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DATE: December 6, 2018

EVENT: Managed Long-Term Services and Supports Meeting

>> BARB POLZER: Good morning everyone we're going to get started.

We would like to start with introductions Linda, would you

please.

>> SPEAKER: Hello, Linda Littn participant advocate.

>> BARB POLZER: Board members on the phone?

>> SPEAKER: Ralph Trainer attendant care consumer.

>> SPEAKER: Brenda Dare, consumer.

>> SPEAKER: Good morning Neil Brady, health care

consultant.

>> BARB POLZER: Any other Board members?

>> SPEAKER: Terry is on, but he does not have a --

>> SPEAKER: I think Tanya is on.

>> SPEAKER: Okay.

>> BARB POLZER: Jim?

>> SPEAKER: Fred is just dialing in.

>> BARB POLZER: All right thank you.

Please bare with me while I go through the talking points and the emergency evacuation procedures.

Please keep language professional.

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

The transcripts and meeting documents are posted on the Listserv under MLTSS meeting minutes.

We normally post them within a few days of the meeting.

Captionist is documenting the discussion so please speak clearly and slowly and meeting is also recorded. The meeting is scheduled until 1:00 p.m., to comply with the logistic call agreements we will end promptly at that time.

If you have any questions or comments that were not heard, please send them to the resource account, at RA-PWCHC@pa.gov. For your reference the resource account is listed on the agenda.

The exit aisles may remain open please do not block them, turn off your cell phones, throw away your cups bottles and wrappers when you leave.

Public comments will be taken during presentations, instead of being heard just at the end of the meeting.

However, there will be an additional 15 minute period, at the end of the meeting for any additional comments.

The 2019 MLTSS sub-MAAC meeting dates are available on the Department of Human Services web site. And now, to the emergency evacuation procedures.

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

If you require assistance to evacuate, you must go to the safe area located right outside of the doors 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 honors suite or you're vacuated. Everyone must exit the building. Take your belongings with you. Do not operate your cell phones.

Do not try to use the elevators as they will be locked down. We will use stairwell one and two, to exit the building.

For one, exit honors suite through the main doors on almost side near the elevator. Turn right and go down the hallway by the water fountain. One is on the left.

For stairwell two, exit honors suite through the side doors on the right side of the door or back doors. For those exiting from the side doors, turn left and stairwell two is directly in front of you.

For those exiting from the back door exits turn left and then left again and stairwell two is directly ahead. Keep to the inside of the

stairwell, merge to the outside.

Turn left, and walk down Dewberry alley to Chestnut, tush

left to Fourth Street, turn left to black buyer I street cross Fourth

Street to the train station.

Moving on I'll hand it over to Kevin for the OLTL updates.

>> KEVIN HANCOCK: Good morning everyone, can everybody hear me?

Okay.

So -- for the people on the phone can you hear me?

>> SPEAKER: Yes.

>> SPEAKER: Yes.

>> KEVIN HANCOCK: Thank you. Okay.

Good. so --

>> FRED HESS: I can hear you Kevin.

[laughter]

>> KEVIN HANCOCK: I can definitely hear you Fred. I'm -- while

you're on the phone I'll turn the microphone off I'm not going to mute

the phone for the people who are on it.

So -- I'm going to go through where we're at with CHC right now

we'll start with the southeast implementation that's the focus currently

we'll be going live on January 1st.

Talking about enrollment plan selection.

Which mostly, will be about the numbers at this point.

Participant communication education and outreach, provider education outreach. Readiness review, which Randy will go through in careful detail.

Inest work adequacy which Randy will go through in careful detail as well, population identification, as well and then we'll go through some standard talking about the southwest as well we'll talk about the type of date, with the operations report, this the first time we'll give a holistic picture of how and what is happening in the southwest. N month actually, we're hoping if the committee agrees, to provide a pretty detailed quality update on the southwest. We have been, slowly starting to collect the data, it starting to ramp up and after the first year -- one year anniversary of the implementation of the southwest we want to present a picture for what is happening for the population in the new program.

So hopefully that will be of interest to people and have some attendance. Starting with the southeast plan selection population as many of you know last month, in November, we the actual enrollment prior to the auto assignment dates was completed but we are still in the party where people can change the managed care selections up until December 21st it will be effective for January 1, we're trying to get the word out to let people know they can change their plans up to December 21st and we're hoping

that people take advantage of that, if they have not been part of the enrollment today, the first slide which shows by population, we are on track to exceed, what we did in the southwest. And there is no one in this room, who is more shock the about this than I am to be pretty honest so the background in that, is the physical health choice programs has had a pretty high percentage of auto assignments compared to the rest of the state in the southeast and we're expecting that we would never come close to what we achieved in the south best because in the southwest if you remember we hit a national record for enrollment.

In the southeast, it looks like we're going break that record again.

For some reason, people, are engaged in enrollment at least, to the level where they can be, the percentage will sound comparatively low this is a really good number when it comes to a managed long-term services and supports program, all of you should be proud of what we're starting to see with people being engaged with enrollment. Stow still want it to be better we'll look for it to be better in the next few days . But we've, we've exceeded what we did in the southwest. At least it looks like we're on track to exceed it right now we're at 39 percent.

People with active plan selection. We ended the southwest with 40 percent.

So we still have a couple of weeks where people, when they make their changes will be making an active plan selection that will be

counted and, when that is counted it looks like we'll be exceeding that percentage that's a really good thing. In terms of break down of the population.

>> SPEAKER: Kevin it's -- it's not voluntary enrollment for the automatic or --

>> KEVIN HANCOCK: The 39 percent is, voluntary enrollment.

>> SPEAKER: Okay.

>> KEVIN HANCOCK: Which is in the south best if you remember, the to the al ended up being 40 percent. So, as I said the percentages sound low managed long-term services and supports programs historically have a low voluntary enrollment rate primarily because the vast majority of individuals are duly eligible for Medicare and Medicaid. Since their primary health payer is the Medicaid program they don't pay as much attention to the Medicaid program. It is just really hard to get, some of the duals to be engaged we're starting to see some success we're proud of that. In terms of break down of the population, NFI duals represented 53 percent of the total enrollments. Home and communitied duals represented 25 percent, HCBS non-duals 11 percent, long term are 9 percent, duly eligible individuals in the nursing facility and long-term care and non-duals are 1 percent, individuals in the nursing facility, the break down between the managed care, keystone first, this is actually, very similar to what we saw in the southwest

for distribution actually, little bit more closer together but, keystone first is at 49 percent.

That's the total distribution of the population, 26 percent for Pennsylvania health wellness and, 25 percent for UPMC.

And in the southeast you remember UPMC was then tightity with the most significant amount of enrollment. So moving onto plan selection by population.

This shows how they ended up, being assigned to an individual plan, 79,306 were part of the auto assignments, 19, 039 for by mail. And phone transactions 22, 165 and 9896 used web portal we would like to see more people use the web portal we worked with MAXIMUS, to improve how it is operating the distribution at this point, it skewed between the phone transactions and mail, and part of the auto assignment process.

Now moving onto the selection by plan this shows the break down I will not go through each one visitedly just highlighting the percentages,

61 percent at this point were part of the auto assignment process.

15 percent were part of mail or fox.

17 for phone transactions and, 8 percent for the web portal and then, you see the numbers in distribution.

Can we ask for the people on the phone if you could mute your phone if you are not speaking we would appreciate it very much. We're

getting feedback.

Okay.

For the individual plan selection over 60, Steve Touzell asks this question he is not here, the n time he asks this question, we will not have the data, to be able to provide it to him. We were trying to be proactive please everybody tell Steve when you see him, we had this data for him he is not here.

So -- this shows the distribution by individuals over the age of 60, keystone first at 37,804. Pennsylvania Health and Wellness, 20,020,647 what is important, particularly are visiteds receiving long term services and supports with this population.

The distribution we have a lot of HCBS will duals who are.

[20647]

Who are over the age of 60 as well as non-duals mostly individuals who are duly eligible and we have a much smaller number of individuals nursing facility who are dual or non-dual as part of the population as well this shows the break down over the age of 60 please remind Steve, once again we had it.

Okay so before we go onto anything else, does anyone have any questions about the numbers?

A lot of numbers we presented the same numbers a lot of different ways.

I'll say it again, this is good I mean we are actually, well ahead where we were in the southwest hopefully it will continue and we did beef up our communication we had a lot of support from a lot of entities. Including many individuals in this room to be able to help get this message out it showed some success we're very happy with it, we're looking forward to incorporating these same lessons learned for the rest of the State to be very honest, now we're starting to face implementation for 3 zones and, in 2019, it is going to be a bear, the next phase is going to be difficult, it is smaller population, covering a larger geographic area, we'll look for suggestions and help you may have to help us get the word out.

>> FRED HESS: They always say third phase is the charm.

[right]

>> SPEAKER: Could you go back a couple of slides, my concern is that, HBS non-duals I would like to kind of see how many of those guys where did they, how did they respond?

>> KEVIN HANCOCK: How do you mean?

>> SPEAKER: Did they do the automatic? The mail? The phone? Portal? I got it down as 11 percent.

>> KEVIN HANCOCK: We have the slide on slide 7.

>> SPEAKER: Can you repeat the question.

>> KEVIN HANCOCK: Sure the question is, the individuals who are HCBS

non-duals, I'm going to actually, paraphrase correct me if I'm wrong the reason why this population is particularly significant is because they're going to be receiving the physical health services want, they're long term services and supports via the community HealthChoices many of them are actually going to be required to make a plan change as well from a plan that is not participating in community HealthChoices there's a lot of change for this population and as noted here, that there were, the HCBS non-duals, this is over the age of 60.

So --

>> SPEAKER: One more back I wanted to get the total.

>> BARB POLZER: Could you use the mic please.

>> SPEAKER: Sure will.

>> KEVIN HANCOCK: Slide five actually.

My name is Lester Bennet.

>> KEVIN HANCOCK: You don't have to repeat the question.

>> SPEAKER: My thought process is, we since they, have to be the ones that are changing if we can kind of figure out how to respond so we can figure out, what would be the best way to communicate with them to make sure that we know what they're doing and they know what that you are doing.

So that's where my thought process was behind that.

>> KEVIN HANCOCK: Sounds good.

That total population is 14,472.

And distribution there were a lot of people auto assigned in that population, 7859.

>> SPEAKER: That's not good.

>> KEVIN HANCOCK: It isn't.

>> SPEAKER: They need to know what is going on.

>> KEVIN HANCOCK: They will already will know what is going on they received their post enrollment packet, hopefully if they were enrolled in a plan they didn't like they -- they will be able to make a change.

We're also sending out a postcard to everybody, not just to those individuals but to everybody to remind them of the it is 21st date. And, to let them know that, let them know they still, have a chance to make a plan change. So --

>> SPEAKER: Additionally would say for any of those, plans HealthChoices, previously the HealthChoices plans sent notification to any of their members, that would be need to move to a new plan and then, for those members that actually had to open authorizations for services for specific care coordination requirements, for the HealthChoices plans that may help some.

>> KEVIN HANCOCK: And the -- only thing I would add to that, would be that one plan actually in particular where this is, going to have to be a focus that's health partners, health partners had 3,000 individuals

who are going to be transitioning to community HealthChoices and you're

right they did send out notification toes th there. We would love for them to make an after plan

selection we tried to do as much as we could, to make sure this

population was highlighted this is valid to your point, this changes a

big deal for them.

>> SPEAKER: I have two quick questions Kevin for the next meeting,

is there any chance we can see a comparison between the southwest and

southeast numbers? To see what the improvement by a percentage?

>> KEVIN HANCOCK: I think that's a great idea, did you get that one

we'll do a comparison between the southwest and southeast, by that point

we'll be able to include all of the total population for up to December

21st.

>> SPEAKER: Great the second question for the, the postcard that

you're sending out, is the Commonwealth sending that or the IEB

sending that.

>> KEVIN HANCOCK: IEB is sending it.

>> SPEAKER: Okay.

Can we get a what that is going to look like beforehand? So we can

notify consumers.

>> KEVIN HANCOCK: Yeah. So what we'll do is, we'll, we'll send

you like a PDF version of it. Thanks for the suggestion.

We'll send to the entire committee and, through the committee you'll be able to Barb will get it, you'll be able to get it as well.

Okay grit any other questions about the numbers.

>> SPEAKER: So I just have to ask --

[laughter]

>> KEVIN HANCOCK: I don't have the answer.

[laughter]

>> KEVIN HANCOCK: We don't have the number yet.

>> SPEAKER: You know what I'm going to ask, do you know how many people chose LIFE versus one of these through options?

>> KEVIN HANCOCK: So, we don't know yet at this point. We look at LIFE enrollment for month-to-month and, we don't know what the impact is, at this point.

So -- I don't know, have you, Chris from your perspective have you heard a lot of people, asking about the LIFE program during the southeast or do you know?

Don't want you to put you on the spot.

>> SPEAKER: I don't know if we, yeah.

>> SPEAKER: We can't really validate the data,.

>> BARB POLZER: Can you use the mic.

>> KEVIN HANCOCK: No he doesn't have, they can't validate we don't have the data at this point, Jonathan and I were talking about this this

among we knew you were going ask this question Nina we don't have it yet we will in the next month's meeting.

>> SPEAKER: Okay thank you.

>> KEVIN HANCOCK: So, thank you.

>> SPEAKER: This is Ralph.

>> KEVIN HANCOCK: Hi Ralph.

>> SPEAKER: I would like to ask everyone there to give a round of applause for the efforts to get us where we are at.

[applause]

>> SPEAKER: Did a hell of a job.

>> KEVIN HANCOCK: Thanks Ralph really appreciate it. Thank you, too thanks for the leadership plus all of our stakeholders for helping us get this far a lot of credit goes to our partners in the stakeholder community.

Health law project gets a -- real shout out for helping get the message for training, aging well obviously was heavily engaged in this as a, vendor MAXIMUS gets a lot of credit for making a lot of fast improvements in the very short period of time that helped people to be able to search their network information and all of the stakeholders have been engaged in this, all of the service coordinators liberty community connections Philadelphia corporation for aging et cetera, et cetera so thank you all.

Thank you all.

Okay.

So we're going to move onto updates on participant communication.

As noted here, all of the, post enrollment packets have been mailed to the participants at this point they should have received them, we would love to hear feedback if they have not received them or if they're receiving information that is contrary to what they had selected as part of their plans. At this point I have not heard of any such cases, have you?

