

Public Forum on Managed Long-Term Services and Supports in

Pennsylvania - June 23, 2015

>> THE SPEAKER: Good morning!

There is such power in this microphone. Not the person who is speaking into it, just the microphone itself.

>> Good morning.

>> AUDIENCE MEMBER: Good morning!

>> THE SPEAKER: What an outstanding, awesome, beautiful-looking crowd. Thank you for being here today, I am Teresa Osborne. I am the Secretary of the Pennsylvania Department of Aging. It is my pleasure and great honor to welcome you all today on behalf of myself and Secretary Ted Dallas and our colleague Secretary Dr. Murphy she did join us in Pittsburgh.

This is five or six of six sessions scheduled. The conversation that has begun during the course of these weeks to continue. It does our hearts so much good to see you all here with us today.

People who are concerned whether you are a consumer, consumer advocate, case worker, director, you name your role and passion in life; that's what brings you to this room with us today.

A few months ago, just before he provided his first budget address, Governor Wolf had a conversation with many of us in his cabinet. Particularly for Secretary Dallas and myself and those who work most closely with us at the Pennsylvania Department of Human Services and Aging. The goals for us and those who gather in this room today those who couldn't be here and joined us in other

sessions and will join us in the future and particularly the days, months and weeks ahead; that we do what we can to protect the most vulnerable and ensure, folks, regardless of age, over 60, regardless of disability, if they need to access home and community-based services, that they have the opportunity to do that, so that folks age in place in a setting they desire. That is what calls us to gather to hear your voices, concerns, fears, challenges, recommendations. You name it, we need to hear from you; that's why it is so, so overwhelming for us to see this room here today filled.

This is the beginning of a dialogue we need to hear from you as we explore our opportunities as Commonwealth to engage and manage long-term services and is supported here in the Commonwealth of Pennsylvania.

We, in addition to this room being filled have a pretty full agenda. I will stop my remarks there. Again, know our gratitude for you all joining us here today. I will turn this microphone over to Secretary Dallas. Thank you.

>> I am Ted Dallas Secretary of Department of Human Services and with me today is Jenn Burnett, deputy secretary of long-term living.

As many of you know, I was here during Rendell -- people ask what is the biggest difference between DHS when she was here and when I came here. One of the things that struck me was, the department had become a lot more closed-off from the people it serves than I remember.

One of the things I hope I can change while I am here is to get

back to the place where we are listening to folks and providing people with the opportunity to participate in the process and participate in the decisions that are going to affect their lives.

For me, today is a day -- starting to move in that direction.

We have had five of these so far. This is our fifth. We have had four of these so far. We have gotten a lot of comments, and that is what the purpose of today, is to hear from you.

We will give you background of what we are proposing. What we want to do is hear from you. We want to understand what your concerns are, what you like, what you don't like and all of us have pretty thick skins up here. Please speak your mind. I don't think it will be a problem with the folks in the room. We really want to hear from you.

I will walk through a couple slides and turn it over to Jen Burnett. As I was speaking about the objective of today's forum is to share our information. Right?

When I said we wanted to be more open and have a discussion, it is not an accident that the document we put up on the web and distributed. There are panels, but our thought was we would put up a framework for how to do it. We wanted to start a discussion to let people say, We like this. We don't like this.

There is one more in Philly on Friday. We will be able to gather up the information and ideas from people who are at these sessions, be able to put that out there and also continue that conversation based on the feedback that we have.

If you go to the next slide -- these are the goals moving to

managed long-term care for the department. I will not read them all to you, but I want to focus on two in particular. The two right in the middle.

Enhancing opportunities for community-based services and incorporating person-centered service plan design.

One of the things I believe in human service is one size doesn't fit all. Everybody is a unique individual and everybody has unique needs.

If we do this, we have to do it in a way that recognizes the individuality of people and their individual needs.

This is not a formula. It is not, If you have this issue, you need this kind of care; this is the same thing for everybody.

This is about embracing what is different and what will work

for the people that we serve.

The other part that I don't think I can stress enough, I think the Governor made this point is enhancing opportunities for community-based services.

I think every policy ever seen, whether national or Pennsylvania -- poll says 95% or above would prefer to age in place and live in their home. I think that is what the move to managed long-term care will get us.

If you look at the department statistics, we are a little below a 50/50 split in serving people in their home and nursing facilities.

There is a disconnect between what people want -- 95 percent and above. There is a want and desire versus what we are able to

do.

To me, if we do this right, that number, which is a little below 50%, will start coming up.

To me, it will take some time. Our goal is to get as close as we can to what people want. People want to age in place and live in their community, which I understand.

I know the Governor often says, You know, I live in the house that I was raised in. My parents are down the road from me; that's what I want for everybody else; that's what we want.

Our hope is, by moving to managed long-term care and combining everything in a coordinated approach, we will be able to help people achieve that vision.

This is just a very, very high-level overview of how this would

work.

Right now if you look at the system, it is fragmented.

Physical health, fee-for-service, managed care and long-term supports and services. We want to combine it under one program to make sure that everybody gets the quality of care they need, we think if we combine it into one managed care entity, that will help us get there to get better healthcare outcomes and stay in the community.

This is our time line for doing this. This is an aggressive time line for doing it. I think being aggressive is good. There are a lot of other states that have done this that we can learn from as we move forward. I think there are 22 or 23 other states that have moved to managed long-term care.

Pennsylvania does have some form of managed care already in long-term care.

For us, what we want to do is have -- issued a discussion document on June 1st -- then going through the session we have.

This time line is misleading. Deadline for submission of comments July 15th and skips all the way down to RFP that is in October 2015. We did that to keep it all on one page.

What will happen, after July 15th, when we get the comments, there will be more iterations and comments coming out and opportunities to comment. This is the first round where we want to hear from folks, we will refine the document and continue to have a process to have people comment.

We want to release the RFP in 2015. Again, this is one of the

things that can be discussed today. Our vision for doing this is doing it in three phases; that would be starting on January 2017 for Phase I, that would be, right now our approach is to start in the southwest part of the state, Pittsburgh area and surrounding counties. Phase II would be a year later January 2018 southeast Philly and surrounding area; and Phase III, January 2019 the remainder of the state.

We think the best way to do this is in pieces. Right now our current thinking is, certainly some folks can comment on southwest, southeast and finish up with the remainder of the state; that would have us -- you know, it is a time line of about three years, but it is relatively quick in doing this. We think there are a lot of other folks that went before us we can learn lessons from.

With that, I will turn it over to deputy secretary Jen Burnett, who will walk through the rest of the slides and then get to the reason we are here.

>> THE SPEAKER: Thank you, Ted.

Thank you for your interest. This room is full. It is fuller than I thought it would be. We had about 50 people signed up all together. There is definitely more than 50 people in the room today; 30 people signed up to speak. I am going to make my remarks very quick.

My name is Jen Burnett. I have been with the State of Pennsylvania for the last five weeks. I started five weeks ago. I actually did have an opportunity to work in Pennsylvania from 2003 to 2011 when I worked in the Governor's Office and then the original

Office of Long-Term Living. I am not a stranger to Pennsylvania, and I am really glad to be back.

I took a four-year hiatus to go work in federal government. I worked for the centers for Medicare and -- what I learned will help us as we move forward -- as Secretary Dallas described, pretty aggressive timetable for moving managed long-term services and supports.

I want to talk about the target populations and then I will talk about the program components and then turn it over to Kate Gillis, who is our press secretary. She will move us through the public comment period.

The real reason we are here is to hear from you. As Secretary Dallas said, we put out a discussion document. It is really just

that. It is to get you to start thinking about what we need to do to bring up managed long-term services and supports and what we need to do.

The target populations, the first population, the largest, are dual-eligible adults excluding individuals with intellectual disabilities, who are over the age of 21 and who have Medicare Part A and/or B as well as Medicaid -- those are dual-eligibles.

What it implies for you is that we are really interested in integrating with Medicare. Part of our work with CMS is going to be to discuss the possibility of how we work closely with Medicare so that those two systems can be integrated. You have a Medicare Medicaid card but it is disjointed. That is a real interest of ours. Any feedback you have on that, would be very welcome.

The second population are nursing facility, clinically eligible individuals over the age of 18, who are also eligible through Pennsylvania Medicaid program that is the second big budget. We have -- 23,000 non-dual eligibles and 104,000 dual-eligibles. The first bucket is those without supports, and the second is with long-term services and supports who are duals. The third is non-dual clinically eligible who we are serving in the system.

The last population is 2200 adults in Act 150 program, which is a state-only attendant care program. We are interested in serving them. A lot of their needs are similar to what we are serving in the non-dual eligible nursing clinically eligible.

I will turn this over to Kate to hear from you. As Secretary Dallas said, one of the most important tenants, and what we are

interested in doing, is making sure that everything we do is person-centered, the person is at the center the individual who is receiving services from us must be at the center of all planning that we do.

We want to continue consumer-directed personal assistant services. We have a long and rich history in Pennsylvania.

Certainly with originally with the Act 150 program of providing consumer-directed services and we want to continue that. That is not something that we want to see go away. In fact, we want to grow it; that's another aspect of it.

Services and supports coordination is really, really critical. It is one of the ways we think we will be able to support people better, to provide clear coordination between people's physical

health, their behavioral health and long-term services and supports, which does not happen today. People fall through the cracks.

We want to also make sure that we have access to qualified providers. We will be working very closely with our very robust provider community to make this transition and to help providers become qualified.

We also -- this is very important to the Governor -- increased access to home and community-based services. Every state that moved towards managed long-term services and supports has done a tremendous amount of support in getting a better balance in where their expenditures are for community-based services.

Currently, as Secretary Dallas mentioned, we are spending less than 50% in home and community-based services. We want to change

that dynamic and build our home and community-based services.

Participant education enrollment support, this is something we are hearing at other sessions that will be critical to help people understand what this change means for them and how to navigate. We will be making significant investments to assure that our -- the participants understand how they navigate the system and what the change means for them.

We are also really interested in preventive services. We don't think that our current system does a lot around prevention. We know that in -- certainly in the Affordable Care Act with Medicare, there is a lot of emphasis on prevention. We want to tap into that for our long-term services and supports populations.

Participant protections is another aspect that we really are

going to be working very closely on. We want to work at really making sure that those participant protections that exist in Medicare and we can build them similar, if not the same, for Medicaid. We really want to align Medicare and Medicaid participant protections.

The last one that is really most critical for me and most important for me is that we are really moving our system towards an outcome-based quality -- continuous quality improvement system.

We want to start pay for outcomes rather than events and services. We want to pay for outcomes. We are interested in quality and improving quality. We think our long-term managed supports services has to have it as a critical component of how we build this. We will be looking to hear from you on what that means.

Kate?

Thank you.

>> KATE: Thank you all for coming. We have 21 speakers signed in right now. I will ask you keep your comments to about 5 minutes. I will be using a timer, here, to respect everyone's time and make sure that everyone is heard.

I can also bring the mic to you if you would like me to or come up front. It is totally up to you. Just let me know.

The first speaker is Mike Rosenstein.

