAI to develop those service plans.

>> **MICHAEL HALE:** Okay.

Ray are you going to speak for UPMC and -- why don't you come up, sit up in the front.

We'll flip a coin to go first.

Okay.

Cousin tro dues yourselves and then --

>> **PAM AUER:** We have some questions about the -- about the interRAI before can we ask them before so it stays relevant?

We have questions about that.

>> **MICHAEL HALE:** Ask me a question about interRI.

>> **PAM AUER:** One of my questions there a lot of people who have questions --

>> **MICHAEL HALE:** Use the microphone we have people on the phone.

>> **BOB THIEL:** We'll make sure they repeat their question as well so everybody on the phone is going to hear too.

>> **PAM AUER:** Someone left their glasses in the ladies room one thing.

One of the questions I have, is -- are they reassessing people are they actually going to test it on people with brain injury or, people with limited cognitive or memory skills are they going to do that? That's one of the questions I have, because I sat in on your conference or your webinar.

Where it said that, the people that you had on the list weren't valid. And one of the most critical people to be tested out of all this, I think are people who, have traumatic brain injury or some kind of cognitive issues because you're not going to get any valid results they're going to tell you what they want, not -- not what is real.

>> **MICHAEL HALE:** Okay.

Two questions, there.

One is -- were any -- through the testing process for FFAD, there were people in the testing initial testing phase for

brain injury and then there were a few not a lot, okay.

In the group that we had, that was, the brain injury associations

had given us to please go back out and reassess, a lot of those people

were not available.

So, they are, right now getting us a new list of people we'll be

doing testing on that new list of people, as son's receive that list.

>> **PAM AUER:** Okay.

Some other people with questions and the biggest thing about the

assessment is, you know, what's it going to do to us? What does it

compare to, the old stuff? You know the old assessments, people are

really concerned about you know, are they going to, automatically, loose

services, if it doesn't, did if it is based upon that, how the

assessment is done.

>> **MICHAEL HALE:** Level of care determination tool, all the

questions that are on the FED, similar questions only asked a different

way are all on the LCD, okay.

So the questions -- are the same but worded differently.

All those questions, also then feed into the interRAI HC the home

care cool, the interRI home care cool is a set up to be for determining

NFC or NFI.

The FE debarks itself, the questions on there, are for functional eligibility only.

As the -- one of the two parts, there's the functional eligibility and financial eligibility.

So it's set up to determine eligibility and nothing else, FED is.

>> **PAM AUER:** Still even when people have the level of care determination done, currently, they still have problems with it, with asking and answering they need people with them and -- how it's done.

>> **MICHAEL HALE:** We'll be having training fors assessors to make they're actual assessors opposed to actual questioners we'll make sure that training, is -- done, just prior to the implementation so that we don't have to do training more than one time it's fresh in their minds before the -- the tool tool is put out there.

We're working with various group those make sure that questions are answered and making sure that it is correct and working correctly.

>> **PAM AUER:** Will the assessors have knowledge in disabilities.

>> **MICHAEL HALE:** Yes.

>> **PAM AUER:** And different disabilities.

>> **MICHAEL HALE:** Yes.

>> **PAM AUER:** You are do you have any questions Theo.

>> **FRED HESS:** This is Fred Hess -- um, I can barely hear the

questions so I may, I could hear the answers I could hardly hear the questions I may ask the same question.

With the interRAI and your other assessors you do realize, how is it really distinguishing between the fact that two paraplegic may have two different totally different needs and two different totally hours where's the human aspect of this and I understand H the -- there is some from the service coordinator is there enough I mean this is -- sounds like it's all going into an algorithm and this that and the other, in a computer program.

>> DEPUTY SECRETARY BURNETT: Thanks for the question Fred.

This is Jen.

I think it's time for us to turn over the podium here to the managed care organizations, many of these questions I think are going to be answered by them and I think we need to let them talk about how they're plan to go do that. And Fred, there is no algorithm.

There's a rumor out there there's a algorithm that will spit out a care program that does not assist I can assure you of that.

>> **FRED HESS:** Okay.

[laughter]

>> **MALE SPEAKER:** So, I'm my name is ray are you sure knock, associate vice president for communities HealthChoices in PPMC health plan I lead our product operations and analytics tammies want to lead in and hand over to Jacqueline I just want to emphasize that you know, -- we understand this say new program there's a lot of change

we can feel that, in the room today.

And -- we really just ask the opportunity to to build trusted with you.

You know our team is, incredibly you know, dedicate today this product.

We've been spending you know a lot of time developing the training all aspects of this program.

You know again, I really, want to emphasize that, there's key features of this program, that will allow a smooth start you've heard about the continuity of care period today.

If you keep your service coordinator you keep your care plan you keep your providers, those features will make sure that, this program gets off to you know a smooth start and there's minimal disruption.

Where there are problems I'm sure there will be some, you have our commitment to really work through those in a very you know, excite yows way we correct any Miss Steps with that I'll turn to over Jacqueline Smith who leads our service coordinate area.

>> **FEMALE SPEAKER:** Good morning before I start on the slides I'm going deviate a little bit from the slides in lieu of the conversation that has occurred.

I want to add to ray's point, one of the things that a question that came up was about, people didn't, the service coordinators won't know the participants.

Well, we're doing a hybrid model where a number of the service coordinators are out there today, are the same people that will be the service coordinators with CHC and even if they, they partner with us from an entity or, they went out on their own and partnered with one of the MCOs.

So a lot of the people that are out there, assisting and helping today will be the same people you'll see come January.

So with that, um, one of the things with the UPMC model is that we have a person centered model.

Where the participant is in the middle of it, we have talked a little bit about the interRAI we have some risk stratification that occurs initially when we're meeting with someone.

And risk stratification is really about acuity and, getting to know that individual.

And then there's the comprehensive needs assessment, but the bigger piece of it is, the person centered service plan and care plan development.

So yo we do use the interRAI tool that's, inherent in our agreement to use that particular tool, that tool soil is use today gather date.

We're asking questions and having a dialogue in our training we're really training the consumer directed approach, to where we're not just sitting there saying, what's the answer to this question or that question? We're coming in and we're asking what can we do, to get to

know you, what do I need to know to be able to know you?

And so at the same time, having a dialogue about needs.

In that conversation, or that dialogue there will be some answers to some of the interRAI questions that just came by that conversation.

It's really important that you the service coordinators and you understand, that's truly a dialogue and it's truly just to gauge data.

So once data is gathered, and in our particular model.

[gather]

The participant is sitting right there with you we're all looking and seeing exactly the same thing that happens.

So, the -- the responses to the interRAI create kind of a shell for goals so we can think about collectively what are your goals what are the goals that you want to have, in your particular care plan.

We can eliminate any goal that comes from the response and we can add goals we can add goal that's are particular to just that individual.

If that goal is that, I want to go to my daughter's wedding that's the goal that goes on that care plan.

So it's all about the participant and what is needed and documented on the care plan and the service plan. And it's definitely participant driven.

And so then the person centered planning team, one of the things that will happen is on the initial visit, we'll work with the participant to look at who are the people that you want included in your

person centered planning team.

The service coordinator can assist but they're just really documenting the people you choose to have as your participants in that person centered planning team, including PCPs, specialists or anyone else your direct care worker you want to be involved in that care.

There's a means to convene that committee or convene that team if we need to, once we have done the initial actual visit we can collaborate with the person centered planning team members by that participants desire.

And then lastly I just wanted to kind of give an overview of some of the training that we have for the service coordinators.

