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NOTE: A link for complaints and grievances will be added under General Information on the participant section of the Community HealthChoices (CHC) website at http://www.healthchoicespa.com/. The complaints and grievances appeals notices will be posted under that link. An announcement will be sent out via the CHC ListServ when they are posted. In addition, contact information for the CHC Managed Care Organizations can be found in the OLTL Updates slides posted at http://listserv.dpw.state.pa.us/Scripts/wa.exe?A1=ind18&L=mltss-meeting-minutes.

DATE: April 4, 2018

EVENT: Managed Long-Term Services and Supports Meeting

>> PAM MAMARELLA: Okay.

Good morning everyone we're going to get started.

Okay let's go around the table and have some introductions please.

>> SPEAKER: Linda Litton participant advocate.

>> SPEAKER: Barb followser liberty community connections.

>> MALE SPEAKER: Blair bore of course, united health care.

>> SPEAKER: Good morning Jack Kane.

>> PAM MAMARELLA: Pam Mamarella new Courtland.

>> KEVIN HANCOCK: Good morning, Kevin Hancock Office of Long Term

Living, very loud sore by that.

>> FRED HESS: Good morning Fred Hess, disability advocate.

>> SPEAKER: Steve ties excel, Philadelphia corporation for aging.

>> SPEAKER: Heshie Ziman peek speak Estella Hyde, council on aging

AARP.

>> SPEAKER: Drew Negele Sharon Sharon Sharon Behun, center of

independent living Pennsylvania.

>> SPEAKER: Ray Prushnok.

>> SPEAKER: Jessie Wilderman, health care Pennsylvania.

>> PAM MAMARELLA: People on the phone?

>> SPEAKER: Tanya Teglow did you hear me?

>> KEVIN HANCOCK: Yeah.

>> SPEAKER: Good I just -- yeah. I can hear you, I just wanted to

be sure you could hear me.

>> FRED HESS: Loud and clear.

>> SPEAKER: Okay.

Good.

>> SPEAKER: Renee Markus Hodi n.

>> PAM MAMARELLA: Do we have Denise Curry on the phon phone? Paragraph is Ralph Trainer on the phone?

Pat is there anyone else that signed up to --

>> SPEAKER: Ralph, Brenda and Denise.

>> SPEAKER: Did you hear Dennise Curry is on the line.

>> PAM MAMARELLA: Thank you.

>> SPEAKER: My phone was muted. So thank you.

>> PAM MAMARELLA: So I'm going to the housekeeping rules.

As everyone knows, we use the utmost and professional language and

behavior here. A point of order if you could direct your comments to

the chairperson.

Waited to be called on and then keep your comments to two minutes if possible.

The meeting minutes, transcripts much the meeting documents are posted on the Listserv that everybody has on their agenda.

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

We have a captionist here as we always do and today, we also have an interpret we were Kim, to our right.

She will be joined or is joined by a second interpreter. It is important that we all speak slowly.

>> KEVIN HANCOCK: Correction unfortunately the second interpreter --

>> FRED HESS: We got another one.

>> SPEAKER: Be here in an hour.

>> FRED HESS: Update.

>> KEVIN HANCOCK: Okay never mind.

>> FRED HESS: Correct the correction.

[laughter]

>> PAM MAMARELLA: Thanks Kevin.

It is important that we all speak slowly, clearly, be sure to introduce yourself it is equally important that we get when we give answers to people, especially when we're interacting with the public

that we repeat your questions, so that the people on the phone understand what question we're actually answering.

Please be sure to tell your -- turn your cell phones off, clean up, take away all of your beverages and trash with you as you go.

As we began a few months ago we're going to incorporate the public comments into every individual session as opposed to waiting until the very end in an attempt to make sure that we hear from everybody who made the time to come to the meeting today. The MLTSS sub-MAAC meeting dates are available on the Department of Human Services web site right now. We have a new member Heshie Ziman, introduce yourself to the committee.

>> SPEAKER: Hello. So -- I -- from Philadelphia.

I volunteer with the LGBT elder initiative.

And I represent people I guess over 60 I represent people with disabilities, long term survivors HIV, long term survivor.

So I am excited about this opportunity and look forward to working with everyone.

>> PAM MAMARELLA: Okay.

Thank you well welcome to the committee. Before we go to the emergency evacuation procedures, I wanted to let the committee know this will be my last meeting here on the MLTSS committee.

I really want to thank Kevin Hancock and his predecessor Jen Burnett for the opportunity to serve.

I have enjoyed meeting and learning from so many of the people on this committee and I hope to maintain a lot of different relationships that I forged since then. And as to the future of how it is going to be structured I'll turn to that to Kevin to answer.

>> KEVIN HANCOCK: Sure.

So just wanted to take a moment to thank Pam for her service to the committee and her ongoing participation. I've known Pam for a long time and she not only is a extremely knowledgeable person about long-term services and supports, and also the managed care platform for long-term services and supports with affiliation with new Courtland and the LIFE Program in Pennsylvania she is also advocate for people receiving great services and she can take personal credit for a lot of the great work we have seen and we're expecting to see as we continue to roll out and standardize community HealthChoices across the State. Can't tell you how grateful we are for her contributions and we're going to be sorry to see her, not have her sitting in this chair right here.

And if you don't mind I would like to take a moment to give her a hand.

[applause]

So Fred Hess who is our current co-chair will be taking over over as chair.

It will be my job to help manage Fred.

[laughter]

>> FRED HESS: Good luck.

[laughter]

>> KEVIN HANCOCK: I don't know Fred if you want to take a word or two on your vision for leadership as the chairman of the committee but -- Fred I've also known Fred for a long time really long time he is -- he is one of the best advocates for long-term care in Pennsylvania for both the over 60, over of 0 and under 60 population.

He knows the system from a provider perspective and from a participant perspective and I would have to say he has been a good friend to the system to participants and to -- and, I have to say, to me.

I think he has been a great sounding board for this program and we're grateful for his willingness to take this on. So thank you Fred.

>> FRED HESS: Yeah what I wanted to do is eventually, get to where more of the people with disabilities themselves, more of the consumers themselves are in here and asking questions.

I would like to get more oriented towards consumers instead of so much information about what the MCOs are making and things like that. You know? So it's all about us, the consumer. So that's who I would like to start to see a lot more with questions from the audience.

And I just really believe it's our program it is for us. So we're the ones that need to speak up because the other guys are not on it, do not know. We do.

Okay.

That's where I plan ongoing with this.

>> PAM MAMARELLA: Thank you Fred.

You want to give us the emergency procedures?

>> FRED HESS: Yeah.

Run!

[laughter]

Otherwise, roll okay.

If you can't. So --

[laughter]

In the event of an 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 require assistance to evacuate you must go to the safe area outside the plain doors. Here, in OLTL staff will be in the safe area to stay with us until we are told we can either go back in here or until they get us out of the building.

Everyone must exit the building. Take your belongings with you.

You don't want to leave them here they may burn up.

You know, do not operate cell phones.

Going to need air time for emergency people. Do not try to use the elevators they will be locked down they will not work any way.

When you use stare one and two, to exit the building for tear

one, exit the suite on the maindoors left side near the elevator, turn right go down the hallway pasted water fountain, stare one is on the left, stairwell two, exit honors Suite on side doors on the right side or the back doors, for those exiting from the side doors, turn left and stairwell two is in front of you, for those exiting from the back doors make two lefts an the stairwell two is ahead of you.

Keep to the inside of the stairwell, merge to the outside. Turn left and walk down Dewberry, to Chestnut Street, turn left to corner of Fourth Street, turn left to Blackberry street and cross Fourth Street to the train station where we'll all be checked to see if we are all there.

Even if we're not all there, like me.

[laughter]

>> PAM MAMARELLA: Thank you Fred we're going it turn the meeting ever to Kevin to give us OLTL updates.

>> KEVIN HANCOCK: Thank you Pam, just to be sure can the people on the phone hear me as I go through the updates if you can speak up tanya yes or no, I would appreciate it.

>> SPEAKER: Yes. I can hear you.

I'm sorry about that.

>> KEVIN HANCOCK: Just want to make sure.

Okay.

So we'll start with quick update on launch information.

I am going to go over here, and -- look at the screen to make sure I'm prettying quick updates okay.

So the first slide shows current distribution of the plans plan enrollment for community HealthChoices.

We have AmeriHealth Caritas, 19 percent, Pennsylvania Health & Wellness, 27 percent and UPMC community HealthChoices 54 percent this is as of the end of March, 2018.

UPMC as you see, if you don't mind going back as you can see, continues to be the largest plan in this southwest and obviously they are a well-known name. We'll continue to monitor this. Most mostly continue to monitor volumes of auto assignments to see if there's any changes we need to make there as well.

If you go to the next slide -- this shows, continues to show, and includes new enrollment including particular. The distribution of plan selection versus auto assignments, we still have 48 percent of individuals being auto assigned through the process. That includes the initial roll outs, as well as the new enrollees since January 1st.

And for those who did select the plan 2 is percent are doing so by phone. 18 percent are using a paper form.

[21.

[and by phone and 2 percent increase it's 1 percent we are happy to see that, it was only available during the southwest pre-transition in November, so arrived on the scene a little bit late.

It's convenient way for people to go through enrollments if they call

the call center for enrollment, they also have an opportunity to be able access the information like the enrollment specialists we continue to

auto enroll individuals who are part of the --

[laughter]

We continue to auto enroll people in the dual special needs plan,

that's 11 percent that's about the same percentage at the end of the

transition period.

So moving on.

We'll get the system Oliver.

[laughter]

Okay.

This slide shows the break down in new enrollments, by age and

population group. This actually, doesn't show the break down by age it

does show by the population group.

Most of the new enrollees are duly eligible you see the spikes I

talked about this last month the spikes occur because that's when we're

informed by Medicare by CMS when a person is actually either eligible

for Medicare in the Medicaid program or they become eligible for

Medicaid and they're enrolled in Medicare. So -- those speaks are

actually, not actually occurring they're part of the cycle of enrollments,

in the way that it is communicated with CMS.

Regarding the other populations we still have a significant increase

in growth in our nursing facility, long-term care the LTC is nursing

facility enrollments and the blue or HCBS enrollment those are individuals receiving the long-term care in the community. There's a distribution, largest population which is the largest population in community HealthChoices are the duly eligible individuals who are not in the long-term services and supports.

This shows plan transfers and, this actually shows, this is a very telling slide. It shows that there was a lot of adjustment in the beginning of the program especially in the January, February time frame where people auto assigned and elected to go to -- they changed plans and obviously they were changing to UPMC based on the volume but that is also tapering off, it has consistently tapered off since the middle of February. And it just means that people are settling into their managed care organizations and adjusting. This is exactly what we expected to see, following the pre-transition period.

This shows the distribution of critical incidences it also reflects the distribution of population as well. We have a lot of -- these are we'll say again we said this last month, since we only met on -- on the 19th of March a lot of this data will look very similar it's only been two weeks. It shows that we do have low volumes of reported critical incidences and we're capturing in this slide, abuse neglect and service interruption. Service interruption is the largest category for participants. But we still see that as being very low volumes Yes, sir.

>> AUDIENCE MEMBER: Hello sir my name is Tony brooks I'm a member of ADAPT, question -- is this involving people with disabilities that the neglect and abuse is all tallied up?

>> KEVIN HANCOCK: All of the population, so it would include --

>> AUDIENCE MEMBER: People with --

>> KEVIN HANCOCK: People with disabilities as well as individuals who are not in need of long-term services and supports community duals as we call them and, the -- the little bit of feedback. We're turning off the mics, it would include include individuals in nursing facilities, also including people with disabilities.

>> AUDIENCE MEMBER: Thank you.

>> KEVIN HANCOCK: Sure. Any other questions about that?

Okay.

Areas of current focus, we continue to have calls with the individual MCOs.

They occur not with the same daily frequency we had at the beginning much the roll out. But we do have a weekly call and we have at least one individual call with the MCOs to talk about ongoing issues on an individual basis and also the, more systemic issues as well. We continue to have weekly participant and participant advocate calls every Tuesday we have a lot of great participants on that call and they are focused on mostly focused on individual cases. There's some -- there's some systemic issues that the participants and participant advocates are pointing out we're grateful for working through those

issues.

But we are, we're really focused at this point on an individual cases.

And then we also continue to have weekly calls with the provider associations and that includes the nursing facilities and HCBS providers they're becoming bi weekly we have them every other week. More frequently now, they're more focused on, some individual cases that we talk about, that is mostly on provider payment issues and the biggest for home and community based providers has been HHE change and ongoing issues that are progressively being corrected but, we still have some problems.

And with nursing facilities it's individual cases that the biggest topic to be discussed with nursing facility associations has been transportation.

And the weekly calls we have with the aging network, aging network supports not only service coordination in the southwest but also the front door for services we talk about both issues with data and also ongoing issues with individuals and their experience with moving into community HealthChoices. So they will continue and they're going to continue indefinitely. We might actually, ramp them up more when we get to the end of the continuity care period to make sure that we're addressing any particular issues that arise following that transition.

So continueded areas of current focus we have mentioned HHA change

that is the system that is used by all 3MCs that provides service authorization that, the data, is -- there's still some gaps in the data that are being corrected but, they're largely being addressed by the MCOs and we appreciate providers willing, continued willingness to identify case that's have had problems. Another problem area with MCO plan transfers, Medicare and Medicaid participant and provider education ongoing issue certainly focus in the southeast. And we know that we need to improve our communication about relationship between Medicare and Medicaid to make sure that the message is clear for dual eligibles. Person centered service planning process is an area of ongoing focus but it, we're -- looking forward to working with participant advocates in doing some validation of how that process is working for participants and making sure that it truly is person centered and then participants needs and preferences are captured on the person centered service plans.

We are, reviewing changes to person centered service plans this will be particularly important at the end of the continuity of care period working with the MCO toss discuss why person centered service plans are changing at all.

And, they have a requirement to do a comprehensive needs assessment with all participants in the community HealthChoices during the six month period and we'll have a good need to understand why on both an individual and aggregate basis we're seeing changes, whether they're increases or decreases that's something we'll be

focusing on, most heavily at the end of the continuity of care period. Transportation to be an issue.

