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DATE: August 1, 2018

EVENT: Managed Long-Term Services and Supports Meeting

>> FRED HESS: Let's get there meeting started.

Where is everyone?

Uh-oh.

>> SPEAKER: Fred?

>> FRED HESS: Yeah.

>> SPEAKER: You want me to take the questions today?

>> FRED HESS: It is up to you. If even having a meeting.

We don't have enough for a quorum.

>> SPEAKER: You might if you check on the phone.

>> FRED HESS: Who all is on the phone?

>> SPEAKER: Jim is on.

>> SPEAKER: You know I'm here.

>> FRED HESS: Tanya I know you're on there, anyone else?

>> SPEAKER: Yep.

>> FRED HESS: Anyone else on the phone?

Okay we have a problem.

Jack is here.

I have two on the phone.

>> FRED HESS: Everybody on the phone please mute your phone. phone.

>> KEVIN HANCOCK: Is Monica on the phone?

>> SPEAKER: Denise Curry is on.

>> KEVIN HANCOCK: Looking for the person representing the drew Negele,.

>> SPEAKER: Not me, sorry.

>> SPEAKER: She is not on the webinar. She is not signed in.

>> KEVIN HANCOCK: Okay thank you.

>> KEVIN HANCOCK: Can I do a roll call?

>> FRED HESS: Go ahead.

>> KEVIN HANCOCK: Good morning everybody this is Kevin Hancock from the Office of Long Term Living we'll do a quick roll call to see if any of these individuals part of the committee are on the line is

Arsen Ustayev on the line?

Is Brenda Dare on the line?

Is drew Nagele on the line or anyone representing him?

Estella Hyde on the line?

Is Jim Fetzner on the line?

Is Jesse on the line or anyone representing Jesse?

Is Janita Gray on the line?

Is Luba somits on the line?

Ralph trainer on the line?

Richard Kovalesky on the line? Steve Touzell is here.

Ralph is on the line. We're good.

Okay.

Okay thanks everybody. Thanks for your patience.

>> FRED HESS: Okay.

Good. Okay.

We almost didn't think we had enough people for the meeting that would not be good.

All right let's start -- well we have already done the introductions we can skip that pretty much, we'll go straight to the housekeeping and committee rules.

Housekeeping committee rules are -- keep your language professional.

Okay? try not to curse too much.

Point of order direct comment toss the chairmaned wait until called on. Keep your comments to two minutes.

Meeting minute tripses are list open the Listserv under the MLTSS meeting minutes the documents are posted within a few days of the meeting captioning and audio recording captionist is documenting the discussion so please speak clearly and slowly.

Also, the meeting is being audio recorded.

We also have American sign language interpreters with us today.

Please speak clearly and slowly.

Cell phones turn them off we don't need the ridging in here.

Clean up, throw away your stuff when you leave.

Public comments will be taken, during presentations instead of just being heard at the end of the meeting however there will be an additional 15 minute period at the end of the meeting for any additional public comments.

The 2018 sub-MAAC meeting are on the web site.

And, it is so long I'm not going to try do it -- we have 3 members whose terms will be expiring at the end of the month I would like to take a moment to thank William White, Veronica comfort and Arsen Ustayev for their commitment for serving this committee we wish you all the best.

Now for emergency priors. We'll go to barb.

>> BARBARA POLZER: Thank you.

Highlight of everyone's day the emergency evacuation procedures.

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

If you require assistance to evacuate you must go to the safe area located right outside of the main doors of the honors suite. OLTL staff will be in the safe area and stay with you until you're told you may go back into the honors suite or you are evacuated.

Everyone must exit the building take your belongings with you. Do not operate your cell phones, do not try to use the elevators they will be locked down.

We will use stairwell one and 2, to exit the building for stair one, exit honors suite through the main doors on the left side near elevator, turn right go down the hall by the water fountain stair one son the left. For stair two exit the honors suite on the side door on the right side of the room, the back doors.

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

For those exiting from the back door exits, turn left, and then left again and stair two 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.

>> FRED HESS: If you guys can remember all that,.

[applause]

Because I never do.

[laughter]

>> SPEAKER: I'm following you.

[laughter]

>> FRED HESS: I said it so many times I still don't get it.

All right. At this time I would like to invite Heather Hallman, Jill Vovakes and Jonathan Bowman from MAXIMUS to come up to talk about the southeast CHC --

>> KEVIN HANCOCK: Jonathan Bowman is not with MAXIMUS he is with the Office of Long Term Living we have a representative of MAXIMUS as part of the communications. You're welcome to come up here if you want.

>> HEATHER HALLMAN: Hello everyone.

Hi.

All right.

Give us a second as we get together. So Fred said we only had two minutes per comments so we does this count towards our two minutes.

>> FRED HESS: No this is say presentation we're good.

>> HEATHER HALLMAN: Okay.

So high I'm Heather Hallman from the Department of Human Services the secretary's office I've been here a few times to talk to you guys about communications.

Jill Vovakes and I will be doing this together.

And Gabrielle will have to keep us with us there's a little arrows that transition and everything ready?

>> SPEAKER: Gotcha all right.

>> HEATHER HALLMAN: How many people have been to HealthChoices.pa.gov?

Okay I really, expect every person to raise their hand it's pretty close. All right.

So this is our web site. Where we have, um, literally everything regarding community HealthChoices.

We also have everything regarding HealthChoices and the behavioral HealthChoices. When you go to the web site, um, you have the opportunity to either click on provider or, click on meeting services that's for our participants and the language that we use on this was actually a suggestion, um, from actually this committee on how to phrase that.

So, then you click and so this is the provider one. Generally this is where you guys are going to find most of the information that you probably would like.

And so when you click on this, first, we have our questions and answers that we have put together. So going around the State particularly the southwest last year where most of these questions came from, we have about 800 questions that we answered.

Put them on the web site. So you can find the answers to all of those questions on there.

And next, we have, um, our subscription to the Listserv I'm assuming every person in here has subscribed to the Listserv?

If not, Fred will come after you.

>> FRED HESS: Uh-hum.

>> HEATHER HALLMAN: Correct. All right make sure you're signed up for the Listserv even if you get the stuff for the MLTSS sub-MAAC I believe we still send everything that goes out on the Listserv to this group. But, you know, make sure you sign up in case we miss something.

And then also, we have all of the presentations that particularly the one that's we did in the southeast, recently for the providers. We have all of those presentations available on there.

But we also just recently did a presentation to the counties about behavioral health and nursing facilities and how community HealthChoices impacts the counties. So that one is up there also.

Do you want to do this Jill.

>> JILL VOVAKES: This is my favorite part. All right so we've gotten a lot of great feedback about the training out here and just reminder we'll continue to remind everyone, these training segments are broken down by provider types.

They are narrated, they're wonderfully done.

And what I like about it is, that you can see how much of a time compliment you're in for when you open up that presentation.

I've had associations and provider offices have use these for their staff meetings. And play them for everyone and then discuss and compile questions to come back to us. So I really encourage you to go out and look at the training segments.

>> HEATHER HALLMAN: I'm sorry.

>> FRED HESS: Can you guys please mute your phones on the phone please.

please.

>> JILL VOVAKES: Okay down to the provider, these are our fact sheets we send these out through the Listserv just in case you want to have a fact sheet or a flier about a particular subject for CHC, to handout to participants or staff, um, they're all available out here and if you have any ideas or suggestions for new topics please let us kne us know. We'll get it out to you.

>> HEATHER HALLMAN: A couple of fact sheets coming out soon, grievances and complaints we'll be doing one on transportation. We'll send out an update on the third party liability which is one we had previously done we want to reiterate that for providers. And also some information on eligibility.

So here's our participant portal for the participants in the room this is where you'll find every piece of correspond answer we're sending out to participants, this will be available here or almost everything is

available here. Right where it says read you can actually go on right now, read the notices that will be send for the southeast we're sending it out in 7 languages English, Spanish, Vietnamese, Russian, Cambodian, Arabic, I always forget one.

It is like, it is always a different language that I forget, do you remember which one?

>> JILL VOVAKES: I got lost --

>> HEATHER HALLMAN: But you can go on the web site see all of them, only only one that is not up yet is Arabic, we're waiting to come back from the authenticator that should be up soon, all the other ones are up there and the initial touch point flier that just went out is up ele there for you to check out.

>> HEATHER HALLMAN: There they r I did this, so I would remember. The languages. Now I think about that.

Russian I missed Chinese.

Which is -- we eventually been doing Chinese for a little bit I shouldn't have not forgotten that one. Here's where all of our participant information is.

The initial touch point flier is updated. The notices are updated.

The only thing that really isn't is the, pre and post enrollment packets we're just waiting on those to be finalized so we can update them.

But they're very similar to what was sent out in the southwest.

So if you want to just check out what they look like you can check them out, recognizing there will be some changes made to them for the southeast.

There's the notices.

>> JILL VOVAKES: Can we go back once?

Yeah.

So the -- the real new item out here is the participant sessions.

So if you look at the up there under CHC community meetings for participants, the invitation is there we have 72 sessions scheduled.

The schedule is out there. So, um, if you have interest in attending one of these sessions in the southeast, make sure that you get out there and register. If you need assistance, there's a telephone number that you can call in the flier to make sure that they get you registered for the session that you want.

>> HEATHER HALLMAN: We do want to remind people this is participant sessions. And we know that sometimes providers want to attend them. So that they can get additional information. But because space is limited we really do want it to be for participants and their caregiver those tend with them. So if space does become an issue, um, unfortunately we would have to trump the participants over providers.

Yes.

>> THEO BRADDY: How do you handle people who are deaf.

>> HEATHER HALLMAN: Yet is, how do we handle people who need American sign language?

There is an option on there to identify any special needs you might have. And so if they identify needing sign, American sign language we would, offer -- bring that.

The one caveat is, we need people to RSVP more than a day before the session.

Because it does take a little bit of time for us to be able to make sure we have someone available for that.

The fact sheets ASL is a language --

>> SPEAKER: Can we have the fact sheets available in American sign language as well.

>> HEATHER HALLMAN: I don't know though do that.

>> SPEAKER: I can give you information about that.

>> SPEAKER: That's not a written language it should be a video I can talk to you about that.

>> HEATHER HALLMAN: They would not be able to read the English version.

>> SPEAKER: I don't want to get into it now we'll talk about it offline. That will be a possibility.

>> SPEAKER: Explain it so it's on the record why it's important.

Speak.

>> FRED HESS: Step to the microphone.

>> SPEAKER: Good morning, I'm Sharon Bhenun, center for the independent living with the American sign language is a language in south has a different structure than English a lot of people who are deaf, their first language is American sign language the second language is English, so they're making -- they need to be empowered have as much information as possible to make their own decisions. So be great to have their information if you're going to the extent vote mean and Spanish and et cetera I'm asking to have American sign languages for the same reasons.

>> HEATHER HALLMAN: Okay.

We'll talk about had internally I will say the languages are based upon the number of individuals who identified that as a language I believe what we have seen in the southeast, is there is essential about, 3 individuals that identified their language as American sign language.

>> SPEAKER: Probably more than that.

>> HEATHER HALLMAN: One of the issues we are seeing, is because we have never -- we've done English and Spanish for all of our notices, participants haven't identified, another language because they know everything is coming in English. So when we send out the initial touch

point flier we had told everyone it's coming in this other languages I didn't get it in Russia, Russia is the one that was brought to our attention, we had to check to make sure it did actually go out.

It is because people did not identify that.

>> SPEAKER: They won't identify that.

>> HEATHER HALLMAN: What would be great if you know an individual who have a different language, preference.

Make sure they call the customer service center and identify that.

Because then, we'll be able to do more of that and have a better language account. Okay.

>> SPEAKER: If we can still talk about.

>> HEATHER HALLMAN: Absolutely we can talk about that.

>> SPEAKER: Thank you.

>> JILL VOVAKES: All right.

So our awareness fliers have already gone out, they went out this week I beli.

>> HEATHER HALLMAN: Last week.

>> JILL VOVAKES: Awareness fliers they went out last weekment and shortly following that, the aging well fliers went out to announce about these participant sessions we've just been discussing.

Pre-transition notices, and, enrollment packets will start going out the end of this month, end this month.

>> HEATHER HALLMAN: It is August today.

today.Jill yes end of this

movement service coordinator will be asked to reach out to the participants and inform them about CHC, separate 2018. So during August we'll have a flurry of activity.

Manage care organizations are, in the process of, if not already, setting up additional training, with service coordinators, to prepare them for that outreach.

And also, I do lead everybody back to that narrated we have specific training for our service coordinators and folks that work in nursing facilities to how they can assist participants in participating in participating for CHC, finally the nursing facilities staff, and MCOs are currently currently meeting with all of the nursing facilities in the southeast, making sure that folks are on Board, I know there's been a few sessions that also pulled in the behavioral health care organizations, I think we're we're doing a lot outreach right now, have some really great communication going on.

>> SPEAKER: For wareness flier U.S. said they went out this past week. How do they go out, to who do they go out to fee for service that receives these.

>> JILL VOVAKES: Awareness fliers went out to everyone that was identified as did moving into a community HealthChoices, so that was

approximately 127,000 folk ins southeast.

>> HEATHER HALLMAN: Caveat to that is that OBRA participants have been identified, as moving into CHC did not receive it, one because we're not done with that entire process yet, very, very close. But, two they have already received information, about community HealthChoices when they got theirs so they would not have received the initial touch point.

>> SPEAKER: Is that wareness flier, is that available on the previous page.

>> JILL VOVAKES: Yeah right above the aging well, information flier.

>> SPEAKER: Question there was a -- training for service coordinators, on the site.

That has not been there for awhile, that being updated this is the one to prepare the service coordinator those go out and talk with the participants about.

>> HEATHER HALLMAN: Should be on the web site I'll go to make sure it's on the web site. We did update for the southeast. So maybe there was a technical issue with that, but it should be I will go check.

>> SPEAKER: I collected yet it wasn't there.