>> I am Michael Rosenstein, speaking on behalf of Pennsylvania coalition of medical assistance managed care organizations.

The coalition applauds the administration's decision to adopt managed long-term services and supports models.

Today, our MCOs provide health insurance, core coverage to 2 million Medicaid, Medicaid expansion and CHIP enrollees.

Our organization provides special needs, plans for dual-eligibles and other Medicare beneficiaries.

Together with State and federal governments we have been successful in improving access and quality care while containing costs.

The NCOs have managed long-term care to improve consumer quality, life and mitigate cost pressures on the Medicaid budget.

We strongly endorse a person-center the design to foster community-directed care, enhanced home and community-base the care and improve quality and health outcomes.

They provide case management to a wide range of consumers with

chronic and complex medical conditions, including older adults and people with disabilities; that experience will be invaluable to the Commonwealth, we believe, as it moves forward toward program implementation.

The coalition agrees with many of the broad program design elements proposed in the discussion paper.

The Commonwealth has chosen the right coverage groups for the program. We endorse the re-enrollment of adult duals in a managed care model. The coverage services, including behavioral health integration and our appropriately comprehensive emphasis on prevention, home and community-based care and self-direction are essential.

Accountability and performance measurements components can only

enhance accessibility and quality of care for members.

The program must be mandatory in order to succeed, understanding that the model will embody opportunity for consumer choice in MCOs, providers and options for personal direction.

The service planning process must be person-centered, maximize opportunities for self-direction and include transitions between settings to ensure quality outcomes.

Strong participant protections must be part of the program design.

Finally, the program must emphasize home and community-based care to ensure the provision of services in the least restricted setting.

The coalition will be submitting more detailed, written input,

however, we would like to offer four specific comments now:

One, we recommend consolidation of the upcoming health choices in MLTSS procurement into a single program. This approach would best serve Medicaid consumers with a single healthcare continuum that encompasses preventive, acute care and long-term services and supports.

Health choices serves many consumers until medical state us requires long-term care providing opportunity for most consumers to enroll in the same for health choices and MLTSS would create a holistic approach to consumer coverage emphasizing preventive care, well-being and well before long-term care becomes a necessity.

It would promote continuity of care through longitudinal case management congruent case networks reduce confusion and reduce

consumer understanding administrative simplicity both at MCO and Commonwealth level. Better marked acceptance of MLTSS and improved health outcomes.

Two, if the Commonwealth, instead, chooses to move forward with separate MLTSS program, you could be even more critical to design the upcoming system and health choices procurements to promote a single health continuum for all of the reasons outlined in our previous recommendations.

This could be done by promoting the participation of MCOs in both the health choices program and the new MLTSS program within geographic areas.

Because of our expertise, the health choices MCOs are an existing resource, and we hope, in the best position to serve

long-term care population in an integrated approach.

Three, to further promote integration, the Commonwealth should align the MLTSS and the health choices zones, aligned zones are fundamental to consumer-focused design that promotes continuity of care.

Four, finally, the MCOs agree that requiring MLTSS plans to enroll -- is the most effective way to integrate Medicaid and Medicare services, rather than a full integration approach; however, we urge the Commonwealth to consider the federal complexity and time frame governing snips as it designs the program requirements. With the expectation that the snip issue can be addressed, the MCOs are prepared to implement this on a more aggressive time line than paper outlines, especially Phase III and Phase II, after you complete

Phase I.

The MCOs are committed to working closely with the department in upcoming planning and implementation process.

Thank you for the opportunity to submit this testimony and thank four the opportunity given to the people of Pennsylvania to secure managed long-term care services and support. Thank you very much.

>> Kate: Our next speaker is Ron Barth.

>> THE SPEAKER: If you don't mind, I am going to sit down.

Secretary Osborne, Dallas, staff and departments from both human services -- I got it right -- and Aging.

Thank you for the opportunity to provide testimony this morning on the Commonwealth's managed long-term services support services

draft. I am Ron Barth president and CEO of -- we are a statewide association that represents over 370 not-for-profit senior service providers. The members serve more than 55,000 old tear -- utilize 150,000 volunteers on a daily basis.

Leading HPA members provide a vast array of services we do provide, I believe, the full array of services; that includes such things as affordable senior housing, adult daycare, both stand-a-lone daycare and in the life programs. A lot of members are in life program home healthcare, Hospice services as far as congregate settings assistive living settings, nursing facilities, independent living retirement Communities more commonly continuing care retirement communities and CCRCs.

Let me say unequivocally that -- it is very supportive Ott con

Celt of managed long-term care services and supports.

A number of years ago -- we have updated it as well, we developed our vision for the future for services for older adults we call it the north star.

In this, seniors are living longer, healthier lives with greater purpose and meaning in their home environment, however they define home. It may not be their original homestead, but wherever they are, it should be their home.

Our vision speaks to consumers and families being able to smoothly navigate through a comprehensive and coordinated set of exceptional services.

Financial sources, government regulations should allow people of various financial means to access a choice of services

facilitating their desired quality of life.

They should be able to access these services when they need them and wherever possible, where they would like to receive them.

Now, having said that, I get to the issues where we say we have a few issues and a few problems. I would like to take a moment, today, to highlight a few of our concerns with the MLTSS discussion draft.

First, we urge the departments to be cognizant of the vast and unique differences among the populations included in the proposal.

Older adults are no longer working, may no longer have family and/or community supports available and may have varying degrees of cognitive decline. Many have already chosen to move from homes into congregate living centers and services and supports they need may

likely look different than those of younger adults covered by MLTSS.

The Commonwealth needs to carefully consider this as details of the proposal are finalized.

We are the MLTSS document speaks to the rework about aing of embarrass constitutional care and community-based services in the Commonwealth. We are encouraged about the opportunities this change creates for addressing the gaps and mismatches between services needed and services available that exist in our current system.

We look forward in assisting you in the discussion and addressing these issues.

There is much to be gained from a more coordinated system caring for people with more chronic conditions; however, we need to be very, very careful to put in the system of managed care, rather

than a simple managed cost.

In addition, as we have advocated for many years, we know that current long-term services and support services in the Commonwealth has a gap for people who need 24 hours, seven-day-a week supports and assistance but may not need nursing facilities, yet these people do not have the income level to privately pay for personal care home or assisted living residences.

We are hopeful that this proposed system will finally address that gap. I emphasize, again, it is not just home and community-based supports and nursing facilities, there is a vast need in between.

That said, we do feel strongly that the noted time frame for implementation of MLTSS is way too aggressive.

It is a significant change to a system that is already complex and that has essential services to some of the Commonwealth's vulnerable citizens.

We urge you to take the time needed to get this right. To ab taken the stakehold Erin put necessary to formulate a plan that will work and use the lessons learned from the first region to improve the plan for the next region, then learn the lessons further and then implement that for the final region.

Stakeholder input is essential. We urge you to incorporate it not just now but throughout the implementation and operation of the program. We suggest that ongoing stakeholder feedback from providers, consumers, plans be formally be structured into the program.

Transitioning into the new program we cannot overstate the necessity for the Commonwealth to assure that managed care plans build and maintain a robust high-quality provider network.

We think it is important to set high standards for provider network, and maintain several options for consumers. Allow consumers who already selected their providers, to continue to utilize them.

As I said before, many leading HPA members live in requirement communities, which are 'unique blend of housing and services. These people have chosen and contracted with service providers in advance.

Protections must be in place to assure that CCR residents are allowed to continue with the choice of providers that they have

already made.

Recognizing the establishment of consensus-based quality measures for home and community-based services is, frankly, in its infancy. Leading HPA considerable expertise in the use of in-house, quality measurement in nursing facilities. We would be happy to assist in tests develop and implement quality program specific to Pennsylvania and apparently I am going over time.

[LAUGHTER]

Let me just add, we very much want to be helpful in this. We do support managed care. We think that you may be moving a bit too fast but are very, very willing and hopeful to be working with you to make this a success.

>> Kate: David Schwill -- hold on one moment.

>> THE SPEAKER: I want to echo one point, sometimes when we talk about managed long-term care, we talk about it as the difference between home and community-based services in a nursing facility.

Ron is exactly right, as you talk more about it, it is a continuum of services and that includes everything from personal care to assisted living to the items that you talk about there. Sometimes when we are trying to convey a point we simplify it. Ron's point is important it is continuing of services.

>> Good morning. Thank you for the opportunity to speak today.

My name is Dave -- I am the human services director in hew discern County. I am the acting AAA director of the Luzerne/Wyoming County area aging on aging.

In that capacity, strive to represent the staff advisory board and older adults with this testimony.

Briefly, I have been a caregiver and had to navigate the system to have my mother receive services and supports she needed during final illness. I began 39 years ago as the director in Allegheny County. I also want to say I am a Medicare recipient, so from that background, I base my testimony.

The system reform has been a long time coming. While the department has taken fits and starts to move in some kind of managed environment the private side of the business decades of experience in managing care -- some of these changes have been for the better and some have not.

Having better service array and provider choice for some of the

better aspects of managed care. So too are care navigators proposed in the discussion paper which makes sense to assist consumers as they move into health homes and other integrated care models.

-- restrictive form Larrys, return strategies and limiting access to care and in the early days poor communication to members and changes in benefits.

While it is recognized the demographics are rapidly changing at least over the next decade careful forethought needs to be given to long-term sustainable change. Reaching out in the beginning to consumers across the various constituents is imperative if the department wishes to -- if the department wants to have a good long-term product.

Please consider a broad representation as the department

develops its request for proposal and beyond.

Having constituent input from the very beginning will increase buy-in and make a somewhat smoother transition to this model.

It goes without saying, there is a long history of managed care in Pennsylvania.

I trust that the department will not attempt to reinvent the wheel and take the best practices that have been proven to succeed and blend them into whatever the delivery model that is finally crafted through the RFP process.

It appears the process wants to regionalize services and possibly have a centralized control system.

I would advocate for local control of the process. This model has worked well in behavioral health system, intends to encourage

services and supports targeted at the local constituents.

There is a system in place. Please look at how best to use existing structures instead of striking out in a unique direction. It may save the department developmental costs in the beginning and ongoing administrative costs.

As I read the discussion document, I took note of the fairly aggressive roll-out schedule. There is a nine-month period between res lease of roll out to roll-out of Phase I.

Thinking back -- May 24th 1996 and estimation at that time was for the entire Commonwealth to be under a managed care model within three years.

In actuality it was not until 2007, when that goal was finally realized.

Granted, that project was a much larger undertaking than the current endeavor. Please allow full constituent comment not only on the discussion paper but on the RFP process.

While the discussion paper is a high-level view of the proposal, the stakeholder involvement is planned through the entire process, please allow enough time for meaningful participation.

This is too important an undertaking to allow the language for another 10 years important older adult of the stake holders are the Apache As themselves.

We have worked with the department as well as older adult consumer to -- meet the ever-changing need of older Pennsylvanians.

As mentioned earlier, a mechanism as rate first opportunity should be considered when developing the RFP. There are existing

partnerships among counties that should be taken into consideration.

There may be AAAs that wish to explore new business opportunities and many positioned themselves to take advantage of the proposed change.

