The following printout was generated by realtime captioning, an accommodation for the deaf and hard of hearing. This unedited printout is not certified and cannot be used in any legal proceedings as an official transcript. Part of this information has been corrected due to a misstatement and will be clarified in the next MLTSS meeting.

DATE: 9/6/17.

EVENT: Managed Long-Term Services and Supports Subcommittee Meeting.

>> **PAM MAMARELLA:** We're going get started in a moment.

Good morning, everyone let's call this meeting to order.

And why don't we start with introductions.

>> **FEMALE SPEAKER:** Barb Polzir liberty community connections.

>> **FEMALE SPEAKER:** Veronica comfort PCOA.

Good it morning.

>> **FEMALE SPEAKER:** CarrieBach, I'm sitting in for Tanya.

>> **PAM MAMARELLA:** Push your microphone.

>> **FEMALE SPEAKER:** Carol Levretano I'm here for Blair Boroch.

>> **WILLIAM WHITE:** Bill light aarp.

>> **PAM MAMARELLA:** Pam more recommend la new court land.

>> **JEN BURNETT:** Jennifer bur nut.

>> **FRED HESS:** Fred Hess.

>> **FEMALE SPEAKER:** Estella Hyyde.

>> **FEMALE SPEAKER:** Matt Jennigs.

>> **ERIC JESCHKE:** Jess he.

>> **PAM MAMARELLA:** We have several members on the telephone I'll

read your names off.

Let us know if you're present on the phone first one being Brenda dare?

>> **JEN BURNETT:** Brenda, are you there?

Are you on mute?

Okay.

>> **PAM MAMARELLA:** We'll come back Steve Jazelle new member on the could you be sill.

>> **MALE SPEAKER:** I'm here.

>> **PAM MAMARELLA:** James Fetzner?

>> **MALE SPEAKER:** I'm here.

>> **PAM MAMARELLA:** Another new member, Juanita gray.

>> **FEMALE SPEAKER:** I'm here.

Can you hear me?

>> **PAM MAMARELLA:** We can.

>> **PAM MAMARELLA:** Tanya are you on the line?

Okay.

>> **PAM MAMARELLA:** I'm sorry if I can't stop calling you Ralph he is on my mind clearly.

We also have I can't really read that name can you help me with that.

Terry.

>> **PAM MAMARELLA:** Terry?

Terry Brennan are you on the phone?

Okay.

So, we're going to go over some is housekeeping rules first and then
I want to review where we are, with our sub-MAAC membership this
does substitute the first meeting for many of our committee members.

So I'm going start with the membership and MLTSS subcommittee
was established back in August 2015 and that the time we had 25 members.

When the committee was established, members terms were randomly
scattered between 2 year terms which commenced on September 1, and ended
August 31, 2017 or 3 year term, that ends August 31, next year.

During the June 7th, MLTSS meeting, Jen Burnett announced members
with terms expiring on August 31, 2017, would be sent
an email asking if they wish to renew their membership for additional 2
year term.

Jen also stated that she would announce during July 7th meeting T
whether we would accept new nominations.

13 committee members terms were scheduled to expire.

These members were sent an email on June 21, asking if they wish to
renew membership for a gigsal 2 year term.

8 of the 13 committee members, confirmed the desire to continue
membership for an additional 2 years these 8 members were sent reappointment
letters on July 20th.

Five of the 13 committee members responded they did not wish to
continue membership for a variety of reasons.

Or gave advanced notice that they intended to redesign.

These five members were sent thank you letters for their service, as an MLTSS sub-MAAC letter, that letter went out on July 20th, at that point there were five vacant slots each really designated to different areas that the office wanted to see on the committee.

That left us with 2 consumer slots, one consumer family caregiver, one for area agency on aging and one for for profit nursing facilities.

During the July 7, 2017 sub-MAAC, Jen bur nut announced Scott Rifkin and Denise Curry would be his replacement for the for profit nursing home slot, nominations for the other vacations would be accepted through the end of July at the August 7 T* meeting deputy Burnett extended the period to accept nominations through the first week of August.

7 nominations were received also, Tanya suggested that we add several representative types.

Accordance with the MAAC operating guidelines, article 8.1, relating to structure and appointments, Deputy Secretary Burnett, considered nominations and appointed new members to fill open vacancies.

New committee members were sent appointment letters on August 24th, for the period of September 1, 2017 through August 31, 2019.

Please join me in welcoming our new members who are, as follows -- Denise Curry, Juanita gray, Linda Litton and Lou and Steve Turzell do you want to add anything to that?

>> **JEN BURNETT:** I think what is really great of the make up of the

committee is that we do have a lot of consumer representation and we're working very hard to make sure we get senior consumer representation I think bill white and Estelle Hyde and new members we brought on board, represent -- do a better job of representing seniors for us.

Also, I wanted to just mention that Lupa Summit is -- a new member representing a caregiver she spent many years as a caregiver has a lot of experience and know how around all the issues related to family care giving but Lupa could not be here with us today.

Welcome everyone.

>> **PAM MAMARELLA:** Launch Jen I'll go over housekeeping rules if you could great your comments to me while until the -- keep our comment toss two minutes meeting minutes the transcripts and meeting documents are posted on the Listserv which is Tiebout o your agenda we have a captionist here today, so -- I'm going remind everybody please turn your microphones on.

Introduce yourself before you speak, and, speak loudly.

Sometimes if you're too far away from the mic you can't really hear you have to lean into the microphone, please turn off your cell phones, clean up after yourselves public comments will be in the end, Fred and I will work towards making sure we stay on schedule to we make time for people have come here on this rainy day.

We're asking as always, to for committee member those talk to your

constituencies to neighboring sure that you are, giving us ideas for agenda items for this committee to consider.

Now I'm going pass to Fred to go over the emergency evacuation procedures.

>> **FRED HESS:** Good morning everyone.

In the event of an emergency or evacuation we'll proceed to the assembly area to the left of the Zion church on the corner of fourth and market. Okay if you require assistance to evacuate you must go to the safe area, located right outside the main doors here of the honors suite, OLT L will be in the area, until you're told to be in the back in or evacuatedded, if evacuation is there everyone must exit the building, and take all your belongings with you and do not, operate your cell phones. Don't try and use the elevators they will not work they will be locked down, stare one and stare two.

