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DATE: October 3, 2018

EVENT: Managed Long-Term Services and Supports Meeting

>> BARB POLZER: Good morning everyone we would like to get started in about two minutes.

Okay we would like to get started now.

Unfortunately, Fred is not able to be with us today I'm going to try to fill his shoes, we would like to start off with introductions Linda, would you please.

>> SPEAKER: Linda Litton, participant advocate.

>> SPEAKER: Jim Peiffer, Presbyterian care, Pennsylvania.

>> SPEAKER: Jim Fetzner comfort care,.

>> SPEAKER: Blair Boroch united health care.

>> SPEAKER: Jack Kane.

>> SPEAKER: Nena.

>> SPEAKER: Barb Polzer liberty community connections.

>> SPEAKER: Jill voluntary voluntary questions, long term living.

>> SPEAKER: Steve Touzell Philadelphia corporation for ranging.

>> SPEAKER: Ray Prushnok, UPMC.

>> SPEAKER: Luba Somitz,.

>> SPEAKER: Any committee members on the phone?

>> SPEAKER: Ralph?

>> BARB POLZER: Ralph, are you there?

Ralpr?

h?

Thank you.

Anyone else?

>> SPEAKER: Tanya Teglo.

>> BARB POLZER: Good morning.

>> SPEAKER: Good morning.

Anyone else?

>> BARB POLZER: All right.

I'm going doing over the housekeeping rules. Please keep your language professional. Direct your comments to the chairman, wait until called upon and please keep your comments to two minutes.

The transcripts and the meeting documents are posted on the Listserv.

The documents are normally posted within a few days of the meeting.

The captionist is documenting the discussion so please speak clearly and slowly, and this meeting is also being audio recorded.

The meeting is scheduled until 1:00, too comply with the logistic call agreements we'll end promptly that the time, if you have questions or comments, that weren't heard please send them to the resource account

at RAPWCHC@pa with the gov the resource account is listedden on the agenda, please turn off your cell phones, please throw away your empty cups bottles and wrappers upon leaving and 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 MLTSS sub-MAAC meeting dates are available on the Department of Human Services web site and the 2019 meeting dates will be posted on the DHS web site in October, now we're going to the favorite part of the meeting the emergency evacuation priors.

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

If you require a assist hang to evacuate you must go to the safe area, located right outside of the main door of the honors suite, OLTL staff will be in the safe area stay with you until you're told you may go back into the honor's Suite or evacuated everyone must exit the building take your belongings with you and to not operate your cell phones.

Do not try to use the elevators they will be locked down.

We will use stairwell 1 and 2, to exit the building. For 1, exit

honors Suite through the main doors on left side near the elevator,

turn right go down the hallway by the water fountain, the stairwell one

is on the left. For stairwell two, exit honors Suite, through the

side doors on the right side of the room or the back doors.

For those exiting from the side doors, turn left, and stairwell 2 is

directly in front of you.

For those exiting from the back door exits turn left and then left

again and stair 2 is directly ahead.

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

left, welcome down Dewberry alley to chest neat turn left to

the cornier of fourth street and left to Blackberry street across Fourth

Street to the train station. Anyone have any questions?

Great.

I'm going to turnover no Jill, who is going to do our OLTL

updates.

>> SPEAKER: Good morning, everyone, Kevin was unable to be here, so,

sorry you got stuck with me.

We're going do get started on the southwest enrollment data.

Okay.

So as you can see, our enrollment populations, have pretty much

staying steady.

For southwest, we're up to 80,000 folks, majority of them again, are

at the NFI duals.

Okay, if we look at the southwest enrollment by month, um, and we

have it broken down by our CHC MCOs from new enrollments, you can see,

that that's staying pretty consistent as well.

We did have a little jump in August, and, um, folks as you can see

are pretty consistent with the trends for MCO choices.

Okay.

Southwest enrollment trend, again, we're staying pretty

steady. Across the MCOs, we did have a little bit of an up tick in

August.

Rebalancing I know this looks pretty consistent here.

I do want to point out, the numbers for under 60, 81.5 percent of

them are, receiving services in the community and, for 60 and up, we

have approximately, 41 percent receiving their services in the community

. So, again, this is, staying pretty consistent since CHC

implementation.

So I do want you to pay attention to the scale for this slide.

It does begin at 47 percent but you can see that there's been a

slight up tick in how many and community based setting, services, um, in

relationship to long-term care settings.

And I know I'm moving along but I know you guys want to get to the

meat of our presentations today, if you have any questions

feel free to stop me.

All right, so -- I think in previous meetings we've talked about all
of the monitoring reports, that Office of Long Term Living has
put together for a managed care organizations we wanted to share with
you some details about the operations reports, that we're currently,
slated to receive, and, share those dates with you.

So on the next couple of slides you'll see a description of those
reports beginning with what we call again, we're going to refer to them
as ops reports, so if you hear anything about Ops reports those are
operations reporteds information that we're gathering, from the MCOs to
report back to the department on their operational functions over months
quarters and annually. So the first report is ops2, which is our
participant and nurse hot line statistics this is a monthly report that
summarizes, each of the CHC MCOs call volume, including the reasons for
the participant call so, um, those calls and the main reasons for them.

All right. So, um as we move through the chart you can see that we
have target dates indicated here where we'll be able to start, sharing
that information in future MLTSS meetings.

The next report is, Ops3 the Department of Health complaints and
grievances.

So this is a quarterly report, that includes the number and status
of Pammant complaints and grievances reported by, the community

HealthChoices MCO to the Department of Health.

Operations report 4 is complaints and grievances details
so this say quarterly report that itemizes the reasons for participant
filing of a complaint or grievance.

Ops8 is services not delivered. So this report, is monthly and it
captures all services that were not delivered for participants, who
utilize, home health skilled care, home health aid services and personal
assistant services. This report, also identifies all nondeliverred or
late trips for medical nonemergency medical and nonmedical
transportation services so just want to give you a little background on
this report, this report, actually is a carry over from the
HealthChoices side of the house we have, tweaked it a little bit we've
actually, had provider input, our home health provider association and
members have reviewed and actually provided input into the development
of this report, so I think this will be one that it also includes like
missed shifts that could include something, that you know a care given
was not able to get there, that type of thing. So this -- this report
will be probably be of interest to everyone here. And okay moving onto
ops21, this is monthly changes person centered planning and it includes
increases and decreases.

Ops23 is, the person centered planning it is cumulative report, so
this report identifies compliance with completing the comprehensive

needs assessment with the five business days from the start date. It also, illustrates compliance with ensuring participants have selected or been assigned I service coordinator.

And if no selection was made, that one was assigned within the 14 days.

It also identifies compliance with completing the person centered planning, person centered plan within 30 days from the date of the comprehensive needs assessment and, it also confirms all participants have a service coordinator. And it measures the average minimum and maximum days from the start date, to the beginning of home and community based services.

So that one we expect, um, as we receive the information we'll be able to share that with the new year.

We also have quality utilization reports, so QMUMs are quality management utilization management reports.

Those again are reports that we have taken from our HealthChoices side and Morphed a little bit to be, um, more in line with the community HealthChoices program.

And, QMUM7 is a denial log, so this is a monthly report that identifies, denials of medical necessity, terminations reductions and changes for covered services.

So this report, um, the first report is due mid of this month and we

will should be able to start providing results for you in December. Okay.

Any questions on those?

All right.

So -- our southeast population.

I do want to let you know this, this number is gone up a little bit.

Yeah.

Gone up a little bit where, we're -- approximately 129,000 now.

But everything else is, pretty much stayed stable, the percentages have not not fluctuated at all.

So, just reminder of the population that is going to be transitioned January 1.

Okay.

All right. Our southeast implementation focus, so OBRA assessments the OBRA reassessments they are completed. So, we're all very proud of that.

We have ongoing participant communication I think everybody knows that, from the southwest we increased those sessions so they're ongoing rightfully.

Provider outreach and education, so everyone knows that we had done our sessions in June for providers, the MCOs are now also doing provider outreach and education. And there's currently some service coordinator INTER-RAI being scheduled and the department has

been going to health systems and provider groups have been requesting a CHC overview, so those are actually getting scheduled and we, most recently, scheduled a session with some MED
advantages groups because they wanted to have more informs on HealthChoices.

I am going touch on the readiness review and give you a status on that, of course we're continuing to evaluate the population and make sure that we're doing appropriate outreach for every group that is, coming up for transition in the southeast.

Okay.

So, exciting part, our preenrollment selections to date we started getting the numbers in.

So this shows you the plan selections, based off the, preenrollment enrollment packets that have been sent out by the independent enrollment broker they're still continuing to go out, they're going out through October 12th we will continue to provide this information and follow this as we go forward. But these are the numbers that we have so far.

We thought it would be interesting to share how people are making their selections. So, um, so the paper enrollment is a very close second to web. So we actually have folks good number of folks have used the web to make their plan selection but the majority of them so

far are over the phone.

Yes, sir.

>> AUDIENCE MEMBER: Well, my name is Zach Lewis disabled in action.

You talked about the enrollment packets going out as of

October 12th, but, like, what do we do with the timing? Because it's

only like a Missouri, left to choice.

>> SPEAKER: We sent these out earlier than we did for the

southwest and,.

[month left]

They're being scattered so that we would be able to resources

available for questions. We have been doing participant sessions since

the end of August, to educate people.

So, so they will have plenty of time to make the selection and they

can make a selection of MCO, up through December 21st to that, to have

that selection be effective January 1.

So I think that we, um, we are giving a good amount of time for

people to make a choice.

Okay?

All right.

So, readiness review, um, readiness review, all 3 MCOs have

submitted over 95 percent of their policies and procedures for

review, Randy let me know if I miss anything here.

Monitoring teams approved over 80 percent, and anticipate that all policies will be be approved by mid October.

The 3 MCOs are submitting weekly network provider reports to the Department of Human Services and the Department of Health for review.

So Randy and his team have been working very closely with the Department of Health, to review the provider network file submitted by the MCOs to determine network adequacy.

And the monitoring team leaders are meeting with the Department of Health on a weekly basis.

To review and discuss any concerns about network adequacy.

Randy's team is conducting site visits and they're conducting those site visits, over the next couple of weeks.

>> SPEAKER: One next week, last week and one in two weeks.

>> SPEAKER: All 3 MC ons they're providing contracts through the internal credentialing process, if you have not heard from the managed care organization, as a provider, please reach out. We
have representatives here the MCOs are providing various trainings for all different provider types.

Including the inter RAI training that I mentioned previously, claims testing. HHA exchange training and training how to work with the managed care organizations.

We also worked with our financial management services vendor to

do a collaborative training for service coordinators for the

participant driven model.

So service coordinators know who to contact, and how to contact for

supporting the participant driven model of personal assistant services.

Okay.

>> BARB POLZER: Question regarding the web site, where participants

can go to see the providers that are in the network for each county.

I know that they were working to get that list alphabet tiesized.

>> SPEAKER: Do we have an update.

>> AUDIENCE MEMBER: October 18th new search functionality.

>> SPEAKER: So the answer to that question is, October 18th.

There will be a, um, alphabetized list and new search

engine available, so folks can search by name. Thank you.

>> SPEAKER: Just a question I know you shared how many, so far

choose or chosen which MCO, are you keeping track of how many choose LIFE

as an alternative? Which ones are choosing LIFE.

>> SPEAKER: I don't know if we have that, that number.

The reason, is that number comes from the independent enrollment

broker.

The independent enrollment broker does not do the enrollment for the

LIFE program we do track separately the enrollment for LIFE we'll be

able to identify if there's any spikes in the LIFE program, enrollment

over this period of time. And we have also included information, about the LIFE program, in those enrollment packets so folks are receiving information, about beige programs.

Yeah.

>> PAM AUER: Since the LIFE program was brought up, can we have some discussion on how that, how that is functioning? How that is working? We've had a couple of incidents with nursing home transition, where there was confusion the person starts and the waiver program and then, they switch to LIFE program and how does that work? And then we had an individual where everything was set up for the person to be in the waiver, they're in the waiver home with services for 7 days a week and, someone from the LIFE program talks to them, they switch it and they have one day a week of services and then everything else is perceived through the LIFE program.

[LIFE]

I think it would be really good to have more information how those two systems, should work together, how people are able to choose it, what it means, there's a lot of confusion out there, about it.

>> SPEAKER: Thank you we can take that back for a future meeting yeah thanks if you could send me some -- if you have any specific examples yeah that will be great. Thank you.

Any other questions?

Okay.

Provider education and outreach. So, um, provider education

sessions, were held the first week of June in Philadelphia at Temple

University and then again the third week of Juan in June Chester dell ware and Montgomery, we

had approximately 1800 folks that attended those provider sessions and

the sessions included an overview of CHC and then we had break out

sessions that were based upon provider type. So home and community

based services nursing facilities, behavioral health services, service

coordination, physical health and hospital services and I can tell you

that I did the physical health session, and, I got stood up twice. So

--

[laughter]

Our physical health providers we've been separately engaging to make

sure they know about CHC.

And I that's been going very well. Initially we didn't have a big

turn out there.

So we did do, a session, with the dell ware community health and

community health for community HealthChoices and, we did a hospital and

health system association session.

With the hospital health care association of Pennsylvania. We did

a session for center of health care strategies. We focused on stakeholder engagement and practices and lessons from the field. So that was actually a spin off, of some sessions we did at the home and community based conference in Baltimore, this year. Where we collaborated with our stakeholders, to do multiple sessions and we received great feedback as a state you know the techniques that we've been using to we're with participants that are, are -- stakeholder groups. And make sure that we have been very transparent and bringing everyone into help develop the community HealthChoices program. So that was a spin off of that.