It is recognized that older Pennsylvanians are only part of the 450,000 consumers that fall under this proposal.

AAAs have been instrumental in working with community partners in roll-out PA Link and demonstrated abilities while working under a cross-systems approach to service delivery.

I would think that one of the bases for the joint venture between DHS and PDA -- I will talk fast -- is to maximize federal reimbursement under Medicaid.

While medical model is appropriate for the physical and

behavioral healthcare needs of this population as well as support  
cord coordination please keep in mind that other supports services  
don't fit well in this type of model as well as other managed care  
initiatives please keep open the option for supplemental services  
being part of the overall plan.

Finally, I would support independent oversight of is the  
process ombudsman is very important in providing -- population  
included in this proposal. I will end there.

[LAUGHTER]

>> Kate. Thank you.

Desiree Hung.

>> THE SPEAKER: Good morning everyone thank you very much.

Secretary odometers born and balance lass, thank you very much for

having this event AARP and members appreciate the opportunity to be able to speak today.

Thank you for the opportunity to comment on the proposal to explore Tim and managed long-term services and supports in Pennsylvania. My name is Desiree Hung state director for advocacy in Pennsylvania. AARP is membership organization with over 1.8 million members living in the Commonwealth.

When we talk to our members who are facing challenges and maintaining independence and require assistance with some activities of daily living, the overwhelming comment we hear from them is a desire to remain in home complaint hitch based setting.

AARP has supported efforts anticipate initiatives to enable more Pennsylvanians and Pennsylvanians with disabilities to get the

services they need at home.

For many Pennsylvanians over the age of 60, the programs supported by revenues from the Pennsylvania lottery have helped to keep them at home, but our over all long-term support systems is heavily weighted towards Pennsylvanians find undesirable.

We need to achieve better balance in system as spending on longterm services and supports in home and community settings is well below the national average according to CMS report in 2014 -- that is when the report was issued.

The proposal to move towards a managed long-term services supports system in Pennsylvania is to achieve a balanced system. It must proceed in a fashion that assures the first priority is needs of the consumers and that they are met.

Financial considerations are important, and a managed long-term services and supports system has the potential to achieve significant savings, allowing more Pennsylvanians to receive needed assistance.

If we approach this effort from a save-money-first perspective, we are risk neglecting the health and well-being of the individuals this initiative to designed to serving it AARP has a number of principles regarding a transition to a managed long-term services and support system. We will elaborate on these principles in the written document we submit regarding this proposal, but for now let me briefly discuss them.

Enrollment and choice: Stateses that adopt managed care programs should still recognize and support consumer choice to the

maximum extent possible. AARP believes people who are enrolled in managed care for Medicaid should be permitted to change plans to return to fee-for-service arrangements at any time, whether for cause or because they are not able to obtain a needed services from participating managed care vendors.

Vendor readiness and network add with a ski: As the Commonwealth transitions to MLTSS and managed care for dual eligibles, it is CIL critical to ensure prior to enrollment vendors that the capacity to meet the needs of the enrollees. Pennsylvania should develop a robust vendor-readiness review process to determine whether managed care vendors prepared to provide all contracted services in a safe, efficient and effective manner.

Three: Involvement of family caregivers.

Family caregivers provide the vast majority of LTSS in the home and community, but there is little mention of their involvement in the program components.

Four is state oversight. We are pleased the Commonwealth is it considering various ways to evaluate quality and outcomes in the MLTSS initiative. In shifting to a managed care program, robust vendor contract oversight and monitoring is critical to ensure that capitated payments do not create incentives for vendors to cut corners on needed care and services for this very vulnerable population. Robust oversight is imperative to ensure that all reporting requirements and performance standards are being supplied with even that they are leading to improved quality and access.

Lastly, reinvestment of savings.

If Pennsylvania's MLTSS program is able to achieve its stated goals, as well as generate cost savings for the state, AARP strongly believes that the Commonwealth should commit to using these savings as an opportunity to continue to improve access to and quality of home and community-based care on a larger scale. Transition to managed care should not be a way to gradually decrease Pennsylvania's investment in and availability of LTSS or other services available to these populations.

AARP looks forward to the you continuing evolution of this proposal. We are anxious to remain involved in this discussion as it moves forward and hope the principles we have discussed will be included as this proposal is refined. Thank you again for this opportunity to share our views and consider us as this process

begins.

>> KATE: Marge Angelo. I hope I said that.

>> THE SPEAKER: Good morning. My name is Marge Angelo market president of -- a participant in the Commonwealth health choices program which is Pennsylvania Medicaid managed care program.

We have long been a partner in the Commonwealth serving state's most vulnerable citizens.

Our mission is to help people get care, stay well and build healthy communities.

We have over 30 years experience in Medicaid managed care and we have expanded our capabilities in the past several years to include experience in Medicare Medicaid plan in the state of Michigan and also South Carolina.

We offer integrated physical, behavioral, MLTSS benefits through Medicare/Medicaid programs as part of financial demonstrations.

As market president, I am responsible for the general oversight and day-to-day operations in our health plan and am also a registered nurse.

As both health plan executive and clinician, I have a unique perspective on the Commonwealth's plan to improve the long-term care system. Amerihealth -- proposal to improve health and welfare of holder Pennsylvanians and individuals with physical disabilities by implementing a program that will reduce -- care -- rebalanced long-term disabilities by implementing a program that will reduce the barriers to care and also support and reduce the fragmentation

that currently exists in the long-term care in Pennsylvania. The proposed program has the potential to improve the lives of over 450,000 Pennsylvanians and will further the Commonwealth's commitment to improving health outcomes for some of the most sick and vulnerable citizens.

We affirm our support for managed long-term services and supports program in Pennsylvania. Additionally, we have experiences in coordinating benefits for dual eligibles in Medicare advantage program through dual eligible special needs plans.

We support many elements the Commonwealth has proposed for the MLTSS program and offering the following comments:

First, we agree with the Commonwealth's support of a mandatory program that includes dual eligibles, non-dual eligibles receiving

LTSS and Act 150 recipients.

We believe that MLTSS program must be mandatory across the state in order to successfully have balanced care, reduce unnecessary costs.

Additionally, we feel including these populations, we will also delay the need for LTSS or at-risk dual eligibles by keeping them healthier and independent for longer through I am intervention and better care coordination.

Second, we applaud the Commonwealth for emphasizing the necessity for coordination between Medicare and Medicaid services for dual eligibles, who make up the majority of consumers receiving long-term services and support.

We support MLTSS program that focuses on integrating care for

individuals across multiple programs and settings, including integration of Medicare and Medicaid services, such as physical therapy, behavioral health, pharmacy and long-term services such as nursing facilities and home and community-based services.

While we recognize the changes in the program, integration is essential for ensuring the appropriate coordination of care that leads to improved outcomes and long-term cost savings. When all payments and services are coordinated -- unnecessary and harmful services are reduced. The long-term system becomes easier to navigate.

Third, we support a regional approach to MLTSS program. We propose aligning it with the existing health choices zones to reduce confusion and fragmentation and enhance continuity of care.

As many individuals may be transferring from the health choices program to the MLTSS program, ATZ their needs and conditions change. Finally we believe that the implementation of the proposed program could be rolled out 18 months rather than 24 months. While we applaud the Commonwealth for wanting to ensure adequate time for implementation, we believe that MLTSS has become well-established model and we feel that the proposed time could be shortened.

In conclusion, we commend the Wolf administration for allowing beneficiaries, advocates you can providers and healthcare plans to give feedback on the proposed MLTSS program we look forward to participator innig with the Commonwealth in the coming months to help develop and implement MLTSS program that will ensure the Pennsylvania's most vulnerable citizens receive the right care,

right time in the right setting. Thank you very much.

>> KATE: Russ McDade.

>> THE SPEAKER: Thank you, Kate.

I am going to put my stopwatch on so Kate doesn't have to come after me.

Good morning secretary Dallas, secretary Osborne deputy secretary and fellow stakeholders I am president and chief operating officer of Pennsylvania healthcare association. We are a statewide association representing over 450 members statewide.

Primarily those providing round-the-clock seniors assisted living and personal care homes.

We appreciate the opportunity to be here testifying.

Our mission is a simple one to ensure that those who need

long-term care receive quality services in the most appropriate and cost-effective setting at each stage. The key words are appropriate and cost-effective. We are on record both secretaries have heard both CEOs and myself say no one should be in a nursing facility who doesn't need to be there. No one who needs round the clock 24-care services skilled care services should be there; however, when a consumer has multiple chronic healthcare needs the most appropriate setting is the nursing facility the system should not be stacked against the care with artificial barriers to keep consumers in the community. We think it is very important that we expand choice in MLTSS program not narrow it.

We are pleased to be here today. We support administration's commitment to long-term services and supports person-centered,

coordinated and focused on preventive services and outcomes however  
behave serious concerns on timing, on the reach and on the extent to  
which at least in the discussion document we will focus on real  
outcomes and quality measures.

I will mention a couple of those.

First, the timing of the plan. Simply stated -- I think you've  
heard both sides of this today, we think the time frame is too  
aggressive.

Not necessarily this phase of public comment but clearly as you  
move from this phase of public comment to RFP in October, which will  
procure all phases at one time, the conversations we have had and  
are interested in revolve around whether you call them pilots, demos  
or developing some Pennsylvania-specific data to try to see that

what we are trying to do makes sense for Pennsylvania, given diverse population and geography, we think it is very important that in between phases the department build the time to step back, look at quantitative data, to ensure that quality measures, savings and outcomes measures are being reached before aggressively moving forward with another phase.

We think it is important you have the opportunity to make design changes to Phase II before implementing Phase II and same thing between Phase II and III.

There are no definitive studies that have showed improved health outcomes and cost savings on frail elderly and those are the folks who need around the clock care we provide. Please understand the difference for folks in the room we are not talking about a

younger individual. The people we care for in nursing facility -P  
orina siftive living are frail need 24/7 services supports and cares  
that are provided in those settings. We don't want to see anything  
in MLTSS program get in the way of them continuing to receive that  
care and services.

The challenges that this population will present to us are very  
reel. We want you to be mindful of the fact that we cannot manage  
the way, the costs associated with caring for frail elders who are  
in need of around-the-clock care and services.

Next I would like to address outcomes. Simply stated reduction  
of facility days is treated in outcome MLTSS programs. With health  
plans given utilization targets to hit nursing facility days,  
assistive living days institutional versus community days.

Some states put a price tag on the measure you will earn more money in capitation rates as health plan if you get people into the community.

Let me make this very clear: Serving fewer people in nursing facilities is not a measure of good quality or positive outcome in and of itself, it is a measure of program goals.

We want to be sure that we focus on only diverting those individuals when it is in their best interest and when there is a quality outcome to be had.

I would like to ramp up, finally, with a story.

A 2014 from New York times it chronic he willed -- debilitating arthritis, lung disease newly blind and growing dementia under MLTSS forced from nursing home into the community where his needs were not

adequately met.

Then he was denied continuation of apparently community services.

