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DATE: January 3, 2018

EVENT: Managed Long-Term Services and Supports Meeting

>> BOB THEIL: Good morning everyone.

We'll call the meeting to order.

First we will take attendance.

We'll run down the list here.

Arsen Ustayev?

Barbara Polzer, Blair.

Brenda Dare.

Denise Curry, Drew Nagele.

>> Here.

>> Estella Hyde.

Fred Hess we have a new member, Heshie Zinman, are you on the phone?

Jack Kane?

>> MALE SPEAKER: Here.

>> BOB THEIL: James Fetzner.

>> MALE SPEAKER: Here.

>> BOB THEIL: Juanita Gray. Pam is not here. My name is Bob Thiel, I work with her.

>> RALPH TRAINER: Hello.

>> FRED HESS: That's where we were getting feedback.

>> BOB THEIL: Ray Prushnok, Richard Kovalesky.

Steven Touzell.

Tanya Teglo is on the phone.

Terry Brennan.

Theo Brady.

>> THEO BRADDY: Here.

>> BOB THEIL: Veronica Comfort, William White.

Okay.

Thank you.

We'll now review the housekeeping rules.

Committee rules as always, please, use professional language, professionalism, point of order, redirect comments through the chairman, wait until called, keep comments to two

minutes, we had a lot of problems last meeting we had people didn't get a chance to talk and we want to make sure we kind of keep that tight schedule as possible so we have time at the end for everyone's comments.

Meeting minutes the transcripts and the meeting documents are posted on the Listserv at Listserv@dpw.state.pa.us.

Under MLTSS meeting minutes, documents are posted within a few days of the meeting.

There's a captionist here as well.

The captionist is documenting the discussion so please speak clearly and slowly.

Please turn off your cell phones please clean up after yourself when the meeting is over.

Public comments will be taken during presentations instead of being at the heard of the meeting there will be additional 15 minute period at the end of the meeting for additional comments.

2018 MLTSS sub-MAAC meeting dates are available on the Department of Human Services web site.

I will not read it out it's very long.

As I said earlier we have a new member, Heshie Zinman, are you on the phone? Next time, I don't know at the next meeting we'll let them introduce themselves.

New the emergency evacuation procedures.

>> FRED HESS: In event of emergency or evacuation we will proceed to the assembly area to the left, of the Zion church on the corner of fourth and market, if you acquire assistance to evacuate, you must go to save area located right outside the main doors the hon honors Suite, OLTL staffing with you.

Everyone must exit take all belongings with, do not operate cell phones do not, try to use the elevators they will not work they will be locked

down, use stair one and two.

For one, you exit through the doors left side near the elevator, turn right go down the hallway, water fountain, on the left.

For number 2, exit through the side doors, or the back doors for those exiting from the side doors it's in front of you.

For those exiting from the back doors, turn left, and then turn left again, and stairwell two will be ahead.

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

Participate turn left, and walk down Dewberry alley to Chestnut Street, turn left to Fourth Street and turn believe to Blackberry and cross Fourth Street to the train station we'll meet there and do a head count.

>> BOB THEIL: Thank you Fred, ray is here as well he just came for the people on the phone.

We will start, the meeting before we start though, these two fire doors in the

back under the sides, lanes have to be kept open, thank you.

We'll start with an update, from Heather -- I'm sorry.

>> FRED HESS: Yeah.

For those who know her, Michelle Sipe was a member of the ADAPT and a huge advocate for people with disabilities she was going to be the one that is going to take over for me here, after my second two-year term.

She passed away last Thursday.

Shell not be with us anymore.

So -- I would like to take one minute in recognition of her and everything she has done.

[moment of recognition]

>> BOB THEIL: Thank you Fred we will start with the agenda.

First up we have, Heather Hallman to update us on the CHC web site.

Heather.

>> HEATHER HALLMAN: Can you all hear me?

Is this working?

All right.

I feel like I'm not qualified to use microphones and stuff.

[laughter]

All right.

So, thank you everyone I will give anyone five dollars if they can repeat Fred's instructions how to get out of here.

[laughter]

No.

Okay.

I figured it was a pretty safe bet.

You did a great job of reading it.

So -- good job.

All right.

So I'm here to talk to you today about the community HealthChoices web site.

So what we have done is, we have created one web site, for HealthChoices all together so if you go to HealthChoices.pa.gov.

I told you I'm not qualified to use microphones.

[laughter]

All right.

So just to repeat what I just said we have one web site for HealthChoices we have HealthChoices.pa.gov.

If you go to that web site, we have 2 portals, so one is directed towards providers and the second one is directed, towards participants so that's one that says information on services so let's start out with participants?

All right.

So whether you go here you'll be given 4 options, it tells you how to apply.

Then you're given that physical HealthChoices, behavioral HealthChoices an community HealthChoices we'll focus on community HealthChoices today.

So on our participant site we wanted to make sure that it is very easy to find documents that all participants have received we want to make sure if we

send something to a participant, that is available on our web site so anyone can see it, or people can print copies for themselves if they loose them.

So -- go back up.

Thank you.

So, um, if you hit read participant documents at the top, all right.

Then scroll down.

There we have everything so we have sent an initial flier we have that there in 3 different languages we'll be especially as we roll out in the southeast we'll be increasing the number of languages we have things available in.

So we have the -- you know informational flier.

We had the invitation for community meetings, which when we roll out in the southeast we'll have new community meetings there.

We have information on the LIFE program and then, also, we included every notice that was sent out so people

could easily pull up any notice, particularly for providers who might be interested in what notices are available.

You scroll down a little bit more, we also have the preenrollment packets that were mailed out by the independent enrollment broker.

The post enrollment packets that's after someone selected their plan and then we also have some links for social media, so people can follow us on Twitter how many people follow us on Twitter.

[laughter]

How many people are Facebook friends with us.

Okay.

That's a little bit better.

[laughter]

Okay.

All right good.

All right.

I'm not even, following us on YouTube so -- that doesn't county don't

know we do a lot of YouTube actually if you do scroll up, we do have information there, we have a little a short video that we had done very, very early in the CHC process.

So that's what we currently have available for participants.

We will be, creating more documents one thing -- actually one I am realizing is not up here that should be up here, we had created a one pager about Medicare because we realized during the participant sessions, people really were concerned about their Medicare now you know it's 94 percent of the CHC is dual eligible, we have a fact sheet we'll put that up here.

Kevin remind me.

If we can go back now, do the provider side, so you click providers, click on community HealthChoices.

All right, first and foremost, we have to subscribe to our -- our, Listserv.

So how many people are on our

listserv?

Okay.

Significantly better this is actually I figured you guys would be the largest group that is I'm very proud of you all for doing that, if you did not raise your hand, you have 15 minutes to get it done or we'll kick you out of the meeting.

[laughter]

Okay.

Just kidding because -- I don't have any authority to do that.

So any way, I'll get Fred after you.

Okay.

So are you so then we also have, publications page we're not going click on that.

We also have, millions of frequently asked questions.

So, if you click on the frequently asked questions, so we had taken and it was not me when I say we, other people pains takingly took every question that we received during the public event this

is the provider events we did in the southwest.

It's provider events we did in the southeast they created frequently asked questions.

So here, I can almost guarantee you if you have a question about community HealthChoices, you can find it on here.

We are looking at ways to make it easier to find these.

Literally I think 900 questions at this point.

So even gist figuring out is your question a general CHC question? Or is it about the independent enrollment broker.

Eligibility system?

So we want to make it easier and we are, working with our IT people to make it easier for you guys but, right now, if you want to find an answer to anything, go here.

All right. And if you guys are bored later in the meeting you can have a

competition to see who could ask a question not in the FAQs I'm not going in charge of that.

Frequently asked questions if we can go back -- all right.

Scroll down.

So next that's just the video that we talked about, so trainings, how many people have taken the trainings on the web site.

Those who have not, you probably know all the information because you attend these meetings on a regular basis, but I really encourage you to take these.

We have heard really positive feedback from people about how easy they are to understand.

And we did a lot of work to make it simple for people to understand.

So, while you might not need to take it, because you sit here every month, um, and you have learned so much about CHC and probably know more about CHC than I do, it's great for you to

get these out to your people.

Who might not know as much.

We have had a ton of great feedback on it, so I really, heavily encourage you.

We're going to use these a lot in the southeast as we move forward.

We want people to have the base understanding of the community HealthChoices the CHC overview training is that.

We then have one just for regular providers, so home and community based providers.

And then, physical health providers and we also have one for service coordinators we actually have it, two different ways, service coordinators could do it through the general link what we really want them to do is do it, through -- that web site by clicking on that other link.

That way we can track which service coordinators have actually taken it.

Because we really want to be able to

make sure that service coordinators are taking this.

They are -- some of the front lines with participants and we want to make sure they fully understand CHC and know how to talk to the participants.

So click that link.

For nursing facilities, again, the same thing we have two different links for that.

We really have I think it's a really great training to teach nursing facilities about not only how does CHC impact them but also how to talk to the participants about CHC.

So take those trainings.

All right? If everybody does, Fred will give everyone five dollars in the room.

[laughter]

Don't you like how I promise things for you.

Yeah.

>> FRED HESS: That's okay you can pay me to do it.

>> HEATHER HALLMAN: Usually I make it for Kevin my fall guy I'm really focused on Fred for some reason today.

Scrolling down, provider documents I've been here to talk to you guys about, we've tried to get out, fact sheets on, a ton of topics that are of interest to providers we've gotten a lot of positive feedback on these because they're just, random topics you don't have to go through entire long training to get your answer it's a fact sheet that is available just there for you.

So we have made them all available right here for you.

We also have two more that I think are almost finalized, we have one, that just describes the community HealthChoices populations. And then, the other one that we really want to get out quickly is how to use the eligibility verification system because I think a lot of providers while they're, we say you're supposed to check EBS every time

someone comes in your door people don't necessarily do that. And we also know that there's new codes and all of that.

So we're going do get that one out as soon as possible. And then below you can see, we have a contact there.

If people want to email us questions we do get regular questions from people.

That we respond to.

So that's it.

Do I have questions?

Was it mind blowing and amazing.

Yes.

>> AUDIENCE MEMBER: The first part is going to be confusing you probably want to change the part that right there you'll want participant or something.

First of all, because we want consumers know where they want to go to.

The other thing is, is there training for consumers on there as well.

As well as providers.

>> HEATHER HALLMAN: We have not developed a training for participants, because we do the in person participant sessions with them.

We have talked about doing a to doing an webinar we can put that up there for them.

No to a webinar like a training webinar.

That we could post on the web site, for them but I think it's a good point that we need to do a little bit better of a job of doing, more for the web site for participants.

>> AUDIENCE MEMBER: Break down your language more too, maybe make it easier for people on the consumer side to read it and understand, people with lower reading level.

>> HEATHER HALLMAN: Okay.

So the comment was that, we should look at lower reading levels with the web site.

That's a good point.

>> AUDIENCE MEMBER: The other thing she was trying to point out is you keep saying webinars, phone calls, many consumers I'm sorry, my voice isn't so loud.

Many consumers especially low income consumers or just people, still do not have access to the computer.

>> HEATHER HALLMAN: That's --

>> AUDIENCE MEMBER: You want them to do the webinars all this other mess.

>> HEATHER HALLMAN: So the comment was that a lot of, participants might not have access to a computer in order to do a webinar.

That is why we have in person meetings for participants, because we fully recognize that and also, it is so much easier to ask a person, face-to-face a question.

So that's why we have tried to make it available in multiple ways we have the

participant help line available for people to call if they have questions.

We also have the available the in person meetings. And, we also try to send all of the information as clearly as possible you know how complicated it can be we try our best.

>> AUDIENCE MEMBER: All this paperwork you presented in front of us I know most of the people I know, would put that to the side and just say, what the heck is this? I just have to sign up for something.

Don't really have to examine what you present.

>> HEATHER HALLMAN: The comment is, people are not going necessarily examine I think that you're accurate with some people absolutely are not going to do that I don't know, if you have -- have, like any kind of suggestion how we could try to increase that I think you know with -- with the advanced plan selection I think it was 40 percent of

participants actually chose their own plan.

And so we recognize that at least 40 percent of them, made that active selection prior to I would love it, to be 100 percent of people making that selection and so, if you have fully suggestions, on how we can improve those ways we absolutely would take them.

>> AUDIENCE MEMBER: Out of the 40 percent, how many of that, is low income and disabled individuals?

>> HEATHER HALLMAN: I could not tell I mean, by definition if they're on Medicaid they're low income.

So -- I would venture to say all of them.

>> AUDIENCE MEMBER: From what it sounds like mostly, um, the insurance is taking the choices showing the people to choose how to choose it.

Not the consumer themselves.

>> HEATHER HALLMAN: Could you

repeat that the -- the insurance was telling them who to choose.

>> AUDIENCE MEMBER: Insurances, the so called counselors that you're presenting.

The person themselves is not looking at what you're presenting they're saying we just have to sign up for it.

They don't know what you're putting on the papers I have trouble understanding what you just went through with this.

Like, Pam said a nice language that we can understand.

I mean, I was here for the last meeting, you guys still didn't -- get what I was talking about when I said people, will not understand this language.

You're taking from what you're saying, not from what consumers are saying.

I came to you and said I don't know how to do this, how would you explain this to me without a bunch of written

words.

>> HEATHER HALLMAN: I fully understand and, for people that are on the phone can't hear, the comment was that people, don't necessarily, read what we give them or understand what we send to them.

And that we need to use words that make more sense to them.

We have for the notices and for everything that we have sent to participants, we have gone through an extensive process with participants.

We actual will listened them to the MLTSS sub-MAAC to give us feedback to say what words we should use we have really tried that.

I will fully -- I fully get that not everybody is going to understand that and needs more one on one sitting and as you have a question I can answer that question for you.

When you don't understand what I say back, I can sit and tell you that.

That's why we really focused on those, in person meetings.

So that people can really tell you, and answer your questions, to your satisfaction.

Drew?

>> MALE SPEAKER: Would it be possible to ask the MCOs to have their explanation of what they are offering to participants perhaps they already do I'm not sure, where that is.

And, see how they do, at putting it into language that people can understand?

>> HEATHER HALLMAN: So, I don't -- Kevin maybe better to answer it.

>> KEVIN HANCOCK: Make sure I understand what you're asking.

You want the MCOs to talk about what information they make available to participants that they mail, and what information they make available to participants that are on the web site, is that correct?

>> MALE SPEAKER: Correct.

I am assuming there would be, same version of the --

>> KEVIN HANCOCK: Tanya thank you.

>> MALE SPEAKER: Yes, Kevin I think it would be an analogous version possibly on their web sites and some analogous information that would be sent to participants.

>> KEVIN HANCOCK: Proposing a future agenda item that's a great idea.

I'm not sure if they were prepared do that today.

>> MALE SPEAKER: They may not be I'm just wondering because, I mean, the participants have to make a decision between the 3 MCOs how are they to do that? I think you probably want the MCOs, to show participants, what they're going to do for them. And you know I don't want to Dog and Pony show or sales pitch I think that, this burden of telling people what it is, and what they're

signing up for should be on the MCOs.

>> HEATHER HALLMAN: Can I make a suggestion if you don't want a sales pitch, which is, MCOs come and show you the web site they will show you the best parts of the web sites.

Potentially, if you guys, would take the opportunity over the next month to go to the web sites an see what a participant, actually sees how they feel about it I think that would be a great exercise for the next meeting or even prior to the next meeting, to give that feedback, I think that will be, on a better opportunity because then you're not having someone present it, it's how you would go and view it. And particularly, every participant in the room to be able to see.

>> MALE SPEAKER: You're not recognizing.

>> KEVIN HANCOCK: You're recommending to the committee members anyone that would be willing to

give feedback not only, to the MCO information and also to, be the content that Heather just reviewed if you have any suggestions how it could be approved improved or -- how we can make it more accessible we are, very, very cooperative and appreciative of any of that feedback.

>> MALE SPEAKER: To follow-up on that, is there a place on the right branch which now will say participant information, right.

>> HEATHER HALLMAN: Because not everybody knows that they're participant, they might be coming in here new.

We'll figure it out.

>> MALE SPEAKER: Just so it's clear where they should go, because that's, just looking at those two buttons people might not know which button to go to.

Is there a place, they do go on the right branch that will take them to the right place on the 3 MCOs web site so

they can learn about their programs and make, an informed choice.

>> HEATHER HALLMAN: We, too my knowledge we don't have that up there yet.