And it is not something that is going to be solved quickly and easily it is definitely an issue. We know it's going to be an issue in the southeast we're trying to get ahead of it there, in the southwest it's an issue. Across the system. And, both for long-term care services as well as nonmedical services. Medical assistance transportation program and the challenges we have with emergency transportation across the, across the system is a challenge. And the reason why community HealthChoices is -- is adding to the challenge is, that we introduced a new service we talked about this before across the home and community based waiver population it is also, new for nursing facilities that have managed transportation in the past and working with the MC Os. But we're confident we'll be able to work through those issues but, just setting expectations, transportation has been a challenge across the State we talked about this at length in the last meeting.

>> FRED HESS: Especially around the urban areas, you know out in the woods out there, because that's, there's more woods out there than what you'll find out here in the southeast so -- a lot more rural area, way a lot more rural area.

>> KEVIN HANCOCK: I would argue, that transportation is an issue doesn't matter where you live.

[laughter]

It is certainly I think the people in Philadelphia would agree that transportation is -- ADAPT has done a lot of work with transportation in southeast to make it more accessible and they had to do a lot of work to be able to do that, transportation is -- it's the gate way for independence we want to make sure that it's service that is accessible and protected but I'm just making it clear it's not going to bize.

We'll continue to talk about the complaints and grievance process and notice for HCBS we don't have a lot of data on the complaints and grievance process that the point. But -- but we're looking forward to continue to present that as we continue to roll out community HealthChoices we'll have more data for the southwest we believe at the end of the continuity care period to present we plan to present on an ongoing basis. We're heavily focused on the end of the continuity of care period it's less than 90 days now. And what that means for service providers what that means for service coordinators, what that means for participants and for service plans and also working with the MCOs, um, we are expected that -- that the June and July roll outs will we'll be talking about the southeast roll out one second Mr. Bennet

we'll be focused heavily on making sure that the transition for individuals is not -- it is truly, the -- their service plans are reflecting their needs and their preferences and, that whatever transitions occur at the end of the continuity of care period, it will

end up being in the best interest of the participants so -- thank you.

Mr. Bennettt.

>> AUDIENCE MEMBER: Hello everyone Lester Bennet, supports coordination I just wanted to know I know a lot of people around here have looked at what happened in other states that's why we have 180 days of COC.

You know, to go through the bumps and bruises, do you think we're going to second that at least until the end of the year?

>> KEVIN HANCOCK: We are not.

>> AUDIENCE MEMBER: Okay.

Why not?

>> KEVIN HANCOCK: Because I mean, we need the MCO toss take over the service plans that's the plant ever point of the managed care.

>> AUDIENCE MEMBER: So just -- I was thinking of this, I wanted to make sure I know. Each zone when they are implemented with CHC they still get that 180 days correct?

>> KEVIN HANCOCK: Every zone gets 180 days if they're in a receiving services in one of our legacy home and community based waivers that's correct and just also, reminder for individuals in nursing facilities, um, if they are, in nursing facility at the time of enrollment in the community HealthChoices, they will be able to stay in that nursing facility indefinitely as long as that person centered stays enrolled in the Medicaid program.

>> AUDIENCE MEMBER: Okay.

>> KEVIN HANCOCK: Last on the list is, lessens learned for the southeast.

If we have time in the next -- the next MLTSS sub-MAAC will focus heavily on participant direction and home community based services we're going to have a ghost speaker Tanya Teglow we'll be focusing discussing how we're incorporating the southeast lessons learned in the -- part of the MLTSS sub-MAAC.

>> SPEAKER: Hi Kevin barb, followser regarding the data integrity, is there anything that the southeast can do to help with that?

>> KEVIN HANCOCK: Absolutely. So most of the data integrity issues some in HCSIS we use in the fee for service waivers but most of the it's not really -- I'm not saying the data is is wrong in SAMs or HIXUS it's been use inned a nonstandard way that's what the clean up is going to have to be. So we'll have to we're going to be providing a lot of information toe individuals who -- providers and service coordinators that support the aging waiver for example and other other waivers, instructions what has to be changed, potentially in service plans for -- for participantness home community based waivers as early as possible. We're planning to do a kick off meeting internally, to sort of plan that out, to also plan out what the instructions need to be. We'll be sharing that with providers so they will be able to, look at that those service plans help do the data clean up. We're really going to

try to get ahead of some of the issues, we have learned a lot from the southwest and unfortunately I always said the southwest was the Guinea pigs but the population is larger in the southeast 50 percent larger we know that they will be a lot of challenges to the data and the service plans we'll try to get that instruction to the providers at least, five months in advance.

And we did not get to the providers really at all until the end of the year last year that's a lesson learned we're going to try to correct.

The MCOs will be helping with this as well. They had to adapt a lot of the data and bring that into their system and, that presented a lot of challenges and they have already given us information that we're going to be able to use to be able to build that up. Thank you for the question.

>> SPEAKER: Entertain one more, not transportation.

>> KEVIN HANCOCK: Of course.

>> SPEAKER: It's regarding the reviewing changes in the person centered service plans.

I sat in on a call last week provider call with the Jewish American federation or foundation and one of the participants was talking they were SC agency that had completed an interRAI, it resulted in the reduction of services, the SC provided justification as to why the hours should not be reduced and they had not heard back yet.

I was wondering do we have a communication protocol for effective communication timely communication or is this just getting used to the

systems?

>> KEVIN HANCOCK: It's the ladder getting used to the systems there has to be a communication protocol, so first of all, if there ends up after the comprehensive needs assessment process is completed if there ends up to be a reduction in hours participants have to receive notification because it is considered to be adverse action and they are eligible to be able to submit a complaint and grievance in this case, it will be a grievance. And they also have the opportunity for for support representation through the that process as well. So participants have to be notified and, there would have to be a communication protocol that exists with service coordinators both internal and external service coordinators and, with the MCOs in discussing the issue and the InterRAI is not the only tool they're using. So just because the InterRAI may provide guidance or informs that states the serviceman hours may be reduced the MCOs have stated they're using other information to build out what would be a appropriate service plan, all the that information has to be communicated to the participants and the participants will need to know what their rights are, if in any way losing anything in this process. So >> SPEAKER: We don't have anything where an MCO would respond within an X amount of hours in and SC would respond back.

>> KEVIN HANCOCK: Between the MCO want service coordination, since service coordination is administrative function of the manage the care organizations, our expectation is the communication is timely with the

participants the MCOs and the service coordinators are to work out their own protocol for the way these services are managed.

So that, that is the expectation they're working that out, as part of the administrative side of the service plans.

>> SPEAKER: Thank you.

>> SPEAKER: This is Atany I hope you don't have mind I have a question. Regarding like the reduction in hours, um, do we have data on how much -- like something -- how many people have experienced hour reduction under the new way the service plans are supposed to be looked at? And do we have an idea as to why those reductions have been happening and, are we going to be discussing that at some point?

>> KEVIN HANCOCK: So because we're still in the couldn't knew of care period Tanya there will not be reduction of service hours for participants going through the transition, torans your question no we don't have the data yet it's too early.

We will have the data and we'll be monitoring changes, after the end of the continuity of care period we'll be absolutely discussing with this committee, what those changes will look like. And explain why.

>> SPEAKER: Yes.

>> KEVIN HANCOCK: So --

>> FRED HESS: Steve has a question.

>> SPEAKER: That's what I wanted to take on that's what I wanted to

hear that after that continuity of care continuity of care, thank you, that period is over we will be able to discuss why like, if there's a drastic amount of reduction why they are. Thank you.

>> PAM MAMARELLA: Thanks Tanya Tanyaspeak Kevin I don't know if this is say question or comment, one. goal asks coordination of care between benefits and Medicare and Medicaid.

But from the enrollment numbers it looks like there's relatively few people who are in aligned plans. Is that representative of the total population? And, if so, do you have a sense of what people are doing? Are they staying in fee for service for example? Or are they in other local managed care plans.

>> KEVIN HANCOCK: So they're about 16,000 people who are in an aligned dual special needs plan in the southwest.

We didn't have any data, that captured it the data did show is the number of people who are auto assigned but a lot of people who were -- selecting an MCO were in a aligned dual special needs plan. So that population of individuals who selected an MCO selected the plan that was aligned to their dual special needs plan. We actually think that 16 percent is pretty good percentage in view of the fact that only 1 of the 3 MCOs really had much of the share of the market at this point, we're hoping that also changes we do think it will be different in the southeast because there will be more time for building out a market for all 3 MCOs and at least one of them is already established.

>> SPEAKER: Is there a very large percentage still in fee for service? Or are they in other managed care products?

>> KEVIN HANCOCK: So that's a great question.

We know that a large percentage of the individuals in the southwest are in other managed care products.

The -- that's going to be different across the State like a Lehigh amount al area most of the Pennsylvania T, they're mostly still in Medicare fee for service southwest there's pretty big saturation of individuals who are have selected a Medicare vantage plan or special needs plan there's a little bit of I difference. Just to be clear, gate way for example and united, two large special needs plans in Pennsylvania they have a lot of membership and they have a presence in the southwest.

We do expect to be different in the southeast a little different in the southeast but -- really the Pennsylvania T is where there is a lot of people still in fee for service.

>> SPEAKER: Southeast you have a high penetration of managed care too and IBC for example which is one of the largest providers not participating in the CHC.

>> KEVIN HANCOCK: We know there's a large -- the configuration is a little different in the southeast. There is a large amount of -- of people participating in Medicare advantage plans as well.

>> AUDIENCE MEMBER: Good morning, could you please clarify the

process you were just talking about with respect to consumer having a comprehensive assessment and found to have a reduction in services? What is the time line for that consumer? Does that reduction start after the 6 month period? Does it start immediately after the comprehensive need assessment by the managed care organization? How does that process work? And can you clarify that for the consumers that are in the room?

>> KEVIN HANCOCK: So if a managed care organization conducts a comprehensive needs assessment and whatever else they use to be able to build up the service plan, if that, in any way results in a reduction of hours the MCOs have the responsibility to inform that participants I don't remember the time frame off the top of my head, Virginia do you remember?

>> AUDIENCE MEMBER: No, I don't-has been we'll get the same time it's a specified time frame they have to be knifed and if it's a reduction in hours of any sorts it is an adverse -- it is considered to be adverse action and they are entitled to file a grievance to if they, disagree with reduction in the hours. They -- it is a prescribed process. If there's any type of adverse action on the part of the MCOs towards the participants justified other otherwise the participants have rights.

>> SPEAKER: Thank you.

>> KEVIN HANCOCK: Came any other questions.

>> SPEAKER: Can I add something into that.

>> KEVIN HANCOCK: Of course.

>> SPEAKER: With the grievance process you mentioned something earlier about support representation.

Are you saying they're entitled to an attorney?

>> KEVIN HANCOCK: On the notice for grievance there's contact information that they, they where they can reach out to some sort of support, like the health law project, for example, offers support for individuals going through the brief grievance process.

>> AUDIENCE MEMBER: That will be free?

>> KEVIN HANCOCK: I can't speak to -- I can't speak to how, it is priced to be honest but, someone from the health law project anyone from the health law project David Yates.

>> AUDIENCE MEMBER: It's free understand we only have 5 attorneys for the entire state. So --

[laughter]

>> PAM MAMARELLA: For the sake of the people on the phone it's free but David Gates let's us know they only have five attorneys across the State I think your ending words were so Wow, I think --

>> AUDIENCE MEMBER: Yes.

>> KEVIN HANCOCK: Okay.

Thank you Mr. Gates. Yes.

>> AUDIENCE MEMBER: Hi yes my name is Patrick.

And, I am from ADAPT.

And --

>> KEVIN HANCOCK: Excuse my could we ask the people on the phone to mute their phone if they're not speaking.

Because we're getting a lot of feedback that is going over the microphone.

>> KEVIN HANCOCK: Sorry for interrupting.

>> SPEAKER: I would like to know if there's going to be a reduction of services being able to file a grievance that would sustain -- would we keep that service before the reduction, so that there's no reduction, would that happen? As we file a complaint will the reduction of services not happen until the complaint is resolved.

>> KEVIN HANCOCK: That's correct if they go through a complaint grievance process, the services would stay intact during that process. Just to be clear it could happen that the services could also be restored if the grievance is found in favor of the participant as well.

>> AUDIENCE MEMBER: Thank you.

>> KEVIN HANCOCK: Thank you.

Great questions.

Do you have a question, sir.

>> AUDIENCE MEMBER: Yes.

Hi I'm Liam Dougherty from ADAPT I have one -- expressed by uneasiness about sort of throwing it back on consumers to file the grievance, and as it was pointed out before I mean if there are

only five legal kind of advertisers statewide that makes me, feel strange that -- and I think the other thing I was wondering about, if you speak to what that process is like. If it is -- if the decision is made in favor of the consumer?

You know, what goes into that.

>> KEVIN HANCOCK: So I have to confess that I'm not an expert on the grievance process.

I'm be happy -- we in one of our previous sessions we had someone go through the process I don't want, because I'm not a lawyer I don't want to present a process where I could get it wrong.

The one point I would like to make and, I -- the point you're making about uneasiness with the capacity for support the health law project and others provide, I think that's a fair point. And we'll certainly talk to the health law project and otherwise we want to make sure that representation is available for people as they file a complaint.

But I would also state that there process is in place and it a Federal requirement, the process is in place to support participants if they have a good case, for why a decision was not made in their favor. So my recommendation would not be uneasy about the process. Because you do have rights. But capacity for support through the process and it is always everything we do is complex.

I think that's a fair point and we'll take that back and we appreciate your points and Mr. Gates point about raising it.

But I will commit to you in a future session to have our legal team to continue to go through the complaint and grievance process I don't think it will be appropriate for me to do that rhyme not an expert on it, unless we can figure out, maybe in the future we can do a handout and make sure that we always have an opportunity to be able to make clear what the process is actually is.

What I'm saying is I think, I feel more comfortable if a lawyer was actually making the presentation on the grievance process are you okay with that.

>> AUDIENCE MEMBER: Yes. Thank you.

>> SPEAKER: Kevin the previous presentation should be out there linked to the January notes.

>> KEVIN HANCOCK: Jill is pointing out correctly that the previous presentation about the grievance process, is on our web site.

And it is, that is always available but, just -- we're making the commitment to make sure that we'll continue to talk about it.

Our lawyer will continue to talk about it.

I can make Jack.

[laughter]

No --

[laughter]

>> SPEAKER: Did would be good to have them come back.

>> KEVIN HANCOCK: Closer to the end of the continuity care.