>> HEATHER HALLMAN: Thanks for letting us know that sometimes things are missing it could be technical difficulties so thank you jail

Jill it should be located under service coordinators

there's an online course 45 minutes but we'll make sure. Participate.

>> SPEAKER: When you click on that, you get transferred to

LTI's site it is not on the site there.

>> HEATHER HALLMAN: It's not on aging well site. That's good to

know that is not there, so thank you.

All right. So, a couple of other things, that also in the ear

trainings August 9th we're doing a community HealthChoices refresher for

staff of the staff, to make sure everyone is up to date on it to see

people the first time around, didn't think about attending the training

need to understand more also doing inperson meetings for legislative in

the southeast to make sure they understand what is going on with

community HealthChoices a lot of other times Kevin and I like do a road

show together we're best friends he doesn't say so, I think we're best

friends.

[laughter]

Here's some resources -- number one is the Listserv which you've

signed up for, if you didn't Fred is coming after you, so remember that

Fred is scary.

Next we have the HealthChoices.pa.gov site you go

to get on the Listserv we have an email address to have people email us

questions. We have the provider and participant lines available. We

have -- independent enrollment broker's number you'll hear from the n

enrollment broker in a couple minutes all of those resources are

available to you guys anymore questions about general CHC and we'll talk about LIFE and

MAXIMUS's role in a second.

Great we're done.

[laughter]

>> JILL VOVAKES: All right.

>> SPEAKER: Hello I'm Jonathan bow plan with the Office of Long

Term Living. I'm the division director for the LIFE program.

Just want to give you some updates on the -- LIFE program

communications, but before we do that, I wanted to just get a quick

background again on the LIFE program, the LIFE program is a Federal

ly regulated program that operates in our state. The LIFE program will

remain an option, continuing for individuals who are eligible

for the program. It is a fully integrated Medicare and Medicaid

program, that offers, long-term care, acute care, pharmacy services and

behavioral health services.

Eligibility for the program, can be seen up here to be eligible for

the program, you must be age 5 or older. Determined to be nursing if a

sill clinically eligible.

Determined financially eligible or have the ability to private pay.

You have to reside in an area served by a LIFE program. Determine that you can live safely in the community setting at the time of enrollment with the -- with LIFE services so just, kind of to recap, what we did in the southwest, what was done.

There were, several communications sent out there was community health choices communication to LIFE participants. This was done to let LIFE participants know that CHC is an option for them, this was requirement of the Federal government.

The LIFE flier that -- that communication, was targeted, at people 5 and older live inned a service area, that a certified LIFE program, they were clinically eligible.

So moving to the southeast, the communications for the LIFE program, as Jill mentioned earlier the -- CLC community meetings for participants, that are, going to be occurring the LIFE program will be covered in the sessions so, individuals attending the sessions, will learn about the LIFE program. We're sending a two page flier to potentially eligible individuals. This is little more specific it is for southeast MA eligible individuals who are nursing facility clinically eligible, age 5 or older letting them know LIFE is an available option. We're targeting there, mailing in the next few weeks. Early August.

And, then, again, we are are going to be sending a CHC communication

to LIFE participants, this is a flier that is going to go to all LIFE participants in the southeast letting them know that community HealthChoices will be an available option for them, beginning in January. And -- also I want to recipe -- LIFE services are available available in all five southeast counties at this time. With the exception of Chester County, there's currently one zip code that is served in Chester county, we are working to develop that county and hope to have that county up and running fully. At some time in 2019.

>> SPEAKER: Potentially eligible participants are including all current waiver consumers.

>> SPEAKER: Potentially eligible would be the meeting the criteria, 5 older and clinically eligible and in a LIFE program area they meet with the LIFE provider themselves. And they make a determination whether they can be care plan to live in the community safely. So the criteria that we have developed for the targeted mailing is, 55 older and clinically eligible and where they reside.

>> SPEAKER: Yes.

>> SPEAKER: It would include anyone that, it would include current waiver people.

>> SPEAKER: That would be confusing if that's a separate mailing. >> SPEAKER: We have targeted about 47,000 individuals.

>> FRED HESS: You have a question Pam.

>> PAM AUER: Yes. Are the fliers and the materials are they on

the web too for people to see, people can be confused by LIFE program

just concerned with it. Do the materials actually state, what your requirements are no longer have the choice of the medical

professionals those kinds of things. Big bold letters it says --

optional, is there something on there we can see, you know, because

people call us and say I didn't know this -- we're able to --

>> SPEAKER: There are LIFE communications posted under the read

section on the web site.

As more developed and finalized they will be put on the web site.

>> PAM AUER: There's something, on there, that does say, everything

is -- you know more than just, your eligibility and 55 and that, but

really what is, required under LIFE program, you know, your choice and

options, much more limited under LIFE program, is that spelled out for

people.

>> SPEAKER: The limitations are not spelled out.

>> PAM AUER: They are.

>> SPEAKER: They are not. No.

>> PAM AUER: To cause less confusion I think they should be. Can

I ask a question I really have been dying to ask for a long time.

>> KEVIN HANCOCK: Just a point of clarification so there are

configurations of the LIFE program that, might be different from the community HealthChoices or the fee for service waivers but, we don't necessarily look at them as being limitations Pam we look at them as being the design of the program. So, we -- so participants will receive the flier if they have questions about the program, if it is something that interests them if they're looking something fully integrated they can do outreach to the LIFE plan will be the responsibility of the LIFE pans are plans to provide the all the details and requirements what participants will need to do, to be able to transfer into the program.

We don't look at them as being limitations it's the way the program is designed.

>> PAM AUER: Okay.

Just very, it is very different.

>> KEVIN HANCOCK: It is a different -- it is a different model of care but it is managed care, it is fully integrated managed care, it offers an opportunity for great, results for participants, if that, that participants choice. It will be the enrollment alternative for CHC we want to make sure that it's available.

>> BARBARA POLZER: Any chance of getting a comparison chart a table. Of the CHC, LIFE LAN-so the, the LIFE plan has to have a comparison chart as well.

So, we have, we're looking at it, we're looking for an opportunity to make sure that, that participants understand it is the enrollment alternative for community HealthChoices.

We are, at the same time we want to make sure to Pam's point we want to make sure we don't, confuse individuals because, we have 19LIFE plans we do have requirements just like within CHC with the 3 managed care organizations there might be differences in the way that those requirements are being met. So if we present them on a comparison chart we don't want to be confusing for participants in they see one LIFE plan presents a -- a requirement in a way that's different from another LIFE plan you understand what I'm saying.

>> BARBARA POLZER: I do.

>> KEVIN HANCOCK: Sure.

>> SPEAKER: Kevin this S* this going to be a separate marketing initiative or going to be included with the over all packet with community HealthChoices that, can demonstrate, to note this is a, alternative?

Alternative to the CHC.

>> SPEAKER: This will be a separate targeted mailing.

Intended to go out about two weeks prior.

>> SPEAKER: It's going to be very confusing too, because quite frankly, but I think it will be better if it was, presented together,

and, you know as a choice, between community HealthChoices and LIFE program but, um, I just think with everything else you're trying to communicate this may in fact be more source of a confusion than an opportunity to provide additional information.

>> KEVIN HANCOCK: So, we -- we are reacting to an experience we had in the southwest with the LIFE plans. We're expecting as had happened in other states for there to be more enrollment in the LIFE plan as the enrollment alternative to community HealthChoices.

We, one of the concerns we had there wasn't enough information that was provided to participants about the LIFE plan during the conversion to community HealthChoices. So, we're taking this measure as corrective measure in the southeast because we just, didn't see the type of enrollments that we were expecting in the LIFE program when we went forward with community HealthChoices. So we, we're actually it's too late, so we'll go forward with the separate mailing we'll pay very close attention to the type of questions that we're receiving.

In enrollment broker is receiving and the LIFE plan is receiving to see if it does cause confusion we'll evaluate whether or not we want to take this step when we go forward with the rest of the State. But, this is a reaction to the fact that, that people didn't have enough information with the LIFE program when we went forward with the southwest we want people to know, it's an enrollment option.

>> HEATHER HALLMAN: I'll also add that the LIFE program is mentioned and output out there, in every communication we have for participants we try participants are not eligible like the nursing facility ineligible group we don't add information into that, we do try to add that in, so people understand the difference between them but it is that fine line between making sure people are not confused but also giving all the information that they have. We're trying everything we can, to make it clear to participants the differences and, giving them their options at the same time.

>> FRED HESS: Daniel you have a question.

>> SPEAKER: Yeah. Couple of questions.

First, is there a cost comparison too how much it cost the State per person on average foreperson in nursing home care versus someone who using the LIFE program, versus someone in the community receiving home care?

>> KEVIN HANCOCK: Yes. Actually it's a fairly straight forward cost comparison. There are four cat guys individuals in community HealthChoices, individuals who are in fee for service nursing facility and fee for service parts of the State, that still, exist until 2020 and individuals receiving fee for service, community based long-term care through the waivers then individuals in the LIFE program we can present that cost comparison if you want me to speak

about it anecdotally, the easiest are community health choices and LIFE the LIFE plan and community heal choices MCOs have a per member payments their costs are straight forward they receive this dollar amount for this type of participant. And then, what would end up being a more of an average would be nursing facility care and home community based care we're happy to present that comparison.

>> SPEAKER: I would value that comparison.

I think having a good idea how the State is, focusing their attention and trying to understand why pieces are being focused on, is, could be very helpful. Secondly, is there a cost, first of all, these services being focused on, people in nursing homes or -- are these, because they don't run, often have home addresses or where they would be able to receive these p mailings.

>> SPEAKER: Are you talking about the LIFE communications.

>> SPEAKER: Yes to the individuals in the nursing homes.

>> SPEAKER: They're included in the entire population that would fit the criteria of 55 and older nursing facility clinically eligible.

So, um, they will be included in the mailing.

>> SPEAKER: Okay.

Do you think they will be able to receive them? A lot of the individuals in nursing homes don't have, mailing addresses. They just have a block address it goes to the nursing home.

>> SPEAKER: We would use the address we have on file that's where we would send it.

>> SPEAKER: Okay.

Finally, once someone is moved from a nursing home, is there, is the Medicaid still continuing to pay for that bed.

>> KEVIN HANCOCK: I'm not sure I understand the question.

>> SPEAKER: Is that bed paid for, whether or not, the someone is moved into a community HealthChoices or, the LIFE program is that bed being paid for to the nursing home.

>> KEVIN HANCOCK: In the fee for service system, if a person is Tran transitioning from the nursing home facility to home, is the bed being paid by Medicaid.

>> SPEAKER: Yes continued to be be paid for?

>> KEVIN HANCOCK: Depends I'm not in any way an expert with occupancy with nursing home facilities. Do we have anyone?

>> SPEAKER: Judy is not here our expert on how, it will be calculating occupancy for I think it's built into the rates so -- I would not say specifically, it would be paying for cost of the bed. But I think, the -- it is built into the costs of the, rate. So.

>> SPEAKER: I'm looking for natural efficiencies for the State of say this is more cost effective to be in the community, or in the LIFE

program.

>> KEVIN HANCOCK: So both fee for service -- I could say with certainty, the LIFE program, and individuals in home and community based services are less costly than individuals who are receiving facility based care.

>> SPEAKER: The bed is still paid for?

>> KEVIN HANCOCK: Bed is still certified part of the reason is because nursing -- we talked about this, many times we know this, state it out loud the nursing facility services are the entitlement we have to make sure we're maintaining access we have to make sure that there's enough capacity in the system, and when we talk about the entitlement we talk about the entitlement for long-term services and Medicaid we have to make sure there's enough capacity in the system with the entitlement service for participants to be able to receive plong term care based upon the requirements for the program we have these certified beds in the past we have reduced nursing facility at capacity it has happened and may continue to happen in the future depends what happens with community health choices with the reality with long-term care we presented this information before is that, you have a steady level of individuals receiving nursing facility services so -- we have, roughly the same number of populations receiving nursing facility services that have been receiving those services for a fairly long

period of time.

So there's still a demand for nursing facility services while the home and community based services have increase at a very steep incline. So we have a lot more people accessing long-term care a lot more people accessing long-term care in the community than have in the past but there's still demand for nursing facility services as well if they, want to receive nursing facilities as the entitlement it has to be made available to them.

>> SPEAKER: Thank you.

>> KEVIN HANCOCK: Sure.

>> FRED HESS: We have another question.

>> SPEAKER: Kevin, this is Matt Seeley, state independent living council, follow-up to something you said a couple of minutes about the LIFE program less people enrolled in the southwest than you planned for?

>> KEVIN HANCOCK: We, so we had, we were expecting an increase in LIFE enrollment because of implementation of community HealthChoices it is the enrollment for community health choice that's based upon experience from other states that have a nation at PAC, program, it's called PACE there, they, did see an increase in the PACE program, whoever the long-term services and supports they were offering they didn't see an increase we were expecting the same thing to happen in Pennsylvania, it

didn't happen part of the reason we think is, we could have done a better job communicating as an available enrollment alternative that's what we're trying to do in the southeast as Jonathan was just talking about.

>> SPEAKER: My question is though, I would assume there's a special pot of money just for the LIFE program? LAN LAN I'm not sure what you mean by a special pot of money we don't have fully special pots of money if you have any idea where special pots of money please let us flow.

us know.

>> SPEAKER: Set aside for -- you know, is money designated for LIFE and money designated for CHC-they're a separate appropriation, that's a managed care.

>> SPEAKER: That gets to my question, does the State have an incentive, financial incentive to move people to LIFE over CHC?

>> KEVIN HANCOCK: No. We want both programs to be available for --

>> SPEAKER: You have to use that LIFE money for LIFE if we.

>> KEVIN HANCOCK: We move money around all the time, we do, we're Medicaid.

[laughter]

>> FRED HESS: Are there any questions or can we continue on.

We have one back here.

With the LIFE program are they in collaboration with housing? Are they purchasing housing for people who older than 5 55.

>> SPEAKER: The LIFE program does not include housing, each of our providers are set up differently. They have the ability to coordinate our work with the housing authorities do housing as -- separate line of business, where they can work to find the individual housing it is not included in our, in the rate calculation the rate set up. But, housing is something that the LIFE providers becausest flexibility of the LIFA program they can be creative are able to work with housing authority toss find housing for individuals.