Okay.

But we, will keep our eyes open because we did have a few examples last year with the southwest. So -- it is something we'll pay attention to.

I already mentioned we'll be mailing the Soviet separate card reminding individuals of the December 21st date to make a plan changing to be effective on January 1st that is -- that is already in the works going out we'll make sure we share the version with the committee, Dan thank you again for the suggestion.

Mentioned that the health law project has been engaged in additional training it's really been focused with the service coordinators we talked about the issue with meaningful contact last month, it is an area

that had some degree of concern for me I have to say that, I continue to be served about the level of meaningful contact with service coordinators in the southeast. But, that additional training from the health law project had a number of attendees it helps them make a plan selection by December 21st we continue to reach out to service coordinators educate them on the importance of communicating this change to their participants we'll continue to do, all the way up until December 21st itself.

But, we have had such great engagement from some of our service coordinators in this process and we have not heard from others. So it has been a mixed bag.

And --

>> FRED HESS: Kevin? Speaking of service coordination, this is Fred, speaking of service coordination, I've been hearing a lot of issues from a whole lot of people about their service coordinators are way over extended and are not able to help the people that they're supposed to be helping. Some of these service coordinators when they first reach outed to me, 129 consumers, I think she is down to 78 which is a ridiculous number, so people are not gotting the service coordinator's full attention, is there any way we can -- become fix this?

>> KEVIN HANCOCK: So, Fred, the managed care organizations have

proposed case loads for service coordinators and if the managed care organizations are going outside of that, we will monitor that, that's a contract requirement.

We will Monday for it, they have to have reasonable case loads to be able to provide the attention you mentioned.

And support to the participants if it exceeding that point they can't provide the attention that is something that would be, that would be something that can be actionable from the agreement, from the agreement standpoint it's something we'll monitor the managed care organization should have to answer the question, and -- I encourage you to ask that question later on when the managed care organizations I think are going to be giving updates.

But, and talking about how they manage their case loads for service coordinators, that's an area where they will, they will be held accountable by the department but it is also an opportunity for the stake hold are group here to ask how they're planning to manage it. They should, they should be prepared to be able to speak about that, thank you for the question.

>> BARB POLZER: We have a request to go back to slide four.

>> KEVIN HANCOCK: Okay.

Slide four, okay.

Is there a particular question.

>> BARB POLZER: Just a request to review it quickly.

>> KEVIN HANCOCK: Okay.

So, slide four, highlighted by managed care organizations and by population category, the distribution of individuals who were enrolled in the southeast. 137406 I'll go through the totals again.

The UPMC, had 25 percent of the total distribution.

Pennsylvania health wellness had 26 percent and keystone first had 49 percent.

And the individual populations 69, 517 were duly eligible for Medicare and Medicaid but not in need of long-term services and supports.

33072 or 25 percent were duly eligible and in need of long-term services and supports and receiving that long-term services and supports, in the community, so they were HCBS duals.

11 percent, or 14,472 were receiving the long-term care in the community but we're not duly eligible for Medicare and Medicaid. 9 percent or 12,009 were in a nursing facility and duly eligible.

And, 1 percent, or 1,336 were receiving long-term care in a nursing facility were not duly eligible for Medicare and Medicaid. So -- okay.

So moving onto slide number 9, continuing with the participant education and outreach.

We've had, we completed the aging well sessions in October and there

were 72 sessions had occurred.

Those sessions did occur in English, Russian, Mandarin, Chinese, and Spanish and Cantonese, inside joke -- in last meeting I used the madarinian,s that not a word.

[laughter]

So I apologize publicly for embarrassing myself.

[laughter]

Service coordination outreach efforts we continue to work with service coordinators and at this point we've had 11,500 meaningful contacts if you look back at the numbers you have will have an opportunity to do that, we've 40,000 individuals receiving long-term care in the community in the southeast.

So, we are at a quarter of the population, two reasons first, it is quite possible that the meaningful contact has occurred and, has not been tracked in any of the systems where it's being tracked at this point, that's something that, hopefully we'll be updating in the weeks to come. Any other reason because it has not occurred that's an ongoing concern for the departments an for the program. Online participant training is currently in development at this point it will not be available for the southeast to roll out, it will be helpful and -- be used for roll out in the third phase, which is Lehigh capital northeast and northwest.

Additional population outreach we continue outreach efforts including ongoing training. And we're looking for any opportunity to do on gone training with any CHC audience that invites us. And we look for opportunities to be able to talk to individuals who would be enrolled in CHC working with community stakeholders to help us identify who they could be, we are -- continuing to work with community organizations city and state officials, health care advocates and senior housing community et cetera, et cetera to present on community HealthChoices and talk about the December 21st date we're not going to stop, until December 21st because we want people to pick their plan or at least let them decide to though if they choose not to make a plan change they can do so at any time and provide information about community HealthChoices an answer any one's questions we're looking for any opportunity to be able to do this, to do public relations via media such as radio or small ads we're planning to day public service announcement as well in the near future in Philadelphia to talk about the community HealthChoices we are looking for opportunities to be able to conduct round tables. We had a round table in the Latino community last night. Where Heather Hollman, Wilmarie Gonzales. I'll be doing one on December 10th another one is scheduled for December 17th, all talking to community leaders and community stakeholders, about the change with community HealthChoices, answer questions and provide

information they can take back to their communities to be able to answer questions as well.

Just going to state we're not going to stop communicating about the community HealthChoices in the southeast until, until the point where people will not be able to make their plan changes but we'll continue to look for every opportunity to talk about the program, in the southeast and the southwest for that matter for people to have their questions answered, and to understand what this change will be meaning for them. If you know of any opportunities please let us know we'll take those opportunities.

So it was requested for me to define meaningful contact. What that means is that, service coordinators actually have an inperson session with their participants to discuss community HealthChoices and to discuss advanced, or the plan, advanced plan selection and to walk them through what they need to do to make a plan choice.

And the service coordinators doing meaningful contact are tracking that in multiple systems aging well is working with us to be able to compile that information. And -- we're using it as a way to mass you're that, that -- type of person to person outreach.

[measure]

For individuals receiving long-term care in the community. Meaningful contact is direct contact with participants to talk about CHC

. So -- any other questions about the population out roach your feedback and your suggestions for going forward are very welcome.

Okay.

Then moving onto provider education, we continue email blasts on topics that are specific that will continue throughout the roll out of community HealthChoices and beyond.

We are looking for a training ongoing training opportunities with providers as well.

We constantly identify opportunities for training with particular types of providers, and we even had a session yesterday, that involved the managed care organizations and the brain injury community about questions and outstanding issues with billing, drew correct me if I'm wrong there are a lot of nuances that service fors the brain injury population are billed the purpose of yesterday's technical assistance session was to address outstanding issues look for opportunities to better standardize the way that billing can be achieved for the group. So that's just an example. But we're looking for every opportunity to do that. We met with nursing facilities a month ago to talk about specific populations such as individuals who are haven't dependent. We will look for every other opportunity to talk to providers about -- about their concerns, their questions and what we can do to make this transition as easy for them as

possible.

We continue to present to the hospitals and health systems, examples include the southeast system in Pennsylvania, looking for opportunities to educate hospitals they do have to pay attention to this, community HealthChoices, yes, it is likely true, that individuals receiving hospital services will have their primary payor be Medicare.

But, there's still the -- the deductibles, that exist in Medicare and the interaction between Medicare and Medicaid services are something that hospitals have to pay attention to, they do need to be engaged in this for their patience who come through their doors.

So, hospital and health system sorttion has been very helpful for us to be able to get the word out.

And, last but certainly not least, we had a transportation summit I'll talk about that later on, we had the summit in the southeast on November 16th we're trying to get ahead of the issues we experienced in the southwest, issues I understand are still there, although lessening.

But, we southeast has it's a different configuration especially with the SEPTA participating as well as a broker used for the medical assistance transportation program.

And we're looking forward to addressing issues or at least identifying issues, so that they could be resolved before implementation or as

least as quickly as possible during implementation there's no disruption of transportation services like we saw in the southeast, we're trying to get ahead of it as much as we could, we had pretty good dialogue on the 16th and, we're hoping that the managed care organizations their brokers, logistic care the MATP broker and other entities all, came away with at least a better understanding of better ways to communicate with each other. Which is, ultimately, the solution.

So with that anymore questions about the provider education?

>> SPEAKER: I had one Kevin any changes in education with nursing facilities compared to the southwest?

One thing that I have in mind it want a significant problem but there were some nursing facility that did not understand HealthChoices to community HealthChoices transition from HealthChoices members who had a change in their needs, entered a nursing facility they needed longer term needs and I think there's some issues where they continue to expect it to -- disenroll the fee for service and fee for service we learned about it, many months later, when they found they were not getting paid by fee for service.

>> KEVIN HANCOCK: So, that was identified as a problem that want the biggest problem we had with nursing facilities in the southeast it was not the nursing facilities that were having the problem, the problem was some managed care organizations on HealthChoices side doesn't

understand there was a change in the process where HealthChoices was going to continue to manage coordinate care for those individualses even after the 30 days if they were going to with long-term care eligibility.

We believe that, we've done a fairly decent job, communicating that there's still opportunities for improvement the problem you're specifically identifying about the fee for service transition or the change to community HealthChoices, is something that, is -- been communicated not only by the department, and the managed care organizations themselves but also, their associations and we're hoping that it will be better in the southeast fewer nursing facilities number one.

And lower, significantly lower nursing facilityity population so we think it should be more manageable to get ahead of the issues so hopefully not be much of an issue.

>> SPEAKER: Sure thank you.

>> KEVIN HANCOCK: Thank you.

Just to go back to the transportation summit I mentioned that it was, did occur on November 16th. PennDOT attended as well as aging, Department of Human Services, representatives across the Department of Human Services including our office of income maintenance, Office of Long Term Living, and other entities involved and the office of medical assistance programs.

It occurred after very significant weather event which was the irony we had a lot of transportation issues to be able to a it happened the session we, many of us were trying to catch a train we were not able to catch the train early they started without us it ended up being a really good conversation my biggest take away was the brokers were not talking to each other yet.

The 3 managed care organization brokers well, two -- and one and the, broker for logistic care, broker logistic care for the MATP program they had not met yet it was encouraged from that point forward they most and have conversations to work the whole thing out. Good dialogue learned a lot. Learned much about the how the transportation work is done with not only MATP and long-term services and sports but also with shared ride as well. And a lot of questions were answered.

And hopefully that dialogue will help prevent issues or at least get ahead of some issues going forward.

Good thing we're, we're going to look for other opportunities for that, that type of communication as well for similar types of issues.

With that, I'm going to turn it over to Randy Nolen who is going to walk us through readiness review and network adequacy in the southeast and then he is going to step into the southwest ongoing operations including walking us through corrective action plans in the data we're

collecting for monitoring reports. So thank you and randy.

>> FRED HESS: Thank you for update.

>> RANDY NOLEN: This is and oNolen from the Office of Long Term Living, good morning everyone.

Give you a little overview where we're at with readiness review in the southeast. All 36 the MCOs have submitted 1 percent the policies and procedures for review and they have been reviewed by the OLTL monitoring teams and the other subject matter experts, all the policies and procedures are in good shape at this point in time.

We continue to work on the biggest item which is the provider network.

We have MCOs submit a Ops5 report to the department every week they also submit a report to DOH, Department of Health, we meet weekly with the Department of Health, and go over these reports to monitor network adequacy.

On the physical health side, provider wise, all the networks are in pretty good shape.

What we're working towards is improving where we're at on the hospital side and nursing facility side.

So we'll talk a little bit more about that.

We does on site visits for all of the 3 MCOs. They went well and no major issues we walked through the systems person centered planning

process. Organization, how they're going it handle service coordination we walked through that whole scenario with them.

Everything went well with site visits. They continue to work on provider contracts, through the internal credentialing process. It is a little slow times that W* that, they're getting providers enrolled. The MCOs provided a lot of training with providers they did, two, 3 day sessions on InterRAI for service coordinators they have been doing claims testing with providers and nursing facilities providing HHA training and how to work with the MC ons a lot of, face-to-face training, and a lot of ongoing training that will be occurring.

Through webinars and things like that, they have been going through the process.

I said the biggest issue we're dealing with is the network adequacy.

On 3 faces we're looking at the e agrees within the CHC MCOs and behavioral health MCOs in the five county area in the southeast there are 3, behavioral health MCOs at this point in time, keystone first has an agreement with all five counties with the behavioral health MCOs, PHW has an agreement with four and they're working to finalize the contract in Montgomery County and UPMC has two done and working to finalize in bucks Montgomery and Philadelphia County we're continuing to work through that process. We're actually, well ahead

where we were last year we do not start get contracts finalized until aft beginning of the year with the behavioral healths MCOs in the southwest the MC, ons in the southeast have been more a lot more engaged they attended our provider meetings in June and have been more engaged with the process and working through that.

Second area we're working through is hospitals that number we're showing is 51 is actually 49.

Two of the hospitals on the list are actually not MA certified enrolled hospitals so out of the 49, keystone first is finalizing contracts with 26 of them.

PHW with 16, UPMC with 30 of them.

They continue to work with them, to got them contracted.

In our -- we have weekly meetings with each of the MCOs.

As follow-ups and the meetings this week have focused 100 percent on network adequacy. We walk through each individual hospital and each individual nursing facility I can get an update where they were at with contracting with them.

On the hospital side it is a lot of the bigger hospital chain, entities that they're working with.

Obviously with the Einstein situation, they're working through that.

Temple has been a little bit harder to negotiate I think for all 3 of the MCOs so we're working through some of the hospital, larger

hospital chains to get these done. The expectation is, in the next couple of weeks they will be done that will bring a lot more of the hospitals on Board because there's four or five under each of the umbrellas. So we're working through that part of the process with the hospitals. Nursing facility side we have a 153 nursing facilities in the southeast.

Which is, fairly comparable to what we had in the southwest.

In those counties so, with the nursing facilities at this time, keystone first finalizing contracts with 55. PHW with 80 and UPMC with 84 they are in the process of working with a lot of the larger entities out there.

Guardian is one of them.

Catholic health systems, guardian has probably, at least 12 facilities, Catholic health systems has six.

And, the Manor care has a number of them they're the larger entities trying to get the nursing facilities resolved we're trying to continue to work forward with that.

