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DATE: July 6, 2018

EVENT: Managed Long-Term Services and Supports Meeting

>> BARBARA POLZER: Good morning everyone we would like to get started.

We would like to start with introductions Linda would you please begin.

>> SPEAKER: Good morning, Linda Liton, participant advocate.

>> SPEAKER: Jim Fettner, comfort air.

>> SPEAKER: Blair bore arc.

>> SPEAKER: Jack Kane.

>> SPEAKER: Denise Curry Pennsylvania health care association,.

>> KEVIN HANCOCK: Kevin Hancock.

>> BARBARA POLZER: Barb poll sister, liberty community connections.

>> SPEAKER: Steve Touzell, Philadelphia corporation of aging.

>> DREW NAGELE: Drew Nagele, brain injury association.

>> THEO BRADDY: Dheo Brady.

>> RAY PRUSHNOK: Ray Prushnok.

>> SPEAKER: Jessie Wilderman.

>> SPEAKER: Luba Somitz.

>> BARBARA POLZER: If we have any members on the phone, please announce yourselves.

>> SPEAKER: Ralph Trainer.

>> SPEAKER: Brenda Dare is here.

>> BARBARA POLZER: Tanya are you on the phone?

>> SPEAKER: She is on the phone.

>> BARBARA POLZER: Okay I thought I heard Estelle?

Stella?

I guess not, James?

All right.

We're going to start with the housekeeping and committee rules.

Please watch language and be professional.

Direct your comments to the chairman wait until called upon and keep your comments to two minutes.

The meeting minutes, will be posted on the Listserv under MTLSS meeting minutes the documents are normally posted within a few days of the meeting.

Captioning and audio recording is happening the captionist is documenting the discussion so please speak clearly and slowly. Please turn off your cell phones.

Clean up before leaving throw away empty cups bottles and wrappers public comments will be taken during the presentations instead of just being heard at the end of the meeting.

There will also be the additional 15 minute period
at the end of the meeting for any additional comments.

And the 2018 MLTSS sub MAC meeting dates are available on the web
site and now for the much awaited emergency evacuation procedures.

[laughter]

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

If you require assistance to evacuate you must go to the safe area
located right outside of the main doors of the honors Suite, OLTL
staff will be in the safe area stay with you until you're told you may
go backflow the hob nors Suite or evacuated.

Everyone must exit the building, please take your belongings with
you and do not operate cell phones.

Don't try to use the elevators they will be locked down. We will
use stairwell one and two, to exit the building. For 1, exit loan nors
Suite through the main doors on the left side near elevator, turn right
and go down the hallway by the water fountain. 1 is on your left.

For stairwell 2, exit the suite is through the side door ones the
right side of the room or back doors.

For those exiting from the side doors, turn left, and stairwell two
is in directly in front of you, for those exiting from the back door
exits, turn left and left again and 2 is directly ahead. Keep to the

inside of the stairwell, merge to the outside.

Turn left, and walk down Dewberry Alley to Chestnut Street,

turn left to the corner of Fourth Street, turn left to Blackberry street

and cross Fourth Street to the train station.

And now we will have Kevin for the OLTL update.

>> KEVIN HANCOCK: Good morning everyone.

I notice that I'm one of the few people in the room wearing a suit.

[laughter]

Thank you Drew and ray.

Blair, where is your tie.

[laughter]

Just kidding.

Hmmm.

Doesn't seem fair okay.

Just a quick update on the governance we did receive notification of

3 individuals on the committee who will not plan to continue their

participation.

And, we have received, nominations for more than 3 individuals who

would be interested in taking those vacant places.

We appreciate the chair and the co-chair's responsiveness when it

comes to the governance we'll look forward to sharing those applications

with you and, discussing how we plan to proceed but we imagine that in

the August meeting we'll be making an announcement who would be

replacing those individuals would be vacating their positions.

So -- okay.

I apologize in advance, for those people who transcribing my presentation I tend to talk way too fast and, feel free to just slow me down if I do.

Okay.

So, some quick updates on CHC.

Starting with some of the data this data has not changed since the last month for the distribution of population for the southwest.

As you see here, 73 percent of the individuals who are part of the southwest distribution are NFI duals and 10 percent are duals who are in need of long-term care in the community. And 3 percent are non-duals in need of long-term care in the community, 13 percent are long-term care duals in receiving their services nursing facilities and 10 percent are -- and 1 percent are receiving long-term care duals or long-term care in nursing facility and non-duals so, the distribution is the same as it was last month.

And, it has been pretty clear that the southwest population distribution is pretastedy I think we will see some differences in the southeast, but the southwest, the population distribution is pretty much steady, it's roughly about 81,000 individuals.

For the distribution of the managed care organizations, that is also the same. Which means that we did have some significant changes

in the early months of community HealthChoices the first 3 months and that's fairly common. If you have a significant auto assignments, we find that participants will start moving to a plan that they're interested in receiving, where they're interested in managing and receiving their services. But for the last 3 months the distribution has been the same. UPMC community HealthChoices has 54 percent of the population, Pennsylvania health wellness has 27 percent and AmeriHealth Caritas has 19 percent, no changes it has been
the same. This is based on the experience we had with the physical health HealthChoices program it is pretty unusual for people to change plans to the point where it actually changes the distribution of percentages. There's always plan changes but, the volume seems to slow down after the implementation period.

So -- any questions about that initial data? First off?

Okay.

Great. So we'll move into the implementation itself. And feedback receiving, from the implementation.

We talked about a little bit of this last month, the feedback came from the consumer sub-MAAC we held locally in Pittsburgh at the end of May and, it is also is feedback we received from participants and participant stakeholders first of all the first, some of the concerns about what is going to happen at the end of the continuity of care period. And the southwest the continuity of care period ended last

Saturday June 30th. Which means that the shift is the managed care organizations are going to be managing the service plans proper directly the requirement is, that the managed care organizations must have completed a comprehensive needs assessment, and long term personal centered planning process to establish a new service plan for participants if that was not done, then the service plan that was in place during the continuity of care period will continue. So assessment needs to be completed and the person centered planning process needs to be completed as well, before a new service plan could be put in place. So with this assessment process, with the change, where the MCOs are taking over the service plan management more directly than occurred in the continuity of care period, there have been a lot of participant who is have been concerned about reduction in service hours. And that's been most directly related to person al assistant or PAS hours. We can state at this point that the Office of Long Term Living, we are monitoring service plans on a lot of different ways first of which is we are going to be receiving monthly reports from the managed care organizations about any service plan reductions. We will also be reviewing service plans to make sure there are no arbitrary cuts. And, that we are also going to be reviewing in detail the person centered service planning process to make sure that the CHC MCOs are actually developing service plans that reflect the needs and preferences of participants. So all 3 are being monitored by the

Office of Long Term Living we also have some stakeholder partner whose
are also helping us too do this monitoring we appreciate that very much.
We have had, some participants from the ADRCs who have been engaging
with participants, to go through the person centered planning process.
They have been able to provide feedback with the MCOs, and the
performance of the service planning process and, we believe that's
particularly helpful to make sure that that's -- that process is
actually reflecting, a way that the needs and preferences of
individuals who are actually being captured.
In addition, we received a lot of feedback from stakeholders and
stakeholder advocates on concerns being brought to them by participants
and their caregivers about how that process is working for them, we have
been communicating that to the managed care organizations and we've been
using if as a way to determine if there needs to be any corrective
action. So an example of feedback we received is on denial notices
that all 3 of the managed care organizations have been sending to
participants.
We received some examples of those denial notices, and, the examples
just reflected, a lack of information that would have been useful for
participants to understand why there was to be a reduction in any type
of their services they were receiving.
So based upon our review and initial reviewer requiring all 3 of the
managed care organizations for indefinite perpetrated of time to submit

all service denial notices and we're going to review them and approve them and they're not approved if they don't provide language that actually articulates the reason for the denial. We're telling the managed care organizations that it is not appropriate for them to be reducing the services. The purpose of the service denial if you remember, is to be able to provide not only information on why the denial is actually occurring, but also providing information that participants can use if they decide to submit a grievance they have a ten day period where they can submit a grievance if the denial notice does not provide enough information for participants, then the participants will not be able to adequately be adequately equipped to be able to challenge the decision on the part of the MCOs if they disagree with it. So, what we are, what we are doing we're reviewing all of the notices to make sure at a minimum, it provides an individualized reason for participants to understand why services ar ing.

>> DREW NAGELE: Kevin that's rearing the side on the denial side I'm wondering if we have the same issue on the front end with the, language and format used in person centered service plans.

I don't know if you've seen, any new ones of those coming through?

And, I'm particularly concerned about those who need their notices to be cognitively accessible. So the language, the type of language used the way it's presented, becomes especially important and I

see, this being attended to on the denial side but, I'm worried about

the front end now too.

>> KEVIN HANCOCK: Good point I know that, we have -- the MCOs have

at least one for sure, of the MCOs have engaged in using cognitive

impairment as an example they have engaged in, opportunities in training to make sure the planning

process recognizes differences in communication requirements for

population that may have some sort of cognitive impairment I know that

-- all MCOs stated recognition of the importance of that, that level of

difference in communication but, what we would love to see would be, we

can certainly, we'll be sampling the service plans we'll be reviewing

for feedback we would love for a participant who is engaged in this

process with the MCO toss be able to provide us feedback if you have

any suggestions how we may be able to do that.

>> DREW NAGELE: I'm not sure, I'll -- certainly think about that.

And we would only know at the brain injury association if someone

came to us, usually they would not come to us unless they knew there was

a problem, so we don't have a systematic way to get at this.

>> KEVIN HANCOCK: It is a tough way I mean sometimes the best way

for us to be able to react to. That's with the service denials, the

denial notices it was the most helpful for us to see examples that

demonstrated the problem. It is really helpful for us to be able to

see examples we can, take a -- take a broader approach we can evaluate

if the approach that we're taking as a suggestion for improvement is

working without feedback or examples on how it is working as

well.

>> DREW NAGELE: Would it be possible for the department to request

from each MCO examples of new service plans that are being written.

>> KEVIN HANCOCK: We can, we have been if we identify the

participant expressed or, is identified with some sort of cognitive

impairment we might ask for some expertise subject matter expertise for

reviewing, to determine whether or not you would agree with the way it

was communicated correctly.

>> DREW NAGELE: We would be happy to work with you on that one.

>> KEVIN HANCOCK: Okay.

Thank you.

I think -- Mr. Bennett had a question.

>> AUDIENCE MEMBER: Thank you.

Hi, hi everyone Lester Bennett, I have an issue that I guichet heard

about the change in the plans. We've done it in inner RAI person,

prior that the consumer had a certain amount of hours after that, the

service coordinator said these are the same hours submitted to the MCO

then there was a discussion on the hours they wanted to reduce them

already there.

From whatever number that was let's give a number in my head, let's

just say, 90 hours per week. Okay.

They wanted to drop them down to like a 60 or something. Okay.

They got in the negotiation let's just say it came in between that number. Well, the consumer is getting a notification that is saying that hours are already dropping to that.

And the question is, we're trying to figure out, I want some clarification here is, when does that start? The consumer -- when the consumer gets a notification that says you know what? The hours are being dropped you have the ability to appeal this discussion, decision what is the hours that should be -- same hours the consumer was getting on the original InterRAI or what they were getting prior to MCOs coming in, is that going to be the hours that person should be having? Or because with the could be assumers are being told whatever we dropped you to, that's what you can get to negotiate to.

That's what you're going to be appealing.

You're appealing already to that drop level, opposed to, where you already started at.

>> KEVIN HANCOCK: Okay I'll give you outline how the process wanted to work if you want me to look at an individual case I'll be happy to if you want to send my way.

Okay.

So the first step is -- the comprehensive needs assessment the assessment process which would include the InterRAI home care tool we talked about before, plus other ways that the service coordinators are working with participants and their caregivers to find out what their

needs and preferences are, so that, there's a
conversation that is supposed to happen between the service coordinator want participants and their caregivers as well as other members of this team like providers and other individuals who might be involved in helping the participants, determine what those hours are. And then, that's, that information is used to be able to inform what the service plan is to be like.

When it comes to the difference between what their existing service plan is compared to what this process, produces, so the MCOs themselves, don't really know the baseline. They don't know how the original service plan may have been developed except for the fact that the service coordinators involved might be the same service coordinators doing the new approach. But the process that they use is meant to be truly reflect the needs and preemptses of the participants.

If the consumers believe the plan before the continuity of care period, reflected their needs and preferences and they disagree with the outcome of this person centered planning process they, they will receive a denial notice the denial notice should be developed in away that appropriately communicates the reason for the reason why the service plan was developed the way it was in away that actually is, transparent to the participants and then the participant has ten days from the post marked date I think.

I always look at Jack I put him in a bad spot, for the appeal to be

submitted.

Then, if the appeal was submitted, the managed care organizations are not in a position to be able to reduce those service hours, until that grievance is resolved.

>> AUDIENCE MEMBER: That's the question.

Which hours are we are supposed to be standing? The ones they got after the interAI, they negotiated back the service coordinator and the MCO, so like I'm saying the consumer is saying, I had 90 hours before you came in the door. Now you're telling me I can only appeal to that 60 hours.

>> KEVIN HANCOCK: If they had 90 hours during the continuity of care period.

>> AUDIENCE MEMBER: InterRAI comes in look you're only getting 60 and, they're like -- whoah, and then so that the question is, to the provider, who was already doing 90 hours, which am I supposed -- I thought that, what they're saying is I thought during the appeal process there is going no change.

>> KEVIN HANCOCK: So the answer to the question is, that if during the continuity of care period they had 90 hours they appealed a decision that was developed from the new service plan the 90 hours would stay in place until the --

>> AUDIENCE MEMBER: I think the providers need to make sure they're understanding that, because they're being put in a position where

they're being told you already got 60 hours I know -- I know that you

because they already sent out that service authorization.

That is -- this is hat providers are telling me.

I am seeing authorization to see that person is only getting 60

hours during continuity of care period they had 90 they're like are you

going appeal? Yes if I'm appealing, where am I supposed to be standing

at 90 or 60 because there's as a provider I'm sitting here saying I

can't -- I can't give you your the 0 hours.

>> KEVIN HANCOCK: What you're saying is the, the providers are

seeing to reflect the new service plans.

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The existing service plan.

>> AUDIENCE MEMBER: That messes up the whole appeal process, guess

what if you do win your appeal process you're getting that 60 hours

that's what the service authorization is for.

>> KEVIN HANCOCK: We'll take that back to the MCOs we'll take that

back to the MCOs see whatever is in the service authorizations it is

reflecting what should be in place during the appeal we believe that,

the service authorizations and the -- the 3 MCOs they will certainly

chime in on this, directly later on, we'll -- the service plans should

reflect, the authorizations for service plans should reflect the number

of services that were approved in place prior to the new service plan

that was developed.

>> AUDIENCE MEMBER: That's what I thought I'm can -- thank you.

>> KEVIN HANCOCK: Thank you.

Spit fire had a question.

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

>> KEVIN HANCOCK: Brenda, two folks ahead of you we'll get right back to you.

>> AUDIENCE MEMBER: Okay.

>> AUDIENCE MEMBER: Just real quick I mean, we believe that, from past experience this appeal process should be -- perhaps longer than 10 days? As a complete, but -- consumer to start an appeal on the records piece, could you clarify you know, let's say someone that has -- had services for 20 years and now, they go to CHC, what happens to those physical records?

>> KEVIN HANCOCK: So the -- first part of your question the ten hours that's --

>> AUDIENCE MEMBER: Ten days.

>> KEVIN HANCOCK: Ten days.

>> AUDIENCE MEMBER: Hopefully that's not ten hours get that on of the reported.

[laughter]

>> KEVIN HANCOCK: Ten hours, no -- the -- the ten days comes out of Federal regulations certainly take the feedback back. Now, the records for service plans.

>> AUDIENCE MEMBER: Yes.

>> KEVIN HANCOCK: -- yes.

