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DATE: May 30, 2018

EVENT: Managed Long-Term Services and Supports Meeting

>>FRED HESS: We'll be getting started in a few mine minutes. So everybody try to find a seat and calm down a little bit.

Good morning everyone, how is everyone today?

We are getting ready to start. Let me start by reading the committee house rules.

Committee rules language and professionalism, please, direct comments to the chairman either me or my vice chairman or whoever happens to be speaking at the time. Wait until you're called on.

Please. And keep your complements under 2 minutes last month, we had a fiasco we had to skip out on part of the agenda and, that's not going to happen today.

The meeting minutes are transcribed, transcripts meeting documents are posted on a Listserv. Listed on the Listserv under MLTSS meeting minutes, they're normally posted within the few days captioning and auto recording the captionist is documenting the discussion please speak clearly and slowly.

Also, the meeting is being audio recorded. Turn off your cell phones, and, pick up your mess when you leave we're not slobs.

Public comments, will be taken during presentations, instead of just being heard at the end of the meeting however there will be an additional 15 minute period at the end of the meeting for additional comments like I said again please keep your comments and your questions short.

The MLTSS sub-MAAC meeting dates are on the web site.

And now for the evacuation procedures.

>> BARBARA POLZER: Good morning everyone.

In 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, located right outside of the main doors much the honors suite . OLTL staff will be in the save air stay with you until you're told you can back in or you're evacuated. Everyone must exit the building please take your belongings with you, do not operate, cell phones and do not try to use the elevators as they will be locked down.

We will use stair one and stair two, to exit the building for number one, exit honor he's suite through the main doors on the left side near the elevator turn right go down the hallway by the water fountain. Stair one is on the left.

For stair two, exit honors suite through side doors on the right side of the room or the back doors.

For those exiting from the side doors turn left and stair two is in front of you. For those exiting from the back Dar are door turn left, then left again stair two is ahead of you.

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

Turn left and walk gown Dewberry,ally to Chestnut Street, turn left to the corner of fourth, street and Blackberry street cross Fourth Street to the train station.

>> FRED HESS: In case you didn't know at the Harrisburg Hilton this morning we were thrown out because of an emergency so, emergency evacuations are very important they did shut down the elevators thank God I was already downstairs checking out.

[laughter]

Did not have to crawl my butt down the stairs. Okay let's get this going.

We'll have OLTL updates with Kevin Hancock.

>> KEVIN HANCOCK: Good morning everyone, it's fun to have Fred as the chairman of this committee, I have too say.

[laughter]

Okay.

I will start with providing a quick update on committee governance, to the next slide. We were in close to the same shirt he has a bigger chest they're going to start thinking that the OLTL has a uniform. So,

starting with committee governance, as you know, the MLTSS sub MAC was

developed in August 20 5:00 established terms where they would be staggered two years or 3 years.

[2015]

For starting this effort. We're at the point where we have individuals who are ending their 3 year terms.

And, for everyone appointed for a 3 year term, the question is, whether they're going to be, whether whether or not they want to consider going forward and they can being considered for a second term of two years.

So, for members with terms that are expiring on August 31, 2018 and hopefully you know who you are, let know if you're not, the OLTL secretary, in conjunction with the MTLSS chair and vice chair, Fred and barb, we'll look at the tabbed answer and absenteeism records to see if the member has a pattern of unexcused absences, that will be a determination to see if that makes sense for us to offer a continued term. If the pattern is identified, the deputy as well as the chair and vice chair will have the authority to, terminate a member's appointment after 3 years of unexcused absences we want people to participate we have a lot of engagement not only with, with committee members but also with the audience it's really important for the committee to recognize that engagement is an important part of, building up and starting up a new program, so we really do want, active members participating and that is definitely a consideration. So we'll

consider attendance and absence records member's knowledge and interest in serving the community to determine whether or not a member should continue for a second term. So that's, going to be one of the factors we will, use in determining whether or not we reach out to you, to see if an additional term is warranted.

So just want to reiterate, if -- as part of this process, if you are concerned about your absence and your, existing committee member, make sure that, if you need to be absent for a -- any committee, it is certainly happening, it's happened with me on many occasions, make sure that the committee is aware that that absence will be occurring. And, so that we know it will be an excused absence. So, we want to make sure that, that as stated we have at least have a quorum we have a number of committee member whose are tanning who are able to be able to contribute and, and, to make sure that we're communicating if there are any real anticipated absences. That is one of the factors we want you to keep in mind. We do want to let those members know, if, in the near term if they're term is going to be expiring on August 31st to give you the opportunity to be able to continue the term as well. So we'll be reaching out to you, if you wanted to let us flow if you wanted to continue with a second two year term let us know that as well.

In the meantime, if there are any vacations based upon termination of absence or otherwise the 3 of us will be working to make sure we fill those absences, and -- just as a reminder the composition of sub-MAAC is

different from some of the other subcommittees of the medical assistance advisory committee is comprised of managed care organizations whether they be Medicare or Medicaid related, it is also comprised of, providers, whether they be nursing facility, or home and community based providers, that is comprised of, participant advocate representatives and, participants themselves the most important member, of the committee no offense to anyone else on the committee so we have a cross section the reason it was designed that way we needed a lot of different voices building out the program.

Look for members to fill the slots that are vacked, we'll look for them, from -- multiple sources, but we'll try to have a real representation of those sources. Just, an example right now we do have we do have robust participation from the participant and provider community we appreciate that etch. We, with Pam Mamerella shall we don't have representation from the LIFE program we want to look for an opportunity to fill that gap as well. So that will be consideration for any vacations.

And another vacations would be, specific types of providers that may not be represented and, consumers or participants from regions.

[Vacanysis]

From the southeast and also from the remainder of the State. So we will be looking for that representation as well. Fred remind medicine we forgot to do introductions. Thinking of probably Tanya we have a

lot of people on the phone participating as well. So do you want to take a moment to do that.

>> FRED HESS: Let's start we'll start with you now Barbara is not there, you get to go first.

>> SPEAKER: Linda Litton participant advocate.

>> SPEAKER: Jim Pieffer, Presbyterian senior care.

>> SPEAKER: Jim Fetzner, comfort report care.

>> SPEAKER: Blair bore arc, united health care.

>> SPEAKER: Jack Kane.

>> SPEAKER: Bill white AARP.

>> FRED HESS: Fred Hess, chairman.

>> KEVIN HANCOCK: Kevin Hancock.

>> BARBARA POLZER: Barb poll sister, liberty communication.

>> SPEAKER: Steve Tozel.

>> SPEAKER: Hess she Zinman.

>> SPEAKER: Drew Negel. E.

>> SPEAKER: Theo brady.

>> SPEAKER: Ray Prushnok. Speak.

>> FRED HESS: Do we have any members on the phone, that would like to say hello?

>> SPEAKER: Yes it's Tanya Teglo.

>> FRED HESS: Hello I got you marked.

>> FRED HESS: Anyone else? Anyone else on the phone?

>> SPEAKER: We should have Denise Curry and Terry Brennan.

>> FRED HESS: Okay.

>> SPEAKER: Hi.

>> SPEAKER: Good morning.

Good morning.

>> FRED HESS: Good morning.

>> KEVIN HANCOCK: Okay.

Okay.

>> FRED HESS: I believe that's it.

>> KEVIN HANCOCK: So I'll, continue with my update, just quick very quickly, also wanted to -- provide a reminder, that -- that is, there will be -- reminder and offer for participants who would want to consider to be part of the consumer advisory council there's going to be free training that is going to be offered for consumer advisory council members. Either present or future if you have an tint in something that, participation in one of the consumer advisory councils, there's going to be training that is going to be offered, it is scheduled to occur on Monday, June 4th, this is, specifically for the southwest region but I think they, if you're willing to make the trip to Cr Apple ry, from here is four hours, they will be.

[cr anberry]

Scheduledded from 11 to 4, scheduled in the Cranberry public Franklin Street, 2525roches text r speed road. If anyone is inletted

in information I can make sure this gets tightly that, some additional fliers will be made available for anyone that is interested in participating in this as well. So just to be clear, registration deadline for that training is on Thursday, may 31st, 2018 and the lunch and refreshments will be provided. So, if you need more information including the address and this is something that you're interested in participating in, it is talk to me after the meeting we'll make sure we get you that information more directly. So -- okay.

So I'll jump into a quick update on a CHC launch.

Slide with the pie chart shows the current distribution by participant eligibility category.

No real change since the last time we presented this. The largest portion of the population are individuals with duly eligible for Medicare and Medicaid, not in need of long-term services and supports the dual population in the community and non-dual population totals to be 13 percent, the dual population in the facilities is also 13 percent and, the long-term care non-duals is about 1 percent. So 14 percent of people in nursing facilities, 13 percent of people in receiving long-term care in the community and then, remaining 73 percent, are individuals who are duly eligible not not in need of long term services and supports. The next slide, distribution between the managed care selections AmeriHealth Caritas, 19 percent, Pennsylvania health and with theness, 27 percent and UPMC, 54 percent the exactly the

same it was since, our last MLTSS which was at the beginning of May.

>> FRED HESS: It will change next month.

>> KEVIN HANCOCK: LAN interesting go to see what happens at the end of the continuity of care period, that's a good point Fred we are getting close to the end of the continuity care period in the southwest we're really not only paying attention to activities, that is associated with -- with our participants in the southwest but we're also gathering a lot of feedback from participants, on their experience at the end of the continuity of care period and we wanted to, we want to have a good understanding what they are most concerned about.

So, just as a matter of background, there was an unprecedented meeting last week in the Pittsburgh area, for it was a regional meeting for the consumer subcommittee medical assistance subcommittee, held in the Allegheny county assistance office in downtown Pittsburgh, it started with a, two hour morning listening session with participants, where a lot of participants told their stories talked about their experience with community HealthChoices also voiced their concerns and then the afternoon was, the formal consumer subcommittee it was a really great experience across the board we did learn a lot. A lot of the concerns were raised were concerns we were familiar with, the afternoon meeting a lot of discussion from the provider community, about their concerns which was not, most all the concern questions heard from the providers were concerns that had been articulated to us in different

ways, and hopefully, we were able to bridge the relationship, in communication between those providers and managed care organizations to have those questions answered but I have to really highlight, the really, important listening session we had in the morning that was really consumer focused, participant focused, where we did receive a lot of feedback interesting, information, information, that will help us to make sure we're framing the end of the continuity of care period, in the most plausible way it can be. It will help us to address some of the concerns that we heard. So we heard 3 themes, most specifically in the morning listening session the first is, a specifically about the continuity of care period is ending what will happen to service plans. So participants they expressed concerns participants and their caregivers expressed concerns about the end of the continuity of care period and then, what that will mean to the level of services they were receiving at the end there is a general assumption that is a perception of managed care, it was, very much perception about health choice ins the very beginning years, that services would be cut by the managed care organizations. So the reality is, that the -- there has been in service cuts, except for service cut that is had been relevant to individual specific issues. There has -- there's been no, just hasn't hammed at this point. But is it a completely understandable fear that the participants have, standardized approach by managed care organization, might lead to, service plan cuts. The reality is that, that there are differences in approaches that

are being implemented as part of person centered planning process for community HealthChoices and, our opportunity to alleviate those fears, is to make sure not only participants but also, the service coordinators whether they be internal, to the MCOs or subcontracted by the MCOs, really do understand the person centered planning process, to be able to articulate that, that person centered planning process builds out a service plan that is meant to reflect the participants needs and services. That fear is understandable although there's been no cuts to service plans but, it is something we have to make sure we're monitoring to make sure there's no standardized formatting of service plans, based upon participant need based upon the tolls that tools that the managed care organizations are using and the person managed process is a requirement in the community HealthChoices and to be very clear was a requirement, in our fee for service waivers is the approach that has taken when the service plans are developed.

>> FRED HESS: Itch something to read. This is another concern that has come through, person wrote me a letter to whom it may concern I have, few issues that need to -- first off I'm going on Medicare on July 1, I called my Medicare to ask them if I had to take the part B since I was already on MAWD.

I pay for that out of my pocket monthly I also told no, I don't have to take it.

So I called Social Security about asking the same question was told

by Social Security, that I had to have it. So, I had to get paper get it refilled out so I did I then called back Medicare and told them I was told, by Social Security, that I had to have it.

In the meantime, I called Lawrence County assistance office to talk to my case worker, well that was a joke.

I got a automated system and left a message as directed I looked on my papers, I file every six months for a name and a direct line, nothing . So, I called Medicare and told them I asked the same question about having, to have part B as well this woman told me yes, I did have to have it, okay.

So I got it corrected. Well I'm still waiting on a call from welfare office, been over a week going on two weeks, when I get a notice in the mail stating that I will be getting my prescriptions from united health care well, I do not want that I have UPMC and that is, what I want to stick to.

So I called Medicare once again, and I said I don't want united health care as a prescription plan, I paid for MAWD the woman said to me I don't know what MAWD is.

So I told her, and she goes well, you can't have UPMC, no more.

I said, what do you mean? She said you UPMC is no longer.

So then I say well that's a lie.

My husband has UPMC for life, she goes on and says I am telling you that you can't have it.

So I said, whatever hung up on her I called united health care and asked who determined me, to have united health care she said Medicare.

I said, I will, I said, well I have UPMC and I don't want to change.

She said okay, no problem.

We can cancel this out but I need to UPMC, so I did and I got more seeks out of my call, than run around Medicare and welfare don't call no one back the gentleman at UPMC was very nice helpful will be able to get, dual, get me dual eligible, just waiting for me to get employee Medicare part A and B which is in the process center.

What that is saying to me is, even though this is supposed to be putting together Medicare and Medicaid, it doesn't seem that there's enough people talking back and forth.

I myself, I have been paying for my Medicare, all right and I no longer work I have not worked since January and I'm still, paying for my Medicare which I should not be, Medicaid should be picking it up UPMC should be picking it up it's not happening.

For some reason, we're not getting communication between Medicare and Medicaid, this is a serious, serious issue for a lot of people.

This is not just the first letter I've had, this is, one of several that I've heard about this.

And it needs to be taken care of.

So I don't know how we'll do that, but, maybe the UPMC and everybody else, can answer this for us today.

How, do we get this taken care of?