>> SPEAKER: I also would remind everyone that in addition to the health law project throughout various regions of the State there is legal services that are available as well. Obviously Philadelphia and Pittsburgh in particular and it is not as heavy elsewhere in the State.

So representation may be a problem I think Colleen can focus on when she comes back is what happens at a grievance itself opposed to just saying, it is available.

Here is what happens in a grievance.

Here's what you need to present for purposes of pursuing your grievance.

And it often can be you may not need a lawyer for the consumer although I think in most instances that would certainly be very helpful but, given the reality I think what you might be able to do through the department's counsel is not only for purposes of this group but also for the web site kind of go through here's what you need think about in terms of timely filing so that services do continue. And in terms of what happens at the grievance itself, what type of facts, do you need to come prepared to talk about? So I think that will be helpful.

>> KEVIN HANCOCK: That's a great suggestion. And in addition to our office of general counsel maybe we'll ask the health law project experts on the grievance process to present with them to talk about from a participant's perspective what they would flowed to consider as well.

That's a great suggestion.

Halene talking about the experience probably CrDrew, you can answer some of the questions you raised as well. They have been addressed to my satisfaction but it will be good for the committee to have the same discussion you had previous a lot of clarification otherwise provided. So thank you Jack.

>> PAM MAMARELLA: We have another question.

>> SPEAKER: Hi, it's Linda.

I wanted to make a comment, about previously the hours of help that are determined and say they get cut I got ten hours of service they wanted to cut me to 8 hours of service, I would put in a I grievance process, do I continue to have my ten hours of care or do they then go to 8 hours of care until the grievance is done.

>> KEVIN HANCOCK: You'll keep the ten hours while you go through the process. David?

>> SPEAKER: That's fine.

>> SPEAKER: You need to clarify that, you get the continuing benefits only if you appeal the grievance within ten days.

>> KEVIN HANCOCK: Got it.

>> SPEAKER: Past that ten days that those benefits will go down.

>> KEVIN HANCOCK: David clarified you had to appeal within 10 days I'm not an expert on the mechanics of the process. He -- he is, that will be a requirement.

So, but -- you can still receive your benefits.

>> AUDIENCE MEMBER: If that kind of begs to question if there's only five attorneys and someone, I assume there's going to be a lot of cutting and, potentially a lot of grievances, people don't have access to an attorney within those ten days they will loose hours.

>> SPEAKER: Also there's people that, do not have access.

>> AUDIENCE MEMBER: Average consumer is not in this room.

>> PAM MAMARELLA: Seems you might have an answer to that? Or comment?

>> SPEAKER: I was going to comment that, with respect to the notice itself, relating to a reduction in service, and I have not seen what the notices look like.

But it should be in bold that although you have I believe it's 30 days to appeal.

>> KEVIN HANCOCK: That is the same although it --

>> SPEAKER: You do need to file within ten days, in order to maintain the same level of service.

So the important thing again, that's why I think both for purposes of this group as well as on the web site the important thing is to get the notice in.

To say you object.

And once you meet that filing deadline there's a lot of things that can occur after that, but the important thing is putting in the notice

of the grievance right away. That's the key point. And that's the message I think we really need to focus on and again and again especially during the coming months.

>> KEVIN HANCOCK: True, that actually could be something if the community is willing to support that messaging. That is, that is an important point to make to make sure you get the notice in. So ADAPT other entities willing to communicate that to participants you deal with and, we'll look for opportunities to communicate that as well. We will make sure that someone in the next meeting is available to be able answer your specific questions about the grievance process.

>> PAM MAMARELLA: Do we have another question.

>> AUDIENCE MEMBER: Yes. I have a question can we -- do we have to call, can we make a complaint via a phone message or do we have to submit it in writing.

>> KEVIN HANCOCK: My understanding when you receive the notice for the adverse action or change in hours it gives you instructions for how you have to mail that, that appeal to make sure it's on file.

>> AUDIENCE MEMBER: All right.

>> PAM MAMARELLA: Follow-up?

>> AUDIENCE MEMBER: I do.

>> SPEAKER: This is Brenda I have a follow.

>> AUDIENCE MEMBER: Just seems very complex.

>> PAM MAMARELLA: Okay thank you. We'll go to Brenda on the phone then to drew.

>> SPEAKER: When you appeal the services continue, obviously ten day there's the date of the letter that's difficult sometimes especially for people in rural areas.

Because then comes to delivery services are not as row liable as you would like to, maybe you would not get that letter until 5 dis after, that date on the letter.

Is there -- Social Security has a clause on their letters that say, you have to have a good reason for asking for things to continue, if you appeal outside of the time period.

Is there a way that we can be guaranteed that same --

>> KEVIN HANCOCK: Brenda it's my understanding that the appeal is date of receipt.

When you would be able to the ten day clock will start at the date of the receive the appeal.

>> SPEAKER: Kevin my side bar with you I don't know if the current letters say date of receipt. It may say date of mailing.

So that's very good point that's been raised so I urge the department to make it so that it i ten days from date of receive, that comes up when someone would like to challenge what is the date you receive the notice so you have to keep the notice itself, to show the post mark date I would hope that doesn't usually get raised in a challenge to a grievance but in the event it might, it is good to keep the envelope but, to address that concern with respect to the delay in mail, date of receipt if you file

within 30 days of the date of receipt generally but within ten days of date of receipt to maintain benefits, that would be a big assist I believe.

>> KEVIN HANCOCK: So, just being mindful -- thank you very much Jack, thank you being mindful of the time we appreciate the recommendations, these questions will become of more -- they obviously very relevant they're going to continue gain relevance as we get to the end of the continuity of care period we can commit setting aside time and having a subject matter experts available to answer those questions in the next M MLTSS sub-MAAC, we want to make sure they're answered and we recognize the complexity we want to be able to continue through the agenda.

>> PAM MAMARELLA: Okay.

I think, Drew had one last question then we'll move on.

>> SPEAKER: I just it is really just, point of order I can't actually remember the presentation that was given about grievances but this level of detail is very important so maybe before the next meeting we could get an actual copy of a letter to see what it says and, that will help all of us to know, what needs to be done.

>> KEVIN HANCOCK: Great question, great suggestion we'll see -- we'll see if we can have the draft notices I don't know where they're@this point do you?

>> SPEAKER: I believe those were all approved.

>> KEVIN HANCOCK: We should be it's already something that you could already submit a grievance in the community HealthChoices now we should be able to share that with the community.

If that you were able to send questions in the advance that would be ideal thank you.

>> PAM MAMARELLA: Movingen.

>> SPEAKER: Why don't we put it in the with meeting notes.

>> SPEAKER: That will be great.

>> KEVIN HANCOCK: Heather's suggestion is put in the meeting notes we'll be able to able to do that. Thank you for the suggestion as well.

So we're going to move onto the agenda we still have a lot to cover we have to get to the update for the LIFE Program.

Just very quickly, we are moving into southeast implementation we've already had our kick off internal kick off and we'll start with public communications and very near future.

We are already as you remember with the southwest we are conducting OBRA assessments to see how many people in the OBRA waiver are more appropriate for community HealthChoices. Those assessments are going on right now.

In the southeast going on right now. We're in the process of planning

out participant communication that the participant communications includes mailers as well as public meetings. Once again will be coordinated by aging well, with partnerships with the area agencies

on aging, Centers for Independent Living, service coordinators and other participant stakeholders in the southeast. We will be conducting as we did in the southwest provider outreach education although it's going to be more than a month earlier this time the first is going to be in Philadelphia. That's a week long event from June 4 to Juan eighth. And we're going to be going through discussing service coordination, how this changes effect nursing facilities, how this change effects home and community based provider physical health providers transportation will be a topic and, we'll just be talking about, what this change means to the southeast, also, talking about lessons learned for the southwest as well.

And then we continue to work for opportunities to identify the populations in the southeast, that may require special outreach and an example would be individuals with speaking a certain type of language that may not have necessarily been addressed in the southwest. We want to make sure we're reaching everyone we may need community support to be able to do that. So that's the focus for communication in the southeast. And there's obviously going to be a lot more to come on this . >> SPEAKER: Excuse me, in the previous meeting you mentioned in lessons learn participant communication from the southwest, there's some confusion. One thing that we saw a lot of was participants taking their Medicare DSNP plan is changed, is that one of the things addressed or an opportunity to take a look in advance of those going out

the changes being made for participant communication?

>> KEVIN HANCOCK: So it is absolutely true the participants were confusing community HealthChoices with their Medicare coverage that is an absolute lessons learned we will be developing and changing our communication strategy to address that.

I think we'll be more than welcome for public comments on the communication going out.

>> SPEAKER: We'll be adding the Medicare fact sheet that was created for the aging well events which did, we had positive feedback on that, that will be actually added into the notice. So there will be a,

I think we're even going to have it as a different color so it stands out so people can read that.

>> SPEAKER: And CMS actually was working with us to do a communication to physicians as well to make sure that the physicians are aware of the differences.

>> KEVIN HANCOCK: For the people who were not able to hear Heather and Jill's comments, the we developed a Medicare fact sheet, that will be included as part of the pre-transition notice for participants.

And, in addition, CMS we, communicated this problem, Blair that you had expressed, with CMS they had a suggestion, they're willing to do outreach to their Medicare providers, um L to inform them of community HealthChoices and, we -- they developed a communication to be able to do it has not gone out yet but they are very much interested in making sure

the providers are also aware of this change because we know that's a source of information for a lot of participants.

>> SPEAKER: That sounds great I think in helping people understand who is affected and describing who is in community HealthChoices part of the description is people with disabilities or people who are dual eligible for Medicaid and Medicare and I think even just a sentence saying that this does not change Medicare plan something simple to that, can help because, it is confusing to help identify who is impacted I can see how it's challenging.

>> KEVIN HANCOCK: We agree that's where we knew we, with the aging well sessions, that became an up front message that you do not have to make any change those your Medicare coverage unless you want to make changes.

>> SPEAKER: It is literally on the front page of the notice in a block, that tells people that.

But one thing we saw was a lot of people didn't even realize they were on medical assistance so they don't understand the difference we actually had appeals that said I don't have medical assistance, well, yeah you do. But -- that is an issue anyone can help continuing that messaging it is helpful.

>> KEVIN HANCOCK: All but four of our appeals were people for confused in Medicare and Medicaid coverage they not want to change the Medicare coverage that's correct.

>> PAM MAMARELLA: Lester, come to the mic so we can hear on the

phone.

>> AUDIENCE MEMBER: Hello.

Okay.

I hear all of us talking about Medicare but I can't tell you from southeast there was a big confusion on the Medicaid portion. The individuals that had the change their Medicaid there was an interruption of services, with the Medicaid for example was gate way, so they were receiving services through gate way, on 1/1 they weren't receiving those services through gate way I think that population is small, but that percentage everybody we all hear I don't have to change.

That's what everyone thought that population I think really needs to be honed in and -- you're the State you're paying for all those money.

Let's make sure it's getting done thank you good-bye.

>> KEVIN HANCOCK: You're talking about the physical HealthChoices population, who were also, receiving home and community based waivers, going into community HealthChoices you're absolutely right there was a lot of confusion for that population because, there were different plans . If people were in UPMC for example, in the southwest they were able to continue to stay UPMC, but if they were in any of the HealthChoices plans they have to make a change they were confused by that they did not know, for example, why they were being enrolled in UPMC Pennsylvania health wellness or AmeriHealth Caritas we agree that has to be part of the messaging it is, a relatively small population, but it is, a

population where most of their Medicaid services, in fact awful their physical health Medicaid services are funded by the Medicaid program it's very important to them. So we completely agree thank you very much for the comment.

So okay.

So --

>> PAM MAMARELLA: We have another question from the public Kevin.

>> KEVIN HANCOCK: Sure.

>> AUDIENCE MEMBER: My question is, why the OBRA assessments a lot of people already in Philadelphia have been getting it. Don't quite understand why if you can explain why they are being assessed.

>> KEVIN HANCOCK: OBRA waiver requires a different level of care or level of care determination they have to be if they are nursing facility clinically eligible if their assessed clinically eligible the standard level of assessment we have in place for all of our other home and community based waivers like the aging waiver independence, and -- attendant care, they can't be in OBRA, OBR's waiver requirement is that they can't be nursing facility clinically eligible we're doing the assessment to make sure, A they're in the appropriate waiver and, B to make sure we're not violating the OBRA waiver by having them in a different standard we have to make sure that they're appropriately determined to be what we call, ICF intensive care facility other related conditions that they meet that level of care standard to be able

to be able to stay in the OBRA waiver if they are, in the OBRA waiver they will not be required they're appropriately in the OBRA waiver they're not going to be required to convert into community health choices they're nursing facility clinically eligible the waiver requirements require them to be in a different waiver and then they would be moving into the community HealthChoices.

Does that answer your question Nancy?

>> AUDIENCE MEMBER: Not really. No.

I just -- yeah.

>> KEVIN HANCOCK: Waiver requirement it is -- long story short it's a waiver requirement we have to do it.

So -- okay.

Pam.

>> KEVIN HANCOCK: So I I'll turn over to Mike hale he will give us an update on the functional eligibility determination and the tool that is going to be used so Mike.

>> >> MICHAEL HALE: Okay.

>> PAM MAMARELLA: Go for it.

>> >> MICHAEL HALE: I'll see if I can get us back on track. I'll keep this on. So everybody -- everybody know we are looking at everybody knows we're looking at redoing the level of care determination tool to the functional eligibility determination tool for helping us determine participants nursing facility clinical eligibility.

FCE, that's the FED tool which is going to be the tool that is going to be used for most functional assessments.

We have had a lot of positive things happen in the last couple of months the first one was, we were able to finalize and secure our contract with the abl aging well who will be the entity overseeing the eligibility determination process and having assessors working with them and contracted through them doing assessment for the eligibility determination. So become in, December I want to go through a time line where we are, this is where I'll catch us up I think.

Back in December, January and early February we did a lot of training internally and a lot of testing of the systems internally to make sure they were working we also beginning January 1, the MCOs began using their internal InterRAI systems for new people coming into the program and transferring that data over to the State system through their interface with the State system.

But only new people not, any of the redeterminations -- none of those were or as needed assessments were transferred over just the new enrollments and then no -- none ever the service coordination entities are using that system yet eith either for reassessments.

So then we move onto March and some of the completed tasks we've been doing a lot of presentations a lot of outreach to various groups who are interested in seeing the system work.