>> AUDIENCE MEMBER: -- you did say that unless it is the same supports coordinator, you know -- you know what I'm saying as I hear it, is that, otherwise, the MCOs will not get these long standing existing records that do you know -- build up all these services.

>> KEVIN HANCOCK: The two case management systems of record for the fee for service system are HIXAS and SAMs all 3 of the managed care organizations have the view only access into the service plans that were in existence prior to the implementation day for CHC they have access to those records.

>> AUDIENCE MEMBER: Yes.

I'm familiar with the networks I'm talking about the physical records.

Kept.

>> KEVIN HANCOCK: By the service coordinators.

>> AUDIENCE MEMBER: Agencies.

>> KEVIN HANCOCK: Can you give me an example of a record would not that be in the system.

>> AUDIENCE MEMBER: When an auditor comes in they come in and check the paperwork reflects what is in HIXUS correct.

>> KEVIN HANCOCK: I would think they would do that, right.

>> AUDIENCE MEMBER: I'm talking about the physical records that's

what I'm talking about, what happens to them? Now? Next year, right now, what is happening with them now? Do they go, right now, in southwest.

>> KEVIN HANCOCK: That's actually a good question I think a requirement for records, Medicaid level records, have to be kept for at least five years even to the end of the service planning process. So, if the service coordinators, continue to be Medicaid enrolled providers they have to follow that requirement.

>> AUDIENCE MEMBER: Let me ask you a question --

>> KEVIN HANCOCK: So the service coordinators are to keep them.

>> AUDIENCE MEMBER: Pretend -- let's say that a existing support coordinator agency in the southwest does not get a contract with one of the 3 MCOs, are they, do they have to give all these physical records to the MCOs?

>> KEVIN HANCOCK: We didn't -- they do have to give them to the MCOs.

>> AUDIENCE MEMBER: Is the question if someone changes from MCOA to MCOB.

>> KEVIN HANCOCK: No, he is asking if the service coordinator does not get a contract can the MCO my thinking would be the service coordinators the MCOs have access to the service plan history and HIXUS and SAMs, the service coordinators plan to continue Medicaid provider enrollments they will have to keep those records for that five

year time period. We'll verify that, that's a really good question I believe that's the requirement. Based pond Medicaid enrollment.

>> AUDIENCE MEMBER: There's nothing -- not these records could -- I've had my own records, in the same agency lost, that's an issue I have had to deal with it, that's many years ago, many years ago. But that's the same agency it is an issue, this could become a whole different set of issues that apparently we're not ready to deal with.

>> KEVIN HANCOCK: We're more than willing to give you a definite answer that's a great question.

>> AUDIENCE MEMBER: Thank you Kevin-hon bet.

>> KEVIN HANCOCK: Spit fire had a question as well.

>> AUDIENCE MEMBER: Part of that.

>> SPEAKER: What point is the past provider knifed that an appeal has been filed, when do the MCOs communicate that to the past providers so that we're all, going back to the Lester's concern so we're not effecting the consumer in away that they're not receiving the services they need too in that period of time, can you just identify what the process would be for the providers as far as notification that an appeal has been formal appeal has been filed they should continue those same hours they were supposed to have. During that the appeals process.

>> KEVIN HANCOCK: Since it's a mechanical question do you mind if I defer to the managed care organizations.

>> SPEAKER: Absolutely.

>> KEVIN HANCOCK: We have opportunities for them to answer that we have a question and answer there is all about continuity of care these are all questions valid to answer. So -- we could have them answer during their updates period or during the question and answer question, if that's okay.

>> SPEAKER: Thank you-hon bet.

>> AUDIENCE MEMBER: My question it I thought you said there will be no changes in service all these providers meanwhile we're without services you'll note do we have any input at all, do you care what we think?

Like everybody here -- what about us? Don't we even count?

>> KEVIN HANCOCK: So the one thing I'll say for sure I never said there would be no changes I did say that, as we go forward, we'll keep you updated on what those changes.

>> AUDIENCE MEMBER: Yeah I believe it.

>> KEVIN HANCOCK: That's fair the other part is, the whole person centered planning process is focused on the participant and caregivers if any participant doesn't care -- if participants don't think they're being represented, they have ever right to complain.

So -- I think you were first and then, carry. Brenda I'm sorry, bend A sorry.

>> SPEAKER: Sorry Kevin. I have 3 questions.

But I'll make them quick.

First is, um, when we talk about post mark date versus letter received date.

I would like to just comment that especially in rural areas and for people who might not be able to get their mail independently ten days say short turn around time, we had participants not receive that mail on day eighth, on participant toss are put that grievance in on participates the last business day of the period.

>> KEVIN HANCOCK: Patty Clark, who is sore subject matter expert on the complaints and grievance pouries is going thans question.

>> SPEAKER: I wanted to add a clarifier to what Kevin pensioned about the ten day.

>> KEVIN HANCOCK: Could mean I was wrong.

[laughter]

>> SPEAKER: So -- if we're talking about grievances, which I think we are here with end of continuity of care and if someone's services are reduced or terminated, the participant has actually 60 days to file a grievance with the MCO, however, if they file that grievance within ten days their services will continue at the current level. Prior, the level prior to a reduction in services.

So ten days in order for the service those stay in place as they are.

60 days, total, to file the grievance with the MCO.

>> SPEAKER: Ten days is awfully short for people who depend on the level of services they're currently receiving that's my point, especially when some people don't receive it until day 8 that's really tough that's happening on the ground here. My second question was people who assessed and see no changes, are they getting notices as well, to say their current level of service is continuing.

>> SPEAKER: No. They would not receive a notice they would just receive a service plan updated service plan with the same level of service.

>> SPEAKER: Those service plans are not coming through to the people in the southwest at least in a timely manner.

I know at least two people who are you know, um, more than 3 weeks past their assessment, who don't have updated service plans so -- I think that process needs to be reinforced with the MCOs.

>> KEVIN HANCOCK: Can you send us the examples?

>> SPEAKER: I can, I can.

>> KEVIN HANCOCK: Thank you.

>> SPEAKER: I won't give you names on the phone I'll email them to you.

>> KEVIN HANCOCK: Thank you for not giving the names on the phone.

>> SPEAKER: Right. My third question result relates to the last point on your slide. Can you explain to me what replaced with

alternate service might be can you give me some exam examples of
that.
>> KEVIN HANCOCK: Sure, person receiving 80 hours of personal
assistant services for example, they were in the tendant care waiver,
they now have A -- attendant care waiver had maybe 3 services that, 3 or
4 different types of service that's would have been available to them
otherwise.
As part of community HealthChoices they have 32 different types of
service that's are now available to them so it is quite possible that
instead of receiving all of their services as personal assistant
services they might have a their needs met, different or better way. Example
would be, if one of the, roles that a personal assistant was providing
was to cook meals, the -- someone in the attendant care waiver was in
the attendant care waiver has access to home delivery meals as part of
the service, they may not need as many hours, those two two hours it
took to prepare hours because they had meals available to them that
would be one example they have a
-- Richer package, especially if they're in the tendant or waging
waiver.
>> SPEAKER: Thank you.
>> THEO BRADDY: Quick follow-up question.
>> KEVIN HANCOCK: She was first then we'll go to you and then I
think, we had another question in the back again. So -- who is first?

[laughter]

Sorry sir.

>> AUDIENCE MEMBER: When I was here at the meeting in April I remember some comments that were in discussion there was someone from your committee that discussed this scale that you were providing to more flexible in moving from 11 to between 9 and 11.

>> KEVIN HANCOCK: Eligibility.

>> AUDIENCE MEMBER: Yes.

>> KEVIN HANCOCK: You mean the functional eligibility determination?

>> AUDIENCE MEMBER: Yes, yes.

>> KEVIN HANCOCK: I think the question was in April I think it was Mike Hale, presented the new tool originally to be implemented on July 1st, now is going to be implemented on September 1st. Whether or not there was the scale that was used to determine, if a person is nursing facility clinically eligible, was going change at there point, if I'm answering the question correctly, the scale at this point will not be -- the way the tool was described to determine eligibility is the tool that will be implemented on accept September 1st,.

>> AUDIENCE MEMBER: Are you saying it will be implemented in September not July.

>> KEVIN HANCOCK: That's correct.

>> AUDIENCE MEMBER: Okay thank you.

>> KEVIN HANCOCK: Sure.

>> KEVIN HANCOCK: Breaking news.

[laughter]

Okay.

Thank you, sir.

[laughter]

So, we decision was made, based upon a request to continue using the level of care determination tool the existing tool for two additional months to allow allow, for more training of the

assessors so we delayed the implementtion of the functional eligibility determination tool for two months because we believe that it will give more time for a more successful implementation. So that is a good point. So should I -- I had you and then Theo and then your boss.

[laughter]

Should we let her go first?

>> SPEAKER: This is a Tanya question as a committee member she -- I think gets the first question.

Carrie Bach voices for independence Tanya is having phone trouble she can hear but can't speak she asked me to.

>> KEVIN HANCOCK: Am I allowed to joke and say that is really difficult for her.

[laughter]

>> SPEAKER: Right.

[Laughter]

You can't even hear her laughing at that.

[laughter]

>> SPEAKER: So her question is back to monitoring of the service plans who specifically at OLTL is monitoring those service plans? And should a committee member hear that there's a problem, who should they contact at OLTL to notify that there's an issue?

>> KEVIN HANCOCK: Any committee member can reach out to me and Randy and Jill Vovakes, Randy's team will be involved in the monitoring of the service planning process quality team will be looking at the quality construction of the service plans themselves. So -- I think Theo you were next.

>> THEO BRADDY: Yeah. Quick question.

I don't -- is that on. Okay.

About the ten day grievance can that be done electronically, or -- required to do it in writing?

>> KEVIN HANCOCK: 10 day grievance I think they can call in an appeal. Is that correct?

>> AUDIENCE MEMBER: Yeah. And --

>> KEVIN HANCOCK: I'll have Patty Clark explain the rules Jack knows.

>> SPEAKER: Yeah. The participant could fill out the appeal form
and mail it in, they could call the MCO or they could also, email the MCO
. Now all that information is on the grievance form that is sent to
the participant, with the decision.

On a reduction or termination of services.

>> THEO BRADDY: That's for both the ten day and the, I think you
said 60 days.

>> SPEAKER: Uh-hum.

>> KEVIN HANCOCK: I think Lavel you want too add to that.

>> SPEAKER: Just notwithstanding is this on.

No.

Now. Okay.

Leval Wilson with the Pennsylvania health law project I want to note
with a lot of the discussion wears in a post continuity of care period
with the health law project we're in a position to assist folks with
their challenges of service denials.

I don't necessarily want to comment on some of the back and forth
that we've had it's been helpful to have that and, to have more input
from the MCOs about what that process looks like for how long it takes
them to make a decision whether a member decides to challenge so during
the question and answer period we're interested in hearing from the MCOs
how long it takes them in an expedited if someone wants to have a
decision sooner it would be helpful to hear that. I'm only up here to

note that the health law project is, um available, to help folks, um, understand the grievance process. To represent people as they're challenge managed care plans our names and contact information are on the notices that folks receive.

>> KEVIN HANCOCK: Thank you very much.

>> SPEAKER: You gave an example a little while ago about in the reduction of service plans potentially there are other options one example you gave was, having meals participated, and brought to you opposed to making them with an attendant yourself. What happens if you want to cook your own meals want to do it with an attendant and, the MCO is, is giving you that option you don't want it, is that an appealable?

>> KEVIN HANCOCK: Yep if they have a reduction in service hours as a result absolutely.

>> AUDIENCE MEMBER: You could say they may see an option as a cost savings I may see an option as I've cooked this way my entire life and I don't want that.

>> KEVIN HANCOCK: From my perspective that would be absolutely appealable.

>> AUDIENCE MEMBER: Okay thanks.

>> KEVIN HANCOCK: All right.

Mr. Kane.

>> SPEAKER: If a consumer calls in an appeal is there any

verification back to the consumer that the appeal was -- received?

They have proof that appeals time line.

>> SPEAKER: Yeah there's a -- an acknowledgment letter that the MCOs send to the participant whether it's a complaint or a grievance when it is filed, they send an acknowledgment letter back to the participant saying it was received.

>> SPEAKER: Great thank you.

>> KEVIN HANCOCK: Okay thank you Patt.

>> SPEAKER: Kevin just to go back to the example this woman just brought up with regard to whether or not the aid prepares the meal or you get home delivered meal what would be the department's position on the resolution of that? So the -- the participant is saying that they, you know this is, what I prefer.

But then obviously there is a financial incentive for the plan to have an alternate service delivery model.

>> KEVIN HANCOCK: Up to the managed care organizations and the participants to come together to make a determination for what is best for the participant.

My -- it really depends on the individual participant, I mean, the participant may have, may want to be engaged in the, meal preparation process that's a valid reason.

If the MCOs have an approach that offers nutritious meals attar paragraph the delivery and they want that built in service plan it's up

to them to, to make the case for why that is in the best interest of the participant from the participant's perspective and their caregiver perspective it's really individual, it's really case by case in my view.

I do have to say that, our system has been heavily rely want on personal assistant service hours for at least two of our waivers for everything.

And we have 32 new services in our service plans, that allow people to take advantage of, a whole new world of different types of services so it's the department's position we have 32 new services we're hoping people will take advantage of them, if it's appropriate for them.

But it is still really case by case.

So -- so hopefully that makes clear we want people to take advantage of the services that are available to them but really it's case by case we can't say which is better for an individual participant, panel assistant service or home delivered meal we just believe we hope the participants who may have been constrained by the design of the waiver ins the past take advantagest more flexibility they have and the more services are now made available to them.

Okay.

Well, okay hi Linda.

>> SPEAKER: I just wanted to bring up the fact that now we're going to person centered care format, that what the person would want would

come into effect more so.

>> KEVIN HANCOCK: Is that reaction.

>> SPEAKER: With the meal planning basically the same thing.

>> KEVIN HANCOCK: It's -- what the preference is, and I mean you

have both, you have both sides, having the conversation I think that,.

>> SPEAKER: So it is taken into account.

>> KEVIN HANCOCK: Absolutely should be, yes.

>> SPEAKER: Thank you.

>> KEVIN HANCOCK: That doesn't, people will -- the plan will

reflect needs and preferences, but -- I can guarantee there will not be

100 percent agreement in the development of that service plan because

people may not 24 hours of personal assistant services for example, but

they may want, 24 hours of service, personal assistant services just, an

example.

So -- good.

Okay.

Great.

So moving onto the next, we have received a lot of feedback on the

person centered planning process, itself.

And, the feedback itself was that a lot of the service coordinators regardless whether therm internal to the MCOs or external,

took a mechanismistic approach the way the service planning process

was developed which means they, relied a little too heavily on the tools

provided to them by the managed care organizations and a little bit

lesson the conversation, that should be taking place between participants
and their caregivers and the service coordinators so -- so we're
requiring the managed care organization those retrain all service
coordinators on what the person certaintied planning process is meant
to be. And, how it is to be executed and, all 3 of the managed care
organizations presented as a plan for the how the training is going to
occur, Linda it gets to your point making sure it is a conversation,
because that is exactly what it should be.

The all 3 of the managed care organizations at least two of the
managed care organizations have already completed a initial retraining
of the coordinators we're expecting all 3 will have that done in the
next couple of weeks you're welcome to ask the MCOs for their
approach for American centered planning we have required them to retrain
all service coordinators. So dish -- okay.

>> AUDIENCE MEMBER: Thank you.

>> KEVIN HANCOCK: Thank you.

>> KEVIN HANCOCK: We're open to continued feedback how that process
is working. And, we have had the managed care organizations themselves
ask us to continue to work with community partners to validate how the
process it is working and provide that feedback to them. So the
managed care organizations definitely want to get this right.