There's a couple of facilities we'll have to take a look at, one declined a contract. With Medicaid in general.

In looking at their population they have out of 45 residence, two of them are Medicaid. So we'll continue to Monday for those, and have their own network. We have one system right now of facilities I think

have 6 facilities are run by the MEMA corporation, we need to have further discussion with them they have concerns with part of the payment system especially on the side of it, we'll have some discussions with them, to see if we can get them moving forward and enrolled it's an ongoing process, the hospitals and nursing facilities the MCOs are working with them to get it done.

Any questions about readiness review or network adequacy at this time?

>> SPEAKER: So I'm not sure this is a readiness review question.

So you don't have to answer it if it's not?. Laughter]

But, can you just review with us or maybe Kevin, what the current plan is for switching over to the FED and maybe, what the, future role of the IEBs maybe, maybe Ginny could comment on that.

>> KEVIN HANCOCK: I better take this one Drew, so -- the plan if you remember, we delayed the implementation of the FED notary public April 1st that's still on track right now we're in the process of retesting it opening up additional training to make sure it is -- it's fully tracking to the definition of the nursing facilityity clinical eligibility that's all going well as well.

April 1st is the implementation date for the FED.

>> SPEAKER: Have there been any changes to the FED.

>> KEVIN HANCOCK: To my knowledge, not to my knowledge at

this point, we'll let you know if there are.

>> SPEAKER: And then, do you know how -- so, once that tool is used, will that change what the IEBs are doing in any way? Because they're going, I understand, to know no home visits in April. Just telephonic.

>> KEVIN HANCOCK: So, I didn't think that was true, actually. So, Ginny you may want to provide a little bit of clarification, just to talk about the update on the IEB if you remember earlier in 2018 we had to cancel the procurement for the independent enrollment broker and we decided to reenvision the process, which included a couple of different activities, one of which was a, vendor forum we had a number of entities about presenting to us different ideas on ways to improve enrollment services not the what the IEB does, but currently, but the broader question of long-term care enrollment which includes not only the, long-term care eligibility process but also the assessments, physician certification and financial eligibility plus, there's an navigation component that's been requested and part of it as well. There's also information referral for the many, many people who go through the process that do not and up being eligible for long-term care, for other types of services that may be available to them.

And there's just a general need that we're recognizing in the enrollment service system for better guidance so that's a current focus, build out an enrollment system that takes that into consideration, we

have to work hoping to have a procurement in place in 2019.

>> SPEAKER: In what year? 2019?

>> KEVIN HANCOCK: 2019.

>> SPEAKER: Next year.

>> KEVIN HANCOCK: Yes.

>> SPEAKER: What happens from April until then what will be the change in IEBs operate?

>> KEVIN HANCOCK: Currently the independent enrollment broker we're extending MAXIMUS's current operations, the independent enrollment broker until through that procurement time period MAXIMUS will be managing the way they are, Ginny do you want to highlight any changes we --

>> SPEAKER: I want to correct, MAXIMUS will continue through 2019.

2019.

Just a correction for 2019, actually 2020.

>> KEVIN HANCOCK: Procurement is in place, we're going to public, procurement vehicle in 2019 it will put in place in 2020.

>> SPEAKER:

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

>> KEVIN HANCOCK: Hold on we have not finished with drew's question.

>> SPEAKER: I'm trying to clarify, will, what the IEBs do change, once the FED is started?

>> AUDIENCE MEMBER: No, the only change --

>> KEVIN HANCOCK: Do you mind coming to the microphone.

>> SPEAKER: Only change there have been interest are faces built --

-- the interinterfaces have been dead once the FED is impresented the MAXIMUS and the system that is storing the FED will be able to communicate seamlessly, which should shorten the process, because -- of the time it takes just for the LCD to get picked and sent and whatnot that's only change, that will be there will be not change to whom visits throughout this year.

>> SPEAKER: They're still going to do home visits and still do the CMI.

>> SPEAKER: Yes.

>> SPEAKER: That will be communicated to the -- to the aging well person that goes out or --

>> SPEAKER: Aging well person that goes out be the FED and that, home visit occurs where the CMI would be done so the CMI information would be communicated.

>> SPEAKER: I see the CMI occurs after the FED.

>> SPEAKER: Yes.

>> SPEAKER: Got it.

>> SPEAKER: Okay.

>> SPEAKER: How does that then coordinator not, with the InterRAI

--

>> SPEAKER: CMI does not coordinate with the InterRAI, FED coordinates.

>> KEVIN HANCOCK: Actually being replaced by the InterRAI,.

>> SPEAKER: That's why it is still going to be done?

>> SPEAKER: In the non-CHC zones yes.

>> KEVIN HANCOCK: Yeah.

>> SPEAKER: Oh, okay.

So, there will be a change, in zone one and two.

>> SPEAKER: Yes in that the CMI will not be required --

>> SPEAKER: Not be done.

>> KEVIN HANCOCK: We can say right now that the, the managed care organizations are using their InterRAI home care now in addition to they're own questions and their own tools to develop the person centered service plan.

>> SPEAKER: But we would not require for -- to drew's point for lot two, for one CHC's transitioning we will not be requiring the CMI.

>> KEVIN HANCOCK: That's correct.

>> SPEAKER: So they're not doing the CMI what are they doing.

>> SPEAKER: They will still do the in-home visit and review the

package and advanced plan selection, advanced plan selection has not been made yet that will be covered during that time period. As well as any other questions or concerns about the application process.

>> SPEAKER: Mostly plan selection.

>> SPEAKER: Probably mostly they will move through the whole packet.

>> SPEAKER: Got it. Thank you.

>> KEVIN HANCOCK: Okay.

>> SPEAKER: Okay.

>> KEVIN HANCOCK: Brenda you had a question?

>> SPEAKER: Thank you I just noticed the third bullet on the readiness review slide, has to do with provide ares I was wondering if you could comment on the percentage the MLTSS providers that managed to contract already or if the people in the southwest region going to face a provide are shortage at all?

>> RANDY NOLEN: No, good question I do not have a percentage of how many we had some difficulty collecting the FTE data from providers, they are not real willing to -- I do know that, all of the MCOs they have contracted with most of the home maleth agencies and other LTSS providers out there I can have some more specific data for you --

>> SPEAKER: I much appreciate that. Thank you.

>> BARB POLZER: I have 3 questions that came through. Ready?

Questions related to the behavioral health MCOs has there

been an evaluation of their network capacity to handle the duals being

added?

>> RANDY NOLEN: Yes, actually the Department of Health has reached

out to the Office of Mental Health & Substance Abuse to talk to their

individuals that oversee the MCOs to take a look at their networks for

adequacy also, the Department of Health is working on that.

Right.

So the dual populations already been served in the behavioral health MCOs the new population is the aging waiver and nursing facilities

residence.

>> BARB POLZER: Well -- do the providers have expertise working

with aging population?

>> RANDY NOLEN: Um, I'm not sure, providers -- in general? Or.

>> KEVIN HANCOCK: We're assuming they mean behavioral health

providers.

>> KEVIN HANCOCK: Fair question.

We are assuming that is part of the, the behavioral health managed

care organizations, evaluation of the providers when they're building

out the network as to whether or not they understand the unique service

requirements for individuals who are over the age of 60, or visiteds in

nursing facilities that's a question we'll better be

answered by OMHSAS we'll be happy to ask them to provide a update on that evaluation.

[OMHSAS]

>> BARB POLZER: This is a long one, are the plans working to contract with the University of Pennsylvania hospital and provider system? Only PHW appears to currently have a contract with Penn yet it is a major provider in Philadelphia especially west Philly.

The concern is that people, who are non-duals and were auto assigned to UPMC or keystone will loose access to critical providers. This includes people in keystone's HealthChoices plan which appears to participate with Penn who are being auto assigned to keystone CHC which does not appear to include Penn.

>> RANDY NOLEN: I don't have that data with me, but we can certainly ask the plans that are sitting here with us.

Ray, where are you at with your contract with them.

>> SPEAKER: Yes. So, presently we have I believe, every hospital in Philadelphia, county with the exception of Penn so that is true we don't have Penn in network at this time we, continue to have a dialogue with them.

>> SPEAKER: This is Chris with the keystone first community HealthChoices, University of Pennsylvania we continue to engage in

conversations.

We do have there's a little bit of language that is going back and forth between the health system as well as the MCO we expect that to be closed, very soon and, finalized by the end of this year.

>> BARB POLZER: Thank you one last question, came through, Kevin could you summarize Jeanne's response, folks on the webinar could not hear it.

>> RANDY NOLEN: She did have a that on purpose.

>> KEVIN HANCOCK: I'll ask her to come back and summarize her own response.

Using the microphone.

>> SPEAKER: Basically --

>> RANDY NOLEN: Closer.

>> SPEAKER: FED is implemented in April -- the IEB will no longer do the CMI for lot two they will continue to do for lot 3.

Other than that the only change for the FED, being implement April 1 for the IEB is the interface that will allow the daily interchange with the information, does that cover it?

>> SPEAKER: Could you repeat the first part please. They could not -- they missed the very beginning.

>> SPEAKER: Very first party. Okay.

The April 1, when the FED is implemented?

The InterRAI will be used by the MCOs and the IEB will no longer need to use the CMI they will continue to use the CMI during the in-home visit for lot 3.

>> BARB POLZER: Thank you I'm not seeing a text pop up on my phone.

[laughter]

>> RANDY NOLEN: Okay.

Any other questions?

>> SPEAKER: This question is mainly for the MCOs.

I wanted to know where they stand -- with their connection to main line health.

Main line health hospital, Jefferson Lankenaue, those hospitals.

>> RANDY NOLEN: Ray and Chris who is here from keystone or AmeriHealth Caritas.

>> SPEAKER: So we are contracting with Jefferson and main line.

>> SPEAKER: And we're actually contract -- this is Norris with PHW we're contracting with main line health we're working on Jefferson and I think we're really close to having them, signed on Board with us.

>> SPEAKER: This is Chris, with keystone first.

We are contracted with both Jefferson main line health systems I want to go back to the University of Pennsylvania we have a verbal agreement with them, it's finalizing the language in addition I wanted to point out is, part of the agreement, there's a continuity of care

period for services.

So, on January 1, they will not loose access to those health systems as, they move into the community HealthChoices program.

Especially if they are a dual individual and they're following their Medicare primary or DSNP benefits as well. So just want to make sure that everyone understands that they will not loose access to those health systems on January 1st.

>> RANDY NOLEN: Okay thank you.

So we'll move into the southwest operations some updates in regards to the corrective action plan and the denial notices first thing I'll talk about the corrective action plan, we had put onto 3 MCOs with regard to the person services planning process they are all still, effectively, active in the CAP right now.

We continue to work with them, on their person centered care planning process.

We have met with all 3 of them we will have continuing meetings with them to review person centered service plans.

All of them have some issues center the around, the format, of the plan themselves.

But more importantly, centered around how the goals and objectives are being written.

So we continue to work with them on that, we have ongoing

meetings with them.

In an effort to ensure that these person centered care plans are written appropriately, so that, individuals know what their services are, know the reasoning for the services and that they have, measurable goals and objectives so the CAPH is still in place we'll continue to work with them, to improve this part of the process.

Now regards to the denial notices, we have worked extensively, providing a lot of technical assistance to all 3 plans, in regards to the non-notices at this point in time, UPMC has been giving the green light to utilize their denial notices we did that a month and a half ago I believe. So they're moving, have moved ahead with that.

Pennsylvania health wellness, we gave approval, last week, to utilize denial notices as most of you know they did send denial notices out that were not approved. There was 153 of them that were rescinded. About two months agoment.

In every one of those cases I have required them to do new assessments on the individuals to determine what their actual service needs are now so they're not basing any denial notices going on in the future on an assessment that was 3-4 months old so they're working through that process I would anticipate that we'll see, or you'll see some denial notices going out from PA health wellness also. We're working with AmeriHealth right now to finalize theirs.

They're being reviewed by me and Kevin and Jill and I'll have some feedback for them.

I would anticipate that within the next week or so, they will have the go ahead to use the denial notices.

Now, that being said, we will continue to monitor those denial notices, they are required to simultaneously seasoned them to the department when they're sending them out to the participants. So we will review them internally, if we find issues with them we'll ask them to correct the language in it, if we find major issues with them we'll ask them to rescind them again and redo them.

I'm hoping that as we move forward it might just be some language tweaks so that, things are clear and understandable for the participants but at this point in time, anticipation is that, these denial notices are going out and we'll work through the system with that.

They all have the appropriate appeal rights and hearing rights to them.

So that participants can follow-up with that part of the process also.

>> FRED HESS: I have a quick question, this is Fred Hess, do you have any consume ares helping you with the language issues on this?

>> RANDY NOLEN: Not at this time, we've been reviewing them internally we have in the past, but it is kind of more of an internal

review based upon the legal training we provided to each of the MCOs back in July.

So it is kind of where we're basing it off of at this point.

>> FRED HESS: Okay I was just wondering because, a lot of the language, I've been hearing a lot of complaints about the language that is going out there, that it is over educated it is difficult for people to understand things like this, I figured someone like say Drew Negele or someone with experience with people with traumatic brain injury or such, would be able to help clarify language a lot better.

>> RANDY NOLEN: Okay.

>> SPEAKER: If I could just add that, that is, sort of the also a next agenda item I guess be talking about it.

>> FRED HESS: Okay.

Okay.

>> RANDY NOLEN: Thanks Fred.

Also I have to tell you Fred I'm very honored because I'm sitting at the table with your place card in front of me.

[laughter]

>> FRED HESS: Ha-Ha.

You get to be Fred for a day how is that.

[laughter]

>> RANDY NOLEN: All right.

Okay.

Based upon that I lost my point in the PowerPoints here. Any questions about the denial notices?

>> BARB POLZER: One came through what's effective date for PHW being allowed to send notices what is the earliest mail date for PHW denial notices?

>> RANDY NOLEN: We gave them approval last week, so -- they can send them out at this point in time.

>> BARB POLZER: Thank you.

>> RANDY NOLEN: I you know I will ask PHW, Norris have you sent any out yet .

>> SPEAKER: I'm not sure I will get the answers.

>> RANDY NOLEN: Okay we'll check on that.

Okay the next thing we'll move into is some of the monitoring reports.

That were utilized in evaluating the program.