We will put that up there, that's a great point and I think that, we can probably just send out the web sites to everyone on the -- on the Listserv for that.

So they can have, access to it, because that's a big point, we do not have that out there yet.

>> MALE SPEAKER: If you can make the place you send them to be the right place, because if you go to these MCOs web sites you cannot find where to go I mean it's not clear.

>> HEATHER HALLMAN: Ideally that's a great point ideally it would be easy to find it would be, easy to Google it will be easy so those are things that we need to improve upon.

Absolutely.

So The o, he had his hand up forever.

>> MALE SPEAKER: My name is Lester with the supports coordination, we're in Allegheny County.

>> KEVIN HANCOCK: Mind using the microphone.

>> MALE SPEAKER: My name is Lester Bennett from Allegheny County right in the center of Pittsburgh where we started all this.

We all said MAXIMUS is going to be able to explain to individuals, what their choices with are I have an individual who called MAXIMUS and could not get any answers so, like these people were saying she didn't have access to the internet she was not able to go on the web page and, see what was out there.

She called MAXIMUS like I explained to her.

She still, like 40 percent you can say she chose, she didn't choose based off what she wanted.

So, we want to give the people

choice, based off what she gets she made a choice of the MCO like we all wanted her to do it wasn't based off what she needed.

She wasn't getting any answers.

>> HEATHER HALLMAN: Can you tell me more specifically, what questions, she.

>> AUDIENCE MEMBER: Asking about Medicare and Medicaid, how it is going to be worked out, if she wanted to go to see a specialist in different areas in different states anything of that nature, there was no answer.

So she made a choice but it wasn't based off of the answers that she was given.

>> HEATHER HALLMAN: I don't know if she remembers the date and time in which she called we can actually go and pull that call and listen to it.

I will say, maximum should have been able to answer her questions about how Medicare and Medicaid work

together.

They should have been able to answer questions what providers were in the network.

They're not going to be able to my knowledge be able to answer the question about whether she can see specialists out-of-state.

Because I think, depends upon the particular management care organization.

>> KEVIN HANCOCK: MAXIMUS will be not be answering Medicaid benefit questions they should be able to they should have been able to answer the questions the relationship between Medicare and Medicaid in coverage and what networks.

>> HEATHER HALLMAN: If you have more information, because, what we've been able to do, if someone had a batted experience with MAXIMUS, they weren't able to answer their questions we've been able to go and listen to the call the

MAXIMUS does training with that particular staff person and then, also shares that information with other staff to make sure they know.

So, I would, if you can possibly get that information, if not, if you ever have future situations, get really detailed information, because they get hundreds of calls.

In a day.

So if you can get detailed information, we'll be able to really check it, okay.

>> AUDIENCE MEMBER: Thank you.

>> HEATHER HALLMAN: Tanya next.

>> KEVIN HANCOCK: Hello Tanya you had a question.

>> FEMALE SPEAKER: Yes, well, more of a comment.

In terms of, like documentation that has gone out, to consumers about the CHC I know myself, personally, any draft of fully document, you ever asked us to look at I personally went through line by

line and edited them, so they had proper language and everything else in them, but the problem with it all was, no one took our suggestions into account or I never saw any of the changes because like when you guys wrote up your documents, you use in yours so many times, so many times in one sentence, no wonder why people can't figure out the language, it has to be made more -- if you actually really want them to understand it.

I understand that you're trying to get through to people at all education levels.

You shouldn't assume that the general population that you're talking to can't and will can't handle the reading a regularly written document either.

You see what I'm saying.

>> KEVIN HANCOCK: Understood Tanya, her two comments she made that -- that a lot of the suggestions that you made, for editing were not accepted and, one comment we can make to everybody

in the -- on the committee, certainly is that, if we're not going to be accepting your edits we should explain to you why.

That's an important component.

And you also made the comment, that -- if a, if you're providing information, we certainly do want to make sure the information is made available and accessible to everybody at every reading level.

But we shouldn't make assumptions based on that attempt and we'll think about it.

>> HEATHER HALLMAN: I will say that we have legal requirements, around reading level and so if edits do make it more of a higher reading level and does not we can use other words to make it a lower reading level we, tend to try to do that.

Not to make people feel like they can't understand it but we really do want to make it as simple as possible.

>> FEMALE SPEAKER: Okay.

What I'm saying is, we need you and your six times in one paragraph, do it repeatedly throughout a document, it makes it as confusing as if you would use synonyms or homophones or something to make the make the document more clearly to read I went through like, I don't know, how many different documents how many different times trying to fix that issue never got any feedback from anyone as to why that was never fixed.

>> HEATHER HALLMAN: I will say, Tanya, I am sorry we never got back to you, to tell you why we did not.

Your edits are not the only one that's we received.

And so, from other consumer we received edits from, they were not consistent with yours we will get back to you more in the future when you make edits.

>> FEMALE SPEAKER: Because if I'm putting that much work into doing them,

a little bit of feedback would be have been nice and, to see some of the changes made in the documents, you don't have to treat people like they're too stupid, don't even have a high school education to figure it out.

If our standard doesn't start to change as people with disabilities will handle the whole culture will never change.

A system as a government, as a people, we should be fighting against that.

>> KEVIN HANCOCK: Understood Tanya we appreciate the feedback the one comment we'll make is to make sure you understand how we're using your comments when we can and cannot accept them.

>> FEMALE SPEAKER: Thank you.

>> BOB THEIL: Thank you very much Heather.

We'll move onto the OLTL update with Kevin Hancock.

>> KEVIN HANCOCK: Happy New Year everybody.

So I'm going to -- and Gabriel you'll keep up with me.

Obviously, CHC is now a live program it began on January 1st in the southwest and we have approximately 85,000 people enrolled in the program right now.

So, I think, we can consider it -- all this is, this program is built on the shoulders of your feedback and the work you've provided and helping make this program successful as it could be, recognizing that there are certainly lots of opportunities for improvements and, just to make very, very clear we're very open and welcome how we can make this program work better for people.

In the end this program is your program, program for participants and we want to make sure that, the goal of the program, to improve participant services and all of the objectives that we

have for community HealthChoices, are meeting the needs of the participants.

So with that I'll give you a couple quick updates on community HealthChoices feel free to ask questions as we go through it, it might just be, help -- the questions you ask might actually cover material we have later in the presentation.

Feel free to ask questions as we go through it.

First, we have five goals with that are part of 2018 the first is, obviously, successful launch of the first phase of the community HealthChoices in the southwest.

The focuses, especially in the continuity care of period will be assure there's no interruption in participant services and assuring there's no interruption in provider payments.

They're beige two sides of the same coin making sure the program is stable.

Making sure that, there's no risk for

participants as we go forward for this, we're working diligently with the MCOs we have calls with them every day.

We have weekly calls with the participants and providers and provider associations, to talk about, any type of issue that's are arising try to get ahead of them as quickly as possible this is built on, the focus of, making sure that, there's no interruption of participant services and no interruption of provider payment.

Second goal, yes, it is true that we are launched in the southwest.

But we also have a year to launch in the -- to implement the southeast.

We recognize there are, really significant differences between the southwest and the southeast.

And, we want to make sure that we're, taking as much time as possible in building out our strategy for this implementation and it's already, to be perfectly honest it's begun, area that's a

focus already been mentioned, from the comments, is to review our participant communication make it better. And to make it more appropriate for the populations we're targeting in -- the southeast to move into community HealthChoices.

One of the biggest differences between the southwest and southeast there are many, many differences one of the biggest differences is the variety of languages that are used by participants in the southeast.

There are certainly many languages in the southwest but, there are many more in the southeast used we want to make sure our participant communication takes into consideration, language differences, cultural differences, requirements for cultural competency and making sure that we're reaching the populations we need to reach, in the best and right way.

And, that is all about, communication.

And we will take any suggestions that you have to offer to be able to help us reach these populations that, may not necessarily, be as easy to -- to, identify through the means we used in the southwest.

We'll also continue robust ready any review process, most of focusing on the building out provider networks we'll start earlier than we did in the southwest we can, number one.

And, number 2, because, we recognize that even the structure of the providers in the southeast is different.

Some ways, it's -- very complex, certainly complex in the southwest but are but there are additional complexities we want to take into consideration.

We were also going to be building on, we have a lot of lessons learned on provider communication and training.

From the southwest we'll be incorporating into the southeast as well.

To a lot of those lessons are based

upon the fact that we need to start earlier and we will be starting earlier and we'll be having, we'll be having, sessions, last year we started sessions in late July, we're going to, planning to do those sessions a lot earlier we may need to do more of them we may need to have more provider type questions as well.

I think that our objective is to is to make sure that, providers know how this change is going to be effecting them as early as possible that is a lesson learned.

We, we were happy the way we approached it in the southwest we know we can do that's one of our goals sir do you have a question?

>> AUDIENCE MEMBER: Yeah.

Hello my name is Tony Brooks from the southeast I'm from Philadelphia I'm a member of ADA parks T.

Just a quick question.

The MCOs, working with people in the southwest are you working with the local services which are provided for the

consumers?

>> KEVIN HANCOCK: Southwest yes.

>> AUDIENCE MEMBER: Have you had any issues that you have to modify or anything like that? That we need to know in the southeast.

>> KEVIN HANCOCK: We're, there are -- well, to be honest we're on day 3, so --

[laughter]

>> AUDIENCE MEMBER: It's not day 3 you started it last year in general -- in the summertime.

So --

>> KEVIN HANCOCK: One thing I'm going say is definitely lesson learned.

We had -- we started a lot of our activities later in the southwest than we plan to start in the southeast part of that related to, procurement issues we weren't able to communicate with the MCOs until the end of margining of April.

Even then we had to build out

capacity to be able to get started we don't have those same impediments now in the southeast we can start, immediately we plan to.

I also know that all of the 3 MCOs are beginning to work out their provider networks in the south.

We'll be building out our participant communication at the same time lesson number one start earlier.

Other issues, we know that based upon what we learned in the southwest we'll be making adjustments even in the even in the way that services are delivered in the southeast probably not major changes we'll recognize areas ever improvement pretty quickly we're planning to incorporate those changes as quickly as we can.

Appreciate the question thank I very much.

Okay.

Also focused on the southeast is, pre-transition and plan selection for

southeast recipients we are hoping to be able to start that earlier as well.

The reason why is because -- we want to be able to provide as much opportunity for planned choice as Heather mentioned we had 40 percent plan selection in the southwest which is really -- Heather didn't state this, this is, compared to other managed long-term services and supports roll outs that's a really significant, that's a really significant percentage.

We want it to be much better than that.

Our goal is certainly to have it better than 40 percent in the southeast part of the way we'll do that is to potentially start earlier.

Then already mentioned we'll be incorporating as many lessons learned as possible from the southwest launching implementation.

A lot of people in the southwest including Fred have told me that -- they

are, Guinea pigs for HealthChoices I would not characterize it that way.

>> FRED HESS: Test subjects.

[laughter]

>> KEVIN HANCOCK: Positive really.

We just, had a lot of, a lot of opportunities in the southwest.

That help us build out the program and any lesson learned that is Incorporated for the southeast launch will be reflected in the way we change the program for southwest participants as well from our perspective.

Not only are they helping with the southeast launch but helping to improve the program for the southwest.

>> FRED HESS: Anything I see going on in the southwest I'm letting them know it doesn't happen in the southeast on the third phase of the roll out.

>> KEVIN HANCOCK: We appreciate that very much, he means it.

>> FRED HESS: Yes.

>> KEVIN HANCOCK: Additional goals we're focusing on in 2018.

>> MALE SPEAKER: You said about the 40 percent, who did make the selection, so -- I guess the converse is 60 percent of people were auto assigned to an MCO I'm just wondering what the process is for those people now, that we're in day 3 of them realizing they are auto assigned and, that, you know, if they're exploring who are the providers in the MCO that they are auto assigned to and they, want to make a switch, what do they do?

>> KEVIN HANCOCK: Sure.

So just to break down that 60 percent a little bit further.

Approximately 9,000 individuals, were what we call intelligently assigned into an aligned dual special needs plan.

That was the, the sister plan to the community HealthChoices plan.

So in addition to the -- in addition to the 40 percent, that selected their plan

we had an intelligent assignment to aligned Medicare product.

That is also part of the process.

But for the remainder they were auto assigned.

And they were informed of that auto assignment what we call post enrollment packet that was sent by MAXIMUS the independent enrollment broker.

They started receiving that at the end of November, through the first two weeks of December.

And, several of those people receiving those, called the independent enrollment broker and made plan changes and those plan changes were able up to close of business, December 29th.

Now, people can make a plan change at any time.

So, if they have been auto assigned to a plan that has a network doesn't meet their needs or requirements, all they have do is contact the independent enrollment broker and make a plan

selection.

The plan change. And if they changed in the first 15 days of the month or the first half of the month, that change will be effective the first of the following month.

If think change in the second half of the month, that change will be, effective the first ever month after that, they make a change today, it will be effective February 1st and if they make a change on, January 18th, it will be effective on March 1st thank you very much for the question.

>> AUDIENCE MEMBER: Lester had a question.

>> AUDIENCE MEMBER: I was just --

>> FRED HESS: Pam do you have one?

>> AUDIENCE MEMBER: Probably quicker if you repeat what I ask.

>> FRED HESS: Sure.

>> AUDIENCE MEMBER: With things

that -- problems I was seeing, people understanding the continuity of care, do you have a cheat sheet, boom boom this is what continuity of care means?

A cheat sheet, with bullets on, okay.

You're auto enrolled, you don't -- here's how to see if the provider has everything you need.

Boom boom boom, this is who you call to help you, switch to your provider if consumers don't understand they're auto enrolled they don't understand, how are they going to understand how to pick a new one because they're not satisfied, or who to go to, what to do?

I know I'm saying a lot for you to repeat.

>> KEVIN HANCOCK: So let me see if I can paraphrase it a little bit.

Pam is suggesting that a guide for participants on A, how to make a plan change.

B, how to evaluate the network of the MCOs.

And C, what they need to do, to make sure they're receiving all their entitled to receive during the continuity of care period.

>> AUDIENCE MEMBER: And they need to understand quick --

>> KEVIN HANCOCK: Quick.

>> AUDIENCE MEMBER: Handbook is huge.

>> KEVIN HANCOCK: It was huge, a lot of the information that you had, mentioned, was included in that handbook.

Having abbreviated cheat sheet is a great idea we do not have anything that is like that, in one place right now.

But we're open to have suggestions how to, to build something like that out.

Actually I think that, we could, we can actually, consider doing something like that as part of the southeast roll out that's a good suggestion what we have done is we pulled all that information together in different places, it is, all

mostly in the, participant handbook.

But, but -- it is certainly a good idea to have something, abbreviated cheat sheet to use your term, all in one place we'll take that back as a suggestion.

>> FRED HESS: I will say this, when -- I did not enroll I went in for the auto enroll okay.

Because everybody I knew had gone in on the computer they sent it through the mail or phone call I went onto see what happened I was on UPMC before, I'm still on UPMC, most of the people from what I understand, in southwest area, everybody -- tell me if I'm wrong this is the rumor I heard everybody was auto enrolled with UPMC, they're the most predominant in the southwest.

>> KEVIN HANCOCK: I'm sure UPMC would wish that is true.

[laughter]

But that's not actually how it worked.

So, after -- a lot of, just to be honest we'll show the enrollment data, UPMC

was the heavily selected managed care coordination but, the auto enrollment actually, weighted more heavily knowing that they had such an established presence in the southwest.

The auto enrollment weighted heavily for the other two plans for Pennsylvania Health & Wellness and AmeriHealth Caritas, if people were auto enrolled more likely they would have enrolled in AmeriHealth and Pennsylvania Health & Wellness.

>> FRED HESS: I was on UPMC, I'm sure anyone on before, remained with UPMC.

>> KEVIN HANCOCK: If you were HealthChoices in UPMC you would have been auto enrolled into UPMC that's correct.

>> FRED HESS: That's what I say that.

That's going to be different pretty much in the southeast with -- who would that would be.

>> KEVIN HANCOCK: AmeriHealth Caritas.

That's part of the auto enrollment logic not to get too Nerdy one of the first steps that the auto enrollment logic it leaks if you were in HealthChoices if you were in HealthChoices, you -- your plan is also a community HealthChoices plan you would have been auto enrolled into that plan that's the first check.

So that is true you would have been enrolled in UPMC you were in UPMC as part of that.