So we've been doing a lot of demonstrations with the PIAA system

InterRAI's HC and the FED how the two interact we did a presentation on the 13th to -- the area agencies on aging through P4A, help set it up through the quarterly meeting we also presented to the LIDE providers and community legal services has been working with us as well on some of the FED questions and some of the things that their groups have -- they work with, have brought back to us.

Also in March, we lookeddality at training plan, at the end user training along with the FEI systems in the up coming months, they will be doing a lot of training of end users the MCOs, service coordination entities and, the AAAs, as well as, internal DHS staff as necessary.

And then the, IEB is going to be continue to be using this is ongoing until, July 1st, the IEB will continue using the InterRAI system entering manually into the system.

Go new enrollees. So if we move onto April date which is page 20 there.

Aging well has submitted all of their training plan we're reviewing all the training plans that they're going to have.

In their time lines and obviously here at the MLTSS sub-MAAC I mark that as done as I am done, I'm done reporting.

Coming up next week on the tenth of April, we're going to be doing FED assessment training with the some of the contractors some of the trainers from the aging well entity.

They're going to be going back and training assessors at the

agencies being contracted by the aging well to commute the assessments, um, so it is a train the trainer type situation.

But we were doing a full day's training with those trainers on the tenth.

The LTSS sub-MAAC giving an update at the sub-MAAC as well then the week of the 16th is, when FEI and aging well will begin their sessions and their training.

Of the end users. And we have listed there the various topics and subjects that will be in the training. Then the 23 through 30th, some end user training and clean up of anyone who also needs to be trained.

People who may need additional training or training that we need to include so that takes us through the end of April.

And let's see.

I also wanted to point out we've had a couple of questions I wanted to get to those on the FED when it comes around training, one from drew in particular. Drew had sent in some questions around the process of determining if a participant has cognitive ability to independently and reliably participate in the interview, should be the same for both the FED and InterRAI I and should result in determining if a proxy is necessary, his questions aging well, if, EI trained they have not we'll include it on training I'll sit on Friday, with the trainer make sure all the areas we want specifically covered including this one are covered, in the training on the tenth.

Has aging well FE -- implementing the procedure with new applicant ness I'll get to that in a second. How is the fact that a proxy used communicated to the MCOs that the person selects?

Um, I have changed the FED itself drew to make sure Proxy is on the form itself.

So, that -- if Proxy is checked, check box for Proxy, actually have their signature will be on it as well.

And that will, signify in the InterRAI system a prox used transferred over to the MCO, they're notified, and there's any service notes would go along with that, would also notify indicate that a Proxy was used so they know the same proxy used for the InterRAI needs assessment tool we've already changed the tool to identify a Proxy as necessary. That is a good suggestion we had not thought of that initially we've already, we're making that change right now.

>> SPEAKER: Can I ask a question.

I'm glad to hear you're carrying through that information from the FED to the InterRAI I, my question has to do with on the FED, um, are you adopting the prior that was described in this meeting when it was first determined that a proxy could be used on the InterRAI in other words there were first two questions or something if they didn't get them right, then interview stops the Proxy is solicited.

>> SPEAKER: That's what we're going to be doing I'm meeting with there university Mary Jane who does the training at University of

Michigan I am meeting with her on Friday, I have a list of things I want her to particularly hone in on the training if self that is one of them I'll be making sure of that.

>> SPEAKER: When you meet with player James could you ask her where InterRAI is at with the updates to the InterRAI AI that were made bit brain injury group, a national group that metaphor two years and, recommended changes to the University of mishmash.

>> MALE SPEAKER: She brought that up to me drew when I spoke to her last I will ask her to do something formal so I can get something to you.

>> MALE SPEAKER: That will be great. The whole group is, sort of wondering what happened with that, because -- we have been reaching out to Mary James and I have not contact from her.

>> >> MICHAEL HALE: I understand I know that work is done, I will make sure she gets something out.

>> SPEAKER: Thank you.

>> >> MICHAEL HALE: Any way, that address that's question. The other one was the community legal service there's a group Kevin and I have been working very closely with them, they wanted to discuss where the cut off was for determining nursing facility, clinical eligibility as everybody knows there's five primary areas that are on the functional eligibility determination tool that is, ADLs, toileting eating, mobil ity and cognition. And there's a range of from needing full assistance in all of those areas which is level one, to not eat needing any

safety answer in any of those area chose is level 11. We have had a cut off point at level 7 which is partial supporting for two domains partial support. Community legal services has asked us to look at expanding that to levels 8 and 9.

And asked Dr. Albert from the University of help, he helped us put together the FED tool and algo rhythm for eligible with these five main areas and so on the date of the tenth the day of the training smart, I'm going to be sitting down with Dr. Albert and folks from community legal services to have a discussion around levels 8 and 9, possibly being included as determination as automatic determinations for NFCE as well.

So stay tuned for that, that's just a matter of changing the algorithms it's time consuming it is going to be a little bit of work on FEI's part I think they will be able to do that, prior to July 1 when we want to implement this statewide. So that's it -- so then, may and June, we have end user training and catch up if all month for end user training on FED administration.

In June we'll have, daily meetings with aging well and MC Os to discuss readiness and make sure that everybody's systems are ready to go and capture everything that we need to capture.

And have a good to go status we already have -- we know we're going to be going with the system in July 1st, but --

>> PAM MAMARELLA: Thank you we'll take question from drew we'll flowed to move on.

That will being everybody will be using the FID tool beginning of July 2nd.

They become eligible for the wink are waiver.

>> SPEAKER: InterRAI A writing is needs assessment they will be used with independence.

So even if they're --

>> SPEAKER: Continuing to receive their services fee for service, the inter RAI will be planned -- tool.

>> PAM MAMARELLA: Let thank you for that.

>> SPEAKER: Are youation the saint eriniter ARAI -- the waivers through the end calendar year. Little hail that's how the system is going to work.

We need to --

>> KEVIN HANCOCK: FED is going to be scrolling not the InterRAI,.

>> >> MICHAEL HALE: They're all in the system, they will be still turned on when determination time comes around for an individual an then

-- when you need assessment is redone the person is needs assessment, they will ask to make sure those questions are asked as well.

Those will be turned on with the algorithms to determine, whether or not response is, maintained as the status for that person.

>> SPEAKER: Through the balance of the calendar year in the non-CHC zones will fed will continue to be used for redeterminations.

>> >> MICHAEL HALE: Beginning July 1.

>> SPEAKER: Not InterRAI, that is going to be used for the CHC zone.

>> >> MICHAEL HALE: Used for designee assessments for the all waivers for the program.

>> AUDIENCE MEMBER: Under CHC though.

>> KEVIN HANCOCK: CHC is the InterRAI AI for the comprehensive needs assessment reassessments I think, what Mike is saying, since the FED, questions are pulled in the InterRAI I that there's overlap in the way that the data is being captured.

In the -- by the MCOs, for for the InterRAI home care tool and the FED.

It is a subset.

>> SPEAKER: I get that, which tool will be used --

>> SPEAKER: That will be done -- with will redetermination will be done in the CHC zones.

They will be doing the redetermination the same way you do them now, in the non-CHC zones.

>> SPEAKER: So that will be using because we are currently using the whatever it is called. At this point. So the fed will be used.

>> SPEAKER: Yeah.

>> SPEAKER: That's my question.

>> SPEAKER: Thank you.

>> PAM MAMARELLA: Thank you Steve, thank you very much Mike.

>> SPEAKER: Brenda had a question.

>> PAM MAMARELLA: Pat?

>> SPEAKER: Okay.

>> PAM MAMARELLA: I think in an effort to try to get back onto the schedule, if Brenda you could submit your question Kevin can add to his OLTL updates at the next meeting and if you need the answer beforehand, maybe you can work with him directly. We're now drafted off of agenda by half an hour I need to pull it back.

>> KEVIN HANCOCK: Thank you we'll miss that leadership.

[laughter]

Fred pay attention.

[laughter]

Okay.

So we're going to actually move through, one more -- I apologize I hope you don't mind I'm going to go through this slide quickly update on

the CHC evaluation plan, this is, providing year one and two activity year one activity for 2017 we've already talked about.

We're basically a planning year talking about how we're going to be building out the evaluation process.

Year 2 solves continued planning as well as data gathering associated with CHC evaluation, we're working with the Medicaid research center out of the University of Pittsburgh to be able to help support the activity. And we'll be providing in the coming months, a very comprehensive update on how that evaluation plan is actually progressing.

Updated information on resources on these slides as well we'll make sure all this information is available to the committee and the audience.

Participant line, et cetera.

Contact information, for the MCOs.

And then, just very quickly, we are going to provide a quick update in the participant advisory committee this gives a background information for participant advisory committee and then we'll ask someone from the participant advisory committee to be able to -- to be able to provide a quick update butter this information includes the actual requirement force the participant advisory committee and, this is directly out of the agreements and short the 3 MCOs have a responsibility of having a participant advisory committee to provide information to provide counsel on how, services are delivered how

communication is taking place and how the program is actually structured for the benefit and the expense of the participants with that we'll ask our guest speaker to join us. To come up and talk about the background for the participant advisory committee.

>> PAM MAMARELLA: That's after LIFE. So before we do that after this, when this happens, we'll hear from colleagues of mine from the LIFE program, John than bow plan, works for the Office of Long Term Living is in charge for life for the department, John if you want to come up. I'm going -- I know we have slated an hour for you I'll ask you to to -- take ten minutes off your presentation so everybody just speak a little faster.

Welcome.

>> SPEAKER: We have 3 chairs up here.

>> SPEAKER: Okay.

Thank you.

My name is Jonathan Bowman I'm with the Office of Long Term Living I'm the program director for the LIFE Program.

And with me today is require DiTommaso and Joan Brad Barry.

Thank you for the opportunity to talk to you today about the LIFE Program.

So -- just going to go through real quick agenda what we'll talk about.

We're going to talk a little bit about the history of the LIFE

Program in Pennsylvania.

Go through the program eligibility requirements talk about the LIFE model of care and services, how to access LIFE services and then going to turn the presentation over to require he will go through the program really hit on the interdisciplinary team which we'll talk about a little bit more as we go through the program. But give you a kind of a give perspective how the program works.

So will be talk touching on the IDT overview, clinical integration of the program and then any questions that you may have.

So just a little bit of background the Office of Long Term Living provides long-term services and supports, to qualifying older Pennsylvanians and adults with physical disabilities.

Individuals must qualify for clinically and financially for all programs.

Programs are provided through waiver services, nursing facilities, community HealthChoices and LIFE Program which we'll be focusing on in this presentation. So the LIFE Program was implemented in Pennsylvania, in 1998 so we are at 20 years of experience with this program in Pennsylvania. The program is called LIFE in Pennsylvania, but nation tally it's referred to as the PACE program for the program of all inclusive care for the elderly. We use living independence for the elderly or the life acronym in Pennsylvania because there's already a PACE program existing in Pennsylvania operated through the Department

of Aging which is the pharmaceutical program. The actual program has been around for about 4 years started in California the goal of the program is to enable frail and older adults to live in the community and the focus is the community setting for as long as medically and socially feasible.

So just to talk about the program eligibility requirements there are just a few basic eligibility requirements to participate in the program.

There is an Angel gentleman built you have to be age 5 or older too qualify for the program. You also have be determined nursing facility clinically eligible this is, the same as other waiver or long-term care programs the same clinical eligibility determination you also need to be determined financially eligibility or able to pay privately this program is a little different because you can private pay for the program in Pennsylvania we have a small private pay population there are individuals who choose to pay privately for LIFE services, also you need to be able to live safely in the community at the time of enrollment.

And this is really determined threw consultation with the LIFE program but, they, the determination is made with LIFE services they can serve you in the community.

And the last piece of the qualification is that you have to reside in an area served by the LIFE provider and in a few slides I'll show a

map of Pennsylvania where services are available.

So just to talk quickly about the model of managed care, as I mentioned before, this does focus on the frail elderly individuals age 5 and older who are nursing home eligible or found clinically eligible.

The program integrates Medicare and Medicaid funding through monthly cappation payments so this payment is, over seen by both the State of Pennsylvania Department of Human Services and centers for Medicare and Medicaid services.

95 percent of our individuals enrolled in the program are dual eligible meaning the providers receive a monthly capitation payment from both Medicaid through the State and Medicare payments from CMS it is a risk base model the provider assumes full financial risk for each participant they enroll, they're able to take the monthly payments they receive from Medicare and/or Medicaid and lump them together and kind of create a risk pool and provide the services that they feel necessary that would best serve the consumers this is of course, done through discussions with the participants and the caregivers.

And Rich is going talk a little later a little bit about the interdisciplinary team I'll save that for him.

This next slide here, really lists out some of the services that are available through the LIFE program these are, determined by the IDT but again, they are done through input with participant and their caregivers. The program covers primary care which is acute care,

doctors visits hospitalizations community based social work.

Interdisciplinary care management, acute care, long-term care

this is such as waiver services in the home, and nursing facility care

if needed. We currently have less than 10 percent of our population

that is served in nursing facilities but they're servedded in nursing

facilities and still remain under the care of the LIFE Program and the

IDT.

Pharmacy services are provided through the LIDE program so when our

providers enroll to become life providers in Pennsylvania they go

through a prescription part D application with CMS, behavioral health

services are also covered. So the providers are responsible for covering

all behavioral health services for the individuals.

And some other examples are in-home care and, home modifications if

necessary.

For accessibility.

Day health center with rehabilitation, recreation occupational,

there's therapy services and transportation is provided.

I would like to mention quickly that all of our providers are

required to have a center so there is a physical center where individuals

go to receive their services and if the services can not be provided

there such as maybe like a specialist services, specialist service they

will be transported to their specialist appointments.

And the program is fully integrated so Medicare, Medicaid provides

services and it is the acute care long-term care behavioral health and pharmacy all wrapped together the provider is able to see all avenues all angles of care for the individual and put these together.

Then -- just to talk about access to LIFE services I would like to mention LIFE is the enrollment alternative to community health services if it is individual and the individuals are available. As community HealthChoices rolls out across the State, the LIFE Program will continue to be a option for individuals who are eligible for the program.

And if the program is in an area where the individual resides.

Information on LIFE Program will be included in transition information, in the transition information, so -- in the southeast of the LIFE Program will be mentioned in the pre-transition information.