Mod ams of care reflect what the goal of the person center the
planning is supposed to be and, they have committed a lot of the

resource those make sure the service coordinators are trained to be
able to get did right as well. The point that I made pretty
consistently I've made it 100 times provider sessions in the southeast
the person centered planning process is virtually using different tools
the theme of person centered service planning is a requirement of
waivers for a long time really wasn't any change so -- what was so
surprising to the department to be perfectly honest is how difficult it
was for the existing service coordinators to adapt to the requirements
which were really not new requirements certainly not universal we've
had a lot of service coordinators had to retrain themselves into what
-- understanding what the service planning process, was meant to
accomplish we're happy to be able to build on that knowledge base it's
not new. Not by any stretch of the imagination the language if you
look at the language in our waivers and person centered planning
process and community HealthChoices agreements they're pretty similar
we're hopeful that the person centered service planning will be
even more successful in community HealthChoices we believe managed care
partners, are commit today making sure that happens.

Participate so next up is, transportation.

Transportation, continues to be a, a point of confusion most
specifically between the coordination with nonmedical transportation and
nonemergency medical transportation that's provided by the medical
assistance transportation program. Or MATP. A lot of acronyms in

this particular issue. So we have seen some improvement in that coordination, people, seem to have a better idea where they need to go but we still have individual examples of challenges with all 3 of the managed care organizations and working with brokers we believe that there is still opportunity for better communication with participants, through their service coordinators to know what they need to do, to be able to access transportation.

Transportation is I've said this before on this committee and I'll say it everywhere I can, transportation from the perspective of the department is the gate way to independence, for home and community based services that is, especially true for nonmedical transportation that is now available to everybody in our -- in our home and community based waivers where it wasn't in the past we want people to be able to take advantage of that opportunity and we want people to understand what they need to do, to take advantage of that opportunity we are seeing improvement but we still have individual cases where the coordination is still a bit a challenge. Lots more to come on that. We did.

>> SPEAKER: This is Brenda Dare I have a comment in regards to transportation.

>> KEVIN HANCOCK: Sure.

>> SPEAKER: I believe that you do believe transportation is a gate way to independence.

But here on the ground MCO also still telling people they get two

nonmedical trips per quarter I think there needs to be guidance to
participants on how to get more extensive transportation put in a
service plan I understand that, it has to be related to things that --
are in their plan but I don't think that people on the ground have
enough information as to how do do that.

>> KEVIN HANCOCK: Participants themselves that's a good point I
agree with it. How would you suggest we do that?

>> SPEAKER: I really think the department needs to come out with
a, guidance document of some kind. That says, you know, this is what
we want to know, this is what you need to be prepared to tell the
managed care organization, you know, we're telling people to come
to us to say, tell them about the things you do in the community, tell
them about your interest tell them about the things, the skills you want
to learn where you need to go to do that. but -- there are
hundreds of people who don't come to us particularly, I have some case
examples I can send you, people who live in extremely rural parts of
Greene County are told there is just gnomon medical transportation, not
-- specifically by any one MCO, there's nothing, because nothing is in
your plan if you had access to transportation before you don't magically
have a set of goals that fit that, the day that service opens up to you.

>> KEVIN HANCOCK: Right.

>> SPEAKER: You understand what I mean.

>> KEVIN HANCOCK: Sure, absolutely, what would hope, is the service

coordinators would be talking to the participants about these services
including transportation when they talk about goals with participants
they talk about goals that may, reflect a need for transportation I
really do think that's the job of the service coordinator to work with
participants and provide that education the participants shouldn't
necessarily have to do it on their own because that's what they're
service coordinator is supposed to be for, with that being said I would
like to explore that with you further. Like, a question I would have,
how would we get to the guidance to the participants in away that --

>> SPEAKER: Right. Let's have a conversation outside of this
meeting about that.

>> KEVIN HANCOCK: Okay.

>> SPEAKER: I don't want to take up too much time I think it's
something that needs serious tension.

>> KEVIN HANCOCK: Could not agree more, if other committee members
have any interest in having that discussion we would be very open to it.

[attention]

>> SPEAKER: Follow-up on that question, or that point Brenda just
said, Tanya has a question as well she was wondering how the participants
are being notified of their new services and, I believe, that went out
in the enrollment packet we have not discussed the enrollment packet in
awhile I told her I would confirm.

>> KEVIN HANCOCK: You mean the new services available to them it

would be part of the enrollment packet that's correct. That's also
available not only on the -- the independent enrollment broker web site
and available with the 3 MCOs as well as our web site.

>> SPEAKER: Great.

>> KEVIN HANCOCK: So -- yeah.

So also the service planning, through the service planning
process, participants should also receive notification what services are
approved observe the service plan as well. Thanks.

[On]

>> KEVIN HANCOCK: Feedback would be further discussion on ways to
improve communication with participants on the benefit, for taps I
believe Brenda makes a good point, since this is a new service to people
. With want to make sure that participants know it's available to them
and how to advocate for that, having access to the service we could not
agree more.

So we did receive, we continue to receive provider feedback
certainly communication, with the MCOs continues to be a point raised
by some providers I have universally heard that's gotten
better. Nonmedical transportation is also an area where, providers
continue to provide feedback on opportunities for improvements.

Providers are actually a lot of the, the physical health providers,
are very familiar with the medical assistance transportation system but
not as familiar with nonmedical transportation. So it is quite

possible that there is an opportunity for not only educating,
participants about the benefit to Brenda's earlier point but
providers as well and -- billing, points ever billing we still receive
billing challenges that providers continue to have some of which still
relate to HHA exchange and some missing information only a few cases
we're still aware that exists but they still exist and when we were
aware of them, we will work with the MCOs and providers to have them
corrected.

Then, new referrals continue to be a point that are discussed with
some providers as well. Lester has a really good point for
referrals for service plans we'll have an opportunity to talk to the MCOs
have the MCOs talk about how the referral process works for new service
plans as well.

We talked about HHA exchange, universe tally HHA exchange, has
become much more accurate in the information that is, reflected in the
southwest participants.

For home and community based services and for procedure
authorizations as well. And we continue to react with the MCOs on
issues that are made known to us. And then, we continue to hear
actually we continue to hear a lot of feedback on the enrollment process
itself. MAXIMUS is also mentioned but the entire process the
enrollment process for home and community and community and community
based takes too long, we're looking for an opportunity to streamline how

the enrollment process is actually working.

>> BARBARA POLZER: Kevin regarding referrals is a tracking being done on reservals? For external coordinators service coordinators? The agencies? That's a common complaint we're hearing from the southwest SC agencies.

>> KEVIN HANCOCK: So just, to make sure I'm understanding your question correctly Barb you're asking if the department is tracking how many referrals the MCOs are sending to individual service coordination, external service coordination agencies at this point, I don't think we, we might be doing it on ad hoc basis but not systematically, at this point the point is the relationship now, between service coordination and the managed care organizations is that it is an administrative function we really want to step back a little bit and make sure what the requirement is, that the participants have, choice of individual service coordinator, so that is what we monitor we can't really monitor the relationship between the managed care organizations and their agencies, although the managed care organizations have been really good about keeping us abreast how that relationship will be continuing at the end of the continuity of care period that's sort of, the way that we've been kept abreast of what is happening on an individual service coordination agency based we've not been keeping track of referrals.

>> BARBARA POLZER: Thank you Haven an the service coordination

agencies have been willing to -- either positive or negative ways. So

, okay.

>> KEVIN HANCOCK: Moving onto southeast implementation give you a

couple updates any other questions before we move on about the

continuity care of period the MCOs will be often presenting activities

on the southwest couldn't intoity of care period be open for questions

later on.

But are there any ear questions for me before we move on.

>> SPEAKER: This is maybe a future question, at some point, will

this committee be able to look at the utilization and the transition,

you know so for example I think, the whole point of this program, one

major point of this program is to, expand opportunities for home and

community based living and, and would we be able to see at some point,

looking at the, the southwest and say okay -- when we started off, this

program, X number of people were using these kinds of services now, six

months later, four more people are using these service that's is what it

looks like, look at the utilization to make sure that it is doing what

we, all hope it will do.

>> KEVIN HANCOCK: Sure. So the committee has every right, to ask

the department to be able to presented how we're meeting our goals and

objecte objectives for the program, number one is home and

community based providing additional a access for home and

community based services for people who want to have home and community

based services absolutely yes. It would be down to the individual
service level for what we would be presenting not only would we be
presenting, how this program is an intervention is supporting the
objective, supporting community based long-term care how, does that look?
On an individual -- on a service plan basis? So we have, now we have
five different waivers, in the fee for service system that, that
provides services in these certain ways, what we would like to be able
to present is how, community HealthChoices is presenting what that home
and community based service system looks like for participants as
well. We're more than happy to be able to provide that, if you
have a specific way you want us to present it, send them our way.
But, the committee has every -- we're hoping that you ask and we
will, plan to present it regardless. So thank you.

Okay.

I'm sorry, someone on the phone have a question?

Okay.

Great. So I'll move onto the southeast implementation and provides
some updates. We had talked about lessons learned from the southwest.
Especially the implementation of the southwest which occurred roughly
between July and December 2017.

We are now in that period for the southeast so we're in the
implementation period for the southeast roll outs lessons learned is to
do everything earlier which is pretty obvious. But we actually are

doing everything earlier and, most of our engagement has already
begun. First is, earlier stakeholder engagement opportunities we've
been engaging the southeast stakeholders since we started talking about
community HealthChoices but we've, been having much more directed
stakeholder engagement over the last several months and every way
possible. And example is we've been engaged with the southeast health
funders, organization or consortium of entities that provide funding and
foundation support for southeast health care related activities. Those
entities we've been having conversations with those individuals, for at
least 7 months even before the implementation of the southwest and we
plan to continue them indefinitely.

They have been a great source for feedback and great source for ideas
for how we can improve the roll out in the southeast.

And in addition enhanced communication materials and training
regarding Medicare versus CHC we talked in in community many times over
about the confusion we saw in the southwest last fall between what is
happening with our Medicare coverage and community HealthChoices. The
fundamental message we'll be providing in Medicare coverage is that you
do not have to make any changes to your Medicare coverage unless you
want to make changes we want to make sure that's clear to participant
boots are duly eligible for Medicare and Medicaid you don't have to make
any changes, unless you want to make changes and we want to make sure
that it is clear that, community HealthChoices implementation is about

their Medicaid coverage not the Medicare coverage. Presents an opportunity for better coordination between Medicare and Medicaid it is about Medicaid that's the message and we want to make sure that's clear as a bell, because we could have we could have done a better job in the southwest. More education and communication on continuity of care we recognize that we learned a lot during the continuity of care period, on what that education should be like we want to make sure that the participants understand that during the continuity of care period they're entitled to a comprehensive needs assessment but, their service plans especially if their receiving community and home care services long-term care services the service plan will not be changing for the first six months they really want to make sure they're engaging with the managed care organizations and their service coordinators to be part of the service planning, as the MCOs, move forward with more direct management of the service plan at the end of the continuity of care period.

MCO provider training and outreach, occurring earlier so I'll talk a little bit later about the southeast provider sessions we've encouraged them to do earlier engagement we believe that's happening right now. We're hoping that the southeast sessions which happened almost two months earlier helped stimulate those Ks between providers and the MCOs.

Earlier OBRA reseasment we're about 97 percent completed with

reassessments. Which means we're almost done, we're actually hoping to have everything done by June 30th.

But, we are about five months head where we were last year. So all of the OBRA reassessments are almost completed this is a lesson learned wen whatted to make sure they were done more completely so individuals who are OBRA will be transitioned to community HealthChoices because their nursing facility clinically eligible know this change is coming their way a lot of time for them to understand what the impactsst change will mean for them.

Data clean up with HCSIS and SAMS the issues we had, caused a lot of problems with HHA exchange and we're already, on track to be -- having a standard data model in SAMs when we, export that information, to the managed care organizations and imported in HHA exchange, a lot of those same issues will be prevented, compared to what we experienced in January of this year.

Then, early pre-transition notices we'll be sending them a month early Ethrane we did, that will give participants more time to be able to do plan selection we'll be hoping to exceed or our goal for plan selection with CHC in the southeast, that we had in the southwest although we're still very proud of the plan selection we had in the southwest we think we can do better in the southeast and the key to that is, more communication with participants on why the plan choice is important to them. These are the lessons we built and the

implementation.

This is some of the date a.

You have seen this already before excuse me one second.

>> SPEAKER: Kevin just -- lessons learned was there ash are ever an analysis -- was there everybody an analysis of the -- portion -- analysis of the portion of people that.

>> KEVIN HANCOCK: Too loud.

[laughter]

>> SPEAKER: Auto assigned, to a plan so for example, were older people disproportionately versus people that were auto assign answer, and attendance at the community events concerned.

>> KEVIN HANCOCK: We did that

analysis that's a great question. The largest portion of individuals were auto assigned were the NFI duals based upon that experience is something we expected but it's still a goal for us to improve that the reason why is because we've -- found more than, more cases than one, that many of our community duals individuals who are duly eligible but not in need of long-term services and supports don't even know they need Medicaid coverage they didn't pay attention to the community health choices roll out, Medicare is the primary payor we still want them to have an opportunity to be able to do that plan selection so, it actually was regardless of age.

The NFI dual population, that was, by far the largest auto

assignment population category. We want to improve. We're very open to discussions especially for fee such as PCA, that work with the population fairly frequently especially the over 60 population how we can do a better job of getting the message out and actually, PCA will be part of that getting the message out, so -- so this, this slide shows a distribution of the southeast population. 127,726 individuals, the vast majority of which are duly eligible, 9 percent. The statewide average is 94 percent, so it's a little less.

[89 percent]

Still a vast majority of the population. What is interesting unique about the southeast compared to the rest of the state, is, in the lower -- do you have an arrow you could point to it. I'm just kidding.

[laughter]

The distribution of individuals in receiving long-term care, in the community, compared to those individuals receiving long-term care in nursing facilities.

In the southeast, most specifically in Philadelphia County, the vast majority of individuals receiving long-term care are receiving those, that care in the community. Which is exactly what we want, for the rest of the state because that does reflect participant references.

So the southeast, in terms of percentages is a little bit closer to where we want to get to, but there's still opportunity for improvement as well. They have 33 percent of the total population in waivers

11 percent in nursing facilities. But, as you can see, the vast
majority of people receiving long-term care are doing it in the
community that's what we want.

>> SPEAKER: In the southwest zone, has there been movement from say
prior to community HealthChoices to now in terms of the percentage of
people living in nursing facilities versus in the community?

>> KEVIN HANCOCK: Not much, not much percentage change from what
we've seen so far, so it is still 20 percent, nursing facility and
16 percent in the community. So we're hoping that will change over
time the southwest will actually be, a focal point because ever the
fact they were first they have a 50/50 split a little bit lesser to a
another 050 split we would like to like to see them moving in the
direction like we are seeing in the southeast. So the -- there are a
lot of reasons a lot historical reasons why the southeast has this --
this type of, direction with home and community based services. But,
as I stated we would like to see this percentage reflected in the rest
ever th of the State.

>> SPEAKER: Everybody heard everybody say nothing was going change.
Those non-duals, in the waiver, that 10 percent those are the people,
that receive only Medicaid.

>> KEVIN HANCOCK: That's correct.

>> AUDIENCE MEMBER: They do have to change out of their
HealthChoices or -- excuse me the HealthChoices plan if they had gate

way they would have to change those people alsory think need to be focused onto make sure they know this is going to be changing and, they have to make a change and they should be doing research to be able to figure out which of these 3 MCOs because that becomes a huge problem. So that's -- I know it's small people and in numbers. But that becomes a huge problem. At the beginning of the year, I was being told that I was putting people in health and safety risk, when I was not coordinating their nursing services that I had no idea about.

>> KEVIN HANCOCK: So you're raising a good point about that ten percent it is true we have a portion of the population in CHC, who are Medicaid primary which means they're not duly eligible for Medicare and Medicaid. And many of those individuals are in the health choices program most of them are in HealthChoices program, the physical HealthChoices program if they were in a a plan that was, in both HealthChoices and community HealthChoices they would have been automatically moved, to that sister CHC plan. And that did represent a pretty significant portion of that population there was another portion of the population that did have to make a change you're right they had to change from their physical health plan managed care organization to a community HealthChoices plan. Those are the people, we would love to see 100 percent of those people, be involved in plan selection to make sure they are making affirmative choice but that is a very good point they do have to make a change for the physical health services, at the

very least to be changed to a -- to a, to a new managed care organization.