I'll try to make this as quick as and painless as possible which is probably not easy it's not been a, painless process to get these done.

The first one we'll talk about is the ops2 report monitoring participant outline call results.

As you can see from the data, the MCOs are required to having an 85 percent level, they're answering all the calls you see from the data on slide 18, by month it's a number of calls they have had and,

then, number of calls answered within 30 seconds. So -- for most part, they're all, they are all meeting that 85 percent level.

Moving forward we will monitor this, in the southeast we'll do it by this report.

We also will have a, what is called a launch indicator that will be monitoring the daily calls.

That will be in the southeast. We will also be monitoring daily calls, on the daily huddles we'll be having, reinstituting these this year, we're starting two days a week next week, having daily phone calls with all 3 MCOs they will increase to 3 days a week for the last two weeks of the month and beginning the week of the 31st they will be daily phone calls that we'll have and, part of that will be updating the phone call volume coming this with the participant hot line.

So, Ops2 is showing that the second part of ops2 report is, looking at abandonment rate by contract, it has to be less than five percent.

As you can see going across I think, for the most part it is, below 1 percent.

A little bit higher in a couple of the months but all within acceptable standards.

All right the next report, that we're look at is the centers around the complaints and grievances the OPS3 and 4 report.

The data we're collecting on that, is the number of complaints,

filed per ten thousand participants aces you can see the numbers we have for the first three-quarters fairly low for AmeriHealth, AmeriHealth has a process in place, that they try to handle a lot of the, potential complaints during the initial participant phone call.

And if they're satisfactorily able to do that, then they're not recording those as ongoing complaints.

And then you can see the other two MCO numbers are a little higher on the number of complaints coming in.

Ops4 is the same report, except it's looking at grievances.

As you can see through the, quarters, it shows the number of grievances coming in by participant filed per 1,000 participants the numbers are low based upon that population.

[10,000]

Then the other thing that we're collecting on this is the, complaint decisions in favor of the participant.

As you can see, some are in favor of the participants as you go across and some are in favor of the MCOs.

So this is a percentage, we're showing here that is in favor of the participant.

And then the next slide, shows the same thing and in regards to grievances that are, resolved in favor of the participant. And that's

after it goes to the internal process with the MCOs review.

The next report that we're looking at that we have information here we don't have information on, I'll walk through another one is the ops8 report.

We're looking to start that report, with appropriate data.

In January, the ops8 report will be the one that captures services that are not delivered.

Monthly report that will identify, all services that were not delivered for participants who utilize home health skilled care and home health aid services and pass, it will also identify nondeliverred or late trips for transportation.

So, ops8 that will be something we'll be reporting on in the future maybe not, in the January meeting but starting in the February meeting.

So we'll get that report to you.

The next one we're looking at is ops21.

That's the report talking about the changes in the person centered service plans.

From the slide we're taking a look at two things. The number or the percentage of plans that had increases in them and the percentage of plans that have decreases in them.

And at this point in time, the numbers are fairly low.

The biggest reason for that is, we were not allowing denial notices

to go out, so services were being continued as they were.

The anticipation is we will see some increase in these numbers especially in the second chart, the percent of plans that had decreases to them.

So, as we go through the next quarter of denial notices going out, the anticipation is that we will see some increase percentages in those numbers as we move forward.

A lot of, we made a lot of additional changes to the ops21 report, a lot of detail was added based on requests we've got, both through this committee and through other public resources, providers, advocate asking for different changes in different reports we looked at on Ops21 we implemented a number of things in this report to address those issues.

The second part of Ops21 takes a look at the percent of plans decreased due to the MCO decision, following a reassessment.

So we took a look at that, again these numbers are low.

And I mean they -- they, do look wonderful at this point in time you know, with caveat that the denial notices are going out, so there are going to be some up lift in these numbers as we move forward.

Slide 28 shows number of pass hours reduced due to the MCOs decisions decisions to reduce services as you can see, the only one that really has numbers in is UPMC.

They have been doing denial notices back since July.

These are the number of hours that were increased across the whole population.

So it is -- involves multiple people.

Slide 29 shows the amount of people that were affected by these decrease in hours.

So, it kind of shows how the plans were set up. And gives you a perspective on how many people were affected by the decrease in hours out of the total population.

This is a report that we'll be continuing to monitor. As you know, by agreement any decrease in services by a certain percentage we are also monitoring at the department level to see the reasoning behind it.

>> SPEAKER: Randy what was that percentage?

>> RANDY NOLEN: Percentage of?

>> SPEAKER: That you're -- you're monitoring? In other words, when do you get involved?

>> RANDY NOLEN: It is a cut decrease in 25 percent.

Of hours that we get involved.

Um, we are at this point we're monitoring all of them.

So we feel comfortable with what is going on with the person centered care planning process. So we're monitoring everything at this point.

>> SPEAKER: Randy, it is Denise Curry, Pennsylvania health

care do these numbers I guess, my question is, how does that correlate to the total population, like what does 15 mean versus, 5 from a percent of the population that they're covering and serving.

>> RANDY NOLEN: I don't know that we had the -- the total number of individuals on it I mean the 15 percents there was 15 individuals.

Out of the total population.

Do you have a total.

>> SPEAKER: I have the total I can look it up.

>> SPEAKER: So UPMC we're serving you know, about 7200 people on the home and community based services.

>> SPEAKER: Okay thank you.

>> RANDY NOLEN: So it is at this point it is a very small number I think these numbers will be affected also with the change of allowing them to have denial notices at this point. So -- anticipate over the next couple of months we'll see some increases in the numbers.

>> RANDY NOLEN: The other report we want to talk about is, QMUM7.

That's the actual denial log we're monitoring things through.

Again the same caveat these numbers are low because of the denial notice situation as you can see these are the numbers of denials, from prior authorizations, um, percentage wise, of all the cases that UPMC runs. That all 3 of the MCOs run so the percentages are fairly low at this point in time. We have changed a number of

things on the QMUM7 report we're collecting we separated the services out so we have a better idea of where the denials are. So we have separate tabs in this report now, for physical health office ises, home and community based services, dental services, transportation services.

So we have broken this report out that they will start reporting separately on all of those areas in their January report.

So we're able to give you a better understanding that on the side for dental requests, this is how many have come in, this is how many have been denied.

On this side of the transportation, this is where we're at.

What we did is we ran into problems when we tried to make it one report count all the denials together. Because on the dental side it is very difficult when you look at the denial notices when a prior authorization for dental comes in, it may have 15 lines on there, because the amount of, teeth that need to be worked on. And they may approach 14 of those 15 and then deny one. And then we were counting that as a denial, in reality 14 of the 15 services were provided.

So we broke that out into separate tab we collect the date better it will be more relevant to what was occurring and be more understandable.

So we made those changes to QMUM7 that will go in he fact in the January reporting period.

>> SPEAKER: I wanted to add that, PHW has started sending out denial letters.

>> RANDY NOLEN: Okay thank you.

>> RANDY NOLEN: Okay.

Any -- she has the phone up she has the questions up -- do you want --

>> SPEAKER: So two quick questions. The slide that has the reduction for pass hours, we know in the southwest that the authorization frequencies have changed like traditionally now they're for fee for service through annual are those hours based off the term of the authorization or, are they calculated for the annual or are they daily? What is the total number equating to.

>> RANDY NOLEN: Number of hours were actually decreased report actual hours in the plan if someone was originally getting, 35 hours they were decreased to five throughout the life of their authorization, whether it's 6 months or a year we counted that as a five hour decrease.

>> SPEAKER: Then for the 25 percent look, the State is looking at anything is a reduction of 25 percent or more.

>> RANDY NOLEN: Yes.

>> SPEAKER: How does it factor into the change how these authorizations are going to -- the authorizations can vary now to what they are today.

>> RANDY NOLEN: When we take a look back at the cases we'll be looking for the relevance of that type of reduction in hours we'll be looking at the person centered care plan, we're going to be looking at the InterRAI and assessments the MCOs did so that we have the adjustification from the MCOs why there was a decrease in hours.

>> SPEAKER: Okay thank you.

>> RANDY NOLEN: Okay.

>> BARB POLZER: We might have to get more clarification on this one. Any idea why PHW call per 1,000 volume is higher.

I'm not sure.

>> KEVIN HANCOCK: Hot line call.

>> RANDY NOLEN: Participant hot line calls, the hot line calls we have seen spikes up and down, depending upon the communications that the MCO is sending out.

In the beginning of the year in January, and February, UPMC's call volume was high with the issues with the ID cards and mailings they were doing.

So we see some fluctuations based upon that.

I think, maybe part of the problem with PHW is them being a new plan in Pennsylvania participants need more explanation on things they were doing I'm not sure if any other trend except the fact that sometimes when mailings go out, people have a lot

of questions.

>> BARB POLZER: Okay can you --

>> SPEAKER: Randy this is Tanya I have a question.

When you have time to get to it, regarding service hour reductions versus like new services being implemented.

How have, how have the two affected each other so far? If a person is chosen to go with the different types of service is now offered under the service plan like you know the different services we know are offered how is it working versus getting a reduction in personal assistant hours.

>> RANDY NOLEN: I think we're seeing reductions in personal assistance hours for two reasons. One the plan initially might have been over inflated. Based upon the new assessments that were to be for the individuals might have been improvement in the individual situation.

There's been some reduction in hours.

I think the secondary reason is that as you said there's more availability at different services. So that's something that we're taking a look at in the past it was only service, a lot of the waivers were we were praying is the pass services now there are some alternatives there are some alternatives like adult day care and may be the reduction in pass hours you're seeing it reductions on both ends for that.

>> SPEAKER: Do we have any inclination if the new services, are working better than the -- past services would have or don't, too early, or is it too early to tell that yet.

>> RANDY NOLEN: Yes, I think it's too early to tell that yet of how many people are switching over to adult day care or, some other issues. So I think it is.

>> SPEAKER: When do you think you'll be able to tell how that is working out that would be an interesting trend to get some feedback with you.

>> RANDY NOLEN: I agree with you on that, it's something we'll continue to look at and talk to the plans as their switching services out to monitor seeing how they're doing, that's something we can do certainly.

>> SPEAKER: Okay.

>> RANDY NOLEN: Much thanks.

>> BARB POLZER: Can you say more about the very low percentage of the complaints filed with AAHC I'm concerned that complaints are not being resolved by phone but participants are being discouraged from filing the format complaints.

>> RANDY NOLEN: We had the same concern, with the low numbers with AmeriHealth in our conversations with them, they presented a policy and a process they go through, in an attempt to resolve any issues that

occur via the participant call when they call in.

So, they will work through that call with them, if they have to, they can get service coordinators on the line they if there's an issue surrounding say there's an issue surrounding something with the physician's office either the waiting time for the appointment was too long or obnoxious staff member that was rude to them -- they're trying to work through that with the first call either by connecting them and talking back to the doctor's office at the same time they have a more, intense process in place in trying to resolve issues before they go into a actual full complaint process.

>> BARB POLZER: Question on ops021UUPMC has been authorized to issue reductions and denials since September but the reports indicate, reductions as far back as June and July the slides moved forward I can't remember the months, how is it these reductions were taking place?

>> RANDY NOLEN: Some of is potentially new recipients.

Could have been for non-MLTSS services or change in services.

There's a -- Kevin was saying there's a number of reasons could have been a change trigger event that changed the conditions, changed the hours that individual needed.

As far as that goes, there might have been, some other related services also under that.

>> BARB POLZER: Last question I don't know we might need more clarification here. Can we go back to slide about hours reduced.

I'm not sure if someone just needs to see the slides or a request regarding the slide.

>> RANDY NOLEN: Hours reduced I think that's 28.

>> SPEAKER: Yep that's the one.

>> SPEAKER: Number 28.

>> RANDY NOLEN: Slide 28 those hours reduced on the plans.

This is the, total number of hours that were reduced out of the hours that were provided.

And, maybe what we can do to try to make this a little more understandable, is in our next submission of the data, we can also, have the total number of hours, that the plans, approve so we can try to work through that.

>> SPEAKER: That's one of the enhancements we'll make to the report.

>> RANDY NOLEN: Okay.

So it is -- talking with Pat Brady that's an enhancement we can make to the report you can see, it looks like say in October UPMC is reduced hours by 3768.

In reality, that's probably less than 1 percent of the number of hours, that they actually provided.

So we will make sure that's clear in the future so these numbers

don't look kind of daunting here at this point in time you'll have some reference.

>> BARB POLZER: That's it from the phone.

>> RANDY NOLEN: Okay.

>> BARB POLZER: Anymore questions for Randy or Kevin.

>> SPEAKER: I -- I think it was Tanya's request, it would be great if we can see some data on reductions PAS and, if there were services that were added I don't know if we'll know effectiveness of this, we'll have data about where the services were added and when others were reduced that might be meaningful-

>> RANDY NOLEN: I agree with you, we'll look at that.

>> KEVIN HANCOCK: So can I characterize it a different way. Ask it in a different way you want to know, detail on service plan changes, and not just, reductions but just a general scene of what is happening with service plans changing if there's a trend in certain types of services replacing other types of services and how, ultimately that it is affecting the person's care.

>> SPEAKER: I like the way of looking at it, yes.

[laughter]

>> RANDY NOLEN: Okay.

All right.

>> KEVIN HANCOCK: Great job.

>> RANDY NOLEN: The next area we'll pull up on the screen is the contact information for the 3 MCOs.

I think that's, the update that the department has for you.

>> BARB POLZER: Comment I've been working in this area with department for 35 years. I've never seen this level of transparency and public sharing of information. My congratulations to all of you have been working so hard to make community HealthChoices a success.

>> RANDY NOLEN: Thank you we really appreciate that I've been with the State for 25 years and with the county for 11 years before that I've never seen the amount of work and transparency and, the input we've gotten from all of the stakeholders involved it has been a great process to work through.

I would also like to publicly acknowledge, Kevin apologizing to me admitting he was wrong to me earlier I know that hurt him grittily.

greatly.

[Laughter]

>> BARB POLZER: Thank you Kevin and Randy we'll hear from aging with and max MAXIMUS, and 3 MCOs they will discuss how to meeting with the communication requirements for the southeast implementation we'll hear from aging well first?

>> SPEAKER: Good morning.

Good morning, I had to take the long way around so I can get the cramps out of my legs I apologize.

We're going to go through these slides pretty quickly if that's ok.