>> FRED HESS: Brings up another question what about home modifications.

>> SPEAKER: Home modifications yes, they can be done as a benefit under the LIFE program.

>> FRED HESS: Okay.

We can continue on.

We have no more questions let's continue.

>> HEATHER HALLMAN: I'm done.

>> FRED HESS: Okay.

>> SPEAKER: Okay.

Good morning I'm Chris ports the director for community HealthChoices for MAXIMUS the n enrollment broker.

We'll go over a little bit about the community HealthChoices process, some of the pre-transition activities and a little bit about some expectations as far as post enrollment.

If you take a look at the community HealthChoices, over the last year, we've done two specific things, we successfully implemented phase one, specifically the southwest community HealthChoices and that's been an ongoing process.

We're in the process right now, of doing, phase two pre-transition planning.

And, for the southeast. So that's the five counties in the southeast area.

So where what are we specifically talking about, we're talking about member questions receive information from DHS regarding eligibility of members who are 21 years of age and dual eligible for Medicare and Medicaid as well as individuals 21 years of age or older and eligible for Medicaid LTSS.

Because they need the level of care provided by a nursing facility.

So, across the State, if you take a look at that big number 420,000, approximately 94 percent of them are dual eligibles.

So it gets into some of the steps specifically that we're planning for right now.

So, we're planning to set a CHC enrollment package that is going to

be comprised of a numbers of various types of information, specifically, there will be information, comparison charts information about basic benefits.

Contact information, for community health choices, to finish the enrollment process.

And really at this point part of what our charge is, to empower to inform and guide. State has 3 managed care organizations. That are responsible for over sight of the community HealthChoices program.

Whether a member is ready to select a plan, member can do it through a number of ways we have online sources we have a call center as well we have the ability to go out and do a face-to-face choice counseling with applicants.

The huge piece I want to emphasize right here is that -- participants need change.

And, part of the -- part of the model of the program is the flexibility and the ability to change plans, based upon providers based upon resources available.

So, applicants, participants can change their plan at any point. Those transfers can happen at any point.

Last piece I want to touch base on is, as I spoke to you about empowering choice selection.

The piece that every applicant will receive at time of post

enrollment what I mean is time they select the plan they will receive conformation letter they will receive a brochure, that have some questions and answers they will also receive, some specific information regarding the plan they select.

>> FRED HESS: Any questions from anyone?

>> SPEAKER: Go over the how to, call in -- something and face-to-face.

>> SPEAKER: It is 3 mechanisms. Call in.

Okay?

Face-to-face. Or see at web online.

>> SPEAKER: How do you do a face-to-face?

>> SPEAKER: So -- after our packet gets mailed out there's follow-up with our call center that information gets disseminated in our enrollment packet. And that face-to-face then gets scheduled, through our organization for through the call center with one of our staff persons throughout the State.

>> FRED HESS: Pam?

>> PAM AUER: So --

>> SPEAKER: I have a question when you guys are ready it's Tanya.

>> FRED HESS: Go ahead Tanya.

>> SPEAKER: Um, is MAXIMUS ready like for people that have to

switch from gate way completely over to the MCO system, to be able to answer like multiple questions about multiple providers, since we're going to have to know, how many of these providers and which providers they can seek when their switching from Medicaid insurance plan that is not going can to exist under the MCOs I just want to make sure that, like -- that MAXIMUS, is going to be prepared to handle that long and in-depth of a phone call with someone because, if not that person is going to have to receive like web addresses or like, actual in hand guides from each of the MCOs when they make their choice so they can cross reference not only what doctors and specialists they need but, service coordinating entities as well.

Is MAXIMUS ready for like a phone call that is not going to be over in 2 minutes.

>> SPEAKER: So, speak to little bit what we flow through experience what we know through experience with the southwest is, during the pre-transition activities going on post implementation period is we had extensive phone calls we plan for that accordingly. We know, given the population and the needs of the populations there's going to be extensive questions, because, simplistically, one of the, number one priorities is making sure providers are in their network and, the person has access.

So we receive on a daily basis, the provider networks. We have

done some lessons learned regarding expanding our search capabilities that is both from call center perspective and through the web. So, we'll continue to do that, there will be an ongoing discussions if things come up on a daily basis with the different MCOs we'll have those discussions as we have in the past.

>> FRED HESS: We have time for one more question. Go ahead Pam?

>> PAM AUER: I have so many questions for -- for MAXIMUS,

my one question is, can we see the data on what the calls are about and how they're being responded to? And, so that we know for future? And then the other question I have is, is the materials you are sending out, how are they being explained? Are they easily readable and understandable?

Because, um, I don't have a lot of faith I'll be honest we struggle on a daily basis anyone that works with helping people get into the system, with IEB staff at the call center having accurate information.

And I just, you know I'm really worried about, people getting information that they can even understand about the 3 providers so they can make a truly informed decision.

Can we see what is really happening we askedded that of the MCOs

we've been asking for data along this whole process I would like to see the data through IEB and MAXIMUS too.

>> SPEAKER: So two pieces to that, first is, certainly we can share the call center data, both from an IEB and CHC perspective. Also, we can share post call satisfaction survey data that gets collected monthly as well. Okay.

The other piece, the other question I'm hearing is the information, we have worked very closely with the DHS of office long term living regarding the information in the packet being concise with that packet that information, is for the southeast that, southwest, that I believe is still up on the web that information, shortly will be on the web for the southeast.

>> PAM AUER: Readability and everything. Okay.

We'll check it out. I'm really concerned.

>> FRED HESS: You have a quick question.

>> BARBARA POLZER: Two that came in over the phone. The first one is nursing facility discussions with residentness the southeast will this take place with the residents spouses and/or power of attorney?

>> HEATHER HALLMAN: So, um, if an individual, has a power of attorney a spouse, or nursing facility on record, they will get the notice from us, so they will, they will also know of that participants are moving into community HealthChoices. And be able to then, help them through those, that process.

And, I'm sorry, was there another part of to that question.

No okay.

>> BARBARA POLZER: No.

Do we not have time for the second one.

>> FRED HESS: Yes briefly.

>> BARBARA POLZER: Okay.

Have any nursing facilities had issues with the billing/software with the 3 MCOs?

That's the first part of it and the southeast will the rate for county nursing if a sill if Is being based upon the CMI over the last four quarters.

LAN-really specific question, I'll take it. So -- we have had -- for the south effort are west, southwest implementation we've had, to be perfectly honest, and an amazing success rate with billing when it comes to nursing facilities and the CHC MCOs certainly, some nursing facilities require a little bit more technical assistance. But, the -- the associations and nursing facilities in general have talked in general about the billing processes worked very well, and in some cases they're more pleased with the experience they have had the with the CHC than they even had the department, because they're paid faster through the process.

>> SPEAKER: Kevin it's Denise.

>> KEVIN HANCOCK: Can I just finish the second part of the question

I'll jump right into that Denise.

>> KEVIN HANCOCK: Second part is the CMI, case index was used for a basis for the rate floor that existness the community HealthChoices so, component of the case mix was used as part of the establishment of the rate floor which will be in place by phase for 36 months and, and it will be, the case mix will index will, case mix process for rate setting will continue to exist for the fee for service system as well.

>> HEATHER HALLMAN: Add want a second even though Fred will want to hit me, regarding the nursing if a sill, MAXIMUS will be doing webinars with nursing home if a sill toys that tuck them how to talk with the participants about the CHC we had good success with that.

>> FRED HESS: I'm not going hit you I promise I am not going beat you we're out of time for questions it is 11:00 it's --

>> SPEAKER: One sentence, MAXIMUS is covering people in the community correct?

Not, people in long term facilities.

>> HEATHER HALLMAN: They're doing both.

>> KEVIN HANCOCK: For the CHC roll out.

>> FRED HESS: Correct.

Okay.

Let's move on, we have a -- --

>> KEVIN HANCOCK: For the person on the phone when I do my update

if you want to ask the question then I'll be lap I to answer it.

>> FRED HESS: Absolutely he is coming upright now. So -- do you want to come back up.

I will keep this on schedule today.

I swear I will.

[laughter]

>> KEVIN HANCOCK: Does anyone want to take bets he is going to be able to do that.

>> FRED HESS: All bets are on, go a lead.

[laughter]

>> KEVIN HANCOCK: I'm Kevin Hancock from the Office of Long Term Living I'll provide CHC updates I think, thank you to Jill to Heather, to Jonathan and the MAXIMUS team for providing updates on the communication for CHC so I will not have to provide updates on communication for CHC thank you for that.

The first slide, shows, so -- as a matter of background we've been working with the managed care organizations two key areas of opportunity for improvement.

The first is the development of service plans, and the second is, the articulation of the service plan denials or service change denies this data that I'm going to be presenting will be talking about service change denial.

We'll also, be -- discussing how many fair hearings have covered and we'll be talking about opportunities for improvement with the service plan development with the managed care organizations a well, I'll be happy to take questions throughout first slide shows how many service plan denials we're looking at.

We talked about this a little bit last month, we made the decision as a department, to require all managed care organizations, CHC to submit all of their service plan denials, to us before their sent to participants because we did see service plan denials that were worded in the way that, would have at best caught confusion, it really did not articulate the reason for denial they just didn't meet what our -- what we thought were our requirements for service plans were. So this slide shows how many we have reviewed.

These are, specifically for home and community based services.

And for home and community based service that's occurred at the end of the continuity of care period. So for AmeriHealth Caritas we looked at 35, Pennsylvania health wellness we looked at 85 and UPMC we looked at 102. We have gone through, each of these -- these service plans at this point. We are still working with Pennsylvania Health & Wellness and UPMC on the majority of their service plans, to get them to be, articulated a little bit better and AmeriHealth Caritas has made more progress. So, at this point we're still working with the managed care

organizations, we will be looking at all service plan denials indefinitely.

>> FRED HESS: First we have a question from Lester we have a question down here.

>> SPEAKER: Could you slow down when you read, could you read slower.

>> KEVIN HANCOCK: I'm so sorry I apologize.

That is not a question that is say critique.

Fair critique thank you.

I drink way too much caffeine.

[laughter]

We have a couple other questions.

>> FRED HESS: Lester has a question and we'll go to Theo.

>> SPEAKER: Lester Bennett, denials can we be specific and talk about what services are being denied?

I'm kind of confused, I -- as a service coordinator, entity we receive the denials for increase in the middle of, June and, the reason, was -- there was no documentation for 75 percent of the utilization of the actual units.

So I kind of wanted an understanding of how service coordinators are getting denials, who gets that letter?

As a service coordinating entity responsible to appeal or is that something the consumer is supposed to be doing? Just, trying to get an

understanding what I should be getting ready for?

>> KEVIN HANCOCK: Service coordinators do not get denials

participants get denials service coordinators are --

>> SPEAKER: I have a letter I can -- I have a --

>> KEVIN HANCOCK: You might be communicated from the MCOs about the

participants services but service coordinators do not get did he file,

participants are getting the denials just be clear.

>> SPEAKER: Well, we are that's the -- that's what I want to make

sure that I'm trying to explain to you that's not clear we are getting

the denials we as a service coordinating entity we're asking for an

increase in the service coordinating units.

Then we are getting a denial so then that's what I was saying that's

something I did not expect the consumer to be getting any way.

>> KEVIN HANCOCK: That's a conversation, since service coordination

is administrative function of the managed care organizations, service

coordinators have a subcontract with managed care

organizations, need to have a conversation with the managed care

organizations about how, service coordination units are distributed.

That is we won't see that at all. The department actually will

not see.

>> SPEAKER: Because well -- there's where there's a lot of

discussion at the beginning of the year we didn't know how many units we

had.

If they would still carry on it's just that -- we are basically getting 40 percent of what we the work we're doing. We're getting 40 percent paid of what is being done is being denied.

>> KEVIN HANCOCK: Just to be clear Mr. Benne text t, service coordination is the function of the MCOs we're talking specifically here about participant services.

Business relationship with service coordinators and managed care organizations is something that we encourage service coordinators that are subcontract withing managed care organizations to talk with their managed care organizations about.

The department is only involved in reviewing service denials for services that relate to participants so encourage you to have a conversation with the managed care organizations about the way your services are being allocated by them that's your business relationship with the managed care organizations.

>> SPEAKER: So are you not worried if the consumers have the option of outside service coordinating entities if they don't get, if they don't get the money to provide the services that service will not be available for them?

>> KEVIN HANCOCK: The department has two objectives when it comes to service coordination, first, that it is offered in unlimited way to

participants. Which moons managed care organizations, have a system of service coordination will be always easily available for participants in they have requirements. The second point is service coordination, at the individual level individual service coordinators are offered as accloys, so participants at any time I'm talking too fast again sorry.

Participants at any time, can change their individual service coordinator, whether it comes to inside versus outside entities, for the department's perspective, service coordination, is an administrative function of the managed care organizations.

So, that relationship is between the MCOs, and the service coordinators if they have a subcontracted relationship, with the MCOs, service coordinators need to work out that business relationship with the MCOs. What we're talking about here, once again are participant denials.

Participant service denials.

>> SPEAKER: I understand that I'm looking from a bigger perspective what the consumers the idea of the service coordinating the actual function of it is a true function that is ultimately geared to educate the consumers to keep them in the independent community. From what I'm seeing is now that service, has basically been given to the MCOs, to oversee yet I don't think that the same intensity for taking care of

this consumers is there.

So that's where I'm saying, I -- hear you say that it's been given to the MCOs and we're giving the consumers the option of having the outside and internal.

I want you to realize that the outside has a deeper connection in making slur that the consumers are independent. I'm watching the -- I'm watching the deinstruction of the waiver to make the consume everies dependent on the waiver I don't see the, because of I see you're looking why am I saying that I don't see the intensity to make sure these consumers are being educated on what the services are so they could eventually be independent off of the services I would hope that would be our goal as as people to make sure that we're not creating people that are dependent by the people that should be actually educating them.