>> KEVIN HANCOCK: I'll start by responding it sounds like there's some the problem is Medicare versus Medicaid eligibility, when you talk MAWD it relate toss Medicaid eligibility, it doesn't surprise the Medicaid folks are not familiar with the MAWD program, that being said, when they, call the county safety answer office, county assistance would be the -- the location where a lot of those questions could have been answered it's unfortunate they weren't able to reach someone directly I'm hoping they were able to reach someone. Happy to hear the positive feedback for UPMC customer service being able to answer those questions. Medicare part D question, whether they have to have it or not I think is, question we would have have to have Medicare answer for sure the point you're making is the point I agree with, the whole point of community health choice asks to look for opportunities for better coordination between Medicare and Medicaid. Even when it comes to the eligibility process which can be very confusing even if someone is enrolled in both programs is looking too make a change or have questions about the program they're looking to have a better understanding. So it's going to be, certainly easy for participant toss go to one place and have a lot of those questions answered although some cases, it is just, would in the be completely appropriate for Medicaid MCO or even us, the Department of Human Services to answer Medicare questions but we can certainly work with the participant to

make sure the questions get answer I had was not sure if, any of the MCOs I mean, Blair and ray you might be able to, provide some insight on this process the opportunities to coordinate between, Medicare products as well as Medicaid products.

>> SPEAKER: This individual is asking to remain anonymous ray and I can take back look what happened, what they were enrolled in, trying to figure out, what went wrong.

Just wanted to ask, were you saying Medicare, part D? Or B? B in boy or D in David is the question.

>> FRED HESS: I believe it was part B.

>> SPEAKER: What was interesting to me about that, unlike Medicare where someone doesn't make a choice they could be assigned to a plan, I'm not aware, of how someone could get a assigned to united health care without making that active choice for Medicare I don't know if there's any question or confusion any point of them being enrolled in united health care for Medicaid we also participant in HealthChoices just not, we're just not in the community HealthChoices so I think, able to look that the person's eligibility history and the both the State Medicaid system and when they were enrolled in united health care we could probably get some answers as to why this happened, and how to prevent that again.

I don't know if you can add --

>> FRED HESS: This is not, this is only one person, this is, happening,

all over the place.

>> SPEAKER: And, I -- you know, to I think to fill in some of the gaps as I understand the issue there, when someone is, um, becoming eligible for Medicare, and they're currently on Medicaid this person may have been you know on UPMC for you, our Medicaid HealthChoices plan, that transition, is, often times, difficult to predict so you don't know when that person, gets through sort of 24 months with Social Security and that, is typically what, triggers that.

But, that doesn't often mean that the person seamlessly is sort of moving into Medicare.

So that's what, really sounds like it happened here, there are I think to Blair's point around, Medicare part B, um, there is the Medicare savings program, which is a program administered by DHS that does provide for that premium assistance. And dual eligibles should be automatically or you know, enrolled in that, I think that's where you know we as MCOs need to be working with you and your case, participants like this and making sure that, people are accessing the benefits that, they qualify for.

>> KEVIN HANCOCK: As well as the county assistance office.

>> SPEAKER: Yeah, currently I don't know we have a data feed to sort of identify those individuals who are not in, that's something I think we'll be requesting.

>> FRED HESS: Something definitely we'll need.

>> SPEAKER: Secondly on part D, if a person does not you know, chose a Medicare advantage plan or a Medicare part D PDP on their own they will be auto assigned I think there's typically one or two plans per market I don't know if that's the case with united. Where, someone if they have not -- because, there's no alternative to Medicare part D. If you're, you're in. That's likely what happened the person was they did not make an active selection for the Medicare advantage plan or, part D PDP, so, Medicare automatically takes that step to make sure that they're not left high and dry without any drug coverage. So maintaining that united coverage is really important, until you know you do ultimately make a choice around your your Medicare part D, it's likely in that process behind the scenes that, she was automatically enrolled into the low income subsidiary program the cost sharing would not be, impacted so,.

>> FRED HESS: You know who I'm talking about right?

>> SPEAKER: I'm not sure I do. Fred fretted that's my wife that wrote that letter. And -- just this particular letter I received 15 or 20 different letters, very, very similar.

>> SPEAKER: I'm sorry to hear that. And it's --

>> FRED HESS: It's a real issue.

>> SPEAKER: Yeah.

>> FRED HESS: Costing people a lot of money, costing people like $135 a month they don't have.

>> SPEAKER: Paying the part D premiums ask not small we need to make sure people are getting the benefits they're qualified for.

>> FRED HESS: Uh-hum.

>> SPEAKER: We've seen in the community outreach workers in doing different service, at different community certainties things like that, seeing a lot of people who are paying for Medicare, plans, that they actually would qualify.

No cost plans helping people enroll in, find what they need to do I see a lot of similar things here too. Yeah. We can use, use this, specific example to try to understand for the larger, masses how we can, we can coordinate better on what, types of data and information are not being shared that, are allowable, to prevent that.

>> FRED HESS: We need to figure out some way where they can communicate this properly.

>> KEVIN HANCOCK: It might be an opportunity for the committee at some point in the future talking about the Medicare versus Medicaid eligibility process we would have people from our Medicaid side talking it through as well as maybe look for, Medicare subject matter experts from the community, like from the APRISE program to talk through, how this could be better coordinated what information I mean, Blair mentioned, identifying and ray had mentioned identifying participants who may need support before they actually, start having problems.

Through some sort of a data feed we can talk about opportunities

like that, in that type of a discussion and maybe, figure out a way to make it better for participants it's never Medicare versus Medicaid you have two different programs have to be some hand offs we can certainly do what we can make to better, that's what this program is designed to do.

>> FRED HESS: Exactly that's, exactly the reason that is why I brought this up because that's exactly what this program is supposed to do, is join Medicare and Medicaid we have to do it a lot easier than what we're doing now, neither one is knowing what the other one is doing.

>> SPEAKER: It's Tanya real quick I was wondering if this is an issue we should bring up in the Tuesday group meeting, too, to see if there's a way we can get the different avenues communicating better with each other?

>> KEVIN HANCOCK: Sure.

>> SPEAKER: If this is, this is a -- across the board problem I think, maybe something that Randy should take a look at and the different people who have been bringing the dual eligible cases to you already might want to take a look at it as well.

>> KEVIN HANCOCK: I have been more than happy to assign that to Randy Nolen.

[laughter]

>> FRED HESS: Poor Randy.

>> KEVIN HANCOCK:

>> SPEAKER: We have the DSNP community HealthChoices coordination meeting coming up on I think it's June 11th.

I don't know if the agenda is set or not we --

>> KEVIN HANCOCK: Oh yeah. Taking, taking some time away to talk about it, Tanya was still talking we're continuing the participant and participant advocacy calls every Tuesday, talking about the launch of community HealthChoices, where we have talked about particular cases and she is absolutely right that's a great venue to talk about specific cases like unfortunately your wife's Fred, we can get more specifics and use this as an example to improve the process.

>> FRED HESS: Yeah. It is definitely not just my wife it is, there's several, several people that this has been happening to, they're coming to me, asking me, how come I'm still paying this, how come I'm still paying this I'm dual, I shouldn't be paying it, it's not just one person it's several, many, many, people.

I'll give you that letter so you can share it, when you need to.

>> KEVIN HANCOCK: Thank you.

>> SPEAKER: Well that's what I'm saying I think it would be a good issue to discuss on Tuesday, if Fred, if you can share the documentation with Kevin or Randy, so, like, everyone can get, a look at what a letter a looks like and we can sit down and iron out what some of the confusion is, to try to, um, quickly correct the problem.

>> FRED HESS: Tanya I gave him that letter, he is going to have

that and use that as an example.

>> KEVIN HANCOCK: Thank you both.

>> BARBARA POLZER: Kathy texted to remind us APRISE can help.

>> KEVIN HANCOCK: If we ever did a presentation for the Medicare versus Medicaid eligibility process we want the APRISE program to be here we encourage individual cases to reach out to APRISE counselors they are amazing in how they're able to navigate the system they truly are. So,.

>> SPEAKER: Kevin just a question.

You mentioned that the department will be monitoring, reductions in care plans can you talk a little bit more about what the department will be doing are there any particular thresholds reporting requirements so forth.

>> KEVIN HANCOCK: Thank you Steve for the question we're going to be receiving, actually, they some of the reports have started we're going to be receiving reports, in the middle of June, that are going to begin to demonstrate, service levels, that include plan increases and decreases, as well as, service denials and, and -- just a general picture of the plan, we will be looking for patterns number one.

We'll also be looking on an individual basis, particular cases that show, reductions or cuts but we will also be looking for patterns one of the concerns that we heard pretty consistently, last week and pretty consistently across the board is that, participant also concerned are

they're going to have a standard number of hours they will they have how they're scored through an assessment process which is not either, it is certainly not the design of the prom, it's meant to be person centered if we do see a pattern.

[program]

Standardization when it comes to service hours when people are responding to questions that's something going to be beared out in the reports we'll be looking at, individual complaints and grievances and look at individual plans, to make sure that, the participants are getting what they need.

And we're also looking for every opportunity for people to, provide us feedback if they're hearing or, they receive some sort of a response either from the managed care organizations or from service coordinators that may not know or, need more training on the person centered planning process.

If they're hearing something that reflects sort a standard that is not person centered doesn't reflect a person's needs and preferences.

So, hopefully that answers your question.

Thank you. So the second major feedback which is very related to the first, is a clear lack of training that was identified by service coordinators in the person centered planning process. As I mentioned earlier, this is, particularly concerning because there really isn't that much of a difference between what we required in community

HealthChoices and what was required in the home and community based waivers when it came to person centered planning.

This, has been, in place with our waivers for a really long time.

What could be new, and, we're looking for opportunities to talk, to the managed care organizations and service coordinators, it could be the tool that's are being used. So, it could be, I was spiking with someone this morning who characterized it as a potential lack of comfort with the tool that's may require a little bit more training and discussion on how they're being actually implemented, with participants.

But, the process, must be person centered that is a requirement in community HealthChoices what we mean by person centered that the individuals needs and preferences, have to be captured, recognized and then translated into what is an appropriate service plan reflecting that participant, that who that participant is, and, what their goals are and,

what, what -- what they need to be able to support those goals it is, that's straight forward. It has always been in place and the -- there should be, fairly easy transition except for the use of new information, in dealing with different participants compared to what was in the fee for service waivers what is existing in the managed care program.

So that's an area we'll continue to focus on and we've talked with managed care organizations about this and all 3 of the managed care organizations have agreed to, augment the communication and training with service coordinators that is internal service coordinators and

subcontracted as much as coordinators what a person centered planning process is supposed to be.

Then the third theme we heard which is no surprise we've already talked about this at length in the subcommittee are challenges related to transportation.

Starting with access to nonmedical transportation and nonemergency medical transportation.

And, how that is being coordinated by the CHC MCOs as well the MATP program, know surprise we know it's, an area where we have a lot of work we still have to do.

Also, they were also, very comfortable with working with service coordinators in coordinating that transportation service coordinators will still be part of in the coordination for transportation for participants. And we'll look for it, why it doesn't seem to be working translating as well, to community HealthChoices service coordinators are still very much part of transportation coordination, as a service plan.

What could be new, here, are -- participants who may not had access to nonmedical transportation. In the past.

It has been added to all of the people who are receiving home and community based waivers and, that could be an opportunity to make sure that, participants understand how the benefit is supposed to work.

The third is, the use of the brokers that, all 3 of the MCOs are

using, two of the MCOs are using one broker and, the third MCO is using a different broker and the brokers coordination may also be a bit of a continued problem. Mostly because it may, A not -- might be a learning opportunity for the broker to understand the landscape of transportation and given regions I think the MCOs have done a pretty good job of identifying those issues working with the brokers to address them. And, also to make sure that, that people understand the benefits they have, with nonemergency medicals for the MATP program and and nonmedical transportation available through CHC and the coordination for both.

Transportation is as I have said before, is complicated certainly in the community. It is very complicated we're hoping it is getting better we know there's a lot of work yet to do. And people in the prior model have been used to flexibility we're looking to make sure that the flexibility is still preserved while people are being to access the benefits. That's the feedback, additional feedback we've received, we talked about communication challenges.

With the CHC MC Os that's with participants in the program, provider feedback, they continue to cite some specific challenges with communication with the MCOs we don't hear that as much at this point with the nursing facility side we have received pretty positive feedback with the feedback and the relationship they have been able too develop with managed care organizations while the transportation is a

challenge in the nursing facility side as well we already talked about nonmedical transportation and billing and, reserva referrals continue to be a problem. HHA exchange, still specific cases may not be in the system, lingering data, and integrity issue we've been talking about for months. Most of those issues have been cleaned up, but there are one or two cases that still remain that may be inhibiting providers for being able to bill for particular services also the administrative costs are a focus for providers that are talking about doing things a different way. And, the independent enrollment broker that process for enrollment continues to be a challenge that we are continuously trying to work through to improve.

So as a quick update for the southwest continuity of care, we have already talked about there and really is not a lot change to, what in service coordination starting with UPMC, they will be offering, they already tougher are offered contracts to the external service coordinators and evaluating all of the service coordinators we have not received any notification with any termination with service coordinator in the southwest. Pennsylvania health wellness, has offered, long term contract for external service coordinators and once again, they are not terminating any of their contracts so there's been no change since the beginning of play as well. With AmeriHealth Caritas there's a change.

They are developing long term contracts with five service

coordination entities they have made thization not to terminate any of the contracts with other service coordinators take a longer evaluation period as well with these agencies. So at this point, the news for service coordination and continuity of care is the department is not received any notification of any terminations at this point it will be a longer evaluation process.

For home and community based providers after the continuity of care period we have not been notified of my terminations that includes both in network out of network providers this point, we're not foreseeing any changes in the network after the continuity of care period is over.

That does not mean that will not happen in the future.

And we expect that as, the managed care organizations get to know their provider networks better, they will refine them. And, that's, something to be honest that's managed care that's something we support.

But we're very happy to see that they're taking a very thoughtful process across the board.

So then, what can participants expect at the end of the continuity of care period, first, and foremost, a comprehensive needs assessment that's a requirement that would occur within the first six months of the program and, that is something that is ongoing with the managed care organizations and participants right now.

The comprehensive needs assessment is the first step in the person centered planning process the frames out the requirements of the service

plan, once the managed care organizations take it over at the end of the continuity of care period. They have not only the, the expectation but also the right for a person centered service planning process.

And, we have already discussed where there might be some opportunity for additional training on what that process is supposed to be.

And then also we're person centered service plan reflects a lot of changes one of the changes is that, in community HealthChoices participants have access in many cases to more benefits they may into the have been able to access in the past and, that might be something that could be augmented in the revised person centered service plan.