The report in the New York Times article which I referenced in the written testimony you have focuses on Tennessee, New York Minnesota and have been tallied successful in MLTSS and have experienced serious quality and coordination issues.

We want to be sure -- in the aggregate numbers, if those states were looking at balance in the system, that man might have been treated as a success story. We got him successfully 2450 the Community once you read the article, you will see the system failed him at least in that instance.

We want to be sure stories like this don't repeat themselves in

Pennsylvania. We are committed to, working with the  
administration. We thank you for the opportunity to testify. We  
look forward to being part of the conversation as you move forward.  
Thank you.

>> KAT. E: Pam Auer.

>> THE SPEAKER: Good morning. I appreciate having the  
opportunity to give testimony on this important issue.

My name is Pam Auer, I am with the Center for Independent  
Living of central PA. I am the director of Living Well with a  
Disability program.

We serve individuals with disabilities at any age to live  
independently in the community. The mission for the Center for  
Independent Living is eliminate and prevent barriers people where

disabilities experience by providing ongoing advocacy and providing services.

I am here today to be an advocate for the prevention on elimination of barriers for individuals that are receiving services today and will receive them in the future with the implementation of managed long-term care program.

There are so many unanswered questions for consumers with what was put out in the discussion paper.

I just want to list some of the concerns we have and some suggestions. First would be my question on person-centered. We really need to be clear when you are talking about person-centered service delivery.

That could go either way that would be yeah, the person is at

the table. The person is there with us. We are going to make the decisions. It has to make sure that people are empowered to make the decisions. We need to continue the hit Pennsylvania has with consumer control, consumer being able to make those discussions; that has to stay in whatever process you come up with.

My concern is that health plans may not have experience paying unlicensed attendants except through an agency. Two would do payroll? Existing financial management services like PPL or will they try to do this in-house? What is going to happen with the financial management services? PPL was a disaster. We have had problems with Christian financial doing payroll for people. What is going to happen with consumers? How does that look? That is a concern we have.

I am suggesting you put the financial out to bid, financial services out to bid and that it be more than one. It needs to be minimum having access to choose who provides fiscal management be services or whatever they are calling it.

For consumer employer model services, who would do the background checks and all of that, that goes to the financial management. What qualifications beyond what already exist from the Department of Health regulations will the plans impose on attendances? Are you getting stricter? What is going to happen? We count on the existing home care agencies. What will it look like for us? Is there still choice as everybody else has been saying we need plenty of choices in home care agencies, service coordination agencies and managed care organizations, I do not support -- I know

a lot of the consumers I am working with we do not recommend one for the entire state. If something goes wrong, you have to be able to go and pick another organization.

I am trying to make it short e by not reading everything.

One of the biggest concerns that we have is recommending to you today that contracts with managed care entities include clear maintains provision that protects consumers from cuts to services or caregiver's pay and benefits.

My concern for our consumers with this whole process, has been from the beginning, that what happens if someone costs too much? What happens -- we have plenty of consumers we work with with high-level of need for services. What happens if it's not cost effective for the managed care to keep them in the community where

they get inadequate services? They get into the cycle where they end up in the hospital, end up in the nursing home and we are fighting to get them back.

We need to be careful in how you are qualifying people for managed care and making sure that they get adequate services.

I agree with the story that Russ just gave, the 75-year-old man, if he had the adequate services, why couldn't he be able to live and thrive in the community?

Why are you only having aging and OLTL in this process? Why is the department developmental services, developmental programs, why are they not included? Why not fix the whole system. If you are working on the system, bring everybody together. Make it work for everyone?

I am almost done here, I promise.

We need advocates -- one of the big things is, when you look at having someone to advocate for the consumers or advocate for those services to get adequate services, yes, there is an existing ombudsman program, but I believe there needs more paid advocates that don't have a stake in the process to be out there to help people through the process. Honestly, as Center for Independent Living, we do that a lot. People say, I called, they came out. I don't know where I am at in the system. Or they get in the system, they don't know how to change their services, they don't know how to do any of that. We can help call. It takes a lot.

There needs to be a designated program to help people through the system.

My last issue, I haven't heard anything about what nursing home transition is going to look like in this process. I haven't heard anything.

It is great to keep people out of nursing homes. I believe in it 100%.

What about the people in there that aren't the frail people that Russ described? What about those people who are in nursing homes because they don't have housing. There is no place in the system to be able to get out. Nursing home transition is a very important part of the process.

What is going to be the plan for that?

I believe, again, that needs to be a program that is separate service coordination doing it. It needs to be a dedicated program.

Thank you.

>> KATE: Sorry. I have to get back to my list. Patty

Dernley.

>> THE SPEAKER: Good morning, secretary Dallas, secretary Osborne and deputy secretary -- I am Patty the president and CEO of gateway health I appreciate the opportunity to be here today and discuss long-term care and support services.

Gateway health is managed oh, that serves Commonwealth Medicaid population over 22 years our mission embraces quality innovation and soundness we are third-largest program and deliver quality care to more than 300,000PA Medicaid beneficiaries in 40 don't.

Gateway health's pro bust provider network encompasses more than 9-X000 physicians and 100 hospitals.

We also serve close to 50,000 Pennsylvanians in 39 counties who are qualified for Medicare advantage special is -- chronic heart failure.

Many have physical disabilities as well as behavioral health issues.

Before I make any policy recommendations, I first want to talk about our model of care prospect I am care management we refer to as PCM. This approach addresses the first person we identify the behavioral, economical, medical, social and spiritual needs of our members in order to intervene and lower barriers to their care.

We understand that health status is heavily influenced by various social and economic factors and that can adversely impact the health and vitality of our members and their communities.

In other words, it is not just sound business decision managed care, it is also the right thing to do.

Not only will managed model put Pennsylvania back on the cuttingth of Medicaid program design, it will also have a very real benefits for consumers and tax payers, including increased quality and collaboration, as well as choice and access to appropriate care delivery Sims achieving better outcomes and cost-savings.

For those reasons we are interested in, woulding with the Commonwealth as a partner to manage one of the largest cost drivers in the Commonwealth.

In Pennsylvania, the elderly and disabled represent only 39% of our Medicaid population but ability for 73% of our expenditures, manufacturing to this model will serve the Commonwealth well.

We support the following recommendations. Make person-centered care a priority. We support consumers who made the plea nothing about me without me for those who desire community-based services versus institutional care. It is important that these individuals and loved one have a choice and service-directed supports and services as long as they are able to.

Additionally we support strong consumer protections that managed care is accustomed to in -- the Commonwealth should also take steps to reduce consumer confusion by streamlining program changes and implementation of MLTSS while protecting consumer's choice of MCOs, or self-directed care.

In the discussion care you discussed launching in southwest PA we are highly visible in that region we recommend you finalize the

geographic zones as soon as possible to allow more time to initiate the Medicare filings and bidding process.

Allegheny County and surrounding Counties in southwest have highest concentration of recipients in the Commonwealth of whom 62% chose Medicare plan to support healthcare needs.

-- serve large portions of special needs and health choices enrollees.

Participatants in southwest PA zone would have the experience and established working relationship to operationallize quickly and seamlessly.

Additionally partnering with aging and disability stakeholders, we recognize they have strong working relationships amenable to coordinating severities in support of the proposed program.

We welcome the Area Agency on Aging and Center for Independent Living to work closely with the health choices MCOs, Medicare special needs programs to capitalize on experience in managing LTSS and identify ways to better coordinate opportunities.

This initiative offers tremendous opportunity to generate sufficient data to advance policy cap for consumer-based long-term services and supports.

We pledge to work with service providers AAA and other long-term stakeholders and emphasize appropriate care settings.

Having an integrated care lifary approach for MLTSS would further support the ability to manage the member's community-based services and provide care for members safely and in cost-effective way for members in the Community depending with these dollars the

services should be integrated into the model.

The member benefits from having behavioral health carved in allows for better coordination of care, better outcomes and reduced costs.

This would be an opportunity to expand scope of behavioral health benefits currently covered at County level such as community-based in-home behavioral support or intensive case managers. Co-managing behavioral and physical health needs would be best meet needs of MLTSS member.

These members will tend to have more complexity to their conditions physically and behaviorly.

Additionally, it is easier for providers, consumers to navigate through the system and mitigate hands off to non-contracted

providers.

The most productive care models -- improved account ability streamlined eligible determination. Will we have sought out and licensed to stakeholder concerns about how to process needs to be streamlined.

We have met with numerous organizations for the past several months to better understand what the barriers have been.

MCOs should have clinical, financial and administrative responsibility for all aspects of care delivery and finance.

Integrate the duals: For the most frail and disabled due eligible for O receives services from a disparate and miss aligned system ofs and providers it is imperative to explore how to better deliver LTSS in a way that also reduces cost pressures to the state

and its taxpayers without comprising quality. Over time all dual eligibles should be part of an inclusive comprising -- address cost and quality issues for poor coordination.

Reaching this goal, however, is complex. A robust stakeholder pro success, et cetera, take time. Gateway health, looks forward to working with the state for Pennsylvanians who are dually eligible for Medicare and Medicaid.

We will submit for detailed written comments at a later date but we thank you for the dialogue today allowing us to participate.

Thank you very much.

>> KATE: Thank you.

Naja Orr. Speaker good morning secretary Dallas and Osborne I am the director of Bucks County Area Agency on Aging.

Thank you for the opportunity to provide public comment regarding the state's MLTSS framework. Bucks County Area Agency on Aging has been charged with planning and implementing a variety of supports and services to assist older adults we serve those with greatest economic needs and those at risk for institutionalization.

There are several things to consider -- regarding program design, number 1, MLTSS should include expertise of existing networks that maximize resources and facilitate proper care integration the AAAs in Pennsylvania have fulfilled older act mandates for over 40 years we lead them to necessary resources support those at risk that require assistance to remain safe in the community and assist those who risk bankers.

AAA managers comprehensive face-to-face assessments to meet holistic and specific needs of consumers representing AAA options counseling and assessment functions will assure the Commonwealth will maintain an appropriate, unbiased and trusted source for some of our most vulnerable consumers.

AAA also advocates for a continued role as community care coordinator for the Commonwealth for older adults while we continue to ensure their adequate firewalls to eliminate any real or pursued conflicts of interest.

Number two, service delivery options should include consumer-directed models as well as full service or combination models. Consumers should have a choice of qualified service providers and providers should be adequately reimbursed to pay

competitive salaries within the region's market standards to support recruitment and retention of a qualified workforce.

Number three, person-centered service planning should include comprehensive care management with face-to-face contact versus exclusively done from a remote location, assessment care planning and enrollment must be culturally sensitive and maintain expedition time lines.

Expedited enrollment provides viable alternative to institutionalization by eliminating the interruption between immediate need and the start of services.

Number four, consumers should be educated regarding the right to appeal, access to the ombudsman program as well as protective services to assist those at risk of bankers.

Number five, regional MCOs selected through the competitive bid process should be allocated a capitated monthly payment for consumers served, contractual incentives should be included to improve consumer's health including reduced hospitalization, improved health outcomes and health and wellness program enrollment.