>> AUDIENCE MEMBER: One thing I did see as I pointed out there was no coordination because no one, the other plan just said well, you left me, and the provider that was paying, providing the service didn't even know that, they could not bill that person no more.

>> KEVIN HANCOCK: Right.

>> AUDIENCE MEMBER: I think that's the coordination piece I think at the top level should be so seamless that the consumer and the provider don't even, don't even -- are not even impacted by where the money is coming and where it's going.

>> KEVIN HANCOCK: The way it should work they have a 60 day continuity of care period in physical health services with the implementation of community HealthChoices they should have had a 60 day period where they were receiving the same services from the same providers regardless whether those providers were in with the managed care organizations or not.

And that should be, seamless that's 60 day period, and during that 60 day period, the participants should have had communication with their new managed care organization on what that transition is going to look like.

So, we do have examples where that didn't work that well we can apply those example those the southeast.

I think you're raising a good point that's a lesson learned we
should capture, actually think we should, when we talk about lessons
learned we should add that as a bullet that say problem that is for a
small population. But the population is Medicaid primary for physical
health services as long as long-term services and support it is does
effect them in a way much more direct than a lot of other participants
thank you.
>> AUDIENCE MEMBER: I say that because I say that because, when you
go around everybody hears I don't have to worry nothing is going to
change LAN-you're right. For them, there will be -- there could be a
managed care plan change you're absolutely right for physical health
services.
Benefit package is the same.
>> AUDIENCE MEMBER: Yeah.
>> KEVIN HANCOCK: What is the different they might have to change
managed care, the managed care plan administering that benefit package.
So this slide shows the distribution as you see, in population by
county.
Philadelphia County, still has the largest portion 87,000.
Montgomery and.
dell ware and 13,000 and bucks has
9,000 and Chester has 5,000.
So -- so for the southeast implementation focus, we've already

touched a on a lot of this, we'll be focusing earlier OBRA

assessments 97 percent completed now, participant communication

planning is also something that is under way.

Aging well will be, engaged to do that participant communication and

that will be starting in the August time frame we'll have a minimum of

60 sessions are going to be scheduled 40 of which will be Philadelphia

County itself.

And we're also going to develop an online participant training so we

have online training for service coordinators, physical health provider

and home and community based providers and nursing if a facilities and we'll be developing participant

training participants can go on the web site and see what it means to

them as well the initial touch flier something we sent out in early

August last year will be going out in mid July so that will be just

going out in a couple of weeks that's the first notification,

participants will be receiving that the -- the community HealthChoices

implementation is coming their way. Provider outreach and education

something I already mentioned.

I -- just hope to go through provider outreach and education really

quickly. We had 9 sessions in the southeast, provider education. We

had five in Philadelphia County and, Temple University.

First week of June and the third week of June we had, one in each of

the four suburban counties all with either, a -- a state university or

a community college they were heavily attended by providers we were very

happy to say. And we had a great, every single one was a great
conversation morning sessions were sessions that were focused on
overview of CHC in those sessions the providers presented a lot more of
an understanding what community health choices would mean to them, which
means they were, not only -- paying attention to what was
happening, in the southwest but they were also talking to southwest
peers what the change meant for them, they had very educated questions
about issues such as transportation. Medicare and Medicaid
coordination.

What service coordination would look like with community
HealthChoices. And just understanding that difference between managed
care payment mechanisms and fee for service payment mechanisms across
the Board it was, a -- every single session I was only -- I was unable
to attend one of those sessions but all the other sessions, that I
participated in were just universe tally very heartening in the way
that a lot of the providers went to the effort to educate themselves on
how this change is going to be effecting them and, their -- the
participants they support.

And in addition we continue to work with special organizations that
work with populations that may be difficult to reach. Based upon the
communities that they live in, are or potential language barriers,
Philadelphia incorporation for aging gets a shout out once again for
hosting a session the third week of June, where we were able to, to

managed care organizations and the department were able to talk about community HealthChoices and, to be able to provide meet and greet contact information so we'll be able to have opportunities to outreach within the communitiness the future great conversation with great questions and, it was really good way to make connections with entities that support populations that may otherwise be difficult to reach. We were very grateful for them to -- for your willingness to do that.

So population identification, will continue to be an effort for the southeast.

And, part of the challenge, and the southeast is making sure that the we're addressing the diversity that does exist in the southeast communities.

Now moving onto communication -- very quickly we already talked about the provider sessions. We will, have a webinar developed in, July 23, specific to county nursing facilities and how this change is going to be effecting them.

The county nursing facilities participating in this webinar were brought to us because they have particular questions on how it is going to be effecting them and all five county ins the southeast have a public nursing if a sill.

So that's the reason why we're, sort of highlighting the nursing facilities they have, we have five public nursing facilities with five very large Medicaid populations all those nursing facilities we wanted

to provide them with an opportunity to ask questions for how this change
is going to be effecting them.

And we're going to be updating all the online training that includes
for service coordinators and nursing facilities as well as home and
community based providers and I already mentioned we're developing a new
online training for participants as well.

Participants I already mentioned will be receiving the initial touch
point flier on July 23rd. The pre-transition notices will be going out
much earlier August 20th, through the 31st which is a month earlier
than we sent them in the southwest and then, immediately afterwards they
will be receiving the enrollment packets from the independent enrollment
broker and they will be going out through the month of September and
that will advise participants what they need to do to make a plan
selection.

I already mentioned the 60 participant sessions that will be held
from August through October I think that's a minimum number possible we
may have more and, we'll also be mailing a life flier did go go out an
July 2 June 22, more will be going out another lesson I'll
highlight is opportunity toss better communicate about the LIFE Program
as the enrollment alternative for community HealthChoices we believe
that, participants, the life preparation, which is, a managed long-term
services and supports option that is fully ingreated, compared to the
coordinated model that is offered by community HealthChoices we believe

that, for participants who are interested in having an integrated model,

the LIFE program chose are available in all but one county, in the

southeast, would be something that we would want participant toss

consider and certainly have opportunities to ask questions about we're

working with the LIFE plans to be able to augment education for the

independent enrollment broker for the LIFE offering and also looking for

opportunity toss do a better distribution of, of information that the LIFE

plan for the participants we think individuals nursing that sill

clinically eligible over the age of 5 the LIFE option is a good option

for participants if it has the type of, benefit.

[55]

The type of services they're receiving, we're encouraging them to

learn as much as possible.

>> DREW NAGELE: Is there a way for participant to be able to sort

of, understand what LIFE would be like under the LIFE plan contrast to LIFE

under the HCBS plan.

>> KEVIN HANCOCK: We're looking for a tie do that, an example would

be to compare the offeringsst 3 managed care organizations in CHC to

what the LIFE plans are offering as well the LIFA plans in general have

a standard, packet of benefits that they offer to participants in the

same way there's an adult benefit package in CHC. We would like to be

able to do it visually to show comparison between the two.

>> DREW NAGELE: Well that would show what the whole menu of services would be I'm thinking more as an individual participant, how would I, make my decision and it would be based on, the person centered plan under the LIFE plan or the person centered plan under the CHC? Do you see what I'm getting at? It's going to be different for every person.

>> KEVIN HANCOCK: Just trying to -- I get what you're asking just trying to figure out how you would think we would, send that -- I'm open to suggestions.

>> DREW NAGELE: I'm not even sure I'm thinking how difficult it would be for a participant to make that decision.

How would they have the confidence to go with one or the other? You know.

>> KEVIN HANCOCK: One of the opportunities would be -- so, there are real differences between LIFE in community HealthChoices. Win of the main differences is, is -- the integration component, LIFE is fully integrated. It fully integrates Medicare and fully and then all of the Medicaid services including behavioral health services physical health services pharmacy services and long-term services and supports. So, having participants under that, the LIFE truly is a one-stop-shop compared to the coordinated approach with community HealthChoices would be one way we would try to compare and contrast the two programs. Another approach would be, for participants to understand the service

delivery model that LIFE uses compared to community HealthChoices LIFE

uses a kind of a hub model with the LIFE centers as a way to receive

significant number of some of their, some of the services they require.

Understanding that, is -- a component of the program

comparedded to the, the approach that, that CHC MCOs, offer which may be

a little bit more decentralized. Would be another way to

look at differentiating the two programs.

>> DREW NAGELE: I actually think the LIFE program is under utilized

has a lot of potential and, I think it is a great idea.

>> KEVIN HANCOCK: I I agree.

>> DREW NAGELE: It's a great idea to market it it's hard for an

individual to conceptualize what life would be like.

[laughter]

>> KEVIN HANCOCK: What life would be like that's not a pun.

Right.

I still think we can do it I think we just have to look for

opportunity toss present the -- the service model offering the care

model offering that is different between the two. We think there's

enough of a distinction between the two, they're both long-term care options. But they both offer services for

overlapping populations, but we still think we can, develop enough of

communication to be able to contrast the two, and -- give participants

enough information to be able to make a planned choice.

>> DREW NAGELE: Do we know where the -- LIFE program ---brenda

--

>> SPEAKER: Comment.

>> KEVIN HANCOCK: Drew has another question. We have another question here after you -- and then, we'll get right back to you.

Flowing anything I mean coming into the southeast is like prime opportunity to do that because, you're going to, have proper potential for that, in denser population areas if you build it around a center. You know, where you know people need to be able to get to it you know, so it is actually more like the European models that are successful in Netherlands and some of the other.

>> KEVIN HANCOCK: California.

[laughter]

>> DREW NAGELE: That's a stretch.

[laughter]

But, um, I just think that, this is a time to really try to market that and really, try to appeal to people who might be on the edge.

>> KEVIN HANCOCK: We agree. Thank you.

>> AUDIENCE MEMBER: So I completed going can to a -- a presentation about the LIFE program and how they would set things up there.

It would be centered more about independent living or being more independent it would be a little more that way where LIFE program would be a bit safer in the safer environment and, kind of easier than your MCOs

and having all those, where LIFE would have it all together integrated as you said, it would be a little safer than the

CHCs or your MCOs.

And the results you're going to have a safer result in that LIFE

from what I understood in that presentation.

>> KEVIN HANCOCK: So I actually would challenge the point of safety

both the LIFE plans and the CHC MCOs have the requirements for

the health and safety of participants.

>> AUDIENCE MEMBER: But well the MCOs would have more control in

the LIFE program and so you would have more chance of running it

yourself in the LIFE program.

>> KEVIN HANCOCK: So --

>> AUDIENCE MEMBER: More control.

>> KEVIN HANCOCK: So let me restate

the program, the LIFE program because of the full integration with

Medicare and Medicaid physical health behavioral health and long-term

care, because there's a -- a hub associated with LIFE had a has a

standard check infor participants that

may increase the need for service need service and also be a -- more

stable model for the delivery of long-term care is that kind of the

point you're making?

>> AUDIENCE MEMBER: Yes.

>> KEVIN HANCOCK: Okay.

>> AUDIENCE MEMBER: Just seems to the environment is more volumed.

>> KEVIN HANCOCK: I'm pretty sure the LIFE programs would agree

with you and we certainly, what you just described is, we believe is a value to the model that's why we're supporting it strongly we believe there's an opportunity for participants to learn more about what you just described.

>> AUDIENCE MEMBER: Yes.

I think it's you have more control in the LIFE program okay.

Interpreter error maybe the control is a detriment.

>> KEVIN HANCOCK: Folks on the phone could mute, if you're not speaking we would appreciate that. Thank you.

We're enjoying the editorial comments.

>> AUDIENCE MEMBER: Okay thank you.

>> KEVIN HANCOCK: Thank you.

So Brenda I think you had a question as well.

>> SPEAKER: Well, comment really and kind of piggy backs on the last one, the editorial comment you heard was, I asked who has more control in the LIFE program because I could not hear really well what was being said. But I think, the main difference from what I can see between the two models is how much the decision-making input and how much consumer direction does the consumer want?

If you really want to control your daily activities,

individually, to a maximum extent then, CHC is much more your model if you don't want that decision make decision-making you want a more predictable, then the LIFE model is more suitable model for you perhaps.

That may be -- especially to an aging population how I see it best marketed.

>> KEVIN HANCOCK: So thank you for the feedback.

I would suggest that there is opportunities for participants in the LIFE program to have input how the service plans are developed.

But --

>> SPEAKER: The service plan yes but, their day-to-day activities are much more stable much more planned out.

If you want to live by the seat of your pants, CHC is a much more I think, better fit. There's much more day-to-day flexibility.

I guess is my point.

>> KEVIN HANCOCK: I think others would agree with you, Brenda there is more of participant Drakes that could be available in the community HealthChoices as model, especially if you're receiving long-term care in the community.

>> SPEAKER: Right.

>> KEVIN HANCOCK: So -- okay.

Great.

Okay.

Then moving onto ongoing communication -- I think, we always have this slide here so just a plug. We'll continue to have the MLTSS sub-MAACs the first week of every month, indefinitely I will continue to present, at at the consumer sub-MAAC it was proposed we had a great session in

the southwest with the first regional consumer sub-MAAC in the southwest
in May and then, follow-up, consumer sub-MAAC in June and, hopefully
I'll continue to be invited by the consumer sub-MAAC to present how
things with community HealthChoices, long term sub-MAAC, focusing with
the fee for service program and providing updates with the community
HealthChoices as well, I continue to presented updates on medical
assistance on the advisory committee, when invited and -- we'll have our
third Thursday webinars including the third Thursday webinar for July
indefinitely.

We, all 3 of the managed care organizations have participant
advisory committees which they have talked about, in a previous MLTSS
sub-MAAC also be local advisory groups as well and we'll continue to
update the CHC web site on all information related to community
HealthChoices to be up to date as possible. Then, as you see on this
slide, this has CHC MCO resource information including email address for
provider and the web sites as well as 180 numbers.

And then, if anyone has not signed up for the CHC Listserv in
the room we strongly encourage you to do so.

Vehicle's office has a much better way to encourage people, I'm into
the nearly as creative I would encourage to sign up for the Listserv the
community HealthChoices web site HealthChoices.pa.gov continues to be
updated on frequent basis we encourage to look on a weekly basis to see
what has updated that has information not only for providers but also

for participants. The MLTSS sub-MAAC web site will electricity

transcripts as well as presentations for the -- for the were offered at

the sub-MAAC we would encourage you to go out there and well to see the

updates if you were not able to attend the meeting. We

encourage you to continue to send comments to RA mailbox ra-pwchc@pa.gov

continue to call our provider number, if you have issues or participant

line if you have participant issues both of which relate to community

HealthChoices last certainly not least the independent inbreaker line

will be used for southeast implementation and continued to be used

forward southeast plan changes with questions asked about CHC, with that

any other further questions before I turn it over to the 3 MCOs to be

able to present the updates on the continuity of care period.

Thank you very much with that -- do you have a order you want to

pool poll thank you Kevin next is the CHC continuity of care updates

with Randy and the 3 MCOs.

>> KEVIN HANCOCK: Randy you're being asked to kick it off.

>> RANDY NOLEN: I'm Randy Nolen I would like to thank Kevin for

taking 40 minutes over of officer time over his agenda slot it is all

your fault.

[laughter]

You take the credit for the program, you have to take the faultings

too.

[laughter]

Real quake as a -- um, overview, one if I'm not here next month you know why because of those comments.

[laughter]

[quick]

Just real quick I mean, the -- the focus what we're doing rightfully is wrapping up the continuity of care period.

Working through the issues that Kevin addressed a lot of them earlier in regards to the person centered care plan, denial notices working through that part of the process we'll continue to work through that as we move into the implementation and readiness review for southeast.

Most of our emphasis will be working on the network adequacy piece so we're working with the MCOs to ensure that they get providers assigned to the network that's going to be the biggest thing we're working on right now.

As far as moving forward.