Educating them on how the service should be used.

So that they can eventually say I have the foundation to be independent, get off of the program by what you're doing with the employment services.

So we eventually want to get the people off the program, I do believe that the fact that we took in the service coordination directly there are the MCOs.

And now, the outside has to have a, a business relationship from

what I understand I can see as a business relationship them saying, we've been put in a silo we're not actually being taken advantage of, to provide, information, we can see that in the fact that we're having problems with transportation where I'm saying the people that were actually outside they could have been, helping you -- actually take care of the consume everies and we're saying, as we keep going on we're being pushed away where I'm scared and very afraid that we're creating the system making consumers dependent instead of making them independent, by being a balance where a lot of people will tell you the service coordinators are basically, helping the consumers understand what the providers need and what the State needs. When they're arguing --

>> KEVIN HANCOCK: Just I think you -- made clear. Your point.

The other thing I am going say, dependent or independent, our goal with community health choice asks to serve people with, we have a lot of -- five different angles for community HealthChoices. Number one, dependency is not a concept we're, we were articulating we want people to be able too first access long-term services and supports in the community. First and foremost.

And we want people who need long-term services and supports to be able to access, have as many services and supports made available to them.

That help them to be able to savely and, have greater quality of life in the community I'm not sure how you define independent or dependent we want people to have a really great quality of life by they're value by their measure that's our goal.

We want them to be able to have that quality, high quality of life in the community because that reflects participant preference.

So I'm not sure, I completely agree with your language.

But, just -- I'm going reiterate again it sounds like, what you're describing play be a business problem between the MCOs and you as an organization I'm going to encourage to reach out to them and have a conversation about it.

>> SPEAKER: I have, thank you.

>> KEVIN HANCOCK: Thank you.

>> FRED HESS: We'll go to Theo we'll go to Daniel please try to keep it under 2 minutes.

[laughter]

>> KEVIN HANCOCK: Try to -- I have a lot of content if you can figure out a way to ask the questions for the other content that allow me to get through little more quickly I'm just kidding.

[Laughter]

>> THEO BRADDY: Kevin what happens to the amount of notices when they're rejected sent back to the MCOs do you have any data on that.

>> KEVIN HANCOCK: Yes. There is the data. So they actually, the MCOs, when they reject the denial notice send back to the MCOs they have the obligation to rewrite it.

And in away that makes sense we're not saying, that the service cannot like if a service level, is not meeting a participants needs, participant always has a right to appeal the point of this exercise is make sure they understand why the MCOs are, making the decision they're making with regard to the services.

So, we make them rewrite them, we look at them again.

And L if they get to the point where they actually, make sense for a participant to understand, the denial notices it can be sent out to the participants and the denial notice gives participants the information about their rights to go through, a -- complaint or grievance I believe that Patty Clark and David gates will be talking about later.

>> THEO BRADDY: I guess employee question is, it can be a forget if after you back to the MCOs what are the outcomes or results whether they get approved or -- denied again?

>> KEVIN HANCOCK: So it -- depends.

That's a good question. Depends, so, it is possible that we're not telling the MCAs they can't change levels of service they can't deny services we're not telling them that, because we have talked this before, there are times when it may be appropriate for service

plans to be adjusted to be a little bit more in line with assessed needs and preferences there could be a change that is a lower level of service, the point to the service denial is to articulate to the participants the reason why if is possible that the participant could see, still see a reduction of their services or receive services at different level than what they're requesting. But it would more, what is most important about this exercise is they really understand the reason why, make sense?

>> THEO BRADDY: Yeah I got it.

>> FRED HESS: Okay.

Thea, turn off your mic Daniel we have a question here from the gentleman in the blue shirt.

>> SPEAKER: Quick question, I think, might lead into next slides.

I'm seeing a very wild swing on denial notices approved.

We have almost, all of the denial notices approved by AmeriHealth and almost all of them denied by UPMC.

That is a pretty big difference and, um, I'm also curious are these individuals who each case is denied or are these repeats, are these individuals who have been denied try to deny them again and did he fly them again or is this all individual cases?

>> KEVIN HANCOCK: These are individual denial notices it might be

multiple -- maybe, moor than one, one person might have more than more than one denial notice I don't know that for sure it's individual denial notices so each individual denial notice could be, looked at individually.

So when you look at the swing, it is, just, an -- this is not a reflection this, what is a reflection of the quality of the denial notice, only thing I would say to the credit of AmeriHealth Caritas is that, in the way they're writing denial notices they have, they seem to have adopted what the department is requiring a little bit more quickly than the other MCOs.

So, to the credit of UPMC Pennsylvania Health & Wellness they have invested a lot of resources and trying to see this improve, at this point AmeriHealth Caritas is a little bit further lead when it comes to this particular requirement.

>> FRED HESS: Ray, do you want to add to that?

>> SPEAKER: Yeah.

If I may I mean, with the, the 101 that were reviewed and denied, you know by DHS, we are not incontinueding to seek approval and send those out again. We have rescinded those denials and re establish ad the previous service levels in all of those cases so to be clear where we are in the process.

>> KEVIN HANCOCK: Just to be clear that's true all of all

3 MCOs.

>> SPEAKER: Moving ahead we're working with DHS and with better language that's more complete and, you know, I think to Kevin's point, better understandable so, participants know exactly why denial might be occurring. That's where we are in the process. We're still working with the DHS on final approval of those letters.

>> KEVIN HANCOCK: AmeriHealth and Pennsylvania health wellness are welcome to chime in as well if they want.

They're shaking their heads.

[laughter]

Okay.

Thank you. Thank you Daniel.

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

>> SPEAKER: How about the concerns and I have some concerns I've heard from different clients.

About not being aware about what the letter is of denial are, they're missing deadlines and they're not receiving them on time.

Is there a way that we can give a -- some type of a grace period for a few days or something? After the denial if possible?

Sending through registered political? You know, that kind of thing, some type of approval that way? If the client can sign it.

>> KEVIN HANCOCK: So the question was if I understand it correctly,

that you would, the regulatory requirements for denial notices the participants have a couple of days grace period to understand or to be able to have more time to submit the appeal or, grievance.

For lack of a better term.

>> SPEAKER: Yes.

>> KEVIN HANCOCK: Yeah.

>> SPEAKER: So they can send through the political.

Ten days is not enough.

[Mail]

>> KEVIN HANCOCK: We're planning to stay with the regulatory requirement. The ten days. We will monitor this -- to see how much of a problem it is. Abut it is -- at there point we're planning to stick with the regulatory requirements.

I take your point.

>> SPEAKER: When we have a vehicle I have a question for you okay.

It's Tanya.

>> FRED HESS: Go ahead Tanya and Barbara and we'll have Luba.

>> SPEAKER: Okay.

Um, when you said we're sticking with regulatory requirements about the ten days, where do those requirements come from? What office gives you those requirements that you have to follow.

>> KEVIN HANCOCK: Part of the managed care final rule, they're

Federal requirements centers for Medicare and Medicaid services.

>> SPEAKER: So it is, CMS. Where did they they girl -- where did they, who tells them what their requirements have to be?

>> KEVIN HANCOCK: It's a -- a lot of stakeholders just like our, the State level regulations Tanya it's a lot of stakeholders contribute to the development of the regulations. Including external stakeholders states et cetera.

>> SPEAKER: Who would somebody have to go to, in order to get those requirements changed? Like what level of like in what government office actually makes the final decision on that the process only takes ten days.

>> KEVIN HANCOCK: Secretary for Health and Human Services normally signs off on Federal regulations.

>> SPEAKER: Thank you.

>> KEVIN HANCOCK: Thank you.

I always feel like I'm answering questions from Congressman Tanya.

>> FRED HESS: Barbara and Luba and there gentleman.

>> BARBARA POLZER: Are these notices being sent certified mail.

>> KEVIN HANCOCK: Actually I don't know that.

Ray would you answer that question from your perspective.

>> SPEAKER: I don't know with 100 percent certaintyity.

>> SPEAKER: They are not.

>> KEVIN HANCOCK: A AmeriHealth Caritas and they are not sent.

>> SPEAKER: They would be sent with the mailing date, there's no requirement it season sent certified mail.

>> BARBARA POLZER: Only going speak from an experience from SCE we send them certified mail to ensure that they get delivered.

>> KEVIN HANCOCK: Right now we do not have those requirements we can certainly make that recommendation.

Fred fed go ahead Luba.

>> SPEAKER: The question, for ray in regard to I guess all 3 MCOs, I'm not clear, what you meant by you rescinded the denials what does that mean for the -- for the participant? Um, does the service plan stay the same? Do you, if they request an increase do they get it?

Could you just clarify you know, how you're looking at that? How you rescind it and what does that mean for that consumer going forward?

>> SPEAKER: So what I have, what I meant to say is that, we, um, called the participant the provider reinstated the services that were in place prior or you know, what were involved in the adverse reaction we send a letter to that same effect. Is that clear?

>> SPEAKER: Are there service that's are restored?

>> SPEAKER: Yes.

>> SPEAKER: If they requested increase do they get the increase?

>> SPEAKER: Yes.

So so any adverse action, decrease or increase.

>> SPEAKER: Okay thank you.

>> FRED HESS: Now this state your flame please so you can flow who you are by the way.

>> SPEAKER: My name is Patrick.

Any way, I wanted to make sure that my statement was really clear.

So -- if someone receives the letter of the denial for services or reduction or changes in services often it is difficult for the deaf to understand what the language is and they're not able to read it correctly. So would the deaf be allowed to receive more time so they can go and go to CILs or some form of services so they can, get the support, when it is to understand their mail correctly they can understand what is happening so they can make an informed decision.

Because English is not their first language.

>> KEVIN HANCOCK: So, just to be -- as with Heather this is the first time I've ever heard there's a graphic language that would be used for, that represents American sign language in writing.

I would love to learn more about that.

And I think we will have the opportunity to learn more about that,

but -- talking about the -- the deaf population specifically, I think we need to know a little bit more about the requirement before we can respond in an informed way.

That being said at this point, we're planning to stick with the regulatory requirement, the time period.

I think, that we're very much open to a discussion or with the committee on -- on what makes the most sense.

I think we need to learn proper about American sign language in print.

>> FRED HESS: Okay.

Go ahead.

>> KEVIN HANCOCK: So we'll go, move along the next slide shows, we're hoping to Pam's point, earlier we're hoping to be able to start presenting more and more data, as part of the committee in these updates because, we're getting more and more data and it just makes more sense and, it will help inform the discussion as to how the program is actually dolling from objective perspective. This, this second slide is from our first quarter of totals of denials and appeals data.

That is sent as part of one of our operations reports as see here, we have calculation of first level grievances -- and how many have gone through the MCO expedited review an external Department of Health review and threaten external expedited Department of Health review as

well.

The total here as noted is, 6 from AmeriHealth Caritas. 21 from hence health and wellness and 20 for UPMC. The results are with, which -- one was denied from AmeriHealth Caritas and five were denied from -- not denied withdrawn from UPMC. And then, some of those, went through an expedited review as well.

So low numbers very low numbers for this program at this point which is not a surprise.

Mostly because, A we were going through a continuity of care period.

And B, it is a new program.

So -- kind of getting, getting used to the program, as were the MCOs so this very low numbers in the first quarter. Which again is not surprising.

Next slide shows number of denies went through fair hearing that's is one. This is the entire first two quarts of 2018.

And, that one, fair hearing is withdrawn. Which means that we actually, have had one activity withdrawn for fair hearings and low numbers the reason why -- this is because it's a new program. It is not at all surprising we have such a low number. But -- I want to emphasize going forward we'll continue to provide this data as well as additional data shall as it becomes available, we started to receive loot of data in June in the program we're hoping that as we go forward,

we're going to be able to present, that data, once it's scrubbed we're making slur we're standardizing the requirements for how they have been submitted to us from the 3 managed care organizations and until we have a comfort level of the -- the quality and composition of the data, we're not going to present it. So this is relevant to what we were discussing today.

Any questions about any of that before I jump into denial notice training?

>> FRED HESS: Let's try to keep the questions really do you know to a minimum we are running out of time for this section.

>> KEVIN HANCOCK: Can I talk fast again.

[laughter]

>> FRED HESS: No.

>> KEVIN HANCOCK: Okay.

So the denial notice process training so, as related to the first slide update we, we had presented, we required the 3 managed care organizations to go through denial notice process training with our office of general counsel with the Department of Human Services office of general counsel there was certainly precedent with the health choices program. And office of general counsel led by our chief council Doris Lesch, presented detailed training that was a very lively training a lot of interaction talking about how those service -- service denial notices

have to be crafted, and actually talking about the process itself.

We believe that will, that will support managed care organizations, understanding of the requirements for community HealthChoices, and we are hoping that will ultimately T improve the quality of the denial notices itself.

So -- with that, denial notice for, we have an expectation at this point, that we have presented our case as to what are the requirements in the managed care organizations they will take it from there.

In addition to denial notice review, we also are working with the managed care organizations under the development off the person centered plans to -- to be brief I will not go through what all 3 of the managed care organizations are doing, or proposing to do, to be able to address the objective, which is to improve the quality of service plans that are, distributed to participants.

But also all 3 managed care organizations have been working with the service coordinators as well as staff to train better on requirements of service planning.

Person centered service planning and -- to actually, to develop a quality service plans that have all the component that is are required.

We have a checklist, that is that is sort of, establishing what should be includ included on the service plan and all 3 managed care organizations completed the training with the staff to be able to address the

requirements we are reviewing service plans to see the improvement at this point. So all 3 managed care organizations have met part of the requirements for improving, service plan developments and the next step is for the development to review and see what the impact is of that training. So -- so far, the MCOs have jumped on this as an opportunity for training, with our internal and external staff.

And, ultimately they, we believe that, we're going to start seeing much more comprehensible and comprehensive service plans for participants regardless whether they're receiving long-term care in the community or if they're receiving long-term care in in a silties.

Okay moving on. Stop me if you have any questions.