Number six, first consideration should be given to least restrictive setting of the consume every's choice. Section 301 (a) (1) of older Americans Act to promote securing and maintaining maximum independence and dignity in a home environment for older individuals capable of self care and appropriate supportive services.

Greater support of home and community-based services will strengthen Pennsylvania's commitment to elder Americans mandates and

is more economically sustainable for the Commonwealth.

Regarding the planning phase, MLTSS care coordination should include better interest grace between acute care, behavioral health supports and LTSS, readiness reviews, training and technical assistance with CMS, policymakers and stakeholders should be completed to minimize any planning oversights.

Regarding implementation, we respectfully request the public comment session be extended through July 31st the two weeks would provide adequate time for the Commonwealth to review and considering recommendations prior to RFP release E regional trainings and webinars should be provided to the community-based organizations at least three weeks prior to roll-out.

Oversight: Appropriate metrics should be tracked ate

indicators of success focusing on community integration,  
consumer-centered care and consumer satisfaction.

Clear performance should be defined and dashboards should be developed to provide uniform tracking tool.

Finally, contract monitoring should be implemented to complete provider performance reviews and ensure compliance.

Quality: The Commonwealth should carefully monitor and limit both administrative costs and profit margins to provide adequate incentives for evidence-based practices.

This will ensure maximum resources are available for consumer services and supports.

Thank you for allow being me to provide input for MLTSS framework.

>> KATE: Jeff Eisman.

>> THE SPEAKER: Good morning, my name is Jeff Eisman I am program analyst for Pennsylvania statewide living council for PA-SILC. All territories have a -- we support 18 centers for independent living in Pennsylvania we collaborate with a lot of community organizations including some of you in this room to provide independent living opportunities for folks with adults in all areas of life, including long-term care.

We thank you for the opportunity and start by addressing the requested areas.

First, we will go into programs design, where we have four recommendations.

We believe that the MLTSS system needs to be designed in a

simpler manner than current system to enable folks to choose home and community-based services up front, diversion and move out of nursing homes through other institutional care -- second, we think enhanced efforts needs to be made to reach those with communication barriers targeted disability populations, particularly folks who are deaf, deaf-blind, cognitive disabilities and particularly minority populations where English as a second language, growing Spanish and Hispanic populations in Pennsylvania.

We also believe rural populations underserved population with limited internet service should be targeted.

Don't forget veterans with disabilities last year \$15 million was saved by coordinating with VA benefits. Think what we could do with other coordination with other state programs for PA veterans.

We agree with comments made earlier that it needs to be extended to provide for more feedback under implementation we believe the time table for implementation needs to be delayed for initial roll-out.

We also think OLTL and aging needs hands-on approach to make sure that no one loses services and supports and providers and staff paid during timely manner during this transition.

We think timely responses need to be made for adjustments to be made in responsible manner with public and private stakeholders when glitches come up.

Under quality we think Pennsylvania should be the leader in balancing our long-term care system and exceeding CMS and independent national quality standards in all areas of care.

We think it shouldn't vary much between counties it is an issue where you go between one counties and quality is not the same.

Other recommendations we have: We commend the comprehensive approach you have for home and community-based services for folks of all ages and disabilities and also nursings homes.

We also think this should be an opportunity to expand urgent care centers, many rural communities still don't have them. It is a place folks can go instead of hospital to get basic care.

We also think that contracts with the managed care entities need to have a clear maintenance of effort and protect consumers from cuts and cuts in caregiver pay and benefits.

We also think that consumer choice needs to be a key component in all services and models when the county only has one employer, it

was not really consumer choice.

We also have concerns about individuals who have two or more disabilities and use different services, for example, folks with physical disabilities who also need mental health supports they shouldn't have --

We think spenddown is an option for individuals to qualify home and Community-based services as part of MLTSS plan.

We also think there needs to be protection for consumers in all long-term care settings.

We also think there needs to be a -- it should be part of a comprehensive Olmstead plan. We hear we have one but it is not comprehensive, doesn't include everyone.

We also think this is a good opportunity to address dual

eligible particularly service gaps for specialists and those who need dental care particularly in rural and underserved areas.

We think managed care organizations who will be doing this, should be trained with OLTL and Aging and particularly those with independent living philosophy to understand how folks can maintain independence.

Last, some questions we had:

Will consumer control and consumer models of care be funded at least current levels and perhaps increase where they find cost savings and keep people out of hospital.

How often will consumers be able to change plans?

How will the proposal improve accessive housing? It seems like this is a managed care for home mods for waiver and non-waiver

programs.

We also question access to assistive technology is going to be impacted particularly those in behavior where aging is part of benefit package.

We have questions about how will it affect consumers with DME, how does it affect providers?

How does this work for consumers who -- there has been push for will focuseses with disabilities those who use Act 150 program if they want to go to work, how does it change their benefits?

It was already members of the juried about preventive care, hopefully that is more readily available.

Another issue that came up in some of the trainings and discussions was, transportation. How are folks who use this going

to be affected under this model?

Also questions about role the department with those multiple insurance and long-term care insurance?

Can you share with us how -- last point, for those who are in age care transitions, for example, folks under 21 going into adult system for folks under senior services is this a seamless transition? We thank you for the time to comment.

>> KATE: Joann T.?

>> THE SPEAKER: Secretary Dallas Osborne and assistant secretary Burnett any name is Joann T. success rehabilitation.

Success provides post acute rehabilitation services for those with traumatic brain injuries?

I do promise, my comments will be brief providers specializing

in traumatic brain injury will provide specific written comments but

I want to make a few remarks.

Regarding this document there is a noticeable lack of mention of cognitive rehabilitation services as well as overall rehabilitation services.

Those with traumatic brain injuries depend on these services to improve the quality of life and level of independent functioning.

I am concerned this lack of recognition of specific rehabilitation services currently provided to enrolled individuals in the home and community-based service waivers for those with brain injuries would not be able to continue to receive them under this model that addresses physical and behavioral needs but not the cognitive and specialized needs for these individuals?

The traumatic brain injury community is a relatively small community and perhaps thought should be given to whether or not the MLTSS model presented is truly applicable to this population. Thank you for your time. There are two cars parked in the grass that need to move. White Toyota Camry with a license plate DCJ0075 and a red Ford, I am not sure what type maybe an SU V Leonard 1 on the license plate.

Next up is Joanie Griffith.

>> THE SPEAKER: Good morning. My name is Joanie Griffin I am the chief clinical officer for Visiting Nurse Association of Hanover and Spring Grove, located in Hanover.

My agency is also a member of the Pennsylvania Home Care Association, which represents over 700 home health hospice and home

care agencies across the straight.

We provide in-home services to those individuals residing in the southwestern portion of York county, as well as Adams County.

We provide skilled nursing, physical, occupational, speech therapy, social work and personal care assistance, following acute episode of illness Hospice care for those individuals requiring professional care at the end of life and home care services providing trained home care aids who assist with activities of daily living, dressing, bathing light housekeeping and meal preparation.

In all areas of service -- we work closely with managed care for years thank you for giving me the opportunity to speak with you today about Pennsylvania's plan to reform long-term services and reports.

Our ultimate goal should be for consumers to have the right  
carat right time by the right people.

I think we all agree on that.

In many cases that is what we in home care can do, but we have  
to make sure that there are provisions in place to allow that to  
happen timely and seamlessly for the consumer. The following are  
some of the most pressing issues that will need to be addressed.

Enrollment and eligible need to be streamlined. Currently,  
consumers can wait months until Medicaid application is completed  
and submitted, care assessment and accompanying documentation is  
completed, and individualized care plan is developed before home and  
Community-based services are approved.

When people are in need of care, they cannot wait months and

therefore, the only alternative may be admittance to nursing facility at a much higher cost for -- than for home care.

One of the goals of managed long-term services and supports is to coordinate care and contain costs and following the relations of the long-term care commission that eligibility determinations must be streamlined and standardized across all settings will be the first step to ensure institutional care is not always the first stop for those individuals requiring long-term care. -- how home care services can save considerable sums of money. For instance, weekly home healthcare visits from registered nurse who can provide skilled assessment and teaching can detect developing problems and prevent those individuals with chronic health diagnoses such as diabetes and congestive healthcare from being admitted to hospital with acute

episode of illness. Home care aid visiting several hours a week to assist may be all that is needed to allow an individual to remain in their own home instead of being admitted to a long-care facility.

Both of these alternatives would be at a much lower cost to managed care organization.

For consumers with chronic health problems the goal is about providing necessary supports to maintain current health status and allow them to stay in their own home as long as possible.

Eye holistic approach which recognizes consumer's healthcare needs do not always fit into neatly-assigned categories. It doesn't remain static and care planning is continual process which does not always fall into neatly-assigned time frames becoming important therefore programs focusing on patient-centered goals with

flexibility to change rapidly as consumers needs change would be most successful.

Finally, consumers must be educated about care options to assist in understanding what the right setting is for them depending on the care they require.

Nursing home may be the most appropriate choice in some instances, but it should not be the first and only choice for consumer looking for care.

Providing care and assistance for individuals who are transferring from one level of care to another, including education about options for care at home would allow individuals to be cared for in the setting of their choice.

Transition to MLTSS will require considerable time, resources

and input from all groups to be successful.

Maintaining open communication between MCOs and providers, consumers and other stakeholders will assure long-term goals of providing quality, affordable patient-centered care are met.

We must make sure the voices of providers and consumers are also heard at the state level to ensure that MCOs are following guidelines to make new initiative a success.

Thank you for providing me with this opportunity to speak to you on behalf of providers and consumers as we work together to assure the success of MLTSS.

>> KATE: Thank you.

Lynette Foreman.

>> THE SPEAKER: Good morning, everyone. Thank you Secretary

Dallas and Secretary.

I am Lynette Foreman. I am a disability advocate and consumer.

Of.

I have attended many of the waiver meetings and believe that there should be nothing about me without me. I just got back out of bed after three years. You do not see everything wrong with me.

Neither will managed care organization.

I am a dual eligible person. I have come close to death three times in the last three years.

I live in my own home, which is a rental. I have my cat, which keeps me very good company. I have excellent PCAs and the one sitting in front of me has been with me almost 10 years.

You don't find that very often.

The program design does not seem to have consumers involved from the start.

Planning this is going -- is the planning of this going to be dumped on us as PPL was?

All consumers -- how will it affect them and notified now to have a voice.

What are our choices? What steps will be implemented?

Who can people call directly and speak with knowledgeable?

If you call the welfare line about information, you are put off. You are given errorrous information. You are told your case manager will call you and nobody calls.

Are we going to go through that?

Who judges the quality? It means something different to

everyone.

What happens to the Septemberers for independent living? They were founded and given responsibilities under, I believe, the Rehabilitation Act of 1968.

What about service coordination, attendant care and providers?

Remember, nothing about us, without us!

KATE: Next up is Rebecca.

>> THE SPEAKER: Thank you. Good morning. Thank you for this opportunity.

My name is Rebecca I am the enthusiasm executive director of Pennsylvania association of area agencies on aging, commonly known as P4A.

P4A functions as membership assistance policy advocacy and

professional development organization for all 52 areas of aging in Pennsylvania.