>> SPEAKER: This is Brenda Dare I have a question really quick if -- go back a slide.

Talking about PA health and wellness and service coordination couple slides maybe.

You said they have offered contracts to four service coordination entities but they're not terminating contracts with any other external coordination.

>> KEVIN HANCOCK: That's correct.

>> SPEAKER: Does that mean the contracts naturally expire at the end of the continuity of care if you're not one of those four or in contract negotiations with all of the service providers.

>> KEVIN HANCOCK: I would characterize as contract negotiating another way I would characterize it, Brenda is, evaluation.

>> SPEAKER: Okay.

Thank you.

>> KEVIN HANCOCK: Sure. Thank you.

Brenda was one of our active participants in the consumer sub-MAAC and listen session we appreciate her comments.

Okay.

So then, the last slide, shows, we presented this to the consumer sub-MAAC as well this demonstrates where we're at when it comes to changes in the service plans reflects Steve's earlier question, at this point we have seen very little changes to service plans just using one example, for January Pennsylvania health wellness, did have changes to 2.5 percent of their service plans. And we think this reflected, panel miscommunication about particular benefits we believe this is an anomaly, across the board we have very little variation in any service plan, in fact less than 1 percent of any types of changes. This could have been up or down.

Across the board we have had very little changes across the board as you can see with Pennsylvania health wellness they were at .1 percent in February, very lone changes at this point which is absolutely appropriate for a continuity of care period that mandates that the service plan has to stay in place.

Obviously we'll continue to present this type of data at the end of the continuity of care period. So, so July, probably will not be that

much different but August might, we might see some changes as well. We'll look forward to your questions at that point.

Okay.

So, moving onto communications, just some quick updates.

So we're moving now into in addition to end of the continuity of care period for the southwest we're moving into our launch for the launch related activities for the southeast.

The first focus, is managed care organizations building out a robust network of providers that will be available for participants, to be able to receive their services in the southeast.

And the first step in that process is the provider sessions similar to what we held in the southwest in the southeast we're going to be, we're going to be using more providers, provider sessions than we did in the, southwest simply because there are more providers and also more participants so, the first week of June we'll be in the Philadelphia area, we'll have five sessions at Temple University to be able to provide an overview of the community health choice those a large group of providers and then we'll have five break out sessions for service coordinators, for behavioral health providers, for physical health providers such as hospitals and primary care physicians for home and community based providers and, I also forget the fifth one -- nursing facilities I'm looking at Judy Patrick I say nursing home providers

southwest we'll have break out sessions roughly 2.5 hours those

sessions will focus on presenting the requirements of CHC and then answering any of the particular questions we may have.

So, they may have and just, review, now, with the southwest we have an opportunity to review lessons learned with the southwest and, that's part of, the discussion we'll have the providers as well . After, the Philadelphia sessions the third week of June we'll hold individual sessions in each of the four suburban county bucks Montgomery and dell and Chester they have the same sessions and the same community to answer the questions.

[delaware]

Update all the online training including nursing home facilities and we'll develop a participant training for community HealthChoices in the near future. For the southeast participants as I mentioned we'll developing online training the initial touch flier will be mailed to participants in the middle of July, which is a little less than a month earlier than we did last year in the southwest.

Then the pre-transition notices will be going out at the end of the August, followed by enrollment packets will be made throughout the Mr. of September, everything in the southeast is earlier and that's a lesson learned.

It's also, an opportunity we have, in the southeast because of the fact that all of the other components of the program are in place the southeast, does have an advantage that way not only are they going to be

able to, to build on lessons learned from the southwest but, also, more time focused on building out networks and communication since the infrastructure of the program is largely in place. Except for the building out of the network.

We're also going to be holding at least 60 participant sessions held throughout the end of August through October. And answering questions to participant regardless of their eligibility levels what the Pam and the change means to them and also to answer their questions about what they need to do, to select their own managed care organizations.

So a lot of communication is going to be focused on providers and participants over the next several months, starting with the provider and with the participants, with the heavy focus, in the August September and October time frame.

So -- that's the southeast.

>> BARBARA POLZER: For all of these communications that are going out to participants, can we ensure that service coordination entities get this information prior to being mailed to the participants? Because service coordinators are typically the people that the consumer reaches out to.

>> KEVIN HANCOCK: Absolutely we'll make sure they have access to all of the information, whether that's the -- whether they're internal service coordinators with the managed care organizations or the, the --

subcontracted external service coordinators we'll make sure everyone gets that information we'll -- usually use the Listserv to be able to communicate that information, that's what you can expect to see.

>> BARBARA POLZER: Okay.

Thank you.

>> KEVIN HANCOCK: Okay.

>> PAM AUER: Hello Kevin.

My question goes back the southwest, when you were talking about the types of the assessments who is doing them.

Is there something plain speak out for consumers to know, the first assessment is that going to be done by Office of Aging? And then, the -- the person centered planning is that the MCO and the service planning is -- the MCO -- because I'm already hearing people saying, well, my service coordinator told me someone is going to schedule with me I'm confused I don't know who this is. The service coordinator implements it, is there something out there, can that go out in advance to say if you don't understand this, you want to go to these meetings.

>> KEVIN HANCOCK: One of the public documentses that's been published

Harry published the document that has information about community health choices, I think Kathy to speak to about how much it speaks to the different levels of assessment they do talk about very least the person centered planning requirements.

In the community health choices proper, I think it's a very good

suggestion, sometimes people do confuse the, the assessment needed to develop a service plan with the initial eligibility assessment.

There is a overlap now, between that assessment, the initial eligibility assessment that is going to be conducted by aging well and, the tool used by the managed care organizations through the comprehensive needs assessment process. So that's a really good suggestion.

>> FRED HESS: Pam can you come up to a microphone please. We can't hear you the people on the phone cannot hear you.

>> PAM AUER: That the is that carry out of Philadelphia or someone named carry.

>> KEVIN HANCOCK: Carry out of Philadelphia.

>> PAM AUER: May still be good to get it to people in western PA in advance whatever you call it, the turn over, in July 1st hain think Carrie was hoping the information would be statewide, that's something that would be --

>> PAM AUER: Can we see -- can we see that in advance, some of us? We might be --

>> FRED HESS: I can't hear you.

>> PAM AUER: Can we see it to see it is, people speak and cognitivetively accessible.

>> PAM AUER: ImI'm not saying Carrie doesn't do a good job, I'm sure she do.

>> KEVIN HANCOCK: I'll pass the request on, that's a good point to have some a one page document could be available to participants.

Just bullets so, we'll -- we'll take a that back as a suggestion.

>> PAM AUER: When you first came out with the IEB, one of the best things was the boom, boom, boom these are the steps this is what you'll have, after this one, this one, this one. And, people can kind of check it off they know, who is coming to their door, because, hearing they're getting these calls and they have no new, who is supposed to be coming to their door, there is not really a lot of, um, negotiatetion, about the times, and, when they can expect who they can expect that kind of thing.

>> KEVIN HANCOCK: That's a great suggestion we have some I think in a piecemeal way, focus on assessments we don't have that on a one bathe, that's a great suggestion.

So I have another question that was sent via text.

Question is, what is being done, by OLTL about the independent enrollment broker the lack of referral to the LIFE programs we've had, as a matter of backgrounds there was an expectation that, LIFE, which is the other managed lock term services and supports program offered by the Commonwealth is the, enrollment to community HealthChoices there was an expectation we talked about this previously, there would be an increase in enrollment with the LIFE program in the southwest with

the, implementation of community HealthChoices.

That did not happen we've been looking for opportunities to make sure A we're getting the word out about levites LIFE it's a great program we want to make sure people know it's an option, that meets their needs and also, that we're making sure that people have enough complete information to be able to make ash informed decision one of resources is the independent enrollment broker through the enrollment process we've taken steps multiple steps to be able to improve

opportunities, for participants, who call through the independent enrollment broker to learn about the LIFE program the first was we asked LIFE plans as well as the association too review scripts and provide suggestions for how LIFE information could be augmented, also to to -- develop a training module which is in process of being developed right now.

To, to make sure that, participants, who -- who call the independent enrollment broker have the commute view what LIFE has a view in terms of community HealthChoices two steps taken with the independent enrollment broker in addition to that we're looking to do a mailer in the near term to participant who is are eligible for community HealthChoices, and also, eligible for the LIFE program meaning LIFE

has a requirement you have to be 55 and over, also, nursing facility clinical eligible tore that population to receive the option of the LIFE could be available to them, so they could potentially enroll in the LIFE

program if they want to make a change from the community health closes we're expecting that mailing willing be going out in the middle of June and, the focus there, is make sure that the participants know all pants of all choices available to them and know what a great program the LIFE program is.

>> SPEAKER: This is Brenda Dare.

I have a question, in regards to LIFE I heard this each time save seen a LIFE program presentation this has come up with several people I know.

Who are participants in the LIFE program who interested in transitioning out of it, into community health choices.

And, they're not clear on the transition process and a whether a gap is is going to occur, every time I've mentioned it I've heard from LIFE program staff they're working on clarifying the transition process.

Can you give me an update on that, at all?

>> KEVIN HANCOCK: So there shouldn't be, we would want to do anything we could, Brenda, to remove a risk for a gap in services between transitioning from community HealthChoices to the LIFE program there's a process that has to occur, that a transfer process that has to occur between the mandatory managed care program and the LIFE program, moving from involuntary to voluntary enrolements.

But, it should be addressed, where it could occur is, at the point of transitioning from one eligibility -- eligibility level to another

level.

And it is it is, process.

Really doesn't have to do, from what I understand with the actual eligibility.

So, we are working through to be able to minimize the risk.

I cannot give you have a specific update on the process at this point.

But, at this point we're -- we are looking for ways to make sure that, that any panel gap in services between, community HealthChoices and the LIFE program is eliminated. Ask that question again. I'm sorry.

>> SPEAKER: I just wanted to add, the policy group we're working on an OPS menu that clarifies that process.

>> KEVIN HANCOCK: There's a -- internal Department of Human Services policy group that is providing a clarifying memo Brenda it's forthcoming.

Some time, over the early summer does that make sense. Some time, it will be published that will address a lot of the concern that's have been raised about the potential eligibility gap.

>> SPEAKER: Could you please make sure the committee gets a copy of that.

>> KEVIN HANCOCK: Absolutely.

>> SPEAKER: Thank you.

>> KEVIN HANCOCK: Thank you.

>> BARBARA POLZER: We have a text from Kathy Cubid she would take an email from anyone that wants to the CARII document, email Ku bcubit@carie.org she is going to send the living to the document for us to include in our meeting transcripts.

>> KEVIN HANCOCK: Just as a reminder we have a lot information about community HealthChoices also available on our web sites to Pam's earlier points it will be great to talk about the assessment process in one place we'll look for an opportunity to be able to do that but, we have a lot of information, on our web site as well. May answer a lot of the questions people may have, what community HealthChoices means for them, whether they're a provider or a participant as well. Okay.

So I'm -- someone starting to give me the hook off here just a to close down very quickly.

Ongoing communications, we'll continue to have the monthly MLTSS sub-MAAC no one in June the provider meetings the next one is in early July. Consumer sub-MAAC continues to be a focus heavily on community HealthChoices.

We look for the opportunity to be able to, to present again in late June about the end of the continuity of care period. LTSS sub-MAAC provides update on community HealthChoices as well as other fee for service activity it is a good location to be able to talk about ongoing operations for long-term services and supports as well.

The MAAC would be providing updates on community HealthChoices thank up, Fred for providing the update for the MLTSS sub-MAAC continue to have the third Thursday webinars indefinitely as well as the advisory committees local advisory groups and providing information on the CHC web site and if you, look at other resources, you can see the CHC MCO contact information the highlight for AmeriHealth Caritas/keystone first.

Just to be to remind folks, AmeriHealth Caritas in the southeast will be called keystone first same program not changing it is just branding in the southeast and, hopefully we'll, do all we can to alleviate any confusion there and as well as contact information from Pennsylvania health wellness and UPMC community HealthChoices the last slide you can see, our ongoing resource information Heather Hallman would be angry if I did not continue to plug signing up for the Listserv, please, sign up for our Listserv if you're not signed up please sign up for it a lot of the information that, we talk about, today, can be found through information we're communicating to providers and participants so please an effort to sign up or as well as go the community HealthChoices web site we have a ton of information out there including a lot of, frequently asked questions and a lot of not so frequently asked questions with answers.

And, that -- we now have them in a searchable document that, may answer a lot of the questions or concerns you may have.

We also have a lot of information with the, MTLSS subcommittee web site including transcripts for each of these sessions the -- you can continue to email questions or comments to the RA mailbox and/or, call or providers participant line with any of your questions as well.

And the independent enrollment broker is also available with their 800 number and their web site, to be able to answer any questions specific to the benefit packages offered by the, CHC MCOs with that, yes.

>> SPEAKER: One quick question when is the meeting in July?

It's not July 4th I hope?

>> FRED HESS: No I would hope not.

>> KEVIN HANCOCK: July 6th.

>> FRED HESS: Ginny, can you come up, you have all of, less than one minute to finish everything.

>> GINNY ROGERS: Great.

>> KEVIN HANCOCK: I think she will need to have more than a minute.

Before she gets up we continue to receive questions about how nursing home transition is going to be working in community HealthChoices. And we're using this as an opportunity to you continue to talk about it and also to articulate it is a little more of a work in progress we look for opportunities to be able to, to -- to adapt suggestions to be able to make sure I'm going it turn it over to Ginny Rogers.

>> GINNY ROGERS: Good morning.

Very glad to be here to talk about nursing home transition it is,

something that is very important to many of us I know, as -- um, especially as advocates, many of you, here in the audience are also want to make sure that nursing home tr continue successful as possible. So I wanted to give you background and move into what we're currently doing with nursing home transition. Basically this, nursing home transition say long standing program for the department.

We have assisted, successfully transitioning thousands of folks nursing facility residents to transition to the community, basically how it works nursing home transition providers, will assist, residents who say they want to live the facility, to address any barriers that they might have, barriers, will van I depending upon the person, sometimes, it may be, something such as, a housing barrier if someone doesn't have housing to go back to, um, that might, involve some kind of housing applications or housing searches, it can be a significant barrier for some pim.

It could be things such as obtaining you important paperwork maybe birth certificates or other paperwork that is necessary.

And also, identifying, what are the community supports that person is going need whenever they leave the facility.