Then most recently, um, we did a presentation at the health systems conference KAIROS health system conference, provided an overview of community HealthChoices and update on our implementation in the southeast.

The MCOs are hosting a train the trainer event, those sessions are limited to two participants per service coordinator entity. And it is a 3 day session, yes, ma'am?

>> AUDIENCE MEMBER: Sorry I should have left you finish. Can -- advocates be part of that, we need to know what that means, that InterRAI, how it is working how to function to be able to support our consumers.

>> SPEAKER: I think we might be able to arrange a separate webinar

specifically for this, this is, this is for the service
coordinators to do, to do the training it's like train the trainer
there's very limited seating for registration if that's something you're
interested in, we can look at putting something together for you.
>> PAM AUER: We would like to know yeah. I think other advocates
would like to know how is it supposed to function when we're
sitting at the table we're able to support the consumer knowing how
the service coordinator is supposed to do it.
>> SPEAKER: Okay.
The registration for service coordinators can be accessed on the
web site there. The dates of the these sessions are
October 24th, 25th, and 26th and then the second 3 day session is the
31st, the 1st and the second.
Okay.
All right participant community sessions this, go around 72, we have
72 participant listening sessions. That have been occurring from
October 27th to through the 19th of October.
And as of, um, yesterday, 52 meetings have been completed.
Over a thousand, potential CHC participants and/or
representatives have attended the sessions.
Sessions have occurred in English, Russian, Mandari for example,
Chinese, Spanish and Catonese. And there's a service coordinator

outreach effort, part of the outreach in education effort for each
region is making sure that all participants have been
contacted and given information regarding the change too CHC and what
that will mean to them. The Office of Long Term Living is actually
tracking the progress of this event. And, aging well is helping us to
do outreach to make sure that service coordinators are doing outreach
to their participants.

There's online participant training is currently in development, we
have talked about this before I know.

As the narrated trainings we have on the web for, providers and
different types of providers we're developing a training for participants,
so, um, we anticipate that will be available, in late October early
November on the web. So watch out for that we'll be sending out a
Listserv when that's available. Southeast communications -- just to
review the awareness fliers went out in July.

I did discuss our ranging well events they are slated to go through
October 19th.

There are some additional sessions just, so everyone knows we did
get some special requests to do some sessions, for folks that they felt
they had a large number of participants, that would a attend.

So, we are going to be conducting a few of them separately.

There are pre-transition notices in the enrollment packets,

pre-transition notices did go out through August 31st and the
preenrollment packets are going to be going out through the 12th.
We are anticipating that service coordinators right now, are doing
their ought reach to inform participants about CHC.
And, like I stated before, aging well is, helping us to do outreach
to make sure that's occurring and, we are tracking that.
And as well as the nursing facilities, folks that are in the nursing
facilities doing, um, some overview with residents to talk about CHC.
Okay.
Ongoing communications, of course, um, you know that we are always
doing sessions here at the MLTSS sub-MAAC the consumer sub-MAAC is one
we have been giving a regular update the LTSS sub-MAAC the big MAAC,
third Thursday webinars, and we, um, have the MCOs have their
participant advisory committees and, um, are CHC web site is always
available for additional information. So, if you think that there's
some information, that we need to be getting on the web site, please let
us know. And, we'll gladly follow-up with that.
Do we have any questions?

>> AUDIENCE MEMBER: I always have questions.

>> AUDIENCE MEMBER: I always have questions.

>> PAM AUER: With the communications we asked different meetings
for a comparison chart between going back to the LIFE program, so people

can be educated on the choices that they're making.

That way they can make an informed choice is there any progress on that?

>> SPEAKER: I don't have a date on that I do know we're working on it.

Does anyone have, do you have a date on that Jeanne than.

>> AUDIENCE MEMBER: I don't have a date we're working on that currently.

>> SPEAKER: It is under development.

>> PAM AUER: It would be great to see it, if we can help out with language and things like that. The other question I had, um, I'm not good with data, all the different utilization reports that you're talking about, in there, which is the report you talked about, what would be -- should we be looking for for the NHT, will there be a specific report out of all those reports you talked about this look for data for NHT?

>> SPEAKER: We are, actually still developing an Ops report, specifically for that, but the rebalancing numbers roll be the first level for that.

I don't -- I don't know where we are, with the development of the NHT report.

>> AUDIENCE MEMBER: It's priority two in the next level what we're

doing right now is, finishing the priority one, which are all the reports

we showed there, we've done a number of technical assistance sessions

with the MCOs.

They should be coming in, we have reports coming in this week. And

then reporting coming in starting October 15th. We will be able to

report off, once we know we're getting good data and those priority one

report which is are plainly participant related reports then we'll move

onto priority two, NHT is a priority two, report we're in the stages of

developing it right now.

>> PAM AUER: Okay.

>> SPEAKER: Would you be able to show slide of the plan selection.

>> SPEAKER: Any other questions while we're pulling up this slide.

>> SPEAKER: Family training advocacy center I'm wondering how many

reaction you've had with the behavioral health managed care organization

and that region in the southwest, with the implementation, you know, you

had a you had a Lion share of the plan of enrollees, already had a connector with

behavior health managed care, it's not the same

in the southeast. I'm just wondering how much contact that

you've had, in addition, how you've been able to assess, the provider

panels capacity, to offer services which are now far more expanded than

they ever were in fee for service in the sense of behavioral health

services to the enrollees.

>> SPEAKER: Ic tell you, that we are partnering with the Office of Mental Health & Substance Abuse, for that monitoring.

[I can tell]

Omhsas and OLTL are very much engaged. Also, um, thank you for the question, because I -- I know we kind of maced that, there is a lot of involvement, with the behavioral health MCOs we're doing a lot of work with the behavioral health MCOs with the nursing facilities there's been some collaborative meetings there for the behavioral health managed care organizations to let nursing if a facilities to know what services are available and hew to engage the services we've also um, had communication with the different counties to assist them, in understanding who their members are that are transitioning to CHC so that they can do some additional outreach and education.

There's a number of health fairs that are happening this fall I know of specifically of one, with Montgomery County they had engaged us immediately and now, all of the other counties are kind of following into suit too, to make sure they can do some outreach and collaboration with the behavioral health MCOs I know that, that part is, is occurring. Does anyone want to add anything else there with relationship to pool pulling in our behavioral health care organizations

>> SPEAKER: I'll talk more about that in my presentation.

>> SPEAKER: Did you get the slide that -- did she get the slide. Okay.

So, I think, at this time we need to move on.

Wilmarie began do less, Dr. Kelley and Dr. Appel and Howard
Dege for example holz.

I'm sorry.

[laughter]

>> WILMARIE GONZALEZ: Good morning everyone, is in on, okay.

It's on.

Okay.

You have to hit the little button.

Good morning everyone.

Always a pleasure to be here.

I'm glad that, questions are being asked, about all of the good
stuff that is happening with the community HealthChoices.

I think that's one, that has been one of the key things that has
helped us as we continued to implement community HealthChoices and I'm
glad that many of our advocates are here, we see them as partners I've
been a long standing advocate for a very long time at the state level
I'm glad to see Pam and, some of the other folks really identifying
things that are really important.

With me today, my name is Wilmarie Gonzalez I oversee the Bureau of
Commonwealth, at OLTL I have Dr. Kelley and Dr. Rppel, and Howard is
here from the unit of Pittsburgh as many of you know, about two years

ago, we started talking about how do we make sure that we know where

we're going, um, until we know where we've been, so, I think

that the Medicaid research center has done a very good job in the past

two years in conducting a lot of analysis and evaluation what's been

going on in Pennsylvania. So with that I'm going to have Dr. Deggenholz

, talk about the activities and the good work that the MRC team has been

doing and helping us with the community HealthChoices.

>> HOWARD DEGENHOLTZ: I'll try to -- thank you Wilmarie it's a

pleasure to be back here. I've presented to this group before, so I

won't go into the Nitty Gritty of he the evaluation I want to share some

updates of some of our findings.

Really address how we've an able to support the department and

Office of Long Term Living.

Perfect. So, just as a quick reminder this is a long term

multi-method evaluation. We plan to be in it for the long hall we've

been using multiple methods to find out what is going on, in the groups

that are going to be or already in community

HealthChoices. So we have focus groups with participants, we have been

doing interviews with participants and, caregivers we've been doing key

informant interviews with the stakeholders we're conducting

surveys of LTSS providers.

And, we've been analyzing administrative data, so I'm going give you,

next slide, I'm going to you overview of the major activities over the past year.

I'm going to touch on, some findings from each of these major activities, related to data collection. The next slide. So, some highlights from participant focus groups that we've conducted. We've held about 10 sessions in the southwest back at the beginningst

of the year, from January through April we identified, major issues of concern, to participants as they were enrolling onto community HealthChoices.

Some of the, some of the topic that come up in the focus groups these were, participants from all ages and also a few caregivers as well. People reported that there were some positive benefits from being on community HealthChoices, lower copays better coverage for die bets testing supplies as an example, there are some areas of concern for example, confusion over the enrollment process. Lacking plan comparison information, we heard that earlier, just this mining. Making it hard to choose the best plan. And, little bit of confusion over why CHC is being implemented one of the quote -TS was if it ain't broken, quit fixing it.

[laughter]

Some concern over medication issues what is covered under CHC, as people were having new formulary rules with regard to their CHC plan

some confusion what was the consumer responsibility.

Although that seems contradictory with regard with people having low are copays I think you can see that some people have some confusion over which specific medications might be covered and there have been changes for some people. Also H transportation barriers, MCOs one thing that people are probably familiar with by now is that, MCOs are starting to use LYFT, alternative to traditional para-transit providers a lot of times there aren't drivers available out in the rural areas it's difficult to get, people call that, the transportation broker, be told they're sending a Lyfte driver consumer there's no one in the they're can provide that service.

Then also, some people getting denies for medical transportation over a certain distance. Range of different are different issues one of the things we do, at the Medicaid research center is when we have these finding questions share them with OLTL right away. And we know that, OLTL has taken our findings along with the information they get from the range of other sources in that influencing their decision and their strategies. So, some people are probably aware of, on the agenda today, update on transportation issues.

And also, the big push that you saw from jail Vovakes on earlier public compliance for the southeast.

[jill]

We can't take credit for prompting that, but we provided external data, that really validated what is going on and the need for communication.

Do you want to say something or you should keep going gone gone keep going.

>> HOWARD DEGENHOLTZ: Baseline. Probably on the one of the activities we're doing is a prepost interview study with participants before they come onto community HealthChoices.

So then following the same people, over a 3 year period as they start to experience changes in their plans, so, we have been conducting telephone interviews, this started in phase one and, phase 3 back in late 2017 to establish that baseline before the phase one or southwest enrollees started on community HealthChoices. And then we interviewed people in phase 3, just to serve as a comparison group. Starting as an a aside. Starting, this October, November it is already October we'll start enrolling a new baseline group for the phase two or southeast area in order to track their experience over time. In all of this work we divided the target population into 3 groups people 21-51, receive HCBS currently. People who are 60 older and people who are dual eligible, NFI population we did I side that sample into urban and rural and then the two regions as I was describing and, as I mentioned a moment later we'll have 3 regions up and running starting by

the end of this calendar year. For our first baseline we interviewed
over 3,000 people.
We had a cooperation rate which is 40 percent,
which is is good, given the health and cognitive issues many parts of
the the population, that is being covered.
Participate as well a the fact there's no incentive to participate
of the consumers.
And I'm going turn to the next, couple of slides and show you just
some quick baseline metrics and the important thing here is not to get
hung up in the specific numbers per se. But what we're doing
with this is establishing a baseline, that we can now track over time
there's are on issues and topics you can't get out of, administrative
data or Ops reports these are the perceptions of the consumers as
they're experiencing, community HealthChoices and note, this is data,
from before people who are actually enrolled in the community
HealthChoices. So, there's a blue bar and gray bar I'll pay attention
to the blue bar. And this is, essentially, people's rating
percentage of the people that we interviewed who said that, they're
personal attendant was the best, ten out of ten. Then, we asked
the same question further rating of their service coordinator, then,
the last two bars recommendation, personal attendant service coordinator
that is asking the same question, slightly different way to improve on

reliability. The gray bar is national data we used as a benchmark you
can see Pennsylvania seems to be, slight lay liar than the, national
branch mark on these measures in terms of the, people's satisfaction
with their personal attendant and service coordinator.

Can I have the next slide.

Now, this is where we, dug into transportation in a little bit of
detail.

So, you can see there's sort of a summary measure and I'll just pay
attention to this, in the interest of time, the blue bar again is
Pennsylvania and you can see, that an average people are rating it
three-quarters of the people are rating their experience with
transportation, as the best, ten out of ten. And then, that's a little
bit lower than the US benchmark for -- in terms of other data, that we
were able to identify.

So, clearly there's some room to improve there, but also the most
important thing is to track this type of measure year over year. So,
stay tuned, we'll talk about these measures again as we start to have
longitudinal data from the evaluation. The next piece is interviews
with HCBS providers.

We conducted a statewide survey of hackers CBS providers. We
developed a new instrument in order to do that we conducted the survey,
late 2017, so, before providers were actually up and running with MCOs

we wanted to get a sense of their participation for dealing with

community HealthChoices. We identified a -- just over 1,000 distinct

provider locations, so that means, if one company, had offices in 3

different counties we interviewed we essential a survey, to each county

office. Sometimes if there was one manager who is responsible for all

3 offices, then that person would only have gotten one survey but it

would have told them, which offices they were, we were asking them about.