I really have nothing else today, I wanted to give the MCOs the time to talk about their, the continuity of care period and the different topics they're going to go through.

So, I'll bring all of them up to the table, I will start with ray from UPMC, with his presentation.

Then we'll go to Pennsylvania health wellness. And then,

AmeriHealth last, so -- turn it over to ray.

>> SPEAKER: Good morning I'm ray Prushnok, the associate vice president for the community HealthChoices UPMC. We were asked to cover a few hour areas specifically we're available for any other questions. So -- my first slide goes through our complaint grievances volume for the year and just little more detail in terms of what we have, you know what we've seen you know volume end. We had 142 complaints, through the first quarter.

You know, they have been you know a lot of very individualized issues the most common issues are CHC operations, so that may be issues around material materials ID cards or you know other aspects of the operations provider Curtity, remember experience when they're working with physical health provider primarily in the this area you know some issues around noncoverred physical health benefits a lot that comes down to understanding the -- the overlaps with Medicare and and -- Medicaid.

These volumes are across about 43,000 members. So relatively low volume of complaints over all. But each complaint is you know, regard less of the volume incredibly important to us in and each individual who brings it forward, we had 29 grievances through the first quarter. For the most part, you know these were for denials of physical health services, pharmacy denteddal and DME this is I think really what you would expect based upon the couldn't you knewity of care period and none

of those -- nothing for HCBS for example. On our next slide, this is
really you know I think where there's going to be a lot more tension a
lot proper focus from us I think a lot more of the questions. So, far
we have had 421, increases for services, through you know, basically,
the first 6 months of the program.

And, we have had 72 denials, throws are for all four for PAS
services.

You can see the, the break down of the approvals and you know
again, just for additional context we have about you know, 7100 waiver
participants served by UPMC right now it's about, 1 percent on the
denial rate closer to 5 percent on the increase side. And the next
slide is, very brief again we, have not made any network changes as of
6/30.

For you know, that folks that work in service coordination you know
we put an emphasis on the you know InterRAI as we headed through the end
of the couldn't you knewity of care period we are, 6 days beyond that
we're still evaluating the performance and just really the completeness
we're still formulating final decisions on how we'll be moving forward
with our service coordination network as I've stated in previous meetings
in other forums, we will expanding the number of partnerships not to
everyone, but we're being for the highest strongest performing network
we can provide to our participants. And -- last slide was, questions
around nursing home transition.

And you know we, have had 62 nursing home transitions, so we, you know looked, through you know, again this is not inclusive of what we sort of consider more routine nursing facility discharges. We're really looking for these volumes to increase as we move forward.

And, you know we have, 54 people who are, in -- you know, process, and from our standpoint those are people where we have open authorizations for community transition services where we're actively in the transition planning. Again this is an area where, you know with are really focusing on seeing these numbers increase in the months ahead, in large part, um, you know with the help of many of the, existing organizations who have been doing service coordination our focus has been getting our nursing facility service coordinators on Board up to speed and building relationships with the participants.

So, that concludes my slides I don't know Ran TJ if you want us to take questions collectively or individually rightfully.

>> RANDY NOLEN: You can take questions individually rightfully. Drew. Flag anything thanks.

Ray, on that transition from nursing homes you're just talking about people who would not ordinarily be discharged because they, have exhausted their benefit and they're going home or whatever.

They're definitely CHC they're getting home and community based services in their home now.

>> RAY PRUSHNOK: Yeah we are looking strictly at people who were who were long stay nursing facility, in the facility, who we assisted to newly enroll in home and community based services upon return that is sort of the, the line we drew.

There are additional individuals who, left nursing facilities as nursing facility ineligible in are not in that total.

>> DREW NAGELE: It would be interesting to note not from your plan but all the plans what the -- what the profiles are of people leaving nursing homes and which particular services are most useful to them in making this transition.

I don't know whether that's something the department would look at or -- you know but it would actually help I think, to -- to promote the work of the nursing home transition teams.

>> RANDY NOLEN: Certainly a good idea for us to try to gather that type of data to profile, who was successfully discharged we can certainly take a look at that.

>> THEO BRADDY: Any thoughts on the team that helps you with the transition like it was, it was an external coordinators or, or -- be subcontractors.

>> RAY PRUSHNOK: Almost entirely not to pick on Shawna, voices for independence has been you know a very close partner you know, so far. We've been working though across many other organizations the AAAs namely and you know, others like triple and you know, the and our model really, you

know is, a -- in many ways a continuation of the fee for service system but again, there's a couple new dimensions to CHC. You know first we have, service coordinators who are based in the facility. Their main objectives and priorities are the quality of the supports and clinical care that is happening in the facility and supporting those residents but they also are, um, actively identifying individuals based upon their, person centered planning in the buildings who we then refer to external partners by in large.

And then we coordinate you know sort of the next land off of the Baton to the community based service coordinator. So they're really focusing that energy where there is expertise around housing and supports and you know, peer-to-peer counseling and helping that person you know get through the transition.

Okay.

>> SPEAKER: You say -- you say can you say a bit more you mentioned the provider networks thinking about expanding your partnerships and also, kind of, working closely with the high performers or the highest quality, but can you say more about what that means? And how you envision that kind of working specifically going forward?

>> RAY PRUSHNOK: Yeah I mean we're been looking at a number ever things I think from the very beginning, we have talked about having what we call hybrid model so we have, internal personnel that provides service coordination. You know, at present, that number is

going to be probably somewhere less than you know, 50 percent, but you
know in that vinted. vicinity, as we fill out the remaining half, we're sort of little
more than half we have already identified some ongoing partnerships and
we're, you know looking to add some more it's a variety of things. It
is the, you know, quality of the performance. So whether it is you
know the, the InterRAI or the care plans or more you know, qualitative
things like the quality of relationships the you know, the responsiveness,
the -- you know, follow-up with our participants it's really are they
delivering on our expectations. And as we move forward you know we
looked at this as not a provider relationship. It is an extension of
ourselves. So, you know, if we're working with an organization, that
is really, our care model it is consistent the same training the same
expectations, that we would have on our own personnel we
like the hybrid model it gives us a strong comparison to keep us strong
making sure we're upholding the highest standards.

>> SPEAKER: Just the same question but, I'm not sure if you are
referring to this beyond the service coordination entities but actually,
your provider network it sex in terms of the, entities which are
providing the services and how you think about, now the continuity of
care period looks like what it looks like.

>> RAY PRUSHNOK: So for PAS agencies and providers more generally,
we have a -- no immediate plans to you know make changes to the network.
You know we, um, we are looking at the few different areas

specifically. So beginning to think through how do we you know promote work force training and education, and how do we begin to promote different you know, sort of value based payments. You know, in the longer run what we would like to be able to see how do we pronote longevityity and the organization that's have invested more in the work force.

[promote]

How do we demonstrate that, that's a work in progress. There's been really getting systems down Patted for the first six months working with providers we have not introduced those new themes it's something we're arrange yews to do.

>> SPEAKER: Ray I'm wondering is 62 the transition, where do those individuals go.

>> RAY PRUSHNOK: So these are all individuals who are who returned to their own home or we worked on supportive housing. This saw, you know, two HCBS and community settings at this point we have, examples where you know, it has been for example, you know, transitions with Jim Peiffer and Presbyterian senior care it's working with organization that's help us supply that housing. We you know, have a set of folks that work on you know, housing relationships primarily.

But the -- for the most part it is, I don't have a break down to know how many returned to the home they left versus you know, um, sort of a new housing but, that's something that I will -- I am interested in

we'll look into it.

>> THEO BRADDY: Ray could you talk about your -- the loam mod process. If there's been any denials with that? And how it's been done?

>> RAY PRUSHNOK: Yeah, home mods have been you know, have been a challenge for a number of reasons. You know I'll be the first to admit it, we, um, we had you know, home mods that were in varying states of approvals that were you know, took us you know, some time at the onset to really, you know, understand and untangle whether it was you know initially approved or if there was a you know sort of final bid that was selected. So the first thing was just sort of getting through you know some of what a backlog on home mods that were sort of somewhere in the process, when 1/1 came that's an area where we've learned a lot. We will apply that learning as we come into January and we know a lot more what to expect. Some of that has been you know a lot of back and forth with service coordination entities to say you know, to get all the documentation to initiate work.

And other places work has been initiated we flowed to catch up and figure where that is.

Terms of our -- you know our process, I mean we're -- we're, um, per the service definition and you know, per the you know the home mod process we're engaging in independent evaluation of home mods. So you know, and -- that independent evaluation, we, then send out and

receive back at least two bids on that, on that home mod request.

So some things are don't require that if it's a sort of a smaller

routine type of home mod but the larger items that's been our process so

far.

>> THEO BRADDY: So the smaller stuff you recall like home

adaptation?

>> RAY PRUSHNOK: I -- I guess I've been calling them all home

mods we can tease that a little more and I'm sure others do. On our

team, but my -- but it's not always even necessarily the smallest things

maybe more, sometimes you know even a stair glide it may be more

expensive but more routine we don't necessarily put that ought for formal bids.

>> SPEAKER: Lester Bennett, let's talk about the transportation

piece from the medical assistance transportation, down all the way to

the nonemergency nonmedical transportation. How are you addressing

those?

>> RAY PRUSHNOK: So as we, um, as you know Lester, we, we've tried

to be as adaptable as possible there are sort of our contract standards

where you know, it is really based around a more formal model, where

providers, provide provider type 59 they have a PUC license,

there's are they're sort of a formal transportation provider.

And that's very different than what often happens with you know service coordination entity that may be going out and buying you

know, voucher there's a cab company or bus passes or you know, other

areas like friends and family. So we have tried to be as adaptable as

possible and where you know, it is on a service plan and it is something

that is going on.

We, have -- by in large just paid for it, plead sure you know, we

work with the service coordinationen at this time to make them whole

make sure there's no disruption. As you also know it's not always

perfect, because you know it requires a significant amount of back and

forth between us but really our goal is to really minimize disruption.

We have a -- a transportation vendor that we use, for managing

our transportation network and coordinating trips. We're working with

them to make sure we keep that same flexibility so they can, continue to

do things like friends and family and otherwise. But again we're going

slow and again, making sure that we, maintain those supports and, you

know, you know -- make sure that we're paying for it, when service

coordinators bring it forward.

>> AUDIENCE MEMBER: Okay.

So your broker that CTS, CTS broker, that is doing your

transportation when do we get some contact with them so we can continue

to make sure these services are being rendered for these people?

Because again we, I they're at the end of it, there's this provider

being paid and that's where we're seeing a lot of, um, problem problems.

>> RAY PRUSHNOK: Yeah I think as we, we move forward more and more

we'll be pushing through CTS again it's sort of again with these

existing service coordinators again we're, continuing to cover what has

been out there.

If you have, maybe more individualized issues we can work through and you want to transition some of that volume you know we can have that conversation.

>> AUDIENCE MEMBER: Okay.

>> RAY PRUSHNOK: Okay.

Pam?

>> PAM AUER: I need to go where Lester is.

I have a couple of questions.

I have a couple of questions.

If consummer consumers take the variety of services out there, the 32 options out there now to try something different with their attendant care, what is the ease of changing their service plan if they're not, if they find it doesn't fit them? Right now, sometimes, changing service plans as it exists at least in our part of the State, sometimes can take a little bit.

Is there -- I'm not sure what it would be like with a larger with the MCO, what would it be like?

>> RAY PRUSHNOK: So I mean, first thing just to complete ignorance I haven't looked specifically to see you know the -- the, um the number of, new service types, that -- that participants have had, that's something I jotted down I'm going look into, to see what extent people are taking advantage of all of the new services that are available to

them.

And in terms of you know, their ability too, you know change or, you know, frankly experiment to see if the service works for them to fill in their gaps, that's really, the conversation with our service coordinator who is regular contact with them always available if the person has a change in condition or would like to have another look at the service plan you know that's really, upon their request and, our obligations are to get out there, with that request, within two weeks time. So that's, what we're working towards and prepared to do.

>> PAM AUER: Along with that question too I was listening to Kevin say that, I don't always hear until the current system, people talking about service planning about all the different option that's are out there, is that part of your training process under PCC to say all the different types of options that are out there? Because, as an advocate, I educate my consumers before they go into a service planning thing but it would be an absolute incredible thing if it was part of, the PCC process, the person centered process. Is that what is currently happening is that something that can be added into it.

>> RAY PRUSHNOK: We've been doing a lot of inservice training, we've done you know inservice training on, you know working with you know, people with brain injuries to you know, working on you know, with the you know, Pennsylvania assistive technology foundation to how to you know, our work flows around home mods or NHT, employment, so we've been

doing a lot of inservice training for our service coordinators. It is
certainly not enough. So you know it's really having the right you
know, resources and, sort of, you know, main office to make sure we can
answer questions but on going way to continue to sort of, promote those
resources. Again you know, another thing I jotted down today is are we
effectively promoting you know the nonmedical transportation benefits?
Are we making that you know a -- a discussion point? You know, so
it is not something that they have to bring up. Those are things again
I can't say we're doing fully. We're you know, we are, but again
that's something we're committed to do and continue to train for.

>> PAM AUER: I do recommend the training, that liberty of PCIL put
together the independent living one.

I did part of the train the trainer it was really good, if there is
any piece to it we could add I think working on PCC, as a community
we've been doing it for so long the big piece will be training people on
their choices. Um, if you, if the different MCOs would reach out for
that stuff.

Another question I'm going to go into NHT questions, when you're
doing your data, collecting your data for NHT are you identifying
barriers people are experiencing is that something that can be seen?
Because as an NHT we've always had to have, they had to have a barrier
other than waiver, to get nursing home transition services it would be
really interesting to see, what barriers are, that you all are

experiencing.

>> RAY PRUSHNOK: To be perfectly honesty don't flow how we're tracking barriers I will find out.

>> PAM AUER: Okay.

How are you tracking the individuals that might be, NFI? And you said they don't -- loose through the system, there's something you know, I know that we are having more discussion on it, are you currently tracking anyone that might be NFI that might be the CILs may be able to help or other organizations.

>> RAY PRUSHNOK: I mean, it is definitely you know, a part of the nursing home transition process, so we -- eligibility once you're out, so that is something we're, we're tracking working with the CILs on those cases emerge.

>> PAM AUER: Okay thank you. Are you sure are you sure.

>> BARBARA POLZER: We have a question on the phone from Joseph.

And he wants to know, what are the numbers researching counseling behavioral therapy or cognitive rehab at this point?

>> RAY PRUSHNOK: Unfortunately I don't know, I don't know off the top of my head that is something I can make sure we provide at the next meeting.

Sorry Joseph.

>> RANDY NOLEN: All right. Um, now we'll move onto Pennsylvania health wellness, Anna Keith.

Thanks ray.

>> RAY PRUSHNOK: Thank you.

>> SPEAKER: It's bright.

[laughter]

Okay thanks folks I'm Anna Keith senior director of strategic partnerships for PA health and wellness.

I'm going to put on my glacis can't see anything close up.

Okay.

All right.

For the areas that we wanted to approach you and share information today, the service hour trends complaints and grievances nets work statistics and our NHT transitions spotlight on the first slide, during continuity of care, we did not have any type of reduction in services that, were the base was arbitrarily reduced. We did see some service hour changes.

And those were reflective of, um, a change in MCO mid month.

Oregon if an individual passed away. We also had trigger events that might temporarily increase a plan and then, when the individual was in a different situation they, returned to their base number they had originally. By participant request.

Primary reasons we saw for service hour increases during continuity had to do with the trigger hours the change in the service plan since January where they identified, new services that were needed.

And then, increased in PAS with service coordinator or if they

elected to use home delivered meals or something like that in addition.

There were no changes in OTPT or HCBS skilled nursing services

atmosphere all.

Okay the next slide.

Complaints and grievances -- those numbers are broken out on our

graph what you see here is an average day to resolve complaints of about

24.

The majority of concerns or complaints came around transportation.

Our favorite topic.