I would like to take this time to thank you for this opportunity on how managed long-term care services and supports should be fashioned and implemented in Pennsylvania.

We are pleased to see the paper is predicated on several recommendations articulated by long-term care services and task forces formed over the past few years. We emphatically support principles in the document. They embrace person-centered care planning, coordination of behavioral and long-term care services, availability of a highly-qualified and provider-led workforce, the provision of services in least restrictive most desired setting and implementation of performance incentives of plan's payment

structure, robust support and educational activities for participants that involve advocacy and ombudsman services reliance on health and wellness services fair and objective grievance and appeal as much as quality and outcome based services.

For our recommendation: As you heard several times we believe this process is extremely fast-moving with such an important and complex topic we strongly encourage the administration to slow the process down to enable full adequate education and engagement. Not just public comments but education and engagement.

It is critical consumers, family members and caregivers are given the opportunity to understand what is being proposed to provide full meaningful input.

Experience from across the nation has clearly shown integrated

care system to work it must be based on active sustained and legitimate stakeholder -- we recommend implementation of statewide committee affected service populations can adequately contribute to all final decisions and desire direction for managing care. We believe this committee should embrace at least 50% representation of consumers and caregivers.

In addition locally-managed focus group approach so voice of older adults those with disabilities can be assembled and heard in most accessible and convene way possible for -- a commitment to consumer choice is at the core of P4A and AAAs with this in mind consumers should have a choice of service options consumer-directed model when it is not the option of choice a full-service agency or combination model should be available.

P4A and A Apache members stand ready, willing and able to collaborate on this best approach in Pennsylvania.

For more than 40 years AAAs served respected sensible stewards publicly-funded -- we have tirelessly cared out unending commitment to mission and legally mandated purpose.

The experience and capacity of the AAA network will go a long way in assisting Commonwealth to meet MLTSS objectives to realign -- create accessible seamness transition for consumers there must be clearly defined role for AAAs.

Due to frailty of aging and complication of various physical and cognitive conditions will need to be actively assisted and directed through this structure.

We recommend the State's final MLTSS blueprint have carved-in

-- conduct -- provide options counseling for consumers of all aging services and care organization in-person face-to-face -- valuing the importance of maintaining a service engagement that is conflict free we will closely collaborate with administration so any real or perceived conflict can be quickly identified -- we have been talking about these as firewalls.

As I mentioned for the past 40 years AAAs have been actively engaged in diversified services for senior adults and caregivers we think most prominently seen in many areas can assist the Commonwealth's administration in planning, implementing and delivering a more comprehensive approach for managed MLTSS.

P4A and AAAs have a new legal truck tour with like service collaborations within network might-pay service models and other

advocacy organizations.

We want you to know we are flexible, creative in putting together the best possible services for those that we serve.

As you probably know, we have many more thoughts about this, like others we will provide much more detailed comments in the future before deadline.

I am proud to say AAAs with the support of P4A have had achievements in the past four decades we look forward to working with the administration for major system reform.

Thank you.

>> KATE: Mark Shay.

>> THE SPEAKER: Good morning, everyone.

My name is Mark Shay, director of York County aging office. I

did not park in the grass.

[LAUGHTER]

Thank you for the opportunity to provide input today regarding Pennsylvania's plan for implementing managed long-term services and supports. The potential impact it could have on members of our communities.

For over 40 years, Area Agencies on Aging have been at the forefront of providing managed care services to consumers in Pennsylvania.

Area Agencies on Aging have developed networks of locally engaged and dependable providers, offering a menu of diversified services for seniors, adults and their caregivers.

The aging network's experience in the areas of assessment, care

management, ombudsman and other services can assist the Commonwealth's administration in planning, implementing and delivering a comprehensive approach to managed long-term services and supports.

It took many years to build the aging network in Pennsylvania. Just as long to ensure the consumer's families and caregivers were properly educated about services and supports.

The proposed time frame for the implementation of managed long-term services and supports in Pennsylvania appears to be very quick.

For such an important and complex process.

I strongly encourage the administration to slow this process down to allow for comprehensive, community education and engagement.

It is critical that consumers, family members and caregivers are given the opportunity to fully understand what is being proposed so that they can provide complete and meaningful input.

There must be a mechanism for gathering comprehensive input in plan design and ongoing operations advisory committees for this process should be comprised of 51 percent consumer and caregiver representatives to ensure inclusion in the process.

I must applaud the discussion document for its focus on consumer choice. Consumers should have a choice in service delivery options. Those options must include a consumer-directed model. When it is not the option of choice, a full-service agency model or combination model should be available.

Managed long-term services and supports should maximize

existing service systems and promote improved care integration to ensure that choice is never an issue.

As a specific example, the system should continue to take advantage of the expertise that Area Agencies on Aging and the aging network have developed to perform strength-based consumer assessment and care management.

These consumer-centered processes are not only extremely effective, but they provide the boots on the ground that any successful managed long-term services and supports initiative requires.

In closing, I believe Pennsylvania has the opportunity to be a leader in managed long-term services and supports. I would encourage the administration to slow the process, in order to ensure

that this program meets the needs of the people it is intended to serve.

There is a tremendous amount of input, dialogue, education that needs to take place, all of these actions take time.

I would also encourage the administration to take advantage of existing networks such as Aging network having a great deal of experience with consumer center focus.

These are the agencies that meet consumers needs where they live. These are the boots on the ground for consumer care and are a essential part of this process. Thank you for your support for individuals needing long-term care.

>> KATE: Our next speaker is Marsha -- [indiscernible]

>> THE SPEAKER: Good morning. My name is Marsha. I am the

program manager for the deaf-blind living well services with the center for independent living of central Pennsylvania. I am deaf-blind.

This means that I cannot see and I do not have useable hearing.

Deaf-blindness is a wide range hearing loss and vision loss and can span over any age, including obviously, those people who are 55 and 65 years and older.

I am here today to bring awareness to persons who are deaf-blind. Until recently, persons who are deaf-blind have not had a voice. We have been isolated and stored away in homes all across the state.

There are not clear numbers on how many deaf-blind persons there are within Pennsylvania, because of the isolation and because

they have not had a voice.

Most deaf-blind persons rely on family and friends to help with simple daily living needs, communication, errands and all of the things that we take for granted.

I, as a deaf-blind consumer, have also applied for a waiver services. I have met a couple challenges among many. When I contacted the IEB agency, the communication was, number one, a challenge.

The agency did not know, first of all, what deafblindness was, nor did they understand how to communicate with me.

Second -- I'm sorry. Just a second.

Second, when I was going through the process, the process is very confusing. What I have heard already so far today is that the

process is confusing for anyone. For a person who is deafblind, who does not have the same access to information as everyone else, this process can be overwhelming.

There's no one to help with this process. You are told to contact this person and that person and do this and that with no explanation of what those things are.

So when a worker came out to my home, again, they were not familiar with deafblindness. We could have persons within the state who are considered to be deafblind but are not labeled as such.

A person who is hard of hearing and visually impaired could also be considered deafblind.

Another issue is that when I got to the point of choosing a support coordination, the support coordination list is not

accessible. The documents that I was forced to fill out with someone's help and other documents are not accessible whatsoever.

When I wanted to communicate with workers at either agency, the IEB or my local county agency, I cannot speak on the phone. Workers are not familiar with talking to consumers through email.

Compass, which is the website management program which is used for service coordination and IEB agency is, again, not accessible for persons who are blind and deafblind. I use very specific technology that helps me access the computer.

So my point among many this morning is that deafblind persons, in order to be not isolated, to have mental health concerns and become independent require the services of a support services provider SSP.

My agency has now developed an SSP program. We have 56 SSPs trained throughout the state. I have an SSP here about me today. This person helps me with communication, environmental information, guiding and sometimes transportation.

The person can also help with daily live being skills like reading mail, labeling boxes and those types of things.

They could also help with errands.

If and when I find out that I have been accepted through the waiver program, I may have an attendant care or a PCA come out to my home. I cannot communicate with that person, nor does that person have the skills that I need specific to my disability; that person does not know how to communicate with me. Knows nothing about deafblindness or vision loss or hearing loss.

An SSP is a very specific professional who is trained. An SSP opens doors for persons who are deafblind. An SSP helps with getting that person out into of the community and being more involved in their personal and community and affairs, whether it be, like I said, reading mail or going to meetings like this.

So my recommendation is, please consider creating a separate waiver for persons who are deafblind, also, do not forget a population until recently has been forgotten and overlooked.

Thank you.

>> KATE: Diana Deiley.

>> THE SPEAKER: My name is Diana Deiley. I am a consumer with the Center for Independent Living.

I have several comments but most I will submit in written

format.

I have been a consumer on the Ober waiver since 2005. I use attendant care visits to perform activities of daily living and have lived in my own apartment for three months.

Having as much freedom as I do now and having things being changed on me, would be very scary.

I agree with most of what the document says, but two things that need to be remembered is our entire lives are at stake when you consider changing things.

Think about those of us who have the most to do with it.

Also, think about our caregivers who may not -- who we as consumers and employers may not know how much we can take care of attendants who are really providing our care and being able and

physically allowing us to be as productive citizens in the  
community.

Thank you very much.

>> KATE: Theo Braddy.S.

>> THE SPEAKER: Thank you. in order to address my primary  
issue I want to talk by need to address attendant care for people  
with disabilities.

I often refer to attendant care services as the great equalizer  
for people with disabilities who depend on them.

For anyone who depends on attendant care, they know what I mean  
by the great equalizer.

I am a C4 quadriplegic and use attendant care services since  
1983 while attending Edinboro University. Attendants assisted me

with meals, getting in and out of bed, personal hygiene and a host of other things for many, many years. Without this great equalizer, I cannot imagine what my life would look like.

With them I graduated from Edinboro University, I went on to Temple University and graduated with honors.

With them I became employed right after graduating from Temple University and became the first executive director of CIL-CPA.

Being employed has allowed me to pay back in taxes way over what has been invested into me by these programs.

Now, let me talk about what my life was like before I started using attendant care services. I remember it as though it was only yesterday. It goes like this.

-- a year and a half of living in a nursing home at age 16.

After finally getting out of there and moving PA I spent three years living at my sister's apartment. My brother came over every now and then and carried me down the three floors to get fresh air and sit on the back patio.

Before I left, I knew I with need to be carried back up those steps and placed in the lonely room again.

I stood many years in this situation relying on my family members for limited care for they too had lives to live as well.

It was a life of isolation and loneliness. Then attendant care services happened, the great equalizer, as I call it.

This is why I must now speak up for the brothers and sisters who are living the same life of isolation and loneliness like I did.

Take persons who are deaf-blind, they need service like I need

and other people with disabilities such as myself, but they need it in area such as support service providers.

Currently vital needs of persons who are deafblind have been excluded, just like people with disabilities who depend on attend S care services for increased independence and opportunities to fully participate in opportunities in all walks after life, persons who are deafblind depend on support service providers, SS Ps, for increased independence and opportunities to fully participate.

The problem that country exists is there are no community-based waivers services that provide -- (audio breaking up) -- dependence upon family members and friends just like people with disabilities did in years before.