[laughter]

Moving onto the southeast implementation -- that's all southwest information. So we are as the communications team has articulated, shifting our focus in addition to operations for the southwest, to implementation for the southeast. Southeast goes live on January 1, 2019 and we have already started our communication with participants, on on what this change will be meaning for them.

This population as noted on this slide, is 127,000 individuals. It is roughly 50,000 more individuals than in the southwest.

Many more of these individuals as I have previously stated are receiving long-term care in the community.

So, for the folks in the -- representing the southeast, you actually are presenting a distribution of long-term care, in the way we would like to see it for the rest of the state. So, whatever you're doing keep doing it.

But -- we are hoping the community HealthChoices will under write that activity in the southeast and, help bring those lessons to the rest of the state. So -- Barb congratulations Steve congratulations, et cetera, et cetera, congratulations.

But looking forward to -- learning proper about what you did so that it can be something that can be brought to the rest of the state . The rest of the State is more 50.

>> FRED HESS: One question from Zach.

>> SPEAKER: Hello there is Zach from disabled in action, Zachary Lewis.

Questioning as a consumer, and the portion that receives services under a waiver, I'm not getting fully of these fliers or any of the information at all I mean I know I can access it online but what about people who can't like, you are saying you sent it out two things already I have asked a couple of people while we were here, have you gotten anything from state or, CHC?

>> KEVIN HANCOCK: I'll use as you an example we'll use you as an example. We'll take your, if you don't mind, we'll take your address

as a follow-up we'll try to figure out why you should have received your initial touch flier by now they were staggered a little bit, so it is possible that you outside possibility that, if you received the mailing if the mailing with you didn't go out until Friday you may not have received it yet you should have.

You should have. So we'll have to, investigate what happened.

So we have a -- we have noted Heather noted earlier we have a lot of demographic information that needs to be updated with our county assistance offices. So, it is boos I believe, some people may have an incorrect address on file we had to use the address that was available we had the incorrect language on file which means they would be getting their flier in a language, might be different than their primary language but -- you Zach, probably sure received it, we'll want to figure out why we'll take your information we'll use you as a case study we'll report back why you did not. Because it doesn't make sense to me at this point you some of received it.

>> FRED HESS: Atypical your check is in the mail.

[laughter]

>> SPEAKER: Came from the Office of Long Term Living?

>> KEVIN HANCOCK: I think --

>> SPEAKER: -- the flier I received.

>> KEVIN HANCOCK: Fliers would have come from the Department of

Human Services.

They may not have looked like they were from the Office of Long Term Living. So -- hopefully, doesn't look like junk mail did you get yours.

>> SPEAKER: I did.

>> KEVIN HANCOCK: Linda did get hers, okay.

So -- we have to figure out why.

>> SPEAKER: Because like literally, like -- 30 yards from her.

I live 30 yards from here.

>> SPEAKER: It's the mail.

[Laughter]

>> KEVIN HANCOCK: Might be --

>> SPEAKER: Mail gets syphoned from the same place I didn't get anything.

>> KEVIN HANCOCK: Was it Daniel that made the point nursing facilities, and -- the distribution of mail, I'm not sure if we made that point earlier.

Pam. Yeah.

Made that point. So -- yeah. Maybe you have a question.

[laughter]

Someone made that point, so -- we might want to talk to facilities make sure they're being distributed appropriately as well.

>> SPEAKER: So I have a question. Even though I

understand things are going as far as the southeast get the ball rolling January 1, until then, I'm having I brought this up where we started this. As an advocate as well. For a bunch of consumers figuring out how to get a denial -- it is -- I don't know though do it. I've gotten it once but that was over I mean, maybe 8-9 years ago, in order to get the DME supplies.

>> KEVIN HANCOCK: Medicare denial letter.

>> SPEAKER: Yes. You're right. Or for -- DME products.

>> KEVIN HANCOCK: Okay.

So -- it will depend upon the service whether it will be eligible for Medicare or not hopefully your provider will help you with that.

Or, you're -- the managed care organization will definitely.

>> SPEAKER: I'm talking about until then. You get the ball rolling how does that work I need -- we need steps, because a lot of people are not getting, the things that they need from the State. We deserve it, we want I -- I want it I'm speaking for a lot of other people, how do we get it?

>> KEVIN HANCOCK: It's, so -- in the fee for service system, the first step would be your service coordinator to work with your service coordinator.

>> SPEAKER: I understand the process in steps but there's a break down somewhere, I've been bringing this up from the Ginny understand how

I need to get a script and I need to send to, the DME supply company and then, where is the denial letter coming from so I can give to the supports coordinator I can give to the date, so the State can whatever they need to do, so I can get the service product. Okay. It's -- break do you know somewhere, it's literally, as far as Zach as a consumer hurting me.

-hain need a little bit more information on the service Zach.

>> KEVIN HANCOCK: We can talk about it when we're done.

>> KEVIN HANCOCK: Sure I think we might be able to help.

>> SPEAKER: Yeah. Fred Fred make it quick.

>> PAM AUER: To explain his situation. What we hear is Medicare does not do denial letters, you're trying to talk to the service coordinator about getting the equipment or service you need they say well we need denial letter and, you can't get one. And the vendor will not put -- take your script and -- get you any type of equipment without knowing who is going to pay for it. They don't get the denial letter from Medicare and the -- um, service coordinator does is not submit it, they're not getting any denial from the State, saying, you're not going do get it through the waiver there's just nothing, people are just left hanging unless, they have pushy people --

>> SPEAKER: I've been bringing it up for a long time that's the golden ticket. Like -- I'm so frustrated I want to extreme, because --

what am I supposed to do about it. And if it's just me, what about other consumers who don't have that voice.

Only six months but, then what happens after that six months you're saying the MCO is going to be responsible for it.

>> KEVIN HANCOCK: MCO is going to certainly help, to be perfectly honest to be very blunt our health care system is complicated.

Part of the reason why you're having challenges.

>> SPEAKER: I understand a great deal about it, what about the people that don't. They're going do get kicked in the ass.

>> KEVIN HANCOCK: Move from one system to the next the fragmentation, creates -- it's communication challenges.

>> SPEAKER: I'm talking about this one now-hain know. Well the system as it exists right now is actually more complex, than -- what we would be doing when we move into community HealthChoices especially if you have aligned dual special needs plan, Medicare and Medicaid.

>> SPEAKER: Six months it will save a lot of lives a lot of people.

>> KEVIN HANCOCK: Hopefully save a lot of headaches, so hopefully save a lot of headaches for people. That's what we're trying to do -- one of the goals we have with our program is, that better coordination between Medicare and Medicaid a that's what you're talking about. It shouldn't matter what kind of service, to have better coordination it sounds I think we'll, be able to help you, with your particular service,

and use you once again as -- sort of a case on, what needs to be done to be able to address the denial notice for Medicare but, but -- we're designing community health choice those make this streamline for people.

>> SPEAKER: Please use me.

>> SPEAKER: Kevin you can just ask Zach to call the participant health line to work through the process.

>> KEVIN HANCOCK: I'll be giving the number for the participant health line, we'll take this --

>> SPEAKER: Rather come to the top.

[laughter]

>> SPEAKER: Can are anyone can call the participant help line in general there are staff there that understand the process shall.

>> KEVIN HANCOCK: What they're advertising is the usest participant help line if you as an advocate, can refer your -- anyone you're working with to the participant help line for these types of questions the participant help line will be able to help them navigate it.

>> SPEAKER: Under the MCO.

>> KEVIN HANCOCK: No with the Office of Long Term Living. Can we get to that slide.

>> FRED HESS: Okay hold up with the questions right now. Because we've only about 3 minutes here.

>> PAM AUER: One quick question the training that the MCOs got on the denial process, is that going to be posted, so that the advocates know what to be looking forward to to help our consumers?

Will that information be out there, so we know. When they get a denial, what should be -- there,.

>> KEVIN HANCOCK: Wealthy about that, that may not be a bad idea it's just basically talking about, the -- regulatory requirements and the agreement requirements for denial notices it is just put in a scripted way. Only thing we have a lot of specific examples for the training it would include the content of the requirements but it will not, include the examples, because the participants it will be a HIPPA violation.

But that's a great suggestion.

Yeah thank you.

>> FRED HESS: Go ahead get it done.

>> KEVIN HANCOCK: I'll do the highlights here. If you go to the southeast implementation focus.

OBRA assessment we're the 9 percent complete for the assessments which means we're having individuals who are in the OBRA waiver, go through a, clinical assessment just to make sure they're appropriately in the OBRA waiver, if they're nursing clinically eligible and OBRA

we'll be moving to the community health choices if they're not inally eligible they're be staying in OBR, that has been 99 percent complete and -- we are very happy to say that the only cases that are left are usually issue between the physician certification and the assessment as well. So, congratulations to all those folks involved in the assessments you did a great job.

Provider outreach education, continues.

We had the sessions in June for a providers, that kicked off, that relationship and, the MCOs and providers have been meeting very frequently, as we build up the networks we're starting to receive reports on that progress as well.

Population identification, incontinues to be an test. There is opportunity force update dating demographic information for clients or participants in the eligibility system and we are encouraging participants to be able to do that by calling the customer service call center and also, talking to the county safety answer office as well.

Readiness review, is ongoing.

For the southeast, it will continue all the way up until implementation and then we'll move into implementation monitoring. Just -- very quickly faux resources the CHC contact information listed on this slide, information on all

3 MCOs.

The next slide shows the resource information I will highlight, the OLTL problem 18007575042 as Jinny and Geeny many participated, they're participant or caregiver to be able to navigate some of the questions Jack was talking about earlier as other web sites call lines, including the provider call line as well:independenten (184)482-4865 and participants and their caregivers in the southeast -- they can also enroll and make their plan selection at enroll chc.com that is not going to be available until after late August that is a wattle can enroll and make a plan selection for community health choices without even having to talk to anyone if that's they're wish. Web site is available. It has participant information. For services as well as provider information, for the MCOs. And we encourage, individuals to use that web site as well as the 1800 number for the independent enrollment broker. With that I'm done.

>> FRED HESS: Okay.

Can we go ahead and I'm sorry we don't have anymore time for questions if you need to ask any questions about this, can you get a hold of him after the meeting please thank you.

I would like to have Patty Clark and David gates come up here, they are going to do -- fair hearings grievances and appeals.

>> PATTY CLARK: Good morning everyone.

My name is Patty Clark.

I'm the with the Office of Long Term Living I work there in the policy bureau.

I do not have a formal presentation this morning.

I think, primarily we're here to hear from David gates and, some of the resources through the health law project.

Related to grievances appeals and fair hearings.

But I just wanted to make a couple of, of points, related to Kevin's comment, about our systems being kind of, complicated, as far as our waiver services, our -- our systems.

A lot of it is guided by regulations with Federal and state regulations.

And, whether it comes to complaints and grievances and fair hearings it is also true it is kind a complicated process a lot of time frames and steps that people need to take.

take. In order to -- um, go through the process.

To two really great resources for people, I think in general participants don't have to memorize the process or the time frames.

But, resources that are very important to them I think the first one is the participant handbook within CHC.

Each of the MCOs, has a handbook for participants, one of those chapter is on complaints and grievance and hearings that

gives the information on the time frames and steps they need to take.

The second resource is the notice, itself, if an MCA denies a service, for someone the notice that the participant receives lists all the time frames and steps the person needs to take I wanted to point that out, so it's not so much for participants to memorize the process but just for them to know what resources are available, through the notices and the handbook and then, also for organizations such as the help law project which can assist them through the process.

So with that I'll turn it over to David.

>> DAVID GATES: Thank you Patty.

And I'm going to be joined in this presentation by aly Loewenstein, an attorney we just hired, who has practiced in New York for many years, in this particular area.

And she is going to be focusing on community HealthChoices we'll be doing this presentation together.

You'll be seeing more of Amy as time goes by.

Let me start with a few preliminaries here.

First of all I really feel compelled to revisit one issue that seems to be a little confusing, that has to do -- I'm sorry to get off track but I think this is important this Medicare denial letter business the problem is, with Medicare denials is Medicare in most cases will not

issue a denial letter until after a service has been provided and billed to Medicare so if you're looking to get a preapproval from CHC, or from the waivers -- you have to provide the service first and bill to Medicare to get the denial. What some states have done is, actually, have determined that there's certain services or pieces of equipment which they presume Medicare will not approve, and they will do away with the requirements of having the Medicare denial. So that's all I'm going to say on that point. Let me now talk about the issue of time lines for appeals, we'll get into this in more detail but there's one point I really want to make at the outset.

I think there's also some confusion here.

That was, there was a question about this requirement around the ten daytime limit, to file an appeal in order to have benefits continue.

And I have heard Tanya ask the question, who made that time limit? And the answer was, it is requirement of Federal government.

Let me clarify something about that because we have looked at that requirement very carefully. The requirement sets a minimum of ten days it does not require the State can only provide ten days.

So, let me give you an example where, the Federal government has actually loosened up that. Social Security has a ten daytime limit but they actually presume a -- additional five days for mailing of the notice.

And, they also provide an opportunity to have the appeal considered on time for good cause if it is filed after the ten days. So those are just some examples, it doesn't say that the State can't go with a ten day. That is legal.

But it doesn't require it has to be that ten days. Okay I'm done with that preliminary stuff.

I'm going to have Amy now get into our main presentation.

>> SPEAKER: Sure.

Who is doing the slides.

Okay.

Can you guys hear me? Okay.

Good. So -- first of all I want to say this is about doing agreements on a service denial or change in services, in CHC and, there's a lot of material here I assume this is all published on the web site so it is going to be something that people can reference it's a lot involved in appeals people should not feel like they should know everything right now this is to sort of highlight certain issues you'll come across and in time lines, PHLP, the Pennsylvania health law project is, always available to talk to people about their appeals.

Pennsylvania health law project is is statewide non-profit.

Operate a help line for clients and advocates we provide free advice

and legal representation. We do community education trainings and newsletters do public policy advocacy around Medicaid issues and another health insurance issues and in particular I'm focusing on CHC.

So I'm going to do, a little bit on, the notices people might receive if there's a service reduction or denial.