For individuals that complained regarding perhaps not receiving what

they expected in courtesy when they called we identified those when we

tracked them down we've been doing reeducation of staff. LTSS issues

were being closely Monday ored to ensure the contractor levels,

as early on with our -- transportation vendor MTM, there was just an

inconsistency in the expectations we had for the transportation vendor

and what we were receiving from them.

Things as simple as defining what door to door meant we had to get

back in and reestablish what those expectations and guidelines were and,

as Kevin indicated earlier we've seen a vast improve improvement in the outcomes much fewer complaints from folks in the

community.

And then, drug form layers was another area that we saw some

complaints and grievances around state contract and Centene corporate

policies.

And another slide -- the ring slide okay just a little more information on grievances. Most complaints and grievances in the first quarter were related to the go live and managed care transition periods.

The pharmacy continuity of care period ended March 1st and resulted in a higher number of grievances.

Appropriate interventions were designed or -- have been designed upon analysis of the complaints to ensure adequate participant experience.

The top grievance was around the brand or generic prescriptions. And that was primarily, the issue.

All right on the next slide are the network slide.

Just running through really fast we are really building the network out, it is -- we have full network access in the southwest. And more providers are being added on a regular basis. With the strong physical health framework to support the LTSS participants.

You can see by the numbers, um, it is pretty thorough.

And then NHT transitions we've been pretty proud of our NHT transition process we started working with community partners as early as, November and December to talk about how we were going do this and, build it out. So you see our numbers there.

In total we've had 74 transitions. We had 20 in the pipeline that should go home in the next 30 to 45 days.

And then we have another 59 that are identified as seeking transition out of the facility and we're working to figure out what the issue is with what they need. Is it eligibility issue? Housing issue?

What that is going to take.

And yep. That slide has some percentages there for the ones were complete. The ones that are still pending those are the ones that just have not gotten out yet. And then a grand total of all folks we're working on in transition is about 186 individuals we've worked on in some form for transition. Those are all folks that meet CHC guidelines

and actively either transitioned or working towards transition.

And that's what I've got for you.

Okay.

>> RANDY NOLEN: Any questions?

>> SPEAKER: I gave them all away.

>> AUDIENCE MEMBER: Hello miss Keith can you talk about, Lester Bennett, again, can you talk about your transportation piece from the -- medical assistance transportation program down to the nonemergency, nonmedical transportation.

[laughter]

>> SPEAKER: I'm sorry I'm laughing because your facial expression kills me.

>> AUDIENCE MEMBER: I'm learning to hide them better.

>> SPEAKER: You're not doing a good job.

>> AUDIENCE MEMBER: If I don't say nothing, people can see what I'm thinking.

>> SPEAKER: Let's go to nonmedical transportation.

It was a learnin learning curbing curve from bus passes to friends and family. We currently live submitted documentation from folks that are receiving a request for reimbursement or, approvals for bus passes or, friends and family reinforcement.

And MTM, has been working with us to do all of the rest of the transportation. Recently, in a conversation with service coordinators as early as this past Tuesday, I talked to them about making sure that the service plans identified transportation, it really helps facilitate movement a lot faster.

And um, they just need to do a good job of being a clamp I don't know for the individual they support to get it in the plan and written right. If it's not there it's harder. It is an eligible benefit, and they should have it. Have it accessible and, as we move into the southeast and we do that lessons learned, we're identifying with groups such as liberty, how did we do that best? We had a recent question, had a wand are wonderful conversation how they have done it, so we can learn from those lessons so we can apply them and not really have as many bumps that we saw, in the southwest early on in January, February March.

>> AUDIENCE MEMBER: I was just thinking, are we, um, so MTM is handling the contracting of the provider ins.

>> SPEAKER: Uh-hum.

>> AUDIENCE MEMBER: So are -- do you have an idea what providers have been contracted?

>> SPEAKER: I don't have that I can certainly get that information.

>> AUDIENCE MEMBER: Yeah. I'm starting -- at the end of last month, when, um, may 30th or the next day there was a transportation meeting and I got an understanding of what I think could be some of the problems is, um, because there is a funding sources that have to be boxes have to be checked off first before certain things be asked of, I want to make sure that process is being done.

Because what I understood was, from the para-transit system, in order to get the -- discount, they had to make sure that the health benefit was not used first.

And that is where that jumping back and forth from, we got two benefits I use it, that's where I was start to go see some of those issues too, hopefully --

>> SPEAKER: This is a system issue.

>> AUDIENCE MEMBER: We're working on it, we're working on it to make it all better, right miss Keith.

>> SPEAKER: In the best world we are.

>> AUDIENCE MEMBER: Thank you.

>> SPEAKER: Yeah.

Noel Neil okay.

Any other questions?

>> PAM AUER: I have one.

>> RANDY NOLEN: Question over he over here.

>> SPEAKER: The difficulty with transportation, and regards to deaf

and hard of hearing individuals is -- is the language barrier.

There's no, there's no barrier.

Architectural, there's no

architectural barriers to the building that's a problem for myself as I

am deaf and using transportation and I struggle to find the right place

where to meet, where to be picked up you he know do I have to walk a

mile or -- the information is very difficult and that denies me access, that communication barriers happens and

then I'm stuck in trying to gain access to transportation.

And now if I think about, people who are deaf and hard of hearing,

and additional disabilities, that even adds even more of a complex

problem.

And, you know, where is the right place to be picked up? To be dropped

off.

Is it close enough to the public transportation where we can go.

Especially like if we're in Philadelphia, and you're at SEPTA, there

is no communication access, there's quite a barrier in regards to SEPTA.

So there's always these -- um, like okay.

I'm thinking of people that have difference disabilities including deafness but have tear balance Palsy anything like that Arctic

you'ral barriers as well as communication barriers having access to communication in regards to gaining transportation, or -- where to be picked up is very different.

So I'm thinking about not just deafness but thinking about all the mobility issues and, how to gain transportation access, all that, but we flowed to have approval to make this, to make it accessible.

Last year deaf person was trying to get CCT and got was denied access and it was, there was not equal access there.

So I think if we can create a, allow that solution have a solution so that all people have access and that it's equal access to transportation.

>> RANDY NOLEN: This is an issue within the system.

That I agree needs to be corrected. Part of the discussion we'll have the MCOs that they need to have with their brokers it will be part of the discussion we'll have with SEPTA, we're in the process of setting up a second meeting with them.

And then, moving forward with the, transportation summit that we'll have some September, in the southeast area, um, that will be certainly be parts of the discussion there as well, in southwest where we implemented it, we need to the discussions with the broker those try to move this forward. Thanks for your point and, it's well taken and appreciated.

>> SPEAKER: Thank you very much. Thank you for listening to
me.

>> RANDY NOLEN: No problem. Pam?

>> PAM AUER: Only fairy ask the same questions but someone else
asked plea to ask this first.

What rate are you reimbursing folks for using their own vehicles if
you're a family friends, they said that transportation MATP as an
example, do 12 cents a mile they have not raised their rates in
years are you looking at that as an option for transportation for some
people that are nonmedical?

>> SPEAKER: Nonmedical transportation rate is paid 50 cents per
mile.

50 cents.

>> PAM AUER: 50, okay.

Well.

Wow, okay I wanted to thank you for breaking down by the barriers

I'm screaming in my head, welcome to our world but -- but the, the
housing issues all those kinds ever things.

But, did I see maybe I missed it, what types of housing they're
going into it, are they going into to specifically, thinking of the guy
the last time had, housing connected to like nursing homes all that kind
of stuff.

Is it -- are they more going towards that, because it is --

are they actually going into their own community? Was there numbers for that.

>> SPEAKER: I don't have those numbers, Pam, but most everyone I can think of has gone back to their home or they have gone into independent housing.

>> PAM AUER: Okay.

>> SPEAKER: Or back to their family.

>> PAM AUER: Okay.

>> SPEAKER: There have been not converted settings.

>> PAM AUER: Okay.

And then, the other question that I have, was, going back to the, the multitude of different services that you can choose to balance out the attendant care stuff.

I asked before, what is the ease of changing your service plan if you change your mind? Sometimes people can be like kind of stuck waiting too get their service plan approval do you guys have an easy process for adjusting service plans?

>> SPEAKER: Uh-hum.

>> PAM AUER: Okay.

>> SPEAKER: I would say that, it really comes down to the service coordinator.. And we're trying our bested to reeducator service coordinators give them more education.

For example, on a recently call with service coordinators, external

service coordinators I invited them if you want our participant

handbook just let me know how many you want.

We'll get them to you because it is listed in there, but you should

go through all of the different services and just know about them so you

can educate people folks don't have to go that direction if they don't

want to. But they should know, what they have, on that array if they

choose it.

I find a lot of individuals don't want a ton of, folks around them

all the time and if they have other options, they will, say wow I didn't

know I had that, that's cool. Let me try it. But the service

coordinator can write the plan and then if that's not working out,

create a new plan.

>> PAM AUER: You're laying out all the services available at the

time of the personal centered counseling.

>> SPEAKER: When we're doing training.

>> PAM AUER: Okay.

All right.

That will be great do see the handbooks awesome.

And then, my last question -- oh, I had mentioned, before the

other training that is out there, um,.

>> SPEAKER: We're using we're contracted with the PCIL to do our

independent living training across all of our markets.

>> PAM AUER: Okay.

Another question occurred to me before I did not ask was, with the service coordinators that are, embedded in the nursing homes, what is their training towards independent living and commitment? And all of that?

Because I have seen in the past where people are, from an outside organization kind of end up embedded they take up the facility men at that time it will they don't amino to or don't recognize it they're your employees they're separate from the nursing home and trained to just see the individual not the nursing home's perspective or -- what is that like? What is that training like for that.

>> SPEAKER: We don't have people embedded in a nursing facility we have people a signed to do

visits and they have a case load of folks they meet with, they're not officed inside the nursing home facility.

>> PAM AUER: They're assigned to the facility they're not necessarily, they're not working in the facility.

>> SPEAKER: Right.

>> PAM AUER: Okay.

Even -- you have to be careful because, even that, we have seen where they, they still take up a mentality I don't mean to take up a lot of time but -- I want to ask these questions. My last question is how are you tracking the individuals who are designated as NFI?

>> SPEAKER: I have to get more information about that.

Right now, if an individual presents themselves as maybe coming out of a hospital, or, they had some situation that might bring them on our radar, they're assigned a care coordinator through our medical management side of the house and that care coordinator works with them on disease management and things that the person has, chronic COPD or something of that nature.

They would work with them, however, I thought it was very interesting and we need to start doing this is connecting them with the CILs and the AAAs to make sure they, they don't have access that they know where to get that information we're not doing that presently.

But we'll do that.

>> PAM AUER: Is that what you would do for someone NFI in a facility or probably NFI going out, do you have a similar process or tracking system when they're no longer able to get your services for some reason, is there a way to --

>> SPEAKER: I don't know the answer to that Pam I can find out.

>> PAM AUER: Okay.

That will be good to know you know, how -- how they're tracked if you're following them so some of us might be able to find them.

>> SPEAKER: That's our biggest barrier ineligibility, that's what held up some of our nursing home transitions.

>> PAM AUER: Okay.

>> RANDY NOLEN: Okay.

Any other questions for Anna, representing AmeriHealth Caritas is Chris.

>> SPEAKER: Good afternoon. My name is Chris I'm with AmeriHealth Caritas.

This next um -- okay.

So we'll just jump right into it, instead of going through the agenda.

So I want to talk a little built about our increateses and decreases in services.

Just want to make note we received 41 increases for personal attendant services and, all 41 were approved.

The top reasons for the request for the request for change of medical condition, or a physical condition, um, usually, as a result of some sort of, trigger event that is defined within the agreement so there was an assessment, completed with those individuals and identified needs for additional services and that's what, prompted the review and approval for the personal assistant services.

For decreases there were total of, 12 incidences where there were decrease ins services.

One was kind of following the same suit we talked about with the example earlier where, another service was put into place to be able to reduce the attend apt service hours so, meal was added to the as much as plan. So, kind of swapping of services even though it's a swapping

it's still considered a decrease on the services that were on the plan.

So that's one of the areas.

The other ones working together with the participant they wanted to again swap services from they wanted to move from, LPN service to a personal attendant services working together with that participant with the service coordinators, to help make that happen on their service plan remaining cases, were, temporary, increases that were added to a service plan.

As a result of some event you know with the individual they either went to the hospital, therefore they didn't either saw an increase in services as a result of that but then reverted back to the original hours after that approved time frame with that individual.

So, even though you know it was a temporary agreed upon time frame for those services it did revert back so it does appear to be a decrease in services. So, as we worked through, again, the participant is kept in the loop with all of these particular items working together with them.

I think kind of, speaking to time frames of how service plans I polite as well answer the question now -- um, if someone agrees to a change within the service plan wants to
go back and change it, once the participant contacts us, it could be verbally, contacts the service coordinator to make that request, we review that and, within two days say okay, yes we agree to make sure

that service coordination the service plan needs to be switched
back.

If we need additional documentation, we would request that and that review could take up to, 14 business days as we're reviewing that. So it is a very, easy process to start.

That review to go back on the service plan.

So, it is a phone call away to kind of switch back. And forth to make that request to us.

All right.

Next slide.

Number of complaints and grievances that we have receivedded you can can see there's 4 complaints and 24 grievances. The top reasons for these items, are pharmacy related, dental related and home health personal attendant services.

As we went through most, as we did the root cause analysis with the most of the grievances and complaints we received almost all of them were related to a lack of information during the unusual request for those services.

So as we went back and reviewed, looked at, through and gathered additional information, um, you know it was able to either be overturned or -- approved on those services.

So it was really education I think on the provider side and, splitting the appropriate documentation. And gathering the appropriate

documentation up front and, I think that's an opportunity that we have moving forward across the Board is making sure that, on initial submissions that providers are aware of what needs to come with throws requests, to make sure that they get reviewed appropriately the first time for network, there have been no decreases in the network.

In the provider network. The, we have actually continued to add providers, after January 1st.

So in the southwest zone, we have added one hospital that went through the contracting and credentialing process we are contracted, with all gain I health with UPMC, so we do have.

[allegheny health.

[very large network from the hospital side as well as the physical health side.

You will see on the physicians and ancillary providers we added over 2,000 providers since the beginning of the year and we continue to do that.

For nursing facilities, we may have had the contracts executed prior to January 1 they didn't get through the full credentialing process until after, so we could not consider them as participating so we've added 33 of the nursing facilities we're contracted with all of the nursing facilities in the southwest zone.

One of the biggest fears and from provider community that we hear is -- is that, we are going to reduce our networks provider networks, to

reduce within the provider that's are providing the services.

That's not the case either on the LTSS sidas can see we've added, 89 entities, as we move forward since January 1st we continue to do that and we, still continue to look and build upon our networks with individuals and providers that are enrolled through the MA program that meet the qualifications for the community HealthChoices
program.

So that is something that I believe as we move forward past the continuity of care, it will still help to increase the services as we move forward.

Nursing home transitions -- when we received our initial file for continuity of care there were 86 individuals on there, that we identified that were in the process for transitioning from the nursing home facility to the community.

We have actually been able to successfully transition 42 individuals,

from the nursing facility out in the community.

And I know the question is going to commas where they went and -- where they're residing through.

I do not have that information but we will go back and pull that as well.

Just to give an idea as to, what type of homes or settings that they're moving into.

So we will, we will bring that back as well.

And currently in process we have 134 individuals that we're working with, they're in various stages, where they raise their hand and they said they want moved and transition from the nursing facility out into the community.

So, we are working together with the nursing home transition providers, um, working together and I know we just had another meet meeting yet voices for independence, triple, abilities

in motion these are entities that we have been relying on and working together with as we move forward especially, trying to get individuals and assist them as they move from the nursing facilities out into the community.

And that's, what I have on the presentation.

I know Lester you'll go right to the transportation I might as well address that right now.

>> AUDIENCE MEMBER: Actually I was not going to go to the transportation, I was going to -- since, you -- and your AmeriHealth keystone first last month, we talked about the NCQA accreditation.