With the bigger piece of it being the whole person centered discussion and person centered planning and how that we need to incorporated that all we're doing and developing the service plans and the care plan.

So that's at a high level pretty much what UPMC does.

Do you want to take questions or -- let the others go.

>> **BOB THIEL:** Any questions for UPMC.

>> **MICHAEL HALE:** Let's have everybody do the presentations the questions are going to be very similar for the 3 MCOs divorce development of service plans so let's have -- all 3 of them go then we can ask questions at the end.

>> **FEMALE SPEAKER:** Okay I'll jump in, hi everyone I'm Anna Keith I'm with the Pennsylvania Health & Wellness.

I've met a lot of folks and out -- I've been out and about.

The assessment tool, well let me give you a quick background.

I came over to the dark side, I'll call that managed care but it's not really the dark side.

[laughter]

After 30 years in the disability movement, working with people of all disabilities, and getting your voice heard in the different parts of Kansas and Nebraska, Texas and other states, I've gotten the opportunity to work with Centene to bring that, with a lot of my peers who have disability backgrounds because we took an initiative as a company, to bring that expertise as we built markets that serve people with disabilities.

So, when we're talking about person first language when we're talking about person centered thinking, there are a lot of folks that I work with on a daily basis that have that background and they're bringing it to a health plan that nontraditional of typical health plans, they're bringing it into our health plan so that we really do understand the challenges that people have with disabilities when I say that, the assessment tool interRAI is used in 24 other states it's been practiced.

It's been practice requested folk that's have disabilities so we --

sort of understand it how it works it's a tool.

And like every tool out there, question recognize it's only one tool.

We use tools within Pennsylvania's health and wellness to identify, the needs of folks, first on a physical level.

Which, physical level -- as a community advocate we didn't really push that as much we pushed people living where they wanted to live and -- having transportation, having social relationships that they wanted.

Real a quality of life.

But a quality of life also has too do with the physical health care, because if you get into the hospital or nursing home you loose a lot of the things you currently have in the community.

To that extent using tools that identify, does the person know how to take their medications and really basic things that you guys all understand.

With the interRAI if we're looking at beyond a clinical model or a medical model looking at a whole person model to get information, so that, we can use that as a sounding board origami -Ping off point to have a conversation with you about what you want your life to look like.

And that's really it's really just a tool that starts the conversation at the end of the day, it's the person that we support that really has to drive their person centered plan.

And it has to be more than a piece of paper that says, here's all the things that we want too do.

It goes further than that, it has to be something that is dynamic which means, it has to change with what happens with your life.

And your life is the focus of it, you are the evener of your plan.

So to that extent you have to drive it.

And, if you're unhappy with something, like where you live -- you have to have that conversation, with your service coordinator, and the people in your circle of support, so that, that gets changed.

And so -- I can tell you in all honesty and those who have met me and feel comfort what I've sheered with you, I'm very entrance parent, Pennsylvania Health & Wellness, there's never been a discussion that I've sat in, where we have been told to cut services, or cost.

There are two areas that we do talk about cutting.

There are -- yep.

There's two areas we do talk about cutting cost.

You'll agree with me.

One of them has to do with non-emergent ER visits.

I'll give you an example of that, I was talking with Fred Hess last week when when I was in over at disability options we were talking about a lady that got stranded at Wal-Mart, and her van or broke down her accessible vehicle broke down she was stuck there for four hours because she could not get public transportation to come and help pick

her up.

So her option was call 911 get an ambulance to get her the tow truck would not transport her.

Those are problems because you guys know if you've ever seen a bill for 911 ambulance visit, you know what that cost.

Okay.

That's an unnecessary cost, based upon a transportation system, that is broken.

That we need partners to come to the table and talk to us about solutions.

That's a cost we need to cut.

The inappropriate use of, of ER visits that don't result in an ambulance, in in-patient stay.

Someone needs to be in the hospital, they need to be in the hospital.

But not as a transportation solution we need people to come and say here's ideas we have okay?

So that's one of the areas that we're talking about for cutting costs so when we, when you're doing your person centered support plan, drive that, talk about what you want.

I would really encourage folks as I've been in the different markets and worked with folks, these are just tools.

Just tools to get the conversation started.

There is no number at the end of any tool, that says your services

get cut.

All right? If anything it's people get services providers get paid that's been our motta at pa health and wellness from the day I started it's into the rhetoric you need to get the services you need.

What does that look like?

And who is involved with that process.

Our service coordinators are being trained in that model.

They're being trained around person centered support planning and person centered thinking.

They're being trained to let the person with the disability drive their plan not the service coordinator driving your plan not the professional driving your plan.

If they start doing that push back.

Say this is my plan.

Okay?

So when you're out there, hold us accountable those things and -- and -- let us follow through you, and trusted we have a hybrid model also when folks come to us that have no service coordination we've been hiring service coordinator those fill that void but people have choice, with service coordination.

You have choice.

If you don't like the service coordinator, you ever ask to change the service coordinator.

That's you're choice.

For those who have a service coordinator that you really work work well, that really knows you, keep that service coordinator.

It's not our intention to change that.

Now, or later.

All right.

That's what I'll close out with.

I appreciate that just -- please, ask the questions you need to ask and, don't jump to conclusions too much but you can get a hold of our teams and we can answer those questions for you.

>> **MICHAEL HALE:** Thank you and finally, last but not least,.

>> **MALE SPEAKER:** Okay.

Okay.

AmeriHealth Caritas.

>> DEPUTY SECRETARY BURNETT: Come sit up front, please.

>> **MICHAEL HALE:** I wasn't going make you move, but it is easier.

Yeah.

Yeah.

People people hi everyone my name is Jen Rogers director of service coordination with AmeriHealth Caritas Pennsylvania and -- um, I'm here with Chris and Kathy Gordon Chris Berette I was going to kick it off and Kathy has more details what the specific requested from OLTL has to cover today.

Next slide please.

So so as you can see by the graphic our model is focused on putting the participant in the center of everything we feel and we know that participants are the experts in their care and we're training to both internally and externally so that, nothing gets done without permission and consent of the participant regarding what services they want.

What CHC gives us the opportunity to also involve a team around the participant and that team consists of individuals is that the participant identifies whether they're caregivers, family members, friends neighbors, roommates or representatives from their clinical team, their PCP, behavioral health specialist or others that are involved with that participant's housing or nursing home transition, nursing home transition coordinator.

We're using our community based services to avoid or to delay institutional care and to support our participants who desire to be in the community. And again I think we're looking at this as an opportunity to train and retrain our service coordination entity partners on what services are available to participants under CHC and how to how to identify them and created a plan that works for the participant.

Next slide please.

So our team is devised of our service coordinators and those are

the folks in the field, meeting with participants face-to-face.

Getting to know them, gaining their trust, so that we can develop plans that make sense.

Our person care connector team, these are our internal folks who are available to answer calls and connect participants with resources in the community.

And really, do our outreach initiatives.

>> **FEMALE SPEAKER:** So I do want to talk about the personal care connector because that person is so important in this process, so our service coordinators are out in the field.

They're in participants homes, we expect them to be out visiting you and meeting with you and being in the community.

But when you have this personal care connector you need something done right away, they're available for you.

They have access to anything that the service coordinator does and I use an example because one of my concerns and we do have a housing coordinator but, you know, you find out that you have to have you have to leave your home for some reason for even a short period of time.

That personal care connector can help take care of the same thing that the service coordinator can.

They're going to be there to back up the service coordinator who is in the field they will do what they need to do to help you get what you need.

>> **FEMALE SPEAKER:** Okay.