We had a pretty good response rate, for this type of population

about 36 percent.

Considering that, we didn't offer any financial incentives to

respond to the survey and many people did not recognize Medicaid

research center so, we felt pretty good about that response rate. We

also did telephone follow-up to make sure that a lot of cases we had bad

email so, calling people on the phone was able to correct that.

We are just getting ready to do a one year follow-up on this.

So in the southwest, this will be be capturing providers first you

know, close to a year experience with the community health lices and

then in the sewage east and central areas of the state we'll be capturing

their participation to be participating in this program.

So, let's see.

I'll go this way, if you turn to the next slide, these are measures

about this and you can see, our survey, it was about evenly divided

between the, different regions of the State.

And, as you would expect, the providers and the southwest were prepared than

the southwest, we'll be

seeing that shift over time. As you can see that as late of December

2017 that number of attending public information sessions, in the

provider community was about 70 percent in the southwest. So it wasn't

100 percent that's again the bench mark the baseline and, when we survey,

providers late 2018, we'll see how the 2018 implementation of the

southeast compares to that number.

Given all the response that OLTL has made in terms of pushing things

out sooner, one would, anticipate that number might be met.

I'm going to I'm going keep moving but I'll point out one last

thing we asked of an over all satisfaction with the implementation so

far and we combined satisfied and neutral, so, the alternative was

negative towards the implementation, at that point in time and that was

hovering around 65 percent.

The next major activity, interviews with key informants this is a

task that actually was ongoing we actually started this even as early as

2016, but 2017 really started in Aarnest to talk to stake stakeholders

across a wide range of cat guys of providers and advocacy

organizations AAAs, CILs every type of organization, um A we really task

cast a wide net, we conducted qualitative interviews more than an hour

long, some people in this room have been participants in those interviews and, we thank you I won't call out anyone by name if you were, thank you very much for you're time.

The list there shows some of the types of Respondents we talked to, have the next slide.

So, I pulled out some highlights from these interviews, some of the early concerns that we were hearing, from provider informants early first quarter in the southwest, was that, they didn't have consistent contacts with the MCOs they were saying hey why can't we, as a provider, have the same person to call each time, we have a concern of the MCO, each time I call back I get a different person the MCO they don't know who we are they don't know our business.

Providers were reporting that this is particular to LTSS providers decreasing the referrals and that, authorizations for service were taking a long time.

And there were also, noted that the training, on how to use the various systems how to use HHA exchange was quite condensed and, took place over the holidays so, conflicted with their time so they were, saying hey, this is rolled out pretty fast we didn't have time to get up to speed on a lot of the issues.

Later concerns is we moved into the second quarter, and, people were approaching the end of the transition period, they were reporting that,

Thyrogen assumers were anxious about their service plans and,.

[their consumers]

Were worried they would loss access to the LTSS services and concerns over consistency that is they would not, they, would retain the services but might have to change the providers so some of that is bubbling up in the second half of the year one category provider I want to mention, community health centers as people are I'm sure aware they serve a disproportionately a high number of machine identified CHCs across the State, sorry so say CHC, that's -- redundant with CHC I'm referring to Federally qualified health centers and lookalike, lookalike centers so one of the things that we found from them is that they have been undergoing a big cultural shift in terms of their billing practices with the implementation of the Affordable Care Act and Medicaid expansion but even working with the new managed care product was quite new for them, they didn't feel they have received much communication about this, so it was gratifying to see that, FQHCs are a target for the phase 2 implementation.

One of the issues they were mentioning specifically was authorizations for payment were time consumer one comment they had to hire additional staff to deal with the community HealthChoices managed care organizations. So -- the next

topic, is the six month follow-up interviews it might seem like I'm jumping around a little bit but I've been doing these pretty much in chronological order as we collected the data. So as we got into June, and July, we started calling people, in the southwest who had been on community HealthChoices for six months, and asking them about their experience. We asked a couple of things.

And I'm to pull out a couple of highlights here. As of the data, pull I had available for today, I am talking about interviews about 800 people. There were total 1500 people interviewed at baseline, we expect that we will be able to complete follow-up interviews with 1200 of those individuals, by the time we close that data collection probably the end of this month.

So to the pie chart, one global question we asked them about their, medical care services and basically this refers to primary care access, in 80 percent, said that, compared to before January 1, their medical care needs were being met the same, and 50 percent better, and only 5 percent were reporting their medical needs were not being met as well.

Next slide.

And then, because transportation has been such a -- such a, important issue, we made sure to include some questions about transportation in the last 3 months.

And, what I did on this chart was I put, the orange bar is that
baseline number from slides I showed you a few minutes ago the blue bar
is the follow-up from over the summer.
And on just 2 questions we had the same question of both time
periods, you can see it's basically the same. Now, clearly, if
50 percent of people are reporting, that their medical transportation is
arriving on time there's a lot of room for improvement there, but when
we ask them that same question six months later, it is pretty much
unchanged. So, we can think of that as, either exactly half
full or half empty.
The most important message is that things are not getting appreciatetively
worse but there's room for improvement.
The last bar of that question is about getting in and out of the
transportation, easily, I thought that would be important given the new
reliance on Lyft vehicles we're not seeing any major changes in terms of
reporting access to the actual transportation vehicle we'll keep
tracking that over time.
The last category of analysis that I want to show you is from
administrative data.
So this is where, partnership with the Office of Long Term Living,
we have access to data, from a range of different data sources including
Pennsylvania Medicaid data, Medicare claims data and nursing home data.

These data go back to 2013 as was mentioned before this is where
we're looking at historical data to find out where we've been, you don't
know where you've been, you don't know where you're going we need to be
careful to know what the trends have been over time. So that we don't,
um, mistake changes in the data, from trends that have been taking
place over a longer period of time.
We have an extensive set of outcomes we'll be tracking through the
end of the study I wanted to pull out a couple of highlights for this.
So, the first one top ten chronic conditions I'm not going pay -- we're
not going dwell on this too much but to point out we have the data to
identify risk factors in the population and that let's us identify,
sub-groups of people that have, particular chronic diseases that make
them, susceptible to hospitalization and other factors we can build that
into our analysis, one number to note is son the far right, we have
18 percent of the population, with Alzheimers disease or other dementias.
Next measure, this is the Ambulatory care, I'm having trouble
speaking.
Sensitive hospitalizations. This is a number that is considered a
negative indicator, indicator of, poor quality and it's been
identified, in the long-term services and supports research
area and policy area, measuring factors that measuring the outcomes of
potentially poor quality of care that took place either in the home

report community.

That could have led to hospital, that led to a hospitalization could

have been prevented.

So you can see that number was actually trending down slightly from

2013 to 2015 we'll be tracking this number, over time.

We would like to see this number, trend takenning to trend

down.

As, the managed care companies, in community HealthChoices start to

pay attention to these, up stringing factors and risk factor that's can

improve the well being of the population.

And the last slide is, rebalancing. So, Jill Vovovkes put up

the rebalancing numbers for just the past year this is a little bit

businessy you can see on the left is the younger population, 21-59 you

can see that, in that population the blue bar is the home and

community based services, and from 2013 to 2015, that was trending

upwards from about 73 percent to 77 percent.

And shifting away from the nursing homes the right we see the 60

plus population, where the shift is in the same direction but the base

rate is much lower. So, the race right there in 2013 started about

34 percent moved up to 37 in 2015.

The rate today, is around 40 percent you can see there's been a year

are year over year trend towards increasing use of home and community

based services we'll be tracking this as part of our external evaluation

. Last slide, I promise to shut up) laughter]

Next steps in the end of the current year and into the next year

we'll doIt round of focus groups in January and February in the

Philadelphia region, we're also, we've also been observing many of those

public sessions using it as an opportunity to identify and make people a

a warm of the opportunity to be, partner focus groups.

We'll always are looking for people to share their opinions about

their experience.

We'll also be doing the baseline interviews for the southeast region

I mentioned that as we were going.

That's going to get started, later this month and it will continue

through January and again that will include about 1400 participants.

As well as caregivers.

We'll also in the middle of next year we'll do that same six month

follow-up in the southeast part of the State so that gives us a quick a

-- you know, that will give us some insight into what changes, have been

taking place in that first six months of the implementation.

Then we'll be continuing to do

the secondary data analysis as I shared, do we have time for questions?

>> BARB POLZER: We have a question on the phone.

How did Pitt identify consumers to interview? Did they find people

on their even or get a list from the state or the LCOness.

>> HOWARD DEGENHOLTZ: Very good question. Thank you.

[MCOs]

The Office of Long Term Living shared with us the names and addresses and telephone numbers of people who were eligible for community HealthChoices based on preliminary rules for eligibility, that back dated to January of 2017 and then we did a random sample of those people to invite, to participate in the study.

We also, I can get into all of the various privacy protections that go into how we handle that data, but basically we selected the peoplality random from a global list provided by OLTL.

>> WILMARIE GONZALEZ: Good any other questions thank you very much.

As you can -- as can see, um, a lot of the information that I think, that the Medicaid research center, has done, um, I think is very unique.

The fact we have an independent evaluator really looking, at all of the various activities for us, and really having the being honest and being open in sharing with us, some of the information, that collecting by interviews they're actually having, with providers directly, and also with the consumers that we have been serving in our fee for service program and I think, it is very telling of many of the findings some of the findings some of them were a ah-hah moments other findings were a validation we knew what was happening with the folks we were serving,

very important to know that is, as we, continue implement community
HealthChoices having good quality of care for participanttion as well as
services have been key so, I appreciate the fact that the Medicaid
research center has been sharing a lot of this information, some of this
information has been shared before, previously.

Our commitment obviously is to continue this evaluation, is, um,
going is scheduled for next 7 years so more to come on how we continue
to progress in the community HealthChoices.

And with that, next slide.

So I'm going to touch a little bit this slide is something that
we've been sharing as we continue having our dialogue with regards to
how quality impacted community HealthChoices. This slide, I think is
very telling it kind of tells you a little bit about some of the high
level activities we have been able to use as designing community
HealthChoices jail earlier today touched on monitoring
compliance.

[jail]

You'll hear more about that, as we continue.

[jill.

[as we implement CHC. You've also, some of the other areas we have
already done previous information A at this sub-MAAC has been we covered
critical incidents, we've talked a little bit in depth about

complaints and grievances you heard today the update on the network

standards for today's discussion, beige Dr. Appel and Dr. Kelly will

talk about some of the performance measures what we call K parks Ms, key

performance measures we're identifying we're really focused on moving

forward as CHC continues as Howard mentioned they independent

have done consumer surveys we have asked our MCOs to use the HCBS CAPS

survey we have presented to this body of the HCBS CAPS survey

that's been validated and used in different states, and we have asked

our managed care organizations to provide a sample on the experience of

care for our participants in the southwest of how they are receiving the

services tod today under communities HealthChoices.

We have also provided information to you all, on the RQR the

external quality.

[EQR]

The Federal requirement for any management care, it states they must

have arks QR they must have a critical role we're going to share with

you today, more importantly they're also helping us very closely in

identifying, our performance improvement projects which, will begin in

January of this up coming year for the next 3 years or so.

A lot of these areas we worked very closely with the managed care

organizations to make sure we do that.

Then, of course you've heard a little bit from Howard, about the

independent evaluation what they have been doing at the Medicaid research center. Next slide.

Here, at high level are some of the elements of the quality strategy, that we have been implementing. We are going to talk today, more depth about the KPMs and the PIPs we live in a world of acronyms so, um, you guys will have to get used to those acronyms we'll talk a little bit proper about the modified HEDIS measures what we're looking at and what we expect the managed care organizations to start reporting to us we gave you a little flavor of some of the things we asked our managed care organization, to start sending to us as, Via O parks S reports our goal will be -- up coming meeting to share with you some of the data, that we have been collecting by the managed care organization and again, this will also tie into some of the quality management, utilization management date that we're going get.

Next slide.

This really is a available for you all to kind of, kind of wrap your arms around it, so you've heard today about Ops reports you've heard about some of the information, that the Medicaid research center has provided to us.