To exit the building for stairs one, honors Suite to the main doors to the left on the left side, near elevator.

Turn right, and go down hallway by water fountain, stairwell is on the left.

Number 2, exit on the side doors on the right side of the room, or the back doors for those exiting from the side doors, turn left, 2 is in front of you.

For those going out the back door, go left and then, left and you'll

see Stirs2, keep to inside of the stare well merge to the outside, turn

left and walk do you know Dewberry to Chestnut street, tush left

to the corner of fourth street, turn left to Blackberry street, cross

Fourth Street, to the train station where we will all meet and gather.

>> **PAM MAMARELLA:** Thank you Fred we'll turn it meeting over to Jen.

>> **FEMALE SPEAKER:** Is this is Brenda can you all hear me?

>> **PAM MAMARELLA:** We can hear you.

Thank you.

>> **FEMALE SPEAKER:** Thank you.

Thank you.

I wanted if it would be please be possible to have a current membership

list now sent out to all of us thank you very much.

>> **JEN BURNETT:** SluSure.

Good idea.

>> **SPEAKER:** It's on the web site.

>> **JEN BURNETT:** We'll send out the link to the membership list.

Good morning everyone.

I have -- I want to provide some updates and then one of the things

that was asked as we prepared for today's meeting was that, we spend

some time talking through what we're doing to communicate with a variety

of different stakeholders as we get very close to the launch of

community HealthChoices on January 1, 2018.

In the southwestern part of the state I'm going to go through in

detail some of the, communications, that we have done that we have,

planned, that are on deck and, give you a sense when those kind of

communications are going to be happening.

I wanted to start out though by saying that I have a new boss, we

have a new secretary for the department of human services, her name is

Theresa Miller I have invited her to come today bullet she was not able

to because she is testifying before Congress today, on the affordability

of health insurance on the exchanges and area that she has a lot of

expertise in.

So she could not be here today, going to try to get her her to the

October meeting very interested in

meeting all of all of you.

Other news in the secretary's office and department of human service

changes -- some of you may know General Novell policy director for DHS

shell be leaving and moving onto become the associate executive

directee of Penn AEYC, Pennsylvania association for education of young

children.

So she is moving onto that, her last day is September 15th.

Following that, Kaitlyn Palmer, used to be OLTL policy specialist in

the department of human services will be taking on the position of

director of the policy office in department of human services.

Dale Adare who was the -- Dr. Adare the deputy for office of mental health and substance abuse services has retired his last day was

Friday.

And he moved onto South Carolina, where is joining his wife and
retirement.

And there is an acting deputy now, in place, as they do a search for
a new deputy that is Ellen Deminico, some of you may have familiarity
with her, she has been in a lot of our -- she has done a lot of our work
as well as work with young children and OCDEL, she has been in OMHSAS
for a number of years really knows the business really taking on her the
role of acting deputy.

There are two new advisers in the secretary's office. And they one
of them will be, working on the centers for citizen.

Which is one of the Governor's responses to the opioid epidemic and
her name is gosh Wen HaGwen Hauck the other adviser is Joann Marks, came from CMS
which was the -- is the office of that is responsible for bringing up
the exchanges she was very involved in the health insurance exchanges
she is now working in our secretary's office, I am excited about that.

>> **FRED HESS:** Can you send an updated list.

>> **JEN BURNETT:** Sure I'll do a follow-up email to you.

Marilyn will help get it out to you.

I wanted to just -- again, constantly asked about the independent
enrollment broker and the status of the procurement we're still in a
stay we can't discuss the procurement publically.

But I have to -- I really, want to stress this, that the data
tinnitus improve month over month.

It's getting better and better we are, enrolling more people than what we've ever done ever in our five home and community based waivers.

I think that, there are situations where, people may run into an issue with one of the call center agencies that is, human nature, nothing is ever perfect.

And, we continue to deal with those on a case by case basis as they come before us.

We're working to make sure that they get resolved within a day.

So there's some really positive data, if you would like to see information on it, we have a nice PowerPoint that I can share with you.

That really talks about our numbers and -- the amount of people that we have been enrolling.

Let me just give you a quick number -- so in November of 2016 I'm sorry, I'll go with August of 2016, we enrolled 538 people in the month of August.

This past August we enrolled 1038 people.

So you can see there's a vast improvement this is more we're enroll ing more than the area agencies on aging ever did when they were responsible for this. And it's pretty clear that has been happening throughout every month in 2017.

So I think we're throw the really rough patch we'll deal with anecdotal situations we got a pretty strong better form answer right now.

All of the performance measures are, within what we have under the requirements of the contract, including things like calls dropped, time it takes to answer the call all of those kinds of things are within our requirements.

So the IEB currently is pretty well on track but again, there are going to be anecdotal situations where we hear about problems.

I also want to share with all of you, that last week we -- was spent the whole week in Baltimore with the national home and community based services conference, that is conducted by the national associations of state -- national state associations for aging gates, which makes up aging offices state units on aging as well as Medicaid, long-term care the office that I'm responsible for those are who -- those are the groups that are members of NASED, biggest conference they have had, they had over 1500 people a tending.

Every state was represented, we had an opportunity to really spend a lot of time talking about what we're doing with the community HealthChoices, there's a pretty big spotlight on Pennsylvania for what is happening, we spent Monday in managed long-term services and supports intensive was all day intensive and I was -- had the opportunity I mentioned this to a few of you on my way in to be on a panel at the intensive with the State of Virginia and the State of Delaware, and the intent of the panel was to say, okay, Delaware you're in a mature state been doing this for five years what's your experience

look like today.

Virginia, you just launched on August 1.

So -- they're 3 weeks in on this panel, whatshipping with you? And

then Pennsylvania, you have not launched yet what are you working on,

what is your focus?

It was a really great opportunity to hear some of the things that

worked and didn't work.

In both Delaware and in Virginia.

Virginia is still on the ground learning about how this is

working.

But it was really, a good opportunity.

I remember being here last year when we were talking about the inaability to get to conferences Jake Kane challenged the

secretary on it, here I was going to a conference thank you for your

advocacy on that.

We also, did a Planery session I was on a session with 7 other states

talking about what is going on in your state.

We did panel on rate setting and managed long-term services and

supports, we did a panel, we did a -- a session on quality and over

sight of MLTSS.

We also did a session on, what our plans are with the CAPS tool, the

client assessment tool.