>> FRED HESS: Like I thought.

>> KEVIN HANCOCK: Sure.

>> AUDIENCE MEMBER: Kind of answered any question I had but you're saying they are making the choices, they are looking at plans, who is they? MAXIMUS?

>> KEVIN HANCOCK: Participants.

Maybe I don't understand.

>> AUDIENCE MEMBER: Doing the auto assignment.

>> KEVIN HANCOCK: Auto assignment is done by -- the computer it's kind of a algorithm it's auto -- it's auto assignment it is really kind of random except for the criteria that is, so the two, main criteria that might, draw a person a way if they were HealthChoices plan or a family member that is part of a managed care plan that's part of the community HealthChoices as well.

That would have brought them to a particular plan otherwise it's random unless we have a weighted percentage.

So -- okay.

>> MALE SPEAKER: Kevin.

>> KEVIN HANCOCK: Hello Steve.

>> MALE SPEAKER: Did you say you were going to provide some data.

So we can get an idea in terms of break down, older adults in particular.

>> KEVIN HANCOCK: Just to finish up the goals we are going to be focusing on employment this year, focusing on employment as a service it is available, in

our fee for service, five employment services are available in the fee for service waivers we'll continue to advocate for those services as well as advocate -- as well.

Right now, the update, for employment services is, improving in our, in our program it's not improving as much as we would like, if you want to work and -- they're in the position where you can -- they want to have the opportunity to work that is -- that's, that's one of our goals and objectives.

>> AUDIENCE MEMBER: Hello. Lester Bennett with the supports coordination I've been patient I'm trying to be patient and -- as possible we're talking about, employment services okay.

What is that network going to look like.

That leads plea to a couple of questions about the network, of this -- program.

You're offering employment services,

who are going to be the providers what is that network going to look like.

It's like we basically told these consumers we'll give them a bunch of stuff didn't actually look for the providers.

I really, am very frustrated with the whole network adequacy when it came to trappings.

We had this Mantra after -- you already said it, and -- it's in my head. And if you want to say it with me you can say it with me, people consumers will get service and providers will get paid, on the first consumers are not getting services there's a question how providers will be paid at the end of last week, I'm -- there was -- issue about, who was going to be able to pay for something, for consumer those get their services.

And that question, came back, 3 different ways when -- based off this, email that I have like why didn't they

have the same answer?

I think that, honestly is there was not a very, um, deep discussion on this network.

How you're going to built it up.

>> KEVIN HANCOCK: Well, I appreciate the comment one thing I have to say is that, if you have know of any participant who is not getting services, right now, let me know.

Let me personally know.

But, they should be getting services throughout the continuity of care, there should be no change in services.

>> AUDIENCE MEMBER: You want me to give the consumer the services, yet we -- for example, we don't know what the MCOs will have a determination on, what is actually, what they will pay me for.

Okay.

If I sit there and say I'm going to do a home modification we don't know if their requirements are going to be

different.

So, you want me to get the services, to the consumers but you want me to, also as a provider to be able to get paid.

If I go in, provide a service for consumers, I go to that MCO and they tell me, you know what you did not meet all the right requirements.

For that consumer to get those services so you would not get paid.

That's -- we're not getting services we're getting services to consumers and providers will not get paid the net work is going to collapse, based off the fact there are no providers in there that have the money to stay in the business.

>> KEVIN HANCOCK: MCOs have the requirement to ensure if it's ongoing home modifications they're going to be completed.

So --

>> AUDIENCE MEMBER: The fact was we weren't told we weren't going to be able do those we thought we were

going to move everything to the MCOs we were told you can do those until the end of the year but you did not give me no requirements, tell me how, did I know the MCOs is going to pay me for actually providing that service.

>> KEVIN HANCOCK: Have you talked to the MCOs.

>> AUDIENCE MEMBER: No, I haven't even talked to them the reality is, why should I already have talked to them, why haven't they already given me that information that is not going to change if that is not going to change that is going to be in their hands already, I was not going to be involved in it, no more.

Now you're telling me you can still be involved I don't run too the State and say whatever are your requirements you're telling me I have to run to the MCO we already are learning now systems.

The service coordinators have been

responsible for educating the consumers still providing their service, and learning new things, all at the same time.

And now you're telling me, why don't you ask them -- get some more information and just piling it piling it on. And I have service coordinators who are, just very lost right now.

This, I believe this is going to still be a good thing I believe that this is going there are going to be some bumps I believe it could have been done a whole lot better.

We can see that, in the fact that, number one -- number one barrier for individuals, with disabilities to live in the community is transportation.

And you're telling me that the network didn't have the number one provider in the area.

We get emails, consumers, consumers okay.

Not no provider.

Consumer, got two two, two different

two different letters telling them, you know what? Last week, we will not be able to provide you transportation no more.

Then two days later.

We will.

That's all in one week.

Before 2-3 days before this was going to be implemented.

I'm giving you what is happening on the ground level.

>> KEVIN HANCOCK: I was involved with that directly just to be clear on the point you're making about the service plans I'll say if again if the service was approved and the service plan on January 1st it's a service that will, recipient is entitled to including the service providers.

So in terms of how the MCOs want, the delivery of those, services to be executed.

They have to meet the requirements, of their agreement.

And they have to meet the requirements of the service definition as well.

So they have a framework.

You should be familiar with.

That describes how those services have to be delivered and the participants are entitled to the services I notify that, when something is new, there will be some points of confusion and certainly opportunities to improve communication.

But with that being said, as a service coordinators part of the expectation of the service coordinator role, now in fee for service or -- managed care, service coordinator is going to be quarter backing the services for the participants that service coordinator is going to be working with the MCOs to make sure the services are delivered.

>> AUDIENCE MEMBER: We didn't -- they didn't get in contact with us, to even discuss anything until, light November or December.

I mean, like, I met with them and told them, you should have met with us a long time ago because you just said to everybody, what we already said, to them.

We have our hands in everything we could have put informed you onto avoid some of these issues but we're being met last, and we're still, saying -- where is the compassion of the fact that we have all this on shoulders to the point where everybody is saying can you know what we don't believe is you're going to stay alive they're going to do the same thing, so it's going to look like you didn't notify what you were doing, why should I stay with you, what -- it's not that we don't know we don't know what we're doing, we're put in the situation we're not getting clear information for -- that's what I said to the consumer look at the fact that, two different letters within the week of the implementation who is it that doesn't know what they're doing.

Is it us as service providers -- or is it just a mixture of everybody.

>> KEVIN HANCOCK: Access issue, no -- no service coordinator could be blamed what happened with the --

>> AUDIENCE MEMBER: That's what it is looking like we're in the front, front lines.

We're the front lines that you -- we're the frontlines you already said, you will be responsible for educating these people that's why she miss Heather showed everybody the service coordinating and training I didn't get even get paid unless I proved to you people that I took that test.

>> KEVIN HANCOCK: I mean you're making a good point about communication.

>> AUDIENCE MEMBER: I understand that that's why I'm trying to tell everybody, we can make this work what's going to have to be about communication, and start, for Philly you

have about to get it you see we're gathering up in here you see that.

You see that.

>> KEVIN HANCOCK: We're looking forward to the -- the aggressive and --

>> AUDIENCE MEMBER: It won't be so aggressive if you, make sure the providers know, no one is going to come in here you have to -- make sure the providers know, they're actually part of the team.

>> KEVIN HANCOCK: We have to do it earlier.

That's the part that I made at the beginning we have to do this earlier I agree with you completely.

>> AUDIENCE MEMBER: All right I'm getting it. Lester is getting frustrated nothing against you -- it's this is what -- I already know this was happening.

I already knew this was going to happy seen it and -- before I went on my family vacation, I sent emails to all 3 of the MCOs said why are we going to meet

finally face-to-face, in October.

>> KEVIN HANCOCK: I do want to make the comment about the access issue we had a issue with one of the largest southwest transportation providers.

Not having coming to an agreement, managed care organizations that since been resolved for the interim period and I think it was, a misunderstanding of the transportation provider on what the continuity of care period actually meant.

>> AUDIENCE MEMBER: Okay with that being said I thought going to leave this alone.

But -- as a person with a disability I'm telling you access does not the ability to provide the transportation, that they need.

Okay.

That's why you see me, they did not have the -- the ability to give me what I need to live independently in the community.

Okay.

That's why, people like ADAPT had to stand out in front of -- my education come to go me you're about to get that's why ADA parks A had to stand out in front much buses to get public transportation now, guess what?

When I was at 3 rivers Center of Independent Living we made sure that the, local yellow cab, has, accessible transportation.

Now is that, going to be in the network.

Because -- guess what I have an email that right here that is telling me, that they won't even pay for bus passes to get on the bus, that allows me to go more places than access where we are the majority of the people, is going to take like two -- it used to take two hours to get from my house, to get to a place to just be there for an hour for physical therapy.

So my whole, why should have I have

to waste all that time I can get on the bus.

Possibly, from ADAPT and people who have fought for me to get rights to get on public transportation, private transportation like yellow cab has that been -- has that been added to the network.

Those are things that I'm like -- whoah as a service coordinator to make sure my consumers get what they need if that has not been done I'm worried what you're going to do in Philly.

>> AUDIENCE MEMBER: What are you going do in Philly.

>> FRED HESS: I will say this, we've had, and our Center of Independent Living, disability options network we have been discussing a lot of things with, navigation, with -- with the consumer focused navigation service, that we're speer heading.

And we're also working on transportation down there, so we can get

that improved.

And one of the things I'm going -- that the CIL has been doing is, looking in on, all 3 of the MCOs and discussing the transportation issues with them.

We've had several meetings down there in the CILs so we can try to get the transportation straightened out fixed where we could actually get in the across county lines even the weekends and evening, someone may want to go to dinner for God's sakes.

Wire working on that, down there and -- have been getting some help from Kevin in this area.

So -- we're having a lot of issues still with the transportation.

>> AUDIENCE MEMBER: That is something that should have been done already that's the point.

That's what I'm trying to say, people at ADAPT, people in the past have, fought to get on public transportation and you're telling me I can't get a bus

pass --

>> KEVIN HANCOCK: To be very clear Lester transportation, has to be accessible for it to be, useful for people.

>> AUDIENCE MEMBER: We're saying we're going to use access I'm telling you that is not.

The para transit system does not meet the needs of people with disabilities, it doesn't, that's why -- service coordinators had to find new and innovative ways, to get things done.

One of them bus passes, yellow cab, those are things that we're -- is that in their network.

Can we get an answer?

>> FRED HESS: MCO.

>> MALE SPEAKER: If I may, maybe touch on a few of these others, there's a lot on top of what Lester is talking about.

First, the you know MCO.

We're getting this program.

Issue -- the most important thing, that I think, we've all been emphasizing

to the service coordinators to the provider network the commonwealth is, you know built the six month, continuity period -- so anything that is in the service plan should continue today.

If there's transportation -- that is being provided by you know, the service coordination, if you're purchasing a bus pass you are the resource people are depending upon the MCOs will pay you for that.

That's the key part of that continuity period, if it's in you're service plan today currently priding that will continue -- in terms of you mentioned home mods, if it was approved previously in it was in the continuity data, that we received it will move forward.

If there's a new request if the Court please the service, you have our fax number phone number, email me.

You know me personally you can chase any of our team members that you know we'll get this approval, we're there

to support -- the participants through this, through this process.

We've not had you know -- begin, we're a couple days into it, the last 48 hours we've knocked you know, I'm not aware this point any service disruption that's occurred -- you know, any issues we're watching it closely.

We've called five thousand of our members, already.

Our service interruption calls started yesterday. And we're calling every waiver participant, and we're, we're working very hard to make sure that launch goes smoothly.

For all these services again, the idea here is that -- keep doing what you're doing we're depending upon you and you're a huge part of this continuity period.

We're not asking you to change how you're operating just continue as you are instead of having approval from the equipment you have been -- you have

the mechanisms to sort of get to the MCO.

Then in terms of you know the -- the, some of these access issues I think, one of the confusing points on this is that, organized health care delivery system and, sort of the -- the -- that's I think the crux of the issue I think it's something we're all working through and the Commonwealth added a lot more flexibility, sending announcements out you received all the providers affected you know, effectively received we're again, continuing to work through our service coordinators who are you know supporting these services.

So -- you know, again I think there are specific issues, where one of our members or you know, we can help, you know, resolve an issue for a participant if there's any disruption or you need anything clarified you know where to find us I think that's going for the other MCOs as well who, you know I know are

working through the same issues we are.

We're -- you know, we work straighted through the new years holidays straight through the Christmas holidays everything that we're doing right now is making sure this is a smooth start we have you know, daily calls with OLTL.

Weekly calls with all the MCOs we have you know our own internal war room structures where we you know, escalate things, at least twice a day.

We're all building the infrastructure to make sure this is smooth.

You know -- I think they're -- there are a lot of issues there I think the most important thing is, you know, reach out to us, if you're seeing a gap.

>> AUDIENCE MEMBER: So -- who is in the network -- I need to know, what is in the network right now, and -- I have an email right here, where it basically says, we have to go through an MTM you know that is the first one.

This is before -- before everything

went out that is basically we'll tell these consumers you'll have to call this MTM have it I got questions, based off, simple ones door to door service.

Consumers get a choice of a bus pass.

Be able to go across county lines these are things I'm explaining -- this should have been done.

So we can continue to move on and I'm saying that they weren't done and now, there is an interruption.

There's an interruption of services let's be realistic it's been cold no one is using the transportation but it is the number one barrier in the community.

>> FRED HESS: Absolutely.

>> AUDIENCE MEMBER: Number barrier that should have been addressed-LAN if you know of a case of interruption of services let us know right away.

>> AUDIENCE MEMBER: I'm not screaming out of the name I do.

She is the same lady that I told you -- she is the same lady that I told you that -- that I told you that had -- a simple question, of like, if I want to go to a certain provider and the different state that, specialized in what I needed, could I be able to go there.

Those answers were not there, this person is definitely, right now she has access.

Okay.

We hooked that up, why should she always have to use access -- when we fought for public transportation what I'm saying is, public transportation, we're saying access is in the network no one is telling me about public transportation.

Private providers have called, we're not getting in the network.

>> KEVIN HANCOCK: I mean, so --

>> AUDIENCE MEMBER: They're not getting in the network how do they serve the consumers.

>> KEVIN HANCOCK: You're

providing bus passes you said.

>> AUDIENCE MEMBER: I didn't even order those bus passes.

I didn't even order them.

Do you want me to order the bus passes I'm not guaranteed to get paid for those bus passes.

And that's what I'm saying those things could have already been addressed.

>> KEVIN HANCOCK: Ray already did address it if you are providing, services the way that you're providing during the continuity of care period continue do that.

>> AUDIENCE MEMBER: All right then we can go back to the of -- when it came in, we have all heard how in different states, how in different states that you just, end up starving the consumers -- here we go.

I can get paid.

Guess what we got this HHA thing whiff to put all this information in too.

Okay.

To be able to get paid.

We're not even guaranteed you you're telling me -- I have to go in and get all this stuff done I'm telling you this -- this could have been avoided.

That's what I want you to know, this could have been avoided.

>> KEVIN HANCOCK: Have to have a better understanding specifically what you think we should do to improve it.

>> AUDIENCE MEMBER: For the number one, the public transportation we said access is in there, I have the email, they're not buying bus passes.

What happens after -- 30 days.

What happens after January -- after July 30th.

>> KEVIN HANCOCK: To answer your question for the continuity of care period I think that, after the continuity of care period I think they're going to evaluate the best approach to be --

>> AUDIENCE MEMBER: That's I

just proved it to you I'm saying it should have already been done that's number one bear year is transportation.

You're telling them to use the para-transit system we know is not going to meet people's needs.

Why, I can't even go across state lines this is something that we here at the state have been fighting about.

>> FRED HESS: For years.

>> AUDIENCE MEMBER: For years when I go to all these PAS, when I go to all these -- association meetings they're still talking about, being able to get paid for -- the right, -- excuse me the direct care workers are not getting a nice liveable wage, they have been screaming to the State we need to increase that.

Now that's going to be dumped on the --

>> KEVIN HANCOCK: Lester you made your point.

>> AUDIENCE MEMBER: Thank you.

>> KEVIN HANCOCK: I think the

other two MCOs wanted to chime in on -- the comment as well.

So I think -- Patty Wright.

>> FEMALE SPEAKER: Just -- trying to address I know Morris wants to say the same thing we want you to continue to buy the bus passes the cab tokens we understand that.