We have not talked a lot about what information, or the managed care organizations collecting and how state, are you going to be able to look at all of that and make sense of it and be able to come to this body and

walk us through how is the, how is community HealthChoices actually
doing? How are you making sure that the managed care organizations are
being held accountable and that we are providing, appropriate over sight
to the managed care organization. So you're going to hear about
HEDIS measured and modified measures.
I did talk a little bit about the HCBS survey that's are
happening now.
Our hope will be that once we get all of the information from the MCOs
our plan will be to share that data with you. So you have an idea,
kind of the response and experience that the participants are getting
and are telling us, in the southwest and all of that is, is sort of a
hub of data we're going try to be able to provide some really clear and
easy reports we'll be able to present to you all. And just on the
oversight reports the executive summary is really, is going to be
something that is going to be more plan specific. And it is going to
be similar to a report card our goal is to be able to produce those
kinds of reports to you.
The division reports is really, for us to be able to produce much
moor detailed reports on the various activity that is are happening for
our participants and in dashboard some of you are familiar with
dashboards.
Dashboard will give us the ability to do, planned comparison, we'll

be able to compare, from plan to plan how well they're doing. Or how
bad they're doing we'll be able to see that our hope will be able to
share with you all that information at a later date I want to invite
Dr. Kelley and Dr. Dr. Appel, to walk us
through. Spike Supreme Court thanks I would like to thank the
subcommittee for the opportunity to share with you our quality vision
but not also to share but to get feedback on the direction that we're
headed. Quality of care for us is very, very important. I'm chief
medical officer for the beige of medical assistance program and Office
of Long Term Living and, I spent the last 14 years really looking at the
quality of care that gets rendered, across both the medical service
standpoint bullet also beyond looking beyond the medical model of care
and looking out into the community to make sure that individuals who are
getting the services they need. We take this very, very
seriously and we're holding our plans accountable.
From our standpoint, there are a few I'm going give an overview and
layer will get into the details but, one thing that we're very
interested in is, using the HED rake S and modified HADIS measurements
that will be reported out to us, probably.
[HAD rake S]
This time if not earlier than this time, that is a standard of care
that managed care plans are expected to do. There's a whole series

we'll pry more detail, but there are, a long list of quality metrics
that not only, pertain to the Medicaid and Medicare population but you
also will see there are newer measures that are adopted that are very
specific to long-term care support services we're very, serious about
having the managed care plans take a look at, and measure, those metrics.
Also, because those metrics will be reported next year this time, we
developed some, what we call key performance metrics that we're asking
our plans to submit to us on a quarterly basis just so that we have some
indication what is happening out there in the implementation in the
southwest and then obviously going forward in the southeast in January.
We'll also talk about our performance improvement projects and again
that's a definition that the, the Federal government has given to us, it
is required that all of managed care plans do these particular projects
and, we'll talk about our focus on the, in the CHC managed care world
we're very focused and thinking in terms of, where our -- where is this
population most vulnerable. Those areas, tend to be transitioning
transitions of care from the hospital back to the community or back into
a nursing facility.
Then, we're also very interested in looking at, the transition of
individuals as they leave a nursing facility, to make sure that those
transitions occur, appropriately, and smoothly we'll be, we'll get into
a little bit more detail, but, from our standpoint, these performance

improvement projects are very, very important we take them very

seriously and our managed care plans, it is anation this is not a process you set a bunch

of data we expect them to be very actively.

[expectation]

We expect them to be very actively engaged to figure out what

is happening measuring what is happening and actually improving the

circumstances so, then Wilmarie already mentioned home and community

based CAPS survey, uniquely we think is a, a nice way to find out what

is happening supplements some of the work that Howard is doing, it is a

nice way to find out is what happening, for those individual

that's are out there in the community, that are taking advantage of the

home and community based services supplements

what Howard is doing it is a process that's has to be Sam dated. Those

are some of the things we're doing to really to make sure, that our plans

are really paying attention to the quality of care again, not just

within the medical model but beyond the medical model what is actually,

lapping out there in the community Howard addressed our long term

evaluation plan we're very excited to be weeking with MRC we think

that, this is going to give us an opportunity to really have a good

pulse of what is happening, historically but also, moving forward as

we're evaluating how well we are doing. My goal is to make State of

Pennsylvania I want us to have the best managed care program, in the country because I want our Pennsylvanians deserve to have the best care in the country that is my goal we should be the best I don't want to be compared to national benchmarks and be below that I want to be better than that.

Because our Pennsylvanians deserve to have best
care coordinated care, to live safely within the community not be isolated but to have the services they deserve so, that is, really the essence of our quality strategy. And, if we want to move to the next slide little let Larry go into the details.

>> DR. APPEL: Sure thank you all very much.

My name is Larry Appel, and I am a medical director at OLTL it is my honor and privilege to talk about quality with you all here today.

I, have the fortune of learning from very good people, Dr. Kelley we share the passion for making sure Pennsylvanians do receive the best care that there is I think we breathe very much want the bank marks to be well above the benchmarks far most every measure that we have.

It is great, to see the work that Howard has done and his team at Pitt this is allowed us to build and define what we need the most.

And, with that, we have developed a quality strategy as, has been outlined.

So as far as the quality strategy goes, we basically as you see on

the diagram we have adopted some key performance measures and some performance improvement projects, these all Stem from national quality foundational measures. The national measures, which we are asking the plans to report on, there are many groups of national measures that the health plans will be reporting on, they're from the health care effectiveness data and information set, the HADIS set, developed by the national quality on quality assurance these national measures we modify them for the State needs as well the national measures touch on many of the topics you've heard about, they touch on patient satisfaction they touch on community transitions, Opioid use, behavioral health you'll see, going forward that behavioral health is one of our running themes. We have sort of focus on behavioral health we found that, large portions of our population that we serve have behavioral health needs we have really tried to weave behavioral health into every quality metric that we have. We also have physical health. Disease prevention really over 60 measures I would be remiss if I did not mention that we also have a dental measure, where we are, asking the plans to report on dental adherence with den dental appointments as well. Based upon
that we identified areas of focus for 2018 some key performance measures. And also some performance improvement projects I guess go ahead next slide great. As far as the -- the performance measures
they come into two groups we have the national measures and some state

measures.

And, you'll see within the National measures we chose, two
behavioral health measures and 3 physical health measures on the
physical health side we are focusing on in-patient
utilization, and you know, the thought there is, that, as Howard
mentioned, several times some things like urinary tract infections upper
respiratory tract infections, consumers can be if managed appropriately,
these things can be medicalled out of the hospital and consumers would
probably prefer that. So, we're asking the plans to focus on the
in-patient utilization also ambulatory care and human AD visits you know,
per member per month, are there, the issue there is they have estimated
13-27 percent of AD visits can be managed in other capacities, such
as.

[AD]

Such as urgent Carolynics or physicians offices we're watching that.

Also all cause readmissions, readmissions,.

[urgent care clinics]

The stems from the disease I see as a practicing heart physician is
a conjest I have heart failure they estimated with the conjest I have
heart failure 1 in 5 get remitted within 30 days in unplanned way,
we're hoping to monitor that and have, work with the plans to innovate
and, develop programs, to reduce that so that, patients are being

carried for more effectively in the community.

On behavioralth side we have adherence to meds for individuals with schizophrenia and this, measure, schizophrenics if they perceive a good relationship with a therapist, and also, if they perceive, that there's benefit to the meds they're known to adhere. And they -- we're also monitoring the number of schizophrenic on antipsychotics in both of those settings, if patients are, if consumers are taking they're medications they're noted to have positive outcomes so it's a hallmark of treatment if they're not, that's where they will get into disorganized thinking and hallucinations and rehospitalizations even suicide events. We're working hard to monitor that.

On the State side, we are monitoring personal assistance services so if there's a missed service or the number of missed services we're asking the plans to report that over their total members we're trying to gauge that.

And we're also gauging rebalancing and these are, of course, LTSS specific measures, and we're trying to stay focused on that as well.

>> SPEAKER: Real quick comment on the key performance measures, we're really looking at this is in-patient and outpatient utilization we're really looking at care coordination.

We want to see, individuals that they can avoid going into the hospital we want to see that.

If it's appropriate.

We want to see individuals if they don't need to be in the emergency department, they're getting care elsewhere, we want to see those numbers go down. So, this is really about, measuring care management and care coordination and expectation, that we have, within the community HealthChoices program. So, our plans for the most part are not paying for these services, but, they should be coordinating these services, and they should be talking to hospitals health systems emergency departments the tie in to the adherence measure, for individuals living with schizophrenia, in the behavioral health HealthChoices we have program called integrated care program, actually the behavioral health plans are looking at this is one of five measures they are looking at we're really trying to, to tie in the activity, on behavioral health HealthChoices side of the fence we're working together, this CHC program is working and and the managed care programs are working closely together with the behavioral health managed care organizations but more importantly with those providers to really coordinate care, so that individuals get the care they need.

>> PAM AUER: On there, number 3, all cause for readmissions are you monitoring nursing homes or hospital readmissions.

>> SPEAKER: Those are readmissions to the acute care hospital but -- you will see, later in one of our PIPs as we're looking at later

as individuals transition out of a nursing home one of the things we'll
be looking at is, whether or not they stay living safely within the
community and not, get readmitted but, if those are individuals in a
nursing facility, and, go to a hospital, and then they come BRAC to the
nursing facility they get readmitted again, those individuals
would be measured in that metric.

Air you were I have another question, number 7, can you explain that
more, what is -- I guess I just don't understand what you're measuring
there. What -- what that meant? The LTSS rebalancing what is that?

>> SPEAKER: I think -- Howard helped us to develop it. We do get
into it later, but allows us and this is, more of a, a programmatic
measure it is not necessarily, commenting on the quality of care, but it
is a, a key metric within the program, so, we added it, because MRC team,
A, developed it but they're measuring it, on annual basis we thought it
would be important enough to actually have our managed care plans, please
measure that on a frequent basis it is
looking at the individuals nursing home clinically eligible. Looking
at where they are at in the community Howard showed a previous slide,
the previous slide deck, where he was looking at the two age bands and
looking at whether or not individuals within those age bands were living
within a nursing facility or residing within the community, in essence
that's what this is measuring.

Howard I'm sure can provide a lot more detail.

>> HOWARD DEGENHOLTZ: Without getting into the nitty Gritty how the number is calculated maybe what you want to take away from this is that, we are the outside evaluator we're looking at the numbers ALTL is looking at the numbers they are asking the managed care plans to report those numbers.

[oltl]

A lot of the numbers will be the same in fact they should be the same.

Descriptions would be, you know, looked into it I think what this does, it says hey look this is a major priority for the over all community HealthChoices and, we're not losing site as outside evaluator,

that is not losing sited as the, agency that is responsible for this over all program and the operations.

>> SPEAKER: We'll talk more about that the PIPs we're looking at transitioning from nursing facilities and, how it is

important to make sure that's done in a high quality way, that those people live in a safe community

That is part of the metric we wanted to tie that into our performance improvement project we'll talk about that in a little bit.

>> BARB POLZER: There's a question on the phone is there any auditing of the HADIS measured reported by the MCAs? If so, please

describe.

[HED rakIS]

>> SPEAKER: The answer is question, we'll be we have used IPRO in HealthChoices for many many, many years our plans willing be held to those internal ought I had standards they will be reporting to NCQA they have very high standards in which they expect, these measures to be audited so yes we'll be use EQRO, to riggously measure those things that are modified hackers ADIS or key performance measures there's a key function that is very rigorous.

>> SPEAKER: Question. Just a curious why there's such a major focus on schizophrenia, rather than looking at the depression, which I think would be morph prevalent have a wider impact on the population.

>> SPEAKER: That's a great question we're actually, going to be focused on both. Part of Howards information, he prided to us there's a very high prevalence of, depression, I mentioned previously, that this is a -- actually was a fairly large number of individuals living with severe persistent severe mental illness we wanted to focus and use a national metric this was a national metric we're going to be looking at adherence to antidepressants that is not going to be a quarterly key performance measure.

But we will be looking at that, on an annual basis but as I mentioned previously, on the behavioral health side, in health choices,

those managed care plans, are participating in what is called integrated
care program this is one of the metrics, that is currently, in that
program. So we wanted to as we move into community HealthChoices we
wanted to see, at least one common metric that behavioral health plans
were focused on, that community hailth choices would also be focused on,
but we will be looking very carefully at several measures, around mental
health including looking at the depression we're also going to be very
focused at, looking at substance use, disorders and also,
looking at, opiod prescribing as we know this population, population
within CHC and dual eligibles are at risk for
those conditions and dying of ap arraignment oid over dose this is one
snapshot key performance measure. We try to limit the number, so we'll
do an annual evaluation which is much more comprehensive.
We had to kind of pick one or two, we felt that this is, this was
one that we wanted tower CHC plans to be very, very focused on and,
working very carefully, with our behavioral health, HealthChoices
programs especially, those individuals that are now, you know, covered
that are narcs FC, that are have community waivers as well as those
that are living in nursing facilities as was previously mentioned I
think the question was asked what were you doing around behavioral
health we want to make sure the managed care plans are paying a lot of
attention to what is going on with the NFC population.

Because, that is a new responsibility for them.

This is a very, vulnerable population we want to shake sure that our
CHC plans are coordinating, as best as possible.

[make]

With our behavioral health plans not just the plans but the providers.

>> AUDIENCE MEMBER: Le Levell Mill er Wilson from the
Pennsylvania health how project I have a question about the first five
measures not the behavioral health but, the HEDIS measures and thinking
about how given that a number of those services Dr. Xelley you
acknowledged are not the responsibility in terms of payment for the CHC
and MCOs for the dual eligibles, it will be the Medicare, advantage
side, DSNP side, made care is paying for that.

Why so much emphasis on those factures let me just say also, it
seems, completely understand the importance of putting responsibility on
the CHC MCOs, but, for duals, some things are beyond the CHC MCOs
control. Let me give you an example.

You could be in a UPMC CHC plan and have gate way as your DSNP.

It seems a pretty big expectation that the service coordinator for UPM
C would be responsible or trying to coordinate the medical side, so
could you say a little bit more about the cohort that you're thinking
about identifying, if it was aligned plan, then it makes a lot of sense
in terms of the expectation of service coordination.

But I have not quite seen the numbers about the misalignment and it seems as though we're putting in expectations on plans that, might not quite be justified, when we have misalignment.

>> WILMARIE GONZALEZ: That's such a good question Mr. Levell, thank you for bringing that up, ozonophore those who don't know OLTL is responsible for overseeing the DSNPs in Pennsylvania we know there are 10 operating in Pennsylvania, 7 like gate way are plan that's are unaligned with the CHC program, where the other 3 of the 10, are.

We have for the past year have been working very, very closely.