We did a session on stakeholder engagement and I also participated

in a meeting with CMS and about 7 other states, on the home and

community based services settings rule that was authorized in
January, 2014.
And that states are working very hard we have a statewide transition plan we're working very hard to make that you are we're in compliance with that settings rule.
A lot of time is being spent on readiness and review.
I believe the 3 MCOs later in the agenda will be talking more -- giving more detail on where they are, with -- readiness review we continue to engage the MCOs.
We had a meeting on reporting templates as well as meeting on housing last week with all 3 of the MCOs together.
That went very well.
We have Ben Laudermilch coming later today to talk about the DHS housing plan.
We also did a training for the MCOs on behavioral health managed care.
Behavioral HealthChoices there was a -- was basically a 101 on how to behavior HealthChoices works. And we have been spending a lot of time, making sure that our staff, understands what is happening we did do an all staff meeting for the Department of Aging, department of drug and alcohol programs Department of Health and department of human services, staff from all four of those agencies were invited to training on community HealthChoices which was held at the forum building

in August.

So those are some of my updates.

I also wantedded to go through some of the communications, that we

have been -- are ongoing.

In terms of phase one in communication with participants in the

southwestern part of the State, in mid July we did put out a COMMCARE

notification with what is happening in regards to COMMCARE in early

August we sent out awareness prior to all the participants, we are trickling in the returns for that a addresses that sheeping

us to clean up our actually our database that is in the client

information system which is the -- kind of the default client

information system for the date used by all of the offices by in

particular by the office of income maintenance and county safety answer

offices in late August, we did, notification on the level of care

determination, outcome for OBRA participants people who receive the

level of care determination who are in the OBRA and what the outcome

of their assessment is.

Whether it's nursing facility ineligible or nursing facility

clinically continue eligible, we are asking -- service coordinators if

we are doing training in September, to reach taught the participants to

inform them about community HealthChoices we really want service

coordinators to be fluent at least in the basics of what is community

HealthChoices.

We have an attendant care participant and an independence waiver

participant letter that is going out in early September.

Also, the reminder letter, about what is happening to people in COMMCARE moving into community HealthChoices or moving into the independence waiver.

And we have one going out to all consumers in the COMMCARE waiver in September.

>> **PAM MAMARELLA:** Jen Fred really has a question.

>> **FRED HESS:** I do.

Number one, do we have time on readiness review do we know how much longer it is.

>> **JEN BURNETT:** We have a time line.

When they do the readiness review, I'll let them give you the details on that.

>> **FRED HESS:** Okay.

>> **JEN BURNETT:** I don't have the exact dates.

I'm relying on a lot of --

>> **PAM MAMARELLA:** Is the next one about communication Fred?

>> **FRED HESS:** I can't remember.

>> **PAM MAMARELLA:** Okay.

>> **JEN BURNETT:** Okay.

Late September and early October the first round of the pretransition letters and enrollment packets will be sent out to all participants that is going out later this month.

And that will include you all have a chance to look at that time and
gave us feedback on it, it will include appeal rights all the
information on how to appeal if people think they qualify to appeal.

So --

>> **FRED HESS:** Yeah I remember.

You just said that the this happened -- either going to be in CHC or
the independent waiver.

The independent waiver supposed to be on CHC also.

>> **JEN BURNETT:** Those in southwest PA COMMCARE participants will
go into the CHC waiver remaining part of the State, we will continue to
run the independence waiver until the phase gets rolled out, to that
area.

So -- they will go into the independence for a period of time until,
we do the roll out in that phase.

>> **FRED HESS:** Okay.

That was confusing.

Thank you.

>> **JEN BURNETT:** Sure.

And mid to late October the second round of the southwest pretransition
letters will be going out and then, in late November, and to mid
December the last round of pretransition letters will go out.

If people are not, do not make a choice of their managed care in
time they will have, we will do an automatic assignment of a managed

care we have a, there's a logic to how that oughted mat tick assignment happens.

In terms of phase two, in 2018, and the southeast participant communication update, in early January, we'll do that initial awareness flier to the southeast participants for community HealthChoices.

Late February, to early March, the first round of southeast pretransition letters will go out.

Early April to mid April the second round of pretransition letters will go out to the southeast. And then, the third round will go early May.

To the southeast participants those pretransition letters.

In late May we'll send out the final notice what the expectation is.

>> **MALE SPEAKER:** Jen I have a question about -- why are there 3 rounds? Are they all going to the same person ear are they divided up somehow?

>> **JEN BURNETT:** Correct they're all going to the same person.

They get -- 3 reminders you're experience in other roll outs like for example, Medicaid expansion is you have to keep reminding people.

People see that, they think it doesn't -- have anything to do with metro it away the second one comes they start paying attention to it.

We want our service coordinatessors as well as nursing facilities to really be making sure they get that people are paying attention to this.

In terms of the -- question on the phone.

>> **FEMALE SPEAKER:** I have a question, I apologize -- I
wanted to know what the programs, HealthChoices program, how is that --
our services going to be improved, by these two new imment -- you know.
How is that going to be part of the updated Medicaid.

>> **PAM MAMARELLA:** Can you state your name for us who we know who is
speaking.

>> **FEMALE SPEAKER:** This is Juanit Gray.
y.

>> **JEN BURNETT:** You want to know how we think things will be
improved?

>> **FEMALE SPEAKER:** Yes.

>> **JEN BURNETT:** Okay.

As a new member I think, um, one of the things that we probably need
to do is make sure that you see the multitude of information that is on
our web site and, that you do some reading and catching up on this, but
let me just give you a quick high level snapshot a lot of detail on our
web site with information about everything from you know, what our
vision is and what our priorities are and, certainly, how we anticipate
that community HealthChoices will make improvements to our
system.

I'll start out by saying, our -- our stated number one goal is to
serve more people in the community.

We know from experience in other states that, managed long-term

services and supports, really gets at the coordination of care between
health delivery systems so today, your primary care physician if
you receive services in our long-term care system if you are receiving
long-term services and supports for example, services in the home, home
and community based services you know, person assistant services those
kinds of services, your primary care hospitalizations and any of those
things generally do not have any information on what you're receiving in
the community.

There's no discussion between for example, the hospital staff and
your home and community based services today.