We have been -- in touch with a lot of the entities as has everyone else, we understand, that a lot of them, purchased JAN thing at the end of December.

So that they can go meet with participants exchange one bus pass or trail pass for the next month.

And, what we have encouraged them to do is to continue to do that, as Kevin said we're evaluating that, but we want you to continue, doing that for the next several months, yes we'll look at the, day 181 long before we reach day 181, please continue to do it, bill as you do under the W code as nonmedical

transportation.

That's the way it's been explained to us that it's being billed today and we want you to continue, billing that.

So, buy the bus passes trail passes the cab tokens continue to bill them as they have been outlined on service plans then everything will be honored we'll be paid.

>> MALE SPEAKER: Echo that, look ester we certainly cover bus passes we'll continue to do that if you have a question other concern you see something happening that you're worried about, please reach out to me you have my number.

You have all my contact information just let us know if you're seeing something or have you have a concern.

>> KEVIN HANCOCK: We had a couple other questions.

>> AUDIENCE MEMBER: I'm Zachary Lewis, disabled in action, I'm also with ADAPT I want to understand from the

MCOs that, once -- you know like that, six month continuity of care is over -- just trying to understand, like -- as far as transportation -- I'm being told that -- transportation or -- nonmedical transportation will not be provided anymore.

>> KEVIN HANCOCK: What is that is absolutely not true.

>> FEMALE SPEAKER: It's a benefit.

Continue will be provided.

>> AUDIENCE MEMBER: Provider, won't be available.

That's service, that service will be available for certain providers.

>> KEVIN HANCOCK: We don't know that either at this point we can't answer that question at this point.

Nonmedical transportation will be made available throughout -- throughout community HealthChoices.

It is, it is an available benefit that's correct.

So --

>> AUDIENCE MEMBER: Okay.

Okay.

>> AUDIENCE MEMBER: I was quiet a couple of months before, I watched it keep doing we're still here I'm going to be quiet again.

>> FEMALE SPEAKER: It's scary you guys keep saying this is going -- that's not going to happen, bullet it's still happening.

I don't want to have to go to the doctors and find out I can not use my pass to get home.

Access does not provide unless you have -- dialysis, the hospitals do not provide service, for a ride home.

I have to come home at 4:00 in the morning riding in my chair.

Because the buses stoop at 2:00.

Take a rest restart back over.

If you stop this, you keep saying, continue -- continue what about the day after.

>> KEVIN HANCOCK: Sure.

So --

>> AUDIENCE MEMBER: It's 181.

>> KEVIN HANCOCK: One points of clarification, the two services you talked about -- dialysis and, cancer related treatments say for example, immune therapy that's medical transportation.

>> AUDIENCE MEMBER: That's for that, when we get put in the hospital, as an emergency, we need to come home.

They're not going to send para-transit to come get us.

They're going to tell us that we have no way to get home, unless someone comes and gets us.

>> KEVIN HANCOCK: You would be --

>> FEMALE SPEAKER: I would have to roll home without the transportation.

>> KEVIN HANCOCK: You'll have nonmedical transportation for something like that.

>> AUDIENCE MEMBER: I have to ride my chair if I don't have the pass.

>> FEMALE SPEAKER: Just to be clear, on this issue nonmedical transportation under community integration will continue for the first six months and then after that, it's going to be reviewed.

Is that correct.

>> KEVIN HANCOCK: No.

No, nonmedical transportation will continue as a waiver service, in community HealthChoices, indefinitely.

>> AUDIENCE MEMBER: The providers --

>> KEVIN HANCOCK: Providers, providers will continue throughout the continuity of care period.

But -- after the continuity of care period is over, the MCOs will be reviewing to determine which of those providers will continue to contract with.

>> AUDIENCE MEMBER: If it's not happening now, how do you guarantee it will happen on day 181, that's what I'm trying to point out to you, it didn't

happen, I have the email in front of me, we've already seen the issue you're trying to put everyone on the para-transit system it's not going to work.

>> KEVIN HANCOCK: I don't think that's -- true.

>> AUDIENCE MEMBER: I'm telling you that's not going to work that's what happened, I have a consumer for 3 rivers Center of Independent Living went down, he stopped using he was already -- he was already done using access.

So we used, the cab and the bus pass.

Those are two things that I have right here.

That -- they're not happening right now.

You're telling them go ahead and use access.

So you're telling everybody that was already done with access, using, the public transportation system, to go back

on access.

That's going to be a -- that's going to be, more increased people, I'm trying to get you to realize that -- you know the network is not adequate enough, to meet the needs right now.

>> KEVIN HANCOCK: I'm going repeat your point back to you -- you are stating that you believe that, the certain types of transportation providers, do not provide, accessible transportation, you think, and -- I know, that community HealthChoices would be better served by having a variety of providers that provide, accessible transportation to participants, beyond access or other types of transportation.

>> AUDIENCE MEMBER: That's what I'm saying built on a network adequacy that's something that should already have been done.

>> KEVIN HANCOCK: So --

>> AUDIENCE MEMBER: That's something, that's basic knowledge when

it comes to dealing with the disabilities community.

So --

>> KEVIN HANCOCK: So -- the response to your question is they have to meet network adequacy.

Network adequacy involves transportation, accessible transportation, so they have to prove to us, and to be able to be certified for meeting the network adequacy by the Department of Health the MCOs have to prove to us, that they're providing transportation, that meets the needs of the participants so -- even if, they -- have particular providers that will be working with, they have to provide all these different types of transportation requirements for participants that need them, it's a requirement of the program.

And we have to -- we have to evaluate that, they have gone through this process, they have -- certainly built enough of a transportation network to be

able to meet the needs of the transportation as it is in the southwest right now we will require them to provide transportation that meets the needs of participants.

>> AUDIENCE MEMBER: I'm glad what they're getting paid over there in Pittsburgh we have a great -- we have a great micro -- excuse me a small area that can actually be implemented across the State.

Philadelphia, Pittsburgh -- Philadelphia is -- Pittsburgh is small version of Philadelphia.

New Castle and up there is a small version of the rest of the state -- a hope we really do take -- I've met with people, my favorite question was -- what lessons have we learned he really do take these lessons and implement this and lead the country how to bring there -- waiver service kept people out of the nursing homes kept them out alive, implement them with the Medicare system has been

paying for things that -- we could have been working together I hope we really do that, I'm telling you it is looking bad I have the email to show you this is looking bad-has been I'll talk to you afterwards that waiver service is not going anywhere.

>> AUDIENCE MEMBER: I'm not going to let it go no more.

>> KEVIN HANCOCK: Okay so -- those -- I'm pretty much out of time we have to actually do, we do have jump into the complaints and grievances and fair hearings process I want to highlight a couple of other things, very quickly.

The other two -- long term living for organizational alignments we'll focus on -- continue to focus on community based LTVS let me finish then after I'm finished --

>> AUDIENCE MEMBER: I want to ask about something here.

Continued focus on community based LTSS.

I see CHC support for nursing home transition, what kind of nursing home transition is that.

Is that transition from a nursing home to a home in the community from a hospital into a nursing home.

I want to know.

>> KEVIN HANCOCK: Primarily it's from a nursing home into the compliant, home in the community.

It may also involve as part of the -- the idea, nursing -- or the hospital diversion, a lot of the, implementation -- the point that you're making I think -- is that a lot of people, are admitted into the nursing home from an in-patient hospital stay.

And, the best -- that is a problem.

That is a problem with our system we totally agree.

All 3 of the MCOs are going to be working with hospitals to look for alternative placement, other than nursing facility.

Services as part of their approach to -- to, to keeping people in the compliant.

That is a requirement for the program.

And it's something that -- we wish we could, do better now.

I'm going give Nancy a shout out.

Liberty has been --

[laughter]

Active in nursing hospital diversion.

>> AUDIENCE MEMBER: She and her group transitioned me out of a nursing home.

You see -- that's -- the last time -- it's the same thing I'm talking about.

That transition from the hospital -- into a nursing home institution.

That should never happen.

And -- this there's a time limit for everything I do understand, I do understand there's limits for everything, when you know about someone being transitioned, being abled person that needs to go into a nursing home as they

say for, physical therapy.

Why can't that be done at home.

Why can't we just provide, provide home modifications between the time of the person being transitioned from the home into a nursing institution.

We need to, erase that, that time limits we need to erase that point.

>> KEVIN HANCOCK: We agree we need to do a better job.

We're going to look for opportunities we're actually looking for -- MCOs are committed as much as we are to making we're starting next week.

>> AUDIENCE MEMBER: Excuse plea I think that's -- it's transitioning people from the nursing home into the community the way it's written I can see how it can be, misunderstood, as the opposite way.

Going from the hospital.

>> KEVIN HANCOCK: When we talk about nursing home transition primarily in the nursing home transitioning back to

the community I think Tony was talking about nursing home diversion as well we mean both we want -- also parts of our fee for service program as well.

It's often the front door as well as transitioning people from nursing home in the community, if that's they're preference.

>> AUDIENCE MEMBER: In terms of improving nursing home diversion as you work with the community HealthChoices MCOs, it may also make sense to bring in the HealthChoices MCOs sometimes.

>> KEVIN HANCOCK: We agree.

>> KEVIN HANCOCK: Also the Medicare advantage partners as well.

Okay.

So -- we are open for -- I'll finish up here.

>> AUDIENCE MEMBER: One more question.

>> KEVIN HANCOCK: Sure.

>> AUDIENCE MEMBER: So my question is, if I'm in the hospital, going

to be discharged home, there's been several times, where the hospital felt as though it's necessary to either separate me from my wheelchair to get home -- they will make me choice we can get your wheelchair home or you can take the bus here's the token.

That's not acceptable especially if I'm going in there for issues you knee, that need me to be off my butt.

>> KEVIN HANCOCK: I would think that's a hospital education issue.

>> AUDIENCE MEMBER: I shouldn't have to be the one explaining educating them how it goes, after awhile, several times, they throw their hands up say you have to figure it out.

What do I do with it.

Who do I talk to, the MCOs where is the answer I've asked that.

We get a lot of -- is that really happening.

>> KEVIN HANCOCK: Good question.

We have -- access to -- the hospital association of Pennsylvania.

They participate in a lot of our -- I think that -- what I would do is -- maybe I would like to talk to you about it, how we can approach educating hospitals the social workers -- and the -- the hospital itself, hospitals -- are focused on -- dealing with acute treatment and then moving people into a different level of care.

Once they're stable that is -- sort of the philosophy of care, I think they sometimes, there are opportunities for education, in the hospital -- system to have them understand the people with disabilities better and understand a better way to manage the next level of services even to prevent, future risk of patient hospitalization there's a lot of opportunity there.

I think the best way to the best way to a preach it is to look for ways of education the MCOs will be engaged in

that education process.

But I think that we need to be engaged as well. And -- need, we meaning the global we -- I love to talk to you properly about it.

I think it's a real problem.

It should be pretty easily fixed.

So --

>> AUDIENCE MEMBER: Know we can definitely have that conversation, however I'm asking this is sense of urgency, because I'll be, going through this process, in the next, week or so.

Like I'll be in the hospital, in the next week or two I don't know what to say once it's time to be discharged to go back home.

Like the plan is to go home.

Which is great.

How am I going to get there.

I need an ambulance ride what about my wheelchair we can't do beige.

My wheel cheer is an extension of me.

It sits in a dusty room.

>> KEVIN HANCOCK: I'm not sure how it seems like such a simple thing for hospitals to -- to understand.

>> AUDIENCE MEMBER: Money thing they will have to pay for it -- who pays for it.

>> KEVIN HANCOCK: It is still -- I mine.

>> MALE SPEAKER: It's part of your mobility I agree.

>> AUDIENCE MEMBER: It's going to be a serious issue in the next two weeks.

>> KEVIN HANCOCK: Can I talk to you afterwards.

>> KEVIN HANCOCK: Okay I have 3 minutes left.

I'll jump to the southwest population slide quickly.

This is -- as of, December 28th and -- we're, landed -- 85,389 people enrolled which was, the transition weekend was roughly about 79,000 people.

So from transition weekend which was November 18th.

To -- from December 28th, 6,000 new people were enrolled into the program in the southwest.

Which tells you a lot about the growth of this population.

This is a lot of growth.

A lot of new enrollments.

The way that the -- the, the -- the break down -- for volumes included UPMC total of 44325 individuals were enrolled that included 10,031 people that were auto assigned and 24,561 individuals who selected a plan -- and 9733 individuals, who were part of aligned dual special needs plan.

For Pennsylvania health wellness, that ended up being 53 percent of the population.

Pennsylvania health wellness, 23667.

And -- 15586 were auto assigned and 8008 is individuals selected Pennsylvania health wellness.

To AmeriHealth, the total enrollment, was 397 and that included, 15868 individuals auto assigned and 1537 people selecting the plan, that is the broke down, UPMC has a presence in the southwest.

They represented the largest volume in enrollment and we'll continue to monitor this.

As we go forward.

That's where it landed.

We'll have final, figures in the MLTSS sub-MAAC this did not include the December 29 data as well.

So with that, -- just going forward, since we're out of time we'll continue in the next meeting --

>> MALE SPEAKER: Is there any age break down.

>> KEVIN HANCOCK: We can get age break down.

>> MALE SPEAKER: We've been asking for that in the last three meetings.

>> KEVIN HANCOCK: We didn't

have age break down the way we can get the age break out we'll get it from our -- eligibility system we have a little bit more access to that data now.

This information, is coming from MAXIMUS they didn't have -- they were able to give us more up to date data, we can get the specific age break down from our.

>> MALE SPEAKER: The reason I'm asking whether there a need for more outreach.

>> KEVIN HANCOCK: To be very clear in terms of age demographics I can say majority of these individuals are over 60.

>> MALE SPEAKER: Last month it was reported to be about -- it was about 5050 split between -- under and over 60 in terms of the -- the advanced selection.

>> KEVIN HANCOCK: That is true.

>> MALE SPEAKER: Since there's, a larger percentage of people who are older people, in the plan itself that is

suggested, this disproportional impact.

>> KEVIN HANCOCK: Auto assigned we'll get the age break do you know.

>> MALE SPEAKER: Really looking at outreach and targeting you know, was mentioned about the community meetings -- that really only addressed needs of a very small percentage of the total population.

>> MALE SPEAKER: Thank you.

>> KEVIN HANCOCK: Okay.

And then just -- to, complete my presentation in the next, update will be able to pry some data from our learn indicators as we previously mentioned we're tracking -- activities associated with the southwest launch focusing on -- no disruption of participant services and no disruption of provider payment, in the next meeting we'll presented the data we'll be collecting from the managed care organizations and the independent enrollment broker and from ourselves reflect how we're doing in those areas.

And in addition we'll also talk about any emergent issues have arisen over the last month, and talk about how those issues were addressed to be very clear, transportation, will be a major topic on the next agenda.

[laughter]

Not -- we actually planned it this way.

Since it's -- area of concern, Lester made clear how important transportation is for all of our population questions want to make sure how that service is going to be made available, we'll have all the 3 MCOs talk about how they're going to provide transportation, not only during the continuity care of period but going forward.

>> AUDIENCE MEMBER: Thank you.

>> KEVIN HANCOCK: Okay.

With that I'm going turn it back over to Bob who will introduce.

>> FEMALE SPEAKER: This is Tanya, you told me to remind you, you were going to -- discuss, during the update the

effect that like, the tax bill might have on the funding for the State what we were going to -- that were to arise.

>> KEVIN HANCOCK: We ran out of time I will answer that question since you asked it, thank you very much we're not anticipating any impact direct impact on -- the tax legislation on this, on -- community HealthChoices.

And part of the reason we know that, there will not be a direct impact is because entitlement programs such as Medicare and Medicaid were not mentioned specifically in the tax legislation.

It was more focused on the way that -- taxes are collected.

How corporate taxes are impacted. This point we're not expecting any how the Medicaid program in general with the tax legislation we'll definitely be monitoring to see if 245 changes.

The thing is --

>> FEMALE SPEAKER: Once they

sort out with the revenue side of it, all that that's when you're going get to what Social Security is going to be and what Medicare and Medicaid will be, how they will change requirements all that, you just really -- want to make sure I want to make sure as a Commonwealth, we want to keep services and programs intact for people.

That's where we might have to change the culture how we think about doing this.

>> KEVIN HANCOCK: I agree with you completely we have to hon monitor it, because -- our system is built, based upon certain expectations.