My name is Brad Levan senior project manager for aging well.

I'm a person with severe borderline on profound hearing loss so I have a particular interest in communication issues.

And I'm happy to be here today, to be able to talk about them.

What I'm going to touch on today is, what aging well's role is in this the process, how we're structured to fill that role and how we're going to address issues of accommodation resulted to communication.

Our task is perform the functional eligibility determination it's a much more lip itsed role than the other players in CHC that doesn't mean it's not important, if you don't have eligibility there's no place to start.

But it is a fairly limited role.

Currently we have contracts with 52 area agencies on aging.

And they will be providing assessors for us, approximately 1200 assessors across the Commonwealth that will be working with us.

We have been training those assessors, to use the new FED tool, when it comes into play on April 1st.

These assessors are currently doing a level of care determinations they have completed the training that PDA required for them to be able

to do level of care determinations.

Offer sight for these assessors comes from four quality compliance and supports specialists and my.

Each of them are assigned to specific AAAs it's our job to monitor how well the assessors are doing their work.

Our work begins with when we receive a request from the assessment.

Request can come from the IEB or through the AAA.

However before the assessment can occur it has to be scheduled.

And I mean that's a very, realistic practicality.

It is the time of scheduling when we're asking, if the accommodations are needed.

We may get information from the IEBs accommodations are needed.

We still have to schedule in that schedule we're going to follow-up to make sure we understand what those accommodation Medes are.

Very simile when we find out the accommodations are needed we'll arrange to provide them, much as the AAAs have been doing with assessment processes they have been using offer the years.

We know, from experience, that some times accommodation needs are not known until you're actually at the assessment visit.

When that occurs should it occur, the assessment won't go forward until until those accommodations can be made we'll reschedule it, make

sure the accommodations are in place.

So there's no sense in trying to go through an assessment, if people don't understand what is taking place.

We also know that communication is a two way process, people not only need to understand they need to be understood.

Our grant agreement with DHS requires that we provide ongoing training to our assessors. We have been developing that training and and providing training as we go along we're going to be providing training that addresses areas such as certain certaintied approach during assessment.

Cognitive impairments and other types of relevant training.

I have to say that, person centered approach, in assessment is one that people question, they say what are you talking about?

We understand person centered planning how can that be part of the assessment.

The reality is you're going into someone's home you're not there, as the inquisition you're there to try to get information to help make a functional eligibility determination.

In doing that we want to make sure that our assessors are sensitive to the needs that people have, as they go through that process.

I don't know how many people in this room, have gone through an assessment process, but if you have, you can understand pretty quickly

that sometimes the way the assessment is done, is more I don't want to say troubling but is more you remember it more than the actual assessment itself. In terms of how sensitive people are in terms of the way they ask what they ask and in terms of the way they interact with you.

I'm a realist, and I know that there's going to be times when our assessors will fall short.

And if this happens, we're going to work to correct that.

What you will find, is that we'll be open minded about the issues and concerns that people have.

We'll be approachable, and, we'll be a collaborative partner in addressing short comings. It will be foolish for aging well to think that we're going to know every situation we're going to run into ahead of time. We're simply not.

But when we do run into situations that we're not sure how to proceed we'll be reaching out to people who do know how to proceed, to get their input.

I don't have a whole lot more I can tell you right now, in terms of how we intend to address communication issues other than to say that, when we know accommodations are going to be needed, we, intend to provide them.

Because of my hearing loss you can reach me better at my email

address I don't do real well on telephones.

My wife will tell you when she and I talk on the phone I usually end up going to a different place than where I'm supposed to. Because I don't understand what she is saying. Do you have any questions or concerns I might be able to address while I'm here?

>> SPEAKER: This is Fred Hess I have a quick one.

When you're doing person centered approach to this, um, are you guys taking into account the John may take ten minutes, to go to the bathroom, but, Larry over here might take 20 or 30 minutes because of his different situation?

>> SPEAKER: Absolutely I think that's one of the things that a good assessor has to do, they have to understand this is a dialogue with someone, and, you can't have a dialogue with someone if they have other things taking place.

>> FRED HESS: Exactly.

And because one of the points I'm trying to make is I don't have a person like me strictly a paraplegic fairly decent upper body strength the difference between him and me going to the bathroom will be a matter of ten minutes per time. You know what I'm saying. And -- with the with the system it is put out there, okay, everybody gets ten minutes for this.

I know the service coordinators can adjust that around a little bit.

But I think they need to have a little bit more leeway than what they have been giving now.

It is just personal opinion and I have seen a lot of people going yeah I can't do that in that time I can't do it in that time. They're going well, that's the maximum we can give you there's got to be more flexibility to that, there shouldn't be a minimum or a maximum period.

>> SPEAKER: Fred we're not looking at any time limitations on how long assessment takes we're fully aware that we may in fact, run into situations where we have to come back multiple times to finish the assessment.

We --

>> FRED HESS: No I'm not talking about, I'm not talking about the assessment time I'm talking about bathing time, toileting time there's a -- a minimum and a maximum that the service coordinators are allowed to put out there.

There should not be a minimum and maximum for anything that is going on during the assessment for bathing personal care or, you know, anything.

>> SPEAKER: I agree I agree.

>> SPEAKER: When you get a second I have a question.

>> BARB POLZER: Go ahead Tanya.

>> SPEAKER: Well I understand that they have like times set up I think we agree with Fred, there should be no minimum or maximum time because, you never know, what the individual situation is.

Like, um, I can bring up my own personal stuff right now I'm not going to.

What I'm saying is, when someone needs their time to do something, that is when they need documentation from a PCP or a physical assessment or someone that knows your client and knows their needs and can help make a better assessment for that individual. It is time to revisit that issue of how documentation can help like and why it should be necessary.

It should be necessary, because the medical necessity for something, assessment tool should not be able to argue with that.

Does everybody get my point from that.

>> SPEAKER: I'm not sure I do.

And the reason I'm not sure I do is I'm doing assessment as a, a process different than supports people may need during the assessment process.

Our view is, whatever supports people need, during the assessment process we'll wait until their available we'll make sure that the assessment doesn't occur until those supports are there.

>> SPEAKER: It is not just about being assessment process, when I

think back what Fred means it is about that individual's every day life.

What, what materials would an individual need to supply to a service coordinator that is only been trained on these assessments, and not on the individual that they're working with, for the individual to be able to say okay.

Your assessment tool may read this is a maximum time allowed for a certain activity, what documentation would that individual need to say even though your assessment tool reads this way, I need more time because of XYZ issues.

How is that individual supposed to get that through the person making the assessment?

>> SPEAKER: Okay I understand your question better now. Thank you. The assessment.

>> SPEAKER: You're welcome.

>> SPEAKER: -- the assessment we're doing is the initial assessment. Abbreviated version of the InterRAI, what we're doing is isn't going to be look at those kind of issues that will occur after the individual has been deemed as NFCE or NFI if they become part of the CHC, they will have the full InterRAI assessment done, which is something we have no part of. We're only doing that first piece, the entry level piece which is, the eligibility piece are you eligible or not.

>> SPEAKER: If I could ask a question please.

Is there a on the FED, are you able to put the amount of time that particular activity takes on that FED or is there a limit on the FED.

If someone has toileting and it takes them ten minutes and another person takes 30 minutes, do you identify 30 minutes or, is there just -- um, a max number for that particular activity.

>> SPEAKER: The way that --

>> FRED HESS: Could someone repeat the question I could not hear her or understand her.

>> SPEAKER: I'm sorry Fred.

I can speak louder most definitely.

If what I'm asking is, is there an opportunity on that FED to put down these specific time that activity takes you?

So, you may take ten minutes to toilet I may take 20 minutes, is there an opportunity to have very clear information, that the consumer or, someone acting on their behalf is providing to you that fully describes gives you a picture what that person's needs are during the assessment process and, my second question is, um, person centered assessments, what is different, now, than it was before, in regard to the, person centered assessment?

>> SPEAKER: Um let me take the first one first.

Kevin said earlier the FED the instrument in itself is the process of undergoing another review.

I know one of the changes that we've talked about is making sure there are comment fields in the tools so that, assessors can make those kind of comments when they observe something that they think, we need to note this, we need to document that.

And that's something that has been added as we recognize the situations are different.

Yes we will have the capacity to make those kinds of notes during the assessment.

One of the things that is different in terms of the person centered approach I need to be very frank about this there's a shift of the transition, that assessors have to go through depending upon the population they're assessing.

For example, Fred if I can use you for an example.

>> FRED HESS: Absolutely.

>> SPEAKER: Your disability doesn't mean you're sick or ill it just means that, your body will not do some things other people's bodies will. Yet there are assessors who have been trained, and what they think is, I need to look at the underlying illness.

My hearing loss has no underlying illness and I don't want people thinking I'm sick I don't want them asking questions or treating me like

I'm sick.

I want them to recognize the difference.

However, if you look at the over 90 years of age population,

every functional issues they have is related it a health issue. Part

of the a person centered approach is helping assessors differentiate, in

terms of what they're looking at.

We're not, treating people with disabilities as if the

disability is ash illness that would not be a person centered approach

we want people to be able to interact with the individual their

assessing and their specific situation.

It is not a cookie cutter approach.

I'm probably going to regret saying this but, Kevin will tell me if

I made the mistake or not -- there have been some people early on in the

process I don't agree with this, they said a trained monkey can do a

assessment with the FED. No. That's not the case.

It is not the case at all.

>> KEVIN HANCOCK: I don't think I would disagree with that

statement.

I don't think I would disagree with that statement no. The FED

is actually like -- the difference the LCD and FED are pretty

significantly different tools.

The LCD it's been around for a long time, it is very long and goes

into different features don't really have anything to do with our definition our regulatory definition for nursing facility clinical eligibility.

We're designing the FED, the FED has been designed at least the component of the FED that is, is going to be focus on making sure a person meets the regulatory definition of nursing facility clinical eligibility it's quick it's clear and it is subjective, because it will, the assessors will be trained to be able to look for nuance individual based Nuances on their particular condition that would effect their eligibility it's meant to be a better experience for participants to go through the eligibility process.

>> SPEAKER: Along those same lines, what's the interrater reliability, since you have 1200 assessors?

>> KEVIN HANCOCK: So that, I mean, it hasn't been tested yet obviously it is fully implemented what we're using, as part of the, evaluation, is to determine, when you talk about interrater reliability about the FED we're comparing with the LCD, just the FED.

I don't know, do we know the data for interrater reliability for the FED at this point.

>> SPEAKER: No.

>> KEVIN HANCOCK: It's not been implemented it's hard to make the assumption we have to, we did do a interrater reliability evaluation

for the level care determination tool and there was, some variances depending upon which part of the state the individual is, in is part the impotece for going with it any way. One of our goals in addition to improved participant experience and the process has improved the interrater reliability we'll be reviewing it, it is early to advance it
. That's a good question.

>> SPEAKER: We'll be monitoring looking for discrepancies between different organizations as one organization tending to produce more one outcome than another within the organization, are there assessors that seem to be producing different types of outcomes than the others.

I do want to go back to your comment, the question about the person centered approach.

Part of what I mean by person centered approach and the assessment is, if we got someone who will do a function better with the assessment if they have family members there, fine. Then we're going to have family members there.

The rule had been with the level of care determination that you needed to do an assessment with the person alone.

That's, doesn't work for everybody.

And there are some individuals I know this is crazy, my brother will do much better with an assessment if his dog is there. So when I talk about a person centered approach I'm talking about training assessors to

be responsive to what the individual needs to be able to participate in that process forward.

>> SPEAKER: So as part of the LIFE programs we do a very similar assessment when FED or the level of care determination is done. Many times my coordinators are in the home at the same time the assessor from AAA is in there, so we don't have to have that participant repeat all of the same questions.

So, is it going to be a problem one, if my coordinators want to be there? Um, it has not been a problem, until now, and two, what if we find an issue, some people from the AAs be competency I can tell you in the 3 counties my program serves from January July July of this year I was actually doing the enrollments and assessments and I found huge discrepancy says with people from the AAAs I understand, it is an issue, some of them I thought, okay.

I have to walk you through how -- I was teaching them how to do the assessment they were like can you help me? I don't know how to ask this person this question. This is kind of scary.

So, I'm happy that these people, are all going to be retrained, but what happens when we find, like who do we go to when we find the issues, AAA or you?

>> SPEAKER: You know that's one of the reasons I gave you my

personal email address.

>> SPEAKER: Maybe it will not happen.

>> SPEAKER: I'm the person who is ultimately responsible for making sure that our assessors are doing what they're supposed to be doing.

As I said every one of the counties that you serve has someone assigned to it.

And once we know there's an issue, that person who is assigned to it, is going to get to the bottom with that issue is, so we can resolve it.

It makes, no sense, for me to believe, that this is not going happen.

It is and, when it does, what I want people to know is that, we're very committed to making sure that we can fix those things, so that people get, accurate timely assessments.

I can tell you that the aging well Board is very committed to that principle part what we're doing is because, we believe, it is important for people to have, accurate timely assessment so they can get services and supports that they need.

And that's part of the commitment that the Board has made and part of their mission statement.

>> KEVIN HANCOCK: Part of your question was whether or not you had an issue, whether or not aging well or even the department would have an issue with the LIFE plans participating in the assessment my assumption

as long as it is okay with the participant it would be no.

>> SPEAKER: Yeah.

>> SPEAKER: Thank you speak.

>> FRED HESS: This is Fred real quick. Do you have any indication of times, what is the average time, that you do your assessment? To where they get the services.

>> SPEAKER: From when the assessment is completed until services start?

>> FRED HESS: Yes.

>> SPEAKER: Okay.

That depends. It has to go through a process that is well beyond what aging well is involved Kevin is --

>> KEVIN HANCOCK: I'll have to take this question, thanks Brad for trying.

[laughter]

So, Fred we don't have good data on this, this is an area where we struggle to try to figure out how to measure, because of the fact that, the -- once a person is determined to be eligible, there's so much variability in the service planning, one thing we're correcting with Ccommunity HealthChoices is that in the fee for service world or the legacy world as it exists this is very much variability from the point of eligibility to the point of service implementation, that has been

always a real struggle for us to be able to provide that question accurately from the point of assessment to the point of this

the onset of services it is a real struggle for us.

The answer to your question is.

>> FRED HESS: I don't need an exact number of days just a rough

guess,

>> KEVIN HANCOCK: We can't even do that Fred.