With the CHC MCOs behavioral health MCOs and darks SNPS on the same topic care coordination there's been a lot of, movement at the national level to make sure all states are doing integrative care, when you look at our both our CHC agreement and MIPPA contract we emphasize this care coordination Jill eluded as well we've been working with very close with AMSASs well as OMAP, who does the health choices program, really trying to emphasize the care coordination and this push you're right. There is higher expectations by the managed care organization which is why on a quarterly basis for the last year we have had all of these plans talking to each other in a room, really reporting out how are you doing care coordination for your consumers? So we've had the behavioral health managed care organizations report out, how they are working with our CHC plans and we've also, have had the DSNPs unaligned and aligned,

having the same conversations with the CC MCOs to make sure
there's a care coordination when you look at the five goals for
community HealthChoices it's about care coordination how we do that is
making sure all these plans all the various systems are talking to each
other and A one of the other things we've been talking to them about,
they have brought it up, one of the baying barriers is the data sharing,
how do we break those barriers to ensure that, there's a seamless
process, for consumers that we're serving in the various systems.

>> SPEAKER: So to further address your concerns, um, in 2018 we're
asking the plans to report these melt metrics on the Medicaid
population they have control over or fiscally responsible for. As well
as the aligned DSNPs moving forward our expectation, is they need to be
managing and reporting on a larger portion of the population so we've
set an expectation, with our managed care plans they should be getting a
fee for service, data.

Medicaid fee for service data, which is available to them we
also, are, we've already pushed out, some of the part darks data, most
of the part D data, to our CHC plans, so our over all goal is to also
work with the nonaligned DSNPs to make sure that in the future, in
2019 at least in the southwest, that there will be more sharing of the DSN
P data, also as immensed the integrated care program in the health
choices behavioral health, one of the requirements is nationally notify

the other health plan within one business day people thought that is an
outrageous heavy lift guess what is it is happening all of our plans and
our physical health plans are meeting that goal it was either 85 or
90 percent of individuals, one day, one bri business day notification. We know this could be done we're
paying for service coordination, administrative function that service
coordinator doesn't know that, that person is in the hospital, that's a
problem. They should know.
That individual is in the hospital.
If they're going to, the emergency room, that service coordinator
should know, what is happening.
You'll see in some of the, in the PIPs as well as the LTSS pleasures
it all, interrelates so we have lie expectations you've raised,
excellent concerns we're raising lie expectations of our managed care
plans we don't want to do business as we have always done business
that's why we have moved to managed care we are expecting them to
really manage the population even though, they don't have the fiscal
control, over in-patient stays readmissions or emergency room
admissions they need to make sure they're getting the services whether
they need them and when they they do the add politicians does that
answer injure question.
>> SPEAKER: It does it's a great statement thank you.

>> SPEAKER: So -- to chime in as one of the plans on the same subject, I think is -- Dr. Kelley indicated, this is -- I think one of the areas where Pennsylvania will be the national leader and they probably are already.

I mean just to be frank no other state is in a nonfinancial alignment demonstration has pushed the DSNP to CHC-MCO data sharing nor have they pushed the use of the CMS fee for service data for quality and for you know, care coordination improvement. So, this is a really challenging area for us and, we do expect that where we're sort of full integrated full aligned, we'll perform better than where we are coordinating with another DSNP we think we'll do better than we think with fee for service they're holding us accountable to improve metrics in awful those groups so, hopefully with you know, better management for someone who is on fee for service, Medicare we can have an impact by -- being more effective in service coordination by, being sort of a better condue it with more information the State is really pushing the envelope here it's a lie bar we're struggle to go meet for all the right reasons it is going to show improvement want pave the way for other states to follow suit.

>> SPEAKER: I had the same question you had I was representing nonaligned S flakes parks, with a physical HealthChoices plan had the same questions what I found through the discussions participation with

the groups we're actually a lot more opportunities than I realized.

When you think about, someone who, is admitted to the hospital, making sure that care is coordinated with the community HealthChoices plan they have all of the services in place in the home will prevent that readmission we've been working through the data sharing opportunities, they will have all the data in the community HealthChoices plan, as far as DSNP activity and, I agree, if you don't have full control, there are certain things that are definitely the DSNP's responsibility to make sure the flexible has the services it will have some impact.

I agree with the comment that is are being made.

>> SPEAKER: Thank you.

We've got just a few mains so -- if I -- thanks very much.

So I've got about six minutes, um, so -- I'll try to keep the rest of this fairly brief.

We do have NCQA did develop four new LTSS specific measures we're asking the plans to report on those four measures for data in 2018 the reporting will be in 2019.

Real brief we don't have a lot of time, they measures all tied together the first is a comprehensive assessment and update on every new member, within 90 days.

The second is a service plan, comprehensive care plan and

update, on every new member within 120 days the third is that plan be
shared with the primary care physician according to H rake DIS within 30
days of the development and the fourth is reassessment and care plan
update after any in-patient discharge from either, inpatient facility or
a hospital. So we are asking the plans, to report on these as well.

And I wish I could talk a lot about that, we don't have a long time
I did want to get our two performance improvement projects, somewhat
briefly.

The two performance improvement projects the way these work is the
plans work with our external quality review organization but EQRO
gets input from the state and there's development of these projects and,
we're working through these final submission is actually due later this
month on these performance improofment projects all 3 plans while they
may identify different barriers, um, and -- have different
approaches all 3 plans, are going to be developing projects on the same
two topics and one is, strikethening care coordination we talk about
that, is everything you've just heard about, and the questions raised so
we're talking about coordination between the nursing facility, and acute
care, behavioral health, darks SNPs, CHCMCOs we didn't put it on
there, but fee for service.

So, this is -- this is one of the performance improvement projects
these get developed implementation will be starting January of 207 2019, barriers

identified and approaches are being outlined we do

hope to be pushing the envelope relating to care coordination we talked

about.

The seconds is nursing if a sill take transition from nursing

facilities to the community and this is, what Dr. Kelley has mentioned

about, ensuring I know it was also the question raised this is about,

ensuring that someone, who is transitioned from a nursing facility to

the community, that we're doing the best we can for that person, to

ensure that they do well, in home and community based setting.

And again, So this is just a, small outline of our quality strategy, next slide

I did want to, go over our next steps real briefly that is we're going

to continue efforts of care coordination.

Between, the CHC MCOs the behavioral health MCOs, DSN

parkses.

Nursing facilities and hospitals.

They're involved, certainly as well.

Also, within the next year, we will be providing updates to this

committee, on the data received on the key performance measures, the

performance improvement projects.

We also are starting with mortality reviews CMS is issued a direct,

guidance in June, relating to mortality review

we're diving into that we'll get you an update on that.

Also, updated coming within the next year on the health information exchange this is executing they're kind of on the cusp of really, villing a high tech exchange for a lot of very important data and, this all relates to care coordination and, the idea that maybe there's not fiscal responsibility there is the ability to receive information accurately and quickly.

And then we, Wilmarie touched on the monitoring and Ops reports we'll give a faither updated there and Howard certainly, will update again, on the CHC evaluation plan.

[Further]

Thank you all.

Go ahead.

>> PAM AUER: I don't know if anyone else had any questions I did not ask, I guess it's Howard questions when it was -- when you were there. But -- um, where is your, you're full report, is it out there somewhere that can be reviewed? So we can look at -- I really have some questions on it, about you know, some of the things that you said like with transportation and, and, how you were evaluating that I would like to see where it started how to get to that because I want to know more about access to transportation, before I ever find out what their experience was, with transportation.

Is there a way to see your report see how it follows see the data?

Any of that?

>> HOWARD DEGENHOLTZ: I'm going --

>> WILMARIE GONZALEZ: Pam, Pam, Pam, Pam.

>> PAM AUER: You knew I was going ask.

>> WILMARIE GONZALEZ: Many of you have been at these meetings we went through this journey two years ago when we developed evaluation plan and, we got, over 200 comments, on that evaluation plan when we released it, evaluation plan is on the web site.

When we designed the evaluation plan we plead a commitment we would come, and provide updates to this commit.

And that's what we've been doing and so, Pam if you're asking whether we actually have a sort of annual report I think that's what you're eluding to, there is not one, doesn't mean that we don't shouldn't have one.

But if that's something that the committee is interested in having we can certainly, I can also bring that back and, share something at a later date. But we do, we made a commitment based upon what we wrote on evaluation plan threaten, is that we well ensure we provide updates to this committee. On a more, regular or frequent basis.

That's a good idea. Thank you for bringing that up.

Yes.

>> WILMARIE GONZALEZ: I hope today's presentation was helpful,

we'll work to come -- I'll tell you just has not just been us Sam August

the historical data, that we've had as well as the independent

evaluation, that the Medicaid research center has put following, for the

past two now we're on the third year but it really has been a lot of

stake holder engagement there's a lot of information and feedback we've

gotten to the various forms that we've had whether it's a provider

session or a participant sessions so, a lot of this work has released a

lot of the information we've collected in the past year.

So, with that, if there's no other questions we are, very grateful

to have come today and be able to share some updated information.

>> PAM AUER: One proper question.

>> BARB POLZER: One more Pam.

>> PAM AUER: I'm sorry, I promise after this -- I don't understand

all of the acronyms all that. If there's a list somewhere of all the

acronyms so I can understand that will be great, is there -- in any of

this data, what you're requesting or expecting from the MCOs, any bench

learns like where we would be able to see benchmarks is there a

benchmark for nursing home transition and, how many people, and --

something like that --

>> SPEAKER: If there are, if they are HEDIS, there are

national bench marks for both Medicaid and Medicare, those tend to be

different the results are different but there are national brother marks

that are available the LTSS measures that we mentioned, those are brand new.

There are no benchmarks so NCQA will growth that information next year by year two or three they will start to put out branch plaque these wait until the second year of a metric to publish any benchmarks that is the reason why we're trying to use, these nationally accepted metrics because for many of them there are comparative merge marks.

>> BARB POLZER: Thank you, Howard, Dr. Kelley and Dr. Aapel we really appreciate your time and providing us information.

Next up we have, Randy and representatives from each MCO on transportation in the southwest and southeast.

>> RANDY NOLEN: Good morning everyone.

Soon to be afternoon.

I'm going turn most of this over to the 3 MCOs to discuss, but, just so -- general overviews in regards to transportation, in the southwest, we did recently, probably within the last 2 weeks, um, send out a clarification to the nursing facilities and the southwest on how transportation is to work.

There was a lot of confusion during the implementation about how transportation will be paid for for nursing facility residents how it will be rolled into the, MCO and the MCO broker model so we have since clarified, the procedures that the nursing facility should

utilize. They have the flexibility, of writing either in the process

they utilize prior to community HealthChoices, they can set up the new

trappings, work with the local transportation vendors prided themselves

if they have the means and vectors do that.

They can work with the, broker with the MCOs they have a choice of

how to set that transportation up.

So, they're -- having ongoing discussions, following that

clarification with the MCOs.

The other thing I will too much on real quake before I will turn it

over to these guys is that, in the sewage east we are continuing to work

with various transportation providers out there, we'll continue to

be working with SRPAA to try to set.

[S rake PTS]

To set up a summit we've played a lot of email and phone tag I will

probably have to turn it over to my expert in the office who sets

meetings up, Mr. Daniel hall to get that meeting up.

So we will get that convened so we address some of the

transportation issues in the southeast prior to implementation. So

that's, the updates I've had what we're trying to correct and, the

clarifications we put out.

I'll go ahead and tush it over to Chris from keystone first.

>> SPEAKER: Good morning.

So -- thank you for the opportunity too talk about transportation.

For keystone first community HealthChoices in the five county southeast region, we will be using MTM as our broker for transportation.

They are a broker in the southwest as well.

They are, currently in process of, expanding and building out the network in the southeast to ensure we have appropriated coverage and, reduce the barriers Forvades to be able to, on train not nonmedical as well as medical transportation part of that process internally with keystone first we're actually meeting small groups with service coordination entities to understand, the barriers and challenges that they're facing today, we know that, in the southwest there was a little bit more than, I think, what we had anticipated, as it a group for transportation, in some of the, the concerns, in that area, so we want to make sure we get a full handle from a service coordinator's perspective what is happening today.

What we can do, to address and, be -- prepared come January 1st.

For transportation. Part of that process is, working and understanding,V writing PTA, the passes through the service coordination entities we're seeing some similarities how they distributed and manage that process. We're seeing some that are, doing it, differently than others so we're trying to figure out what the best way, for individuals to maintain and receive those continue with those

passes so there's no disruption on January 1st that is the plain thing
we're talking with the service coordinators about is the plan stays in
place, we want to make sure everything is in place for January 1st as we
move forward and gather that work through that process that is the one
thing we are going make sure will not happen is everybody will have
their transportation, come January 1st we don't want any
disruption in that process.

So MTM has been in contact with SA parks TA they created the accounts
and in process to create the passes, we're working on the distribution,
still has not been finalized what is going to make the most sense for
the southeast region at this point. Just, we're trying to get all that
information, from the south -- service coordination entities to
determine how the best process is going to be. One of the items we're SEPTR is the
releadsable month lay places they're doing a
month-to-month place for push chasing back the ones not used it's not a
reloadable pass so we're trying to figure out what process will make
sense, does if make sense to go month-to-month or reloadable so we're
having those discussions internally as well.

And trying to, to figure out the distribution like I said whether
it's via mail or personally delivered so we're working through all that.

One of the items that I think that, we all learned in the southwest
as well is, trying to coordinate the transportation the -- majorityst

population, has primary carrier. So for you're medical trips, um R actually I'll go back to nonmedical. Nonmedical trips and services need to be part of person centered service plan. Through that whole process.