Moving on our community health navigation team, this is a critically important role that we're embracing in AmeriHealth Caritas because these are the folks that help reengage participants we lost contact with that are struggling with some need that is going unmet.

They're able to meet participants where they are in the community and try to reengage them with services.

And our nursing home transition team again will be engaging with community partners, to coordinate efforts to help make transitions reality for individuals who wish to move back to the community.

>> **FEMALE SPEAKER:** Every participant, every participant has a right to live in the compliant.

And it's our job to help make that happen.

>> **FEMALE SPEAKER:** Next slide please.

Okay.

So our approach to training is really to embrace the independent living philosophy in everything we do and the, importance of knowing the history making sure all the service coordinators are affiliated with AmeriHealth Caritas whether they're existence today or newly on boarding today are well ware of the importance of the independent living philosophy we're training our team to demonstrate their ability to have a person centered approach to planning and monitoring, and conducting

the interRAI and comprehensive needs assessment what is critically important we're very proud of we have two certified master trainers who are available to both our internal and external staff for training on the interRA irks to make sure there's uniformity in the approach how that tool is used.

Our service coordinators are also being trained on how to facilitate person centered planning team meetings and this is a concept again that I know is going to be new I think it's an opportunity for Pennsylvanians enrolled in CHC to have a team approach will the service coordinator is responsible for not dictating how that meeting goes down but facilitating so that the participant has an allias, and have someone there to document and steer the planning the care planning.

Our service coordinators must understand the as much as authorization process, and they're role in both coordinating physical behavioral and community LTSS resources so -- um, we are utilizing innovative providers and participant advocates in the community to train our service coordinators and service coordinate writing ofen at this times we have a dedicated team of trainingers who are available to both service coordinators that we've hired internally and also to service coordination entity master trainers and people had many, many, years of experience in LTSS and how to train teams of individuals who are coordinating these services.

We have a phased in approach to training we've already been meeting

with the service coordinate entities in the southwest and talking with them about our plan is, for training them on our model, on a Mary a health care it is and how we're doing community HealthChoices we're are going offer and utilize ride alongs for performance evaluation and training and importantly support for the service coordination entities that are using our system and also new basically to CHC how to best facilitate meetings with participants.

We have plans to provide provider trainings webinar and online and where necessary to recognize the important work that service coordinators are doing today in an effort to not duplicate training for the sake of getting a tick in the box we're making all our training materials available, by print and electronically for both participants and service coordinators alike.

>> **FEMALE SPEAKER:** Okay.

So, I wanted to talk we wanted to talk about the interRAI because we know how important that is to the discussion.

And and Anna you spoke to this, it's a conversation it's a tool.

But part of that is, it's the training that we put into our service coordination team to understand the observational things that happen, you know one of the thing that we talk about is how are we going to know they need a home modification.

That -- that may not be in the interRAI how do we know that, they -- want to be, meaningful employed, so these are all, there's all these

things that go into our training program, in addition to just the interRAI our team is taught observational techniques.

You know, I have done this, I've been a field base case manager I've gone into the home and done this assessment and I've walked out and if it weren't for the fact that I was so well trained, this you know I have someone telling me how great they're doing their concern is if they tell me they need help, it's a weakness I want to help them because I can see that -- you know, we just need a couple of hours to get someone up and dressed and out of the house and, get them to college or get them to work and we have done that. And we can do that.

Because we're training our staff to observe, and understand that there's more than just this tool.

I do want to talk about the person centered planning team because that is key to this process.

The interRI is again a two -- we're in your home for two hours we need, to have the input with your permission, to speak to other people, who may -- remind us or remind our participant hey this is something that we spoke to.

But, but it you choose into the to have a person centered planning team, that's okay.

We're fine with that, it's everything that you have to you know, that you give us we'll work with to get you what you need.

But again you drive this process.

You're the expert.

We're just the facilitator in the process and making sure that we fulfill those needs what services, what community resources.

What additional support is out there.

So, so the interRI being a tool it's all these other areas that we're responsible for making sure our staff, are well trained and understanding the entire process.

>> **MICHAEL HALE:** Okay.

Okay.

Hang on a second The. One thing I wanted to point out, in something I have been talking about when everyone questioned about the interRI and the FED and the new forms new tools we'll be using.

That is that, that -- none of these things simply spits out a service plan.

Okay.

There's no answers that you'll give, that will generate a number of units of service you're going to receive.

That does not exist.

Okay.

And I'm I feel badly that, that rumor has existed out there because I know it has frightened a lot of people.

As you have heard, as it should be, from all 3 of the MCOs you have heard that this is person centered I see the graphs that they put

up that are fairly similar.

The person is in the middle, person centered service plan that through the discussion and through the use of various tools, the interRI tool is one of those tools.

The biggest part of interRAI is the selection of data, something we've never been able to have before on a regular basis.

Around needs assessments and eligibilities.

We can store that data we have that data available to us we can also make that data available on then to, interRA irks and the University of Michigan for inconclusion in their studies okay.

So that's the primary, the largest aspected of the interRAI tools I wanted to point that out before we took questions, Kevin do you want to say something.

>> **KEVIN HANCOCK:** No.

Great thanks.

>> **THEO:** Um, couple of things.

And no particular order.

Especially to the MCOs, I am hearing the right terminology.

And I'm hoping and praying that is just not words, that you all feel and believe, we should hear.

It is easy to say the terminology it's easy to say person centered counseling and consumer choice and it's easy to say, you all are people with disabilities are in control, easy to say that.

But reality is, that is not always the case.

You know it sounds good.

Terminology you're using really does sound good.

But when the rubber hits the read, that's a whole different thing.

I've been doing this for 40 some years.

[road]

I'm still having a hard time communicating the passion, to my staff to what independent living philosophy, and living well really means.

I'm wondering you know, how do you all have such a --

[laughter]

A way of it, that you all can do that, so well.

You say, you use master trainers.

Who are these master trainers.

Are they people with disabilities? Are they people who are, living with a disability and understand what it means.

So -- I'm just saying, it is easy to use the right terminology.

>> **FEMALE SPEAKER:** So Theo let me be clear the master trainers are for the interRAI, they have actually, have been working in LTSS for six years the reason why we did we had our, our staff train a become master trainers is so that they could teach consistency in the application of the tool.

Right.

Because you want people to understand everyone too understand the

same way.

That doesn't mean, service plans service plans are the same way because everyone has individual needs and that's what is so important, when Anna was saying you speak to us, this is say conversation that we hear what you say.

Because everyone's needs are different, everyone's goals maybe different.

Right.

That's what, that's really important for our staff to understand that.

It's not what we decide it's what you tell us.

>> **THEO:** I'm willing to wait and see you know, I'm a person who can wait and see.

The same time you know, I'm an empowered person.

But you're not going encounter a lot of empowered people with disabilities you'll not have people like me or anyone else speaking on their behalf it's going to be important service coordinators and personal working on behalf of the people with disabilities, truly understand what this means by consumer control person centered and -- really understanding what it means to live with a disability and not be speaking from an able bodied experience which is typical, I don't care how much people say, you do.

You know?

And, and that's hard to communicate and train.

That's my point, with all that being said, I can wait and see.

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

>> **BOB THIEL:** Okay.

>> **MALE SPEAKER:** I have a couple of questions behalf of Kathy Cary and from my own personal interest that is, how the plans are going to interact and work with people with dementia, particularly with Alzheimers and how they will, participate in person centered planning process in addition I think another population will be the LGBT community and how the plans are planning to be sensitive to the needs particular needs of LGBT members.