CHC we'll be able to do it it's a contract standard it is one of the

areas we've been trying to -- to correct.

With moving into managed care in the fee for service world it's

just, is too much variability we've not been able to capture it, we've

also struggled with, some of our case management systems as well

being able to help us track it. We have some, variability in the

way that service start date actually is captured, in some of our case

management systems we can't, give you even accurate guess.

>> FRED HESS: Okay.

If we could get those average in the near future, I would greatly

appreciate it, I'm sure I'm not the only one I'm certain there are a lot

of people that would greatly appreciate it, they can figure out roughly,

you know, what to tell people, that oh your services will start in ten

minutes, six months, it took me 8 months to get my services started.

So -- you know I'm hoping that we're doing a lot better than 8 months,

intervals.

>> KEVIN HANCOCK: I do too.

We can, we can definitely provide with community HealthChoices.

>> SPEAKER: Fred one of the things I can speak to, is the reality that Kevin suggesting that we simply don't know now I can tell you this that when I say we're committed to accurate timely assessments I'm talking very specifically about our ability to get the request for assessment to get the assessments scheduled to set it up, to conduct the assessment and then to pass it on we're going to do that in the most efficient ways we can.

I want to give you two examples what we're doing.

Um, we're working with all of our AAAs around the operational plans and taking a look at the internal processes to sigh, what is working what is not working how they can make improvements on it.

One example that, that really struck me is -- a AAA using the system, where -- it was automated the next person to be assessed, was coupled with the next assessor, who is open.

And, you just had to do that the next person up is, who you get who you do.

What they realized is they have people who are driving 40 miles in different directions between assessment.

They made a very simple change which is now they have a pool of here

are the next 15 that need to be done picked ones you want to do.

And while you might think that would create chaos, it is important to remember, that within chaos, there's always self organization and low and behold the assessors started talking to each other and saying well wait a minute you have to pick up your kid at day care this is close where the day care center is, why don't you take these 3, bottom line is if they cut down on the number of days, that it took to get the whole assessment process finished.

And we're very committed to doing that type of work with our AAAs.

Fred

>> FRED HESS: I'll have to say thank you for that, it's good to know something like that is going on out there, they're talking to each other trying to get it straightened out fantastic, that's fantastic that much you.

>> SPEAKER: Brad thank you for your very thoughtful presentation. And the approach you're trying to give with the assessors, it's an awesome job that you have, to train 1200 people, on that approach.

And, I think that is 1200 people who actually, turn over fairly regularly, if I remember the typical tenure of a AAA assessor of 2-3 years it's going to be an ongoing job to train these folks as well.

>> SPEAKER: Absolutely.

>> SPEAKER: I want to ask a question give a little more context to

how this topic even came up. Because Pennsylvania health law project is getting you know, feedback from individuals about -- um, throughout the entire process, of CHC of, um, perhaps, people not, knowing or understanding, what a person's preference is for communication are.

And so that's why this topic came up.

I think it is important that we address the topic both from the, perspective of the very first call perhaps to a MAXIMUS call center then to a MAXIMUS IEB then to the AAA assessor, and then, to the CHC service coordinator and possibly a care manager as to exactly, how the assessment for communication preference is asked, you say it's asked in your case in the scheduling, which is, seems -- is a great place to do it.

But then, where is the documented and most importantly, how is it communicated on in the next chain so that everybody doesn't have to discover this preference on their own.

Okay.

So, we're not looking to each person to answer this separately.

But rather for a way, that the -- person's preferences which is actually, required by Federal law, and in the contractual language that each of the MCOs has it is required that this be assessed and, documented and it shouldn't have to be assessed at each of these five

points along the way.

It should be a continuously available known preference, and, we're talking about, not just, preference for communication but, really, preference for how to understand information so we're actually tieing in cognitive accessibility here. So the way materials are presented the way services are described may have to be in words but it may have to be in pictures for some people.

So this is a really important topic for people who have known disability and where this preference has to be addressed according to Federal regulations.

>> SPEAKER: One of the things I can tell you we're working on, and I have left the AAA membership meeting to come here this morning I'll be heading back there, one of the things we're talking about with the Board of directors about is the reality is when you design an information system like this, what we'll be using in CHC it doesn't matter how many people you put together it doesn't matter how much time you put into it, how many contingencies you think about you'll miss something.

It is just the nature of building the system like that.

Because there's so much activity taking place all at once we're working on all of the ultimate ways to provide information, to the IEB which is where we're going to be connecting become and forth. We're not going to be connecting with the managed care organization. We're

working on alternate ways to get information to them in a systematic way . So the type of information, that you're talking about, is not something we can do in the system as it stands today whether that change is down the road I don't know. But, we're not going to wait to see if it changes down the road. So, we're having discussions now, about what is the best way for us to do that. Should it be centralized in the aging well office, or should we, localize the control for that at the AAA level so it is not something that, we're ignoring it is something we're trying to figure out what is the best way to communicate that information, back and forth.

>> SPEAKER: Okay.

So there's not a system currently for communicating this information.

Is what I'm hearing you say.

What could be done so this preference for communication something learned about interacting with the person, the participant, could be you know, could be included in back to the IEB, the IEB to the CHC and MCO, this should not have to be reinvented at each step of the way.

>> SPEAKER: I agree with you I think the ability to notify, the need for accommodations is, is something that is very doable the question is, what is the most effective way to do it, in the time frames that we have right now.

And, part of agreement with DHS is we will make sure we can communicate those kinds of things in data collection systems. The data collection system has a place for comments whether that gets flagged and noticed I'm not sure that is the case we have not used it and tested it as an example if we were to transfer a case from one county to another, that right now, has to occur in a dedicated E mail change between the IEB and aging well.

So we're looking at that type of a work around until we can establish a stronger way to do it. But, accommodations will be noted on our part and passed on.

>> SPEAKER: Even those accommodations you described of having a family member present, if that's needed, it seems to me that, needs to be ascertained right up front and then communicated at each step of the way.

So, dedicated I mean, email seems like a loose system maybe some people would do it, some people would not do it you know. And it seems like we need a more fail safe method, for this information, to be passed along.

>> SPEAKER: If I can add to this, we do receive this is Jeanne we receive from our system the preferred method of communication and that will go directly to MAXIMUS through a file transfer and MAXIMUS updateses the system daily.

With new enrollments and new applications and new requests for assessment and that preferred method of communication, goes into that as well. So there's a data element, that does follow the person through.

I think, I have to go back and double check this I think what Brad is referring to is that, if the assessor identifies there's a difference, from what was communicated, they may or may have the ability to change that method of communication they would have to do that, in a -- either on the comments or in the email. We can work on that, but the purpose of that is, we don't want assessors changing the information, that we have, in our system.

So there's a conflict.

They need to let MAXIMUS know so MAXIMUS can, let the CAO know also, so this change goes all the way through the system.

>> SPEAKER: There is a field for preferred method of communication and, who is the first entity to fill that out.

>> SPEAKER: The county assistance office.

>> SPEAKER: What we can't do,.

>> SPEAKER: They're not even here.

>> SPEAKER: I'm sorry, -- you know, if they approach first county assistance I'm thinking more about the transition you went through we would get from the county assist office if not the first contact MAXIMUS is the first tact they will capture that.

>> SPEAKER: That really worries me, because if you say that, the approach that Brad described is a very, thorough approach to assessing the preference but, you're coming in at step 3 I think, if I counted right.

So --

>> SPEAKER: Some cases yeah.

>> SPEAKER: Yeah.

>> SPEAKER: So, they should be able to change what is in that field.

>> SPEAKER: They can, but they need to not do it in the system.

They need to alert MAXIMUS so it is done all points, the system doesn't communicate with all of the other systems if they only make the change in PIA, then, it doesn't communicate to the other places whereas if they notify MAXIMUS, MAXIMUS can update, and make sure that gets updated throughout all of the systems so anyone that is having a contact with -- if they change the change in PIA it will only sit there.

>> SPEAKER: I think part what we're our thinking is we know that sometimes, people will not communicate what their needs are.

And, when we get there, it's the first time we'll know that, we need some way to make that, available to the system.

The second thing that we know that happens is sometimes people will continue their needs and when you get there you realize, either, they didn't state them in away we captured them correctly.

But the needs, were not understanding we're in the understanding what those needs are, when that happens it has to be clarified some way, that's where we have to get the information, back into the system, so that people, then know it.

>> KEVIN HANCOCK: Only thing I'm going add is that, the issue that you're highlighting Drew is challenge we have with the enrollment services system to begin with, it's so many hands off involved in the process and -- level of complexity that, that -- exists right now is, is -- presenteds, presents risk so what we're trying to do in this envisioning process is look for a better way to streamline it and have a little bit more of a one-stop-shop, it's a more positive participant experience and results are ultimately, a lot more streamlined, to say the least.

>> BARB POLZER: Brad I have a question from the phone.

Do you have data on the number of times accommodations have been provided and the type of accommodation?

>> SPEAKER: We do not.

That is data we will have, but we do not have it now.

>> BARB POLZER: All right thank you.

Do we have anymore questions for Brad?

Okay.

All right thank you we appreciate it.

>> SPEAKER: Thank you.

>> BARB POLZER: Next up, we're going to have MAXIMUS and because of time, how about if we have MAXIMUS in the and 3 MCOs present we entertain questions.

Thank you.

>> SPEAKER: Good everyone, Chris from the project director for -- sir. Good morning I'm Chris portesses project director for max us community HealthChoices in the independent enrollment broker I'll go over a number points of information for you.

Our part of getting back to your question that was asked we're part of identifying the needs and -- the different formats is it's across the Board across all of our functional awareness I'll go through these slides but feel free to ask the questions.

As you had indicated.

MAXIMUS, PHCHC communication for the mirandas we really identify the need assessment of language preference, communication preference and need for auxiliary aides in existing in new PA CHC participants is provide to a MAXIMUS in a number of ways, provided in the eligibility files we receive, via enroll the paperwork and information comes from the CAO and the CSR the -- the call center staff person, and receive request from a participant or a -- power of attorney or authorized representative, to schedule an interpreter or in-home

visit or, request materials, in special format or non-English speaking.

A need can be identified, during MAXIMUS outreach events, conducted in the community or in the nursing facilities.

N slide.

MAXIMUS is committed, to effective communication.

When an individual, is identified as a person with the disability, effects the ability to communicate, or to assess from an -- if there's a request for auxiliary service or support, MAXIMUS, staff will consult with the individual, or authorized representatives to determine what aides or services are necessary, in order to provide communication and particular situations.

Some ways we're doing that -- usage of the interpreters or language line, TTY capabilities for calls MAXIMUS visits with the support of non-English or ASL interpreter, CHC web site.

CHC enrollment packets and additional CHC materials those are available in six languages.

The outreach calls via customer service representatives and the electronic dialer.

And, an addition we'll be rolling out in the spring, will be employment based video phone process with the interpreter.

Multi-language and multi-format, Pennsylvania community HealthChoices materials, includes preenrollment brochure the enrollment

form, the health plan comparison chart, community meetings fliers, Medicare fact sheet flier.

The MAAC MLTSS meetings calendar and the nondiscrimination insert in the LIFE flier for population 55 plus.

And MAXIMUS PA CHC south Eastern Pennsylvania, foreign language plan selection outreach campaign results are below within the information we received for the non-English speaking, we contracted, we contacted directly 5155 people.

We spoke to 82 percent of them to gain the advanced plan selection. That's 4227 applicants.

Some additional resources for PA CHC participants and organizations, the ease of the web site access including scalable fonts, selectable language and remediated materials that are text to speech capable. Outreach at nursing facilities. CHC participants

can get on site eastbound person support from MCO choice counseling and enrollment, informational webinars, CHC informational webinars are available in nursing facilities and other organizations committed to assisting and informing eligible Pennsylvanians regarding community HealthChoices.

And the outreach meetings MAXIMUS outreach staff interact with special needs groups and non-English speaking populations to ensure the CHC information is understood by all and distributed to all.

>> BARB POLZER: Thank you Chris are you able to stay?

>> SPEAKER: Absolutely.

>> BARB POLZER: Thank you.

AmeriHealth?

>> SPEAKER: How are you?

Good.

Now it's on okay.

So -- there's more than just language communication issues and, what we did last year to prepare our team for CHC, because of the population we will be working with we had our contact center go to one of our providers and there were a team of there were people there, that got to speak to the communication issues that they had been barriers they were trying to overcome. And so, some of those barriers were related to if someone has a disease effects their speech and they're slow to communicate it is the time frame that it takes to being able to, call into participant or -- our contact center to be able to get someone, to wait for that time for that person to communicate.

So that's the first line of the defense or the first line that when people are calling in, is the contact center making sure that team understands, how to address communication concerns. So that, if they're calling in, it would be in the system, it would, everyone would have that information because they called there.

If it is my team the participant, um, personal care connector, they would be calling as part of the initial outreach and then that information is shared it is in the plan of care there's a communication area in the plan of care.

That could be shared with everyone, in AmeriHealth who has access to that participant. And so they have to have a certain level of access noter to have access to that participant. So if the communication plan is, um, in there it's specifically talking about assistive devices or assistive technology, they use a communication Board or if they have a brain injury and they're speaking using a communication Board, if they have if they're a person with a hearing impairment what type of -- assistance they would need during the assessment, um, languages and any they get to use the language communication we would use our interpretation line so that would be, that person would be on the phone as part of our outreach we speak to ensuring whoever the participant wants to have there for the assessment, or part of this process, we remind them, during the outreach call and then a letter goes to the participant, um, explaining to have that you know, they're welcome to have whomever they would like as part of that process.

Let me go through your questions. So then I talked about how we you know, it is the participant contact center, outreach process that's

how we identify with the communication preference or need is, it's documented in the plan provider.

So that referral involves like that entire process. What you know, what are the communication needs, how do they -- what's the approach, how do they like their -- you know, they're care done, what hours do they want their care done that's all part of that referral process.

That is the service coordinator, making a phone call, to the provider.

I talked about how it was actualized by the interpretation line and -- ensuring that the participant has the people that they need, or -- would like to have with them.

Um, how is the information, about the potential services, that the individual may receive under CHC communicated to the participant, so, it is in our handbook the handbook is available, in any manner that the participant would like to receive this, I checked with our our communication team and they said they have been able to supply any format, so if they needed it audible they could get the, handbook as a -- a CD Rom, get it in any language, our service coordinators are required to review all of the benefits with every participant at the first visit and then, annually.