How or what will they need to be successful as they, they live in the community? So, the nursing home transition providers, will work with that person to identify, all of those issue areas then develop a plan to help them transition so in the last year and a half or so OLTL

has made some changes to the program, much of this was based on feedback that we received via surveys in other forums where our providers would often talk about some people wanted to get in on the game they wanted to essentially be able to transition folks out of nursing facilities at the time we had a more I would say limited in terms of providers we had essentially over 60 percent provider and under 60 provider per county or area.

And now, um, we have more providers available per county, so that, part of this was, how can we potentially effect more folks out there in facilities may want to transition maybe if we expand thed provider base we would have more opportunity to do that. The other thing is we had also, worked on the rate, for people that were providing nursing home transition and we were able to bring the rate, up to a service coordination rate for the units of services that were provided so that is, two of the changes that we made also I wanted to talk about within the Department of Human Services there is an over all focus and goal of serving more people in the community this goal is across the department and is something that we have been asked across the board as OLTL as well as the other program offices to kind of see what are the things that we need to do, to help people one identify the people want to live in the community and then, what are the supports and how to do we help them to be able to be successful in the community as possible.

So, um, with this goal, we're looking at it from all kinds of

perspectives and certainly there program nursing home transition is one part of the how OLTL will potentially be able to serve more people in the community okay.

So in our discussions with the, as we transition to community HealthChoices sorry I can move on. In our decisions with the community HealthChoices MCOs, they have identified how they will work with people in facilities and, some of that, obviously begins with identifying first of all the people that want to leave the facility, and then by MCO, basically, referring them to either service coordinator that is working within the facility, or depending upon how it is set up this can vary by MCO they may refer them to, a nursing home transition agency or subcontracting with an agency. So that, that will vary. So similar to what I explained before, either that service coordinator or the, transition coordinator, the assist in a person to identify barriers and to address those barriers in order to be able to have a transition date basically, just again remind people as we did in the southwest implementation we're always going to have people who are in process, who are in facilities who want to leave and who are currently working with transition coordinators because of that, we want to make sure that folks will be able to continue working with their identified transition coordinator through this continuity of care period so we're going to continue to do that as we get closer to the implementation daylight ofismmentation in January we'll be reaching

out to the nursing home transition providers making sure that we have information about the people that they're working with, kind of where they are, in the process.

Because we want to make sure that the information we're providing to the MCOs, is appropriate, that they have as much information so they can just continue to work with that providers.

The other provider is, we are saying it is very important to work for those nursing home transition providers to work closely with the MC Os, the CHC MCOs we are encouraging those providers to reach out to and work with the MCOs. Make, establish a relationship if that has not already happened.

So, in this slide, basically, the providers are required to contact them, to contract with as providers in order to be able to bill for services.

So any services that, that provider provides, following January 1, January 1st onward, will be paid by the MCOs through the contracting process that you work out with the each MCO, OLTL will no longer be paying for any transition services after, 1/1 for anyone who served by a CHC MCO.

Okay.

So, some -- you have a question?

>> SPEAKER: Yes.

>> AUDIENCE MEMBER: This is Zach Lewis from disabled in action, I'm confused about as far as continuity of care and my experiences, with trying to transition people out of nursing homes.

The bottom dollar for nursing homes is to keep the consumers there, that's how they make their money.

So, why would we they want do all of the sudden give up their golden goose hand over the paperwork?

paperwork?

>> GINNY ROGERS: We've been working with the nursing facilities over the years they recognize when someone wants to leave we have support of nursing facilities to work with those individuals to move forward.

And I know that, people probably have different stories that they can tell but, I think that's been part of,

experience over the years is developing relationships with the nursing facilities, the folks that work at the nursing facilityities and the social workers administrative teams to be familiar with the program, and -- to recognize that transitions happen every day. There are people that, that go into the facility and leave, because they're only there for a short while and they're able to receive the services that they need and they go back out.

But in addition, there are people who, based on whatever their barrier is, they may need additional support that's kind of

what we're talking about, there's -- there's a continuum in terms of need and what people need to be able to leave.

So, um, if there are we can talk more about more about potential barriers to working with nursing facilities.

But we can, help you with that.

If you need help.

Does that answer your question?

>> AUDIENCE MEMBER: No. Not necessarily.

>> KEVIN HANCOCK: Hi Zach can I just add, to what Ginny said, I mean nursing facilities have -- they're much more open to transition than they have been in the past, there's some exceptions but no question about that, but, one of the -- they have, they're changing they have been changing their business model for a long time where they focus on, short term rehab a lot of nursing facilities are recognizing the reality to people want to age in place and stay in their own homes or, be able to transition back and receive long-term care in the community as well.

In many cases I think that, it's been, the experience of the department nursing facilities have certainly evolved but they have become partners in the nursing home transition process.

So if you -- I know you might have a different experience we would love to hear more about it, but, we've had some pretty good partnerships with nursing home facilities and the facilitation of the nursing home transition. It's been our literal experience.

So --

>> FRED HESS: I will say this, I actually know one person that was in a nursing home and I see what you're saying Zach because, they told him, you can't leave, we own you.

His wife actually backed up a pick up truck through his property into it, had kidnap him out so yes they actually said we own you, you can't leave.

Is that what you're getting at is that still happening.

>> AUDIENCE MEMBER: Still happening.

It's still happening.

>> FRED HESS: Uh-hum.

>> SPEAKER: This is Brenda Dare I have a question as well.

What about for individuals who will not be CHC eligible once they move into the community are there still funds available to assist those people with addressing transition barriers.

>> GINNY ROGERS: Hi Brenda, yes there are for folk that's are not, in community HealthChoices are not, CHC eligible the NHT program will still work for those folks to assist them in transition.

Yes.

>> SPEAKER: Okay.

>> FRED HESS: Pam you have a question.

>> PAM AUER: I have a complement and question.

In some aspects Ginny there's a right, that some of the nursing.

>> FRED HESS: Can't hear you.

>> PAM AUER: Some aspects Gi for example ny and, Kevin are right, some of the nursing homes, are working to get people out that's not you know, necessarily, the -- the across the board colon thing I would want to know is, during the nursing home transition, what will the CHC are the MCOs do, when you get because we still regularly, have to educate and educate, and pull nursing home staff along. Literally pull them along, to get that person out.

Will the MCOs go that extra mile or, um, are they you know, is that, where they're going to work with us, how is that going to happen.

What is going to be the assurances to help people out I have another question, about NHT, but -- I'll let you answer that one.

>> GINNY ROGERS: I can answer that, um, I think that it, I think that some of this is going to continue where some people are going to be difficult to transition and there may be, reasons either through folks that are just, I don't want to say negligence I want to say that may not necessarily want to help the process. They're not necessarily standing in the way. But maybe not, helping it.

Sightly it's going to be across the board where we're going to continue to work with the MCOs, we'll develop operational reports so that they can work with us, in terms of, reporting details of transitions that they do, that they have not received that information yet.

So, that's still in process.

I think also from hearing back from people like you, who are out there doing the work of nursing home transition hopefully working with the MCOs to identify, what the issues are and as exactly as Zach had talked about if there are facilities where it's extremely difficult and you know there are people there who want to leave that's something I think we can also try to get involved with and work on across the board.

So we're, we are going to continue within the department, to have nursing home transition that is a goal and, work really hard to make sure that we're addressing those issues.

So, so -- more to come.

And, so air you were I guess I'm going to wait until after you -- your -- unless you're done with your presentation I would like to know numbers if you're going to have that in there, and another question on the way, someone asking me to ask, is, um, working on housing what are the -- are the MC Os are doing towards the housing issue? You know, if we're getting, from an MCO, a benchmark of the 85-95 percent of people out within a year sounds like they might are not have the same idea of what housing is like to get people out.

But then, you know, you know the -- how are they working also on, home mods for NHT that is one of our biggest issues you know, what are they doing to get people out with home mods are they going to let people, get the mod done before they come out? Sorry. Because that's kind of an issue right now happening people are going to have what they need

before they get, hopefully I'm asking can what they're asking. Those are questions that, we need to know.

>> GINNY ROGERS: Okay.

Okay I'm going to cover that in the presentation.

>> SPEAKER: I have one question in terms of the nursing home transition people you know, people who have, experienced, moderate to severe brain injury, there's been a trend that hospitals and, even well, trauma centers and acute hospitals, have started to send those people more to nursing homes than to rehabilitation hospitals. So, they end up, and the reason for that is, that their perceived as not being able to benefit from the acute rehabilitation that, needs to occur and rehab hospital where you have to be able to participate in 3 hours of intensive therapy per day. So, if someone doesn't sort of meet that criteria, they're sent to a, a nursing home. And, often times, they're not able to initiate a request for you know, or to express their desire they want to get out, of the nursing home unless they have a advocate who then maybe calls the brain injury association or another advocate.

So I guess I'm wondering specifically about those kinds of people and whether the nursing home transition that now as I hear you describe it, is going to be embedded in the MCOs.

Is it going to be, the same contractors or is it going to be the MCO

people, and how might they, specifically, look for these kinds of people who, who may benefit from transitioning out.

>> GINNY ROGERS: It will be embedded with the MC Os my nursing is the MCOs themselves have decided to use a variety both service coordinators within their own, within the MCOs and also potentially subcontracting with the existing providers I think that, is actually a very positive way to go because we have a lot of providers who have, a great deal of skill doing transitions. Especially, addressing, a lot of the barriers that you've heard some of the, some folks talk about today.

I would like to suggest we're not going to be able to solve the entire conversation today. But, I think, one of the things that I appreciate, was we did each of the MCOs talk with us, specifically about their process, for nursing home transition.

I found it extremely helpful to do that.

I would suggest having them come back and maybe at a future meeting just doing a a discussion of how you're going to do nursing home transition, how you're going to address harder to serve people, and, what that looks like for your MCO I'm seeing some heads shaking. So I'm happy to hear that you'll be interested in doing that. Because, um, when I heard it I thought it was very valuable it made me feel better about the fact that, in fact the MCOs will be responsive in terms of, picking identifying, people and helping to address what those

barriers are.

And actually really wanting people to be served in the community as much as possible.

>> SPEAKER: That's a good idea to have them specifically address people who may not be able to speak out for themselves, that is also an opportunity I think, for education and training within the MCOs which the brain injury association has offered to all 3 MCOs we could address that specifically with them.

>> GINNY ROGERS: I think that's probably needed yes.

Absolutely. So, um, I know there's a lot of questions, there's -- um, one more slide -- one more slide.

>> FRED HESS: Go ahead finish your slide before we take anymore questions.

>> GINNY ROGERS: My answer your question.

>> FRED HESS: Might answer your question.

>> GINNY ROGERS: So, um, CHC update so what we're doing right now is there has been a long standing problem at times of eligibility in terms of ensuring that people know that they're eligible for home and community based services before they leave the nursing facility in our current program, that is established, like as people go through the eligibility process, that's determined after where they leave the facility in most of the time.

We have been working OLTL staff and, the office of income

maintenance, and office of medical assistance program to essentially identify a long term solution to that problem. So that, we will know, prior to that person actually discharging, what their eligibility is and to close those gaps, so that upon day of discharge if someone has, um, needs for the waiver services, that those are actually in place on day of discharge and, um, providers are able to bill. So, um, this is a, a -- significant can be a barrier, I think to our success in terms of, um, this gap in eligibility, because, it may mean, well what is happening today we're hearing sometimes people are leaving without the supports that they need in place. Because of the eligibility gap.

So, we are, have been having targeted meetings to address it and, um,

I just wanted to make sure you knew that, we're going to keep you up on dated on exactly what it is, that we come up with, to address that problem.

So, um, I can keep talking why don't we take more questions.

>> AUDIENCE MEMBER: You were talking about the communication being good between the agent and the other programs.

But, essentially they aren't because a lot of consumers, are not finding out until their family is ready to pull them out they don't know where to find these resources.

I'm running up and down the streets, and people are asking me how can I do this? And, another -- other people, in the nursing homes, I'm seeing them on the street getting food, they sneak out of the

nursing home, so they can come get food in the line because they can't, do it in the nursing home.

They can only eat what they're given and most of the time it looks like slop.

So, when I tell them about the transition program, and I initially, pull over and, talk to them on the phone. Get that process started you're saying that everybody is coming together to work on this.

But many consumers are not reaching it.

Many family members are not reaching it.

Once your family member thinks you're good in the hospital, and, everything is fine and you're working on doing this, it is up to the HMOs and the CSB or any other program to choose whether you're going to be, chose, to be pulled out of the nursing home.

You're not getting a say in the platter until someone helps pulls you by your hand to get out.

And I'm doing this on the streets.

Flurry go.

I just had a young man 24 years old, put in a so called rehab as you guys are putting it, which is actually a nursing home.

After about 6 months to a year in a nursing home they loose the house. So they become homeless, where do they go are go to next?

We all know it's limited housing for accessibility.

And everybody is saying they're helping each other. But the only

one that is being really affected is the consumer themselves.

>> GINNY ROGERS: Right.

>> AUDIENCE MEMBER: I've had 3 people in the last week, ask me about transitioning out of nursing home. Family members, a person, and another family member. You're telling me this is being educated inside the nursing home.

>> GINNY ROGERS: One of the things we have is, so -- as an advocate you're being contacted by people which is great. So, um, currently the nursing facilities and nursing facility social workers are one way that someone can talk to the nursing --

>> AUDIENCE MEMBER: Nursing home picks who they want to help. It doesn't necessarily, it's not necessarily that person that wants help.

But there are many people in that line they pick a certain person each time.

>> GINNY ROGERS: There's not --

>> AUDIENCE MEMBER: It's not just a certain group.

>> GINNY ROGERS: Just to address that, there's a secondary area for whatever reason, a social worker is unable to assist the person and choosing a provider, we do have an 800 number through OLTL you can contact, if for example, you Michelle, could contact that number, in --

>> AUDIENCE MEMBER: If they don't have a cell phone? Or no way to -- to call out. Because many nursing homes don't have it.

Only way a consumer gets cell phone, is if a family member, or they sneak one in and nine times out of ten it gets stolen being used by another consumer.

>> GINNY ROGERS: I think there's still remains a role for people who are in the community, who are interested in continuing this line of work.

So, um, in terms of helping people to transition from the community.

So, I don't think it, it negates the need for advocacy. Especially, if you're already working in the facilities.

>> AUDIENCE MEMBER: I'm not doing it to get paid. I'm doing it because -- I am one of those people.

>> GINNY ROGERS: I understand. Right.

>> AUDIENCE MEMBER: My flame is Karen.