>> **FEMALE SPEAKER:** I'll attack that question.

Sensitivity to disabilities all the way around is part of our training model.

And understanding the challenges of different disabilities.

So, from a training perspective, we spend a lot of time with the service coordinators internally and our teams that speak to folks on the phone.

That's a big deal.

So beyond service coordination it's anyone that might interact with an individual with a disability. And or demansia.

Their family members, and, understanding that it might take a little bit more time to get an answer to complete an assessment to do a plan

and it really just comes down to not treating everyone as if they're walking well, able body person.

And it is an individual by individual basis.

And that's just how our training works.

People have to put it in practice and make sure we're doing what we're doing.

Tim I would like to add to that, one of the things that we're doing, we're learning from those who do.

So, that we're including resources that are already out there in the community.

So, such adds the TBI population and, truly understanding how do we work with.

[as]

With individuals that have traumatic brain injury, so, we're not doing this in a bubble.

We're also using other resources that are out there in the community.

>> **FEMALE SPEAKER:** Let metacone to that, I appreciate that because we have been doing that, working with our CPA we've got we've got negotiations in process to have a annual calendar that brings in the community members from different areas and disciplines to train our staff.

This is not an internal training where we just, put PowerPoints up and train them when I'm talking about training, we're using the

community to come in and train our folks we're bringing in the disability populations to train our folks.

It is a community process.

>> **BOB THIEL:** Okay anyone else have questions?

Let me get the second.

>> **MALE SPEAKER:** Let me get the second part LGBT neither of you addressed that.

>> **FEMALE SPEAKER:** You know that is San excellent point you know what I don't think we did enough to work with our staff to understand that.

And I would like to make sure that we do include that and we'll welcome the opportunity to have that discussion.

Our staff are trained on all types of sensitivities but specifically having that conversation is so important.

And thank you for bringing that up.

>> **FEMALE SPEAKER:** Resources to help them.

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

>> **BOB THIEL:** Okay.

Anyone else want to ask from the other providers answer from the other providers or go to the next question down front front.

>> **AUDIENCE MEMBER:** Yes, I have a two questions if consumer goes with UPMC do they have to utilize their doctors because consumer was trying to like switch and they could not switch they had to use the UPMC

doctors.

>> **MALE SPEAKER:** So the answer is no.

Our network is you know quite expansive and goes far beyond UPMC hospitals and physicians so there is certainly a wide array of choices that you know, connected to us or not.

And you know we believe our close connections with our integrated delivery system serves as a laboratory where we've, learned a lot on working as a you know, provider payor, we've taken those lessons and a lot of collaborations with regional health systems outside of UPMC.

>> **AUDIENCE MEMBER:** Oh, she would not take her doctor when she tried to enroll, what she supposed do about that?

>> **MALE SPEAKER:** I'm not sure I understand the question.

>> **AUDIENCE MEMBER:** Special use for Medicaid medicine any way the special needs plan for folks with Medicare and Medicare -- and -- this is about this lady back there.

Trying to get information she uses doctors by Penn, the doctors were not in UPMCC's network if managed care rolls out, if she decides to go with UPMC, will she have limited choices in the doctors she has known for years? What will happen to consumers like her?

>> DEPUTY SECRETARY BURNETT: Ray can I start out with you're talking about, right now your HealthChoices and HealthChoices issue.

Which definitely special needs plan unit in HealthChoices should be able to help you through that.

Help you through those issues in terms of the future community

HealthChoices coming on board and UPMC issues I'll pass it back over to Ray.

>> **MALE SPEAKER:** Yeah this is I think certainly be easier to handle individually, but -- you know, what I can -- say broadly is that, by no means is every physician in our network.

However, if you as mentioned you're dual eligible and you, have a physician you're seeing through your Medicare that doesn't change.

You don't have to change your Medicare through community HealthChoices.

You can you know, continue if you use your red and white and blew card fee for service in Medicare that's great.

If you have an Medicare vantage plan is not ours that's fine tax for individual providers questions I'll gladly take down the names to see if we can add them to our network understanding that's notes not always a possibility.

>> **AUDIENCE MEMBER:** Hello.

My name is Tony I'm from Philadelphia I'm an individual with a disability.

My question is, about this interRAI program you want to start.

I got injured through an accident.

And I went into a hospital how do you guys initially get to me before being transitioned into a nursing institution or, trying to get back home? Because you know, there's this point in the life of a person with a disability, who comes from going to thible body point to a

disability point there has to be changes in the house, has to be modified changes all over.

How do you initially get do me, if it's either I'm at home or in the hospital?

Because you know from the hospital, we are being transitioned into a nursing institution. And most of us, who have experienced that, don't want anyone else to experience that, how do you get to us before we are being transitioned and how long does it take.

>> **BOB THIEL:** If we can have each of the MCOs answer this question separately.

Thank you.

>> **FEMALE SPEAKER:** So I'm speaking behalf of UPMC, you're asking the question I can't you're already in the waiver program or you're not in the waiver program?

>> **AUDIENCE MEMBER:** I'm initially, understanding my disability so I could, either be in the hospital from an accident or, I went in for a test, I might be in the hospital for maybe 15 days or, a whole month and, from that you know, sometimes your house is not accessible for you to go in if you're using a modified device.

So between that time, that you have been determined to have a disability or you've noticed you have a disability how would you MCOs contact me, as an individual instead of me being transitioned into the nursing home because you know the programs out there, are just telling

us if you have a disability you have any kind of disability, that first place you transition into is a nursing institution.

I want to I don't want to be transitioned into a nursing institution.

How do I get to you guys? How do you guys get to me.

>> **KEVIN HANCOCK:** Would be assume you're enrolled in the Medicaid program?

>> **MALE SPEAKER:** I do not know, about that.

>> **KEVIN HANCOCK:** We'll have to step back a little bit.

So -- the community HealthChoices manage the care organizations will be become involved in your situation, after you're already eligible for the Medicaid program.

>> **AUDIENCE MEMBER:** Question -- the question is, before I am transitioned into a nursing institution, I'm taking it from my example.

This is what happened to me.

I was in the hospital, they checked me out treated me but, I could not go home.

So I was transitioned into a nursing institution because my home was not accessible.

I lived in a nursing institution I did not have the ability to live in independent in the -- in the community for almost a whole year.

I didn't have information about how to get the process going for me to live independently, in the community.

So, the transition into the nursing home.

I hope you are changing that model, where that -- you -- you get to know me, before I am transitioned into a nursing home.

That's where I want to cut it off before going into the nursing institution.

Because I was told, in the hospital, only place I can transition you right now, is in the nursing institution.

>> **KEVIN HANCOCK:** Speaking for the department, we, we feel, we feel the same way as you do.

We want to do whatever is possible.

To make sure that any interruption of, is -- exists for if a sill placement.

The reason why I ask the question about Medicaid he will gentlemannability managed care organizations are not going you until you're already enrolled in the program, they can talk about the process what they would do for nursing facility diversion after you're already enrolled in Medicaid.

But, prior to that, story is say little bit different because, you would actually have to become eligible for Medicaid program for them to be engaged in your situation.

And I think that, if it's already with the MCOs if you could talk about what that would be, after he is already known to community HealthChoices whether he is a waiver recipient or not.

>> **FEMALE SPEAKER:** So I will start it off I'm going take it that already in the waiver program in a nursing facility and, while you're in

the nursing facility, there's care managers that are in the facility.

I mean, sorry in the, hospital that are working with you and so our service coordinators would get involved, in where is the next transition.

So what needs to happen to savely bring you from that hospital stay, back to the community.