What we see from that, in the result is that people, end up being
unnecessarily going to nursing facilities, when they maybe could be
served in the home I have a recent experience of that very thing
happening it wasn't someone who was in longterm services and supports
but as he was recovering in the hospital, the hospital came to him and
said you need to continue your recovery in a nursing facility and this
was a person who had never had long-term services and supports.

And he said, no way.

I'm going to figure out how to get services at home. And went
about basically doing his own discharge plan in order to get home and
not have to go to the nursing facility which is where the hospital
preferred to send him.

That kind of disconnect we will be reducing through this

coordination between primary care and long-term services and supports.

In other words, physical health services and long-term services supports.

So that's our number one goal is for that, to serve more people in the community and to insure people get services in the community if that's where they want to live.

Second -- second goal is, again, speaking of coordination to coordinate between Medicare and Medicaid today, the Medicare payment which is an insurance payment for people who qualify for Medicare and Medicaid payments there's no coordination between the two. And as a result there's a lot of lack of coordination again people bounce in between systems because there's no coordination.

So we intend to take baby steps towards making improvements and coordinating between Medicare and Medicaid.

We have already begun some meetings around that, we have got some tools, we're sharing with the managed care organizations.

Third one is to improve quality and accountability.

We feel very strongly that we'll have better quality over sight of 3 managed care organizations. And we'll be able to hold them accountable whereas today, we have several thousand providers that we have to hold accountable.

Very difficult for the stale to do that and so we think, the managed care organizations will be able to help us with that.

Now the other area is to make improvements and advance program innovation we asked the MCOs to help us or tell us how they would innovate in the area of improvement in housing, improvement in employment for people with disabilities improvement in technology and improvement for the direct care work force.

We know that the direct care work force is really the foundation of the services that we provide in long-term services and supports, whether it's in a nursing facility or in home and community based services those direct care workers are essential to the quality of the services that we provide, so we, we want the MCAs to tell us and, we ask them to tell us how they would make improvements it's going to be one of the areas we'll be holding them accountable for I would say, the last area is improve efficiency and effectiveness of the system.

So those are pretty much our goals and how we anticipate that they will improve the system.

Getting back to communication and we will make sure that you have clear idea where to do your own research on the things that we've covered over the last two years that this committee has been meeting.

Which I think can help you kind of see how, you know where we've come from and what we've done, in order to get where we are.

We've been spending a lot of time with this committee getting input how to really address all those areas that I just talked about this committee has been essential in helping us make sure we get that ri right.

>> FEMALE SPEAKER: I'll be able to give some insight I listened to your -- like you said improvement what your goals are.

But me being a participant, one end, know that service coordination and the way the program is set up is not really adequately working right now.

>> JEN BURNETT: Right.

That's what we heard we went out did a series of listening sessions in June 2015, that message came across at every session the system we have set up today is not working well.

>> FEMALE SPEAKER: The service coordination and, there is a way -- and the way it is set up and the participants need to be more involved in their own care. And that is a problem. And getting abused by the service coordinators and providers.

>> JEN BURNETT: Maybe we should take this offline and have a conversation about it directly with you?

And rather than in the committee, I think, my staff and will follow-up with you and get some more details what you're talking about?

>> FEMALE SPEAKER: Thank you so much I'll let you continue.

>> JEN BURNETT: Okay.

Sure, thank you we'll follow-up on that, phase 3 that's the last page are phase the Lehigh capitol, northwestern and northeastern part of the State we're talking about that phase of January of 2019 and again, just move everything forward July, August and -- September and

October we'll be doing a lot of the similar communications and as we, as we move along and get these things out we'll be learning from what we do in the southwest to help improve, make improvements to how we roll out the southeast.

Jest general communication updates I talked about this.

We did send out in late August, a continuity of care provider fact sheet that went out in late August, sent taught providers outlines the community health choice provisions in regards to remaining continuity care how to avoid service disruptions.

We also have a CHC101 training that is just in the final stages of being prepared.

I actually took a look at it earlier this week for service coordinators and nursing facilitieses in the southwestern part of the state, that's going to be made available online.

And we're working with our contractor, Darrying consultanting as well as the agreement we have with aging well to put together the trainings.

We have been sending out bi weekly fact sheets on community HealthChoices related topics including, questions and answers.

And we I think I mentioned all of these.

The August 31 we did the housing and template session with managed care organizations we're doing another training webinar training with managed care organizations on September 15th on protective services and

community HealthChoices managed care and, to really talk them through
their responsibilities under both adult protective services and older
adult protective services.

And I think that is saw that I have.

I did want to say Fred gave me a question which is the aging well
contractors are supposed to do 20 trainings for consumers in the
southwest have they been scheduled yet? If so, how will consumers
be informed of the trainings if not when they will be scheduled.

We're in the process of scheduling them we have a schedule, starting
mid September and going through early October.

And they are going to be in Greensburg, Uniontown, Kitting,
Pittsburgh, New Castle your place Indiana, Brownsville, Monica, Lindora,
PATTAN Johnstown and those are some of the trainings we're doing in the
southwest.

Those are the one that's have been scheduled so we have a schedule,
she can certainly get it out to you, it's not complete yet.

And then, consumers are getting informed both through
our communications out to consumers as well as we're hoping the
associations are getting, communications, we're asking associations to
get communications out to their memberships to that consumers can get
told that.

You have sent them out.

Okay.

Second question was, when will the webinars for service coordinators

be held? Those are -- we're going to start scheduling them in mid

September look over to Pat, mid to late September, when we're going to

be doing those.

Start September 20th.

Thank you very much Lester.

[laughter]

>> **PAM MAMARELLA:** William do you have a question.

>> **WILLIAM WHITE:** Bill white, AARP, we know the all that the staff

has done, we want to complement you've covered a awful lot of bases I

realize that it's all new to all of us I'm just saying, a lot of work

just want to complement you.

>> **JEN BURNETT:** Thank you I've got a great team it's not me, I

just talk about it all this work is getting done.

>> **PAM MAMARELLA:** Carrie has a question.

>> **FEMALE SPEAKER:** Thank you Carrie Bach these questions

are from Tanya, two quick ones.

One she would like to know if the department has done anything to

reach out to primary care physicians to notify them of what is happening

with CH creek? And her second question is for clarification on the

communication about the OBRA waiver, she indicates that the documents

specifies people between the ages of 18 and 20 she is wondering

if that covers them through the 20th year or, if they get changed over

when they turn 20?