[name]

To piggy back on what Michelle was saying I know for a fact, that -- um, a year or two ago, a friend of mine took another person, was in our own nursing home -- nursing homes in Philadelphia I had to help her she was asking me and do we flowed permission to go -- where are you?

Were you in one, how do you travel, do we flowed to go with you, to help you travel? I mean I didn't actually, I went I went to see her.

I I do community activityist stuff on my own I went, I went with a friend to tell her I've pointed her in the right direction I was hoping

she would use her communication to approach the right people to contact the stuff.

She is saying you need permission to go there, I said no, I am on my own, living in an apartment, I take, I take public transportation I don't need to ask for anyone to go anywhere I want to.

Even when I was doing these, whether I was in I would go out during the day you were allowed, to be out, by -- less than 31 days if after that you'll loose your bed.

So she, didn't did not, she did not have the time the right reason, because she could still, was confused about where to go and if there's a waiting list.

So the communication is not is not there.

If she is asking me, I mean like, where does she end up going so it's plain and simple there is no communication.

>> GINNY ROGERS: Well thank you for letting us know that. It sounds like, we can do some work in terms of meeting with --

>> AUDIENCE MEMBER: This is only like, within the past two years.

>> GINNY ROGERS: Okay.

Thank you.

>> AUDIENCE MEMBER: Hello.

Hello my name is rodney Witmore, adapt and liberty resource he's work for -- I'm an independent living specialist and, I go out to nursing homes.

I get phone calls every day from consumers that are in nursing homes that want to transition out of nursing home.

I go out there I do the intake paperwork.

Try to go to the over NHT department and asked them, I might be the win that goes out there that does the housing application with the nursing home residents.

And, come to find out, one of the main barriers is the resident might have a criminal background.

So that right there is is a barrier that I keep coming across like you can't help them out because of the criminal background.

>> KEVIN HANCOCK: Us too.

We're facing the same issue.

>> AUDIENCE MEMBER: What can we do about it?

>> GINNY ROGERS: Honestly I would ask some of the folk that's have been successful transitioning people I know that it is a barrier. And I think that, it is certainly an issue when, in terms of, housing, that has subsidized housing is certainly, problematic. So, um, I would, request, if we have anyone who has done there successfully like -- I would say, working with landlords or providers that are potentially outside of the public housing arena but obviously you're dealing with the cost then. Affordability will people be able to afford something that is not subsidized some of those have been ways people have been successful.

>> AUDIENCE MEMBER: Also -- sorry. Also, if you are or your working with a nursing home transition coordinator they have access to regional housing coordinators who can assist with other various resources or ways, they have been helpful in other situations, where there's been a barrier such as that, because that's not always or should not always be, something that keeps someone from being able to access subsidized housing.

Thank you.

>> AUDIENCE MEMBER: Okay thank you.

>> GINNY ROGERS: Okay.

Thank you for -- talking about that.

>> KEVIN HANCOCK: Can I just -- so we're looking for every opportunity to be able to, we as a department are looking for every opportunity to be able to address this.

We recognize that it's a challenge I think, Rachel was making a point for opportunities, but, we, will continue to seek support, from our communities partners and advocates for suggestions how as Ginny said your best practices and your experiences and how to be able to address this, we, um, we want to be able to find ways to place people in the community, regardless of their past situations.

bullet but we do recognize it's a significant barrier we're looking for opportunities to be able to think creatively how to address it.

>> SPEAKER: I have a suggestion real quick.

You know the enrollment ineligibility guideline book, can we put, more information in there about nursing home transitions and where people could go to get the information and where people can go to get help?

Begin if this he need it? Under CHC if they need it.

>> GINNY ROGERS: Tanya, which line were you referencing?

>> SPEAKER: Enrollment ineligibility guideline books that we're working on.

>> GINNY ROGERS: Okay.

Good suggestion.

>> SPEAKER: Can we make sure that information is in there too.

>> GINNY ROGERS: Yes.

Thank you.

>> FRED HESS: Theo.

>> THEO BRADDY: Yeah.

Nursing home transition is a problem.

Major problem.

And advocates know this.

And I'm sure you all know it, too because you've been hearing this ongoing.

And if it is going to be an MCO objective, to continue this as we move into the CHC implementation, my challenge to the MCOs would it be

possible for you'll 3 of them to somehow create some sort of regional opportunities for people to come together, and, really share the best practices.

If it's going to benefit all of the MC ons, why not have and arrange some regional best practices meetings where a great deal of these advocates you know I know a bunch myself can come together and really talk these things out. Because enough people in this room, I believe that could figure this thing out.

And instead of this, really listen to people like these individuals that came to the table and presented some real life problems and we shake our heads like you know, we want to help but we don't help.

>> GINNY ROGERS: Yes thanks Theo we support that. And I -- I just wanted to say too, like, as we, as we talked about, some of the changes the program over the last year and a half part of this was the recognition, that we have not been as effective as we want to be, in that is what drove some of those changes.

But, I think we have not gone far enough it's just the initial like an initial step we definitely need to put more resources to what we're doing in terms of, working with people in the community to address the barriers.

So, I think we need to be more involved.

>> FRED HESS: Go ahead.

>> SPEAKER: Ginny you mentioned the gap you're experience in

Philadelphia it's not been a gap in the eligibility process. It is has been a gap in the processing process. So, that coordinating the activity, between the nursing home the independent enrollment broker and the CAO is really where the issue is.

Quite frankly it's a matter of a sense of you are againacy againacy. Urgency and getting everybody on the same page and if I necessarying a very complicated to make sure the day of discharge that person has service ins their home. And it really is isn't eligibility, most of the folk questions worked with, are already eligible it's a matter of processing a 1768, managing and coordinating that with an MA103 form having the county assistance office, to recognize this is something that we need to do today, and not be treated as just another community referral.

And, it -- from what I've heard from our staff any way is that, apparently the IEB just basically, processes these as a community application rather than a nursing home transition application that needs to be done today.

Because they don't send the 1768 until they're notified of the date of discharge.

Well just by virtue of things going through the mail and everything, nursing homes are required to make referrals, to the nursing home transition coordinating entities, based on, the resident's response to section Q of the MDS.

>> GINNY ROGERS: Thank you for bringing up that.

>> SPEAKER: There should be a plethera of folks who are you

know, who would be interested in NHT the gap issue I'm not sure it's an eligibility issue as much as it is a, coordinating issue of bringing all the paperwork together, at the right time to make sure that services are in place thank you.

>> GINNY ROGERS: We don't disagree it definitely is, contributes to the problem.

>> FRED HESS: Daniel.

>> SPEAKER: Thank you, my name is Daniel Kleinmann I work for statewide independent living council I have two I believe quick questions. First, is there any of the MCOs going to have a ceiling or a cap on the amount of hours that a person required in the community, if they, are eligible? Is there going to be someone who might be have too disabled to be in the community under the terms of a person with disability or a judgment of the --

>> KEVIN HANCOCK: To answer you're question no, there's not a cap there's a expressed requirement in the agreement if a participant choose to live in the community, as their primary place to receive long-term services and supports, the CHC MCOs are required to provide that option.

>> SPEAKER: Good to hear. Secondly, are the MCOs aware of all the coordination that goes into a completion of a successful transition? The process, that needs to be in place before someone can be successful in the community and how, how much labor is part of that process sometimes.

>> KEVIN HANCOCK: We have had a number of technical assist al assistance decisions in a formal technical assistance requirement describing that with the CHC MCOs they're familiar with the approach the department has used to provide nursing home transition, that being said every nursing home transition I think that, everybody would agree is say little case by case. So do they know globally how nursing home transition is supposed to work we believe yes, are there Nuance could require further education, absolutely.

I think highlighting Steve's example of his expertise there's no question about the fact that the MCOss will have the opportunity to work with the long standing nursing home transition coordinators to learn how the process is supposed to work.

>> FRED HESS: We have a question -- I'm sorry, we have a question over here.

>> SPEAKER: Jim Peiffer with Kevin's support, we both nursing home and affordable housing in our communities so we've designated 7 of our affordable housing communities through the HUD home preference we've been able to make a preference for nursing home transition clients.

So, far we have not been inundated with the referrals it is fairly flu, I would mention that I was just talking to one of our service coordinators in our HUD housing communities yesterday, and, one of our first referrals, and they happen to be a APMC client it took about 7 weeks to make the successful transition into one of our affordable

communities but, they're very complementary.

[UPMC]

The UPMC team and the services they were able to get we're hoping we'll be able to continue to get some referrals into our affordable communities it is an eligible preference I think that, a lot of people don't realize it is available to them but, the owners report sponsors of those organizations, do have to be willing to create a preference because often you know there's 50 people on the waiting list ahead. So with the HUD homeless preference allows for that exception and the HUD office in Pittsburgh was very cooperative in that process as well.

>> GINNY ROGERS: Thank you.

>> KEVIN HANCOCK: Just to highlight, Jim as someone who is involved not only in traditional nursing facility services and also in independent living you're representing the model with partnership based long-term care is evolving and how you're looking to provide a array of community supports as well as facility based supports that's the partnership we're seeing involved in the long-term care community where, people are trying to build out the system based upon the references of individuals to age in the community we appreciate the work you do, in providing these options,.

>> FRED HESS: One last question we have to move on.

>> SPEAKER: Hello my name is Tony Brooks, Philadelphia, ADAPT DIA.

I -- I'm a person who was transitioned out of the nursing institution.

It took a long time through, liberty resources in Philadelphia, for them to transition the problem is the nursing institutions practices the way they treat an individual in a nursing institution it is, it is very bad it's very sad.

So what happened to me personally social worker lied to my mother, lied to my mother, telling her why I'm in a nursing home institution I was using opiods and drugs which I never used.

Okay.

That the first thing he told my mother. Next he said the reason why I'm in here to is to rehad a bit Tate

me, I never d I was Tran percented into the nursing home facility, I was in bed in 3 weeks, waiting for a wheelchair to use, it took them 3 weeks to get a wheelchair to use. You said, rehabilitation, exercise all that. It was just one hour a day. Because are because they said they have over 100 people to serve but they served me one hour I did not care about it I did my own exercises all that. It is the nursing home transition the nursing home services how to treat people, how to -- how the -- the work is in a nursing institution, you guys shrub investigating all these nursing home institutions out in the counties all that. Because, one thing to do is when you get into a nursing institution they take everything off you.

Your paperwork. Your ID your phone all that.

They tell you you have to rented a phone for $50 a month.

Your SSI, DI check which is going to be coming in, they're going to give you $40 out of the SSID, why would they treatus like that when they're telling us the State, is helping us service you in the nursing institution in a bed. The bed I believe it cost a lot for one month, for one person in the nursing institution.

How much does it cost, to service one person in a community? In an affordable accessible community based services how much does that cost and, servicing in a person in an institution.

The next thing I want to talk about the time frame.

He said 7 hours.

Else may say, 7 weeks. Someone else may say it takes 8 weeks someone else will say it takes 90 days to get it -- from the day that -- is it, what the first what's the name of the first one?

We just talked about that, the services they come to you first, before they start transitioning to the services independent enrollment broker.

There's an issue between that and the nursing institution.

When they try to get in contact with the individual they are resistant to give out the information to that person it happened to me.

It is -- it's so emotional what you hear what is happening to a person in nursing home institution.

I lost a friend in a nursing home institution because you had a UTI they did not want to take him to the hospital.

You know, you have to be checking their, you should be investigating each and every nursing institution. Like the gentleman said, we have invisible disabilities we have physical disabilities.

What are you going to be doing with those with invisible disabilities and physical disabilities.

Thank you.

>> GINNY ROGERS: Thank you for talking about that.

We will take that back.

Thank you fled Fred can we not block the doors pleads, in case there's an emergency.

>> SPEAKER: Real quick that's what I was referring to, those practices whereas you know, when you go into the nursing homes you're state ID or Social Security card or you're birth certificate, disappears.

Social workers take that months to get back to you that's what I'm referring to you. The you know, some of those are, some of the experiences -- I've had to deal with. As far as, helping people to transition out.

And advocating for them. But, you know, the way some people, described it, 7 weeks that sounds great.

That should be a -- gold standard if anything. But -- that's, that's my original question.

His example.

Is how do you deal with that?

that? Paragraph the way you make it sound it sounds great and if we can get to that point, that will be great. How do you guys get do that? How do you even punish or sanction those nursing homes who want to keep those people in there, so when they keep the cost, of that bed going. That's what I was originally getting at.

>> GINNY ROGERS: I know we want to move on I just wanted to say thank you for the feedback and I think that the idea having the MCOs come back and talk about what their processes are going to be, something we can schedule in the future.

So -- thank you.

>> FRED HESS: Yeah we really have to get moving on because we're already way late.

For our next part.

Which is going to be the CHC's service coordination going to be discussing that.

First one will be AmeriHealth Caritas with Daniel and Jennifer.

>> SPEAKER: Hello, I'm Danielle I'm with AmeriHealth Caritas director of OLTSS and, I also have here Jen Rodgers.

>> SPEAKER: Hello everyone Jen Rudiger, director of keystone first, southeast zone.

>> SPEAKER: So we're here to talk about the AmeriHealth Caritas

Pennsylvania HealthChoices service coordination credentialing.

So briefly, for the first slide we have the importance of the narcs

CQA accreditation and AmeriHealth Caritas we support thal council quality NCQA for case management and LTSS services. As a framework for the organizations, to deliver efficient effective person centered care, that means people's needs, helps to keep people in their preferred setting.

Aligns with the State and MCO requirements.

And why do we, do NCQA accreditation for CM LTSS is important is because, it helps organizations, use up to date evidence, and, professional standards.

Assists in systematically assessing population health management programs.

Outlines consistent framework in development of individualized service plans and helps to establish consistent measurement improvement of participant experience and satisfaction.

Would are are organizations are evaluated in the following core areas , which are, listed in NCQA standards. And it is program description, assessment process, person centered care planning and monitoring, manage care transitions, measurement and quality improvement.

Staffing, training verification, rights and responsibilities and delegation.

So the next is we have a PACH service coordination

credentialing.

AmeriHealth Caritas, requires that the service coordination, entity, will commit to obtaining the NCQA accreditation of CM for OLTSS when stipulatedded in the SE's signed provider or administrative agreement,.

[SCE]

Delegated contract, NCQA process takes the-12 process it is lengthy, it depends on the organization's readiness.