And than, how to request a grievance David is going to finish up, discussing how to actually prepare for a grievance and what happens on the day of the grievance.

So I did put some acronyms here you guys are familiar with many of these, um, especially LTSS because I think that's in the title of the subcommittee.

[laughter]

But, um, quickly, PAS is personal assistance services that's what that refers to, if you see it on the slide.

And, PCSP is person centered service plan.

So you will also see that.

You can go ahead so -- the reason we're talking about service denial reduction notices is, in the southwest, as of, July 1st, continuity of care ended for the HCBS services so, people did start receiving notices towing them that the services they had been getting under the waivers, were going to change and people all along, not huge number had received denials of sometimes of requests for services.

The thing to know about, reductions and terminations of services, that people were receiving under the waiver, under continuity -- under the continuity of care period, is that they can't be changed unless the person has had a comprehensive needs assessment, completed and, person certaintied service plan.

So we have heard of someone that had not had that done and seen reductions. That's important. The needs assessment, quickly, is a -- assessment of someone's physical behavior of health, social emotional, and, other needs including their supports in the community, as well as their goals and preferences to evaluate what the person needs and the person centered service plan, takes that and then looks at what the person wants from their life in the community and what they want what can be done to achieve their goals in the community.

That has developed into a plan. So those things are not done the person should not be seeing a denial, should not see a reduction or termination of services at all.

Has to be written notice I think you guys have figured that out it has to be sent at least ten days before.

As Dave said it could be sent more a than ten days the plans have the ability if they want to send something more than ten days they don't have too give ten days notice. So it is important to open and read the political.

From the plan valuable rights I think some of us know about that we'll talk more about that more.

If someone doesn't understand what the notice means they are a little lengthy talk to the service coordinator. And find out more about it and keep the notice, the letter -- and the envelope because of that ten day deadline you want to make sure you, know whether or not it was sent within ten days as well.

So the post mark is telling you.

So there are 3 basic denial notices, there are complete denials partial approval chose are also denials and -- approval of a different service, other than what was requested.

But they're all denial.

Of a different sort, the complete denial will say, denied completely.

And it means, that the plan is, either going to stop a service, or they're denying entirely a request for a new service.

I put some examples up here you'll notice, through out the -- we focus on personal assistance services those are very common waiver services, that people receive.

And, they are the services, that have been facing the most reduction . So those notices that Kevin's team had been reviewing, most of them were about personal assistance services.

So for example someone may have been getting 20 hours of personal

assistance services this type of notice would tell them if that's ending.

It's also the notice, some will get that he requested something like a vehicle modification.

And the plan had determined not to cover it.

Not to approve it.

Through we have seen some plan to use this notice these are templates.

That says complete denial whether they're actually reducing a service so read the notice carefully, to see really what is happening.

Okay the partial approval, which is, also a partial denial is, um, we'll say, approved other than as requested.

And this means, the plan is reducing one or more services.

Or, if someone is requesting a service they're only partially approving it.

So in the personal assistance context, someone might have been getting 49 hours and the plan is reducing to 25 hours a week.

Or, someone might be requesting 30 hours of personal assistance for the first time and the plan is intending to reduce it to 250.

20. The final sort of generic notice people get is an approval of the different service.

Which is also denial. So, it is -- it will say denied as requested but, the following service or item is approved.

This means the plan is going to stop a service, but offer a

different one or if someone has requested a new service, it means that they're not going to grant that service, but they're going to put something else, that they -- think, would be sufficient, in its place.

So, if someone might have been getting 25 hours of personal assistance, it might get a notice saying, we're not going provide that. Instead we're going to approve the adult daily living services instead.

Those are just examples.

Okay. So this next slide is about adequate reasons for reduction.

So, Kevin had talked about the review that the Office of Long Term Living is doing of all the notices.

And, the reason for that review is to make sure that there say reason and explanation when a service is reduced denied or changed.

There is language in the template that requires the notice having in detail the reasons why something is changed or being denied.

Including references to whether it is you know, whether it's medically necessary, what that means.

And other guideline that's are used.

So what is important is, to think about when you see a notice, do -- does this tell me anything about why I'm not getting what I requested?

And the inadequate notice, which is you know, we're grateful to OLTL, for taking this on but they're looking at some of the notices

because some of the language was not really up to par. So some examples are, if you see something this service is not

medically necessary doesn't really tell you anything. It just two

words. It is a conclusion. It doesn't explain well how is it not

medically necessary.

So some other things we've seen are you are assessed as needing

fewer personal assistant service hours that's also inadequate it doesn't

explain why thing are different.

You had a change, have you had a change in condition or some reason

why 20 hours is okay, but 30 hours is sufficient last week those are all

inadequate, those are examples we are still interested in seeing

notices. Doesn't sound like a lot going out right now because the

office of long term living is review them but we're interested in seeing

notices if they leave you guessing as to really why something is being

denied because if you don't understand why you don't understand what you

need to appeal or whether you want to appeal maybe you'll agree with the

reason who knows. But you need to know why.

On notices as well, the other thing to keep in mind is for people

who have limited English proficiency or who are visually impaired

notices that come to them in English or in the normal font size, may not

be adequate for them to actually read you know they're just not readable

. So notices need to come in a way that someone can read. If you

get a notice, that you can't read, due to vision impairment or language access issues, you can request a notice in a format that you can read and actually resets the time for you to appeal.

You need to be able to get a notice that you understand and can read.

Okay.

So so this is -- so this is the crux of the presentation you got a notice, now what?

And, after reviewing it, if you decide you want to challenge it you can file what is called a grievance.

Grievance is a type of appeal it is essentially request to the plan that they change a decision about reducing spending or denying a service.

It is the term used for most appeals in managed care in the CHC program. There is another term called complaint but, when you're talking about like a service denial whether something is medically necessary, we're really talking about grievance.

The participant can request a grievance.

If someone has a power of attorney or a guardian that person can request grievance.

Anyone else including a service provider can request a grievance on the participants behalf although in that third situation there needs permission in writing, permission of the

participant.

So some of the types of decisions that can be challenged in the grievance are, completely aligned with the notices we discussed.

So it is decision those suspend or terminate a service or item.

Deny it in whole or in part.

Or to deny a requested service but approve a different one.

And, um, so throws are decisions made by, the managed care organization by the plan.

But, you can also appeal decisions by the service coordinator, regarding the person centered service plan.

So if the person centered service plan doesn't include, services that you requested, or in the amount that you requested them, you can appeal the failure or the decision not to include that in the plan.

That's really important because that is sort of you know because what goes to the plan for approval is this, is this person centered service plan that maybe you already think is not going to help you reach your goals.

So you have a right to receive your person centered service plan.

In fact you're required to receive it and sign it. If you disagree with anything in it, or anything that didn't make it in it, if there's a place to say you disagree mark that place, if there isn't write it out

or tell the service coordinator and file an appeal I want to emphasize it, it's not always clear that is another point and another thing that can be appealed. So give you an example. Let's say your service coordinator, you think you need 30 hours of person assistance.

The service coordinator says well you know I have -- I can't approve 30 but I approve 20 let's do 20.

And you know, they go ahead that's what they submit that is something you can appeal.

Or another example might be you know if you want your vehicle modified a person, the service coordinator can say I don't think that's going to happen let's not include that.

That's a decision you can also appeal.

Okay.

So, requesting a grievance, first ever all it could be done by phone,

fax and mail it's important to note, whether you are looking at the ten -- that ten day deadline people were discussing earlier you can do this by phone you might, if you can, you'll want to follow-up in writing.

But, it doesn't always have to be done through the mail.

Mail is good, because it say paper trail.

But -- you know if you're on the wire and this is the last day to request an appeal you can do it with a telephone call.

If you do do it that way you should ask for a and write down the name of the person taking the appeal.

And the date and time you're making it. Because a lot of phone calls are recorded.

So, it is confirmation you actually requested the appeal.

And then afterwards if you can, send a letter confirming that you requested the appeal.

What you'll want to include in the appeal grievance, I should call it a grievance it's what we're talking about.

You want to include in the grievance request are number of things.

When you get a denial notice, it will include, a grievance request form. So you can fill that out.

And, a lot of this information, is asked for there.

But, if you don't have that for some reason you want to be clear that you're requesting a grievance.

What you're appealing and why. So -- you know I'm appealing the decision not to deny my vehicle modification, I need this modification understood to be able to engage in these community activities that I like to engage in.

If you want the services to stay the same, so if you had been getting a service, it is being reduced or denied, you're going to want to say I want this to continue while the grievance is going forward.

You're also going to want to indicate whether you want to do the grievance by conference call or in person. And who is going to represent you if anyone.

And as well as -- um, all information, that the plan used to make the decision.

So quickly, the time to file a grievance there is what we were discussing earlier.

If you have are getting services, already getting services they're being changed somehow, you have 10 days or prior to the effective date, to request that.

So if as you can see that doesn't mean, prior to the effective date of whatever the change is going to be, could be 15 days.

So that's something to be, to keep in mind.

And I will say that the notices don't make that clear. They say ten days, but if effective date is further out than ten days, I'll give you an example of this, you have until just before the effective date to request it.

If there's not a service you need to keep going you actually have 60 days to request an appeal whether you want do that or not is up to you.

But you know we usually say getting in earlier is better.

So this is my orange Blob person who got a notice here name is Anya, on July 17 she gets a notice saying we're personal assistance

hours being reduced on August 1st.

July 17th is more than ten days, before August 1st. So the notice is dated July 15th which is the date that, they're counting from.

So she actually has until July 31st to request that grievance she will continue getting the services now, should she wait until July 31 probably not, it is probably good to get it in and not play around with questions where am I with the dates playing games with that I do want to emphasize it's not clear from the notices.

>> SPEAKER: Can I ask maybe a stupid question.

>> SPEAKER: Who is asking.

>> SPEAKER: Right over here. You had said earlier some of these notices may require a signature.

>> SPEAKER: Person centered service plan you have a right to sign it.

You're supposed to sign it.

You can -- you can sign it over option our could say I saw it and disagree with it.

>> SPEAKER: That's my question you said that you cosign it and there are it would a spot where it says you could deny it or --

>> SPEAKER: Not necessarily that spot at all at this point.

[laughter]

>> SPEAKER: My stupid question you do not want to sign it.

>> SPEAKER: What I had said you had it sign it over objection.

You can say I'm signing this and I disagree or you can refuse to sign the reason that, people want to -- they depends how it is written each plan has a different person centered service plan, some of them may have an indication whether you disagree or not. And have you sign. But it is -- yeah you don't necessarily have to sign it you do want to indicate whether you have seen it somehow.

>> SPEAKER: I would bring this up I would think that, just my thinking would be signature would mean -- would okay compliance I don't know that, that makes sense.

>> DAVID GATES: The reason why, if -- in fact, this service plan contains some services that you would agree with and some reductions or change U.S. don't agree with, we want to sign to make sure those services, would go through but to indicate that there's other -- disputed services.

>> SPEAKER: I'll bring there up the signature, under objection, kind of -- I'm thinking that I don't know everyone would understand that.

>> SPEAKER: Yeah I mean I would argue even if someone signs it she can still object later on I don't think that the signing it is not going to -- I would argue if I ever saw that doesn't mean that you don't can't appeal the decisions made in the person centered service plan.

>> SPEAKER: Thank you.

>> SPEAKER: Okay.

So after requesting the grievance you're supposed to gets an acknowledgment letter. We have heard from someone who said one plan said they don't send them out that's not what is supposed to happen. You should review the acknowledgment letter make sure it accurately describes what you're appealing and if it doesn't. Contact the plan to clarify. Of course if you're getting, ask for the services to be continueded, they should continue pending grievance.

Now I'll turn it over to David.

>> DAVID GATES: Thanks Amy. So -- Daniel you have a question.

[laughter]

>> SPEAKER: Pardon me I did not want to interrupt David, but -- there's a couple of comments I had during your session. First of all, I really thank you for explaining you did a really good job I've heard a lot of explanations of the grievance process and, have been, thoroughly frustrated how confusing they often are really appreciate you did that very well.

First you said there was 3 types of denials one being, a flat out denial, two being a partial denial and three being a -- a approval of other services.

Do they all say approval or 2 of those 3, say approval at the too

much the letter do they look like approvals even though they are denials.

>> SPEAKER: I don't have them in front of me I think the -- um, let's see.

I think, one -- definitely there's an partial approval notice it does say that.

That's why, it is confusing. Because in our mind it's a partial denial.

I believe that the third -- there is -- the other one does say approve tally almost positive it took the language from the top of the --

>> SPEAKER: Second part of that question is, um, does the State of Pennsylvania recognize all 3 of those as flat out denials? Do they differentiate the types of denial?

>> DAVID GATES: Go ahead.

>> PATTY CLARK: Yeah. We would, we would recognize them as denials.

I do have the, I do have the partial approval notice in front of me.

And it does say the language in it says the service or item is not approved as requested.

So it does specifically say that it is not approve as requested.

That would be considered a denial.

>> SPEAKER: And related to all those questions, is when someone is receiving that letter and, might be mislead, okay I'm seeing, I'm seeing words approval in there, I'm seeing that or maybe I'm not getting all my requested services I'm just getting a diversion saying I'm getting this or that service. Are these are they going to be, when they're being assisted along the way, by, potentially, lawyer like yourself, helping someone through the grievance process.

Are they, going to be receiving the same like, to me, I could be very easily confused by this, this letter that it says approval on it, suddenly I know I still have the 60 days to appeal that.

But, I might need assistance because I perceived that wrong.

That letter wrong. How would you go about, helping an individual, consumer, who may have been mislead by misunderstanding the letter?

>> DAVID GATES: Yeah the first problem is, for the person to realize, that there is actually a denial involved. Because frankly, we get people after they come to the realization that they're not getting the services they requested.

Which -- and, we can go through how we helped them at point. But, I think, so, part of the -- these templates have been approved by OLTL. So that's what we're working with.