>> **JEN BURNETT:** I'll that I one, attendant care not the OBRA waiver

, through 20.

CHC starts at 21.

So it's through 25 20, that's with regard to people going into OB remarks A attendant

care waiver very small number we got about 10 of them in the southwest

maybe not even 10, they will get that communication and it's through

20.

Because CHC starts at 21.

The first question -- can you repeat that.

>> **FEMALE SPEAKER:** Yes. Has there been any communication.

>> **JEN BURNETT:** With primary I have care physicians.

>> **FEMALE SPEAKER:** Correct.

>> **JEN BURNETT:** When we did the four provider sessions in southwest

PA, one of the break out sessions was with primary care and, physicians,

basically the physical health networks that was hospitals and,

physicians, not a lot came to it.

But it was a very good conversation with them how to reach them.

We are working with the hospital association of Pennsylvania the

Pennsylvania Medical Society, Pennsylvania medical society in the southwestern part of the state and chapters that are pretty active in some of the counties out there.

So we're working with all of them to communicate with them the primary care and acute care world.

And the FQACs, Federally qualified health centers.

Federally qualified health centers.

Those -- centers are, a lot of our folks gate lot of their primary care.

>> **FRED HESS:** That's another acronym that I got get used to I guess.

[laughter]

>> **PAM MAMARELLA:** Drew you have a question? Drew.

>> **MALE SPEAKER:** Thanks Pam, the new service called benefits counseling -- that requires training from Virginia Commonwealth university and the certification has been close today any providers not under contract with Social Security.

We believe there's a new training through Cornell university that one is open to providers but it's, we've had trouble getting, response from OLTL about whether that training will be cemented benefits for counseling.

>> **JEN BURNETT:** Yes. That's true.

I know that we are working with the Virginia Commonwealth university and our colleagues at ODP, office of departmental programs to bring the

Virginia Commonwealth training here to Pennsylvania under contract because today, our providers have to travel to VCU to get that training so we want to bring it here on site in Pennsylvania.

I'm not sure of the status with that I have to check with people that are working on it.

It's been probably 3 weeks since I heard an update on it I know that we have staff working very hard to make that happen.

Along with the folks at ODP.

We're aware of the Cornell training I'm not sure, I don't know who you've been working at OLTL maybe we can talk about it afterwards maybe put you in touch with Jill over here --

>> **AUDIENCE MEMBER:** I have not heard about it.

>> **JEN BURNETT:** Get us more details so we can Jill Hobakus, stand up Jill will touch base with you get more details on that you can follow-up.

>> **MALE SPEAKER:** Thank you.

>> **PAM MAMARELLA:** Brenda has a comment.

>> **FEMALE SPEAKER:** Can you hear me?

>> **FRED HESS:** Yes, Brenda.

>> **FEMALE SPEAKER:** Okay.

So I want to mention that the aging well training schedule that you mentioned a little while ago, we would definitely be interested in hosting one of those here in Washington, at the triple offices. And I

emailed you as well about that.

>> **JEN BURNETT:** Okay.

I'll make -- I'll make sure is that aging well has that, can you --

do you need a contact person for that?

>> **FEMALE SPEAKER:** Yes, I can be.

>> **JEN BURNETT:** Okay.

>> **FEMALE SPEAKER:** Just respond to the email I sent you and pass it along.

>> **JEN BURNETT:** Thanks for reminding me.

>> **PAM MAMARELLA:** Fully other questions.

Jesse.

>> **MALE SPEAKER:** Jen can we go back to something you were talking about earlier I apologize if you said this in previous meetings based upon the experience of other states what percentage of folks end up being kind of auto assigned versus end up choosing their managed care organization.

>> **JEN BURNETT:** It vairs depending upon the efforts of the State made really good state would be in the neighborhood of 75 percent it's more around 45 percent.

So -- choosing.

It's a very low amount that I mean really good state that's done a lot of stakeholder eastbound gaugement I'm hoping we get over 75 percent it will be -- that will not be, that will not surprise me.

But, continue to get the word out.

>> **MALE SPEAKER:** Just on that, do we anticipate that, managed care organizations will I think we've talked about this previously we do anticipate that managed care organizations will be advertising if you will to consumers about why their program versus another may be --

>> **JEN BURNETT:** They're allowed to market.

We want them to market.

So people know what their choices are.

>> **PAM MAMARELLA:** Okay.

Do we have any other questions before we move on the agenda.

>> **MALE SPEAKER:** This is Steve I have a question.

>> **PAM MAMARELLA:** Go ahead Steve.

>> **MALE SPEAKER:** First of all Jen just to say you did a really nice job last week at national, certainly representing Pennsylvania and, was really good to hear all of your comments and share with everybody else out there in the world.

I want to go back to the IEB, and I am just wondering if you know, certainly nice to see that the enrollment numbers are going up.

But are we also seeing some progress with regard to the number of returned applications as you know, especially for older adults

that's been up to 80 percent of the folks that actually reached out have not returned their applications.

I was wondering if we're seeing any improvement there?

>> **JEN BURNETT:** Steve I'm going to have to look into that.

I don't know the data, that I'm looking atmosphere does not have information on that, but, it is -- could very will be that we're tracking that I'm sure we are.

I just don't have that, in front of me.

So let me look into that I'll get back too this committee on, what I learn about that.

>> **MALE SPEAKER:** Thank you.

>> **PAM MAMARELLA:** Estella.

>> **FEMALE SPEAKER:** Estella Hyd is it open for any of us to tend the aging well session if we want to.

>> **JEN BURNETT:** Yes, absolutely.

>> **PAM MAMARELLA:** Thank you very much Jen Burnett, next on the agenda is Steve --

>> **JEN BURNETT:** One more thing.

Pam one more thing from Je kneel.

>> **JEN BURNETT:** With regards to someone who came with you last time Fred, she asked about the CPR certification, for personal assistant services aids and so, I doesn't know anything about it, at the time I said I would look into it. And this is the answer we received, aides or personal assistants are not certified by OLTL in regards with regards to CPR it's never been a required for OLTL.

However, home health aids or certified nurse aides paid by the individual, in turn reimbursed when they working for a nursing facility.

So in other words OLTL does not have a requirement in personal assistant services that they are, certified in CPR.

It is a good idea though to, especially if you're in the consumer directed model to, get your Aides qualified for CPR.