And outreach and education efforts will continue to discuss the LIFE Program. The independent enrollment broker will provide education on LIFE Program. To enroll or for more information on the LIFE Program you could call the independent enrollment broker directly they are educated on the LIFE Program and will be receiving more training on the LIFE Program and, they will be able to refer you to the appropriate life provider that serves your area.

And also you can enroll in a LIFE Program by contacting the provider directly and they will work with you through the enrollment process.

So the next slide here is just a slide that shows you where the life

services are available across the State.

Pennsylvania has one of the largest PACE or LIFE Programs in the nation.

We really have a lot of our state covered here. The counties that are shaded in blue are currently have life services available.

And those in red are areas that are currently under development. So we really have a pretty large coverage area of life services across Pennsylvania.

The white areas have not been assigned any providers. And are not under development at this time.

So with that, I will turn the presentation over to Rich he can talk more about the IDT and clinical integration of the program.

>> RICHARD DITOMMASO: Thank you.

So there are I feel like my job today is to try to take some of the lofty concepts associated with the LIFE Program and talk about how they actually work.

On a day-to-day basis and the lofty concepts are like the interdisciplinary team, person centered, come prelens I have care what does that actually look like on a day-to-day basis?

The age range of our participants is 55 to 102 in my program, everybody is different. We have people lows goals and needs are more by cognitive impairment, Alzheimers and demansia and folks trying to

maintain function during the trajectory of chronic illness.

We have folks frankly that are end of life stage of care are more driven by symptom management and pallatitive care and we also have folks who have severe physical limitations some of them as a result of a chronic disease and some not.

The slide you see in front you have, kind of captures the essence of a model which is the participant.

The care team that takes care of them to the left you see the services that are typically prided by the life provider directly with it's own staff while they're performing care management for their participants.

So, it is in in-home care, primary care, transportation, adult day services and to the right you will see the contracted medical services that we coordinate, with long-term services and supports. Next slide please.

So some of the distinguishing components of the LIFE Program, are that it's the health provider that is ensuring managing the care across every setting whether it's traditionally covered by Medicare or Medicaid . The care manager is a full interdisciplinary team I'll outline those people in a moment.

The life organization provides most of the supportive services within it's own staff.

And, the Medicare and medicate benefit limitations and conditions,

do not apply so, it allows us to provide the right care at the right time.

So we're able to waive the criteria for things, like episodic skilled home health or hospice for example, in order to flex those services how people need them and where they need them.

Next slide.

Thank you.

So on the -- in this slide on the left you see the interdisciplinary team members our Federal regulation prescribes these 11 individuals on the left, are part of the person's care team.

The physician the nurse, the social worker, and the recreation therapist are mandatory team members on the team initial and the annual assessment and change of health status assessments and the others, participate if they are actively involved in the delivery of services and the care plan which they are most of the time.

The IDT members, it is a large interdisciplinary team.

And on the right-hand side, of the slide I'm trying to describe what they actually do on a day-to-day basis.

A lot of their time is involved in initial and ongoing assessment of participants it is very thorough they do center in the clinic in the person's home.

They're doing home safety assessments and visits.

Routine episodic care planning, they're seeing people in

the clinic for routine assessment and evaluation but also, episodic illness it comes up.

There are daily update meetings this takes a good bit of time on a daily basis to get updates on the status of individual participants new problems that they're bringing to team members.

People who are hospitalized, or -- who are transitioning from one care setting to the other. And at those meetings the teamworks together to plan for the evolving needs of the person on a daily basis.

They're coordinating care with other providers with whether they're medical specialists or someone is in in-patient setting. And they're doing service coordination and set up that could be things like having DM E delivered to the home and making sure that the DME company understands the needs of the person in the home, coordinating visits with our staff in the home, there maybe family members that need to be trained on the equipment. If not the participant, him or herself.

Or managing care transitions. People that go into the hospital, we have daily peer-to-peer contact with personnel in the hospital to start planning discharge. Medication reconciliation is very time consuming activity for the nursing staff. And they're providing care and treatment on a day-to-day basis the physical and occupational therapists are doing treatment running well ins programs and in addition to their assessment responsibilities.

We spend a lot of time on patient and family education and training

it is an uncapped service and it takes a a lot of time.

Could involve training caregivers on new equipment or medications or it could involve educating folks on the trajectory of their illness and why are things changing now, why do you feel differently now? What is lapp happening.

So I wanted to do a little bit of deep dive and focus more on one of the distinguishing characteristics of the program that is the integration of primary care with long-term services and supports.

So what I've listed here are some of the benefits of having your primary care physician and a nursing team integrated with your supportive services.

Physician flows right away about problems and changes of condition.

Caregivers family, aides, drivers all those people are also receiving information pertaining to patient status from the physician's perspective. Physician knows the lifestyle family and cultural issues from a variety of sources. And they can tailor their care planning to be highly individualized. Nursing is involved in every case, during triage, medication reconciliation, home visits, they're a side kick to the primary care practitioner.

Providers have small panels of 100 to 150 participants.

That gives them time to get to know the person more thoroughly than electronic health record can capture.

Provides time for conversations, about participants goals and to

repeat information often takes a lot of repetition to help people understand their conditions and how they can participate in their own care.

The supportive services can be tailored with the advice of the physician to the best advantage of preventing hospital admissions and readmissions.

Our primary care practitioner are responsible for managing care, across settings and so number of the obstacles that prevent people coming back out of the hospital timely or going back in, too soon are avoided. They coordinate care among the person's medical specialists.

And participants have realtime access to their center staff can be brought in to see the physician or other team members on short notice.

One of the important things about having -- about primary care in the PACE model is that the shift that occurs, from disease management to symptom management to end of life care happens naturally.

And access to pallatative care may not be available elsewhere, because of no reimbursement mechanism. Hospice what is normally regarded as hospice care is more of an opposition.

And not an all or nothing proposition where the participant has to give up specific services in order to receive Pallative care or end of life care it could be integrated with the current needs.

Staff visits to the home and, there's a population competency within the staff, and the physical, the centers provide a physical access to clinical care that's very helpful. We have lifts and facilities are

accessible we have aides to assist people. In the examination rooms a lot those barriers to primary care are avoided.

So I was talking to our medical director about the benefits of the integrational primary care with long-term services and supports from her perspective.

In chatting about specific individuals there were two that came up as five examples of hers not a necessarily because they're the most complex individuals. But, um, when she was our primary care staff full she happened to take care of these people and as we were chatting about them I asked letter to give me a little bit of a narrative on them and what happened to them. Which I'll try to condense for you from her lengthy narrative that I have in front of me.

So Emily is a 84 year old female when she came to us living in a senior high rise she has CHF and was in decline becoming unable to plain taken her apartment and her normal daily activities. Hospitalized 3 times in the previous 12 months due to the -- chronic heart failure.

And her Locus score was 19 a moderate comparative on the moderate cognitive impairment she was approaching she was in a mild depression range of the Geratric depression scale when she joined the program she stated that under no circumstances, that she want to leave independent housing.

She has a son, but, the son due to distance the son was only able to go things like grocery shop once a week or call her on the phone during

the week.

After she joined the program there was a thorough medication reconciliation based upon last orders and the medications that we found in the home it was clear that she was not taking medications as prescribed.

And really could not articulate the purpose of which medications are which and what they were being taken for.

So she came to the day center on a daily basis until, we could establish confidently the medication, that she was actually taking and to get her on a consistorrent regimen.

The day center, participated in wellness and physical therapy activities for gate training and conditioning. Six months her MoCA and GS scores had improved she reported improved endurance was back to doing some of the home chores that she had been doing in her apartment she was visiting family. She had become before she joined the program she had become isolated was not downstairs meals and started doing that. After a year in the program,

her CHF was progressing she had kidney failure as well.

Course was on a typical trajectory which results in heart and Renal failure she was hospitalized a couple of times every time she came home to increasing supports, personal care and home chores and, support from the clinical staff.

Who did a lot of family education to educate them through the progress of the decline. About 2.5 years into the program it was

obvious that she was dying sled no desire for dialysis. And we provided symptom management in a home and personal care increasing personal care and pallative care for symptom management she passed away in her home with family.

With the assistance of the LIFE Program. And several of our staff members also attended her funeral and provided family support for their grief afterwards.

Gloria, is a -- is a little bit of a very much actually a different person much 62 year old with intellectual disability.

Who had been in either the ER or the in-patient hospitalization 11 times in the year preceding enrollment in our program. And it was very ive dented that she was one, tired of going in and out of the hospital despite follow-ups with her regular PCP and adjusting her insulin dose, she still was unable to to maintain so it was clear when we did her initial lab work that her blood sugars were high, she had a A1C of 13 after enrollment she began attending the day center regularly and during that day center attendance, she would work with the nurse in the clinic on measuring her blood sugars and self-administering her insulin with education and guidance from the nurse. She would do this herself on the weekends she had meals at the day center home delivered meals and this combination of education and the daily glucose monitoring provision , regular provision of meals, um, resulted in the first year she was in the program she did not have any ER or hospital visits.

I think that's it.

>> SPEAKER: We want to make sure I know we're trying to be quick too I want to make sure we have plenty of time to answer any questions I know LIFE Program always has -- spurs a lot questions and we appreciate hearing them, I want to kind of try to summarize if I could what you heard from Jonathan and rare about the program, so -- integrated, local care, provided by the providers themselves, come together, in what we call the IDT report interdisciplinary team that really pulls together all of the needs and services that an individual has, um, into one program.

And so as Rich mentioned their staff meet on a regular daily basis to review all of the participants that they care for, what that allows for is that, in realtime changes, um, based move of the needs that change of an individual, certainly, since we're talking about a subset of the CHC eligible population who eligible for life 55 or older we talk about seniors I talk to people, I'm 55

I'm not a senior, how dare you, historically the waiver program started at 60 it helped with some some of that transition to long-term services and supports that individuals needed as they began to age.

And, even more so, what our providers are seeing is the increase in the cognitive mental health needs that, folks have and being able to come into the program at 55, really helps with some of that early onset dementia, Alzheimers diagnosis.

So you heard a lot about the integration of care, and

services.

I think what you also heard is, um, some of the barriers to access for home and community based services things like transportation, completely included in the program. Things like, transportation and in-home supports so if you are going to the day center on a particular day, to see your doctor, and too see your podiatrist, to have some of your PT and OT, there would be someone from the LIFE Program if you need that help, that would come into your home in the morning, help you get out of bed, shower, dress, get ready for the day and then, the LIFE Program van would come pick you up, take you to the day center go have all those services and socialization and meals while you're there throughout the course of the day it's really kind of what we consider the wrap around of home and community based services around the individual whether they're receiving services in the program during the day, or they need those in-home supports. One of the other things I wanted to mention that Rich touched on when we talked before Emily living in an independent high rise and other than transportation we know housing is a huge barrier to access to home and community based services broadly speaking about the individual provide providers across Pennsylvania we have 11 program providers they have seen, no matter if it's urban suburban or rural areas of the state, housing is of course a huge issue not only housing making sure where they are as they age actually remains safe. So, things like home modifications that the providers can assess an

individual's home and see if it, can be modified to remain safe, is one aspect of it.

And the other thing is trying to figure out innovative ways to partner with housing.

So some of our providers like Pam at new Courtland and Richality community life are partnered with local housing authorities, this have housing options available to folk that's are within the program, or, also, figure outweighs ways to serve those individual living in a independent high rise. Other partnership co-location with some HUD housing high rises and HUD apartments all various different types of model that's the providers individually have figured out how to assess the needs of the community that they're serving and figure out how to address some of those barriers.

So I want to stop talking because I know hands are starting to go up.

But thank you guys very much to let us talk about the program.

>> PAM MAMARELLA: Why don't we start with Kym, do you have a question from your partner?

>> AUDIENCE MEMBER: Yes, I have a question.

There is realitying to ADAPT I'm with ADAPT.

I think this LIFE Program looks really good, it seems like everything is all there and wonderful, but my Karen is who can participate in LIDE?

Like do they have a choice? If they want to go to the day center.

[LIFE]

Or not. Do they have a choice they can stay home for the day?

Or -- you know if they're board if they go to the day center or what?

Do you know, do they have some choices in that in that program.

Ands Iability to make sure you're respecting the dignity of that person.

Because it would be a risk you know, do they have a right for for the risk of everything being messed up?

>> SPEAKER: Really great question there's a couple thing, I want to highlight.

>> PAM MAMARELLA: Can you repeat the question.

>> SPEAKER: Thanks Pam, absolutely. The question had to do with dignity and respect of the individual. Certainly in their role in making choices about their own aging process. And about their lives.

Particularly, Patrick asked if they have to attend the day center and what that looks like in terms of if they can stay at home.

>> AUDIENCE MEMBER: Risk.

>> SPEAKER: Risk associated with having the LIFE Program responsible and provide all of those services one of the thing I'll mention I'll turn to Ricl to talk about it is that Federally CMS has been working with states to try to expand the LIFE Program population to serve folks under 5 in a LIFE Program model. They have continued to try to work with states to be able to figure out Jonathan if you want to say anything more about that too, in terms of trying to see the program

be accessible to folks under 5. One thing I wanted to mention. One of the other things that we often kind of, chuckle about too is if I'm a senior who has spent my whole life at home, by myself I like to read what the heck do I want to go to a day center to go out, to hang out with a bunch of other old people we laugh about it, because you know, you don't have to that's not what you like to do that's not part what you like to spend your time doing that's part of the considerations of who you are as an individual part of the care planning that goes into place with the interdisciplinary care team, with you yourself being part of that decision-making as well as your family and in any in-home caregivers you want to add to that.

>> FRED HESS: No forced Bingo.

[laughter]

>> SPEAKER: What I would say is something that is interesting is to me at least the average age of the participant has dropped by 4 years in the 16 years that I've been involved in the program so we are seeing proper people who don't want the prescribed day center attendance to meet their social means so if we're going back to our first comment about the program, everybody's different, that's in the program we're working with throws individuals we try to accommodate their preferences and -- the day center there's some folks that come to the day center to see their physician physical occupational therapist, meet with the social worker intend to minimize more of the other activity that is are

offered there, because -- they don't, you know they have other interests or have their own social engagements outside of the program.

>> PAM MAMARELLA: Estella?

>> SPEAKER: Yes.

With all that you offer, if I was eligible for both life or CHC why would I choose CHC?

[laughter]

>> PAM MAMARELLA: Estella I would like to know that myself quite frankly.