And so, that service coordinator would be responsible for putting those things in place by your choice and where it is that you would like to go.

So that you don't go into the nursing facility.

And ensuring that takes place.

>> **AUDIENCE MEMBER:** You know, I don't know how much energy and time you guys put in, but -- to me, it took more than six months it took more than a year.

From the hospital for 15 days, staying in the hospital, the transitioned me into a nursing institution.

And that point, from being told you cannot go back into the community you cannot go back home, that's my -- that, that is one of the things that broke me down I was transitioned into a nursing home institution, in the nursing institution too I was being treated like nobody.

It is not my, it's my story but -- I want you to understand that the -- the compassion and energy that you feel when you you are being

told, this.

How are you going to think about it how are you going to get this process.

I know they have, social workers out there, are you guys going to be connecting with the social workers in all of the cities? Paragraph.

>> **FEMALE SPEAKER:** Hospitals in our network the care managers social workers service coordinator the team, would work together, to ensure that transition.

So -- there is that connection.

And there's that opportunity.

That you're saying, I don't want to go into a nursing facility I want to go back into the community. And that's what the service coordinator's job would be to get you back into that.

>> **THEO:** How do the care managers, locate --

>> **KEVIN HANCOCK:** Theo can you use your microphones.

>> **FEMALE SPEAKER:** How would the care managers notify and locate him and -- there's a UM process that occurs in case management in the facility, from a managed care organization so it's already enrolled with us.

That happens on the day of admission.

So that care manager is involved in that care immediately.

And, that care manager, then would notify the service coordinators that, this is, what needs to happen, so, just by admission, is that

notification.

>> **AUDIENCE MEMBER:** You got it -- to a point where I still want know how long is it going to take me, from the time you have noticed or if you have -- you've got to know about me being in a hospital.

That transition into the nursing home that is where I want to cut it off.

My home is not accessible, how long will it take you to -- modify my home.

What are the steps, from the ER to staying in the hospital and the hospital might tell me oh you can just stay in the hospital, for 15 days.

From that point where the hospital tells me I'm staying in with them for 15 days, then I have to take care of myself I don't want to move into a nursing institution.

>> **FEMALE SPEAKER:** The timing how long that would take would depend where it is you're going and what needs to happen.

But -- understand that it's being worked on as soon as it's identified.

So, there might be some type of modification that has to occur in the event until that home is ready or that facility is ready, so -- all of that would be directed and coordinated by that service coordinator with your involvement. And the timing and your understanding here's where we are, in this phase.

It may be a matter of finding housing.

You know, it may that you just can't go back to the one you were in.

>> **AUDIENCE MEMBER:** I would love to be in my home in the community.

Modify it and let me go.

>> **FEMALE SPEAKER:** It may be until that is modified, what is the step in between getting it modified.

So all of that would be on a case by case and would work with that service coordinator with your participation.

>> **KEVIN HANCOCK:** Before we leave, do either of the other MCOs want to add to anything?

>> **FEMALE SPEAKER:** I want to loop beacon that, the internal process is pretty similar.

But one of the things that we would also be looking at is, we probably outreach to community parters like the CILs you live in New Castle it might be disability options or you're in Washington I reach taught triple.

I get some of the advocates they have great home modifications and voices for independence has a beautiful home mod program and rehab program.

So wherever you're living your choice community.

Reach out to our partners to see where they want to help as well push, push it.

Because maybe home evaluation is needed you want to go home.

Right.

So -- it's going to take some modifications but we need to know what that is going to look like.

What it's going to take, to do it.

Does egress need to be longer right?

So you can live in your home what if your home is on the third floor of a, row house?

That might not be as easy and you might have to look at what other choices could I make now that I want a first floor level to get to my house.

Right?

Do I want a lowered sink, which can lower my sink.

That may depend how long you want strangers in your house that will facilitate you getting into your own home, as quickly as possible.

The internal health plan process is pretty much the same.

We know where you are and we know if you have a case manager or not, or service coordinator it's the community process that is really what we need to do to get you out as quickly as possible and then everything is individualized.

Hope that helps.

>> **FEMALE SPEAKER:** So -- I kind want to take it back a step before that.

We're out communicating with these hospitals now to tell them, that

we have a diversion program that you're, you are a participant, with our program.

And that our job, is to help you, go loam.

And so, we absolutely understand your concerns with being transitioned to a facility, while you're you know like while you're waiting for all this process to take place.

But part of that is, our job and what we've been doing is, educating the providers the hospitals the social workers discharge planners that this program exists.

And that we need to be called first we get the in-patient alert we flow that, you're there.

But we want them to think, hey, there's other resources there's other services we can go a different path than just send someone to a facility, okay.

>> **AUDIENCE MEMBER:** Human beings -- we're just tell them everything is --

[inaudible]

You make your decisions.

We made our decision.

You know.

We're not giving any -- you know.

Get them service coordinator who completely -- this becomes hard you know.

Doesn't give plea any help at all.

Because -- you also can have done, not aware of it.

Also, because we do it -- that is I'm not done.

I'll be out there.

Where someone is -- they don't ask you, do you know do you know computers you can.

[inaudible]

You don't know even know us.

Nothing, with us about us.

You may all make decisions for us we're not even involved.

>> DEPUTY SECRETARY BURNETT: This is Jen Burnett I totally appreciate what you're talking about.

>> AUDIENCE MEMBER: Don't built tonnize me.

>> DEPUTY SECRETARY BURNETT: I'm into the patronizing you I I'm acknowledging you, the MCOs don't understand us without us.

Is that what you're talking about.

Pair think that's what you need to do, and -- what Theo said earlier I'm going to watch what happens here.

And I'm going to be paying a lot of tension attention to it.

We have been, we have been commit today hearing the voice of consumers throughout this process for the past 2.

5 years.

>> **AUDIENCE MEMBER:** I know, we're all involved we've heard that before.

I'm an old lady I know I'm not -- this administration, is doing nothing.

>> DEPUTY SECRETARY BURNETT: We'll move forward with community HealthChoices we hope that you will be watching us and giving us the feedback we need to hear from you.

As we are moving forth.

>> **AUDIENCE MEMBER:** I call that the plan -- rape, torture, death.

What do we do --

>> DEPUTY SECRETARY BURNETT: Yeah. I that I -- yeah.

Spit fire -- spit fire I think we have one of our committee members that wants to react to you it's Tanya, in Erie, someone want to put the phone on, so let Tanya speak up.

>> **FEMALE SPEAKER:** Okay.

Um -- just real quick.

I understand the great gravity of what is going on there rightfully about all of this.

I mean, I have cerebral palsy myself I use the services I think, something we all need to keep in mind right now, is -- we are actually in we're actually damn lucky that these guys are willing to listen to us,

as much as they are, they need to be treated with the same respect you want to be treated with yourself you understand me on that? Paragraph.

>> **AUDIENCE MEMBER:** Words from people you like you.

>> **FEMALE SPEAKER:** I -- itch heard enough about today.

You know what -- I can understand it I get it.

I do --.

But you're not seeing -- what you're not seeing is the amount of time that people and I and everyone on the subcommittee has taken out of their lives, to try to make this work.

And really, I mean -- yeah.

I'm not, real thrilled with the idea of an insurance company knowing every aspect of my life.

But you know what, we're -- you have to remember something we're not going to be acting as --

>> DEPUTY SECRETARY BURNETT: Tanya thank you so much.