>> **FRED HESS:** Absolutely because there's a lot of people out there, with bad hearts you know and, CP remarks is a must especially for people with disabilities our physical health is not exactly in the greatest shape as is.

So I think it should be a requirement of training.

>> **JEN BURNETT:** Okay.

>> **PAM MAMARELLA:** Okay.

Thank you Fred thank you Jen.

So, we're going to be joined by Stephen Whitaker and Charles Hill they're going to talk about encounter data.

Welcome.

>> **MALE SPEAKER:** Thank you good morning I'm Stephen Whitaker, with the office of medical assistance programs bureau of claims and management.

We've been invited here to discuss some encounter data hopefully answer any questions you may have on the encounter data.

Charlie hill will be handling the presentation I'll give it to Charlie.

>> **JEN BURNETT:** Thank you very much for participating today.

We did have a question from one of the members two months ago what exactly what we're going to do with the encounter data my response at the time is we're learning from you, if you come today to tell us a little bit I know my staff is has been working closely with the BCM, to learn what we do with the encounter data.

>> **CHARLES HILL:** Good morning.

Thank you for inviting us to talk about that -- get a little closer to the mic.

Okay.

My name is Charlie hill.

I work with the department of human services, office of medical assistance programs.

I am the that's correct DU, encounter data unit supervisor for the Bureau of claims data management our job is to really to make sure that we kind of control the process of encounters -- and make sure that we get the cleanest most accurate and timely encounter data possible.

I will be working closely with OLTL staff, in thosen deafers as the CCHC and MCOs.

>> **PAM MAMARELLA:** Can you move the mic close for the people on the telephone.

>> **CHARLES HILL:** Sure.

All right.

>> **FRED HESS:** Unless you got a big mouth like me.

[laughter]

>> **CHARLES HILL:** Sounds good.

Okay.

Will you be loading the presentation?

>> **AUDIENCE MEMBER:** Technical difficulties.

>> **CHARLES HILL:** I want to apologize when we get the slide up we recycled a few of our PowerPoints.

So there are references to PH MCOs which is the HealthChoices programs those should be CH MCO references.

>> **JEN BURNETT:** While we're waiting Charlie maybe you can just, for people here in the room don't know what is an encounter what is encounter data maybe give a high level.

You have a slide like that.

>> **CHARLES HILL:** That's our first slide we'll start with what is an encounter.

And, by definition, it is a medical service or product received by a community HealthChoices MCO member, from a provider. And encounter indicates what services products have been provided to the CH MCO member and by which provider.

So it is simplest terms, encounter is basically a pseudo claim.

Includes most of the information that you would expect to see on a paper claim submitted by your family doctor facility or pharmacy.

And that information of course is submitted to the CHC MCO.

We should be on slide 3.

This is a somewhat general overview, what we tried to include you know, CHC specific references within the document.

>> **PAM MAMARELLA:** We can keep moving forward without the presentation.

>> **CHARLES HILL:** The purpose of encounter data, there are many, all encounter data is store in the department's data warehouse.

And extracted for specific a variety of managerial an lick at this time call participates monitoring and access of care, contract management, assist in the department of capatation rates also help with proud and abuse investigations.

And Federal and/or state reporting.

The encounter data, that's essentially how we would use the encounter data.

But the encounter data can be used by the CHC MCOs for similar analysis and over sight.

Next slide.

We do have specific types of files sent we refer to them as transactions.

First transaction -- well let me start all over, all encountered are submitted to the department, via FTP, secure file transfer process in a Hipaa file for ma'am, includes the following file transactions or file

types there's the HIPAA, 837 we refer to as an 837 file.

Transaction.

To the right of that, is your NCPDP transaction.

And under HealthChoices program we currently do process maternity Karen counters I'll go into more detail what is specifically we look at when we're seeing an 837 or an NCPDP file.

Next slide.

Here's a little more detail on the claim types.

We have 837 professional encounters.

They include encounters including professional cross over claims, for members dual eligible and those would be those members who are eligible for both Medicare and Medicaid for doctor administered drugs.

There's an 837 institutional encounter.

Which includes encounters submitted by facilities including hospitals anted long-term care providers.

They include inpatient, outpatient cross over claims as well as outpatient, drug claims and long-term care claims.

837 dental is obviously for dental services.

And then we do have NCPDP encounters.

They are encounters for pharmacy and compound -- for medications filled at the pharmacy.

Next slide.

All encounters are processed through the State's Medicaid management

information system MMIS.

It's a claims processing system known as PROMISe, it's designed it

would actually assign a unique internal control number for ICMN for processing tracking the reporting purposes.

The region code based upon the guy Graham above there the region

code, ICN identifies what type of claim was submitted.

The Julian date the date the encounter was received and the claims

sequence number identifies where the claim fell within that batch of

encounters.

Next slide.

Speaking to the ICN, those first two digits are region codes, and

they help us identify specifically claim type was submitted.

And region code 31 you'll notice on the top theelol medical

encounters these would include doctor office visits hospital

outpatient and in-patient and long-term care claims.

Region code 33, is for outpatient drugs administered in outpatient

setting.

Region code 29 is for drugs administeredded in doctor's office.

And region code 36 is for point of sale prescriptions filled at the

pharmacy you'll notice references to voids and adjustments.

Actually voids are let us know if there's a previously submitted

encounter, was adjusted or voided I should say.

For example, if a doctor may have originally submitted an incorrect

billed amount on the initial encounter claimed to the MCO that claim

would have been processed accordingly and sent to us for processing the

encounter.

Later that doctor may have resubmitted an adjustment to the

MCO.

And adjusted the billed amount we would expect that the MCO to send

us back an adjustment to change that encounter that we have the actual

billed amount as well.

And voids are basically the deletion of the original encounter,

submitted to the DHS.

So it's just kind of wiping that counter out of the system.

Next slide.

Encounters are not considered accepted until they pass all of

the department edits.

So the system does go through and looks at the encounters makes sure

you know the recipient is enrolled not only in MA or Medicare or that

they're enrolled in the correct plan.

So -- we do have edit this is go through.

Denied encounters must be submitted we process them until they pass

all edits.

Next slide.

>> **PAM MAMARELLA:** Request I ask a question.

>> **CHARLES HILL:** Sure.

>> **PAM MAMARELLA:** This is an area I don't have any expertise whatsoever.