[9]

Based upon the standards I just listed. And for AmeriHealth Caritas, the SCEs must obtain the credentialing, certification within the 12-18 months of the signed provider agreement. Dependent on the SCE's individual NCQA accreditation of CM LTSS time line. General feedback entities under grossly negligent NCQA accreditation, include accreditation provided valuable insights on areas of improvements the stain standards help shape and how and when what to measure in LTSS and emphasis on the importance of care transitions help enhance the staff training, establish new best practices.

Any questions?

>> SPEAKER: I have a question.

So I represent LGBT community.

I would like to know with all of this credentialing, I have to say that I'm new to this process and so the acronyms just like blow my mind.

[laughter]

But I'm going to keep it simple.

In all the training and all the credentialing that folks are required to have how much of that, has to do with LGBT cultural competent. Which is an area that is unfamiliar to most service coordinators. Most providers I would like to know, how AmeriHealth Caritas has is weeking LGBT cultural competent in everything you do.

>> SPEAKER: We have class -- within the a player health caritas which brings in the population across the board, it would bring in all populations, population health assessments based on certain areas.

>> SPEAKER: So are your folks trained? With regards to LGBT cultural competentes, do you know the language of the LGBT communities do you meet needs folks that are LGBD have, it comes to this area if you don't know that, then you don't know that.

>> SPEAKER: Sure I appreciate the question. And, it came up before, Steve I think you brought this up, at a previous sub-MAAC mealing it is an important one I think that's where we would love, the resources in the provider community to point us in the right direction for internal and external training, so that we're getting it right.

Because if we get it right --

>> SPEAKER: Oh, my --

>> SPEAKER: Okay.

>> SPEAKER: Okay.

>> SPEAKER: So, while yes there's a standard, it is -- the NCQA, LTSS accreditation is, a plaque if you will, we need to meet as a health plan and, would.

[a mark]

Extends to the agencies seeking accreditation it needs to mean something. And to your point I think looking to available resources is, the right move.

>> SPEAKER: So essentially you flowed to operationalize.

>> SPEAKER: Absolutely.

>> SPEAKER: Your cultural competent, when it comes do that.

>> SPEAKER: For CHC that is important I agree with you.

>> SPEAKER: Great.

>> KEVIN HANCOCK: As a requirement, in the agreement, cultural competency is something we consider it's not specific to the LGBT community certainly it, it would consider be cluing that the community, it's a lot of specific populations across the State, that culturally competency is specific language or termination requirements directly relevant to a particular population. All 3 of the managed care organizations have a requirement to be able to meet the terms cultural competency that being said, they can, also use help. As can we.

At the department.

>> SPEAKER: Right I was going to say you know, most, when we talk

about cultural competency, we talk about gender we talk about race. LGBT cultural competency is never touched upon, it is, it has been recently.

So I would just ask you, um, consider when you look at all those cultural competencies, that you consider highly LGBT cultural competence, there are LGBT people in every one of those populations that have, that their own cultural competence. LGBT is specific.

>> KEVIN HANCOCK: I could not agree more and, I think we recognize some of that, particular challenges and risks, for the LGBTQ population, and, we would want to make sure that they're being addressed as part of the person centered planning process. So I think the point is that, I think you made the point Heshie, that, unfortunately new, and -- there's a lot of opportunity for learning across the board.

>> FRED HESS: Heshie they don't know how to talk to us bikers either right.

[laughter so -- yeah.

>> SPEAKER: So, the credentialing for keystone first is really at the entity level where the entity is making a commitment to pursue NCQA accreditation indult plat ligged accreditation, is there any credentialing of individual, at the individual service coordination level, other than specific requirements, that imposed as part of the part of the agreement with OLTL.

>> SPEAKER: If I understand your question, if where they are

employed or accredited for the CM LTSS process, then that, service coordinator is trained to those Stan reasonable doubt standards meeting our requirements.

>> FRED HESS: Okay.

>> PAM AUER: Pam Auer, CIL CP PA adapt. My question is, with the credentialing are you requiring the credentialing for -- has it been required for every state you've done the manage the care in for service coordination?

This -- and, the other thing that, Lester has not come to ask he wants to know too, why wasn't this brought up, a lot earlier, this type of credentialing money date, um, for service coordinators to be able to be prepared my understanding it takes a long time doesn't it to get this type of credentialing you've done a lot of requirements around it.

Those are my questions.

>> SPEAKER: Sure thanks Pam the NCQA CM LTSS accreditation just started in January of 2018 I believe. So it is relatively new. Therefore, there have been early adopters in the room I know there are service coordination entities across the Commonwealth early adopters got under way quickly and early.

So I can't speak for I think this is a standard we've agreed to, at a player health caritas, keystone first that we really, think about the Commonwealth and, what was your second question.

>> PAM AUER: Just for, just requiring it for Pennsylvania then? Or did you require it you know in other states that you've been become MCOs for long-term services and supports?

>> SPEAKER: So it is new so this year so, um,.

>> SPEAKER: It's basically new to this year being brought out for Pennsylvania.

>> PAM AUER: Okay.

>> SPEAKER: Okay.

>> PAM AUER: So the credentialing is only for Pennsylvania, other states have not had to have this level of credentialing.

>> KEVIN HANCOCK: Follow-up question are you, are you planning to implement this, credentialing requirement with other MCO or other state managed long-term services and supports programs or are you not in a position to be able to answer that question right now?

>> SPEAKER: Yes.

>> SPEAKER: So right now, um, this Chris Rowe with AmeriHealth Caritas, keystone first as of right now we're not in a position to a this is enterprise wide requirement we're looking at our, agreement with the department here for community HealthChoices and, our NCQA accreditation requirements and moving forward aligning that with our service coordination entities as we move forward through the process.

Soality this time I cannot answer for the rest of our enterprise as

we move forward if it's going to be implemented.

I would say we have to address that on a state by state basis as we move forward with the LTSS benefits.

>> PAM AUER: Any give or take since the requirements and credentialing could take a while or, um, could take a lot for service coordination agency those do is, there some give and take there for some of the agency those get up to this level?

>> SPEAKER: It is a great question. And I think there is we spoke to that, in the slide. That it is 12-18 months given it takes on average we're told by NCQA the months to completes, start to finish your readiness for the survey.

So I think that absolutely that will be something that we would consider.

>> SPEAKER: That's part of the readiness being ready. So, that if -- if those are the things we would consider.

>> KEVIN HANCOCK: Only thing I would add the department has been talking about NCQA long term certification for a long time as part of the MLTSS roll out I know Wilmarie as part of her presentation talked about standards and requirements I know we've had early adopters

some of them are in this room right now, eventually gone through and completed the certification and, we as the department supported and think it's a very good thing it's an objective standard for quality from our perspective it's worked with physical health and we believe

it can be translated to long-term services and supports so we, we're supporting it, with our managed care organizations because we think it's a good thing we also know it's a good thing for service coordinators, to go through the process, and there is a lot of opportunity I would encourage service coordinator those reach out to some of your peers, who have actually gondola the certification to talk about the experience and maybe, maybe, you know, talk about how you might be able to have some of your questions, answered about the process itself.

>> FRED HESS: Okay.

Any further questions?

Nope. Okay.

Let's move on.

UPMC is going to come up and speak about the accreditation requirements on their behalf.

Come up ray.

>> RAY PRUSHNOK: All right I'm ray Prushnok, associate vice president of the APMC I'm not going to cover the same ground I'll quickly go through this, so my first slide, you know again, this is, what you know, NCQA.

[UPMC]

What we wanted to you know, thanks Fred, easier than bending my neck to try to speak to the mic what we were really trying to express here is that you know, the -- first the MCOs are required to be, accredited by

NCQA by our contract with DHS as an the organization by the end of our second year that's a requirement on each of us.

And, the case management accreditation this is what it covers, if you want to go to move ahead just for reference as these get posted and distributed you can see the, standards on slides 3 and then slides 4 and no need to go into those in detail.

But, you know sort of, now moving onto slide five, I think lastly what we wanted to express is we're not requiring it, at this time.

I think we're making decisions on, um, longer term delegated partnerships with service coordination entities, um, and we're not, considering NCQA in that process we're looking at your performance and your work with us during the continuity period and you know that really comes first and foremost.

But, something that is important to point out, and why this is important to all of us as plans as we think about there, is that if an SCE has the NCQA case management accreditation you basically get a 100 percent good to go pass whenever we, get our accreditation reviewed.

So -- it, it basically takes some of the burden off of us, but whether or not a -- downstream delegated entity is accredited or not, that doesn't mean that there's still not, active over sight and you know, um, interaction with the MCO it is just really helping us you know again as Kevin said meet that objective standard.

I think longer runs as we we move ahead with longer term

partnerships this is something that we will be, we'll be moving towards but it again I want to emphasize as we go through, continuity this is you know we really are looking at performance and cooperation and working with the -- the service coordination entities, it is not, a cut point for working with us, post continuity.

So I'll stop there.

>> FRED HESS: Okay.

No questions?

January?

>> SPEAKER: George from the Harrisburg area.

The situation is so, complex for people.

Just recently, had a friend in Washington area.

DC.

Who became homeless. He said it takes a genius to be homeless. I'm wondering when the State is going to contract with Wattson super computer to manage this whole situation.

[Laug

>> FRED HESS: I don't understand the question, what is the question?

[laughter]

>> SPEAKER: The question is, is the complexity of -- of the entire situation is beyond anyone's paradigm to deliver any kind of appropriate care.

It is so complex that the, the level of genius that it takes to navigate the entire system is beyond most people in the room.

>> KEVIN HANCOCK: My answer to your question would be I hope not.

If we're going to keep trying.

So it is a complex system desperately complex system.

Relevant to everything we're talking about, with provider, provider and service coordinator certification but, but we're going to keep trying. That's our job.

I think that's true of everybody in the room.

So, yeah.

>> SPEAKER: Hi I'm Daniel Kleinmann I work for the statewide independent living council and I was curious as to did you, have you had any service coordinators go through the process I know you're a big -- have a lot of coordinator ins southwest region and might have gone through this process, have you seen a change in quality of service coordinators after this process, is there a really impact. And -- I care you're seeing it in your evaluation I know your evaluation is not qualified for it, but if they have gone through the process, have seen a change in their, quality level, would that impact their ability to stay with your program?

>> SPEAKER: I think that's a fair question I think, what I would say is you know, the organizations have gone through the early adopter process those are the only one that's have sort of cleared that

bar so far, it is still so new from the January implementation. Those organizations did show you know, the additional, effort to go through this through this, that reflects on, the culture of quality, that may be in some of those organizations. But, again, we're not seeing, sort of that having that, you know, certification that the point which we decide to contract we'll work with longer term partners to help them through you know the standard.

>> SPEAKER: I understand there's a fair cost to going through this process, that there's a -- um, across cost, to be considered qualified to go through the process do you see that as a barrier to smaller service coordinators agencies to go through this process?

>> RAY PRUSHNOK: Yes that's why we staked out this position.

>> SPEAKER: Thank you.

>> THEO BRADDY: Sort of my question. That's sort of my question. What would be the average cost?

>> RAY PRUSHNOK: I think it's $14,000, with your application or, if I'm not --

>> SPEAKER: Yes. Push plush $14,000.

>> RAY PRUSHNOK: $14,000.

>> THEO BRADDY: To be that, the reality is, that's going to put some SCEs out of business.

>> FRED HESS: Okay.

Any other questions?

Okay let's move on with PA health and wellness.

>> SPEAKER: Hello everyone I'm -- I'm Anna Keith with PA health well ins.

>> SPEAKER: I'm Norris Benz. With PA health and wellness.

>> SPEAKER: With when we were asked to provide credentialing processes, what we brought you was our current process we're using and I did want to make a shout out, as far as the, entities that have, gone forward with their NCQA accreditation, echoing what ray has been saying, that's been an obvious activity that we've seen through some of the ways that documentation has been handled and the quality standards put in place we just want to, we -- let folks know we appreciate the work they have done that way.

Although PA health wellness has not made any Stance, that it is a requirement at this present time.

So, for our service coordination, go through this quickly in the interest of time. But, um, primarily what you're service coordination process includes, which focuses on the engagement, how you build a holistic person centered plan and then, how you encourage and educate individuals about the full array of services that may or may have been available before 1/1, so that they can, learn and make choices beyond what they thought were available to them.

Which can, round out, what their day may look like and their

access.

The credentialing process, is a universal process that PA health wellness uses with all of the providers.

So, to that extent, we outreach to the providers and then if you can see up on the slide, I don't need to read it to you, it's a 1, 2, 3 -- complete the form there's nothing you unique to the as much as coordination process other than meeting the qualifications that have been established through OLTL.

And, that was, similar prior to 1/1 and then we execute the agreement with the service coordination entity.

And then finally just going forward, um, we continue to impress upon everyone that we will, facilitate a hybrid model, working with a number of service coordinators, we're looking for out of the box ideas, that can increase the level of quality in care and people reflow receive receive and how that is done, post continuity of care

we'll continue to work with all service coordination entities we currently are working with.

And threaten post continuity of care, just, defining what the appropriate accreditation standards might be, within the community HealthChoices framework.

Do you have anything?

>> SPEAKER: I don't.

>> SPEAKER: Okay.

>> SPEAKER: You covered it all for once I'm not going say anything.

[laughter]

>> SPEAKER: Yeah.

>> FRED HESS: I'm shocked. That's all right don't move guys.

Can we get the -- all of the -- MCOs up here at the table please

question and answer time for you guys, from the audience.

And, from the members of the board here.

>> PAM AUER: Do we ask questions or around accrediting.

>> FRED HESS: Question time are you sure push can I stay here.

>> FRED HESS: Stay right there.

>> FRED HESS: Okay.

That works.

Okay.

Okay.

Hit them with the questions.

>> SPEAKER: Hi, Tony brooks again from Philadelphia.

This accreditation and service coordination teams which you're

trying to get this accreditations to.

If they cannot pass the accreditations what are you going to do and

what are the service coordination teams going to do for the consumers if

they're not -- is it you, the MCOs who are taking over that position or,

you have to create a position for that did you understand?

>> FRED HESS: Anyone? Want to answer that?

>> RAY PRUSHNOK: Like I said before, it is not a requirement at some such point it was we were requiring it we work with a service coordinator to get through it, if they could not again, but we're not requiring it at this time. So --

>> SPEAKER: That's in the future.

>> RAY PRUSHNOK: If we did I mean it would, it could be, it could be something that we would, you know, use to determine whether or not we would work with someone longer term. If they were --

>> AUDIENCE MEMBER: What if they have the service coordination teams which have already built a real good repour in the community and in the city and all that and, because of this, accreditations they cannot continue that in the community, who is going to take that place?