So, the nonmedical trips, we understand for the most part are going to be our responsibility, electric maybe some coverage through the darks SNP may add that value benefit. We'll add that, for the most part nonmedical trips are going to be our responsibility. For

the medical trips you have a couple of different areas that come into play.

So you have, if DSN parks offers transportation, weeking to coordinate it through the DSNP to ensure we're, going threw the, the correct pay ors and LATP, for the doctor's

office, physical therapy, x-rays.

[MATP]

Working through the broker to coordinate, that happens through the service coordination team in conjoins with our team, internal PCC personal care connector team to help make sure that happens. If it gets through the point where it is MTM our broker that is coordinated through our PCC team to MTM this way, MTM knows that, we're collecting the appropriate information, for the trip.

Whether it is, a stretcher, whether it's someone that just needs a,

taxicab or some other mode to be entrance ported or Bariatric

transportation, relaying that all up to MTM so they can set the most

appropriate trip type. LTM knows it's either part of the service plan

or approved service through keystone first to move forward with that

trip.

So that kind of eliminates where if the provider or the participant

is contacting directly the question from MTM was it an approved service

that is kind of the process we follow, to help kind of streamline that,

in insure we get the appropriate modes scheduled.

Sorry going through my notes so I don't make sure I miss anything.

Of course technology is not working.

Some of the lessons learned as well from the southwest to southeast,

mileage reimbursement, once this is established, MTM would be writing together

to issue the mileage reimbursement

to the individual, there are forms needed to be done and sent to MTM one

. earlier lessons we learned those forms ask for a physical signature

if it's a nonmedical service, Pam is giving me -- an eye right now if

it's nonmedical service it doesn't require that physician signature so

we're aware we've made those adjustments and taken that into account. So,

that will not be an issue moving forward.

So yeah there's a lot of um, a lot of lessons learned we have taken

into account. We do have operational meetings as wel well with our broker on,

weekly basis. And we've separated them

into two separate meetings, one for the southwest, one for the southeast.

It's all the same people, but we want to make sure there's no focus

lost as we move from implementing the southeast we don't want to lose

any traction or any of the momentum in the southwest as well.

So again MTM is our broker you'll hear more from someone embarrass

up here as we move forward.

Thank you.

>> SPEAKER: Assuming the passes are for the fixed route system,

right?

>> SPEAKER: Yes. S

>> SPEAKER: From the city of Philadelphia, what do you do with

nonmedical para-transit.

>> SPEAKER: That's where MTM actually comes in and would help

coordinate that, they're building that network, the fleet of

prieders that will be able to perform those services.

We would schedule that, with MTM they would reach out to the

appropriate providers.

>> SPEAKER: Currently that's through SAPTA are they going to be

involved with that.

[SAPTA]

>> SPEAKER: That's part of the discussions going on, as we move

forward.

>> SPEAKER: Question back here?

>> AUDIENCE MEMBER: So um, you'll have this in place, you'll have there in place, December because otherwise it will not work if you don't have it in place in December.

>> SPEAKER: That's what we're having those discussions with about the service coordination entities to ensure that, the monthly passes and distribution, we did, we do have that as an agenda to discuss to make sure that all 3 MCOs are in the same page, so one of the, the challenges, that we're hearing in and we're, hearing from some entities not all, is that push days purchase the passes in December, when they submit those climbs, is it in December that they submit the claims for January service or hold that, and submit in January to the MCOs so, those, some of them currently today, will do all of the distribution, so what they do is they buy middle of the month or the end of the month, have everybody come in, get distribute the passes and then not submit the climb until the first or -- first week of the following month so there's no challenge there.

They're putting out that money upfront.

Obviously before they get reimbursed so that's, obviously something that is why we're talking to the service coordinators we want to make sure as we have those discussions with the

OLTL those -- all 3 of the MCOs and ALTL are on the same page as we
move forward we anticipate having that all, coordinated in place
for January 1st.
>> SPEAKER: I have a question, would that exclude now people that
have the CCT card can connect transit which is part of SI parks TA you can call in
for you're.
[SRPTA]
I know right now, people have those cards that you go on SAPTA it's
a high price, they come back it would be just to write ride on
regular Septa, they ride on with the CCT cards?
>> SPEAKER: I don't have the exact answer for you on that.
I will take that back we will, get that answer for you I think, I
want to stress to everyone in the one thing we're stressing in our
meetings with the service coordination January 1, nothing changes we
will be able to, because we're moving from December into Jeanne, that's
the continuity of care period we're not anticipating we're not
anticipating changes these process questions do not want
anyone to not, get their trips to the doctors office or dialysis.
>> SPEAKER: We have a question from Lev environment ll and a
gentleman behind him.
>> SPEAKER: Okay.
Immune. Hi Levell Pennsylvania health law project.

I have ray question that you might be the steer for the other MCOs too you mentioned it's not about nonmedical transportation there is some still confusion when participant also seeking nonmedical transportation you mention you have a broker who should they contact, should they contact, they're service coordinator, should they contact the broker, should they contact you're participant line this is nonmedical transportation can you clarify you can chip in as well lots of different parts who do you go to as airplanant when you need the nonmedical.

>> SPEAKER: Nonmedical they shrub working with the service coordinator, they are in the field, meeting with participants.

We also have a personal care connector line, that individuals, can -- reach out to as well so that's where keystone first where keystone and AmeriHealth Caritas community HealthChoices it should be working through the service coordinate year our personal care connector line.

>> SPEAKER: One follow-up if I could, if they is the broker's number out there or explain you deal with, the participants don't deal with your broker.

>> SPEAKER: For our process we want our personal care connectors to be working together they are making slur they capture all the appropriate information for that trip.

And dash MTM understand that's is improved services part of the plan the individual participant is working with the service coordinator

our personal care connector and our team will be connecting with MTM.

>> RANDY NOLEN: Gentleman in the back here?

>> AUDIENCE MEMBER: Give someone else a turn.

>> PAM AUER: I'm talking to someone right now who is, in the southwest.

And, she explained to me, I'm wondering where the consumer control those how do you need to tell you're service coordinator you want to like a trip do you have to tell them, I can't? And -- threaten, how -- I'm not understanding the process, because -- if you have to go through the service coordinator for every trip, whether it is it just a nonmedical or medical, nonmedical, immune, it just seems like it's taking away a lot.

Of you're control, in that situation.

>> SPEAKER: That's part of the person centered process.

As they're working through those trips are identified, as part of their goals and, through that whole process. And they're establishing those trips so part of, say the -- monthly passes -- there may be -- based upon you're goals -- you need X amount of trips to pry that -- you go a lead and --

>> SPEAKER: Who schedules that trip you're putting it in your plan.

>> SPEAKER: That will be service coordinator.

>> PAM AUER: I don't know I think some of the could be assumer ins

this area, the State right now, as they have the transportation --

they're -- social, a lot of times is coming to the Center of Independent

Living, is it not be on a schedule basis, they're using it, okay we'll

take a trip and go over to the capitol and we have two days notice or 3

days notice, is how is that really working.

Do they have access accord together person I'm talking to, the

people are feeling constricted.

The person said it's a nightmare, down there. Trying to use A go

through your as much as coordinator.

When you're used to be an independent person and if you have the

ability to use your, tickets or your card, um, to go where you would

like to go now you have to, tell someone, every time, you want to go

somewhere to schedule in order for them to schedule it for you.

>> SPEAKER: I apologize if I wasn't as clear. So as those trips

are identified, that's supplied so, for those tickets tokens whatever

you want to refer to them as they're not mailed out on an individual

basis sent sent out, they are X number of, ten trips, part of your

service plan, that is sent out.

Ahead of time, you don't have to keep calling in each time.

>> PAM AUER: Who is schooling the broker.

>> SPEAKER: Through the personal care line.

>> PAM AUER: You have to tell someone.

>> SPEAKER: That's part of your service plan. So that's part of
that process.

In identifying the numbers there's a change to the service plan,
that should be working together with the service coordinator as we move
forward.

>> PAM AUER: I'm not understanding it I guess.

>> SPEAKER: My I interject. Easterly with UPMC. Air you were
can you bring that closer.

>> SPEAKER: So our approach is the participant is has been
identified, as having a need for social transportation, the service
coordinator is integral part of that, the service coordinator,
identifies the plan of care, that the member, requires, transportation
four days a week for whatever purpose. That goes, in the plan of care,
is communicated to our broker, coordinated transportation solutions, our
broker, will in their system, identify this participant, has access for
the month, 30 social transports.

The participant, has the ability to call the ten digit number to
coordinate the transportation solutions where they would
typically call a taxi company or whoever to provide the transportation
and they can, coordinate their own transportation.

Up to the total balance that is in that system. So -- if they have
30 transports a month, they can coordinate that directly with

coordinated transportation solutions and get their transportation for them.

>> PAM AUER: Right to the broker themselves.

>> SPEAKER: Correct. initially this wasn't
coordinated that way, they were to be coordinated threw the service coordinators and, through some push back.

We, identified that the members do need, and want to have, control of their own transportation.

So we get that and that's the direction that we're moving for.

>> PAM AUER: Which one are you with?

>> SPEAKER: APMC.

>> SPEAKER: If I may, my name is Jay I'm from Pennsylvania Health & Wellness. We operate, we have MTM as well.

But we operate like I peaks MC if the
individual on the service plan is screaks number of trips per month, that individual or their contrary graver, can schedule with MTM directly, you know, if there's schedule weekly within 24 hours we ask that our participants that if they are scheduling something, for nonmedical transportation, that 24-48 hours on that, with folks I know sometimes that doesn't we're and we we're with the participant to -- to accommodate those types of rides but for the most part, someone is calling in they're talking with MTMA and -- they will schedule MTM will

schedule that trip with the provider.

The prototype of provider and then, you know, they are makessed up

and, go where they need to go.

>> RANDY NOLEN: Question back here.

>> AUDIENCE MEMBER: This is -- Zach Lewis disabled in action. As

a consumer who lives in this southeast and receives the zone 2 travel

mass I'm a convinced on these calls that need to be played, when

I just -- you know, kind of, go where I want to go and do what I want to

do I don't -- I don't understand I can't I would have to explain to

anyone where am I going and yeah.

Paragraph.

>> SPEAKER: If you have that trail pass and that's part of your

service plan you queue would not have to call in to schedule those trips

each time. You would be able to use the -- the service, as you are.

Today.

>> AUDIENCE MEMBER: So -- para-transit service you're saying?

>> SPEAKER: This process.

We're talking about? If you're -- you say you have a -- trail pass

currently.

>> AUDIENCE MEMBER: You know I'm planning in the wintertime because

of my, the declined health I plan on you know, using para-transit in the

future A and trying to -- steps that you're, referring to, is that we're

going to have to go through, these phone calls.

To -- let my supports coordinator know, where am I going?

When it comes to these trip ins because the trail pass service is --

>> SPEAKER: It would be one time, at the beginning so that you

would get your monthly pass throughout the month you would not have to.

>> AUDIENCE MEMBER: I'm asking why would I have to explain to my

supports coordinator or anyone where I'm going.

>> SPEAKER: Part of the community health choices program, is that

every individual, that is LTSS eligible NFCwriting,

they are to have the benefits nonmedical transportation, that will be

part of you're service plan.

>> AUDIENCE MEMBER: If I'm going to a strip club --

>> SPEAKER: We're bouncing from multiple different services here if

you're using the fixed route those bus passes they will still work.

>> AUDIENCE MEMBER: I understand that. Right.

>> SPEAKER: If you're using shared ride, para-transit that has to

be scheduled the same way as usual, we're not, reinventing a new system

here.

You still need to schedule those meetings

you call ahead to the prepare you're setting that up with, if you are,

using a nonmedical transportation Cleek say a -- taxi or Lyft program or

whatever, nonmedical transportation you're going schedule a meeting with
the brick otherwise -- orrises, they're not going to know to come.

>> AUDIENCE MEMBER: That will be the para-transit service U.S.
would call them like you normally do.

>> SPEAKER: So what happens, in the person centered plan is they,
you -- you talk with your service coordinator to develop amount of miles
of transportation or trips of transportation that works for you.

They're not going to specify, oh you're going to go to these
places, this is you're set places for the month.

That's not what we're doing we're not trying to tell you how to run
your life that's not you're goal.

We want you to make all those choices on you're own, we just need to
check in, so we can, um A bill the State we need to make sure that the
-- the bill --

>> AUDIENCE MEMBER: Don't exchange it.

>> SPEAKER: We're not exchanging it.

>> AUDIENCE MEMBER: Don't exchange it, we're --

>> SPEAKER: We're not exchanging we're adding.

>> AUDIENCE MEMBER: Don't change nothing you have to ask --

>> AUDIENCE MEMBER: Hello everyone. Less sister Ben net with
supports court nation, let's go back to the mileage reimbursement I have
some crashes I'm worried about my consumers excuse me you're not mine

but -- rhyme worried about the State's consumers all of our consumers
with the compliage reimbursement I want to make sure we take into
consideration our require al areas with the mileage reimbursement that
is going to be family and friends that's not going to be the Lyft that's
not going happen, something come to play attention is the person paying
attention to, is -- I was only able to give out the State's money if I
check sheen criteria, compliance insurance, then you know what? One
thing -- I went to the next part was, wait a minute these providers I
have no idea just because Igorot their license and their insurance, I
have not, if that's the actual vehicle the person is being transported
in I want to make sure? That mileage reimbursement if we're
transporting people with disabilities A they're being protected.
And in a -- the proper vehicle. A vehicle that is going to keep
them safe.
So that vehicle, so -- when we are talking to our people right now
telling them things are going to change or change, we need to --
especially with the compliage reimbursement in the rural communities,
people have I have it, that's that family and friend. That
familiar lay or friend, may not be they're giving me a insurance card to
for that vehicle I put it in my head, how is that person with a
disability getting in that vehicle. Is that vehicle, actually even safe for them. We're
shipping out funds can we discuss how we'll look at that provider

priding that transportation.