Some will say that people with deafblindness can qualify for

other waiver services such as attendant care services and/or, in fact, being served. This is certainly not certainly not the case.

Attendant care workers are not trained to function as SSPs.

SSPs require specialized training on topics such as human guide techniques, mobility, cultural deafness and more importantly the services need to be provided in the language and communication method used by persons who are deafblind.

For example, SSPs may need to be fluent in English and American Sign Language, comfortable conveying the sign messages of textile communication or be familiar with assistive listening devices or print on palm or another communication method.

Enrolling agencies such as maximus and service coordination agencies do not fully understand how to communicate with persons who

are deafblind; therefore, persons who are deafblind are not treated fairly and are therefore excluded.

If you are are serious about breaking down barriers and giving services needed, you need to have a waiver that addresses needs of a person who is deafblind, similar to the waiver and autism waiver to address the needs of persons with diverse disabilities. Thank you.

KATE: We will try a new Mic. Vicki Eiker.

>> THE SPEAKER: Thank you. Good morning secretary Dallas, secretary ounce burn and deputy secretary Burnett. Thank you for inviting us here to provide input.

We are encouraged about the increase sense of openness we feel and the opportunity and the commitment to have these meetings and to actually collaborate with consumers as well as providers.

My name is Vicki Eiker I am the director of cult management --  
post acute brain injury provider.

We have multiple programs in Chester and Allegheny counties.  
Needless to say, seeing the southwest is going to be going up first,  
we are very interested in how this is all going to roll out.

Typically brain injury providers work with ComCare waiver which  
was specifically developed for people with traumatic injuries. We  
are celled to provide outpatient home and community vessel  
vocational services.

Providers in the brain injury community who want to participate  
with the ComCare waiver and provide residential or structured day  
services have to be credited. It is an international body that  
ploys standards of quality and outcomes specific to brain injury

providers.

Several of the things that we have concerns or questions about is we obviously don't really know, no one really knows what this looks like. What does managed care look like for a specialty population? Does it mean that the services are capitated? Only a certain numbers of services provided? How does that fluctuate as the consumers' needs change? Steppical typically people have fragile as Joann Tagney pointed out earlier, there are significant cognitive needs that are ongoing for all consumers who have that mattic brain injury. We are concerned in terms of addressing those cognitive needs.

One of the issues the brain injury has had on an ongoing basis is the enrollment and assessment process.

Since it is very difficult to address cognitive needs, not only does the assessment tool, as well as the assessor have to skills about how to recognize and list those needs so that they are accurately and realistically for toroid.

We are worried about the cost and payment.

Being in the behavior for a number of years, since they were, itemy, initially provided, there was a real lack of transparency and collaboration in terms of how the rates were set and there was little opportunity to have interaction with being able to either challenge or even understand how the rates were set and what went into them.

We really hope that we will be able to work with you going forward on those types of things.

In the brain injury waivers, there are specific services regarding cognitive therapy, counseling services, structured day and enhanced one-to-one services. These are under the bundle of therapeutic services are they going to be part of the managed care, you know, menu of services and enhanced one-to-one services? We just want to make sure that the services, particular to the disability population are included in the menu and that the people who are deciding what services are approved are going to have the knowledge and expertise to help with that process.

One of the other things we would like to talk about is the quality measures, we really look forward to working with you about quality outcome members. To be accredited you have to have a robust quality measurement system that focuses on outcomes, consumer

satisfaction, et cetera, et cetera.

Again, we would really hope to have a collaborative discussion about what quality measures could be used so that we do -- basically, are part of the process in determining, because we already have an entire menu of quality measures that we are using.

We would like to consider or suggest that the brain injury services be considered to be carved out in terms of the initial roll-out since it is a small population, a very specialized population, we want to make sure that we have time to actually work with how brain injury services are provided and for many years we have been told from licensing to the quality metrix team, et cetera, et cetera, that brain injury, well, you don't fit here, but these are the only standards that we can apply to you; therefore, we feel

that we really need a pretty robust communication process to make sure that the round peg/square hole does not continue. Purchasing the last thing I would like to mention is on Page 11 of the discussion document, it references fully integrated workforce.

I am not sure what the department means by that. I do know that in some cases, when I see that wording, there is a move and bias towards making sure that all consumers with a disability can be appropriately served in Community-based employment practices and I know that for the brain injured community and I've heard from other disability communities as well, that that be done on a person-by-person basis. There are some consumers need long-term supports and services that includes for their vocational services as well.

I appreciate the opportunity to provide these comments. We will be providing more comments in writing. Thank you very much.

>> KATE: William Kepner.

>> THE SPEAKER: Good morning. I promise to keep it brief but I'm sure my colleagues would like that.

I am Bill Kepner CEO for united disability services we are headquartered in Lancaster, PA providing 13 different home and community services and supports throughout the Commonwealth county.

We are members of a lot of coalitions. The whole idea is we are very engaged with our colleagues.

In many cases in a competitive sense but we work well together to have a unified voice. I think a lot of the things I will be saying today are not just in respect to my organization, but to many

of my colleagues as well.

By the way, we just celebrated our 50th anniversary of enhancing skills and restoring lives.

Despite how I look, I didn't start the organization, just want you to know that.

[LAUGHTER]

I do want to sincerely thank you for taking on this huge commitment to improve access, reduce costs, taxpayer risk and improve outcomes through this program.

I also thank you for the opportunity for stakeholders to give input into what certainly is going to be the most significant change in how Pennsylvania serves its citizens' healthcare needs.

As a provider we want this model to accomplish this important

work and want to collaborate in any way we can to help make it work.

UDS applauds your departments for including key components like a person-centered program design.

We believe very strongly that participants must have maximum opportunities for self-direction. They must have input, choice, be able to live in least restrictive environment as possible while system stability and viability is maintained.

Over all key goal in your discussion document is to lower cost through rebalancing we like to call it or increased useage of HCBS.

We are very excited to be part of that solution.

Regarding those services and other key component of your design calls for services in care coordination.

Your document says vendors will provide these services. This

coordination of LTSS is key component to the success of the program.

Those of us with sequencive experience providing high-quality care coordination hope it doesn't exclude us.

I personally met with 10PA and national MCOs over the past 18 months and received mixed reaction on how they plan to handle this. Many have case managers. Most admit they don't have a social service model; that's not what they are able to practice. Many don't make home visits. Most work via the phone.

In you want to ensure the health and welfare of our vulnerable participants, please consider the opportunity in RFA for current FC providers to be lieutenants in the field working collaboratively in the field and driving better outcomes.

Participant choice is an important factor. Will consumers have

a choice of MCOs? We believe choice and competition includes services to participants and will encourage each MCO to do their best for the participant. It also benefits the state. As you look to offset risk, you are not locked in with one if one under performed you can keep services intact while you seek replacement. Delaware is a great example.

It is also important that participants have a choice of service providers. It works both ways.

Choice is critical and really does benefit the participant.

The managed care contract should require MCOs to have networks broad enough so a participant can choose which agency him or her wants assisting them.

There should a choice in every county rural or not to maintain

a provider accountability and quality.

Several parts of the Commonwealth's HCBS long-term support services have been awarded to out of state vendors experiencing very difficult transitions and average results.

We recommend the departments require contracting of local vendors working where local providers let's keep jobs and opportunities in PA. Let's guarantee a more fluid transition, implementation and great results.

Don't carve out local providers by bidding and little being them to that service. Many providers diversified personal care delivery but feel punished because of the diversification. Let's keep it a level playing field.

As you focus on home and community-based services we reinforce

the departments continue to include nursing homes. I am glad they are part of the very important continuum of care.

We are also wondering what is happening with the nursing home transition because little has been said about that in the document that we saw.

Just a recommendation with some of my colleagues. As we look to make some changes, let's consider some common sense, personal care supports for participants, our current home care licensing limits what services HCP service providers can provide. We encourage the department ises to work with the Department of Health to adjust regulations so direct care providers of home care can do things to help people live more independently things like changing a bandage on pressure sore unskilled family members do these things

regularly. Keep the important protections under the licensure but why not consider some possible rule changes to allow cost effective providers to handle for support to participants in their homes.

We also know rural areas in PA are dramatically different to serve than urban areas. We do not believe the first two phases do not prepare for serving rural areas.

UDSF and colleagues would certainly welcome the opportunity to partner with the state an interest to explore how to make this transition effectively work.

We certainly acknowledge that the current healthcare system has uncontrollable growing costs, a growing market to serve and is in a bit of a crisis.

As HCBS long-term support service providers we want to be an

important and collaborative partner. We support pay incentives. We want to be drivers of quality outcomes. UDCF is looking for any technologies, smart phone applications and other devices helping us to monitor health and we will be using those in the field.

We can be innovative problem solvers and hope local providers will be given an opportunity to play a key role in access to care, care coordination and great outcomes.

In closing, we thank you for this opportunity to give input and for this opportunity to advocate on behalf of older Pennsylvanians.

We would welcome a statewide stakeholder meeting and would love the opportunity for collaboration so that we could be unified as a solid team to really make this a high-quality solution. Thank you very much.

>> KATE: Terry --

>> THE SPEAKER: Good morning. My name is Terry Shade I am the CEO of spear trust Lutheran Hospice and life.

You may know us about previous name of leather republican services south central Pennsylvania. Our name reflect commitment to Lutheran heritage and reality that people come to us because of their trust in us.

We provide a variety of services throughout central Pennsylvania including in-home care, home healthcare, Hospice, telemonitoring services, a life program and senior living services.

Our company is also a member of the Pennsylvania home care association, which represents over 700 home care and Hospice providers throughout the Commonwealth and it is my privilege to

serve as the Treasurer of the association.

We are also members of the Pennsylvania life provider alliance, which represents the Commonwealth's 19 life providers.

Thank you for the opportunity to present my comments today on the Commonwealth's plan for managed long-term services and supports in Pennsylvania.

My comments will focus on three recommendations for a strong MLTSS program. Streamlining the enrollment eligibility process, educating MCOs on the importance of home and community-based service providers and ensuring fair and transparent provider reimbursement rates.

First, the MLTSS -- for the MLTSS to be successful for home and community-based care, we need to fix the Medicaid enrollment and

eligibility process.

Early this morning, Secretary Dallas you mentioned 95% of people want to be at home, yet under our current system, eligibility for Medicaid-funded, in-home care and the life program takes anywhere from 4 to 6 months to be determined.

Hospitals can't keep people in the acute care setting waiting for approvals to come through. Without a streamlined process, nursing homes become the only alternative for people who need care right away.

If the goal of MLTSS is to coordinate care and contain costs, then the enrollment problem must be addressed first.

I am pleased to see the emphasis on home and community-based services throughout the Commonwealth's discussion document,

including financial incentives for managed care plans to use community providers in a managed care payment system home and community-based settings will become a defacto entitlement.

To make the entitlement really strongly suggest administration follow the recommendation of the long-term care commission and streamline and standardize the eligibility determinations across all settings so institutional care is not always the first stop for the long-term care population.