And again I talked about communication preferences.

It is in the plan of care it's a requirement of our comprehensive

needs assessment to document the participants chosen communication plan. How do they want to receive the information? So, um, Dr. Nagele in the case of someone who has a cognitive impairment ensuring they had the people that, their support system there, so that, however they would like to receive that information, whether it is, pictures or -- um, time I heard time frames earlier, I heard you know, limiting time, it would never be our expectation that a service coordinator would limit the time of the assessment, what we do is we look at someone for if a teeth if we're there tear get to go the point where they're you know, if it someone with a cognitive impairment or a speech impairment where we have to take our time, it should never be our expectation, that okay we reached our two hour limit we're going to leave it should be, I'm looking at this person and they need a break. I'm going to schedule and come back when, when it is appropriate, and when they, they can finish this assessment.

>> SPEAKER: Can I follow-up quickly on that, and if every MCO would address this, because sometimes the -- the preference for communication might be that someone communicated with you by email, by phone, by cell phone or by text.

And, receives, communication back in those ways. Are you, prepared to make those accommodations?

>> SPEAKER: Oh, absolutely. It would have to be secure email

teach them how you know, how we do that and how, to access that, but that is absolutely whatever their preference is, that's the way we do it is in our system and in our participant overview where it says how do they want to receive you know information from the service coordinator.

>> BARB POLZER: Thank you Kathy do you want me to wait for the rest of the questions?

>> SPEAKER: Please.

>> BARB POLZER: Pennsylvania health wellness.

Do we have Norris?

>> SPEAKER: Yes. We have.

We have a presentation, that was sent over.

Thanks.

Good afternoon I'm Norris Benz and Jay from PA health and wellness we'll get start the.

At the Pennsylvania health wellness, communication preference our participants is documented upon our first contact with the participant.

The language or format alternative is note in the participant's case file we train our staff and our service coordinators our service coordination entities extensively on the training on the -- language, preferences of our participants.

We have employees, would are available for interpreter services we

have employees on staff that are, Spanish speaking Russian speaking Chinese speaking and speak Korean and, of course we have access of full-time for interpreter services for over 100 languages.

Our customer service line is comprised by bi lingual staff and support for realtime language services from languages from Albania, through yugoslavia we have participants who may need screen readers or anything else they may require assistance, with, 24 hour nurse line.

Our clinical, team, there -- um, 60 percent of the staff is bilingual, speaking Spanish and of course we have the availability to call up the use of live translation services if necessary.

N slide.

So our materials, brochures they're interested in the, top five most popular languages we actually have, we brought some of the examples of our brochures here if anyone is interested in seeing that. Our manuals and handbooks, they are available in Braille, upon request.

Our online materials are available in high contrast if necessary.

And we have audio and screen readers available, upon request.

Anything you want to add?

>> SPEAKER: Much like AmeriHealth, you know, we identify what the preference is, right away.

We, um, make that part of the case file and, we'll work with the

participant to address and communicate with item inity preferred choice.

And manner.

Whether it is language, whether it is, through a specific media.

Being emailed, text message, become and forth again you know the learning curve with secure email et cetera with the participant we do work with them, specifically, to meet their needs and their preference.

>> SPEAKER: Next slide.

So this is as Jay said the participants communication, method the prefer the method is documented in the file we work with the participant to make sure that they're preferred mode of communication is what is utilized. We pair the participants with service coordinators, who are prepared to assist them in the language format of their choice.

And, their communication needs, participants communication needs, that's part of the person centered service planning process.

Happy to answer any questions.

Thanks.

>> BARB POLZER: Okay.

Ray?

>> SPEAKER: So -- all right. So, to in addition to I think a lot of things here we have, maybe just to quickly run through the communications that we'll be occurring so, this early stage, our member

services team is beginning to take you know inbound calls from you know, southeast Pennsylvania about inquiries about network value added service and those types of things and individuals ready to enroll of course are forwarded to the IEB. And as we, one of the things was mentioned earlier is that language preference, communication preference those, data elements are incorporated and we, you know work with that MAXIMUS data, to make sure we're, communicating with the people and the ways they prefer, we also understand that many times that preference may not necessarily be accurately reflected. So -- as we, you know get ready for a much more you know diverse population in south Eastern Pennsylvania the first place where we'll be you know identifying, language preferences, especially will be as we start doing our participant welcome calls you know beginning in January. There's an additional focus with home and community based services each of the managed care organizations, will be you know calling everyone with HCBS in the first days of the program. And in order to identify service disruptions again making sure that our translation services, and language lines are available. We have a increasingly growing staff on our member services side with people Spanish speaking we go outs individuals that speak other languages as well but we traditionally rely on language and translation service for that and we're you know beginning to you know, go through our translation of required plan documents. So

as -- you know, members, begin to receive welcome kits, welcome brochures and provider information, and as well as you know, their ID cards and other information, so -- again, that is all you know part of our season a reasonable doubt communications, similarly we have, begun hiring service coordinators in the southeast and our -- we per the agreement and per our you know focus to make sure that population really reflects this same you know cultures languages and you know diversity of the population we'll be serving so we, also, you know, been hiring you know, very diverse you know, work force, that speaks you know, many different languages. So, looking to then you know align the service coordination team appropriately with people based upon you know language, preference and -- in addition to that, one of the thing is we when we develop a new authorization and you know pass that information to a provider you know we have the capability and use you know that opportunity to you know put those types of preferences in the authorization if someone is looking for an attendant that you know, has specific you know language or cultural differences. So -- um, I'll stop there in the interest of time and you know we'll entertain any questions.

>> BARB POLZER: Thank you ray.

I'm going to take time to have two questions from the phone.

And this is for Chris.

Can you clarify the purpose of the campaign you mentioned, was it to reach out to limited English proficiency individuals.

>> SPEAKER: Yes, it was.

>> BARB POLZER: Chris's response was yes. I have a question that is for everyone aging well, MAXIMUS and 3 MCOs.

Are you currently involving consumers in developing trainings for your assessors, service coordinators or other staff?

Doing so, would drastically enhance the quality and usefulness of training as you could learn directly from consumers, what makes sense what doesn't and what is important to them.

Anyone want to take a stab at it first?

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

>> BARB POLZER: Okay.

>> SPEAKER: This is NorrisaPA health wellness we're working with the consumers we can't of course talk to participants in the Philadelphia area, at this point.

But we have a, advisory committee, we're working with them, and, we also work pretty closely to get feedback and advice from the Pennsylvania health law project.

So, um, we do, we are engaging consumers with limited what we can engage in the southeast. But we are working with them, to try to get, help and advice how this process could be improved.

>> BARB POLZER: Thank you.

>> SPEAKER: This is Kathy from AmeriHealth Caritas, that's actually part of our participant advisory committee, one of the questions that we asked we one through, um, the -- the comprehensive needs assessment process and then, speak to the concerns of the consumer, you know how we, how we address the questions how do we make this better? How do we streamline the process. So it is part of the packet.

>> SPEAKER: Yeah we, you know similarly have our quarterly PAC meetings participant focused and service coordination is a central part of each of those meetings in addition to that, we -- um, we have been doing what we call our participant forums that we, also do quarterly across the different geographies where it is not the same standing committee members where we, invite you know, people from you know a specific area so, southern Blair County or Allegheny County or Butler County we've done you know, various regions so far this year and try to again you know, use those as forums to get you know, consumers from maybe better informed, that are more active and advocacy in getting participants who maybe less informed in sharing that we take that information back and use that for training but the present time we don't have a participant led training for service coordinators I think that's good feedback we'll consider.

>> BARB POLZER: Okay thank you drew.

>> SPEAKER: So the Pennsylvania health law project has received feedback from participants in the southwest region, specifically having to do with service coordinators not being open to the idea of communication via email, so or text and I'm talking about two way communication not just one way. So we're talking about two way communication here so I think, what I heard you all say is that you will explore that and make and find ways of making that possible if that is the participant's preference.

Am I reading too much into that.

>> SPEAKER: No absolutely correct.

>> SPEAKER: You're absolutely not reading too much into it, we are -- we do make email communication available of course there's security issues and the training on how you secure email I'm not aware what we're doing on text messages but I will certainly, look into that and -- report back to the committee on that.

>> SPEAKER: I need to confirm, how our team is addressing text messaging we use some email.

>> SPEAKER: I think the text and cell is, particularly an issue because people, that you have in your employ may not wish to use their personal cell phones for that purpose they need a company issued phone and sometimes, you need to be able to have that -- to have a secure texting app on the phone in order to do that, if that is the participants

preference.

There are many PHI secure apps available, for free.

>> SPEAKER: We're not allowed to use free apps, company prohibittion against that, cell phone is -- cell phone use is not an issue for our service coordinator, our -- we provide them, company issued cell phones for our service coordinators I'm not really sure what we're doing on I apologize I don't know what we're doing on text messages I'll report back to the committee.

>> SPEAKER: PHP wants to -- PHW wants to pay for things, that's fine.

[laughter]

>> BARB POLZER: Okay.

Lester.

>> SPEAKER: Hello everyone Lester with supports coordination one thing I wanted to hear if the managed care organizations were happy, with how they were getting the information the preferred communication.

Because you're almost like, at the end so yeah there was talk about we have some assessors and everything and, MAXIMUS, so I wanted to know, how would you guys improve, front line communication I can hear a more detailed understanding of the differences in how people want to be communicating from the MCOs as a opposed to. Miranda musts and -- aging well. So do you have any

suggestions for those guys to get better better.

>> SPEAKER: So Lester I was trying to see the IEB refer will thats they're secure so I could not get it open, in time I wanted to see what kind of information we were receiving.

I was listeningening to that before I thought a great idea before some way we made that initial call we knew how to approach that.

Again I could not get into my IEB referrals to see whether it may be in there, they may be sending it to us the staff may be very well, that's part of the process, they have to review it, it is attached to the file we don't get it for everyone. But we're getting those referrals with the documentations so I am going to look at that and see what I get.

Okay.

>> SPEAKER: Okay.

>> SPEAKER: Lester I would agree as well we're relying upon the information that we're provided.

That being said, you know we have steps in place, that if there is, sort of a disconnect, someone says I need I need Cantonese it is found out maybe Mandarin, we have that ability if we have to, to work from our end to adapt quickly.

We can adapt quickly to the changes I think all of us have said we use language line and real live interpretation. I'm talking

about on a language issue.

If there is a, situation where, someone needs a screen reader and, we have not been -- that has not been identified, um, previously, we're going to work quickly to get that those accommodations made.

And, move forward with that.

>> SPEAKER: It would seem to me, that the very first person receiving the very first call, should ask if there's a communication need of some special sorts so it goes, all the way through from that very first call.

And if that's not the person wanting the services that is making that call, then I would hope that who is making the call for them, would say, that the end recipient, of that service needs this, this and this.

This all seems a little crazy to me.

>> SPEAKER: That is part the MAXIMUS script, the initial phone call.

And the data is also, we do capture through the data file transfers that go through each of the different stages of the enrollment are the language preferences.

What we don't really have a great way of capturing right now and sending all the way through the system is, those other alternatives like, requesting screen radders something along that line and that's something you can certainly take back and look how we communicate through outside of just manual notes. But the language preference

does go all the way through the system.

>> SPEAKER: Well that would seem like all of those preferences or special needs if it was noted in that very first call, if the script is changed a little bit to see if anyone needs a special need, it would speed up the process.

>> SPEAKER: Yes, it is not just capturing information, it is also then capturing in data element we can then convert the files into -- so -- we do want to capture it but figuring out the best way to communicate that we can certainly improve on that.

>> BARB POLZER: Question on the phone could the plans easily identify who they are currently servicing who are deaf, deaf-blind, hard of hearing?

>> SPEAKER: Sure, if it is someone in LTSS that on, as part of the assessment they are areas to identify vulnerable sub populations that are reportable so that's where that would be, documented for the service coordination and anyone who has access to that file.

>> SPEAKER: Right if it is not, if it hasn't already been documented, we, make that documentation upon our first meeting with the participant.

>> SPEAKER: The same it's in our as much as coordination and case management system but it is not, I don't think it's structured data for

folks that are not in LTSS.

>> SPEAKER: Zach?

>> SPEAKER: I was wondering if that would include if there's a question for a person who is deaf would that, would that, could that person have an interpreter provided for a person who is deaf?

>> SPEAKER: Norris Benz, PA health and wellness, someone is deaf requires an interpreter we would make that available.

>> SPEAKER: That's the same for AmeriHealth Caritas.

>> SPEAKER: Same for UPMC.

>> SPEAKER: Thank you.

>> BARB POLZER: Another question came in on the phone.

Over the phone. Can a nursing facility, access member information in the CHC MCO portals if contracting/credentialing is not yet finalized.

Or must they rely on promise.

>> SPEAKER: Okay for AmeriHealth Caritas we'll get that verified.

>> SPEAKER: Yeah we'll check that.

>> SPEAKER: So I think that, you know, for a nursing facility for checking you know, eligibility and you know, which MCO is the first and best place to go for that information, um, but I do believe, all providers are loaded in the system I would have to confirm again there's sometimes, issues around address mapping until we sort of get into the

program where that might not be 100, EVS is the first and best place to check eligibility and plan selection.

>> KEVIN HANCOCK: Just, to be clear from the department's perspective, every provider should always check eligibility using EVS that's what it for, EVS will be able to demonstrate if a person is maintaining Medicaid eligibility and identify which managed care organization they're participating in ray is right, the first place is the provider should be checking EBS.

Hopefully they're doing that now as well.

>> SPEAKER: Another question.

>> BARB POLZER: On the earlier question about the data accessibility, the request is, can they provide the actual data for the next meeting?

>> KEVIN HANCOCK: I'm not sure.

>> BARB POLZER: Pat which I'm not sure.

>> SPEAKER: That is the deaf and, hard of hearing and --

>> BARB POLZER: Oh, okay.

Okay.

>> KEVIN HANCOCK: Just to clarify they're asking the MCOs provide the data.

>> SPEAKER: Great correct. Poll will positive thank you.

>> KEVIN HANCOCK: They're all nodding their heads too.

[laughter]

>> BARB POLZER: Okay.

Michelle?

>> FRED HESS: I have a inquiry.