Tanya thank you for that I want to say, spit fire all the folks in the audience, that have not been participating on -- monthly basis, with the committee, we are very, very committed to and many of the changes and input that we've had, really -- have helped us, make the contract that we have with these MCOs be very strong around consumer protections, and consumer input.

I either you to get involved, as we move into -- most of you are from Philadelphia we'll be coming to Philadelphia this is not stopping.

Right now, we're getting ready to launch in 3 weeks it is happening in southwestern Pennsylvania.

I would advise the folks in -- the south eastern part of the State who will be starting in January of 2019.

To please be paying very close attention I think you've got some advocates advocacy organizations amongst you that are helping you to stay in close touch who is happening in southwestern Pennsylvania.

And then provide us with input we're -- we're going date of birth paying close attention to doing tremendous over sight of the MCOs in order to make sure some of the things you're concerned about, spit fire don't happen.

That is what our job is as the State.

You know you need to show a little respect for the committee that is sitting around this table, that has worked for the last two and a half years, very, very hard, to try to craft a product is that going to work for people we now need to see how it works we need to make sure it works.

And you're -- your input would be better served if you would help us, figure out how to make things better instead of, worrying that it's -- that everybody is against you.

Because that is not the case, in this room.

>> BOB THIEL: Question in the corner.

>> DEPUTY SECRETARY BURNETT: Hold on I have a committee member that wants to react.

>> FEMALE SPEAKER: Different topic.

>> DEPUTY SECRETARY BURNETT: Never mind.

>> AUDIENCE MEMBER: Said since in January it's going roll out in Pittsburgh I want to know when it's supposed to roll out in Philadelphia.

>> DEPUTY SECRETARY BURNETT: January 2019.

Okay.

Go live -- it's going live in 2018 -- January 1, 2018, in south, 14 counties in southwestern.

>> AUDIENCE MEMBER: You are rolling this out, January 120 is the.

>> DEPUTY SECRETARY BURNETT: 2018 for the southwestern part of the state, for the five counties in the south eastern part of the state it's going live on January 12019.

>> AUDIENCE MEMBER: New Years eave.

>> DEPUTY SECRETARY BURNETT: New Years day.

>> AUDIENCE MEMBER: Beginning of the year.

New Years day.

>> AUDIENCE MEMBER: Yeah.

>> BOB THIEL: Can you reach your microphone.

>> AUDIENCE MEMBER: You keep saying us people from Philadelphia.

But -- it's not only us people from Philadelphia.

We're representing the people in western that also could not get here I get emails all over.

Saying what are we going to do?

They're not here, they're not able to sit at this table.

We were able to -- we found out we got up and we came.

Not many of our brothers and sisters can do that.

You guys were just talking about a lot of things that are happening the lady getting stuckity -- having the -- at Walmart.

Around the State, that's not possible for everybody.

Most people, have to leave their wheelchair behind.

And pay over $600 to get put back.

>> **FEMALE SPEAKER:** That's exactly right, the tow truck would not work to get her wheelchair, so -- that's why disability options came to her rescue helped her out which we heard the story about it, is a great story she was the fortunate one.

>> **AUDIENCE MEMBER:** Right even when you go into the hospitals every time, I go in I have to have a living well letter -- stating I will not go into a nursing home.

Even when you get put in a rehab.

If they have you over six months, they find out you got a home they're going to dig for that home before they leave you outside of those doors okay.

I got stuck in there for a good while.

As soon as the day after I got transferred out of the nursing home, they tried to take everything out of the bank.

They say I own -- I owed them.

Every time we go in a hospital, I have to keep a letter in my

backpack, for medicines I take, the Dares I communication I and my living will if you don't have that that's the first

place they will ship you is the nursing home, where do we stop before we

get there, Tony talked about his.

I'm telling you about mine.

What about our other brothers and sisters -- that don't know, what

is out here.

You're saying I'm evenly talking for Philadelphia.

But most of us do get around on the internet.

I live in Philadelphia.

But I get letters from -- people, all over the State.

And asking plea how do I get this, done.

That done.

Apparently someone is falling through the cracks.

Or not informing people of the right process.

You're saying these insurances are going to cover.

What about the people that don't know about the stuff.

How many people have to fall through the cracks.

And you were talking about people on training on your committee.

Is any of them disabled the ones that go out to do the outside

training?

Any ever them.

So how are they going to learn what it is really like and unless

they're sitting with a disability right through.

And being a person with a disability.

>> **FEMALE SPEAKER:** We welcome, we have bring providers in, we -- we bring in the disability options network they have been in to speak with our team we bring, we bring our participants experience in so they understand, so they get it.

Because, again, you know, this is your program we're just facilitating it, you -- we want --

>> **AUDIENCE MEMBER:** Who are you going to bring in, you're bringing in all these committees.

What are the actual people that are you're bringing in that are actual consumers.

I can name 20 people in the business, are you going to let them all in.

And then tell them to tell me what to do? That's what this documentation is, we have to go go by the rules you're saying it's consumer, it's consumer operated.

The consumers inside, and I can't even read these notes but the consumer, consumer was inside when the M circle was up side, all those things, the person should choose what is outside not what is around them.

And the.

>> **MALE SPEAKER:** And just so I want to state, in addition to the training that is going to be happening with the service coordinators, we're going to be forming a participant advisory committee.

So anyone that is, enrolled with us, we would encourage them to be able to join our committee there.

Under way they can pry the real life experiences and help us, Taylor some additional trainings it's going to be an evolving process we're going to learn as well.

>> **AUDIENCE MEMBER:** Anything in this evolving process male it's learning from individuals -- every individual has a different goal and different mind set what they want to achieve.

So -- we will, we welcome that feedback from everybody as this committee is becoming feedback from individuals throughout the process.

>> **PAM AUER:** Can I follow-up to Michelle's question she is very valid asking about it, it's part it it's more an adviser I don't know if Theo is here, advisory doesn't mean a whole lot.

He as he said to us, because it is, you can take whatever we say and it doesn't mean a whole lotted.

Are you hiring people with disabilities, are you, did you do the trainings? You said disabilities options network being contracted they're using their consumers and not necessarily just their staff, what are the other MCOs doing in order to train their service coordinators and make sure, um, that they know disability because, you can know about disabilities, and, still not have a clue.

I'm not trying to be rude but what you said today, was insulting to a few of us the lady in the gray --

>> **FEMALE SPEAKER:** Such as what.

>> **PAM AUER:** Maybe I'm sure you didn't realize it, when you were talking about you said something about people with disabilities and, serving them -- what?

About being normal able body people.

>> **FEMALE SPEAKER:** What I'm talking about, so --

>> **PAM AUER:** And you may not have realized it was insulting and you didn't mean it that way.

>> **FEMALE SPEAKER:** My family member would be insulted it wasn't intended that way but for -- I have a physical disability with my leg, okay.

Causes me, some days -- I'm good, some days, not.

What I'm talking about the talking well you would -- never really ever engage with, they receive it insurance services, but, they don't ever sit down with us and talk about their life dreams orchi Oregon choices, folks that have insurance, like some of my peers that have Blue Cross and blue shield when we talking about the walking well, we're not we're talking about folks that never want to talk to us or answer our phone call.

They don't need anything from us unless -- one a day they go to the hospital.

Right?

>> **AUDIENCE MEMBER:** They're afraid.

>> **FEMALE SPEAKER:** They never get stick or they don't even need

anything.

>> **AUDIENCE MEMBER:** Most of the time they're afraid.

>> **FEMALE SPEAKER:** Sure.

>> **FEMALE SPEAKER:** When we use that term it's really just the folks that want nothing from us, because they never need anything from health insurance.