The program changes at the Federal level and require state level accommodation for those changes that could have drastic impact the way the services are being delivered.

So we have to pay attention to it.

To answer your question specifically no we're not anticipating -- impacts.

Based upon the -- the Federal tax legislation, but we have to monitor just to see if, any new changes arise, that -- to require significance changes to our programs in Pennsylvania.

>> FEMALE SPEAKER: As we did get the information in, we can I would like too make sure that is open communication is open with you, to have further discussion with that and how we could go about, making sure that our future is solid as a Commonwealth.

>> KEVIN HANCOCK: Absolutely thank you for the offer.

>> BOB THEIL: Thank you Kevin will stick around for any public comments at the end, as well.

We'll now have Helene Loux is doing a presentation on fair hearing and assist in any answering any questions judge Speers and Judge Lewis will be on the phone to answer any questions.

Helene.

>> HELENE LOUX: I'm Helene I'm an attorney with the complaints office, I'll be talking about fair hearing grievances and appeals I want to begin, with when an participant file a complaint or a grievance? If a participant is unhappy about something a CHC MCO or a provider has done, the participant, can file a complaint or grievance or if a participant, disagrees -- with the CHC MCO's decision a participant can file a complaint or grievance.

Next.

So let's talk about what a complaint is.

A complaint is, a dispute or objection, regarding a participating health care provider or the coverage, operations or manage management of a CHC-MCO.

Complaints are pretty broad.

So let me begin with that.

So some examples of complaints, a participant is unhappy, with the care the participant is receiving.

The participant cannot receive a service or item.

The participant wants because it is not a covered service.

Or item.

Or that the participant has not received a service, that the CHC MCO has approved for the participant these are just examples.

A complaint can be anything.

It can be you go to the provider they have uncomfortable chairs you're unhappy you can complain.

It is very, very broad.

Opposed to -- agreements much more, narrow definition.

Grievance is -- a request to have, a CHC MCO, or utilization review entity reconsider a decision, considering the medical necessity and appropriateness of a covered service.

Some examples of when a participant can file a grievance.

CHC MCO denies a service a

participant requested because it is not medically necessary the CHC MCO decreases the service, a participant has been receiving, because the amount of the service, the participant has been receiving, is not medically necessary.

CHC MCO -- because the service requested is not medically necessary as you can see it is really is not medically determination, with regard to the determination that is requested for you -- if a participant files a complaint it is a grievance it's not a problem the CHC MCO is responsible for making sure it goes to the right classification, same for grievance, if it's a complaint it will reclassified don't worry when you fill out the form, you fill out the wrong complaint or grievance.

Depending upon the subject of the complaint, the complaint will have one or two levels of CHC MCO review.

All complaints are subject to what we call a first level complaint review.

As opposed to that, all grievances have only one level, of CHC MCO review.

Complaints or grievances can be filed, orally or in writing.

If in writing, the complaint or grievance can be mailed or faxed to the CHC MCO.

A participant can write a letter -- or use a complaint grievance request form.

>> FRED HESS: Where do you get.

>> FEMALE SPEAKER: The complaint grievance request form will be sent to the -- the participant receives notice from the CHC MCO, telling the participant's the CHC MCO's decision I cannot answer it but I have a feeling you might be able to just call up -- request the form also you don't have to use the form.

That's one way of filing it you can write a letter -- say -- this is what I'm unhappy about, here's my complaint.

Same for a grievance.

>> AUDIENCE MEMBER: Someone

priding a grievance orally, who are they doing it to to.

>> FEMALE SPEAKER: To the CHC MCO staff, if it's orally they're responsible for writing it down.

>> AUDIENCE MEMBER: Can you ensure the consumer gets the documentation.

>> FEMALE SPEAKER: We call it an acknowledgment letter, that will include -- what your complaint or grievances are about, it will request, that you sign here.

If it's correct or you call the MCO and tell them, this is wrong.

And it will also include instructions about the complaint or grievance process.

>> AUDIENCE MEMBER: Can you please repeat the questions.

>> FEMALE SPEAKER: Sure.

So the complaint or grievance who can file it.

It can be filed by the participant, themselves.

A participants representative.

Or the provider.

Participants representative, can be anyone that the participant uses.

This is for beige levels of complaints and for the grievance.

If the complaint or grievance is filed by a representative or a provider, participant must provide written consent, for the representation, other provider, to be involved in or act on the participants behalf.

And if you need help filing a complaint or grievance -- there are several options you can ask the MCO for help.

And they're required, to help you.

You can contact your local legal aid office.

Or you can contact the Pennsylvania health law project.

If the complaint, is a result of a decision by the CHC MCO, the complaint must be filed within 60 days of the date

the participant receives, a written notice of the decision.

If it a complaint, as it a result of the failure of the CHC MCO to provide a service or item in a timely manner, the complaint must be filed within 60 days from the date the services, should have been provided.

And time frames by which services should be prided, will be included or are included in the handbooks.

If it the complaint was as a result of the failure of the CHC MCO to decide a complaint or grievance.

Within the time frames for deciding a complaint or grievance.

The complaint must be filed, within 60 days, of the daylight the participant receives written notice of the MCOs, for to timely decide the complaint or grievance.

With regard to other complaints there is no time limit.

There's no time limit.

No time limit.

I mentioned that -- complaints have to be filed within 60 days of receiving a notice.

So now I want to discuss, when a participant will receive a notice.

You can receive a notice, because a denial because the service or item, is not covered service or item.

Denial of payment, after a service or item has been delivered to you and a denial of your request, to dispute a financial liability including cost sharing copayments, premiums deductibles co-insurance and other participant financial liabilities.

This notice will explain what a participant can do, if a participant disagrees with an MCOs decision.

That information, is also included in the participant handbook.

Let's talk about who can decide, your complaint.

First level complaint review

committee, must include, one or more, CHC MCOs staff.

The CHC MCO staff, may not have not been involved in or may not work with someone involved in the issue the complaint is about.

If the complaint involves a clinical issue, the committee must include a licensed physician and the physician must decide the complaint.

The other committee members can offer input.

They can offer input in the cases but the actual decision has to be made by the licensed physician.

So once your complaint is filed, the CHC MCO has 30 days, to decide, a first level complaint.

And send written notice of the decision, to the participant.

I want to clarify what that means it doesn't mean, 30 days to decide, and then, send notice it means, 30 days from the date a participant files a complaint,

until the date, until the complaint -- until the participant receives the decision.

>> AUDIENCE MEMBER: Can I ask one question, from the Pennsylvania health project.

Can you go back to that first slide.

The one just before.

So, keep going one more.

Not back -- the one that has the slide about the -- the physician, having the medical review.

That's it much that's fine.

That last bullet that reads out the complaint involves a clinical issue the committee must include a licensed physician the physician must decide the complaint.

Essentially, your paraphrasing this to say the physician decides what is the role of the other people that are on the panel? What do they do?

>> FEMALE SPEAKER: Offer input, too the extent that the input is something, it's a hard question to answer

because every complaint is different if it's something clinical no one knows anything about, input would be different.

I can't answer specifically, depends upon the issue of the complaint.

But we're required by the final managed care rules if a complaint involves a clinical issue, it must be decided by the licensed physician.

>> AUDIENCE MEMBER: Same issue is going to be for the grievance too, the physician must decide, the grievance or the complaint I'm just previewing the issue.

>> FEMALE SPEAKER: Obviously a grievance, grievances all grievances because they all involve a medical issue.

>> MALE SPEAKER: Right.

Okay.

Still trying to understand the department given any guidance to plans about -- what those other -- people on the panel are supposed to do.

>> FEMALE SPEAKER: I can't answer

whether they have given guidance, it's not a new requirement this is something that is always existed in the HealthChoices program.

It's always been a complaint, involved a clinical issue.

It must be decided by a physician the only change to this is, on the second level complaint, it used to not require a physician decision now a second level complaint that involves a clinical issue requires a physician decision it's not a new requirement I don't know if there's been guidance, within the HealthChoices or not.

>> AUDIENCE MEMBER: That's fine thank you, maybe putting a pin in it for -- to hear from the plan at some point not necessarily immediately right now, to hear, what how they handle the grievance in the roles of other participants I understand the departments not understand answering it it's the plans, not Miking sure there's

consistency between the plans about -- how they, um, get input, from the nonphysicians that are part of the panel would be of interest thanks.

>> FEMALE SPEAKER: Welcome.

>> AUDIENCE MEMBER: I have a question on that part that following up from him, it says, it must include a physician and the physician must decide the complaint.

Is the physician, going to contact that consumer's physician because that physician knows that person's health and what they need and don't need, better than someone that is sitting in an office, making a determination without kneeing that consumer at all.

>> FEMALE SPEAKER: I would have to defer to the plans how they actually, operationalize that I would imagine it depends on the subject on the subject of the complaint and the information the physician has.

>> MALE SPEAKER: I understand

the process, as it -- you're outlining it. And -- it makes perfect sense in terms of, physical HealthChoices but in terms of long-term services, and supports -- I would think that, there would need ton -- other people, um, because there could be clinical issues that have -- that -- have to do with the long-term services and supports.

Not necessarily, medical issue.

>> FEMALE SPEAKER: That's why the term is clinical not medical.

>> MALE SPEAKER: I'm talking about the physician deciding component.

>> FEMALE SPEAKER: That rivers to a clinical issue.

>> MALE SPEAKER: The physician may not have expertise in the clinical issue.

>> FEMALE SPEAKER: I'm speaking from memory for a grievance I would have to double check for an agreement keeping in mind grievances are the ones that are mostly medical the requirement

from the Department of Health regulations is, I'm going to paraphrase like a similar specialty.

As someone prescribed the services it's not -- you can't have a gynecologist deciding -- what a podiatrist would decide, there's a requirement they be similar specialties.

>> MALE SPEAKER: Okay.

So -- it could be -- a physician or a physical therapist or --

>> FEMALE SPEAKER: It must be a licensed physician.

It cannot be a --

>> MALE SPEAKER: That's my point is that -- that person alone, may not have expertise, in the area of the grievance.

>> FEMALE SPEAKER: That's why there's -- input as as far as who decides, that is not a department decision, that is required, by the Department of Health rules, governing managed care programs.

>> MALE SPEAKER: This is the long-term services and supports it needs some flexibility on that it can't be run like a medical program.

>> FEMALE SPEAKER: I'll take a step back -- I'm not -- very familiar with the long-term services program I'm answering from the point of view, complaints grievances and fair hearings this is what the law requires.

>> MALE SPEAKER: We need to adopt for long-term services.

>> FEMALE SPEAKER: That is -- I understand all that all I can tell you at this point is the requirements this is all stuff we can take back and discuss.

>> MALE SPEAKER: Would you please.

>> FEMALE SPEAKER: We need to do within the program, is follow, the various rules that apply to it and there are a lot of different rule that's apply to managed care, complaints grievances and fair hearings as far as, licensed

physicians deciding, that is a department in Department of Health rule and statute.

>> MALE SPEAKER: This is exactly the concern about -- community HealthChoices asks that you're going to take thing that were, worked its for HealthChoices.

And make a -- square peg, fit in a round hole.

And -- that is not what we are expecting.

That's not, going to serve consumers well.

So we need to do something with it, not just to say this is the way that it is.

>> FEMALE SPEAKER: I'm going to defer to the people that -- are involved, with the program.

To answer that I'm just presenting how the complaints and grievance and fair hearings work.

So if that's something that needs to be discussed.

>> MALE SPEAKER: You're here at

the CHC meeting.

>> AUDIENCE MEMBER: I'm a consumer this is an example I need -- the durable medical equipment.

I sent in my paperwork to get durable medical equipment probably the durable medical equipment helps me with moving around.

So right now I'm stalk in bed.

Per se.

I've sent in the paper work.

I've not gotten no replies I'm still waiting on the -- the durable medical equipment.

I'm stuck in bed.

What -- how long does it take, for the decisions and -- that physician who is sitting in -- in a meeting.

Does he know what I am going through.

>> FEMALE SPEAKER: What one of the requirements which is an -- not included on my slide is -- that, 30 days is the out set, but the requirement that is,

imposed on the CHC MCO is, expeditiously as the participants health rares.

So -- hopefully the participant -- obviously I'm not there in the room, but the -- when the complaint grievance comes in the CHC MCOs should be looking at it and saying this person cannot sit, for 30 days.

This person needs an answer within two days let's get our committee going, let's get these done as fast as possible I'm going skip ahead of my presentation -- and you as a participant can request, what is called expedited review.

Which is deciding a complaint or grievance, faster.

You can do it, with the help of your provider, your provider would submit a letter saying, John needs this complaint or grievance decided, as soon as possible.

Because -- he is sitting in bed, please make a decision.

And, the time frame for that are -- if your provider submits a letter, I'm going get it wrong, either 48 hours or -- 3 business days, I have it on a slide.

And we'll get to it.

But it's very, very quick.

And even if your provider does not submit a letter, but based upon the information, the CHC MCO has, they can decide it quicker, it will be decided quicker.

>> AUDIENCE MEMBER: So -- let me just say I need a manual chair.

Which has to be modified for me.

I get my physician to write out a prescription saying he needs a power chair or manual cherry go to assist, it takes them from the day the letter has been faxed in or sent in, it takes them 6 on 50 days to get back to me.

>> FEMALE SPEAKER: Should not take them 60 days there are things in the contract, that it addresses the same frames I don't have that 234 front of me

I'm into the going say the exact time frames it's 2-3 business days.

>> AUDIENCE MEMBER: No.

>> FEMALE SPEAKER: If they're not filing on time, if they're not responding to you on time that is something that you can file a complaint about.

>> AUDIENCE MEMBER: Okay.

Because this, this has been issues which has been going on with us, people with disabilities, like we requested manual chair, they tell us oh, in the next five years, you can get a new one.

But, in between that five years, my chair breaks and, it cannot be replaced what are you going to do all day.

>> FEMALE SPEAKER: I'm going defer to people that handle the CHC MCO program I'm talking about the complaint grievances I'm not familiar with the program should answer that.

>> AUDIENCE MEMBER: It's all related.

>> KEVIN HANCOCK: So the way

that I see it it's related you are eligible for durable medical equipment as part of the community health choices.

The case where you would be, filing a complaint or, grievance or, in this case would be grievance, in the Helene can correct me if I'm using the wrong terminology -- would be, if they denied, you're particular request for a service that you're eligible for so -- um, you would -- go through the process and I think that, when you go through this process, your service coordinator is -- your service coordinator should be very familiar not only with, the service you're requesting but also with you as a person.

That service coordinator should be making sure in this process, that -- that the other people who are involved in helping make a determination, as to whether or not that benefit is going to be approved for you.

They know, what your requirements are.

So if it turns out the service coordinator and the first level, still wasn't successful in having that approved for you, you can go into the, the grievance process.

>> AUDIENCE MEMBER: Just to figure out what you're saying.

I have a service coordinator and home based services.

And, I request for a manual chair.

I get assist, it takes them 60 days to get back to me.

Why is it taking them 60 days to get back to me.

Through the MCO, not through the State the complaint site.

Between you and I, I have sent you the information, for the durable medical equipment.

It is taking so long to get, what am I going do.

>> KEVIN HANCOCK: I can't -- I'm not sure why it would take 60 days for -- yeah.

>> AUDIENCE MEMBER: It took me, took me 6 months, to get my manual chair.

Six months.

>> KEVIN HANCOCK: Was that in the current fee for service program?

>> AUDIENCE MEMBER: In the service program.

And it took them six months to provide me with a chair.

>> KEVIN HANCOCK: I don't know the particulars of the case.

I would like to know about the particular case.

>> AUDIENCE MEMBER: It's out there, there are stories about that.

>> AUDIENCE MEMBER: This is Zachary Lewis again, just -- I don't know if this happens Tony or not, for instance any time we ask for something through our -- supports coordinators it seems like there's a backlog a huge backlog with the State to give an answer, for a determination learn, there's a yes or no.

I think that's, part of what he is talking about, whether it be a wheelchair or, a piece of, durable medical equipment or, whatever it would be -- whatever it is.

It's always, takes forever for the State, to get back to us and -- I've asked this question a long time ago, like, who is the State, why can't we go through the State.

And to whom whoever that is specific person is and ask them like -- what's going on.

>> KEVIN HANCOCK: That would be me.

[laughter]

>> AUDIENCE MEMBER: Until you say no.

>> KEVIN HANCOCK: That would be me.