Well, um, as a personally felt I was paying attention ahead of the game, now, whether I was trying to discuss last month was there's a distinction in the two a accreditations whether it comes to case management.

One is, for the physical and the LTS. And I want to make sure that

we're all on the same page I think that should be for the MCOs.

Now for service coordinated entities, why isn't that we are just not for the LTSS only. Meaning you can coordinate, for LTSS services only.

Because as -- um, there's a distinction again that's my understanding am I wrong or am I not right help me out?

>> SPEAKER: You are correct, I'm actually going to ask Kathy to help address that.

>> AUDIENCE MEMBER: That will help service coordinated entities know where they should be going, should I be sticking -- doesn't make any sense for me doing the LTSS and physical it doesn't.

>> SPEAKER: Lester it's Court and jury.

>> AUDIENCE MEMBER: Hi I like her everyone.

>> SPEAKER: Okay you know that's really important to understand, the difference between what is the health planned NCQA and what is LTSS case management NCQA and some of the entities have already they were early adopters have gone through it, so, what we have been trying to do, is -- work with some of those entities, to get the word out to like talk to people, the entities have not gone through it, so you know what they're looking for, checklists, you know, processes, policies things like that.

And, our job is to help you. Make sure that you, you -- have the policies too match what our program expectations are.

So, um, I absolutely understand like the question plaque with that

and, really, we want to coordinate with you and help you, okay.

>> AUDIENCE MEMBER: Thank you.

One of the other things I would like to talk about is the fact

that, in this -- this is for all 3 MCOs, um, you guys can talk about

the NCQA actually you guys addressed did for us, you don't have to.

But one ever the things is we all know we added a new service, one of

the new services is the P pest eradication service, I don't know if

I've -- policies and procedures from the State to you guys to us -- I'm

in the middle of a situation right now, where the provider stepped out

providing services because they said that, there were bed bugs there,

there was no proof of that. But the consumer is the one impacted. So

the provider just stepped out. And I wanted to make sure that we have a,

a poll signed procedures, okay, let's get proof of that.

[policy]

If there is, that situation, you can step out, because you're

putting other people in danger at the end of the day, it's almost as if

I see bed bugs or we -- I think there's bed bugs I didn't see, it could

be fleabites these people have, these providers have stepped out the

consumers are sitting there, saying I have no services and then,

if that steps out, and the consumer -- then the process is, well I

need some to clean up, well the provider is gone, as a person who is bed

bound how am I supposed to, checklist the personal -- excuse me the

check writes that the, the pest eradication service said you have to do this before I can provide that service, well my PAS provider is gone they were doing those types of things now they're gone, how am I supposed to get that done I need a whole policy and procedures on that, how this pest eradication service should be ran.

>> SPEAKER: So that makes sense too. What we really should be doing it sounds like there's a gap in maybe the way we went through the benefits because, there's very specific requirements, to pest eradication. But I have to tell you, if you called us let us know that the provider stepped out, that's something that we should be addressing and we should be helping get that covered.

And I've done that I've done that, whether people have had really bad bed bugs where we worked, diligently with the provider to make sure that person got the care they needed.

You know, whether it's -- moving them temporarily whatever we flowed to do we can't have providers just not continuing to give service, they need to reach out to us and let us know so we can help get this covered.

>> SPEAKER: I look that the as a service coordination side, should we reach out to the service coordinator from the provider side I need to know who those providers are, so we can provide education and as a more global issue that we need to address or is it isolated to that individual agency or, entity. So, those are some of the things that I

look at from my side and okay, say is there education we flowed to

develop for the provider community as well.

The first thing we want the services to continue and make sure that

happens but then, is there something we need to address on a global you

know, concern and, is it across all 3 MC works those are some of the

thing that if you're ware of this, please make us aware. So we

can address it.

>> AUDIENCE MEMBER: Thank you.

>> AUDIENCE MEMBER: Thank you.

>> RANDY NOLEN: Okay.

Any other questions?

>> AUDIENCE MEMBER: Really?

>> RANDY NOLEN: Okay.

Turn it back over to Barb and Kevin.

Thank you folks.

>> BARBARA POLZER: Thank you Randy and Mcos the next item on the

agenda is an open QA session for the MCOs so does anyone have any other

questions?

My goodness, well hearing no questions um --

>> SPEAKER: We have one -- I have one and another one coming.

>> BARBARA POLZER: Okay.

This one is for all MCOs from Teresa heart man, can the MC works

address the change in payment from fee for -- fee for service, just turned

off to capitated rate I'm sorry, it just turned off on me.

There we go.

Can the MCOs address the change in payment from fee for service to capitated rate for external service coordination agencies. Will we remain units based billing or transition.

>> RAY PRUSHNOK: So, this is, ray Prushnok from UPMC, during the continuity of care period we by in large maintain you know the same sort of unit based fee for service billing as we move forward we're looking at a variety of other models that are you know, um, you know, FTE based and PMPM based just again, with different flexibility as we look for longer term relationships but we by in large have been plain taken ning fee for service billing.

>> SPEAKER: This is Chris with AmeriHealth Caritas, similar process, we are evaluating these service coordination entities and working through, um, the financial arrangements and reimbursement different methodologies with service coordination entities as we move forward.

But until that agreement is executed and agreed upon upon the entity and our organization it would continue to be on a fee for service basis.

Unit based.

>> SPEAKER: This is Anna I would have to echo what ray has said.

We are currently at a fee for service basis but exploring other ways we would do payment going forward forward in the future.

>> BARBARA POLZER: Okay.

One more question, from the phone and then we'll take, Lester, there is from Mary Ann of those transitioning out of skilled nursing facilities do you have demographic data, as to who is successfully transitioning? For example, are those transitioning more physically or cognitivity challenged a demographic on age as well. Just wondering if this is working better for the senior population ore physically disabled.

>> RAY PRUSHNOK: Um, this is ray from UPMC unfortunately I don't have that data, but we can prepare that for next meeting just an observation that I think, we're at about 4 percent under age 65 in our nursing facility population right now it's almost certain it's mostly older adults.

>> SPEAKER: This is Chris Pratt with AmeriHealth Caritas, we don't have that information with us we'll go back and gather that information speak there is Anna Keith I don't have that in front of me we can bring it in, it's pretty varied I can tell you without having the hard numbers -- we've gotten a lot of referrals that we have worked through with our CIL partners as well as our AAAs I would almost say 50/50 but it will be interesting to see what it is. We'll get that demographic data.

>> BARBARA POLZER: Okay thank you. Levall.

>> AUDIENCE MEMBER: Hi, Levall Miller Wilson from health law project I was wondering if the plans could help educate me and us a

bit proper about person centered planning.

About communication with participants.

And, noting earlier in the meeting we talked about making a distinction with the grievance. That when, a plan informs their members that a service will not be prided, it is clear that the participant has 60 days to appeal and ten days if they want to continue the services. Participate I want to back up between the date that participant receives the notice and talk about and get proper clarification from the MCOs, and perhaps the department about what happens when there's disagreement about the person centered plan.

And if the participant is, the plan says, um, I've got 40 hours and let's just use, personal assistant services and in the planning stage there's a disagreement between the MCOs service coordinator and the participant about the plan.

How does that consumer that member challenge the person centered plan? That's before a notice is sent. But there's some disagreement is that, would we consider a grievance or would we consider that a complaint? Can folks, MCOs give us their perspective about what the disagreement that occurs with within a service coordinator and the participant, about person centered planning.

>> SPEAKER: So Levall Kathy Gordon, AmeriHealth Caritas.

My question is, are you speaking to a service or, because the -- the person centered service plan, belongs to the participant.

So basically what the service coordinator should be doing is facilitating the process.

You know through conversation, through, um, understanding it's really important to use the plan of care the person certaintied service plan as what is important the participant that's what they should be focused on, if it's about a service if there's a disagreement on a service that's a grievance to me our staff are trained that's to be brought back as a grievance when it's in the home or just a conversation it's still a grievance it's still -- it's still where the participant is saying, I don't agree with this.

So, it should be brought back to the management team and it should follow our process.

>> SPEAKER: That would trigger their different looks to that I'm not as a participant I'm not going sign the person centered plan in which every plan here, has -- a requirement that the person vine the plan.

I'm not going do sign because I disagree before the goals so then, does the, does your service coordinator let's deal with non-legacy folks or folks have internal is the direction to that service coordinator that is a disagreement we'll send a grievance letter saying we disagree how does --

>> SPEAKER: I can only speak for my team. So, we actually have multiple levels of intervention before, so it's automatically a

grievance it really is a manager supervisor's role to call and make
sure they understand what the concerns are, because, we should, we
should be pulling our person centered planning team together we should
understand what the real concern is from the participant this is their
plan so -- there's multiple levels of discussion to make sure that we
understand you know, what -- what it is, the concern.

I feel like you're talking about a service.

>> SPEAKER: I'm talking about a service.

>> SPEAKER: Okay.

Good the person centered service plan be loaning to the participant
it should say what the participant you know, what is important to them
if it's -- a service was approved they disagree with the service, than,
that is -- they say, well, I really think I need 56 hours the service
coordinator should not be saying we are only authorized for 40 let's
see how you look in 90 days what they should be saying is, I'm going
that I back, we'll need to follow through, and -- you know, I will have
my, supervisor manager will be you know, do you want to file a
grievance this has been brought up a couple of times today I was kind of
sitting back there wanting to say you know when they said about how does
a participant, may not know to call or may not understand it really is
the service coordinators role to be their advocate they
should be making that call they should be helping them make that call.
We should be helping them.

That, we we should be advocating for them.

>> SPEAKER: So that's -- this is helpful dialogue other plans may chip in, but it's helpful to hear about that and -- and again, that could be, you don't have to wait to send the notice, it could be much earlier. Where the participant is saying, I'm not signing that document it's about a service we have a disagreement the as much as coordinator, at least on the AmeriHealth standpoint is now on notice. Um, because the participant has verbally trig reasonable doubt that service coordinator in the planning processive a disagreement about the service we need to -- um, we flowed to go, do battle a bit.

>> SPEAKER: Well, so -- I don't -- batted will is not a good word.

>> SPEAKER: That's a loaded word, loaded topic.

>> SPEAKER: It's really the service coordinator's role to advocate for the participant and make sure that, when their bringing this information back to us, you know this is the way they understand it, this is you know, what they're disagreeing to again we have multiple levels of review it doesn't just go, we're calling them or trying to understand you know what did we miss, maybe you know maybe -- when the service coordinator, didn't understand what the real like why they needed those extra 16 hours, it is still a grievance. They have every right but it's still the service coordinators role to safety them with making sure they understood you know this is a grievance and you're going do get this information, we should be notifying them within two

days.

>> SPEAKER: Okay.

>> KEVIN HANCOCK: Other plans want to weigh in on that plan.

>> SPEAKER: Kevin --

>> KEVIN HANCOCK: Can Patty, I'm sorry --

>> SPEAKER: This is Patty Clark I work in the Pat say bureau in OLTL we had issued a -- in our QA documents had kind of issued a clarification on there. And indicated that, in fact it would be a grievance and -- the, um, I'm sorry, it would be considered the, denial if during the discussion there was a disagreements between the service coordinator and the participant on what was needed in terms of level of service and it would be considered a denial and the plan would issue, should issue a denial notice to the participant for that and then the -- the participants action of, saying I refused to sign this service plan because I disagree with a level of service, that's the trigger for denial notice or if the person verbally says I disagree with this that's the trigger.

>> SPEAKER: Ray from UPMC, everything Kathy said is, consistent you know you did ask about person centered planning.

You know, um one thing that we've tacked onto the front end of our assessments is a -- you know, what we call our sort of person centered Mini assessment where we just kick it off with the person's goals it's part of our training and you know part of our, our retraining as

Kevin indicated that something that we're going to continue to focus on,
we're not perfect, we're getting better.
It is a new instrument for our folks too. But again, we're --
we're working you know to make sure we start off with the person's goals
as Kathy said multiple times that is that person's plan, you know we --
being person centered, you know, really is about
listening, as much as it is sort of gathering the, appropriate
information through the assessment process.
>> SPEAKER: I'll just do my plug on person centered planning this
has been a passion of mine for years out of KU, it was -- it was, in the
80s so -- um, person centered planning before we could even start
the plan we have to have employees that understand what it is.
We do a pretty thorough training on person certaintied thinking.
So, philosophically getting behind a person driving their plan and
the person, voicing what they want in their life, even if as
professionals we don't understand people having a right to risk people
getting to try different things.
That's at the foundation of person centered thinking.
Moving over to person centered planning, it is, necessary to have a
thorough built out plan to even to get to a really good service plan so
prior to the last six days, we had, we had different types of, person
centered planning, skill sets across the Board.
And the perfect world did would not be that way it is from the worst

you could see to fairly okay but not really quite there and -- it is
going take some time to get there, but the person centered planning
investment the actual tool after people get it, get rights, get choice.
After that part when you write the plan it takes the relationship
and that's going to take quite a long time I had an individual tell me
the other day he has 7 service coordinator ins two months.
That doesn't get a relationship that doesn't get a plan. So
services are just, the -- check the box that's where we don't want to go
if we want to see good person cent reasonable doubt planning that will
take building the relationships so the person trusts you
enough to tell you what they do or do not like, you will get to the true
services you know get off my soapbox but the thing is, we flowed to get
there it is going to take some time to get there Levall when folks
disagree with their services, the health plan needs to as an
administrative function of the MCO those service coordinators need to
be properly trained they need to know what the processes are, and they
wear two hats one is a champion for the people they support and educator
of the things in their community that they have access to.
And then also, through the MCO recognizing in a lot of cases, is it
always are you going to the Medicaid funded service first? Or are you
looking at the community around you.
So, just sort of a balance but it is going to take some time I know
that's not the answer you're looking for but -- that's what I got today.

>> SPEAKER: We were just trying to get better understanding about
person centered planning.
It is easiest, most illustrate I have through a denial of a service,
because that's what the grievance notice would say.
Disagreement about personal assistant services not disagreement
about person assistance planning.
It is easier to have a grievance about the service, than it is,
about I disagree about the, the goals, in a person centered plan.
But we do, need
relationship person certaintied planning it is some we were just dealing
with grievances and denials I was trying to hear from plans about the
approach before that, whether that notice would get triggered so there
is helpful.
>> BARBARA POLZER: We have a question on the phone from Stephanie,
what criteria, will be utilized by each MCO to make a determination on
whether a contract will be contracted to a FCE ore individual employees
of FCE.
>> SPEAKER: Can I grab that because ours is easy we've not made a
determination to determine nature any contracts with any service
coordination entity.
>> RAY PRUSHNOK: I covered this in fair amount of detail earlier
it's about performance and, the quality of our relationship. Along
with our you know frankly our administrative needs, geography and,

capacity.

>> SPEAKER: There is cross with AmeriHealth Caritas.

We.

[chris]

We did make a decision to, terminate our agreement with 18 service

coordinate nationen at this times in the southwest zone this is a result

of, just number of participants that those entities had within that zone

. It was there are 30 and, as we move forward and, looked at the

financial viable moving forward that is the decision made internally

that does not mean that's the entire approach going to happen throughout the entire state but

that's where we are with the southwest part of the state.

>> AUDIENCE MEMBER: Lester, you said you dropped 18 service

coordinating entities as a consumer do I get to choose -- okay.

So they were right back to your agency with your MCO correct did you

tell them they have the right to choose another service coordinating entity and -- did you give them on a list.

>> SPEAKER: So here's the process was, we submitted a plan to the

department, to make them aware so we sent out the, the actual physical

written notices then we made actual phone call to those individuals to

make them aware what was happening and, provide them a list of, the

agencies that were continuing on, offering them a choice of external

service coordination, or, choosing one of our internal service

coordinators they were provided that choice some of them are still in

that process of making that decision today.

So, it is, it's ongoing right now so it's ongoing communication with those participants as we move forward so, they were, verbally prided that, they're also directed they could go to the web list and find elision of agencies as well. It is kind of a -- it is not a -- it is not we're just leaving them out in limbo we're trying to assist them through the process as well.