But those of us that do -- or, will significantly at some point in our life that's who I was talking about, we do bring folks in, that have life experiences that are very tragic, that they have had, and family members it brings a lot of understanding but until you walk in the shoes of a person that lives it every day we don't have any understanding of that level, we just know.

>> **PAM AUER:** That's why I'm asking if you're hiring people with disabilities.

>> **BOB THIEL:** Just a point can we have everybody just answer Pam's question about that.

>> **FEMALE SPEAKER:** Pam we're committed to 20 positions it's not just training positions.

It's any position.

If you go onto our web site we're also at the hiring fair, tomorrow.

In Harrisburg.

We're hiring positions any position someone would qualify for to come and work for us we want people with diverse background to be apart

of you're culture.

So, it is not just, does the person have a disability, so we hire

them.

We are committed to people, of diverse backgrounds being employed

we've set aside positions we want to make sure, include folks with

disabilities.

>> **PAM AUER:** Trainers --

>> **FEMALE SPEAKER:** Trainers are key, also folks that engage

day-to-day on the phone with folks.

That -- exactly.

>> **KEVIN HANCOCK:** Can I speak to the point -- question we have Pam -- the point you made about trainers being engaged as partsst hiring

process is a key one.

Where one of the areas where -- the MCOs are challenged are that --

they, they are prohibited from direct marketing with participants so, I

think that all 3 of the MCAs would want to have participant engagement

as directed participant engagement as part of the training process.

But might be a challenge because of the fact that they are not in

the position to be able to direct market with participants at the same

time.

That being said I think that the point that you also made about

hiring individuals with disabilities to be part of the training team

makes a lot of sense.

>> **BOB THIEL:** We have another question behind ray there's a gentleman with a question.

>> **AUDIENCE MEMBER:** First one quick comment about what Tony was saying a couple of minutes ago, someone who spent five years in a nursing facility, nothing home like about it, it ask a facility.

I really have to echo what he was saying.

And then secondly, 3 in the front from Ameri health is it miss Rogers is that what it is -- hearing what happened in Iowa and I think there's a lot of fear in the room about you guys will do the same thing here.

How can you guarantee you're not going to screw it up here like you did there.

Thank you.

>> **MALE SPEAKER:** So -- so, this this AmeriHealth team that is working with community HealthChoices this is not the Iowa team this is, there are some lessons that we've learned from the Iowa process.

But -- this team has, extensive experience weeking together, with within the LT serks S world, that and we add as we move forward, we lessoned learned we take a look what we've done and again there is, community HealthChoices.

Excuse me this is not Iowa.

This is, AmeriHealth Caritas Pennsylvania communities HealthChoices and we are committed to this program, working together with the

department, to -- ensure that we, are successful and long lasting in this program.

>> **AUDIENCE MEMBER:** That sounds great I appreciate that.

And I heard Pennsylvania is different than Iowa.

That all sounds great.

But, what it -- you know --

>> **FEMALE SPEAKER:** What do we have to prove that.

>> **AUDIENCE MEMBER:** I understand this say different team you're still AmeriHealth.

Same employer.

What happens when you guys do or if you do.

>> **KEVIN HANCOCK:** To speak for the department it's not just a different team it's a different program.

Community HealthChoices has a different objectives than Iowa and certainly different objectedtives than some of the other states Pam mentioned earlier Nebraska, or Kansas and -- Texas.

Our objects is to we heard about the challenges that exist in the existing system and existing fee for service system, with service coordinators, with the delivery of services with nursing facility diversion we have we have been gathering that information not just for the last 2.5 years for planning but for the last 18 years of, living these programs question use them as the foundation for for building a better program with community HealthChoices taking all

these lessons learned not looking to save money and -- long-term services and supports system to build out a better system that addresses system fragmentation and addresses care coordination and just to make it work better for people because we actually want that to happen. And -- we, I can't speak for Iowa but we know what happened in Iowa.

I cannot speak for the Iowa AmeriHealth Caritas team but I can speak for what Pennsylvania is trying to do with community HealthChoices I have interacted enough with the Pennsylvania AmeriHealth Caritas team as well as UPMC and Pennsylvania Health & Wellness.

It's just -- a different mind set we want to build a better program that makes this system work better for people.

And we want the people who are -- who are going date of birth recipients of this program to be absolutely part of the process and full partners we've done that to this to date.

We've been very, very much involved in getting as much feedback do make this program work better expectation is that will continue I guarantee, that -- that, the folks who are -- who are, vocal and raising concerns will continue to do that we need to hear those concerns we know on day one our program is going to have opportunities for improvement we'll take this steps, to make those improvements over the next year.

When we get to the southeast, I -- our program will be, when we January 1, 2019 we think we have a pretty good program now, January 1,

2019 when we build up go Philadelphia and the five counties in the southeast, we know it's going to be a better program based upon the feedback we get from you and the lessons learned the lessons learned and, we get from the southeast implementation and, our goal is to make this program better than the system we have right now.

A lot better than the system we have right now.

And -- continuously better for participants as we go forward.

>> **AUDIENCE MEMBER:** I understand that I think it's nice you're coming to their defense.

I'm from the SILC I'm from here in Harrisburg I have no skin in the game.

I will not to be -- I'm not a provider.

So my question is really, you know I hope you Mr. Hancock share our concern about them.

Not you know, I hope there's things in place, that prevented it and they provide you with the some sufficient guarantee this will not happen, that's my only concern if you have that, great.

>> **KEVIN HANCOCK:** Fair question I mean, just be very clear we have over -- the department has over sight responsibility for all all 3 managed care organizations we not from a financial perspective but also from a service delivery perspective, we have, we have we have a -- absolute responsibility to to participants in and taxpayers to make sure this program is working and I know that you'll held us

accountable we -- we encourage you to do that.

>> **AUDIENCE MEMBER:** You don't realize that -- you're putting inter internet, there are people that can't afford more than one meal a day.

Let alone the internet.

What about people that are homeless veterans in a wheelchair or something.

>> **BOB THIEL:** We'll do one more question.

This is our last question for the MCO panel.

Pam you have a question?

>> **PAM AUER:** Last question, and I understand I agree with her really needing to pay attention to more than people that have the internet there's a lot of people out there, that you'll have to reach that I don't know if you really unless you continue to talk more with those of us that do the activists and advocates the CIL staff, um you're not going to know how to reach them, appropriately but -- the -- the other question I wanted to ask before, didn't get a chance to, would be interRAI and the service coordinators, connecting them and the training all of that.

How much are each of the -- MCOs going to give leeway to the supports coordinators in a judgment and documentation, you know when it comes to okay, the testing what we find says that person needs a -- ten hours but we flow that as a consumer why we need more hours than that.

The service coordinator knows that.

Is there going to be -- and, can we can my of the advocates in sit in on the training that you're doing with the service coordinators that we know because, um, we're great believe it or not we're a great allias for you if this is done right.

But us knowing up front what is really happening so we can use that, to help advocate for our people, um, is really important.

So there's a couple of questions there.

That I wanted to ask, how you know, what is the supports coordinator going to have and also, can we be trained and can we, know what is happening on the inside, so we can bring it back out.

And -- um, and educate our consumers.

>> **FEMALE STUDENT:** So that is an absolutely great idea, what I really like to do is, to schedule time so you can hear what our how our trainer does the whole process, does that, does that make sense? Like if I, we had our trainer walk through what they're doing and how they're training.

So I mean -- you're welcome to hear what they're doing to train to the interRAI but -- to understand the whole interRAI process how, how they were educated to your point, that interRAI doesn't say they get ten hours it really is, looking at the whole picture.