[laughter]

>> AUDIENCE MEMBER: I'll meet you at the doorman this a good advertisement of the HealthChoices

these are conditions in the fee for service program I'm not sure about the six months. And I will talk to Ginny Rogers why it would take that long to go through the approval for durable medical equipment it should never take six months, unless there's some truly scandalous issue.

>> AUDIENCE MEMBER: A lot has too do with the -- who the first payer is.has to do with the first payor is, if you -- if that's a service covered by HealthChoices for example and go through that process or if it's a Medicaid or a -- Medicare covered service.

So, all of that has to be explored the service coordinator is the first one to help you work through all of those different parts of it.

>> AUDIENCE MEMBER: I asked -- I've asked this question, when I first came here as far as, clarity, that type of bureaucracy and red tape, it -- I understand the process you know as a

consumer I understand how that works it just seems like it becomes cloudy to a point where -- I've given up on asking a lot of thing from the State.

Through my supports coordination unless it's something simple.

It's easy to give up sometimes, what do you do with that.

Because I want -- if I need something, that is going to help me or help my independence, and we have to wait for the State, to say yay or no.

Why even bother.

>> KEVIN HANCOCK: This is not about the complaints and grievances process this is about coordination of services if it's true that you are on Medicare, if possibly a Medicare primary one of the things we're really trying to do with community HealthChoices is to make, the system work better for people who are duly eligible.

And to have better coordination of services between Medicare and Medicaid.

So the hope would be that, the community HealthChoices managed care organization will have a bettered in that, you're going through this process on the Medicare side, so that it could be sped up a little bit on the Medicaid side for approval, for -- but, we don't want people to give up for services they need we will do anything we can to make sure that you don't have those types of barriers that you'll be able to access services you'll be eligible to receive.

>> FEMALE SPEAKER: I'm going dove tail what Kevin said one of the ways you can help yourself with the barriers is, filing a complaint.

With the CHCMCO, that's one of the subjects that they can address.

>> AUDIENCE MEMBER: Um, lady came up to say, you might be dual eligible or you might be under Medicare or Medicaid.

You send them the letter to Medicaid, or Medicare or whatever.

Does this issue of, where you sit and wait and, wait and wait why do we have to sit down so long when we have sent a letter to Medicaid, Medicare and insurance and MCOs and everything we are still sitting and waiting.

>> KEVIN HANCOCK: You shouldn't have to.

>> AUDIENCE MEMBER: Okay.

My five years is coming up, when I'm going to get any must durable equipment and it is taking so long I'll write out all the times send to all of the my CO and I'm going write everything date of birth and send it to them.

>> KEVIN HANCOCK: That's okay.

>> FRED HESS: We have a question?

>> AUDIENCE MEMBER: You had mentioned that a provider can assist, with submitting a complaint.

Or a grievance I was curious if that you said a letter had to go giving them authorization to do that.

I was wondering if there's any formality or formal complaints -- does that have to be -- letterhead or is there specific form or does it have to be a particular content tore.

>> FRED HESS: Scribbled on the napkin.

>> FEMALE SPEAKER: I'm address as a provider or a representative for a complaint it can be -- any way you want do it, has to be something in writing, for a grievance there's something actually specific requirements.

That the MCOs are aware that they have to be aware of.

That's to protect the member that the provider doesn't abandon the grievance halfway through.

>> AUDIENCE MEMBER: Just one follow-up to Tony's issue about Medicare for a dual Medicare and Medicaid it's not completely clear that the complaint process if made care, the consumer for a dual has Medicare and Medicaid the

complaint process is about the Medicaid benefits, but if a Medicare is taking along time, to make a decision, it is not completely clear that a decision, on the complaint side is going to make it go any faster when Medicare is the first payer for durable Medicare.

The part that is hard in the complaint process to illustrate's Tony's point interested in hearing more what exactly do you expect from a complaint process if the end result is, it's Medicare's issue.

The complaint is about Medicaid.

So what do you expect, to come what is a consumer expected to come from this complaint process the Medicaid side.

>> KEVIN HANCOCK: I can thans, so -- one of the outcomes of the complaint, that relates to the Medicare portion of a person's services would a least them to -- the CHC MCO to be aware of the need for the service -- so, it's informative.

At least.

The CHC MCO may not be able to do

anything with the complaint or they may as a service coordinator be able to, to -- maybe, intervene at some level on the participants part to see what is stuck in the Medicare side of the services but, it's really meant to educate the CHC MCO, if it's Medicare related it will help, educated the CHC MCO about the needed benefit so that, it might actually help them begin the process of preparing for that service if it's something that Medicare will be actually be covering.

>> AUDIENCE MEMBER: We have factors we would hope that would prompt the CHC MCO to provide the service, that Medicare has not been covering.

But it's not, a covered benefit necessarily, if it's a wheelchair that is going to pick up as a payer that's going to be a covered benefit.

That's something the CHC MCO and it's in the compliment to helping the member, maybe, the C hackers C will

end up end up paying for the wheelchair it doesn't have to, right.

>> KEVIN HANCOCK: Doesn't have to, if it's a Medicare covered service, right.

Correct.

It would still be informative.

I would actually, I would still encourage a participate tonight make sure the MCO is aware of the concern.

>> AUDIENCE MEMBER: Hi Dave gates I want to get back to the appeals and grievances piece.

And -- attorney Loux you mentioned about the, what we call the expedited grievance, having grievance that will be decided, quickly enough to make a real difference in the person's situation. And, there is a requirement, of a service typically buy by a physician in order to on Tine that quick or expedited, grievance decision.

Will the community HealthChoices MCOs, be able to dispute that physician's

certification and to deny an expedited grievance that does happen in HealthChoices fair hearings.

>> FEMALE SPEAKER: Okay.

Fair hearings is obviously different.

Because that's decided by the Bureau of hearings and appeals as far as, whether or not the CHC MCOs can disputed a provider certification, no.

The rule is, if you get a provider service, the CHC MCO must issue a written decision within 48 hours of receiving the provider certification.

>> AUDIENCE MEMBER: Thank you.

>> FEMALE SPEAKER: Let me go back to options after a first level complaint is decided.

>> FRED HESS: One second can someone on the phone please mute your feign we're getting a lot of feedback in here.

And I'm sure it's disturbing everybody else on the phone.

Thank you.

>> FEMALE SPEAKER: If a participant does not agree with the complaint decision, what the participant can do, depends on the subject of the complaint.

If the complaint about what is listed on the slide I'll go over that in a minute the participant, may request a fair hearing from the Department of Human Services.

May request an external complaint review, by either the Insurance Department or the Department of Health.

Or, can request beige a fair hearing, and an external review I want to.

>> EMILY: If a size it cannot slow down the request for the fair hearing it's off to the side is one way to look at it.

If it's a decision to deny a service or item, because it is not a covered service or item, a decision, to not pay a provider after service or item has been delivered, the MCO's failure to decide a complaint or grievance within the specified time

frames, the failure of the MCO to provide a service or item in a timely manner.

Which may address some of what we have been discussing and -- CHC MCO's decision to deny a request to disagree with the CHC MCO's decision that the participant has payer provider those are the times that the participant can request a fair hearing or external review or beige the fair hearing and external review.

All other complaints, you can only are -- the participant can request a second level complaint review.

That's second level complaint review is within the CHC MCO.

>> FEMALE SPEAKER: When you have a minute, Tanya, I have a question.

I'm on the phone I do have to leave in like, 15 minutes.

>> FRED HESS: Go ahead Tanya.

>> FEMALE SPEAKER: My question is, that if something is, denied through this MCO appeals process, if a person is on services my way waiver, could they

then use their services my way like whatever the service or could the question might be --

[inaudible]

>> FEMALE SPEAKER: I have no idea.

>> KEVIN HANCOCK: So -- I'm going try to paraphrase your question Tanya you're asking if the MCO, if the MCO denied any benefit or service you're eligible for I think that would be, I would look to, to -- Helene correct me if I'm wrong, if you're denied anything from the MCO you're eligible for you would be able to be eligible for the grievance process.

>> FEMALE SPEAKER: Right.

The question about eligibility through a waiver.

>> KEVIN HANCOCK: Services my way is a budget way to budget your services, that you're eligible for and Tanya is a recipient of services my way.

I still think that -- you're eligible for

the services but you're -- questioning whether or not you would be able to, grieve the total, cap for your budget is that right?

>> FEMALE SPEAKER: Question.

>> KEVIN HANCOCK: Really good question.

>> FEMALE SPEAKER: Total cap I can't, not familiar enough with the program to answer that if it's a medically necessary reason that you're denied the service, then it is a grievance.

If is not medically necessary, it would be considered a complaint, once again I'm going emphasize, if you go through the wrong door, the MCO is responsible for putting you in the right door.

>> KEVIN HANCOCK: So --

>> FEMALE SPEAKER: That's really not my question at all ma'am.

My yeah is, if someone is denied a service, through the MC Os, once they're on a waiver, like services my way, when they are taking control of their whole

budget in order different products right now that their insurance doesn't cover as long as they can show, they need it, to better their lives some way and, they handle their budget and everything else, responsibly, then could the person using the services my way, then step in be like okay I can take care of myself, and here's the year to saving give me the product, is that still going to be an available option under the new rules of how all this works.

>> KEVIN HANCOCK: So let's, can we explore that a little bit Tanya what you're asking for, is whether or not, you can -- the cap for, services my way should be, what we would like to call budget neutral it should be, you would be eligible for the same level of services you're managing your funding for your services a little bit more directly.

But the cost of the services should be the same services that would be available for anyone else, if they were

having someone else manage the cost for them.

So, what you may be asking for is whether or not you can go above, what other people would be eligible for.

I think that, let me explore that a little bit, take that back a little bit.

My impression, though is that, I think the answer to your question would be, no.

You would not be eligible for the grievance you're still, you have to live, within -- the budget that would be the same as for everybody else.

It's -- Levall is making hand signals right now.

I think --

>> AUDIENCE MEMBER: I think it's tricky I think it's tricky --

>> FEMALE SPEAKER: That's really, that's not really what I mean though.

Because -- right now, sometimes they tell me, wait for an insurance denial use your services my way money, on

something.

Okay.

If the insurance, denies it, then for services my way to pick it up.

But I don't know if services my way is going to be able to have that same, effect that it does, now.

You see what I mean.

Because -- like my main wheelchair I bring to the -- the subcommittee, I didn't have to go through, the insurance at all for that, because I saved up many the money you there my services my way through -- services my way, still going to be able to do that.

>> KEVIN HANCOCK: Yeah.

>> FEMALE SPEAKER: If it is, that can help a lot of people if so they can have more choices in like, equipment, and goods and services, that they have access to.

You understand the point that I'm trying to make now?

>> KEVIN HANCOCK: Yeah I mean,

I think, I did get too questions out of that, to answer your questions the services my way benefit will work the same way now, in community HealthChoices as it does in the fee for service program.

You'll be working with your service coordinator, um, in community HealthChoices, probably a little bit more but, the benefit itself will be working the same.

That being said you did raise an interesting question about, you know the flexibility of services my way, compared to, the way, the services would be available on an individual basis with the CHC MCOs I want to take that back it's actually a legal question I'm looking forward to posing to Helene and her colleagues it's -- because it's an interesting, interesting configuration the way we manage our services and we would want to, to give the right answer.

>> FEMALE SPEAKER: I know a lot

of people want services my way and if they work they might have an easier time, like navigating the system and living a life they might want to choose and that's why I am so -- April to come and be able to do the presentation so we can really discuss more good things that services my way might be able to do, if we're willing to look at it, in a little bit of a different light now.

Because I think, we can even get it to do more things than what it is currently doing.

>> AUDIENCE MEMBER: Can I say one follow-up to Tanya's issue without having the department address it it's a -- for her, it's also involves a population I think we're all concerned about.

Is, um, what happens, when a participant, has a condition, that requires more services.

Because of -- deterioration and it requires a hospitalization, it is not going to be reduced it's going date of birth for

new participants to CHC that are saying I need more or older participants that have a set level of services and are now saying, actually I have a condition that is made it -- my condition my physical health condition, needs more services.

So, in that situation, again, with Tanya's situation, how do you increase her budget that's an area where, if the MCOs are not willing to increase the budget, what are the remedies for the participant.

>> KEVIN HANCOCK: That would be increasing hours on the service plan for example, someone has expressed a need that requires more, personal assistance hours for example.

>> AUDIENCE MEMBER: That will be.

>> KEVIN HANCOCK: They should be working with the service coordinator to make sure the service hours are added to the plan, should be part of the person centered process and something

they pick up through the assessment process as well.

And if the MCOs are, denying the increase in hours for whatever reason I think that will be subject to a grievance.

That could be something that they could grief.

>> FEMALE SPEAKER: Actually depends on the reason, it would be a complaint or a grievance.

>> AUDIENCE MEMBER: Depend upon the reason, it really would not depend upon the reason too much, it depends on, if I'm asking for something that is a covered benefit, for the CHC waiver, assistive technology employment skills, home adaptation, home health aid these are all covered benefits if I'm saying I want that and the MCI is denying it, that doesn't matter why the MCO is denying it I want the service that's a benefit.

So that's not, that's a grievance.

>> FEMALE SPEAKER: Not being

familiar enough with the program I assume that the reason they're denying the medical necessity reason I don't know if there's other reasons I'm not familiar with the program that's why I'm hesitating over whether it's a complaint or grievance.

>> KEVIN HANCOCK: I would not being the lawyer I'm going to say that, I think, Lavell would be correct, it would be subject to the grievance it is say covered benefit.

>> FEMALE SPEAKER: Okay.

>> AUDIENCE MEMBER: Get a little worried I saw on the presentation throughout medical necessity, all these services are not medical services and the I want to make sure that grievance process, does I think that's where you were going, it really applies, for nonmedical services.

>> KEVIN HANCOCK: Absolutely.

>> FEMALE SPEAKER: Yes.

>> KEVIN HANCOCK: I missed, I

was -- having a side bar conversation outside Drew I caught what you were stating.

Terminology is coming from our Federal partners, but, it does include nonmedical services, it is the whole keep of community HealthChoices covered benefits.

>> MALE SPEAKER: I appreciate that, there's -- Federal terminology here.

But, I'm sure that, centers for -- Medicare and Medicaid would want the right expert applied to the grievance.

>> KEVIN HANCOCK: Agreed.

>> MALE SPEAKER: What I've been thinking about is two sets of grievances and appeals for both the 19B side and C side of the waiver for CHC, for notwithstanding the Federal regulations on the health care side -- one of the things that the -- 1915C side of the waiver a laws is for example, if you exhausted a certain benefit under Medicaid under typically what would be

under the health care side would be prided, um, allowed on the 1915C side of the waiver, for example, some of the DME equipment that might have been denied for some reason or another.

Might be considered on the C side of the long term services and supports sited of the waiver. And -- as I read the as I read the waiver application there's a specific set of grievances and appeals procedures that are written, within a the four corners of the application.

So, I think some you know, some of this stuff is really, um, pretty tricky and being able to determine, you know, what -- where you're going, with a grievance or an appeal based upon the service, and whether noter it's sort of a health care service or if it's something on the LTSS side.

>> KEVIN HANCOCK: I mean I'm going take that as a comment.

We would love suggestions how to better communicate that we want to

make sure we -- the MCOs I'm sure would want to make sure that the participants understand what benefits they're eligible for and how the process they would fall to be able to access the benefits whether it comes to the grievances hopefully, it will be -- if it something they would not necessarily be eligible for on the B side of the waiver were eligible on the C side of the waiver that the MCOs in the service coordinator would take steps to make sure that they didn't have to go through a grievance process to access it, it would be seamless to the participants I would assume all 3 MCOs would agree wanting to make that, process the seamless as possible if it's -- if it is a covered service they're eligible for -- and, I would think that -- also procedurally, that -- grievance process would kick in whether the MCO denied the service regardless of where which part of the waiver it would be eligible for they would not have to go

through multiple levels of complaints and grievances.

>> FEMALE SPEAKER: MCO denies they should be sending a letter, a notice it includes, the option for the men to telling the member report participant what they can do.

Which would be file a complaint or grievance.

>> FRED HESS: Pam you have a question.

>> AUDIENCE MEMBER: Just wondering is this taking two different grievance systems trying to put them together.

>> FEMALE SPEAKER: Multiple laws trying to put them together.

>> AUDIENCE MEMBER: I'm wondering you know I have not heard anything yet one of the key parts to the long term living grievance process is that ten day free services stop can't do anything is that still part of that.