>> AUDIENCE MEMBER: Thank you another question, basically a comment here, um, one of the things we've all said, um, is the -- the communication between the service coordinator.

That requires plea to be calling back and basically doing more work.

So I like to understand the whole process for asking for additional units for service coordinators because I don't know if the MCOs are aware that you create, you polite have given me my 144 unit ors you might have given me what was left at the end of the year but because of the, the CHC period, I'm doing more work than I am, and I'm being told by, people we're not even authorized to even discuss with you, additional service coordinating units but we just leader with all of you guys, that we're going to have to talk about it between the service coordinator you just put more work on me when I asked you for more money for the more work you're telling me no.

>> SPEAKER: That gentleman in the red had his hand up longer than I've ever seen anyone.

>> SPEAKER: So Lester to answer your question, um, I saw the request come in and -- they were yesterday or the day before. So -- that's been responded to, your team has been notifying us and we respond.

You know. We authorization more -- okay.

All 3.

Okay.

>> RAY PRUSHNOK: I would need to see a specific case.

Before I could respond you know, if there's -- express need where additional service coordination need to occur employee understanding is we would be granting those cases.

>> AUDIENCE MEMBER: What I can tell you I've seen being denials when they're asking, watching it.

We're telling us to go do InterRAI, I'm -- explaining to them we're all hearing, transportation issues, PAS issues we're, the units you already gave me are being used up and -- what we're saying is, there's no respect of the fact that I've already used throws units you've given me a stop of you only got -- you only get this many it's like -- you're telling the public that we have to do more work. But behind closed doors we're asked asked and being told there is all you get this is where, why is it not looked at I'm submitting the same request I did do the Office of Long Term Living that says, there is why I flowed these units I'm not asking for units to get extra units this is why, they're saying I got that, we're not giving you know units right now.

>> KEVIN HANCOCK: To be fair to the 3 MCOs, I think ray's point, if we have a case, we'll take to the MCOs and have them, defend it. Is that fair?

>> AUDIENCE MEMBER: Sure.

>> KEVIN HANCOCK: Okay.

So if you send it our way we'll take to the MCOs and then -- um, they can discuss or defend how they -- arrange the payment relationship to the SCs. Thank you.

>> BARBARA POLZER: Time for one more.

>> KEVIN HANCOCK: That gentleman right there.

[laughter]

>> AUDIENCE MEMBER: I'm not sure if I understand how this works.

Are you saying -- who decides the hours that you give to the providers? And the -- the service coordinators? Service coordinators and how many hours are given to the -- the consumer?

Is it, based upon what the service coordinator demesne? Or who is authorizing the amount of services in the end?

Or at the top or bottom however you want to view that.

>> KEVIN HANCOCK: Kathy you answered that question already. Does anyone want to -- jump in first?

>> SPEAKER: Sure-LAN do you want to be spokesperson.

>> SPEAKER: So I think, um, so -- during continuity of care it the services, that were authorized, it came over, from when they were in their over waivers so any, additional services, I can give you an example.

When Chris was speaking to the increases, he had that slide up. We had many participants who would call us and say, um, the care givers going to be in the hospital. And so, for two weeks they needed additional hours then we would authorization those additional hours and, when -- you know the caregiver was stable we would go back to aces as long as the hours went back, the increase is dependent upon the K. That we're hearing so -- um, we have increased, I think there were 41 or 42 increases, a lot that was, you know, the participant service coordinator doing their assessment, identifying a need and then it was addressed.

>> AUDIENCE MEMBER: So is it related on so is the service coordinator the best person to go through to negotiate more hour ins or are they going to, if that's their -- the -- the individual's advocate or, how do you get to that if the person is not satisfied with services, is it the service coordinator, that you're supposed to approach first?

>> SPEAKER: So, so that actually goes to -- Levall was talking about earlier was if you're not satisfied, you -- you are you know you're with your service coordinator, they're you're giving them the information for your person centered service plan.

If you do not agree with that, you flowed to tell that service coordinator, you do not agree with that. You have the option I mean you can say, you can comment on your person centered service plan I do not agree with this you are can write that.

You can also, tell your service coordinator that you, you know, that you want, additional services, and then, they have to follow whatever their plans process is for that. But, really, you -- if you're saying to me, I -- I think I heard the word bargain was it -- and , I want you to be able to like, this is why I need this service.

And have that discussion but it absolutely, requires someone else taking action after you do not agree with that.

>> AUDIENCE MEMBER: So you would say, the support coordinator is the best person, to go back to?

>> SPEAKER: Yes.

>> SPEAKER: And, the service -- the service coordinator has the responsibility, forum, communicating, that disagreement to the plan and that triggers a certain number of, protections that, that -- um, we start to go down a pathway, that the MC ons have to follow but it is triggered, by the participant telling their service coordinator, I disagree.

Um, there's no wiggle room on that. Once the, once that -- the service coordinator flows that they have a responsibility to the plan and the plan needs to start taking a bit more of a formal approach.

Right.

>> SPEAKER: I can speak for AmeriHealth Caritas over the last two weeks we've done intensive training to ensure that everything we taught back in November, December and January was reinforced, so that the service coordinator understands it is, there's -- there's no reflexion, you know the service coordinator, it really making slur that they come back and we understand what the need is.

So, if we want to make sure that, we understand what the service coordinate -- what the service coordinator brought back we reach out to the participant and say talk to us about what happened.

What your needs are.

So, but I mean it's -- you know, at that point, it is considered a denial, if we have not authorized it.

>> SPEAKER: Levall we have one little layer in there there, at PA health wellness we called integrated care team meeting we've encouraged the external service coordinators to ask to attend that behalf of the folks they support.

Um, but that integrated care team, if there's a plan and the individuals asking for an increase that it might be significant I want to go from 40 hours a week to 140 hours a week whatever.

It might trigger a review, before we have to go to the grievance process, where the integrated care team looks, has there been a triggering event, health condition, something going on with that person?

The service coordinator can come and talk with the team.

To discuss it, so it doesn't, move towards that denial process.

They just want more information.

So it is an opportunity for the service coordinator to look at the plan and, help advocate for the person.

>> SPEAKER: I'm hesitant to hear that. Because -- and maybe we'll have more conversation with the department about this.

But whether a participant at the core says, I disagree, that's black and light.

It is not, well maybe you change your mind the next day.

And let me think -- maybe you'll change your mind sit on it I'll be back to make sure.

That's -- that's a disagreement.

And I think it triggers.

>> SPEAKER: Yeah --

>> KEVIN HANCOCK: To be clear the department, I mean -- Patty made clear of the department that is a -- that's a grievance. So -- you will go through the process itself.

>> SPEAKER: Could I add though, don't forget there's a time that the, the plan and the service coordinator do have a period of time to develop that service plan and finalize it, so, it could be the protocol of the plan that if the there's a plan developed, a service plan developed there's a discussion between the participant want the service

coordinator, that there's a -- the participant says I disagree with this, there could be a protocol within the plan for the service coordinator to go back to the supervisor and talk about it, within the time frame of the developing that service plan and I'm seeing that as being -- okay.

>> KEVIN HANCOCK: Good think I think.

>> SPEAKER: It's all the discussion that goes on, but -- as said we need to keep in mind if the participant, expressed disagreement with what is being proposed, and, what is being proposed is not changed it remains the same. Then it will be considered, a denial.

>> SPEAKER: There's -- I think we're working on these processes some that are from fee for service and some we're trying to understand how this plays out in community HealthChoices that's my first comment. The part is, there are lessons to be learned from other other context in special education individual education plan IEPP world, the parent there's a separate piece of paper that the parent signs I agree or disagree that, it is -- um, that may be helpful in this situation, that is different from signing the person centered plan in which you can have your cake and eat it too the participant signs the plan whether they agree or disagree, there's another piece of that paper that may be needed here where the participant is actually saying I agree or I disagree.

I've been read my rights, so to speak.

I, I don't. We don't quite have that in the system.

It may be helpful it may not right now I'm going back to his question, about very much at the Mercy of the service coordinator when that -- participant, expresses, disagreement the service coordinator, has discretionary steps to take that is -- there's no written document really about communicating that disagreement.

Is there.

There's in written, the service coordinator has to say, Levall told plea that he disagrees.

It's not -- he is signed a piece ever paper. Where I explained the servicesth disagrees with the amount scope and duration.

 >> SPEAKER: Right. So -- um, I think I talked to you about there is that, I'm having that statement added to right before where they sign right I think that's important.

 >> SPEAKER: That's AmeriHealth that's putting that in their person centered plan. Right?

 >> SPEAKER: Yeah.

 >> SPEAKER: Does PA health wellness or UPMC have that language in their personal cent reasonable doubt plan.

 >> SPEAKER: I also think that, what you said, and what I heard is, really should be every service, we should review every service and say I agree I agree or disagree. Because most most service plans have more than one service.

So I understand that is are that's a really great idea that is reviewed that way. We do ask them, do they understand their services, you know like do you -- do you know how many hours you get -- you know, what service U.S. get, such of things because of always surprised when I -- claims report it doesn't match anywhere the number of hours we want to make sure they do understand that.

So -- we do is that, but -- agree or disagree we flowed to add that per service.

So -- um I think that's a good thing.

>> KEVIN HANCOCK: Just reacting to what you're saying, only things about concern meze about this is -- person centered planning process, right now is always -- pretty complex because of the review of the, the assessment of need, and -- the review of the tolls, if we -- now add a layer where -- by individual services it sounds like it would be by individual offices there would be some sort of acknowledge of the participants, and -- service coordinators that there's a -- a disagreement.

Creates -- to thing from my perspective I'm just react to go what you're saying rightfully, because you and I were we have not talked about there, this is the first -- it is -- adds -- level of complexity to the process. At the service level and number two, it -- kind of -- gets in the way of the conversation that the person centered plan is going to be between the service coordinator and the participant you

automatically have a step, that will -- um, create an opportunity it
will -- maybe for the best, I'm not saying it shouldn't be done.
And -- like as this plays out it might be something that -- we have
to clearly, mandate.
But it will get in the way of the -- the relationship we would like
to see developed between the service coordinator and the participants,
that we actually don't completely think it existness the fee for service
systems, fee for service waiver now.
>> SPEAKER: There's -- there's a level of level of trust.
At the end there's services that are either in the plan or not.
>> SPEAKER: Hear you. We have to figure out a balance what you're
saying.
>> KEVIN HANCOCK: We recognize we want to make sure every possible
-- opportunity -- every possible opportunity participant toss understand
the rights.
Yeah.
So -- okay.
>> BARBARA POLZER: We have to end can we ender taken more.
>> KEVIN HANCOCK: How many more questions do we have.
>> BARBARA POLZER: Do you have one? Todd and Dan one on the
phone.
>> KEVIN HANCOCK: I think we can take those 3, if that's okay.

>> SPEAKER: The communication that came out yesterday on --
terminating contracts with providers there's a 90 day notice to the OLTL,
the 45 day notice to the participants I am just assuming that the --
providers would be contacted, around a 90 days as well -- or -- fully --
any requirements on -- whether a provider is notified.
How many days.

>> KEVIN HANCOCK: There's no requirement ins the agreement for MCOs
notify providers of when the termination is going to take place.
But I think it's a fair question for the 3 MCOs for how they
approach that process.

>> SPEAKER: It is -- it's -- per the provider agreement Supreme
Court speak same with AmeriHealth.

>> SPEAKER: Question on the phone --

>> KEVIN HANCOCK: Pennsylvania health wellness is confirmed it's
the same as well.

>> BARBARA POLZER: All 3 use the SC entity to create and submit a PC
S fee to the MCO or the MCO create the plan send to us to follow.

>> SPEAKER: Just restate the question I have think --

>> KEVIN HANCOCK: To restate the question to who create the
physical service plan the external SC entities or the internal SC entity
the manage the care organization has a hybrid approach to the service
plan development.

>> SPEAKER: PA health well ins it is assigned service coordinator to that individual to have the relationship with.

>> KEVIN HANCOCK: It could be either.

>> SPEAKER: Same for AmeriHealth Caritas the service coordinator who is assigned.

Are you sure push so the case where the external service coordinator sends the service plan we have a disagreement, we -- work it out with the service coordinator.

>> BARBARA POLZER: Dan?

>> SPEAKER: Just a complement on the appeals and grievance process I think, that the fact that we need someone, outside of you Kevin you know, with respect to you, to explain this, just slows how complex there process is.

For our consumers to -- to get this.

I think is -- is a burden on that.

I like what Levall brought up about having consumers sign off what they're agreeing to.

Would it be something we could look into where instead of making it ten days for the consumer to say hey I don't agree we know how the mail works we flow it's a issue in Philadelphia especially I don't think it's realistic to assume that every consumer will respond to that know what it means, I would it make more sense to have the consume every agree to the services that the point say yes, I agree do this I want to appeal

it? The SC's responsibility to follow-up within those ten days to verify the consumer received it and they agree with it instead of putting the burden on the consumer to figure out how do I get around this process I know -- community legal services they have good intentions are not gag to be able to handle the volume if this were a issue, especially in the southeast.

>> KEVIN HANCOCK: Pennsylvania health law.

>> SPEAKER: Community legal services I don't know how the process is burdensome.

You're putting the burden on the consumer to understand what is coming in the political. And -- you already said that denial letters are confusing the State has to review them, the process is cumbersome for the consumer.

>> KEVIN HANCOCK: Recognize the process is very complex.

A player health caritas is already stated that they have a approach in place where they can sign off by service is that correct. We're -- open to continuing ways to better inform participants of the rights in this process.

We will talk BRAC your suggestion.

>> AUDIENCE MEMBER: It will be helpful for consumers to have an easier pathway to appeal something instead of putting the burden on them but thank you.

>> BARBARA POLZER: One more came in through the phone.

Participate.

>> KEVIN HANCOCK: Do you have a question.

>> SPEAKER: Yeah I just -- I just really quickly wanted to say that I support as -- I have to take my CEO hat put my consumer laton for a minute I support the individual sign off of services, as a consumer it is scary when you -- have that conversation, with your service coordinator and you, disagree with the piece of it, and you're waiting for someone to make a decision somewhere, you think that affects your whole plan if I disagree with the service that someone is offering me I want to be able to say that A through X remains the same. And Z changes.

And changes.

A through X.

I will support individuals sign off on each service.

>> KEVIN HANCOCK: Thanks Shawna, my reaction from the department's perspective.

We -- we have the individual -- one of the 3 MC ons affirmatively stating that they're going to take this approach. We want to require the 3 MCOs or do we want to have the MCOs, to presented an approach to reflect how they -- interpret, the requirements that Patty Clark detailed? So -- we're oop to having a continued conversation about this particular issue and I think Levall plead the point a little earlier with the community HealthChoices this is brand flu when it comes to, nonmedical

services and how the grievance process is supposed to be working. And

the role of the service plan which is a little bit different than you

ever saw in HealthChoices, physical HealthChoices we're open to

suggestions how to make it work better that's to -- to our friends at

liberty community connections as well.

well. Participate.

>> BARBARA POLZER: Last one I promise it has been reported that

during COC the supervisor of the SCE will not have access to the

individual MCOs network system.

Is this a true fact?

If yes, will the MCO staff be providing regular supervision and

guidance to service coordinators.

>> SPEAKER: Do you want me to go first again. So the

supervisors are always secondary service coordinators we have primary

and secondary as much as coordinators in our system.

So every supervisor, from a service coordinator entity, is

secondary, to anyone that is a signed to them. So -- that's how it

works for us they have access to the participants files, for anyone

assigned to their staff.

>> RAY PRUSHNOK: We haven't given full and access to the external

entities due do security and fire wall systems it would be true you

don't have open access to awful your employees all the case files within

our system, we are you know, we are providing the individual, assessments

service plans.

>> SPEAKER: And -- this is Anna I echo what ray said we don't have full access for externals bottle do have access to notes and -- information.

>> BARBARA POLZER: Thank you everyone for your time next meeting is August 1st, same place and meeting adjourned.

[meeting adjourned]