Part of it is, is educating participants and one of the reasons why

we requested to do this, today is to start that educational process. And, we will be available to speak to other groups and participants not just in this room but in other areas local areas and Amy is in Philadelphia. I'm in here in Harrisburg we're, more than happy to go out and do a similar presentation of for participants to explain this to them so they know when to call us that's really the first step but it is, I can are confess it is a challenge because the way, the language is written we have to get word out we would hope that people, whether they see this notice will talk to their service coordinator and we would hope the service coordinator could help explain to them the plan is saying, you would get this service, rather than the one you requested. We would hope that would be the role of the service coordinator in addition but again, we're proper than happy to go out and do trainings in person, by webinar by other means to get, to explain to folks, this whole process.

>> PATTY CLARK: Can I add something I'm glad you mentioned that David I was going to say probably the first, point of contact someone would have, if they get a notice they don't understand it, is to call their service coordinator and say I received this, what does it mean? Um, that would be a good first step.

>> SPEAKER: I wanted to say thank you again for breaking this down for the consumer perspective I think I've heard this explanation was not

from the consumer perspective and, receiving this letter.

Pair wanted to thank you again for breaking it down thank you.

>> DAVID GATES: Okay.

Do I go to my next part -- okay.

>> FRED HESS: Yeah. Go ahead. Does anyone have anymore questions real quick?

>> DAVID GATES: If there's more questions, we'll be here.

If there's enough time.

>> FRED HESS: We have one.

>> DAVID GATES: Okay.

>> SPEAKER: Why isn't the service coordinator getting a copy of this notice?

I mean, in my thinking -- the service coordinator in a lot of instances, is a big advocate for the participant.

And, for some people, I mean, I may have have a -- a lot of individuals out there, are not going to understand this. And it if the service coordinator gets it and says you're getting denied ten hours or whatever it is, the service is, you may want to appeal this.

>> PATTY CLARK: Yes, I agree I think the question that was asked earlier was about service coordination units.

>> SPEAKER: That is Lester's question, that's a different question.

>> PATTY CLARK: For participant direct direct participant services

the service coordinator would be aware of that I'm not sure of the internal process with each of the MCOs it is, maybe I don't know if -- ray or anyone can answer that question, because it is an internal process as far as the way their systems work.

>> SPEAKER: I understand it's not a question of the health law project in general why is the service naturor not being informed.

>> PATTY CLARK: They should be aware and have a copy much the notice, whatever system the MCA is using the service coordinator would have access to that and be aware of any communications that went to the participant I don't know exactly, specifically how that works?

>> SPEAKER: It's communicated the request for services is coming through the service coordinator, whether it's external or, internal and -- you know the -- I don't believe we're, we're sending letters out formally brought it's churn are communicated sometimes the adverse action is generated by the service coordination entity they're telling us that they you know, um, you know are in favor of an increase or proposing a reduction or you know the larger you know, participant centered planning team meeting is deciding that, you know to -- they have adverse reaction there's communication but I think our current process would, externalize we're not sending a copy of the letter formally.

>> KEVIN HANCOCK: Only thing I would add, is that, aside from the participants the caregivers one individual probably knows the most about service level of participants would be the service coordinator in this model. The service coordinators are part of the development of the service plans they should intimately know what is happening with the participant services that's I think Pennsylvania health wellness wants to chime.

>> KEVIN HANCOCK: I'm sorry sir. Question -- um, as far as you guys are you, like have you, I might have missed it, have you or are you guys going out to different CILs or service providers? Like -- by request.

>> DAVID GATES: In the health law project.

>> SPEAKER: Yeah.

>> DAVID GATES: Oh.

>> SPEAKER: This should be automatic thing -- consumers know and the sports coordinators know, just -- I would not want -- mind if you came to my CIL explained that.

>> DAVID GATES: Yes we have done, two webinars.

One on person centered planning.

Over 100 participated in that and Amy and I did another one on this piece on grievances we had I don't know how many participated in that, that was like --

>> SPEAKER: Over 100 also.

>> SPEAKER: We have already done that.

I have actually done video that's are posted, on the Center of Independent Living of central PA. Their living well web si web site about health choices at community HealthChoices.

And we look forward to doing more of those and, with Amy now in Philadelphia, we look forward to getting her out there and about in the five county region, um, so, if you're interested, please contact her after the meeting because, we really are going to do a full court press about this I wanted -- AmeriHealth and Pennsylvania health wellness wanted to --

>> SPEAKER: Great. So -- only thing I wanted to add for AmeriHealth Caritas we actually our service coordinators will generate the denial letter and it is up loaded into our system so they have access at all times it is a part of that participants record.

>> FRED HESS: Two more we have only about ten minutes for this segment.

So, let's hurry.

>> DAVID GATES: That's right. So um -- so I guess, I'm going say what is important I think for people to understand, first of all the grievance pro dress is an informal process they should not feel intimidated they should not feel that they are under scrutiny that is

going to be like in a court room it is not, like a court room so by all means they should utilize their grievance rights and not be fare full about that.

It does however, it is useful to have some advice in preparing the hearing and because, it is more than, just a conversation between the participant and the individuals who will be deciding your grievance which are called the grievance panel. You will want to provide some documentation if you have some you'll want to really, focus, your grievance, on what the points are, on which the, MCO has denial the request.

So and -- frankly this is the reason why I think, that whatever system the MCOs use, the service coordinators should know not just, whether the service was denied or not but what the specific reasons were so they can assist the individual in formulating their grievance presentation.

You do have a right participate sometimes if you don't indicate that an MCO may actually go forward with out your participation.

It is important that you make sure that they have the right phone number these are done typically over the phone and I have had cases where people have been called at an old number or a wrongfully in fact, just, just last -- this week, I was called by the State bureau of hearings and appeals at a wrong feign number for a hearing that I was

holding. So you have to make sure they get the right phone number.

You do have a right to an

inperson grievance in that situation it's not required that all of the grievance panel members be physically presented you need to consider that.

Prepares, you can move on.

I talked about talking about what you want to show at the grievance you want to think about this in advance and what information you will need you will want to show what the need for the service is.

You want to, if there are issue how the MCO made its decision and the notice you want to discuss that as well.

Let's move on I want to talk about medical necessity I'm going skip to the second medical necessity slide. Because that's really the key here.

This is ram I important.

So medical necessity is a requirement for services, under community HealthChoices, but those services despite the name medical necessity, they don't have to be medical in nature.

So the -- there are four criteria and if meet any one ever the

four that meets the criteria for medical necessity the fourth one is the one we'll focus on most of the time in long-term services and supports.

And that is really important, so I'm going read this. Will provide

the opportunity for a participant, that means someone in community HealthChoices receiving long-term services and supports, to have access to the benefits of the community living, and achieve person centered goals, and to live and work in the setting of his or her choice.

So this is where, we go back to the person centered plan, we don't have time to get into this in detail again but this plan is so important, because you need to make sure, that those goals, are in there, your preferences are in there.

How, it addresses your desires for community living.

And you want to then focus on those goals and those preferences that are in your person certaintied plan in developing your argument, if you will your presentation to the grievance committee. You want to make sure what you're asking for you can document, or you can explain how that is going to assist in reaching the goals, that specified in your service plan. You have to have the person centered service plan, we said atonias yum make sure you get a copy of your person centered service plan. You also have the right to get documentation from the managed care organizations.

And so you should request all relevant documentation, that is a subject of the grievance that is requirement that they have to provide that to you.

And you'll want to see what exactly, they have in their records. They

-- it is not a secret they have to provide that.

If they use, any kind of, what we call tasking tools to determine

how much time they will allocate for certain personal assistance

services, you have a right to see what those tools are, if they were

used, to reduce or deny services you have requested.

Let's move on here.

We talked about reviewing evidence.

In terms of the person centered plan.

We do have I know I'm skipping but we don't have a lot of time.

So -- forgive me for that.

I assume this presentation will be up on the CHC web site.

>> FRED HESS: When we post ton the web site.

>> DAVID GATES: I want to get to the -- the review evidence.

There should be a link, there it is. So -- going back to the centered service plan we did a

webinar you can find it on YouTube when this is posted you will have the

-- whole address for that, so you can see our webinar on person centered

service planning because that is so critical.

Next slide.

Okay comprehensive needs assessment.

In in a you want to see focus on exactly where there is a difference

a discrepancy between what you need, what you believe you need and what

the MCO has said, what exact lay, is it, where did they come to a different conclusion.

So that's really important so you can focus in, not just say well 20 hours a week, they're giving me 150, what are the actives of daily living do they say you can useless time and focus on those.

[10]

Try to explain why you need the amount of time you're requesting.

So -- what kind of evidence would you have?

Medical records.

Assessments by occupational therapist or physical therapists.

Doctors or providers letters supporting, what you are requesting.

As long as they actually describe the need doctors letters that say this person really needs you know 20 hours a week are not terribly helpful this they can explain why, what the person's medical condition is, and therefore because of that medical condition they need these kinds of assistance these kinds of services that can be helpful the service plan you had plan you had prior to community HealthChoices can be helpful it raises the question if you've been receiving say 40 hours a week, before community health choices now they're saying 20, you can -- if we were doing that case we would ask the question, what has changed between the time you were authorized for 40 now, they're saying 20.

Records, from any providers, have aids, have them complain about the -- that the participant service needs, are beyond those, authorized.

And again, always tie those back to the medical fleity definition, and particularly that fourth prong that I went over.

And another thing that we think is, very useful.

Is time tracking. That, you work with your personal a answer aides to actually track the time it takes for various components, tasks and activities that you need during a given day.

Because it really helps, when an assessment is done the plans will have this assessment, they will say based upon our assessment, we have determined you need X number of hours and you say well I disagree I need more.

Well based upon what? What do you have to prove that you need proper?

And again you need to actually be able to show them, that you need more.

So one of the ways we have done this is, to actually have the individual working with their aides to track and actually do a little schedule so today, it took me half hour, to get washed and another half hour to get in clothes and half hour to transfer into the wheel Clair toileting took so much time write it down, we actually recommend folks if they can -- working with

their aid to Descartes you can put ton the refrigerator door have the aide write in for each particular activity they are supposed to be doing, person centered service plans will list the specific activities, and so for each activity list, by day, how much they are spending on each of those activities. So, if there's then a dispute you can bring to the grievance panel your chart that says okay, you are assessment said this, this is the actual amount of time it has taken during this week to do these activities, of daily living which are part of my person centered plan that is.

>> FRED HESS: After a week, real week after you go, you do an average on it and -- that's the best thing to present to them is the average of what would normally take I don't use the bathroom, as long as -- say Zach might.

It might not take me as long as him blah-blah-blah, so it is definitely an on individual basis.

>> DAVID GATES: Thank you Fred.

I'll hire you out you're already hired.

[Laughter]

Yeah. Some other lawyer has you ) laughter]

Preparing -- you've done this -- sorry?

>> SPEAKER: Okay.

Witnesses you are permitted to have people, come to the grievance

with you or be on the phone with you it can be someone who can provide some additional information.

So, for example your Aide would be very helpful they can help testify how much time it takes and, if there's some dispute why it needs to take so much time.

They can explain in detail exactly what they h to do, it was before community health choices a gentleman is a member of this committee, and I was representing him and his aide came in and she actually, brought all of the particular personal care items they needed to use, to toilet him.

I mean it was embarrassing but, we won that case.

Because -- it was, it was clear when we went through this is what I do first this is what I do second. And it takes me this much time for this, that much time for the other thing. That's the kind of specificity, you need in order to present a good grievance.

And I don't want to imply that the grievance panels are out to get anyone.

But they need to have good information, on which to make their decision.

If all they know is, there has been this assessment done and the assessment says, 20 hours, and you come in and say well, I disagree I need 30, but you don't have anything to back it up, the grievance panel

is going to decide, in favor of the plan because, all they have is, their -- the plan's assessment so give them something, that they can really, look at, and consider.

Witnesses, again aides, informal caregivers can be helpful in describe and and doctors and other providers I'll skip over some of this stuff is more complicated we talked about the grievance procedure. It is informal.

Actually oh, um, you can have someone else present your grievance you do need to be there, you need to participate, either by phone unless you have signed a paper to allow someone else to do the grievance on your behalf. Presenting -- make sure you've given copies. I'm up to presenting your evidence. I'm really try get through this quick.

Presenting your evidence. You do want to, make coins for example if you have a assessments from a PT or OT, if you have this written schedule, that you've done, make sure that you get copies made give them to the panel or if you're doing it, actually mail them beforehand.

Or fax them if you can.

Fax them to the appeals unit each of the managed care organizations have appeals units.

Who actually handle all this.

Make sure you have your name and -- whatever your plan ID number is

on each page if you fax it.

So it doesn't get lost or confused.

And another thing is, at the day of the hearing, when you have this -- if you have mailed in any documents and I think, this unfortunately is, important, that you go over, the documents that you have already sent in with the grievance panel to make sure that they have them.

Sadly in other cases we have seen documents have been sent in, that got misdirected in a plan's mail room and never reached the grievance panel. So they don't have them.

So you have -- don't assume, that because you mailed them in, that the people who are deciding the case, actually have the documents make sure you ask about that and if they don't, you can offer to mail them again or you ask someone in the appeals unit to go look for them because often they have been misfiled.

Okay.

And -- so the timing, is into more than 30 days.

From the grievance request.

Or, additional 14 days if you ask an extension but there San opportunity if this is a situation where you do not have ongoing benefits, that is where you, you -- it's not -- it is a newer request for a service this is most commonly where it would be, but it is something, that is critically important you can ask for something called

a expedited grievance. In which case it has to be done within 3 days.

Throws are done over the phone.

And they're specific criteria for that and, we can discuss, we can tell you about those later.

That's -- basically, it.

>> PATTY CLARK: Yeah.

And then, if someone guys through the grievance process and they receive a decision notice, from the MCO, that they don't agree with, then the next step that someone can can take is then they can file an appeal with the Department of Human Services.

So that's, kind of the next step they can follow.

So just because the decision did not go in their favor with the MCO, doesn't mean all of their options are exhausted then they can -- file an appeal with the Department of Human Services. And the decision notice that the participant, receives, from the MCO, has all of those instructions on about filing an appeal.