>> FEMALE SPEAKER: Yeah that's

something -- yes continuation of services if you request a complaint or grievance or if you request a fair hearing, within ten days the participant has been receiving the services, they continue to the services at the same level.

>> AUDIENCE MEMBER: This is great the training, is important for us so -- people in the room, know we don't know what we don't know.

We're hearing stuff there has to be a similar version to go around the consumers especially if there are different levels they have not experienced before.

In the grievance processes.

Especially dealing with MCOs a lot of people, haven't done that.

This has to be broken down and put into, again you know, a one pager bullet point this is what I do, this is what I do, is that already done.

>> FEMALE SPEAKER: In the participant handbook it is simplified and

written out what the different -- what each -- complaint is, what a grievance is, the options are, which way you can go, depending upon the decision.

Where you can go for help, so that is one set of resources I know about.

Another one, is -- when you get a decision, if there's a decision, notice, that also includes the instructions.

The acknowledgment letter if a complaint or grievance is filed.

Also includes instructions.

I can't speak for if it's anywhere else.

Okay.

>> KEVIN HANCOCK: Just to follow-up on that point I mean, you have the participant handbook the draft of the participant handbook with that language if you want to provide us comments the way we can simplify message or even further or make it more accessible we would appreciate that very much.

>> FRED HESS: We have a question.

>> FEMALE SPEAKER: Does this

process apply to the FDE, the participant not agreeing with the FED, functional eligibility determination.

>> KEVIN HANCOCK: No, it does not this is for the CHC MCO covered services there is an appeals process for people who are determined not to be -- functionally eligible or financially eligible far a long-term care, that's part of the eligibility process.

That -- that goes through the fair hearings process and when they receive their notice, they're not eligible for not eligible for long-term care either because of -- financial eligibility or functional eligibility, that notice will give instructions on what they need too do, to file an appeal that is, separate from what Helene is talking about.

>> FEMALE SPEAKER: During that annual review, when the participant, needs to continue to be in a nursing home clinically eligible the other process is the one in place, in the CHC.

>> KEVIN HANCOCK: Exactly right.

Anything the MCOs are doing during that process is collecting information the determination is made outside.

It is a separate process.

Thank you for the question.

Thank you for clarification.

Too.

>> FEMALE SPEAKER: I want to turn back to what the options are, after a first level complaint decision.

I mentioned, that the participant can file a fair hearing.

The participant has a 120 days, to file, a fair hearing I want to emphasize that, because that is a big change.

For people familiar with any department program, it is always been 30 days.

This is now 120 days if a participant wants to extra external review from the Department of Health or the Insurance Department, that request, must be filed within 15 days of the date the participant

receives the written notice of MCOs first level complaint decision.

Second level complaint must be filed within 45 days.

From the date the participant receives the written notice of the decision of the CHC MCO's first level complaint decision.

So I want to turn now to second level complaints we'll talk more about external review and fair hearing later.

So who can decide a second level complaint?

That review committee must have 3 or 4 individuals, at least one third of the members may not be employees of the MCO.

CHC MCO staff may not have been involved in and may not work for someone involved in the issue the complaint is about.

Again if the complaint involves a clinical issue the committee must include a licensed physician and the physician must decide the complaint.

>> FRED HESS: Here I'm sorry I have something on this because, keeps saying that the physician, now, when I get home modification, it has nothing to do with my physical health whatsoever.

Bullet I still have to have the home modification, it has nothing to do with getting plea better or, or giving me a pill or anything like that.

So, what is the physician all about, me needing to get a home mod.

>> FEMALE SPEAKER: What I'm hearing you say it's not a clinical issue in that case the physician doesn't even -- doesn't even need to be on the committee.

It's only if it's a clinical issue, you need the physician.

>> FRED HESS: Okay I was getting confused I thought -- I was thinking that a doctor even had to make that kind of decision whether I get a home mod or whether I get home transportation.

>> FEMALE SPEAKER: It's not a

clinical issue the doctor does not need to be on the committee or make a decision.

>> AUDIENCE MEMBER: Is there something that defining the clinical decision what is clinical can be.

>> FEMALE SPEAKER: That's something not written down that is something can be considered for adding into the handbook or somewhere else.

>> AUDIENCE MEMBER: I would quality of life.

Quality of life.

Instead of --

>> FEMALE SPEAKER: Very broad it's something I'm -- I can't draw a bright line here for you.

But, that is something that we should probably, consider as a department, including some kind of definition in the handbook.

>> KEVIN HANCOCK: It gets back to -- the point drew was making earlier about the different models.

>> AUDIENCE MEMBER: Excuse me

even you are getting sometimes with all these acronyms and so forth.

How do you think the consumers are going to be feeling?

>> FEMALE SPEAKER: Actually --

>> AUDIENCE MEMBER: You're having trouble up here.

>> FEMALE SPEAKER: Only time I keep rushing through CHC.

So -- I don't think, I don't know if -- the other acronyms just to clarify I think that have appeared are DHS, Department of Human Services.

Insurance Department, PID, the Department of Health.

>> AUDIENCE MEMBER: You have the notes in front of you.

>> FEMALE SPEAKER: Everything once again.

I understand.

And -- everything is written down in the in the handbook.

>> FEMALE SPEAKER: They want to throw the handbook in the trashy can tell

you in two minutes they're not going to understand it.

>> FEMALE SPEAKER: So something else that is helpful, is, if you have a question about a complaint or grievance, you can call the MCO.

>> FEMALE SPEAKER: And do it again and do it again, do it again.

Do it again.

>> FEMALE SPEAKER: I can tell you what we're offering for help you can call the MCO you can call your legal aid office you can call the Pennsylvania health law project.

I do understand, it is complicated.

>> KEVIN HANCOCK: And then we also made the request I'm hoping Pam is willing to take that back for an opportunity for how we can, better present the information, from the participant handbook.

>> AUDIENCE MEMBER: Could I jump in, just we've been referenced a couple of times I know we're on the

agenda I know that time is he grievances and complaints and grievances and appeals is giant eye, just a note what we do at the health law project, I think it's a pitch a bit about, we provide free level services, how participants successfully challenge and overturn MCO's denials of covered benefits.

So we mostly are in the grievance process.

We don't deal with necessarily complaints, about seat cushions, as you noted in terms of your example of complaints.

We deal with, um if an MCO is denied, as Fred noted, a denial of the home modifications, whether that's the CHC service coordinator, that is saying, no Mr. Hess, we're not going give you that home modification.

No, Mr. Hess, we're not going give you employment services in the amount that you requested.

No Mr. Hess, we're not going give you

the assistive technology, that you requested.

That what we do, with all of those covered benefits, under 1915C, is that that's the grievance process.

That's not a complaint.

And what we do, in a limited basis triaging, is representing, counseling advertising folks about how to challenge successfully.

Those MCOs. And -- I know that, time has not permitted you to get to the grievance process.

Procedural protection that's Medicaid beneficiaries are entitled to. And we're looking forward to making it easier to read because it is very difficult to understand, what we do with the health law project is in our limited way are available to counsel and advise people and sometimes to represent if we think that denial is going to significantly impact the quality of life, folks know our service and know our individual attorneys David

gate Social Security here he has been doing it on the OLTL side we're hopeful we won't have to do much on the managed care side but we're concerned.

And so -- especially, for those folks that are, going to be, um, new participants or folks six months from now, that are losing their continuity of care, protections, that's the kind of work that we're going to be, using to process miss Loux, is describing I wanted you to know we're the only game in services because they have income service limits if you make a certain limit, legal services the other legal services programs can't help you.

We don't have an income level.

So if you're above is it a percent of poverty, we'll go ahead and do that representation.

In our like I said, given the resources we can't do everyone.

So I just wanted to note --

>> FEMALE SPEAKER: For basic

questions such as, how do I file this, that is something that, you are perfectly able to call your MCO and say, how do I file this?

Back to a second level complaint.

Someone files it, CHC MCO has 45 days to decide a second level complaint and send written notice of the decision to the participant.

If the participant is unhappy with the decision at the second level complaint the participant may request, an external review, by either Department of Health or the Insurance Department.

Those requests must be filed, with either DOH or PI within 15 days,st date, of the participant request receives the written notice of the CHC MCO decision, and, if it is filed within the wrong department,.

It's another issue where you don't have to worry is it a really a complaint or a grievance.

Talk a little bit about the external review.

The Department of Health reviews complaints that involve, like, the way a provider provides care or services.

The Insurance Department, will review the complaint if it involves, the CHC MCOs policies and procedures.

>> FRED HESS: What does PID stand for.

>> FEMALE SPEAKER: Pennsylvania Insurance Department, DOH is Department of Health.

>> FEMALE SPEAKER: I want to turn now to grievances we've been talking about a lot any way.

If you feel all grievances, have the same time frame.

60 days from the notice of the decision from the CHC MCO.

You will participant must receive a notice of the decision.

So that gives it a firm start date.

The notice will include, the reasons

for the denial or reduction of services, and should explain the reasons at a sixth grade reading level and include, every reason for the denial or the reduction of services.

And I mentioned before, the notice will explain what the participant's options are.

It will also include at the end, where you can go for help.

All grievances must be decided, by the same type of grievance review committee.

3 or more individuals at least one third of the members, may not be employees of the CHC MCO.

CHC MCO staff may not have been involved in and may not work for someone involved in the issue of the grievance is about.

And it must include a licensed physician and the physician must decide the grievance.

>> AUDIENCE MEMBER: To beat a

dead horse that's issue on the licensed physician, since a grievance in a covered benefit includes, nonmedical as we've noted, it could be including employment skill development.

The amount and scope of job coaching that has LTSS wants to get into the work force the MCO makes the determination we're not going give you that job coaching in the way you want at least, and the -- the participant, appeals that, through the grievance, so that's a denial of a covered benefit.

Grievance.

That the first line to go to the committee, or to the MCO is a physician is ultimately deciding that, because that's what it says.

>> FEMALE SPEAKER: I'm going did he determine because I don't know the program well enough, what would be the basis, for having decided that service, when is not a medical service, should be denied.

>> KEVIN HANCOCK: The point they're making we agree with the MCOs agree with as well there's a level of expertise that is required for some of these types of services that, are beyond the scope of the physician.

The physician even a physician specialist may not have the background and expertise to be able to appropriately, have the context they would -- they could still be part of a group of people helping to decide the outcome of the grievance.

But other, levels of expertise would have to be involved in helping inform how that grievance is being decided.

>> FEMALE SPEAKER: I think the issue backs what basis is it being denied if it's not being denied on medical necessity, then it should be going, the complaint route if it does not require clinical review, it will not need a licensed physician on the committee.

>> AUDIENCE MEMBER: Definitely

going through the grievance route it's not a complaint.

I just think that, we're going to have more conversation, and thought about how that determination of the -- of the participants grievance, is getting determined and we would be interested in hearing, don't need an answer right now.

But, we will soon and I think from the plans too, how are you making your decision, your the front line.

So whether that is in Centene, AmeriHealth UPMC, how are you handling the grievance when it's these other, nonclinical matters.

>> KEVIN HANCOCK: So the -- I agree with you, that the MCOs should have an opportunity to be able to address how they're -- how they are, approaching grievance from a nonmedical -- a nonmedical type of service that would be eligible, under the 1915C side of the waiver we'll take that,

we'll make sure we make time to be have them to go through that in did he did he stale we need to make sure how that, if there's any, differences in the approach, how that approach is, is included in the participant handbook as well.

I agree completely.

This once again this terminology is from our Federal partners we as a department are acknowledging the difference between the requirements for a medical service and a -- a service that is, part of the 1915C community based waiver.

So --

>> AUDIENCE MEMBER: The doctor, who is contracting the doctor? Who is bringing the doctor?

Who is paying for the service?

>> FEMALE SPEAKER: CHC MCO.

>> AUDIENCE MEMBER: Okay there's no conflict there, right? There's no conflict they're paying the doctor to make that final decision?

>> FEMALE SPEAKER: I see your point.

[Laughter]

You're stealing my next couple of slides.

Because -- if you don't like the CHC MCOs decision you can file a fair hearing which is with the Department of Human Services.

>> AUDIENCE MEMBER: It will go up any way.

It may create the potential to have keep fighting and -- I don't know.

>> FEMALE SPEAKER: I understand that I and I'm going to address that because the Federal law does require you to go for the grievance process first that is say change for people familiar with the regular, with the HealthChoices program, you used to have the option of filing a fair hearing, right away.

There is not, something we have any leeway on the Federal law is very, very clear you must exhaust the grievance

process.

Before you can request a fair hearing.

>> AUDIENCE MEMBER: Part of the question I think that, again, putting a pin in for the CHCs to present can the CHCs at some point come back and say, this is how we, this is the fairness of our grievance.

Yes. We for our grievance process, pay someone to be a physician, we ultimately decides the grievance and so, that may look like, well if you're paying, they're not going to bite the hand that feeds them, that's her point.

Part of that is saying, okay.

Let's hear from the CHC MCOs, about how that is, a unbiased process.

Given the financial issues that, go on.

Again, the CHC MCO is paying the licensed physician who is making the decision.

So why would that licensed physician, do anything or have a say. Thank you very much.

That's really the essential request.

And, it is just, asking you don't have to, explain it, right now it's just saying to the CHC MCOs, can you tell us proper about the fairness, of your process.

>> FEMALE SPEAKER: And that is fine.

And I will also point out that the department monitors, complaint grievance decisions.

>> AUDIENCE MEMBER: Who monitor that's from the department?

>> FEMALE SPEAKER: I don't know who monitors it.

>> KEVIN HANCOCK: We'll look into it.

Long term living would be monitoring, obviously it's the launch indicator for us in the beginning we'll be paying attention to all grievances that happen during the continuity of care periods for all 3 phases it's something that we're always going monitor it's a quality indicator for how the program is running even if you have

a lot of grievances for the same types of services theres something wrong with the way that, people are accessing the services or -- understanding the services, for that to occur.

That's -- something we're going to be monitoring very aggressively it's an obvious quality indicator.

>> AUDIENCE MEMBER: Can you say more about this over all process of, who is there a person at OLTL is that you Kevin the Deputy Secretary or have you designated, this is our -- monitor, of grievances.

>> KEVIN HANCOCK: So we'll have -- it's under our quality bureau, Wilmarie Gonzales, it's the over all evaluation of the program, that unit that is going to be part of the program evaluation will also be L involved in helping, to -- not only look at, the outcomes of the grievance process but also help, facilitate the questions for the grievance process we may receive.

>> FEMALE SPEAKER: Along those same lines the MCOs are required, to keep documentation of the grievance.

Who filed it, what it was about? Who decided it, when it was decided.

So those are all things that can be looked at during monitoring.

>> AUDIENCE MEMBER: Just seems to be like a -- ongoing process.

You're not happy with one person, you file a grievance.

You're not happy with another person, you file a grievance.

You bring in a doctor that you never saw before, they make the choice for you.

They're working for you, they're going to fight us until the end.

Basically that's what is going to happen we'll go through, maybe six months of grievance, go through a lawyer that you guys are paying for, that you, they may not be able to provide what we need, and we're the ones that

bitten in the ass.

>> FEMALE SPEAKER: I want to address the things in the statements I cannot change the system should never take six months as -- a -- a decision or grievance must be within 30 days of request.

For the grievance if you're unhappy with the grievance decision you go -- request a Department of Human Services fair hearing, that decision must be made within 90 days, of your initial request for grievance, not including any time you took between the grievance decision and requesting a fair hearing.

>> AUDIENCE MEMBER: That's four months out of a year possibly more after you file a grievance of something else doesn't work out.

>> FEMALE SPEAKER: I'll also remind you good the expedited grievance review in case, it is needed.

And that is, 3 days, and expedited fair hearing can also be requested.

>> AUDIENCE MEMBER: How long is that.

>> SPEAKER: Three days a hearing must be decided within let me just check my notes I can't remember if it's business or regular days.

It is must be decided within 3 business days, from the request for expedited review that's from the Department of Human Services is making the decision.

So hopefully we're not talk 6 months.

>> KEVIN HANCOCK: We're getting close to the end of the time.

>> FEMALE SPEAKER: I'm happy to get going.

>> KEVIN HANCOCK: Since this important we're willing to keep going if everybody else is.

It should be a committee decision obviously.

>> FEMALE SPEAKER: I've addressed a lot of what -- I was going to

address.