I think one of the -- if I might say Rich if I polite I think, that life still struggles to get the word out that we exist I think, that -- in an effort to reach the many because there is a more of a boutique program, sometimes we get lost in the shuffle I know that department right now is working really hard to help us do that. That didn't just happen under CHC it's always been a bit of a struggle for us I think the other -- answer to that question is, fact it has to do with an it is a integrate I have program, if you really want to keep a fee for service Medicare, and you don't understand the benefits of integrating both Medicare and Medicaid you might make a decision not to go with the LIFE Program I know Kevin wants to to add something.

>> KEVIN HANCOCK: So, speaking for the department they're both fine options excellent options for people, especially people who are duly eligible for Medicare and Medicaid. The LIFE Program, what is, special

about the LIFE Program, is truly it's true integration.

And, it is a one-stop-shop for just the Stated as Fred just stated it presents an opportunity to pure integration between Medicare and Medicaid behavior daily health services physical health services and long-term services and supports we build a lot of our consideration for the person centered planning process, on the interdisciplinary team from the LIFE Program, all that being said, I mean the LIFE Program, the LIFE Program, is geographically based a lot of people, like to have a more expansive opportunity to be able to select providers in a network we are hoping that, people will always look at community HealthChoices and the LIFE Program as equal options both desirable but, just -- whatever their particular preferences are, where they live, they're making a selection that is, that is best for them.

We want, we want people to have close between these two managed care models we are, we think that we're, very lucky to have two great choices to be able to offer.

>> SPEAKER: I'm glad people have a choice by all means.

But I am familiar with LIFE it is available to me.

I will tell you that integration is absolutely everything under stop so to speak, is very appealing to seniors.

>> KEVIN HANCOCK: I could not agree more.

>> PAM MAMARELLA: Drew.

>> SPEAKER: I agree it is very appealing to seniors and, to --

people 5 with disabilities my question is how does it work when there's more of a catastrophic kind of illness or disease that comes up, such as cancer that is so far outside of the model or, say like a -- um, a -- organ transplant I mean, does the life provider take responsibility for these extraordinary costs or not?

>> SPEAKER: Yes.

>> SPEAKER: And so -- um, I just -- think follow-up to that is that, that might be a disincentive to providers coming into the program unless they're, the compensation model includes some way of being compensated for those outside the norm extraordinary costs.

A organ transplant could cost $100,000 or more.

>> SPEAKER: Typically, you would see stop loss insurance to help mitigate those circumstances.

Purchase a super policy and pay a premium that is based on your membership and they provide a guarantee of coverage you can Taylor those policies to include or exclude specific items. So that you have you know a reasonable premium you can just have it to cover all of your in-patient or you can have a more global stop loss policy with deductibles that helps to mitigate some of those cases. They don't happen that often they can climb into 7 figures.

>> SPEAKER: Are you saying the LIFE provider purchases that insurance.

>> SPEAKER: We're actually full risk so -- we, I can only speak for

my program but there are a number of PACE programs that participate in stop loss programs.

>> SPEAKER: Thank you.

>> PAM MAMARELLA: The gentleman at the end and then --

>> SPEAKER: My name is Tony brooks my question for example I'm a person elderly, who is already in a COBRA which is already suitable for me I get to the age of 5.

Do you integrate my old program with the new program or are you just , stripping the program and taking away the program?

>> SPEAKER: So um, the answer to your question is, yes it's a pretty big change.

But again, we're not we're still kind of in a learning phase the aging population is dropping I think you know, we have some considering to do.

Can you tell me, specifically, like, the program that you have in mind?

>> AUDIENCE MEMBER: Okay.

>> SPEAKER: Maybe transitioning from.

>> AUDIENCE MEMBER: I'm a person with a disability. For example I'm working with a independent living center, which is providing me services in-home services a PCA, travel to the hospital and all that.

And I get to the age of 35 this program has been helping me for maybe the past 2 years, 3 years before I got to 5 to 55 as get to 5 this LIFE Program is introduced to me it is going

to go through what is the flame -- excuse me.

Far goes through a different program, it goes through the program, when this program gets to me I have to choose I don't want the life program will I still keep the previous program I'm working with.

>> SPEAKER: I can thans. The LIFE Program is a voluntary option.

This is always will be a voluntary option there's never a mandate to enroll in the LIFE Program, that's actually Federal regulations that you have to voluntarily choose to enroll you can also voluntarily choose to disenroll at any time. It is always a voluntary option.

>> AUDIENCE MEMBER: Thank you.

>> SPEAKER: Okay.

>> PAM MAMARELLA: Okay.

>> SPEAKER: Quick question about one of your slides and that's in regard to the map that you showed.

In regard to where you provide -- or where LIFE Program is not currently present in Pennsylvania.

So I notice in the southeast there's one county that was not, does not have a LIFE Program. Are you referring to the physical LIFE Program because I'm wondering whether or not like for example Chester County was not identified as having a LIFE Program.

If I live in Chester County, if a LIFE Program in Lancaster also has part of the geographical location Chester, can a Chester resident participate in one ever the LIFE Programs in Lancaster County?

>> SPEAKER: Um, that's a great question. Chester County is currently by a LIFE Program

there's a Coatsville zip code is served by a LIFE Program out of Lancaster. Otherwise if you are a Chester County resident life services are not available at this time. We are working with the undeveloped areas of the State in looking for ways to expand the LIFE Program across the State.

>> SPEAKER: Based upon zip code and not by county?

>> SPEAKER: It is, actually both.

Depending on which area of the State we're looking at typically the -- we would like to assign counties just because it is, it's easier for administrative participates but, when you look at counties such as Philadelphia, oral gain I those are kind of carved out into zip code regions, I'll call it, where there's multiple providers serving a particular county.

And they will each have a select number of zip codes.

>> SPEAKER: The second question I have is, is the LIFE Program exempt from the HCBS final rule home community services rule.

>> SPEAKER: Yes, it is.

Yeah.

>> SPEAKER: Community health choice ins.

>> KEVIN HANCOCK: No.

>> SPEAKER: Okay.

Thank you.

>> PAM MAMARELLA: Blair? Blair Blair you've heard across the Commonwealth, challenge with transportation for participants, you find challenge ins the LIFE Program, particularly for those not attending a adult day program you have capacitor scheduling conflict issues how would you resolve those?

>> SPEAKER: Speak I'm sorry.

I had a hard time hearing that question. Would you mind repeating it? Bore bore sure I'll be happy to. Thanks. You've heard throughout the Commonwealth there are challenges with providing participants, provide transportation to participants.

Do you find any capacity, challenge ins the LIFE Programs? How do you resolve those I know you have more of a private model for those I wanted to hear particularly with those members that are not attending at a meeting their transportation requests.

>> SPEAKER: I think, so to answer your question, we don't have any capacity challenges ourselves.

I think where the challenges might be for folks that are not you know, oriented to the day center, they still have access to I can't remember the official name for access in Allegheny County. Pardon?

>> SPEAKER: Para-transit?

>> SPEAKER: Yeah. We help folks if they don't already have it you know arranged.

To use the public transportation system.

I don't know I think in general, there's a capacity that sense of general there's a capacity issue.

>> PAM MAMARELLA: I can answer for my program there's a -- um, algorithm the number of participants that we serve versus the number of vans, we don't have fully capacity issues and we transport people who don't come through the day center to any kind of medical appointments and, um, we certainly have you know an expensive proposition it's part of the LIFE model Kevin said it transportation is the gate way to independence and -- so I think that, the providers, of the LIFE program staff up in this area you'll note that the driver of the transportation is part of the interdisciplinary team.

It was because we think, that you know these are the people that are going out, in people's homes, on a regular basis. And can provide us with the information to serve the whole person.

So I don't know, does that answer your question? We're strong on our end on transportation.

>> SPEAKER: Great.

I -- there we go.

Yes. It does I was asking the question really through the lens of, thinking about the statewide problem and, I got the impression that it was not a challenge for the LIFE Program and, was -- wanting to hear

about it, from the standpoint of, how can we apply that to -- our statewide problems and, I think when you said it's expensive, probably is part of the equation.

>> SPEAKER: One ever the things I'll say too on behalf I can speak broad arely to all of the programs, as Pam and Rich said there's different models for each of their individual programs address it, many of them have the vans they own part of the program, some of them have partnership with transportation organizations. Some of those more rural area chose focuses a little bit your question kind of what we're experiencing in the State, um, some of the providers do shifts in the way that they do their transportation services for individuals coming to the day center. So -- in are making sure people in our al areas are not sitting on a van, for an extended period of time.

Waiting to get from home to the center or vice versa.

So -- making sure that, kind of in their scheduling of the day, in how the day program itself runs, being a little more in the shift based, so that folks like I said are not hanging out on a van for hours.

>> SPEAKER: Thank you.

>> PAM MAMARELLA: Fred we have a question on the phone.

>> FRED HESS: Okay.

Here's a good question for you guys.

When I turn 5 I decided to go into the LIFE care program, the

attendant I've had for all these years does she follow me, or you know -- does she have to get hired into there, do I get to maintain my, my continuous will I keep mitteneddant?

>> SPEAKER: We use both contracted and employed staff. So you will be correct that the person would need to be employeed, by us or the agency that employees them.

Would need to be employeed by us.

>> FRED HESS: Okay.

Okay.

But so, basically yeah. I would have to have them go down there and, sign up with you guys to become my attendant? And continue to remain my attendant.

>> SPEAKER: Correct.

>> FRED HESS: I wanted to make sure on that, a lot of people, they have had, if you could get an attendant to choose, for 3-4 years, which is a rare thing you don't want to get rid of them.

Okay.

Period. So -- yeah. I just wanted to make sure, that my attendant would be able to follow me in the program.

>> PAM MAMARELLA: I'm going to go to the gentleman in the from the public if you could introduce yourself.

>> SPEAKER: My name is Daniel Kleinmann I work for the Pennsylvania

statewide independent living council I would like to ask you a couple of

quick questions first, do you surreined are render access to your prime primary physician to the being access life, do you have

have the same access and care you received beforehand?

>> SPEAKER: So, um, to answer your first question, you do change primary ircare provider that's part of the structure of the PACE

model primary I care physician, has experience, agrees to be accountable

to interdisciplinary team.

>> AUDIENCE MEMBER: My second question, do you have access to

specialists if you require elective need or, say -- you have a you

need -- become the surgery, that may not be life necessary do you still

access that.

>> SPEAKER: I'm not clear what you mean by necessary.

Can you --

>> AUDIENCE MEMBER: I've heard some stories about, um, LIFE Program

in determining that the certain surgeries not life necessary. Like

elective surgery.

Who makes the decision on that?

>> SPEAKER: So the, the -- those services are covered because

they're Medicare and Medicaid services the question is, whether they

are, medically necessary and appropriate for the person at the time.

That, in our organization that decision is made with the primary

care physician and the team and a participant.

We have not had I can tell you that we've had, I can't think off the

-- all the years I've been there the denial of that kind of service we do a lot of education with folks because you know you have to keep in mind sort of the age range of our participants.

But, um, the participants do have an appeals process, if they disagree with the denial of the service by the team and it is a pretty intra cat and strictly governed process. It -- from the standpoint of my program we have not really seen a lot of that occur and I would encourage anyone who disputes that kind of a denial service to use the appeals process.

>> AUDIENCE MEMBER: One last question the team, that you talk about the identifies needs, who makes up that team? A lot of people with disabilities or developmental disabilities require complex or specialized for review, are those opinions included if they're not part of the LIFE Program.

>> SPEAKER: The interdisciplinary team the members you saw listed there, you're not limited to that list of members. You can actually, bring other specialists in to be part of the interdisciplinary team I would say that most frequently occurs with behavioral health with us.

The LIFE Programs can -- have other consulting members of the team based upon special circumstances.

>> AUDIENCE MEMBER: Thank you.

>> PAM MAMARELLA: Thank you.

We're going to go to Barb I think we have a question on the phone

and I think -- Patrick, has another question and then for the sake of time we're going to need to move on.

So Barb.

>> SPEAKER: Thank you, is there a cap on the number of personal assistants hours someone can have within the LIFE Program? Fred Fred good question.

>> SPEAKER: No.

Hours if that's what is needed.

>> SPEAKER: Yes.

>> SPEAKER: Thank you.

[laughter]

>> FRED HESS: That is quick.

[laughter]

>> PAM MAMARELLA: Okay.

>> SPEAKER: I'm Marsh's with the Pennsylvania assisted living association you were talking about housing options is assisted living part of those housing options.

>> SPEAKER: Assisted living is an option for housing. Yes.

>> SPEAKER: Just to clarify the LIFE Program is exempt from HCBS final rule.

>> SPEAKER: Yes. That's correct.

>> AUDIENCE MEMBER: Thank you.

>> SPEAKER: Okay.

>> PAM MAMARELLA: Okay.

We'll go to Patrick and then, the phone.

>> AUDIENCE MEMBER: What is the social standard and feasible for socialization? And what is feasible for socialization.

>> SPEAKER: So Patrick's question was there a standard and -- for socialization within the LIFE Program.

And that is the feasibility of -- providing or offering socialization into the program.

>> SPEAKER: That's not a question I've ever heard before. So I'm not sure how to answer it.

Some degree it is, self determined.

>> SPEAKER: Yeah I would add it's very individualized. So based upon the needs of the participant the interdisciplinary team will pleat with the individual family and determine what best meets their needs.

>> PAM MAMARELLA: I guess I would add to that January than, not only needs but wants which we see as part of what it is, we should give attention to.

So I would add that.

>> KEVIN HANCOCK: Do you want to say anything about the structure of the LIFE Program includes socialization with the life centers as well you actually have -- socialization is a fundamental component.

>> SPEAKER: Correct.

>> KEVIN HANCOCK: Philosophy of the model.

>> SPEAKER: Social -- a lot of activities are facilitated to help people you know form friendships based upon their interests, but I was thinking about his earlier question about what if you don't feel comfortable in that Millue, you want something else,.

>> KEVIN HANCOCK: Personal preference.

>> SPEAKER: That's what I was thinking. Yeah. When it comes back to what the individual expresses as their goals in their needs, we have some people coming into the program who specifically want to make new friends or, participate in the activities that are involved in the center.

Once they do, their mechanisms for them to provide input into the activities that are offered, at the center but as you can imagine in any large group setting, it is hard to get everybody's individual requests covered and so, um, people do seek outlets on their own outside of the program.