So I am just a little confused.

So can you just clarify for me, are all encounters medical in nature? So you're talking about Doc PTOT, would not include things like a ramp being built for someone's house, it's just strictly can you explain it Carl whichever under the physical HealthChoices program, that would be correct.

We don't have any thing specific to home modifications but it's my understanding that we will.

Under the CHC program.

Procedure codes that will be available.

>> **PAM MAMARELLA:** Broadly everything is, CH MCO pays would have an encounter --

>> **FEMALE SPEAKER:** Yes. Yes. Exactly.

So under the waiver program, the MCOs will be paying just fee for service for most part, they will be using the same procedure code and such to pay for services as we do today and the department will, receive encounter data for those services.

So that will apply, to your physical health, facility, and, home and community based services so yes, we will receive encounter data.

It will come in under that professional claim type that Charlie

referenced.

>> **FRED HESS:** Does that include durable medical equipment also.

>> **FEMALE SPEAKER:** Yes.

>> **FRED HESS:** Okay.

>> **PAM MAMARELLA:** Thank you.

>> **CHARLES HILL:** Okay.

The next slide is on response files we have two response files that we send back to the plans.

The first one is well actually, generate response files to the MCOs can see which encounters were accepted and which were denied and need to be resubmitted.

The response system generates unsolicited U277 and that response to the plans with the outcome of the 837 medical encounters submitted.

So they -- we provide them with the U27 code, so that's a CHC MC on O on the response file, that they receive back indicates which field may be an error so the MCO can correct ther other and resubmit.

Similar to that there is an NCPDP response file.

NCPDP are the pharmacy claims and they return a denial code as well that identifies when the corrections are necessary.

The plans would resubmit them if they're actually denied.

Next slide.

From a contract perspective some of the things we do for compliance or review we confirm encounter timeliness.

And 837 encounter which again is mostly medical encounters, must be submitted by the CH MCO found acceptable in PROMISe on or before the last calendar day before the third month after the payment a Judith call end month in which the MCO paid adjudicated the claim.

Comes taught approximately 90 days if a medical claim was paid January 1 the CHC MCO must submit that encounter to us by April 350, 2017 in this example.

We have timeliness requirements for NCPDP encounters they must be submitted by the CH MCO found acceptable in PROMISe, within 30 days of the adjudication date.

The for example, pharmacy paid January 31, 2017, they would have to submit that encounter to us, by January 31 -- so, it's pretty cut and dry.

>> **FRED HESS:** It's basically -- 120 days?

>> **CHARLES HILL:** 90 days for medical encounters or 837 encounters and 30 days for your NCPDP plans.

>> **STEPHEN WHITAKER:** If it was the first of the month, it would fall where it could be 120 days on the medical.

Depends when it falls within the month.

>> **FRED HESS:** Long time to go without.

>> **AUDIENCE MEMBER:** Can I clarify something.

I just want to make sure.

I want to be clear no one will go out without services it is, this

is encounter data so this is a report from the MCOs, about what they

already paid for. And those are our due dates of okay MCO you process

and paid for this claim and you have until the end of the third month

past the month you adjudicate that claim to submit to us.

>> **FRED HESS:** Okay.

>> **AUDIENCE MEMBER:** Better?

>> **FRED HESS:** That's berry was thinking that the consumer will have

to do without in.

>> **FEMALE SPEAKER:** No, no, this is strictly, a report from the MCOs,

a picture if you will, of what they have processed and paid.

>> **FRED HESS:** If it had to do with the consumers waiting that long

I was going to be inquire.

>> **CHARLES HILL:** Good point.

Okay.

DHS staff do run monthly report toss make sure encounters are

submitted timely and accurately.

We continue to review, the CHC MCOs on a monthly basis.

And that brings us to -- our last slide.

The next slide -- there it is.

This is just to show you that we do, each CHC M creek O will receive

a certification and testing packet.

Certification is completed to ensure that the DHS can process the CHC

MCO files with a accordance with the HIPAAT it uses test for dummy data.

And is intended to demonstrate the processing system which is PROMISe,

can accept and adjudicate and rush a U277 or NCPDP response.

And we also confirm that the MCOs can receive and process our

response files.

So what once the MCO is certified they may actually begin to submit

production of real data, that will be processed and stored in our data

warehouse.

And that's kind of a general overview of how it works?

>> **PAM MAMARELLA:** I have a question I'm not sure if it's for you Jen

or Charlie.

Or Stephen Whitaker I would imagine you'll have pretty substantial

comparative data for the 3 CHC MCOs will that be any way be made public

to people?

In the aggregate?

>> **JEN BURNETT:** Yeah. I think we'll have to look at what it is we

can make public and I -- I know that people who think -- are more into

this know exactly what we're going to be doing I don't.

So, yes. We are going to be making reports available I just don't

know the level of detail how much, of the data is going to be made

available.

We will likely do the same thing that Lisa Allen does with the

medical assistance advisory committee we're pretty much modeling

community HealthChoices on the work we're doing in HealthChoices.

So whatever data that she is doing reports through to the consumer sub-MAAC or medical assistance advisory committees we'll do something similar to that.

>> **PAM MAMARELLA:** Okay.

Thank you.

>> **STEPHEN WHITAKER:** I wanted to mention one other thing, all encounter data which will include CHC eventually is reported to CMS.

They get massive files of everything that we have, so this will all go to CMS.

>> **PAM MAMARELLA:** Thank you.

Do we have any -- Jesse, do you have a question.

>> **MALE SPEAKER:** So, maybe you said this earlier is this, is this data then used to at all in the adjusting of rates for managed care organizations? In terms of --

>> **CHARLES HILL:** Bureau of financial management, sorry.

Our bureau of financial management does use encounter data.

For Capatation rates, but exactly how that works I'm not sure.

But they do use the data for that.

bur Jesse,

that's are for the fee for service, system we have that presentation by Mercer a few months ago that talked about how that data, went into -- going forward, we're going to have more accurate data on managed -- that

is managed care data.

Under will include both the claims data and the encounter data and

that will be used by our bureau of financial operations to -- and

working with Mercer to get certified actuarial certified rates it will

continue, it will inform future rate setting processes and it will

continue that's an ongoing thing that happens every year.

>> **FRED HESS:** Any other questions?

Pam okay.

Thank you very much for that presentation.