>> SPEAKER: So I know this is, actually in the area where we

receive some push back from individuals that have tried to submit for

mileage reimbursement because they were submitting, um, those documents

up front.

There was, um, they -- I know there is a minimum set I don't have

that right off the top of my head what MTM is requesting as part of that

form, but the supporting documentation, for those individuals, so we I

know we did receive push back from individuals because we are requesting

documentation, along those lines, I can -- go back and get the actual

specific requirements as to what they were requesting from those

individuals I don't have that right in fronted of me.

>> BARB POLZER: This is for okr you Chris for you. Do you have nea consumer

education materials is that explain how transportation is covered for

example, bus passes, mileage reimbursement and et cetera, and what kinds

of purposes the information in the member handbooks does not go into

much detail and a lot of people don't even know it's available.

>> SPEAKER: This is January Breyer from keystone first.

[john]

We're planning on creating a flier that would be available

to a participant that is say transportation at a glance that would

summarize the different transportation options, how to arrange

transportation, sightly that, would -- would help people fully

understand what they're options are.

>> BARB POLZER: Thank you.

>> SPEAKER: Okay.

>> RANDY NOLEN: Go ahead.

>> PAM AUER: That would be great if all 3 providers did that.

To go back to what Lester said, I have to wonder, about the mileage

we want to be as easy as possible I knee Lester worries about his

consumers what application ATP require to pay in the millage, do they

require all the Sharons all that.

[MATP]

Do they require that, to get reimbursed, okay.

>> SPEAKER: MAA attention PA.

>> PAM AUER: Application ATP they have been doing it for a long

time if they don't require all the insurance raj --

>> SPEAKER: I have a complement

when we can put some of about this transportation Noel noil hold on,

I'll get back to you.

>> PAM AUER: I lost my train of thought there.

I would not want to be above and beyond anything that is already

asked for.

Just because it is already hard enough for some consumers to, get

transportation period whether it would be through mileage or shared ride
. The other training I wanted to say about what Zach was asking, you
know A the comment about the strip club I guess the yeah is, are they
asking in the care plan where you're going? Are are they asking you,
what is the goal for you to have the nonmedical transportation? Because
I agree with him I don't want to be reporting on everywhere I go in my
life in a person centered plan but I understand that in order to
be on the waiver and to get the service you have to have a goal for
nonmedical transportation. So, that would be my question, how are the
service coordinators being trained, um, for that.
>> SPEAKER: In many cases you're not going to have specific places
it is going to be categories.
I want to go to clu clutch church or grocery store or familiar lay or
friends and Recreate typically you're service coordinator will talk to
the participant what they want, what will be what makes it meaningful to
live in the community for them, how transportation, can support that --
so what may be, of interest to you, maybe, different for another
person.
Or, another person.
>> PAM AUER: What if I, I give the categories you're talking about
in there, but there's something else that comes up that doesn't fit that
, am I not going to be aloud to use it or reimbursed for that trip?

Because there's going to be places where people may want to go to or --

that may not be one of those categories generally don't want to say it.

>> SPEAKER: Like airstrip club.

[laughter]

>> SPEAKER: You you have a categories general entertainment,

socialization I think that's probably the categories that type of stuff

would fit into.

Whether it's to a baseball game or a a strip strap,

that is general entertainment that will be --

[laughter]

>> SPEAKER: Tanya?

>> SPEAKER: Yes.

Um, I that I, it would be a idea we

when work owning the guide book we include a special vacation on --

transportation for all the plans like all the plans to give us some

of the information on how nonmedical transportation directly is going to

week so we can put it right in that enrollment eligibility guide book

whenever it comes out.

I don't know if then Ben hill is

in the room or pass it onto Kevin do see what they think about it, it

would be a really helpful place for this to go. So people are looking

at which plans they want want how each plan weeks there's a small

section in the guide book that explains how the transportation works

with each plan that will help everybody else how to do it and you can

use it get transportation if is needed in the different in the different

ways you can get did how it is billed and how it is used and everything

that will be a really good idea and it will help a lot of people out.

>> RANDY NOLEN: Thanks Tanya, Jill and Jen are in the room.

>> SPEAKER: I just wanted to let you know TanyaN is Jill, we do

have specific guidelines from CMS on our member handbooks.

So if you're looking to add something to the specific member

handbooks for the MCOs, we would not be able to modify that however we

can speak to the MCOs regarding additional guidance for participants.

>> SPEAKER: Okay.

All I know is we're supposed to be weeking on a eligibility book I've not heard

back much, when the group is

going to hear about it whether if is going to be put together,

distributed to the I'm just saying this is another one of those helpful

areas we really want to do something with this we should.

>> SPEAKER: Absolutely we'll follow-up and get back to you on that

one.

>> BARB POLZER: Can we have the other two presented presented I

want to be fair to them.

>> SPEAKER: Jay from PH washings.

>> SPEAKER: We have a slide show.

>> SPEAKER: We have aic slide show we'll buzz through, L traction M is the same company that, keystone first and Pennsylvania health wellness uses.

The goals here and I know there's some questions and concerns, the goal of having MTM working with us, is that we eliminate the barriers for folks, to get to health care or get to where they need to be or where they want to be. We want to ensure transportation does not disrupt their continuity of care.

We want to ensure that, if we're using or whether we use MTM, that is not driving someone away from Pennsylvania Health & Wellness I'm sure keystone feels the samurai we want this to be a reason why you stay with, either of our plans. Because transportation has become an enhancement to you living in the community.

The other thing and, this gets to sort of where Lester was going here the reason why we have the broker is to help us, eliminate fraud waste and abuse. We treatment, we don't go into the relationship thinking there will be, but in some crieses, some people, do that.

This helps us to minimize that, makes sure that taxpayer dollars and your dollars everyone here are used appropriately.

So that's why we've engaged MA pollution, they're a major player number 2 in the country priding money medical.

[pollution traction poll pollutionmore than 23 years ago. My gosh.

They have been doing this A across the country.

I believe, they are in 27

states next slide.

Back one A sorry.

There we go.

I apologize.

27 states I was right.

So and they're serving over I believe, almost 12 million people a

cross the country. We, I believe, in -- I don't want to Supreme Court

for case. But, we have had a very beneficial relationship with MAM.

Over all we have good participant session, there are issues. We know

that when we find out there's an issue are tackling with them, reworking

to improve their services and the way they are priding you, access to

transportation.

Daniel do you want to go into how.

>> SPEAKER: First and foremost one of the reasons why we're using MTM,

Pennsylvania health wellness is not a transportation company it's a

very complex, transportation is a very complex subject.

And, we want to -- we want to be the experts in what we do.

We ranger have the experts, MTM, do what they do best.

And that's the nonmedical transportation piece, they do all across

the country. Weightily they can do this fairly well in Pennsylvania as

well that's why we decided to partner with them.

I want to say, see that we've been seeing increased growth with the

use of nonmedical transportation since January 1st that means more

people are using this service.

Talking to their service coordinators about it it's a slow growth, bottler using

nonmedical transportation to do that.

Sorry Lester I'll get back to you in a second. A.

>> AUDIENCE MEMBER: That's okay.

>> SPEAKER: I wanted to say we're seeing, increased usage and

increased individuals the beeline is 675 use blue line, and 310 unique users as of

second quarter.

And then, next slide there shows where they're coming from, which

counties are being used. Little bit duplication, sometimes, people

from west moorland county to Allegheny County or from Washington, county

to Allegheny County that's why you see some of those big numbers in

Westmoreland and and Allegheny County I wanted to find out, um,

schedule trip, how the success right is and, um are you sure so we're

having very lie success rate that means people are getting where they

want to go. And, there are some reasons I can't it is not happening

correctly and short notice basically they're calling nonmedical

transportation too close to the deadline.

Or, every once in awhile we have trouble with our vendors or there's
no vendors available for that particular time hopefully as we grow that
network that will be less likely that case. I'll get to you in a
second. So dash so -- I also was bigging around why things are not happening this
is say break gown of case by case basis.
So next slide.
I'm trying to get through this so you can ask questions, guys. MTM,
we're very proud system, but we're also, um, we're trying to stay build
plans for the future with their progress, being partners with them.
We are definitely trying to, stay in line with the standards of
Pennsylvania set.
Because, they're kind of the, the -- they're the ones that basically,
call the shots we're trying to make slur, what they're goals are, are
our goals and that, in a is communicated to MTM and the
providers working with MAM we're also looking to grow those connections
we're asking MTM to build up bare network in the southwest and as wee
move in the southeast we're hopeful we'll see, a lot of those providers
like S septa working with us as well.
Supreme Court speak couple of other training that, Suzanne you
brought up an individual having some issues in the southwest called it a
night player we want to know about ridesser explanation and we are
weeking with LAM to improve rider explanation I'm sure keystone first is

as well. Making sure that freaks are using and getting the most

appropriate type of transportation if someone needs a para lyft is a cab

showing up those types of things we need to know, and we are weeking

with participants on a regular basis on those types of issues so,

holistically we want to make sure that, not only are people getting

where they need to be or want to be, but that ride is a positive

experience and that they are, being appropriate laically

transported.

>> SPEAKER: I'll turn over up

mc very belief.

>> SPEAKER: Rile be very brief, as for upmc we have, a very robust

transportation network in the 14 region one counties.

Give you a break downst vehicle of

the vehicles we have 330 ambulances, 22 stretcher vans stretcher vans is

a commodity, not many left out there in the southwestern Pennsylvania

market. 561 wheelchair vans and 610 taxi and delivery vehicles these

numbers do not include Alyft we did partner with L app ft they

are used in a very small percentage of transports as long as the member,

meets the criteria to get into a Lyft vehicle from a mobility needs

standard origin destination. We limited Lyft usage right now in sewage

warn Pennsylvania to Allegheny County. We did expand it expanded to

all of person Pennsylvania not only for you're community health lices

but for or SNP plans we saw a decrease in client and service as
mentioned earlier in the more rural counties and I have my even belief
why that happens but, it worked better in Allegheny County we're
limiting to Allegheny County we're giving the member the Clair if they
want to use Lyft or more traditional transportation provider.
I gave you a snapshot of a month, in the life of compliant
HealthChoices you can see -- I used August data total transportations,
trip leg is a one way transport we provided 3111 one way transportness
the month of August, total canceled calls 29 percent and total trips
performed 2198 canceled calls can be anything from the member
cancels when the vehicle hits the door it could be, the member
was ill called in and canceled the entrance port or it could mean
something, as -- critical to us that we could not find the
transportation provider.
Next slide is -- highest trip volume is on weekdays as you would.
>> SUSWETHA: Specced. In those limited incidents were able to
find the transportation provider as the aqu right tiy increases we find
more difficulty finding the service you're program is securing beratr
right c balloons it's more limited real estate source more available in
al grain I county. There's not many providers equipped to do it they
say they can do it, bottler not equipped with the manses to move slavery,
a bari tax r arraignment c appreciated, there's also some variance

there's one provider to the next what qualifies one for the

transportation, if they weigh 350 pounds they're 5-foot 2 they request

an ambulance, that could be done by a traditional ambulance service.

If they're 560 pounds then you need bariatric, to get them in and

out of the vehicle not only the member but the ambulance crew as well.

Call center stats, you can see the numbers range anywhere from the

300 range per day, to an excess of 500 calls in the call center per day.

Abandoned -- August is the worst

month we've seen A with average talk I'm are time we've actually started

a pilot program to get participants and service coordinators off the

phone instead of a 6-10 minute phone call we want to limit do you know

to a few mains and right now, according to the transportation solutions

they will try too screening that trance for the for you, while you're on

the feign, you're holding for a few minutes while they're reaching out

to providers, if they schedule it, they will give you the reservation

number A and the conformation number if they can't, they escalate it internally,

they will stop, that he

warrant you off the feign, find a provider by IV writing A a message to

you're phone let you know that transportation was scheduled and what or

would need to be rescheduled.

That's -- time constraint I'll answer any questions that you

have.

>> AUDIENCE MEMBER: There is a quick question.

Is there um, any need for service coordinator to eye that the trips are across county line ins.

Whether it comes to transportation.

>> SPEAKER: Cross county lines no. Across state lines possible.

Some providers, especially on the para-transit side the wheel Clair vied, they're licensed by the public utilities commission, they have roles where they can and cannot travel on the ambulance vied, no.

>> SPEAKER: We're the same, I think we're probably going to run into that is more MATR. Through our broker where this thing is the dash we're scheduling that.

>> SPEAKER: Pam?

>> PAM AUER: I'm curious, I appreciate you, putting that honestly up there, the -- trips that have not been able to be scheduled.

If you're saying that now, can't wait to see your responses when you go to phase 3 or the middle of the State.

The more rural parts but, my question is, if they can't be scheduled what is happening? Are they just not going anywhere? They are stuck in the houses or are people trying to schedule them trips? Find providers.