>> PAM MAMARELLA: Okay.

We have time for one more question in the room then we'll go to the phone and then we do need to move on.

>> SHARON BEHUN: Just as a quick follow-up to what Patrick was saying I think what he is probably maybe getting at is because he is deaf and his primary language is American sign language, do you have other people that use American sign language because that creates isolation you have -- see it happening across the State you have one

person deaf isolated living in this situation and another person over here, but no one gets anyone together. So that's a -- I think that's maybe what he may be getting at.

Is, the socialization what is the feasibility of linking up with other people he can communicate with. Or any other participants can.

That's what is something that should be thought about.

>> PAM MAMARELLA: Thank you.

Okay.

>> AUDIENCE MEMBER: I was looking at the general participation for -- participants who have a hard time communicating and socializing as well. So -- that is my concern.

>> PAM MAMARELLA: Okay.

Thank you.

Okay.

Palet --

>> SPEAKER: Brenda.

>> PAM MAMARELLA: Brenda do you have a question?

>> SPEAKER: I would like do know if a person is in the LIFE Program, what is transition out? How does that transition actually wind up with enrollment into community HealthChoices?

>> SPEAKER: That is a great question, so the -- the question is, how does an individual that wants to transition from the LIFE Program end up in or transition into community HealthChoices the LIFE Programs

are responsible for developing a transition plan working with the individuals to transition to their whatever program they like to transition to in this case it would be the your example is community HealthChoices.

The individual would voluntarily, assign a form to voluntarily, disenroll from the LIFE Program and the department would work with the individual to transition from the program and threaten also, um, enroll in CHC through the independent enrollment broker.

>> SPEAKER: Are assurances made there's no gap in service when that transition is created?

>> SPEAKER: Yes. We're working to assure there's no gap in coverage.

>> SPEAKER: Thank you.

>> PAM MAMARELLA: Thank you. And we really have to -- we're way over schedule and we're going to have to end that here. If anyone has any other questions or comments you certainly can use our Listserv we commit to of course always answering any questions that come in through the department.

So thank you Joan and Rich anCh and January than we'll move right now to have Erin Ninehouser and Renee Hodin to come to talk to us about the participant advisory committee.

>> SPEAKER: Thank you everyone. Okay.

New at this.

Okay.

Don't hold it. Yeah.

Okay.

Thank you all right, so my name is Erin nine houser I'm the consumer engagement manager with the Pennsylvania health access network, is a statewide consumer driven organization we do education outreach and enrollment for the marketplace Medicaid Chip I live out in western Pennsylvania we've been working to educate and support people throughout the transition.

I want to introduce our main presenter Renee Hodin, with community catalyst is one of our -- best partners they're a national organization Renee has been with the organization for 20 years.

Currently she serves as deputy director for community catalyst center for consumer engagement and health innovation so Renee has years of expertise in making sure that consumers are at the table, when decisions around, how health they have a lot of expertise, about what is happening in other states have rolled out MLTSS programs and she is going to talk to us today about the really important role of the participant advisory committees and ensuring a lot of the issues that came out in the discussion today, are addressed in a systemic structured accountable and ongoing way, by the managed care organizations

so, Renee I'll turn over to you thank you again for being here, virtually today. Hod hod great thank you Erin.

I'm getting feedback.

>> FRED HESS: Badly hang on.

Is that better?

>> FRED HESS: Go ahead. Hod hod is that better?

>> FRED HESS: Are you on a speaker phone, turn off your speaker

phone?

Hod hod I'm on a head set.

Nine nine can you switch over to hand held. Hod hod I can.

>> KEVIN HANCOCK: You have to be speaker with head set that creates

feedback. Hod hod how about that. I'm in a room with compu computers. Okay hod hod hold on.

>> SPEAKER: Came can you try that better.

>> SPEAKER: I'm speaking through my computer now. Nine nine

okay.

>> SPEAKER: Okay.

Let me turn off -- I'm still getting feedback I don't know about you.

Okay can you still hear me?

>> FRED HESS: Yeah.

>> PAM MAMARELLA: That's better.

>> SPEAKER: Okay.

That's much better okay great.

How much time do we have?

>> FRED HESS: Very little.

>> SPEAKER: Let's keep to 15 minutes.

If we can.

>> SPEAKER: Okay.

I will -- try Jame -P through this as quickly as possible.

So, um, thanks so much Erin introducing me I'm going to power

through some of these slides, skipping through a bunch give just a quick

road map on the slide about where, what we're going to cover.

All very briefly.

Erin basically covered who we are, what we do. I'll skip ahead to

very brief reminder about why the participant engagement platt matters give an example of engagement then focus

most of the time on some of the lessons we have learned around getting

started with the advisory committees of all shapes and sizes and how to

overcome obstacles to participation.

So, um, let's see if we can switch to slide five.

Okay.

So um, so Kevin already provided the -- the main Rationale

for putting together participant advisory committee that is it is

required.

However, there's many, many, many more reasons to do it.

And it starts with the fact that it is the right thing to do. It

really is it is in line with the saying that I'm sure many, many people

in the room today appreciate the it is moral obligation to ask people

about the their needs. People who are being -- on a practical basis

this, participant advisory committee can be feedback loop and provide the early warning system.

I'm still getting feedback is anyone else getting that too?

>> FRED HESS: We're hearing that pretty good.

>> SPEAKER: Okay.

I'll try to move on, as I said you know know, participant advisory committee also offers, um, a feedback loop from the participant being served and to the plan and can serve as early warning system especially as we're transitioning. It also helps to field test messages from the plan.

Going onto slide 6, this is just a very helpful framework, from the national academy of medicine showing how how, participants and family members can be engaged how it is critical to achieving key outputs and outcomes, little small but you can see for instance leadership is, regardless if they're making in the industry, the word patients, participant, knowing -- creating structure such as the participants advisory committee.

We're going to end up together with many other things with better engagement, better experience, better decisions, better processes and the ultimate outcome that's are are lower cost and better cost. Our next slide please.

This is some early lessons about making participant advisory committees work.

Some of the lessons are first clarifying goals right up front, setting expectations right up front that is critical to getting meaningful buy-in from your participants involved in the committee.

Affirm that is importance right up front again of engagement to the to community HealthChoices to the plan.

Offering training is very, very helpful both for the consumers that are engaged, as well as for staff.

Developing tools, that support engagement, things like you know Jargo n busters, are really very helpful. There's many more that could be listed.

Regularly assessing the experience and learning from that experience is also a lesson that we learned from -- from consumer advisory committees in various settings.

Making sure that the communication is very clear. And at the right levels it is critical we'll talk about a little bit later and then providing financial there's a to overcome obstacles to participation also critical. And again, I'll address some of that a little bit later.

So next slide I'm going to give one example I have two in here but because of time we'll skip. So slide nine, this is a Commonwealth care alliance, this is a health delivery system. It is a method, a non-profit organization carrying for people who have Medicare and Medicaid.

And, they started out serving people who were older than 65 and

senior care options program and then about four to five years ago, they started serving people who were younger people with disabilities and in their one care program. The organization itself, has a strong history of consumer engagement in that it was found by advocacy and consumer organizations who have continuing role in nominating the board. And then their board itself, includes at least one third people who are consumers or consumer representatives. Next slide please.

Thank you. I'll get the top one, about the senior care options program you have, Commonwealth care alliance had two different approaches to consumer engagement but for purposes of today I'll focus on their one care approach. In which they have dedicated resources to establishing a two multiregional consumer advisory committees. Because they cover the whole state they have some both in the interpart of the state as well as western Massachusetts and have members from the different counties that are good for diversity. They also really democrat on disrated their organizational buy-in by dedicating a budget to create a consumer full-time consumer liaison position. And that liaison has direct access to the reporting relationship to the executive leadership.

So now I'm going to keep going skip the next example and we'll go to slide 13.

Getting started.

Okay.

Slide 14?

Okay.

So, first thing to be to reiterate as I said before first is the importance of being clear about your goals, particularly for recruitment . And, although, Kevin outlined you can look back at that slide later, the particular requirements they are Harmonois with these two, identifying participants and/or family members, with direct knowledge of or experience with long-term services and supports through the CHC program.

We also want to make sure that in recruiting members for the pack PAC, it's representing the population we serve we'll talk about diversity in that.

Next slide please.

I want to cover some recruitment strategies that we found that work really well. Starting with the job description.

To the right you'll see a very, very small version but we can certainly provide that that afterwards, a job description should include a description of the CHC and the MCOs, it should describe the goals and responsibilities of the members of the PAC and be very clear about this time commitment.

There should also be a nomination or application form that should include things like, you know, contact information but asking people to provide a statement of interest, and also, very importantly, making sure to note what kind of a accommodations they might need in order to participate.

In terms of the strategy for actual recruiting and doing outreach using staff and providers as well as other viewers participating perhaps in other programs PACs those might be other ways for recruiting people for applying for submitting applications to this PAC.

So, going through the clinical front line staff, reaching out to the leader community partners other community partners and then, of course, you know, plain old advertising whether through the web site like a newsletter, placing fliers in relevant locations. As well as participating in community events.

Next slide please.

Are I mentioned before, we're looking for diversity, looking for representation of the diversity of the plan and, this particular plan for the consumer, community health lices, the CHC.

And demographic factors there are many.

I'm not going to go through them all here, but I think that having this checklist in front of you, both demographic and non-demographic factors, um, in selecting recruiting and selecting a PAC that is diverse you want to think about you will of these to make sure that you are covered the first day of the population being served. And the next slide.

I mentioned before the application form is really important for understanding more about people who might be on, who might want to serve

on the PAC.

Those applications once they're gathered, should be screened. People should be selected for an interview.

That interview should include, QA allow for QA about what the participant advisory committee would be like it could be inperson, it could be telephonic or by Skype we want to make sure that people who are applying are clear about the roles ands responsibilities as well as, time commitment.

But you also want to spend time in the interview getting to know the potential participants.

So you understand, their interest, their expectations why they, are what type of experience they might have in serving in this sort of role in the setting.

Next slide.

After the interview sending acceptance letters with brochures who have been selected, inviting them to an orientation session this is not a training exactly this is an orientation session to reiterate the purpose, the roles ash responsibilitieses, examples from other places of how PACs have worked and what they have done, talk about what the vision is, for partnership between the MCO and the PAC and also getting to know the -- getting to know people, staff, especially the staff, who will be -- assigned as lead on the PAC. But other staff may be needed as well. And other -- know each other, of course.

I want to reiterate that terms of in terms of staff at the orientation center orientation session very useful to have your most senior leadership attend.

That is the importance of the PAC, and the commitment of the organization to the strategy.

Slide 20 switch over to the obstacles.

In the next one we we have the we'll talk about major obstacles with participation and without going through every bullet, you can start see this as a checklist for folks overcoming obstacles, folks may be thinking just listening to the very beginning of this meeting some of this stuff is it is certainly well-known to folks in the room, but having a checklist is really helpful. So, language. Making sure that the discussion and especially written in plain English and on sixth grade level, staff can be trained to do this. Providing interpretive services depending who you have in the room, whether it's a different language, or it is sign language, included. And so forth.

That is something that is important to overcome the obstacle of having a diverse participants groups.

And offering ongoing participant training and support.

Skipping along, literacy level is covered above in language, next slide please.

Serious illness and disabilities.

You know, this is something that comes up a lot.

We're just working on a project a national project research project.

And is about people with serious health and disabilities this is the main concern of the organizations that were recruiting for their participant advisory committees and there are many, many things that organizations, can do to overcome obstacles for the participants, to be part of the -- to share their knowledge. Obviously there's asking about needs I mentioned earlier.

Ensuring locations are accessible for all the different abilities.

Compatible with assistive tech technology, making sure you have time in the agenda for people using augmentive and assistive devices.

And as necessary, and appropriate, caregivers could attend with a participant to support them.

Providing transportation or stipend, also helps people overcome obstacles, assigning people to help participants get from the entrance to the meeting room and then, also, offering opportunities for other modes of participation. Like a conference call we're doing today or Skype.

Next. Next slide please.

Okay.

Most of these have been covered,

the other section of obstacles is a good thing to check, thinking about meeting scheduled to of course date participants needs this is not, what

they do in the -- for their full-time job they probably have full-time jobs or other responsibilities and, so evenings and weekends are probably going to be your best bet.

Location is close to public transportation and/or providing transportation services.

And as we talked about before, Stipend for participation including potentially compensate people for their caregiver duties. Next slide and this is the last one.

Last obstacle is cuts across the board many people have repurr constructions of providing feedback what their experience has been in the plan.

Those assurances that they will not their participation will not effect their services has to be made up front and has to be in written materials and this has to be an honest discussion at all, at all meetings and a ground rule around confidentiality around people's individual situations I'll stop right there I know it was very, very fast. And we covered a lot. Happy to take fully questions at this time.

>> SPEAKER: Okay.

Let plea ask a question for people in western PA raise your hand if you've been cock are contacted about the participant advisory committees by the MCOs?

I know, I don't know that there are dates set yet I don't think the first meetings have happened I think they're planned for some time in

April. These are all we wanted to present this information these are really questions that we want to be asking the MCOness terms of their preparation but we really appreciate the opportunity to talk about this, these are going to be a really important vehicle for getting meaningful consumer input to shape you know how the plans interact with people. And improve over all program quality so thank you for the time and -- Pennsylvania health access network will be partnering with disabilities options network AARP and other organization those host consumer trainings to help empower people and prepare them to go into these settings which can be a little intimidating if it's someone's first time, stay in touch with me if you would like to connected thanks again for the opportunity to present.

>> PAM MAMARELLA: Thank you very much thank you for helping us get back on schedule, looks like we have a question in the back then we'll, move to the MCO -- CHC-MCO question and answer session will be part of the additional public comments we'll -- mash that two those two things together today we have a question.

>> SPEAKER: Yes. Zachary Lewis executive director of the.

[inaudible]

ADAPT member, a question as far as me being a consumer, and asking questions about the PAC. Even though, it is a mandate is being apart of the participant advisory committee like a rule for consumers like how, does that feedback go to the State? Does it go to the MCO or -- what?

>> SPEAKER: Um, it is not a requirement for consumer those participate it's a good opportunity -- I'm sorry, if I misunderstood the question the feedback as I understand it, at the advisory council meetings is given to the MCOs, but could also be given to the State, if you feel like the issues being brought before the, the committee are not being sufficiently addressed within the MCO.