>> RAY PRUSHNOK: It is as you look at NCQA review process, it is really about you know, training policies and procedures and making sure that you have adequate controls as an organization.

And you know, as we look at that it is an important reflection of that organization's ability to manage a program this important. So in order for so, that's why you know we as a health plan NCQA accredited and why the others pursue it as well, so from our standpoint, you know as we look at something as central to this program as, you know service coordination that's why something like this needs to be considered seriously.

Now again we're not requiring it at this time.

But it, in the case that, there is, clear reason why one would go that direction. Because again it does put better controls in place.

>> AUDIENCE MEMBER: Another question, have you guys really taken into consideration that some of this service coordinations companies and teams and CILs and stuff like that, have you taken into consideration that they're just a non-profit organization which is trying to help the community? Instead, because -- somebody's office can be in his house, for example, because he doesn't have a space to renal to paying all this, he is doing it through his house he has created a office in his build requesting is he doing all this.

You send out this accreditation to him, with aify all that.

But he doesn't have it.

So are you going to drop him off?

>> SPEAKER: Well, just for PA health wellness, we haven't at this time decided, we have not -- we're not requiring NCQA accreditation and, we certainly appreciate the, non-profit nature of the providers that are serving, our community our participants and, you know when we have, where we have, service coordinationen tightities that are working with our participants doing a good job, certainly we want to keep that relationship going, we don't want to reinvent the wheel. So, that is, something we look at and, we want to keep, our participants with the service coordinators when they're having a good relationship.

>> AUDIENCE MEMBER: Well to end it all I'll just add this, please take into consideration little companies which are helping the community because it is not everybody who can run to the, to the DHS office or the CIL office or to a place where they feel like they have the connection over there, remember it's through the communities, that you get this connection going.

Thank you.

>> THEO BRADDY: Question when you say not at this time, is that short term or long term? In your planning?

>> SPEAKER: Well, I said not at this time because, I mean our -- our, current plans are, to not require NCQA accreditation we certainly, want to, we want to get through the continuity of care period looking forward to implementation in the southeast and, um, you know I can't say that you know next year we won't have a different plan but, I would say for the you know, not to too distant fought year we're not requiring NCQA accreditation.

>> THEO BRADDY: I flowed to be clear, PA health well ins not at this time, UPMC, future maybe? Are you sure push future maybe.

>> THEO BRADDY: AmeriHealth Caritas right now?

>> MALE SPEAKER: Moving forward as we get pasted the continuity of care period we're looking for our service coordination, entities to pursue the NCQA accreditation we believe that's going to help enhance the quality, of this program, as we move forward, with, um, as we

improve the program.

>> KEVIN HANCOCK: Can I just asked something from the department's perspective. So, the managed care organizations, they are taking different approaches when it comes to quality certification but they have to manage under the quality of requirements of the agreements. So, in the future, if there's a situation, where the managed care organizations are not meeting the standard that's are set, by the department, and also the objective standard that's are set for MLTSS programs, they're going to have to evaluate whether or not they need to be able to implement as part of their providers and service coordination entities some sort of a quality requirement that they know can be, could be -- supporting, those objectives so the most important part of this program is, providing services that are meeting, participants needs and preferences and in a quality way and the point of the MCO accreditation is to set the baseline for the standards being met that's why the reason why NCQA developed the long-term care and Pennsylvania supported the department of these long-term care requirements, Pennsylvania as a Commonwealth supported support thed the department of these care requirements we want these programs to be the highest quality for our participant participant this is is a pathway to help establish that from a service coordination perspective.

>> AUDIENCE MEMBER: Um, Michelle --

>> FRED HESS: Hang on one minute we have a board member that has a

question.

Barbara.

>> BARBARA POLZER: Two questions that came over the phone, wanting to know if the MCOs can confirm by what date, service coordination entities must be NCQA, CM for LTSS accredited.

That's question number one.

>> SPEAKER: At this time we don't have a specific date.

Outlined, that's why you see the window of time frame from whether we execute that long term agreement with the SCE entities as we move forward. So, there is into defined, cut off date, to obtain that accreditation.

>> SPEAKER: PA health wellness it is not a requirement for us at this point. Are you sure PRURB I said it before, not a requirement.

>> BARBARA POLZER: Second question is Jessica Michelle, what are the chances that the NCQA requirements will change for UPMC and, PA health and wellness.

>> RAY PRUSHNOK: Let me say one thing to be very clear about NCQA, so we are, those standards I put forward, we will be required to meet those standards.

So, as an MCO we are required to meet everything that you saw up there. Therefore anyone we delegated responsibility to either they need to meet those standards, directly through NCQA or we will, on the back end, make sure that they have adequate controls to meet those

standards. So again back to the, requirement on us, as an MCO from the State, is that we do all this, within two years. So, two years from now, you know, we need to be you know we need to make sure we're there. Again, these are things that we would you know, have really any delegation agreement with a downstream provider. So these are things that in our contract, regardless what you do with NCQA, we're going to have some similar types of controls in any contract we execute for something that is sort of a delegated part of our administration. So, this is one of those areas where you know again it is a it's a requirement whether or not you you know, as an individual organization, seek it out, you know pay for the certification, and do that independently, that -- that really doesn't matter as much as what we're going to be required to do, to -- you know, have over sight of the program.

>> SPEAKER: Just to echo what ray said the quality components of the program, and the contract, um, they apply to all of us and they could come a time when we have to demonstrate, those quality requirements through NCQA, but you know currently that's not our plan but that could change.

>> FRED HESS: Daniel is next I'll get to you. Daniel is next to you I'll get to you.

>> SPEAKER: Sorry,.

>> SPEAKER: I have a little bit of challenge question, because it

kind of, is a hypothetical assumed hypothetical.

As you go through the process, I know you'll evaluate some of those service coordinators which you have many of that are, some are not meeting the standard you'll want to close those contracts down.

However those contracts often, mean that those service coordinators have a long standing relationship potentially with members of the community and a that you would want to make sure that, that process is a smooth transition.

Can you talk me through a little bit of the transition plan you have, in place, as you close down those contracts? Um, we don't want necessarily, um, bad contracties to serve the consumers incorrectly not to a higher standard but as you do that process, correcting the behaviors what is that going to look like?

Sorry for the challenging question.

>> THEO BRADDY: Good question.

>> FRED HESS: Yeah.

>> SPEAKER: I like a challenge Daniel I'll take that one. Ann Keith with PA health and wellness.

We have yet to close any contract so I'll put that out there we have contractual requirement force notification to any provider that we are changing our services with. So that's set.

I won't say there's not been discussions about quality of service coordination, within our health plan how we coach and bring about

training, for providers so they can improve the quality of services that they offer.

Um, we've done numerous audits, of service coordination in the community. There's not consistency across the board about documentation what people are doing so we identify there's some problems that need to be resolved going forward I think, as folks have experienced through working with PA healthness, we want folks to succeed, we go do greatest toss help folks along that line.

If we got to the place where that just wasn't a possible we had demonstrated -- trying to help an organization get better.

We would have to make that decision we would follow our contractual requirement to notify and to that extent also, notify the individuals that are supported. And, work with service coordination internally. Or an external partner to help us make that transition, with folks with full notification and lots of time to get that process through.

We're not at that place yet.

>> AUDIENCE MEMBER: Thank you. Anyone else want to thans.

>> SPEAKER: Hi this is Jen Rogers director of service coordination AmeriHealth keystone first the only thing I want to add to that, I think it's important to note today, is that with us we've gone to great lengths I think you've heard, Kathy Gordon say it many times if you've been to the provider forums and where else we want to give every service

coordination entity the training tools and resources to do exactly what we need done, we want done, on behalf of the shared participants. It's access to our system. Training on our system, training on our process and the resources that we speak about, and talk about to elevate visit the program the program I don't want the take away people are swimming alone I think that we've gone to great lengths in the southwest senior service coordinators are meeting eyeball to eyeball with service coordination teams to make sure their questions are answered and they're confident when they go out and participants homes to conduct the first visits under community HealthChoices.

>> RAY PRUSHNOK: In addition I you know, Ray from UPMC, in addition to what the others have said there are you know, notice requirements we will, you know, send, send letters, express you know choice, have a -- you know transition plan that we submit to the DHS.

You know, involves that how we're transitioning any of the case loads from an individual provider those are all process things really what it comes down to though is the person centered planning process. Making sure that you know, that -- participant may have had a long standing relationship we just potentially disrupted having that conversation making slur question clearly understand their needs making sure we are, you know, building a person centered plan that you know helps them stay independent. So -- that's really where the most more than step is, we'll have transition plans we work with -- with DHS at

the point we decide to you know, to determine nature any contract.

>> SPEAKER: Thank you.

Fred

>> FRED HESS: Fred okay.

Go ahead.

>> SPEAKER: Tony from Philadelphia, Michelle just asked a question.

With accreditation if they failed it, you know, some -- service coordination terms, advocates and people who you know don't really get paid for what they do. So this is like, us, now telling us we need to go look for work for people with disabilities, it is out there, we flowed to go, get the job do do.

We flowed to go get a job to do. In one of this cognition teams we people with disabilities the teamwork staff, and you, cut cut the contract L is going to happen to us, people with disabilities, advocates and, also a question, a question which came up, do any of MC Os at the table, do they have any

all the MCOs coming into the southeast because I'm from the southeast I don't know what you guys are doing in the southwest.

But I hope in the southeast, you have a very good relationship with the community out here.

>> SPEAKER: I will take that first, ray if you don't mind.

Norris Benz, from PA health wellness we do work very closely with the disability community we do have staff members, with disabilities and you know like our -- as Ann indicated our current plans, we are not,

planning to to terminate any agreements, currently. We're working with several organizations that we think need some additional safety answer we want you to succeed we certainly want our members our participants to have the relationships with the coordinators that they have worked with in the past, so, we want to work with you. If there are areas where, improvements need to happen we certainly want to help you succeed, and, we -- wastrie to work very closely with the disability community and, looking forward to coming into the southeast.

>> FRED HESS: Okay.

By the way, I -- I work with UPMC as of right now.

I on their PAC which is their -- participant advisory committee.

So, all 3 of them, do have to have a participant advisory committee.

It's about 51 percent of everybody on that PAC is a person with a disability.

>> FRED HESS: Pam you have a question?

>> PAM AUER: Unless they want -- I wanted to answer that last one.

I have a couple.

>> SPEAKER: Are you sure push yes there are you know, we have a diverse work force including you know, people with disability that is are supporting our product. And service coordination areas.

You know and then in terms of you know, I'm -- you know, to swaze your concerns I would like to hear more about what you're talking about, specifically around the service coordination support role, that you're

describing that is something that I was not aware that I assume liberty is doing.

You know that's something that we would be interested in to learn more about.

>> SPEAKER: And I was just going to echo that, we do, participate and work together with the disability community with the agencies advocacy groups in the southwest as well as the southeast with keystone first and HealthChoices program we look to build upon and continue that for community HealthChoices as we expand in the southeast as well.

>> FRED HESS: We have a question from the phone or text.

>> BARBARA POLZER: Question from Charlie brown. Will others like joint commission or CHAP be acceptable or only NCQA.

>> KEVIN HANCOCK: Good question.

>> FRED HESS: Anyone going to answer it?

>> KEVIN HANCOCK: We met with the joint commission they are expanding in the space as they have not finalized their own criteria.

So I don't think we'll be able to in a position to answer that at this point we know NCQA is finalized the requirements for the certification some of the other certification bodies, um, are not, are -- joint commission for example is, something that, that affects physical health I think it's something, that the MCOs look forward for physical health providers they're just entering in the long-term care

space. But, we're certainly open to conversation about that I think we need, I don't -- there's more I think they have the lull over it, before we can say, we can he wait what they're doing compared to to NCQA that's a good question we'll pay attention to it definitely.

>> PAM AUER: I have a few, but really wanted to,.

>> FRED HESS: In the mic Pam air you were I thought I was, sorry I really have a few questions I wanted to support what Tony had said about, you know, if the MCOs, hiring people with a disabilities not only you know using our supports coordination Social Securities that exist, but, really, hiring, people good people with disabilities, um, to be doing the work at all levels.

And, not just on advisory levels.

But really being able to contribute and, build the programs.

My next question, we've been asking a bunch, what are the numbers for NHTM I'm changing the topic I would you like to know and hear what is happening with nursing home transition in the southwest? Um, from the MCOs because, a lot of us are really concerned about it.

>> RAY PRUSHNOK: I'll go first this is ray from UPMC there's a lot going on.

You know I think, there is a -- maybe an old number but I know, our team has, has worked through 11 nursing home transitions, that have been successfully completed that's a small number we're looking to really

push that. You know, as really priority item for our team.

We, have Mr. More in the queue, in addition to what came across on the continuity file, from DHS we reached out to all of the NHT provider those get a comprehensive list who they're working with, we continue to support those cases.

And, you know, in addition to sort of the day-to-day work around of NHT you know, we, you know, I guess on that note we, do have nursing facility service, you know coordinators, who are actively, um, meeting with our participants, identifying you know people either through the section Q or through individual conversations.

Have an interest in transitioning and we are you know, actively working those cases that's a major priority for us.

As an organization it is something that DHS is really promoting.

And it will look different than it did before, we'll have the nursing coordinators and the community based coordinators and really having, external partnerships in our case to -- help bridge the middle.

So, people that have expertise and housing, um, building out you know community supports and helping that person you know go through the transition process is something we're looking to continue and then, also, you know, a plug for something that Anna and her team organized we have a housing summit where all MCOs along with 300 housers and you know, folks from various you know various backgrounds supporting social supports in our community they got together last week and we, you

know, focused in on some of the key questions how we can collaborate as MCOs and housing community. So I expect this to be, an area where you know, we continue to see a lot of progress.

As you heard from Jim Peiffer we worked with PSE, we worked with Jim and brook side we're getting things in process to really, you know, have a robust NHT program.

And the program is set up in away where you know, not only are we, in this because this is the right thing to do, helping people live independently all the incentives in the program push us to do this and, with a lot of competition a lot of the suggestions that was made that the MCOs from Thea we get together and work through this, you know regionally I think that's something we're open to, is proven by our previous efforts getting together at the housing summit and other forums this is an area where we want to be the best we, you know are looking to really succeed.

So we look forward to the challenge we look forward to reporting back on a lot more progress.