>> SPEAKER: I'll share for RPMC, we have a process those ina ability to provide service, escalated to the health plan if the

corrugated transport solutions ask not grind a provider in the net work
racially the service coordinator or some cases even the member will
contact me directly.
And in my 40 years I have a lot of experience a lot of relationships
with providers I'll be able to call a favor get someone moved. But
that doesn't happen all the time.
So, in many cases, we do have to reschedule the appointment and then
, express a sense of urgency to coordinate the transportation solutions
to get this transport scheduled for the rescheduled date.
>> SPEAKER: Very similar to what we do, we have actually a
transportation rapid response team so that, if a participant or a
provider, caregiver A experiencing
issues with a no show they can call us directly and then we're going to,
we're going to expedite that up through the system to make sure that you
know that ride is rescheduled as soon as possible.
>> SPEAKER: I would also like to say I was, I -- I kind of dug
around myself and, I talked with the people who are doing this, they're
very dedicated to making sure that no one gets left behind. Or no one
gets, um, in a situation, where they need to be somewhere and
they can't.
If there's a need, a genuine need to make to a certain place at a
certain time we have a very creative staff to be able to find a way to

flying it work.

>> PAM AUER: Are you building that back into CTA and, um, and --

and MTM, they're using that, they have trouble

getting to one trip they're not going to get to another activities in

the community.

>> SPEAKER: So we have a similar excalation process where John and other care team are

involved to schedule the trip get something scheduled for the

appointment time or week to have it rescheduled as soon as possible to

have that taken care of but yeah that's part of the ongoing conversation.

Is if there's another provider, it is not in network we are weeking

together with this out of network option for this incident, writing to

bring them into the network for future instances.

>> SPEAKER: We'll go do Lester we have a number from the phone.

>> AUDIENCE MEMBER: Hi everyone is Lester again I want to get some

understandingst mileage reimbursement.

Who are we reimbursing, reimbursing the

consumer or provider that goes back to making sure we understand the --

the requirements for that provider. Play concerns again is the actual

and the rural areas, we're having the provider is going to be familiar

lay and friends of that consumer being in a safe vehicle. So -- who

are we reimbursing, reimbursing consumer or provider or make sure we

understand that providers are, a lot of concern we're putting them in

unsafe vehicles.

>> SPEAKER: If I understand the question, friends and familiar lay

scenario, it is the participant arranging with an individual with whom

they're familiar to provide them the ride.

The participant, will get reimbursed. So, it is up to that

participant be to be comfortable there's no state credentialing of those

vehicles that the participant chooses to ride in. in.

>> AUDIENCE MEMBER: That's a concern because, they could be getting

in -- they could be, for example, I was checking vehicles and, I will be

checking and seeing in realizing after awhile, once we start get nothing

there, did I actually check for the vehicle

vehicle for the provider that is not the vehicle they were in, because

they didn't -- because of their aability,

they were using a different vehicle I was being told to check the

license of the provider, but then ask them for their insurance for their

actual vehicle. That vehicle, that they were giving me might have not

been the vehicle the consumer was in.

>> SPEAKER: I'm not sure the scenario for friends and family.

Am I missing -- friends and familiar lay I'm going my rather will Braille to drive me.

>> SPEAKER: If you say friends and family, it could be redirect

care worker.

[bill]

>> SPEAKER: Friends and family A is at the participants control.

So, if the participant wants to take advantage ever the friends and

familiar lay benefit, the participant are choosing who shows up and

takes them to that appointment. The MCO has no control over that, we ask a

specific question, the vehicle,

the -- the licensing all those important things we want to make sure

it's a valid friend or family trying them in a safe vehicle, but the

participant, is really in control of that process.

We're not going to -- you know send you a -- one of our friends in

our vehicle.

>> SPEAKER: I get that, the concern is, that the vehicle, they're

actually in.

That, that screen --

>> SPEAKER: Green we know.

>> SPEAKER: If there's any -- if there's anything that happens who

is going to be responsible because there was increase in the amount of

insurance that they had --

>> SPEAKER: I get you, I understand you. Let me tell you that,

again you're in control, the participant is in control of which friend

or family and which vehicle they get into.

If there's an issue or a question, with regard to the safety of that

vehicle, or a concern, then, maybe friends and family is not the option for that participant maybe they need to go by traditional provider. Which we provide credential very well.

>> AUDIENCE MEMBER: That's where the concern is, we don't have that in the rural areas.

>> SPEAKER: We have it, you can't see it I'm sure, my colleagues to the left have, providers in every county.

If we don't have a specific provider in a home base, we will have providers that will go across counties lines we have rural coverage we have coverage in every county with regard to friends and family A that's the participants discretion if they want to pick the friend and family member they have to follow the same credentialing process to make sure they say who they are, and the vehicle they say are providing if there's like a comfort level that doesn't exist with that vehicle or that prepare, you always have the ability to use our traditional trappings.

>> AUDIENCE MEMBER: So you're telling me as the consumer I have to be, as the consumer I have to be aerier that I am getting I'm choosing to get into this vehicle if there's something that happens is on the consumer's responsibility.

>> SPEAKER: Yeah. Yeah. Really. So -- again with that friend and family, you're making the choice, the participant is making the

class.

They don't have to make that choice they're choosing to make that choice to use a friend or family member they can opt to go bay one of our traditional means who are -- very credentialed there's a very extensive credentialing process that does, providers have to go through, not only, at our request through CTS's process those vehicles are inspected routinely physically and available lay inspected by CTS routinely there's always ray safe means to get the participant to and from their appointment if the participant chooses friends and family that's on you as as long as the friend is credentials Noel Neil we'll move on there are questions.

>> BARB POLZER: I'm going get in one in here, quarter off we open to additional questions, not related titration, we can also, raise your land.

Early on in the viable west the MCOs let the transportation brokers descried which trips counted as nonmedical leading to consumers getting denied for trips that should have been covered because the brokers did not understand that things like attending church or Board meeting are appropriate nonmedical trips. Ask all 3 MCOs confirm that it is the service coordinator, who approves the trips as part of the person centered planning process, that should have never been the broker s call, especially if they weren't fully informed what traps a consumer

should have access to.

>> SPEAKER: Always the service coordinator discretion with the writing PMC.

>> SPEAKER: With AmeriHealth Caritas it is always worked through the service coordinator or the personal care connector lines the broker never had that decision.

>> SPEAKER: Okay.

>> SPEAKER: What was happening in the southwest was with us in the beginning there has been, education, and information sharing with LT police as well as we have instituted this rach I had response team should there be issues with the specific individual's rides or concern that should be covered and is not covered, we ream we have encouraged folks to call our rapid response team and then, we're going to week with MTM to say yeah this is this is correct. There is on their plan there is -- a val valval I had ride. Neil Noel right back here.

>> SPEAKER: Liam Doughetr TJ Philly ADAPT I had a question.

So along the lines of the strip club.

[Laughter]

I was wondering if you ask speak to -- like the, um A sort of scarcity the -- like on the one land you need to have kind of this detailed robust person centered plan if the category is just entertainment who is to say that you would be given you know,

you were given however many rides without justification I was

wondering if you would speak to that I think it goes beyond strip clubs.

[laughter]

>> SPEAKER: It is a person centered plan. If you talk to your

service coordinator this is where you're at we're not trying to box you

into a medical box.

That's not our goal.

And I understand you want to be able to say hey I want to go to a

baseball game or I want to go to a football game that should be within

my rights to do that, if I have the -- the mean those do that.

But that has to be built into the service plan and in the sense that,

we talk to your service coordinator and say this is where this is how

I'm working.

This is what -- my goals are.

Socialization, is one of those things that helps us keep -- but it

is a part of your relationship with you're service coordinator making

sure that conversation happens, you don't have to tell them, okay.

Yeah. I need to go to -- this club every Tuesday because they have

great writings.

[laughter]

But at the same time, um A you can say.

[Wings]

You can say this is the plan I'm going to be going on, week by

week, build it into my plan.

>> SPEAKER: All you have to say is entertainment and

I have a suggestion for all of the you as far as the southeast goes uber provides more medically accessible

vehicles they have more wheelchair accessible vehicles.

>> SPEAKER: Vairs bay market there are non-in southwestern

Pennsylvania there may be some in --

>> AUDIENCE MEMBER: In southeast.

>> SPEAKER: Let me give you my response I hear very

clearly what the audience is saying.

I'm not participated to give you a response with regard the social

visits, but I will, I've taken very good notes I'll take that back.

Exclude with service coordination, so that we fully all as a group

understand what you're ask is and then, develop a response for that. That's

correct.

>> AUDIENCE MEMBER: My name is Lewis I'm the ADAPT of Philadelphia

I wanted to ask you a question, do any of you own a nursing home?

No one here owns a nursing leam. Or plan to get one?

[laughter]

>> SPEAKER: We own some,.

>> AUDIENCE MEMBER: Okay.

That's what I wanted to know. Thank you.

>> AUDIENCE MEMBER: Have you ever been in a taxi.

>> SPEAKER: Yes.

>> AUDIENCE MEMBER: Did you ever tell them you wanted to go to a strip club.

[laughter]

>> SPEAKER: Full disclosure, probably.

[laughter]

>> AUDIENCE MEMBER: Well --

>> SPEAKER: I don't dispute. Yeah.

>> AUDIENCE MEMBER: Okay.

>> SPEAKER: I don't disputed any of the asks I heard today I don't.

I just need to -- I need to share that with the team, at APLC health plan so we can -- you don't have to explain.

[upmc]

All -- all I will do is try this right back to the right people articulate you're urgency and, you're questioning we'll get a response that we can share with the group probably in the flex visit.

>> AUDIENCE MEMBER: Why are we different from you.

>> SPEAKER: You're not different from me, I fully acknowledge that.

>> SPEAKER: Zach Lewis disabled in action, so again, I'm still

confused why do we need the form -- or supports coordinator as to where
we need to go, like -- um, for example, when I get my trail pass or I
will see him for a scheduled visit or not a scheduled visit, he asked me
hey how are you doing, I'm good, are you using your trail pass or
getting out in the community.

Why isn't it -- why can't it just be limited to that, hey human zones
are you using in the stones 2-3 zones 4 or 5 times a week whatever the
situation may be.

What is wrong with that.

Like, it is -- too invasive as far as I'm concerned. My sports coordinator
the State doesn't need to know where rhyme going.

>> PAM AUER: Are you using the community? Supreme Court speak so
let me, let me try to make sure I'm clear, from our standpoint, from APM
C standpoint. You don't need to call coordinated transportation
solutions overtime you want to use your pass. The service coordinator
will enter into the service plan the need. So if the need is, unlimited,
five times -- every day, um, I'm using that as an example, that's
what will be entered into the service plan.

That's what will be articulated to coordinated transportation
solutions. Transportation solutions and their system, will see that
you have unlimited or you have five times a day, five times a week
whatever it is. Um, all you need to do is call and say rhyme ready to

go.

Schedule that with coordinated transportation solutions you're gone.

No one really will

well really care where you're going, it needs to be clear in the service

plan how often that transportation is rared for your social visits.

Does that make sense.

>> AUDIENCE MEMBER: Do you have a service plan? Do you have a

service plan?

>> SPEAKER: I do not.

Again I hear you loud and clear.

>> SPEAKER: Everybody is getting a trail pass for 30 days of

service that they go where they quantity.

And they're in the southeast portion of Pennsylvania. Flier going

to be hopping on the SA parks TA bus or CC traction.

>> SPEAKER: With regard to bus bass passes if we give you a

bus pass for a month shall you can use is it all day loaning. We don't

care you know, really where you're going.

Prosecute if it comes design to para-transit those vehicles have to

be scheduled just like me, if I need a vehicle I call and I schedule the

vehicle.

You're no different you'll -- call and schedule you're own vehicle

it happens to be articulated in your service plan, CTS knows about it, in your

system, the total number of

transports you're allowed via you're service plan you can use them as

freely as you wish.

>> SPEAKER: I hear you loud and clear.

>> SPEAKER: In the sewage west we deal with medical transportation

weigh deal logistic crier. Dottle let them know I need the ride taken

do I need to call them myself they don't need to pry service, I had to get

surgery, they told me I needed to find out whether I found out when my

scr surgical prior was I did that, we don't have any transportation

for you, they told know calling at a specific time it's at the end of

the dry you guys told me to call I called twice I called twice to find

out how to schedule the ride and when they told me how to do it I scald

the second time to get that done, they said we don't have anything for

you basically.

What am I supposed to do that with that.

>> SPEAKER: I can't la Graham

isfic care, I don't know -- no connection to what we care, they will

manage some transportation for you, far -- a reason ortolan you're

community health choices plan. So, the 2 don't match they don't we're

together. If you need, if you need to contact llagistic care. If you're community

HealthChoices

member under apmc health plan you need too deal with coordinated

transportation solutions we'll get you all the transportation you need.

Nothing to do with them whatsoever.

I know what they do, but I'm not sure how it comes into play with community health lices.

>> SPEAKER: What your experiencing is through MAA parks through the medical transport matp is part
of the medical transport options there are specific items what we ask if you need assistance with coordinating those you week together with your service coordinator for that, assistance, to help schedule or -- week
to get set up we know a lot of individuals right now that we,
week with in the southwest weren't registered didn't not fill out the paperwork for matp we helped work through the process, matp A, should be priding medical transportation if for some reason they're not able to that would come to us we would work with, our transportation providers to be able to help get you to and from your appointments.

So, I knee, I think, probably there might be some confusion when you say logistic care that's the provider for matp in certain counties.

>> BARB POLZER: Guys I'm sorry we have to wrap this up, thank you everyone for attending and the next meeting, will be November 7th the same place, thank you.

[meeting concluded]

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