>> DAVID GATES: Okay.

I skipped a lot.

>> FRED HESS: We to skip a lot because we're falling behind a little bit. But what we're going to do because the grievances -- and, this issue is so important, that's why, I let it stretch a little bit longer.

So what I'm going to do to try to make it upright now is, we're going to go to the CHC MCO questions and also, put that in with the, with the additional public comments and such. So we're going to go into a question period right now.

If we can get representatives from the other two MCOs up here please.

And, you guys can stay there, just in case.

If they have any questions, for you, about the grievances and appeal s next.

Okay.

Okay.

>> DAVID GATES: We have a webinar in our web site that has all this on it, too. So you don't have to wait until this comes out, from the CH C web site.

>> SPEAKER: It's on YouTube the same place you'll find -- you can find it on YouTube.

>> SPEAKER: I have a question.

I'm Zachary Lewis from disabled in action.

I actually have a question and a grievance kind of with the house as far as you know we're supposed to be meeting in like an accessible place this building access to it is not, accessible and my grievance would be, who do I talk to, file grievance with regarding like the conversation for the leg rest on my chair they're being broken, I cannot get into the

doors.

I can get into the doors once I'm on the third floor those doors are heavy hurt. Like hell. So get upstairs to the elevators to get -- in here.

>> KEVIN HANCOCK: You can, you can -- file a concern with me.

My team, schedules the room.

This was -- so we tried to achieve two things with this room. First we can, do a microphone based sound system here, which make it's easier for people to hear. It technically, technically accessible for from ADA perspective.

>> SPEAKER: If we can open the doors downstairs just keep them open, at least for the days we're going to be here.

Just for the hour --

>> KEVIN HANCOCK: We'll ask for -- we'll talk to the building to provide feedback.

Be the reason why we picked it, this is the most accessible the largest to accommodate the size.

>> SPEAKER: Room is great. The access getting to it is the issue hank-we'll provide the feedback if it's something that accuracy of recollection -- improved, easily we'll definitely make the decision as well.

>> SPEAKER: Kevin just a question --

>> SPEAKER: Fred I have a question for the MCOs when we get a chance okay.

>> KEVIN HANCOCK: Okay Tanya Fred stepped away, so -- we have one yes actually two questions, at the table right now and we'll come to yours after that, if that's okay with you.

>> SPEAKER: Yeah that's fine.

>> SPEAKER: So just a -- as part of the process can the plans require an independent medical evaluation?Ry don't recall that in the agreement or not, that something that could be required? To resolve a manner.

>> KEVIN HANCOCK: I'm not sure what that means exactly Steve.

>> SPEAKER: If a participant presents evidence from their physician that they need, certain product or service, can the the plan disagrees can the plan require an independent medical evaluation.

>> KEVIN HANCOCK: The way I would that all 3 of the manage the care organizations have -- utilization review type of component to their organization and most likely it will involve, medical reviews so, my assumption is that would, would always be the case.

I don't know if the 3 MCOs would want to chime in on that as well.

Ray? Pennsylvania health wellness we would never ask a we don't believe that's a request we can make of a participant to get an

independent review of --

>> KEVIN HANCOCK: No the request was, whether or not the MCOs could do their own independent medical evaluation. Justifying their decision I guess.

>> SPEAKER: We would not do that.

>> DAVID GATES: I can say that in the regular health choices arena, where we have more experience, we have cases these mostly involve, you know, what we call shift nursing cases where the plans have in fact, hired an independent, third party -- independent is not the right word.

Third party medical reviews in cases also, I would also note, that if you then get to the fair hearing that was mentioned, there is a provision in the State fair hearing regulations that authorize administrative law youth to order an independent medical review. Although it is rarely happens it is in the regulations.

>> KEVIN HANCOCK: Thank you for the clarification, third party might be different but -- do the 3MCOs want to make a statement, no.

Okay.

>> SPEAKER: Hi, I'm liam Philly adept I was wondering from Kevin's PowerPoint earlier about the, the very large difference in the rates.

UPMC and -- the cases approved I was wondering if the MCOs could

pecan that.

>> KEVIN HANCOCK: Just repeat the question.

The slide that showed denial notices the volume of denial notices for Pennsylvania health wellness and -- UPMC more denial services not approved by the department compared to AmeriHealth Caritas.

>> SPEAKER: It was just UPMC just wondering if we can hear more about that.

>> SPEAKER: Sure.

Liam, as I stated a little bit earlier, we, um we rescinded each of those notices reinstated the services, we are not seeking approval for those reductions.

We're not looking to seek a new letter that would, then, reinstate the reduction.

If you're following so -- we, um, we are, we're just moving ahead you know with future assessments or you know, if the person has a new identify need we would reassess that individual we're not looking to you know have those adverse actions going into place.

>> SPEAKER: The State on the slide was June 30th, since that time we have -- as Kevin noted the department hosted a training by the department of -- department of general counsel we all participated and, I think that we're all making progress in improving the quality and

substance of the letters that are at issue.

>> KEVIN HANCOCK: And speaking from the department that's the feedback I'm receiving as well.

I want to make a point of clarification on my presentation, when we were going through the corrective action plans, the a player health care it is slide, all 3 were involved in the corrective action service plans and I think that, Mr. Gates did a wonderful job of clarifying the importance in response to the grievance and appeals. So -- yeah.

>> FRED HESS: Okay.

From Fred we have a question on the phone real quick Tanya go ahead with your question.

>> SPEAKER: My question is, for the MCOs it is a general one, when you're going over doing the person centered planning, with clients how are you making sure that you're talking about every aspect of the care of the individual, may need are you, are you really, keeping track of like, okay.

They have, X number of dollars appointments here's how long it will take for the person to get there. Are you asking the right questions for like okay.

You're going to PT they need to do that PT at home.

Is all that being accounted for correctly in the service plans?

That way, maybe the future, if there's like, the denials for things that

can be cleared if it gets in the way or not needed so much in the way that the questions and assessors can forward the service plans are going.

Do the assessments allow all for those types of questions and then, how much how much do they allow for the individuals say I need -- to go do do XYZ additional activities for like, the integration.

What kind of documentation would help the MCOs be able to clearly see what individuals need at this point I guess is what I'm asking.

>> KEVIN HANCOCK: So --

>> SPEAKER: This is Brigit, director to have the service coordination in southwest for AmeriHealth Caritas, when we do person centered service planning the -- the comprehensive needs assessment the InterRAI AI is the starting point of the discussion pro dress foreperson centered care planning.

As part of that -- you know we do training towards, motivational interviewing.

You know. Relaying returning your feedback and questions, to make sure we're understanding what are your concerns are, with respect to your care.

Sightly, that's all part of the person centered planning process.

To have your feedback how you want to receive your services.

How care is to be received based upon the preferences how you and where you want to receive them, establish the goals and threaten desir

ed outcomes.

That you hope to achieve and how, the LTSS benefit package can best support your needs to achieve those goals.

>> SPEAKER: This is ray from UPMC I would echo you know, bridgett's points a lot of these things you know are in part captured on the InterRAI that's the documentation about the person centered planning process needs to be much more of a conversation and we also, have several mini assessments that you know, so -- one, that is more broad that we introduce at the beginning of the -- of the assessment that is about your individual goals, and, you know sort of getting your expression and your own words about what the services mean to you.

Also around transportation. So that know about getting to services or appointment we're capturing as much as we can.

>> SPEAKER: This is Norris PA health and wellness I'll echo what was indicated the person centered service planning is the key and -- we want it to be as comprehensive as possible to have as much information that reflects. You know the participants needs as possible.

So, we certainly want that information to be included.

>> FRED HESS: We only got ten minutes left make sure your questions are quick to the point.

Not, exaggerated long drawn out anything. Okay.

Go ahead Zach you're up I guess.

>> SPEAKER: So, this might be a more specific question. How to question.

As advocate as a consumer, if I'm receiving nursing services, and it's time for me to get a new wheelchair, how does, can you -- what are you guys going to do, to be able to stop streamline the process and help, you know as far as bureaucracy. Because, you know there's so much back and forth going on with the process, as far as I need to stop, receiving services from the nursing services, and, then be billed is like a lot of billing issues with that.

How can you guys, what are you guys going to do or what has been done or the process to streamline that process.

How do you streamline that.

>> FRED HESS: How can you make it go quicker to get his wheelchair?

>> SPEAKER: I was asking you were talking to each other.

>> FRED HESS: Anything from anyone. On his question?

>> KEVIN HANCOCK: I think maybe a different way to -- Zach correctly a different way to ask the question is -- can you explain your process for, spike spooky was told in order to be able to get assessed for a wheelchair I cannot have received nursing care services.

So, that means I have to -- stop the nursing care services for a day

or two --

>> KEVIN HANCOCK: That's not true.

>> SPEAKER: I'm telling you what I was told.

>> KEVIN HANCOCK: You were told incorrectly.

>> SPEAKER: I was told the process was, in order to -- to be as far as billing they're saying, the nursing, Penn care at home, they're telling me they're not going to be billed for it, so you have to bill the insurance for it.

And -- of course, if I'm getting services through Penn care at home, they -- receive all the billing.

They are saying they're going to stop service for a day or two in order to get the assessment and -- to get the assessment for the wheelchair once the assessment comes then you have to go back to get fitted for it. Then it means you have to stop services with them again so -- people who are doing the assessment can build the --

>> KEVIN HANCOCK: That's just to be blunt that's not correct.

>> SPEAKER: When we're finished I need some clarification on how this does wore with you guys.

>> KEVIN HANCOCK: We'll reach out to the provider to make them understand how it works.

>> SPEAKER: I understand it -- this is what was told to me, if I'm eligible to get a chair for five years it's bush 8 years I still have

not gotten it because I've been constantly under the nursing services need them.

>> KEVIN HANCOCK: That's not true.

>> SPEAKER: How does it work.

>> KEVIN HANCOCK: Ginny will talk to you how to sounds like you have a specific case. But your provider is clearly not interpreting the benefit correctly.

>> FRED HESS: Just even the answer is going to take us way over time we only got like 8 minutes so -- yeah. Get with them.

>> SPEAKER: Point me in the right direction.

>> FRED HESS: We have question over here.

>> SPEAKER: Little bit off topic but -- what about when you go for people who when you vote for people who run Medicare -- voting. For the person that is running based on Medicare and pled.

>> FRED HESS: I don't understand that question at all.

Can I talk about who to vote for?

[laughter]

>> KEVIN HANCOCK: No.

Patrick no we can't answer that question.

[laughter]

>> SPEAKER: It could be an interpreter error I know it seems funny but I'm trying to get to the bottom of it. Hold on.

>> FRED HESS: Doesn't make a lot of sense.

>> KEVIN HANCOCK: Sure.

Encourage people to make good decisions when voting for people who are --

>> KEVIN HANCOCK: Okay.

>> FRED HESS: We have questions on there.

>> BARBARA POLZER: We have a number of questions that came in over the phone.

Do the MCOs have a time line, when the service plan trainings will be held for community SCIs?

E,s.

>> SPEAKER: I all all 3 MC observations the weeks of October 15th and 22nd, each of -- we have not set our individualized trainings yet.

Maybe the I'll defer to some others.

>> SPEAKER: We have a meeting or a call on that tomorrow.

To independent kind of finalize we're looking at the middle to end of October.

To hold that.

>> SPEAKER: Same thing we're looking to start in September for some of the training for AmeriHealth Caritas.

>> KEVIN HANCOCK: Only thing I would add from the department's

perspective the MCOs are engaged with service coordinators much earlier has a lessons learned we appreciate that very much.

>> BARBARA POLZER: Next question is, would each MCO state the software requirementses, which will be required for billing.

>> FRED HESS: Okay.

>> SPEAKER: For UPMC, um, providers, um, providing home and community based services would be asked to use HLA exchange for billing purposes no other requirements beyond that, it is not really a software requirement it's a web-based platform.

>> SPEAKER: There is Chris brown from keystone AmeriHealth Caritas.

There is into s software providers providers can use HHA exchange as well as any clearing house that they either have current relationship with or, look to enter into a relationship to submit claims providers also, there is the least favorite form of submission is say paper claim submission. So you do not have to go through an electronic submission you can submit a claim through paper obviously that's slowing down the process a little bit. But there are no software requirements.

And.

>> SPEAKER: To be same same for Pennsylvania health wellness we don't have any, software requirements provider dollars use HHA exchange or any clearing house, and they do have the option of using, submitting

paper claims as well.

LAN-just going back to the previous question relating back to the service coordinator train it's my understanding on August 21st there will be a training between, the managed care, 3 managed care organizations and -- the financial management services vendor PPL, service coordinators will receive information regarding this train energy the near future that's something that is happening months earlier than it did last year we're happy that training is engaged much earlier thank you.

>> FRED HESS: Jeff asked me a long time asking to ask these questions he is just finally stepped up to the table do it.

>> SPEAKER: Okay thank you Fred.

, here behalf of disabilities rights Pennsylvania, some of you know about our public forums and if folks want to comment on community HealthChoices waiting lists or any disability issues we can 3 forums the first one is Tuesday, August 14th from 11 do 11, at triple CIL, in Washington, PA the second one is, Thursday, August 16, from 7:00 p.m. to 9 opinion at community center in Philadelphia.

We'll have online one, on Wednesday, August 22, from 10 a.m. to 12:00 p.m., we don't have the final web address or fine are phone number yet that will be -- all this information will be available on our web site. Disabilities rights pa.org we're located on Facebook. If you

want to look us up under disabilities rights Pennsylvania. Any other questions contact the disabilities rights Pennsylvania, office finally, folks can also, do our survey monkey and offer comments on our through our web site up through Thursday August 23rd. Thank you.

>> FRED HESS: Okay.

All right we have I'm sorry we have time for no more questions. It is actually 1:00.

So I am going to let everybody know our next meeting will be here September 5th.

And -- same time, and -- same place. Okay.

Everybody have a good day.

And thank you for your tanning thank you everyone.

[meeting concluded]

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