And talking to the people who support you, or support you who say, you know what?

I see that, maybe -- you know, after they go to the doctors, they're more fatigued they need more help, and those are things that we really like to hear because -- okay.

We flow that, you -- go to the doctors on Tuesdays we want to make sure we have that extra support there for you.

So it's more than just, this is what the interRAI says it's so important to see the big picture and to hear everything.

>> **PAM AUER:** How do we get that? But reality is that at some point , somewhere, there's going to be a discrepancy it's -- you know, are they going to have the ability who is going to have the final say what is you know, step by step, and you know, I was listening talking with some of my other people some of the other things is, you know, with the grievance processes.

All the way through -- people need to know that up front because there's going date of birth discrepancies, everything that is sent out can you go to Kevin at the state.

If up a prep between the MCOs but I'm going to be quiet I want to let the other MC Os Mr. Chairman if that's okay.

>> **BOB THIEL:** Answer the same question please as Pam said regarding --

>> **FEMALE SPEAKER:** So the answer is yes your service coordinator should, be your advocate help I you get that through if you're not choose a different service coordinator get a different one, advocate

get another one.

Yes, I'll happy to have folks come in and sit in on our training and listen and happy to provide you information.

>> **MALE SPEAKER:** And you know, I think our answer, would be consistent.

So, the again it's a person centered process, the service coordinators is working, with the participant on the service plan.

And if there is a disagreement it's not the first line of defense is work through with the person centered planning team and the service coordinator.

If there is ultimatedly disagreement that escalates and the supervisor will work with the participant and the service coordinator and, make sure that, you know, the plan is appropriate, and then, again that's where, if there's still continued disagreement we have mechanisms like the fair hearing process, where that person can exercise their rights and get an independent judgment on whether or not we got it right.

So -- I will, you know, also emphasize that, our service coordinators will be highly trained the team we've brought on already has been through more than 33 weeks of training and they have been on board doing aloft scenario building and role playing spending time you know really -- cultivating their skills including training from people with disabilities, through the UPMC disability resource center.

We employ people with gateses we

take these things seriously we can do a better job working on this, the interRAI part it's a person centered process where the person is there with the service coordinator working through that service plan development.

>> **BOB THIEL:** Thank the MCOs for taking questions and comments and listening Kevin would like to get, quickly through the IEB. Enrollment just wants to hit a couple of slides.

>> **KEVIN HANCOCK:** I won't include the entire presentation as part of the distribution for the meeting we want the to hit two slides -- just to give you the total numbers, that occurred with auto assignments. Auto assignments and plan transition actually took place on November 18th.

>> **MALE SPEAKER:** As a reminder for people, participantness the southwest can continue to change their managed care organizations all the way up until December 29th. But these are the results from the planned transitions by population.

We had -- 79,433 individuals part of transition process, 57,959 were, the -- dual eligible not nursing facility clinically eligible populations 7893 were the home and community based dual population. 2522 were the home and community based non-dual population. 10,241 were the long-term care or nursing facility dual populations. And 818 were the long-term care non-dual populations so that is the

break out of people who went through this transition process in the southwest in November we'll move to the next slide and show how they broke out by plan selection.

For the advanced plan selection represents the number of individuals who selected their plan or, were part of an aligned dual special needs plan.

That total was 38,680 individuals who selected the plan that is, roughly, 50 percent of the total population.

For -- from a state comparison this is say pretty great outcome we're pretty pleased with plan selection we hope do better in the southeast using this as our goal, compared to other states we're very happy with our advanced plan selection.

Sister assignment, that 1886 individuals those are individuals who were, in a HealthChoices managed care organization, they were a non-dual individual and HealthChoices managed care organization they were assigned to a -- a aligned community HealthChoices managed care organization, and then the auto assignments were people who were auto assigned in the plan because they didn't make a choice or otherwise I'll finish and answer your question very quickly.

So -- as it turns out this is the distribution obviously UPMC had the largest percentage of roughly 50 percent, Pennsylvania Health & Wellness, 28.5 percent. And AmeriHealth Caritas, 21.2, that's the rest of the information will be in the meeting minutes.

>> **AUDIENCE MEMBER:** I'll make this comment again all these numbers up here where are they coming from, are they coming from the actual consumer or the companies that they the the companies that the consumer is working with you? Are you hearing the actual voices? Or is it being pilled out for them.

Half the stuff you get up here today I don't understand what they're doing.

I have a BA.

>> **KEVIN HANCOCK:** Sure so the -- for the people who -- the 38,680 individuals who selected the plan, the assumption is, they they selected the plan.

>> **AUDIENCE MEMBER:** Assumption how do you know that is true.

>> **KEVIN HANCOCK:** The way we know they would have reached out to the independent enrollment broker.

>> **AUDIENCE MEMBER:** No they won't.

That's why you're having problems with the consumers now, whenever you get a phone call, from a 1800 number from the insurance.

Consumers get frustrated they hang up.

They don't really participate in it.

You said some got put in automatically they didn't want to answer what you're putting on those papers the packet is really big.

The terms you're using and the acronyms, many consumers are not going to understand.

I don't understand.

>> **KEVIN HANCOCK:** One thing I have to say.

So -- to be able to make the plan selection, they would have actually, they would either mail something into this.

Or they would have called the independent enrollment breaker the independent enrollment broker would have called them as a reminder.

But the participants would have -- would have called themselves.

But to your point, we always look for opportunities to improve the way we communicate to people.

>> **AUDIENCE MEMBER:** That's what I'm trying to tell you you're saying all these people are going to call in.

99 percent of them are not.

You're getting very few that are.

You'll put the ones that, don't answer, into the audio.

So either way they're going to be chosen.

It's going to be chosen for them not by them.

>> **KEVIN HANCOCK:** I understand that.

>> **AUDIENCE MEMBER:** Either you class or it will be chosen for you.

>> **AUDIENCE MEMBER:** Either way you are end up stuck in a program you're not sure of.

>> **AUDIENCE MEMBER:** From what I'm understanding from everybody -- that you're able to --

>> **BOB THIEL:** Can you please put your microphone on.

>> **FEMALE SPEAKER:** Sorry for the people on the phone my understanding is within all of the companies you can change after your initial --

>> **KEVIN HANCOCK:** You can change at any time.

>> **FEMALE SPEAKER:** It's not like you have to wait until next year and before seventh.

>> **AUDIENCE MEMBER:** Wait 2 months after the process starts.

>> **FEMALE SPEAKER:** No.

>> **KEVIN HANCOCK:** You can change at any time.

It's not effective immediately the day of the change.

There's a little bit of a delay.

Yeah. Right.

Jen mentioned earlier, if you make your change first half of the month, the change is affected the first of the following month, if you make the change in the seconds half.

>> **AUDIENCE MEMBER:** I'll scare the consumers and they're going to be put into a program.

Either they don't understand or they just sign because they want to get you guys off their back I don't understand a darn thing about the programs that you just put out here.

All I notify is someone going to choose I'm still not going to get what -- get that choice you already have a program now.

It's going to be your choice.

Not ours.

>> KEVIN HANCOCK: All I can ask you help us communicate to the participants better as we move forward in the southeast.

>> BOB THIEL: Okay.

That will conclude the meeting if anyone has any other questions on comments -- you can email RA-PWCHC@pa.gov.

Next meeting is January 3, 2018.

>> DEPUTY SECRETARY BURNETT: Thanks so much boob for stepping in for Bob thank you search committee I have really enjoyed getting know you all.

And -- thank you you everybody.