>> SPEAKER: When I tried to register, under the --

>> BARB POLZER: Closer to the mic please.

>> SPEAKER: When people are trying to register, to get their doctors, or keep their doctors, the hospital has signed on, to one insurance but they want to choose the other.

But the, the hospitals are still having issues with picking who they're going to work with.

So you're on that time line and it is, you know they're scared they're going to lose everything. When you change to keystone versus I don't know the -- the initials HH -- whatever.

UPMC when I went on the computer, it told me I could only apply for UPMC.

I wanted to apply for keystone.

It wasn't letting me.

Then I got in the mail I was applied for keystone the hospital also choosing the doctors are choosing what insurance you're going to, not the person if they're told by their hospital that no we're not taking -- that insurance, but you have to go -- with the other insurances, that is

going to cause a lot of problems with consumers who have a lot of medical needs.

I can't get up and just switch to a whole new doctor explain my medical background and start all this over again.

And that's what is happening to a lot of people besides myself.

>> SPEAKER: With the six month continuity of care period cover that concern if a MCO is not contracted with that.

>> KEVIN HANCOCK: Michelle is talking about the physical health doctor right? You're talking about your primary care physician right?

>> SPEAKER: Yes.

>> KEVIN HANCOCK: So the continuity of care it would be a -- the continuity of care would be 60 days. For someone who was -- um, a physical health provider.

>> SPEAKER: If they get -- sorry.

If they get, an insurance that they want to change to, it is even going to take longer the doctor is not going to touch them.

As long as they don't have the insurance, you're saying there's a six month grace period but the -- money that is, the different doctors I've been to, have put that we can't take you because we're not accepting that insurance yet.

>> KEVIN HANCOCK: A lot --

>> SPEAKER: Still it's still on the table who is doing what.

>> KEVIN HANCOCK: I guarantee that all 3 of manage the care organizations are going to talk about and find out who your doctor is.

But, you know --

>> SPEAKER: No it is -- I have called several different ones.

Several times, you're talking about us getting on this phone, with the counselors.

I had to have someone hold the phone with me, I got put on hold for 20 minutes.

And -- still didn't get anywhere.

I looked it up on computer, with the counselor at liberty resources which is a center.

We both were looking at the computer saying, UPMC.

And that is my only choice.

And then I found out later, it was going to be keystone a lot of consumers are told that is the only insurance I think it is first insurance on the -- on the actual database.

>> KEVIN HANCOCK: So maybe you're talking about a web site, maybe a web site issue?

Chris?

>> SPEAKER: They're enrolling us without letting us choose. They're choosing it and then if we don't like it, then we change it.

>> SPEAKER: This is Nathan, MAXIMUS, CHC project manager. So I think you're referring to going to enroll CHC.com, then, seeing which MCO your PCP is associated with.

>> SPEAKER: No.

No.

What I did was, I went to they were taking about us registering so I went on the computer and it said who I wanted to register for.

The computer turned me down and said no, when I went into liberty resources, a counselor did it with me.

And we, we both used keystone as an example.

And we said she doesn't want to go with this she wants to go with this.

But the computer does not allow you to register.

When we called the hospital, they're giving mixed information they're saying, that the social worker has to contact you and go through all this.

We're supposed to be doing this on our own the hospitals are not supposed to be choosing for us.

You said you'll choose put us in an enrollment that's like the doctor's choosing, who they want to take back.

My doctor could easily turn me down and tell me to go to another doctor because they don't want the want the insurance.

>> KEVIN HANCOCK: To your question I think, we do need to know who the doctor is.

>> SPEAKER: We need to identify which web site.

>> SPEAKER: It's not only my doctor I'm getting more than just myself.

These are, issues around the city.

>> KEVIN HANCOCK: We have to know, to be able to eval whether it's a web site program, whether it's on enroll CHC or determine if it's a network challenge that the 3, 1 or all 3 speak being so it's not just the one hospital it is multi-places.

>> KEVIN HANCOCK: Do you get my point I think you're getting my point we have to do a little research to -- to address your concern.

I think that's --

>> SPEAKER: But it is hitting, -- not hitting just me it's other hospitals I am getting calls asking people, they're asking me for help.

I'm still going through the same process.

So if I'm not understanding it they're not understanding it.

There's still a big gap between -- there's a gain more bigger gap between doctors and the insurances.

Because if the doctors try not to take the particular insurance, then that means the person has to move to another doctor.

>> KEVIN HANCOCK: If they want to stay with the doctor, that's

correct. Long term in I way. At least they do have a 60 day

continuity of care period but long term they will want to move to a

managed care organization that's the provider these want to -- to work

with.

So -- but if we don't mind we'll get that information from you much

and -- we'll do a little bit of research we'll use your specific situation as an example we'll evaluate whether it's a -- a data

problem on the web site.

>> SPEAKER: If you just want to add also the -- the IEB web site is

being updated on a weekly basis we provide that --

>> SPEAKER: When consumers you're asking consumers to sign on.

Consumers don't know that it is going to be changed, week after week.

They're getting on there they're signing on for whatever if you're

going to a hospital, and that's the only hospital that the insurance is

taking, the people are coming to that insurance, because that's the only

thing on the computer.

It only gave me one option.

When I did it for the first time.

>> SPEAKER: Did it look like this.

>> SPEAKER: I think I understand what she is saying she looked for

her physician.

>> SPEAKER: This is the CHC they're speaking to, is that what it

looked like.

>> SPEAKER: Okay.

>> SPEAKER: All right.

>> SPEAKER:

[side conversations]

>> KEVIN HANCOCK: It sounds like keystone, enrolled that same doctor as well.

So -- that's the reason but --

>> SPEAKER: Kevin we discovered yesterday there are a lot of problems with the listings on the various providers on the web site.

So, it actually, seemed to have to do with how far along they were in the contracting process, and, whether they had a fully executed contract and not and -- even, after that what is the time frame for getting listed and there's some listings that are there that are inaccurate.

I think there's, this is what I think is being expressed, there's a lot of, confusion about whether a provider is or is not participating.

>> SPEAKER: Yep.

>> SPEAKER: This is Zach from Philadelphia ADAPT, this is exactly why we came to you last month asking you to, extend the open enrollment period.

This is exactly why, because of these hiccups.

Also, like this is why PAADAPT we came from the Governor's office

after we began chanting to the hallways we had to go to the extreme his office and in the hallways, and he -- you know, finally met with us.

[scream]

He met with PA ADAPT he red our demands he is said he is not perfect, there are a lot of mistakes being made and a lot of mistakes made he met with us he said he would get back to us by next Tuesday which is a greatly thing I mean he said he would work with us.

But -- this is why we came to you before, about the same issue.

But -- you know, again, he said he will work to get back to us n week and -- without the power of ADAPT we were not able to do this. So -- this is why we keep asking you to extend the enrollment period.

>> KEVIN HANCOCK: So, I did have a, I did receive a copy of the concerns that you raised really appreciate your willingness to put them in writing. It's very helpful and it was actually, if when we talked about this last month having them in writing actually makes it something that is actionable. So thank you very much for doing that.

>> SPEAKER: They were many writing last month as well.

>> KEVIN HANCOCK: I did not receive any demands in writing last month.

Just to be -- but, going through them, we do, we're working on them, we did have some questions about the MDS request I think we do have to do some follow-up I would love to know who would be the best person to

work with, for that particular question?

>> SPEAKER: We always got the data.

So --

>> KEVIN HANCOCK: Who would be that -- follow-up person for the MDS.

>> SPEAKER: Who wants to get out of the nursing home find out transition.

>> SPEAKER: You should be the person Cassie.

>> SPEAKER: He is our contact person.

But I'm just saying, that we have always got the MDS and we were able to take people out, because we had those numbers and data. We wanted to be able to monitor that people are getting out. We're.

>> KEVIN HANCOCK: So you're just, having -- kind of, a return back to what you had prior to 2016 is that right? That's the way I read that.

>> SPEAKER: Yes.

>> KEVIN HANCOCK: Managed care organizations are going to be responsible for nursing home transition how would you see the administrative functions.

>> SPEAKER: The we want to make sure the community is making sure it's being done and the rate this community wants this community is made it pretty clear that, they rather be in their own homes rather than nursing home we want to make sure that job is getting

done only thing we can use is the LDS numbers we need -- people are saying -- we are taking it.

So I mean, in order for the community, to be able to account for its own people we need of the MDS numbers.

To make sure people are not stuck in the nursing homes for rehab we get them put for all kinds of reasons we get stuck there.

>> KEVIN HANCOCK: I can see, I want to I hear what you're saying.

I can see the community but there's also a provider based rule that's associated with receiving the MDS data previously we never released the MDS data to adopt we released the data to, to nursing home transition providers or entities that were involved in the --

>> SPEAKER: We got it at -- all those committees it is not -- anything that you can't share with us I've already been in meetings with Washington where they said we could get the MDS numbers.

At the Federal level I mean, if we have to go to the Federal level to get Pennsylvania's we will. But I mean -- it would be better to get it from our --

>> KEVIN HANCOCK: This, I just, the one I think this is going to merit further discussion there's a lot of stuff happening right now with MDS right now. At the Federal level, there's been some concerns about information gaps with regard to MDS and whether how useful it is and -- the relationship between Medicare and Medicaid I think this merit as lot

of discussion.

Happy to discuss it, you guys may be -- what's that?

>> SPEAKER: Asked for the last five months, nursing home transition . And -- we you know, our argument is, Gin in. Y knows our argument as soon as we didn't get the MDS nursing home transition providers.

The minute we didn't get it, they stopped not doing it because they knew the State wasn't looking at it either and I called and called about a nursing home, for 9 months and then until it the State called them up harassed them they finally did it, that's been a problem since 2016, the nurse homes know you're not looking at the information, no one is paying attention.

So -- however you're going to do it, you need to get the providers not just the MCOs.

>> KEVIN HANCOCK: NHT providers are going to be working with the MCOs and community HealthChoices I think we got to talk this one through I actually -- I think that you're probably not going to get what you want out of that -- but I'm happy but I want to make sure.

>> SPEAKER: How do we get what we want.

>> SPEAKER: As far as what we, talked today with the Governor, as -- ADAPT requested demanded last month, to extend the period of the southeast, enrollment for the -- they worked with us on that, that needs to happen, otherwise, you're just throwing us under the bus. That's

the reality.

Secondly on the MDS, you need to -- that needs to be -- needs to make it public.

It has not been so, needs to do so, figure it out you used to do it.

>> KEVIN HANCOCK: I'm not sure I understand it.

>> SPEAKER: MDS raw data you have it,.

>> KEVIN HANCOCK: We do.

>> SPEAKER: Can you make it public.

>> SPEAKER: Do you know who was.

>> KEVIN HANCOCK: Asking,.

>> SPEAKER: We need talk about it, it needs to happen. That's Federal law.

>> KEVIN HANCOCK: It's not Federal -- I think, I think --

>> SPEAKER: You have to report MDS to CMS.

>> KEVIN HANCOCK: I don't want to argue with you I just want to understand the problem.

>> SPEAKER: That's true.

>> KEVIN HANCOCK: I want to understand your request.

For MDS everything else I this pretty clear.

>> SPEAKER: Kevin may I suggest as an MCO what we would appreciate

is, if -- um, this is, dead -- if we -- if we had the -- there it is,
if we, we would, we would welcome the accountability if we had the structure data on people that newly checked off on the section cue they would like to return home.

And to report back that we -- we've met with and had conversations with those participants.

As you know as an accountability metric for MCO we welcome discussing so that, we're ow reaching those individuals but we're not receiving the data in a structured way presently it could be useful.

>> BARB POLZER: Linda? Do you want to say something?

>> SPEAKER: I'm seeing part of this as being a HIPPA violation too, information could be given we can't say who wants to be moved from the nurse home we can give you a number.

>> SPEAKER: We're not asking for names.

>> SPEAKER: We don't need names.

>> KEVIN HANCOCK: Actually that's helpful Linda.

I actually when I read the request I did see, that we wanted an explicit list of data from MDS we need to talk it through, what that particular request is not clear.

Looking forward to the conversation.

>> SPEAKER: Do you know who was coming out of a nursing home.

>> KEVIN HANCOCK: I'm sorry?

>> SPEAKER: Do you know who wants to come out of a nursing home that's what we want to know.

How many people in nursing homes would you --

>> KEVIN HANCOCK: We know from MDS, how many people from nursing homes, have listed as ray mentioned,.

>> SPEAKER: That's what we want.

>> KEVIN HANCOCK: Do you want to know the individuals.

>> SPEAKER: We want the number.

>> SPEAKER: We want the anybodies.

>> SPEAKER: We want to see you know how long it is taking for them to know, what areas is the numbers from one area. Speak okay.

>> BARB POLZER: Guys only one person at a time.

>> SPEAKER: We don't need anything identifying.

>> KEVIN HANCOCK: So that -- it wasn't clear, in your request.

>> SPEAKER: How do you judge to know they're getting out if we don't know how many people there are.

>> KEVIN HANCOCK: I'm more than happy to talk about it, aggregate data exchange by nursing facility for people wanting to -- I'm not sure we can do by nursing facility that could be personally identifying.

As well but -- happy to discuss, ago agree date data nor people who want to go -- that wasn't clear in your request.

I'm happy to discuss that.

Very happy because I think I'm a little more comfortable with what you're asking.

>> SPEAKER: Lastly, we requested that, the Governor, to work with us to so as the MCOs roll out, there's the six month, the period we're not talking about that specific time, but -- I worked with my support coordinator agencies for a decade now they know me best you don't.

MCO, we are requesting we continue to have our service coordinator agencies, you -- figure it out this is what you do you get the paid the big bucks to do that. Lastly -- attendant care we wages up we've been saying this for years we need that to happen, now more than ever.

We look forward to a response from the Governor on Tuesday.

And we really look forward to, having a positive response, now, specifically on our personal request of extending this otherwise it will blow up in your face just know it.

>> BARB POLZER: Okay --

>> SPEAKER: This Zach from -- from ADAPT, um without, our attendants, you know, we're not able to be here I would ask you as much as we need to.

Our attendants are crucial key it's our life line to independence.

And we need then to be able to afford to work with us.

We need help with this.

>> BARB POLZER: Okay unfortunately we have a hard stop at 1:00.

I thank everyone for attending and participating.

The next meeting is January 4th.

Same place, 10 a.m..

Thank you.