Most grievances are decided if you're unhappy the options are for all DHS fair hearing, request for external review by the Department of Health fair hearing the external review the time frame for fair hearing requesting is 120 days obviously if you're concerned about, the length of review, please request right away.

Don't wait 120 days.

Request for review must be filed within 15 days of the date the participant receives the written notice of the decision.

I want to talk briefly about external review, by the Department of Health.

In that case, it is not an MCO doctor, it is a, doctor who does not work for the MCO, it has issued within the 60 days, could be appealed to the court of decision, if it is against the CHC MCO they have to comply with the decision.

And expedited review which we

talked a lot about.

So I mentioned that, it was, when an MCO decides the complaint grievance faster than the normal time frames.

>> AUDIENCE MEMBER: Excuse me.

Question.

Why is that even like, part of the process.

Like, why would that not be commonplace for everybody to just put it as part of the review and every single time or every single you know -- supports coordinator that has -- you know, I don't understand why that is even a process there.

Doesn't make sense to me.

>> FEMALE SPEAKER: I am not sure how to thans other than the MCO can decide on their own as wouldn't everybody with that issue, put in an expedited review.

Wouldn't everyone who has an issue or grievance, just automatically put in the expedited review.

>> FEMALE SPEAKER: Not everybody is and obviously depends upon the services.

And why it is needed.

>> AUDIENCE MEMBER: If I'm having a grievance, I want to know now, why would I not put in a expedited review right away.

>> KEVIN HANCOCK: It's a way to prioritize the -- they have to be really first.

So you might have, safety --

>> AUDIENCE MEMBER: If I put it in, I might not get in aid.

>> KEVIN HANCOCK: If you have ten coming in on the same day the point of the expedited review, Helene correct me if I'm wrong is to prioritize the grievances are really related to an individual's health and safety.

>> FEMALE SPEAKER: Exactly if waiting the normal 30 days could harm your health you can request an expedited review and it becomes a

workload issue.

Remember you need 3 people to decide, the grievance and, so I assume that is why it's not, always -- given and, the ear thing I pointed out much earlier is might not be, 3 days is needed but the MC Os are required to decide the grievance, as expeditiously as the participants health requires it might be making sense to decide within 15 days.

Something to keep in mind I have not gotten into it yet is what can happen, during a complaint and grievance review?

So during a complaint and grievance you as a participant can far.

So you might want to participate, deciding within 3 days, really hampers participating you may want to participate in person, it's a longer time to decide, it allow U.S. to participate in person the other thing a participant can do, during a complaint or grievance review, is provide additional information.

You might file your complaint review or grievance review the day you get that denial notice.

It might take you a couple of days to get the additional information.

And you can send that additional information, to the MCO and the MCO must consider it.

I think I'm at review committee for expedited complaint and grievance I want to say the review committee for expedited complaint must include a licensed physician, and again the physician must decide the complaint, review committee for expedited grievance is the same as regular.

I briefly talked about the time frame before for deciding and expedited complaint and grievance it is 48 hours of receiving a provider -- if the provider says, your health requires a faster decision, or 72 hours if the MCO decides on their own, than a faster decision is required.

A participant can request that the time frame be extended by 14 days.

We're imagining that would happen is let's say you get the -- you request an expedited review, you splitted the request, you call your doctor's office you say please come and help me.

Please testify at this review.

Please send in a piece -- send in a letter.

About why you need this service, and -- the receptionist says I'm have I sorry the doctor is out of the country until Tuesday.

So in that case you can call, and say to the MCO I need an additional 10 days, up to 14 days, before you decide.

After an expedited complaint, or grievance is decided pretty much similar.

You can request a fair hearing from the Department of Health.

You can -- request you can request a expedited review from department of review or Insurance Department.

Or you can request both a fair hearing, and an expedited external review.

I want to turn to what happens after a complaint is filed I just touched on it pretty quickly a few minutes ago we talked about acknowledgment letters.

I want to remind everybody the acknowledgment letter will include a summary of your complaint and grievance you read it it's all wrong.

There's instructions to call, your MCO.

You read it, it's right the instructions are to return, a signed copy saying, this is correct.

You can ask to see, any information, the CHC MCO has about the issue the complaint or grievance is about.

At no cost to you.

As I mentioned before you can ascend additional information to the CHC MCO.

A participants as I mentioned can attend the complaint grievance review

CHC MCO will tell the participant's location date and time of the review in advance.

You can appear in the review, by person and tell feign if available by video conference.

If the participant is not attending the review, the review, must be conducted as if you were there -- and it will not effect the decision, of the CHC MCO.

Quickly about fair hearings, they're conducted by the Department of Human Services.

As we mentioned before, there is no longer direct access to fair hearing.

As required by the Federal law.

Participant must participate at the fair hearing that can be by phone or in person.

The CHC MCO must also participate or will participate in the fair hearing to explain why the CHC MCO made the decision.

Or explain what happened.

The participant can ask the CHC MCO for records or records or information that the CHC MCO has about the issue, at no cost to the participant there's instructions in the handbook how to do this, instructions in the notices you get from the department.

How to do this.

I mentioned before the time frame for deciding a fair hearing, regular one is 90 days from when you filed your average grievance or complaint.

Not 90 days from when you requested a fair hearing.

The only thing that impacts the length of that 90 days is how long it takes after you receive a decision, to request the fair hearing.

Expedited fair hearings that we talked about that briefly.

If you provide the Bureau of hearings and appeals with a signed written certification, from your provider, explaining why you need an expedited

hearing, BHA will conduct a fair hearings expeditely or quicker if the participant provides, if the -- if the provider testifies at the fair hearing why you need a decision, within 3 business days, BHA must provide the decision within 3 business days.

My last slide, addresses continuation of services which we also discussed I just want to reiterate that because I know it's very important.

It's services that you have been receiving.

It's a continuation.

It can be, any level of review, complaint, grievance, fair hearing. And the request for review, must be made within ten days, from the mail date on the written notice of the CHC MCOs decision.

The CHC MCOs decision will include instructions, about the requesting about the services and the time frame.

So there's a reminder there -- once

again it's also in the handbook.

>> AUDIENCE MEMBER: Can I ask I understand the time limits and -- one issue, not time limits here but the time limits of how much time we have to go -- but one important note is just understanding, what triggers -- this whole process, again in the grievance -- context, that -- it is triggered by a CHC MCO decision, to do something, ear than other than what the participant is asking for.

I would like, more personal assistant services I would like assistive technology.

And the CHC plan says no -- or, we're going to give you something different than what you're asking for.

Again the asking for is the covered benefit the CHC plan is saying no.

It seems as though I'm raising this, that -- the service coordinator, could say, at the service coordination meeting, no, Mr. Miller Wilson we'll not give you that.

But that's, but -- again, it seems as

though what triggers -- the -- is that, determination that the service coordinator is saying Mr. Miller Wilson we're not going give you that, can I go ahead and appeal, based upon that oral decision or do I have to weight for the CHC MCO to send me, the service plan the written decision, that says, no -- we're not going to do that.

>> FEMALE SPEAKER: If I understand the question correctly, the service plan will not include the service the participant wanted.

So, it's not -- doesn't even make it there if the Court please the CHC MCO, to re.

>> AUDIENCE MEMBER: That's an issue that sometimes comes up I'm in a service plan I want more services, and, the service coordinator, let's do new services let's just make this as clean as possible.

So called clean, new participant I've got CHC plan X I'm meeting with the

CHC MCOs service coordinator for new, LTSS services.

I want home modifications Mr. Miller Wilson.

Plans never going agree do that.

We're not going to -- even put that the ISP.

>> FEMALE SPEAKER: File a complaint or grievance depending upon the services and reasons you can call the MCO and say this is what I wanted can I have it and the MCO says no.

It is not -- I'm going do use the terminology used it's not medically necessary you can file a grievance even if it was not submitted by the service coordinator or a physician or anyone else.

>> AUDIENCE MEMBER: Okay.

>> AUDIENCE MEMBER: And then -- it's -- I'm asking for new services and if it's a ten day notice, from the written decision of the MCOs if the MCO is saying we're going reduce any amount

come July 1, 2018 if you live in the southwest in the CHC MCO says end of the continuity of care period we'll start to reduce, that needs to be in writing.

Is that right?

>> FEMALE SPEAKER: That is correct but -- I'm a little confused because you started with new services.

>> AUDIENCE MEMBER: I started with flu services I'm switching --

>> FEMALE SPEAKER: Continuation.

>> AUDIENCE MEMBER: Consideration of services and CHC MCO on July 1, 2018 pasted the continuity of care period says we want to reduce services, um -- that has to be, in writing that's not an oral.

>> FEMALE SPEAKER: Correct you must receive a notice of decision, that says, let's say you're getting ten hours of physical therapy, the MCOs says, 6 hours or medically necessary, there should be a written notice of decision that notice of decision should include, how to continue

getting services, and what you can do, if you disagree with the decision.

>> BOB THEIL: We're over time now.

Obviously.

I spoke to Kevin he said if it's okay with the committee he'll stick around for any other public complements regarding anything else.

>> AUDIENCE MEMBER: Can I ask one more question it's not related to the grievance.

What the transportation thing again I know favorite topic in the rural areas, are those transportation providers contracted with all the MCOs now too, we talked about access a lot.

I'm wondering what from Fred lives in Greene county all those transportation providers contracted.

>> KEVIN HANCOCK: If they are on -- the person's service plan, they're Medicaid enrolled provider or part of a no HCBS, they're covered in the continuity

care period the MCOs will have to pay for the services regardless whether they're contracted or not.

I think that -- at this point the MCOs built out helped build out their networks in all of the areas, at least enough to meet network adequacy but during the continuity of care period, the point I'm making is that, it doesn't matter they have to -- they have to pay for those services.

>> AUDIENCE MEMBER: Kevin can you repeat the question.

>> KEVIN HANCOCK: I was asked to repeat the question I answered question no one has any requested what I was answering.

Pam had asked, whether or not, there's -- I'm going to paraphrase it, there's -- that the, the providers, transportation providers, in rural areas, are contracted with the MCOs my response was that it's during the continuity of care period and Medicaid

enrolled provider or part of not HCBS or organized delivery system they have to pay for those services any way.

It doesn't platter.

So -- Henry asking a question.

>> AUDIENCE MEMBER: On the whole grievance process is there fully grievance process is there any data from HealthChoices we could take a look at?

I know this, program is entirely different, but -- it might give us some feel of you know how many grievances are filed, how many of the MCOs actually overturn on their own and how many go to insurance or health.

>> KEVIN HANCOCK: Great suggestion, to provide data, from health choices, collect it we can certainly, we can certainly present it.

When the MCOs are asked to present, on their complaints and grievances process we'll present that -- not only the community HealthChoices grievance data if any is available also HealthChoices

data to set context that's a great suggestion thank you.

>> MALE SPEAKER: Kevin we had talked about the possibility of having an advocate observer involved, with -- new waiver applicants.

That would depend upon, getting -- MAXIMUS involved any -- progress on that.

>> KEVIN HANCOCK: We talked about that a little bit, doesn't -- we talked about using another venue other than the MAXIMUS for the information.

But -- we can certainly, consider having that information, we have to consider, protections of the participant, privacy protection for the participant, we had actually talked about using I think, one point it was suggested they use the area agencies on aging but, with the MAXIMUS could also be involved as well as long as the participant was willing I think what is being suggested here is that, that you would have a advocate

participant be involved with the initial meeting with the -- CHC MCO during the initial comprehensive needs assessment is that true.

>> AUDIENCE MEMBER: It's both the -- go ahead.

>> MALE SPEAKER: Both for the, the assessment and also, in the development of the service planning is that what you were saying.

>> KEVIN HANCOCK: I consider them both to be part of the same process.

So I -- I told you before, that, I -- if the participant is willing, than, we would certainly support it, you just -- tell us how you want to approach it.

>> AUDIENCE MEMBER: The challenge is the concern is -- for new participants in the southwest zone, that are -- are newly eligible for long-term services and supports don't benefit from a continuity of care period.

Making sure we have a good

understanding how the person centered planning process works which includes the assessment and the planning and with the consent of the participant, um -- seeing how, each of the MCOs, goes about doing that.

And -- we're interested in a -- observing that, essentially.

Not necessarily getting involved in advocacy.

But really just trying to observe the process, and learn from that. And it is not -- pointing at one particular CHC MCO it's saying we want do this with all of them with selected samples I think the question comes up is -- how do you identify who those participants are, and how does the department do that.

>> KEVIN HANCOCK: Happy to engage in that conversation, we didn't talk about MAXIMUS, which would be the easiest way to identify who they are we did talk about, we talked about, use of the area agencies on aging potentially

who would also, position to be involved.

>> AUDIENCE MEMBER: Because the area agencies on aging have a potential conflict not -- I think the MAXIMUS independent enrollment broker approach, I'm going say independent enrollment broker MAXIMUS would be the ideal way of identifying those participants again, of course the buy-in, is the participants have to agree.

On that front and just some issues I think to work out just to know that, the -- the goal is to, to just really understand at a ground level, how it working.

>> AUDIENCE MEMBER: Why wouldn't you use the already contracted PCC people, why -- why won't our organization we do some PCC you have the -- the regional already and -- why won't -- we could be objective and listen.

But we also are going to keep on the other side of that, hearing what that person needs, to be able to, be able to balance both of them.

>> KEVIN HANCOCK: Just a -- once again paraphrase, the question, Pam had asked, why person centered counselors is that are part of the ADRC, process, be used potentially to fulfill that role.

I'm not completely sure, Pam I understand how you would see that role, relating to the person centered counselor role is available, to everybody, who requests it through the ADRC process and, they, they can be helpful for enrollments, they can potentially be helpful in helping to answer questions through the comprehensive needs assessment process with the MCOs, but -- I'm not sure how you would see that role.

>> AUDIENCE MEMBER: Right from the front door it's -- when I see, back to the way the navigators were I see PCs being able to be navigators too, that person is trying to get evaluated to get services, we're helping them to try to get services why won't listen to the

assessment process, to be able to hear what is really happening, because you're part of the PCC you have to determine what the needs are you'll hear that, but you just go through the process, of -- them being assessed.

You're going to put that together, through a true plan to be able to report on, how the assessment was done, help that person not get lost in what they really need and what they really want.

>> AUDIENCE MEMBER: I think it needs talking out, there's clearly interest from some members of this committee and the other advocacy communities a concern about person centered planning process some of is more just logistics and details about that, what are the issues of objectives is -- what are you trying to do.

On the one hand there's observation, which is more passive just -- we just want to see, how person centered planning works in this new environment.

Because, past committee meetings have talked about there.

But on the other hand, as Pam noted the there's this other tannings what happens if you're observing something and it's going off the rails a little bit.

What happens if you're identifying the assessment that is going on, isn't really informing the person centered planning process, in away.

What happens if it goes away, down this pathway of, oh, I asked for something, and it's not actually being provided, I'm confused.

That gets more into potentially advocacy and those are, two pieces that are different, in terms of the objectives.

I think that's something we need to talk about a little bit more.

>> KEVIN HANCOCK: I agree the more passive approach we want the feedback we're very much interested in supporting happy to talk about T I think

to your point Pam we need to flush out that idea we would love to talk about did more with you.

>> BOB THEIL: Jack had a question.

>> MALE SPEAKER: First Helene thank you for looking to make what is an archaic process, much more clear.

I get concerned that you have given a primer to everybody here today.

About the process.

But -- there are 85,000 people who may not understand, what this process, involves it is complex.

It is complicated.

Kevin I'm going to urge you to bring Helene back in a few months, so we can get a sense of, how the process has been working out. And we can use her expertise to help guide what changes might be made, in the process.

But also, I think it's the committee and -- and you have to think how do we better explain this process.

I realize it's in the handbook.

Handbook is lengthy a lot of information in the handbook, these are important rights people have to be aware of, ten days in particular it's very important -- not everybody knows about it.

Thinks about it -- so -- um, we have to -- give this more consideration but Helene I thought you did a very nice job.

Thank you.

>> FEMALE SPEAKER: Okay.

>> HEATHER HALLMAN: Thank you Mr. Kane we support that recommendation the timing for the return as long as -- as Helene is willing is up for discussion I think, a thought would be, at the end of the continuity of -- at the exact end of the continuity of care period will be early summer.

Much better wage for that kind of discussion that's a very important recommendation.

>> BOB THEIL: Okay thank you we'll adjourn the meeting the next meeting is

February 7th in this room.

Thank you everyone.

All the presenters everyone have a good day.