>> SPEAKER: I would like to add a few things to that, without being too rerepetitive, we spoke to it earlier there is the question about the discharge plan the social works the nursing facilities not knowing the transition process, so I take that on as, something that we need to do, to educate, those social work teams, and, discharge planners at the facilities to say that we're here as a service coordinator, with the

participants in the nursing facilities we can start talking about if they do identify, how that transition is going to look. So -- that's an education and training and communication process that we're well under way in the southwest.

And then, someone also spoke to, we talk about the gap between, facility and community based eligibility if you will, so, we're looking to the NHT coordinators the entities are already doing this work they're doing, a really fantastic job to be the subject matter experts help us with the participant that is present barriers whether they be housing or services in the community we've had success with transitioning someone from the facility and they went into the LIFE program, we've had success with the exploring the options program and getting, nontraditional discharge plans in place, because anyone who wants to leave, has every right to do so.

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

I think there's work to be done. Bullet there's progress being made.

>> PAM AUER: How many are you transitioning.

>> SPEAKER: Don't have the numbers off the top of me head.

>> FRED HESS: You'll have to say in the Mic so everybody can hear it. Air you were I just asked for AmeriHealth's numbers that's all they don't have any right now.

>> KEVIN HANCOCK: Just the department will commit to, asking all of

the MCOs to be able to provide updated nursing home transition numbers for the next sub-MAAC.

>> SPEAKER: Do we know, Pam I would, I would -- probably under estimate what we have, we, went on a different path with nursing home transition at PA health and wellness, we started early on in, December, January, identifying our CIL partners and AAAs to be the nursing home coordination teams in the field.

They bring a lot of expertise, and knowledge of their community.

And, the nursing homes in their regions, so, partnering with us and our internal team, we have contracts with those entities to do our nursing home transition.

And they submit a number of names every month of, folks that have been identified in process.

And I think last count we had somewhere between 40 to 50 individuals in the queue to be transitioned they're in different stages of the transition we have a really unique pilot we just initiated, with brook side.

That will, identify and help us with folks that are senior that's are looking for transition to defeat loneliness issues we're excited about that transition where throws numbers come from. So -- um, that's with the community transitions.

So -- that's, where we're at.

>> PAM AUER: Can I do one follow-up.

One follow-up question.

Because I know that Lynn who is listening in, would kill me if I did not, housing summited you had, you mentioned ray.

Were there, home mods providers included that's a big part of getting people using, um, especially with nursing home transition.

>> SPEAKER: There were home mod providers we look to folks that are were not in the room usually together. We had, we had -- landlords, housing authority, self directed housing project, self determination housing project the housing alliance. Number of providers and home mod providers were there too, we did break out sessions in the afternoon and, they talked about housing challenges and how we can continue having conversations going forward about how we, create more housing opportunities for people with disabilities.

>> FRED HESS: Okay bill go ahead.

>> SPEAKER: Bi lift l light from AARP, I just, wanted to reiterate, that the majority of folks in nursing homes, are elderly citizens.

And, I just don't want to lose focus, that the great needs to transition folks, which -- Pennsylvania is very high, in nursing home addations I'll use that word.

Occupancy. So, just to reiterate, AARP is very interested in everybody, being transitioned. The page report of the folks are, elderly.

Thank you.

[bill white]

>> FRED HESS: Okay.

Okay.

>> AUDIENCE MEMBER: Nancy from disabled in action. Employee first question is what, how do you identify the people in nursing homes? Is every single person and/or their family there are people that can't communicate being asked if that person wants to move out?

>> FRED HESS: Good question.

>> SPEAKER: Hi Nancy, yes.

>> SPEAKER: Yes. That's -- Norris Benz PA health wellness that's part of the person centered approach we use a multi-, pronged a preach to help this process, move forward.

I mean, we look to the, the nursing facility, because a lot of times they know that their residents who can transition, we work with the centers go independent living, because they have been doing this for a long time they have a lot of expertise in this area. So we really, look to their expertise to help move this process along and, one of the, core components and of course the AAAs as well they have been doing this for a long time. One of the core components of the program is that, it is about choice.

And, having participants get services, where they want them. And, we flow a lot of participants want to transition, out of nursing facilities we want to we want to make that happen.

>> RAY PRUSHNOK: I echo the same thing. There's -- everyones L -- there was a significant pipeline before January 1 we're incontinuing to work with coordinators get established and build relationships with the facilities and our participant living in those building U.S. know, they're identifying people each day.

And you know we'll continue to look to things by the NBS for other indicator touses sort of prompt action it really comes down to a key feature of this new program. Being the requirement to have a nursing facilitate service coordinator it's our requirement that coordinator gets to know all of the parenthesis wants in thing.

>> AUDIENCE MEMBER: By -- thank you my other question is, what will the MCOs do for people in hospitals to make sure if they want to go home, do not go to a short term stay but receive, those services at home. Like IVs, getting extra hours whatever they might need what is your position on that?

>> SPEAKER: Norris Benz PA health wellness, we agree with what you said that's part of the person centered planning process.

We agree with that totally.

>> SPEAKER: So Nancy this is Jen, I think that operationally we flowed to remember that during the continuity of care period, secretary hancock gave the service coordinator entities that are billing fee for service, the ability to in the spirit of CHC to go to discharge planning meetings be there with the team as those decisions are being made. So

we know exactly what needs to be set up.

And that that is executed that so that participant does avoid an unnecessary placement, and the right supports are set up at home.

So that's something that I know many in the room know that's a little bit different and how things are done today and fee for service I think that there is great opportunity to make improvements there and we train our service coordinators about internally and externally to be at the table.

>> SPEAKER: Echo much of the same this is a challenging issue, sometimes you know, we -- we don't always know, that a person you know was admitted, you know, especially if they're not receiving their health care coverage through the MCOs in DSNP or full Medicaid within CHC we have some feeds from hospitals we have a different ability to see if there's an authorization coming through to be able to act as soon as we know that person is in.

We don't always know that, you know with enough time to -- sort of interSeptember so really the work comes down to working with hospitals discharge planners making sure their educated on the resource that's are available and that is sort of a never ending you know, hill we'll be climbing working with service coordination partners and directly making sure we can educate hospitals the only option for discharge is not you know a nursing facility that, there are supports that can be wrapped around and help that person succeed.

>> AUDIENCE MEMBER: So I just want to say, I mean, discharge planners are not the answer because they come and go.

So, what plans do you have to actually get to nursing home administrators hospital administrators they don't even know that the people are disabled. They're in there for some medical condition they have no idea. That they have a long term disability if you've ever looked at the discharge it is based upon able body point of view they don't even ask the right questions so I'm we're really concerned because, we have done tremendous amount of work in that area. When a consumer calls us tells us they're in all the add voluntary case we do around that, they really don't get it.

That, there are these services that these people live in the communities so I think you really have to talk, to the administrators of hospitals, and / you're really going to be able to withhold funds from them maybe they will listen.

>> FRED HESS: Theo?

>> THEO BRADDY: Yes. Um, I made Kevin aware on a personal basis I commend DHS and limb, for making transportation a key part of this CHC implementation.

And so my challenge to him, comes to the MCOs is this -- um don't let transportation become one of those areas that you can't resolve.

You cannot talk quality long term supports and services without

addressing transportation and affordable transportation.

Nonmedical transportation. As hard as it looks we got to figure it out. And I believe we can so, again, thank you all Kevin for making, transportation apart, nonmedical transportation apart of the CHC, implementation.

But the MCOs you really got to make it a priority.

>> FRED HESS: Uh-hum excellent transportation and housing both must be a priority because without them, there's no sense of people with disabilities being in the community.

None.

>> KEVIN HANCOCK: And I would add employment to that list as well.

>> FRED HESS: We have a question out here come up to a mic please, state your name.

>> AUDIENCE MEMBER: My name is Ed health man from the moneys association of Pennsylvania, speaking about transportation, a problem the southwestern providers are experiencing, is the payment of third party liability on the patients that have a managed Medicare product have that have a copayment for ambulance.

That is met with mixed rums results, when the MCO has the copayment that bill is submitted to the CHC, not the transportation breaker the CHC plan, that is net being paid or the amount being paid is the fraction of what the copayment is.

I don't know how to bested address that. So folks maybe you could help me.

>> KEVIN HANCOCK: Well I think, we probably need to know a little bit more about the circumstances of the, of the way that it's billed.

To be able to answer the question correctly I did think, I think I -- if I'm not mistaken it was brought to the fee for service sub-MAAC, it was.

>> SPEAKER: We were told to bring it here.

>> KEVIN HANCOCK: I'm trying to figure out the best way to answer your question.

>> AUDIENCE MEMBER: So essentially what occurs, many of these plans, have anywhere between 150 to $300 copayment.

When the ambulance transports the individual who is primarily a Medicare eligible transport, so Medicare is billed, the MCO, Medicare MCO, they pay less the copayment.

Which many times is really a very small amount.

Then the copayment is billed, to the CHC.

And to date, most of those, have not been paid.

And those have been paid, are paid some small amount, and looking at some of the CHC communication of benefits they reprice that copayment amount, to the fee for service Medicaid amount.

>> KEVIN HANCOCK: I think Igorot I I got it, I would look to the MC ors to respond, I

can tell you the requirements, they are under the Medicaid program as a residual cost left after Medicare pays primary.

And, the other requirement is that the participants themselves, are should not be balance billed for any, costs that are left over from after, Medicare and Medicaid pay.

So, the MCOs if you're willing to just talk about it's a very specific question and, if you need more time to research, but it's an important question, because, of the relevance of the type of service, and the relationship between Medicare and Medicaid payment. So, I'm not sure ray or --

>> RAY PRUSHNOK: I'll I think we do flowed to have a further conversation divisionally I would like to learn more about this I mean it's often happens it's not just isolated to, ambulance providers. The -- as the Medicaid plan you know we, you know look for the primary payer, you know, to pay their portion we don't pay based upon the primary payor's rate we pay based Medicaid rate, if the Medicaid rate is, we negotiated with the individual ambulance provider, is less than what was already paid from a Medicare standpoint there would be no balance due. Again, the particulars of this situation it seems like the experience is in fact different than what was happening for fee for service that's what I would like to learn more about. In particular.

But, you know that's -- that's generally how sort of the pay ors end up working.

>> AUDIENCE MEMBER: Twist to there is, the ambulance providers have a direct contract with the managed Medicare product.

DHS just paying the premium.

In that contract, it was negotiated.

That coy payment, was considered a part of the payment for that, through the Medicare MCO.

So, now, to say it comes back and well did would be whatever Medicaid would pay.

I don't really understand how, you can step into a contract that's been arrived at by two other parties inmently.

I think the amount that is owed is the copay.

>> KEVIN HANCOCK: One thing this is a very, very specific I -- I'm offering if you're willing to set up a meeting with the 3 MCOs and you to go through this, in pretty careful detail.

>> AUDIENCE MEMBER: We would love that.

>> KEVIN HANCOCK: Okay.

We'll take that as a follow-up to the -- the department will schedule it, the department will represented, we'll invite all MCOs the next step is to have individual meetings with the individual MCOs if they have a different approach I think this, this merits a deep dive if you're willing to do that.

>> AUDIENCE MEMBER: Absolutely.

>> KEVIN HANCOCK: Thank you.

>> FRED HESS: We have a question over here.

>> AUDIENCE MEMBER: Just to let you know, um, last year I was, supposed to be taken to the hospital, the ambulance would not take my chair, I was supposed to leave it on the corner.

That I could not do.

I waited until the next morning went to the emergency room.

When they let me come out of the hospital, they said you're not allowed to go home, without someone.

Now, I I live on my own.

I don't have a baby-sitter floor do we have accessible ambulances.

The one thing they did have, they said they would take me home first, in the van bring my chair after me.

Now I don't know how I'm supposed to sit up in the vehicle.

Because that's not going to work.

When I tell the doctor they have to provide the transportation, oh, no, no, you got to call your insurance, you have to call your social worker.

I'm the only one in my house.

There's no one else speaking for me but me.

I'm lucky that my attendant came and got me.

And as far as transportation goes under CCT, you can't even get to a hospital.

You got to give them an address, across the street, or at a -- a

shopping mall or, a restaurant.

To get to the hospital.

They, CCT will no longer take you to a hospital, and unless it is dialysis and you're stuck with your doctor to get that transportation.

I go to about five, six different doctors a month.

I can't afford that type of transportation on my own.

If I take Uber that will be what, ten dollars each ride.

Depending how far you have to go.

So this transportation issue needs to be hit.

And hit now, before we all get stranded.

I have will too many medical issues, I'm getting ready to lit one more.

I don't want to be stuck on a corner waiting for someone to bring me home.

If I want -- if I want to come home I want to come home.

Not, not under someone's hand.

I mean it looks, nice all the insurances are coming together.

Insurances are coming together, in the long run after the six months it looks like we're going to be out under their hands not our own they take over the control of everything, and, someone doesn't fit in all these nooks and crannies they have to find a back up system someone is going to fall through somewhere it is not, you guys have to have a back up system if the -- if the HMOs take their part, and the

service coordinators, somewhere, someone is going to fall through those cracks.

Someone is not covered you're saying it is not going to -- it's going to, going to work for six months. What about after that.

Six months.

All that is connected.

You guys want to do it at the, as a test to be in with I don't want to see myself in the hospital, in the next yeah.

Paragraph I spent enough time in it.

I want to be able to get my medicine, get out and get back to my home and keep my independence.

I don't know how else to explain it to any of you.

Until you were there.

You can walk in the hospital, and see what a person is like.

But you'll never know what it is actually like.

For them until you you sit in their Clair.

Or on their crutches.

What you're promised through the social workers is one thing the communication to the consumer, is totally, something different.

You're hearing one part of the story everybody needs to be a table.

Including the consumers I don't know how -- else to keep putting this do you guys somewhere along the line, we all have to come to the table.

You keep saying we, as the -- the HMOs,.

This is not me as a HMOs, we as the people.

Forget that HMO mess.

You got to be a person first.

I don't know how else to say it.

But all this medical mess, and I'm just like the gentleman at the end of the table, I didn't understand none of that stuff, that you -- used all these letters for if I don't, understand it I have a medical background.

Educational background.

How are all these other consumers going to understand it.

Someone someone explain that to me it doesn't make sense I've been coming to these meetings for how long.

I'm still not getting it.

>> FRED HESS: Okay.

I'm afraid that's all we have time for today.

Our next meeting is will be right here July 6th at 10 a.m. until again 1:00.

And we will see you then.