There are too many players involved in submitting a Medicaid application providing backup documentation, undergoing care assessment, developing an individualized care plan. For instance, our Cumberland life participants have their clinical eligibility determined by the air agency on aging in Cumberland county but

financial eligibility processed through Bedford County assistance post office my hope is switch to managed care will leave one entity, the MCO to take on these responsibilities instead of passing the consumer and their information along to several different entity as long the way.

Financial incentives MCOs to use service providers is a great way to ensure that more individuals get the care that they need at home. Without a smooth enrollment process, these consumers may not ever have that opportunity.

Second, we need to educate MCOs and others about the benefits of in-home care.

One obstacle we have learned through PHA's communication through other states with these programs is MCOs lack the knowledge

about what home and community-based providers can do for consumers and how care at home can save MCO big money.

We must continually work to educate the gatekeeper organizations about life, the program life.

It is true unique among healthcare providers and even a large percentage of healthcare community is not aware of what the program has to offerer. For that reason, we would recommend that Life continue as a distinct option for frailest eligible beneficiaries and that independent third party options counselors be used to assure that the potential conflicts of interest do not impede individual's awareness of or decisions to be served by Life and the other managed care enrollment options.

It is not just the financial incentives from the Commonwealth

that should push MCOs towards Community care.

For instance, a few visits a week from home care attendant can help monitor enrollees health status plan for healthcare.

Weekly home health visits will assist a patient in continuing their therapy, monitoring their medications, which is one of the biggest reasons out there for rehospitalizations, regular visits from Hospice providers to nursing home residents have shown to decrease rehospitalization the last 30 days of life.

The final issue that I would like to address is the rate setting. The biggest concern about a new MLTSS program from a provider's perspective is a negotiation of MCO contracts. Provider advocates call for baseline payment rates equal to the current Medicaid reimbursement so that providers will not see a loss in

revenue; that's not enough. The Medicaid rates already do not pay for the cost of home and community-based services.

We would recommend that the base rate be at least 10% over the existing rate.

I would like to thank you for the opportunity to speak with you this morning. I hope the administration will keep the lines of is communications open for providers like spear trust Lutheran. Thank you very much.

>> KATE: I believe we have one last speaker. If I am incorrect, let me know. Thomas Earle.

>> THE SPEAKER: Good afternoon, secretary Osborne, secretary Dallas and deputy director Jennifer Burnett, my name is Tom Earle. I am president and CEO of liberty resources Center for Independent

Living in Philadelphia.

I am also the current chairperson of the board of directors of the Pennsylvania centers for independent living association, commonly called PCIL, which is head quartered here in Harrisburg, which represents over 20 other Centers for Independent Living that are recognized and funded by federal and state governments to advocate and support people with disabilities across Pennsylvania.

We currently have a footprint -- an operating footprint in all 67 counties across the Commonwealth.

From the onset, we would like to relay that we applaud the Governor and his commitment to strengthening our home and community-based service network for our seniors and people with disabilities through a new system of MLTSS.

Today, over 50,000 seniors and people with disabilities who eligible to receive nursing home facilities are successfully living in their homes and communities across Pennsylvania instead of expensive and undesired nursing home placement.

The quality of the lives of these people depends on the effective delivery of the services and supports provided through Pennsylvania's Medicaid and home and community-based services waiver programs.

I am here today to talk with you about how this new service delivery system must be structured to protect the independence and quality of the lives of people with disabilities.

For more than 25 years, Centers for Independent Living and other community-based non-profit and count-based organizations like

our network of Area Agencies on Aging have developed strong and unique expertise here in Pennsylvania in the art and science of creating plans of individualized care that carefully build on self-direction, choice and family resources that minimize cost to tax payers while ensuring that our seniors and other people with disabilities can lead full and independent lives.

I am here today to plead with you: Please don't tear down the existing network of what state government and its community partners have done over the past 25 years to build a strong system of long-term care services that meets the needs of seniors and people with disabilities.

I don't have to tell you that seniors and people with disabilities strongly prefer to stay in their own home homes.

It's not only confirmed in the independent living community but also repeated AARP studies on long-term care.

The heart of my presentation today will involve three key recommendations that respond to the overview of MLTS responded and released discussion draft.

One concern that we want to safe guard against relates to the concept of maintenance of effort. We don't want to see MCOs profits and savings coming specifically from the reduction of hours for people with disabilities and seniors through their individualized service plans and the number of hours of home care that they receive each week.

This could be achieved in a pretty methodical manner. The savings that are generated from this side of the equation should be

reinvested into the system to provide more opportunities for care for people with disabilities in the community settings.

We are ask that DHS and Analling look at average number of hours a personal assistance services provided under new managed care system, compared to the average number of hours of this service actually provided per waiver participatant over the past three years and that this benchmark could be set aside so that anything -- any savings achieved beyond that would be put into eye a reinvestment fund dedicated to projects approved by the state.

Other existing home and community-based services would require similar protection in the contract between the state and the managed care entities.

There is precedent for this approach, already in Pennsylvania,

in the very successful reinvestment fund that is a key component of DHS's behavioral choices managed care policeman.

A second critically important element of managed care is recognition of assuring quality of life of our seniors and people with disabilities living in the community requires a broad array of both medical and non-medical services.

We know that managed entities have -- we also know the reality that managed care entities do not currently have the expertise of non-medical community-based services.

These services must be based through the looking glass of functional assessment, what it is a senior or a person with a disability needs to live independently in the community, which is much different than a medical necessity standard.

Our CILs and AAAs have years of experience in person-centered planning and these are the organizations that are already networked throughout Pennsylvania that can go into consumers homes and sit with the consumer and their family in informal settings to determine what resources they have, what family members can provide and what functional assessment and needs the individual with the consumer will need.

We also applaud Governor Wolf's Executive Order, which he explained in February, which very importantly addressed the need for a quality home care workforce, one that provides quality services and retention, so that we can reduce the turnover that is experienced by some agencies across Pennsylvania.

As one of my colleagues mentioned previously to me, the rate

reimbursement must be looked at so that our caregivers who help our seniors and people with disabilities live in the community independently themselves earn a fair-living wage and also have healthcare.

Currently the system is not structured that way and that needs to be corrected and, again, we are very excited with Governor Wolf and the cabinet's commitment to address these workforce issues as we expand community-based services.

The last point I would like to make is something that I reference as a no-closed-door policy, which is, where we might have an individual, senior or person with a disability, whose cost to live in the community might actually exceed the cost to live in a nursing home.

A dear colleague Joe Peppi. Joe was vent dependent, need the 24 hours of care, 7 days a week. He affirmatively chose to live in his own apartment in the community in Chester County. He did not want to be in a nursing home.

We are going to encounter a couple people like this. It is very important that they also have the choice to live in the community and that profit or savings or expense do not preclude them from that option under this new model.

We are convinced in the aggregate, the expanded number of people that will be able to serve in the community will save money across the state in an aggregate amount that the few people who require 24/7 can still choose to live in the community.

The other challenge that does not seem to be addressed in any

level of detail is nursing home transition. Liberty Resources and other members of PCIL, along with AAAs have transitioned many consumers out of nursing homes.

Currently, for example, Liberty Resources have 15 people ready to move out of a nursing home on a waiting list because of lack of affordable accessible housing, which has been encountered in other parts of the state as well.

In closing, let's please stop referring to our seniors as the frail elderly. My father is 92 years old. He has advanced Parkinson's. He is a decorated World War II veteran bomb a deer veteran as you may have seen the movie Unbroken he was the pilot similar to the character he received highest air force honor. He is still alive. We just celebrated his 92nd birthday. If I were ever

to refer to him as frail in front of him, I think he would slap me.

[LAUGHTER]

Let's make sure we respect our elders.

[APPLAUSE]

>> KATE: Thank you.

If there are no last speakers, I feel like an auctioneer.

Going once. Going twice. There is one?

>> FEMALE VOICE: I don't know how I got skipped.

>> THE SPEAKER: Good morning, everyone. I will be brief. I  
promise.

My name is Brittany Holland. I have been a direct care worker  
for the past 10 years. More recently I became home care for living  
well through the Center for Independent Living of central

Pennsylvania.

Home care for living well is a home care agency allowing individuals with disabilities to have more control over their care, such as choosing a qualified attendant and communicating effectively with staff.

I believe I bring an interesting out look to this topic. I know how it feels to be the underpaid uninsured attendant struggling to make ends meet. I also understand the struggles of helping people live independently. I see people struggling to leave nursing home because of approval of services.

How long will the process be to approve services? What tools will be evaluated to deem someone nursing home eligible?

Another important concern will be capitated reimbursement rate.

If each health plan is sit setting their own rate how do you ensure a provider will be able to pay worker decent be wage? Is there a reimbursement rate? How will the provider or direct care workers ever be able to afford health insurance if rates stay the same or decrease? Something has to change.

As a provider, I am concerned about consumer choice. Will each health plan be monitored to assure variety of providerrers for an individual to choose from?

How easily can an individual switch from one provider to another?

Also, who will be responsible for ensuring there is no disruption of services during the switch?

I would like to know what competency requirement is expected

for each direct Carol worker. We have to meet OLTL Department of Health requirements and was wound earlying if that will change.

Direct care workers have been used for many years. How hard will it be to work with a consumer if they are considered out of network.

In pleasing I want to remind everyone it is more cost effective for people to live independently in the community rather than forcing them into nursing facilities.

The consumers I work with on a daily basis have families, own homes and more importantly own lives. If the consumer choice is taken away, all of these things will change.

Thank you.

>> THE SPEAKER: One last call from the auctioneer.

RESPONSE]

On behalf of Secretaries Dallas and Burnett. We cannot thank you for those who spoke today, for those of you will leave your room and talk to your partners in this work and think, I have more to say. We, again, need to continue to hear from you.

Call, write us, tackle us, whatever you want to do, in terms of ensuring we hear what your cares and concerns are.

A wise mentor told me if passion could solve all of your problems, we would have no problems to solve. That passion is indeed palpable in this room as it has been in all of the rooms across the Commonwealth and with more conversations like this and dialogues to continue.

As Governor Wolf has reminded Secretary Dallas, myself and

other members of this administration and those who work most closely with us on a daily basis, everything is on the table, except the status quo. We cannot do the same things and expect different results. To hear it with compassion, and commitment in the room and desire to work with us in an area of fairness and transparency is important to us.

Of all of the words shared today many stuck with me but one in particular from an individual in the back of the room who spoke earlier, I believe it was Deanna who said, this is my life. We recognize that in terms of, we are not in a factory making widgets. It is important work in terms of the widget makers of the world.

However, we make decisions every day. We advocate and at the end of everything we do is a life. As Secretary Dallas mentioned

every life matters. This is our time in our Commonwealth to improve the system, improve the experience of care for individuals who need to secure those services to maintain the quality of their life in their homes and communities with the dignity and respect they deserve.

We look forward in terms of continuing to work with you, dialogue with you. Please keep in touch with us. Let us know what your cares and concerns and fears are as we move forward in the days and weeks and months ahead. Thanks for your time. Please enjoy the rest of your day and travel safely. Thank you.

[APPLAUSE]

(Forum concluded at 12:02 p.m.)