And Kevin I don't know if you want to add anything about that.

>> KEVIN HANCOCK: That covers it, we would definitely, any opportunity to be able to receive feedback whether it's in the participant advisory committee or, this committee or any other vehicle will be used to hopefully improve the program that's definitely a vehicle to pry feedback to the State.

>> SPEAKER: I would just add in I mentioned something about this earlier, that feedback loop is something should be discussed early on.

To make sure that the participants understand what is going to happen to the input, with the input they provide and how they're going to hear back about whether it was accepted or not or modified, et cetera.

>> PAM MAMARELLA: Thank you.

We're going to ask the CHC MCO toss come back in case there's any questions for them now.

>> KEVIN HANCOCK: R Representat ives of all 3MCOs could come to the table near a microphone that would be very much appreciated

and be able to answer any questions. Actually --

>> SPEAKER: Kevin, I have a question for them --

>> PAM MAMARELLA: One second Tanya.

>> KEVIN HANCOCK: Tanya I'm going to ask the MCOs one question first if that's all right.

>> PAM MAMARELLA: I'm going to turn this meeting over to Fred, thank you have everybody.

>> KEVIN HANCOCK: Okay.

So if the MCOs would be willing to talk about -- how your efforts building out participant advisory committees evolving.

That may provide an update build up with very well with the present ation from the plan. We'll start with AmeriHealth Caritas.

>> SPEAKER: Hi it's Patty Wriglt, we have our first participant advisory committee meeting scheduled for April 10th at the Jewish community center in squirrel hill.

We have contacted participants and providers both by mail as well as for participant referrals we reached out to a lot of those service coordination entities advocacy groups, we did mailings as well as getting feedback from our providers.

This will be our first meeting so it is somewhat of an orientation meeting.

And, a number of the things that we will cover are suggested topics, et cetera.

But one of the things the thing we want to make very clear that the feedback from the participant advisory committee from both participants and the providers, is very valuable to us and important and we will clearly outline how that feedback will be brought back to the organization. So it will be shared to executive leadership, information from the committee will be shared back to any department that may be impacted by their feedback a as well as that information will be funneled through our committees as well as go all the way up to the QMUM committee with our chief medical officer.

So do we do have senior leadership that will be attending, canning are Court and juriy chief medical as well as our chief medical officer, director of service coordination, will also have representatives initially from our contact center and our communications group.

Since right now, they are the teams having most of the face-to-face or telephonic interactions with some of the participants and the providers and we're looking forward to feedback on how they feel those interactions have been going.

And during that Kathy will also be kind of giving an overview of how we've been training the service coordinators beige direct hires and entities on the value of a participant led person centered service plan.

We'll also be getting feedback from the providers about the best way to coordinate the communication and the information that is on a

participant's service plan to include providers in ingreated team approaches and getting feedback from both participants and providers on how they feel that process is initially been going since the implementation.

Kathy anything else? So, we are, we do have representation of both community well duals and LTSS members. And but we would like to see a few more members join our participant committee. So, I will share with Fred or someone so you can send it out in the meeting minutes our contact for this, because again we do have participants that have indicated that they would like to join us but we would like to see a few morgen the committee.

>> KEVIN HANCOCK: Okay thank you Patty, estella, Tanya has a question and estelle has a question.

>> SPEAKER: I want to go through the 3 before I ask.

>> KEVIN HANCOCK: Great. So doctor Thank are thank you.

>> SPEAKER: Okay.

So we still have been rounding out our committee in the southwest. We're in the interviewing.

>> KEVIN HANCOCK: Introduce yourself.

>> SPEAKER: I'm sorry. Kevin.

Thank you I'm Anna Keith with Pennsylvania Health & Wellness.

We're rounding out our committee participants and we are looking at an April date probably near the end of April for our first meeting.

Our committee is the scope of our committee is to act as a focus group to fossil Tate the participant perspective on the quality of care and services offered by Pennsylvania Health & Wellness and then to offer recommendations or improvement based upon the participant's experience this committee reports to the quality management committee and the meeting minutes are forwarded to our board of directors. So it is our intention to make sure that we're very transparent in the feedback of representation at this time in the southwest and how we're doing and what we need to do better.

And we, will take very seriously those, that feedback from the participant advisory committee and in moving forward on how we do services and supports.

>> SPEAKER: I'm ray Prushnok with the community HealthChoices UPMC I want to say that our community engagement, our participant engagement manager Amanda is in the back, on the right side over there. So -- she is, actually been the person who has been leading conducting our participant interviews to date we have I think, spoken with and interviewed maybe 15 participants we're still accepting applications going through that process, please reach out to me, grab a plained, our email chc participant@upmc.edu for our PAC.

We have a -- our first meeting scheduled on April 26th we, look that the as really a formative meeting with orientation, generally it will be

a forum for updates, benefits, potential changes to benefits.

Complaints, quality and sort of accepting that general feedback.

As Kevin indicated earlier, the PAC will be 60 percent participant, with you know at least 25 percent LTSS we're targeting for you know at least five participants with LTSS hopefully more.

And you know, quarterly meetings in each zone and, we are again sort of trying to keep good representation with providers participants targeting about 18 people, maybe more depending upon where we land to make sure we have you know, diverse representation, similarly, our you know, our -- CHC executive management team will be present and you know be actively participating in these meetings and, we'll be reporting on out to the APMC review board accordingly and sharing you know our -- feedback not only across our organization but with OLTL.

>> KEVIN HANCOCK: Okay.

Okay.

>> SPEAKER: Am I allowed to ask employee question.

>> FRED HESS: I was going do say, Tanya go a lead you're on.

>> SPEAKER: Okay.

My question is simple at the beginning of the presentation the presenter said, the -- the participants advisory committee are required but employee question is really is centered around this.

What are the MCAs required to do with the data and the information that they gather with the participants how can we participants be sure

that all their time and all their work all their energy they're going to put in to this committee, is not just a simple okay, well, up to that, now we don't have to do anything else with this, what is going to be done to make sure what you are doing is actually used in the policy on what you do and how can the participants be ensured the thing that they say is acted upon, benefits of public, which is why we would be doing this any how.

>> FRED HESS: Good question Tanya do we have a good answer?

>> MALE SPEAKER: I think Tanya this is Ray, participants can vote with their feet, not everything needs a -- sort of requirement, and you know hammer from the State I think we see this as the incredibly important opportunity to get ahead of issues all the participants in the committee will be able to help us address issues before they become wider spread, us being responsive is going to be how we retain make sure the word you know serving as many participants as we can.

>> SPEAKER: Tanya I think the other benefit to this is, the feedback we will meet a minimum of four times a year because it's a minimum of four times once a quarter March was kind of pushed into April because of weather it's.

But, as you outline, your feedback within the meetings when we return to the next meeting part of the, requirement and the commitment actually, from the MCO team is to make sure that we're reflecting to you, how we do value your input and your opinion and we would be updating

you as to how we took the information what we did as we moved it through committees, we will be able to demonstrate are straight how your information and feedback has movement and life within the committee so it will be an ongoing dialogue. And while the committee may physically meet we have also made accommodations for people to join by phone as well in the interim, we will provide updates either by email or whatever, communication method that the committee members have indicated so I think, it is something that you will see a feedback loop on an ongoing basis.

>> FRED HESS: We have time for one or two questions if they're really short or quick. You had your hand up first we'll go down here.

>> SPEAKER: Yes, please.

I'm very interested in the ratio of participant toss staff et cetera, you're putting into your PACs as well as the age specifically including those that are 60 plus.

That's not a very out spoken group.

>> SPEAKER: We have identified key leaderships senior leadership that would be in attendance it is, it's interesting Estella you asked one of the things we wanted to make sure was that, um, the room and the committee, was really comprised of, providers and participant and that was not a room just full of -- MCO staff.

So, um, they -- the CHC agreement does outline the composite of the committee.

Of how many, um, members versus providers it has to be comprised of.

And that has helped everyone guide to be able to say, here's a core number, so for AmeriHealth we would like to do is have a committee of members, not counting the staff, of a committee of 30.

So out of that, we have 6 providers, representative we've gotten providers from vision, dental, behavioral health, physical health nursing facilities and behavioral health, the rest of the committee are dual eligibles as well as LTSS we're trying to have a diverse representation of the population and that's part of why we have reached out to add voluntary Kasity groups like CILs there may be some participants might want to say,

are not used to putting their hand up in the air, advocacy groups play know them better than we do we're using them to help make introductions for us so we can encourage those participants to join the committee we are, reinforcing the Mets message to them, we will help them with the expenses as outlined to make sure they're able to get there, we're choosing venue that's are community centers we know are accessible to all members of the population.

>> FRED HESS: You mean all members are not like me.

[laughter]

I will definitely ask a question I don't care.

>> SPEAKER: This is Anna I'll add a little bit to Patty our committee is not as large as there, 60 percent will be, participants and

that percent are identified as coming from LTSS services then we also have, caregiver family caregivers involved in the committee, we recruited from the AAAs as a nice well rounded
group mix in the diversity we're still in the interview process if you know folks interested let me know please.

>> SPEAKER: Several that sit on the council.

>> KEVIN HANCOCK: Before you get started just -- as part of the presentation, the MLTSS updates presentation we have the agreement requirements published as part of the minutes for this meeting just to be very clear, expressly require for the participant advisory committee will be in the CHC updates they were reserved by Erin and --

>> SPEAKER: Our answer is largely the same, so starting with 18 people that sort of the -- minimum with ten participants, six providers with different types of direct care worker and caregiver family caregiver representative and you know the -- we have spent you know, time with area agencies talking you know, so for example, you know, Steve Williamson in Blair County trying to get geographic diversity and age diversity reach out that way, as well as locally and you know, Allegheny County and spoke with Don up in
Lauer Lawrence, trying to reach around make sure we're getting a age distribution and geographic distribution as reflected with the population.

>> FRED HESS: Uh-hum. Okay.

>> FRED HESS: Okay.

Go ahead.

>> AUDIENCE MEMBER: Okay.

Okay.

Zach Lewis as a consumer.

Because we all know consumers relationships with their supports coordinators is critical, my question is, whether consumers will consumers be notified if they will be losing their external supports supports coordination option?

And also will we be getting a 60 day notice prior to like the continuity of care, because the notifications indicate that, the -- the service coordination entity is -- could end immediately because of this, is just administrative.

>> KEVIN HANCOCK: Can I just, repeat your question so what you're asking is, if at the end of the continuity of care period if the managed care organizations elect not to work with certain service coordinators will providers will the participants be notified, is that the question just to be clear.

>> AUDIENCE MEMBER: Yes.

>> KEVIN HANCOCK: Okay.

And -- that will be for the MCOs? Obviously, the answer from the department's perspective is yes they will be notified and that I will have the -- the MCOs answer.

>> SPEAKER: Yes for AmeriHealth, if there is aen at this time that we will not continue with, beyond couldn't continuity of care period we'll be notifying them by letter, we'll notify the participant and Kathy and the service coordination team, who will be offering them the option of a new service coordinator. And, the option may be directly service coordinator or service coordinator from one of the entities that we may choose to continue with, so the participant would definitely, have a option and will be notified within those 60 days.

>> SPEAKER: Same answer for UPMC, 60 days and then the participant will be notified.

>> SPEAKER: And this is Anna with PA health wellness we have the same answer within 60 days we would, we give at least 60 days notice.

>> FRED HESS: I have time for one more.

>> AUDIENCE MEMBER: This is Matt Seeley with the statewide independent living council back to the question asked on the phone, um, what assurances that the participants that ask questions at the advisory meetings if they're comment or concern is adverse to the MCO, is that question or comment will make it's way to OLTL?

Or the stay however you look at it.

Hannie.

>> KEVIN HANCOCK: I can start to answer, it's a requirement they have to report back feedback from the participant advisory committee so

they don't give us that feedback, they will be in violation of their agreement. So I don't think that will happen. At the same time these 3MCOs I mean the -- we've had a great communication relationship with all 3 of the MCOs and I think, across the board the departments, the MCOs and all of the stakeholders are recognizing the reason why we're having success as we are, because of the ongoing communication open feedback and looks for focusing on the opportunities to make the program work better.

I don't have fully doubt we're going to receive feedback especially if it's something that will improve the program, love to hear confirmation from the MCOs or contradition.

>> SPEAKER: I think, what we look forward to is robust discussion, it really -- this is, ash open dialogue otherwise it's an advisory committee so I know for us I'm sure the others will say the same for AmeriHealth we're not holding the committee just to be able to check a box off and say we have met this contractually you're the participant you're the center of what we're doing and we want your feedback. Eventh something like communication.

It is not always it may appear to be in first shaky topic communication itself is very important.

It could be that we always send things out on yellow paper and participants may feel very strongly that blue paper just works better. It is easier to read.

Individuals with some vision challenges there might be feedback that, just the font really should be different.

And, our design or internal team may say we really like using italics but, the thing is, we bring it back and say, but the participant -- we're here for the participant, and they're telling us it should be block printing that's what is easier for them to read and they want to see bullet points they want to absorb, they want to see the information quickly and Succinct, that information has to come back the one thing we'll have, everyone on the committee will be given the assurance because I think that there is -- there could be some fear and hesitation that yes, you know service coordination is a key part of this.

And we do not want fully participant to come into a committee, and be concerned, that if they have a view or a strong opinion, that maybe different than what we have, that they would, ever have to fear any type of negative feedback or repurcussion we value their input our commitment is to show how we're using the input to better enhance our program and our services and even possibly the way we communicate.

>> FRED HESS: And, that's all the questions we have -- LAN-just -- other MCOs we will have --

>> SPEAKER: I can tell you one of our participants on our committee is our lead at PA health wellness for grievances and appeals she was selected to sit on the committee as well.

And, she will be the litmus test to see if there is a concern brought she knows to go forward and investigator if it needs to escalate we're pleased to have her involved that's Coby Mil es you probably met her we're happy to have her on a kind of to make sure it has to move out we have it.

>> SPEAKER: You know formally yes we'll be reporting back I also, expect that OLTL will attend some of these meetings so I -- I mean.

>> SPEAKER: Yeah we will.

>> SPEAKER: We flow the obligation it's something we'll.

>> SPEAKER: We will --

[laughter]

>> FRED HESS: Yeah.

Okay.

All right ladies and gentlemen, that's all we have for today.

Our next meeting is going to be right here, on may 2 10:00 right here in this room we'll see you then.