We really appreciate that.

>> **JEN BURNETT:** Yeah. Thanks so much Charlie and Steve I really

appreciate you guys coming out.

>> **PAM MAMARELLA:** So is Kevin Hancock here?

>> **JEN BURNETT:** Kevin Hancock is with a meeting with CMS today.

We have our annual meeting with the CMS staff in all of the

offices that have any Medicaid business are meeting with him, Kevin is

representing OLTL he is not here.

But Marcia I think I saw Marcia is here, Marcia is here to talk

about medical assistance for workers with disabilities hello, can you

come up here so the people on the phone can hear you as well.

Thank yo you.

Pick.

>> **PAM MAMARELLA:** Just blame it on the rain.

[pause]

>> **PAM MAMARELLA:** Why don't we get started let PowerPoint presentation catch up to you.

Nick pick Okay. Hello my name is Marcia I'm here from the office of income maintenance to talk to you about the medical assistance far workers with disabilities program.

Known as MAWD before we get started on a high level overview I was a asked to address programs due to incoming budget cuts we did verify that the budget office -- okay.

Okay.

Sorry about that.

We verified with the budgeted office although, the legislature did reduce general funds, those funds used for MAWD coverage will be replaced by tobacco funds, so there's net zero adjustment meaning there's no change in eligibility requirements for MAWD, no change in covered services, those eligible on MAWD and no change on number of individuals that can receive coverage for MAWD.

>> **FRED HESS:** Any change on the price people paid for MAW.

>> **FEMALE SPEAKER:** Same cost.

If you're seeing MAWD numbers have dropped, it because of Medicaid expansion, with Medicaid expansion more individuals have moved from MAWD to a premium free medical assistance coverage.

Now, I want to go through some basic information.

And -- this whole presentation is tailored more towards when you
need waiver services but maybe your income or resources exceed the limits
, so we can look at MAWD, just bare that in mind, it allows individuals
with disability toss work keep full medical coverage now individuals can
earn more and still be I believe gentleman I believe for waiver services.
If they're eligible for MAWD program.
So individuals with income exceeding, 300 percent of the Federal
benefit rate which is currently 20 it 05 a month, may still be able to
receive he will waiver services in a MAWD category as long as
they meet requirements that we'll talk about soon.
Now to get into the eligibility requirements, nonfinancial and
financial requirements.
Nonfinancial requirements, include age must be at least age 16 years
but less than age 65 once you turn 65 you're not eligible for MAWD.
Must be employed and getting paid and self-employment is acceptable.
And this is where I'm going stop and explain the two different two
categories of MAWD we have the PW category which is for workers with
disabilities and then we have the PI category.
Which is workers, for workers with improved disabilities.
So for those that are, in the workers with disabilities category, we
do not have, very strict rules about work if you are, baby-sitting your
neighbor's child once a week getting paid for it or walking your
neighbor's dog once a month getting paid far it you're working, you meet

the work requirement if you have an improved disability you're in the PI

category it's a little bit more strict, you must be working at least,

40 hours per month and getting paid minimum wage or more for those hours

worked.

Whichever category you're in, you have to have a disability.

For the workers with disabilities, category you have to have a

disability that is, expected to last at least one year, and meets the

Social Security Administration standards except for the inability to

engage in substantial gainful activity.

For workers with improved disabilities, you're no longer disabled

for Social Security Administration you still must have a severe

impairment per the DHS medical review team.

And no matter which category, PW or PI, you must be willing to pay

a monthly premium, that is 5 percent of the individual's monthly countable

income after deductions that's very important.

>> **FRED HESS:** I do have a question right there.

The -- does that count your work and your Social Security disability

income.

>> **FEMALE SPEAKER:** We'll get into that.

We'll go through an example how we figure out the premium how we

figure out if they're eligible.

>> **FRED HESS:** Okay.

>> **FEMALE SPEAKER:** Before we get into financial eligibility requirements I want to touch on primitive eligibility for MAWD, applicant may be authorized for MAWD before a disability is proven.

As long as the applicant provides all of their verification for income verification resource verification and provides a disability statement from a doctor or a keratin error maybe, a health sustainability medications form, employeability assessment form something like that.

If they provide all that information, then, the CEO can authorization up to 3 months from the authorization date for primitive eligibility for MAWD still get all the services covered and the MA benefits the CAO will refer that person to the DAP program disability advocacy program, DAP that DAP worker will help them talk to the doctor, get everything that they need, so we can give all the information to the medical review team if it takes longer than 3 months to get the information we need it can be, extended they can get eligibility for another 3 months.

For MA.

Knew to discuss financial eligibility requirements.

We do have a $1 $10,000 resource limit resource of the spouse if the individuals are married are counted towards that $10,000 limit. And resources are not excluded, for families with children under age 21.

We'll get into the differences on the next slide, between waiver eligibility requirements and MAWD we'll talk more about those.

Countable income has at or below 250 percent of the Federal poverty income guidelines and the chart FPIG the chart, has the 1 person, two limits, one person is 2513 and for two people, married person, is $3,384.

Earned income, let me get into the -- let me say one thing the energy of the spouse is counted when we look at the two person income, earned income destructions are used to determine he will gentleman I believe it's really important if gross income exceeds 250 percent of the FPIG and individual disabled and working they should still apply for MAWD because of these earned income deductions, that we have.

That's really important.

Okay.

And on slide five, for waiver we already talked about the income limit is gross income, compared to 300 percent of the Federal benefit rate which is currently $2,205 a month, for waiver, we use the net income after the earned and unearned deductions compare to 250 percent of FPIG, which is currently 2513 a I month for income and resources if a person is married the income resources of the community spouse are not determined to for determine eligibility for waiver but they are flor MAWD resources we discussed this, resources are excluded if the individual, applying for waiver services and is eligible for on the waiver category lives with the child less than 21, but not for MAWD.

There's no work requirement for waiver.

Eligible waiver category we already discussed there's a work requirement for MAWD, no premium or there is say monthly premium for MAWD and spousal imPoverishment and fair consideration, do apply for services if you're applying for married, spewsal provision means you look at all the assets the accountable assets as the date they're eligible for waiver services divide that in half, that's the half, they get to keep free and clear we're not going make them use or reduce those resource those pay for the spouse receiving waiver services for the medical benefits.

Fair consideration is the provision where we are looking at asset transfers that occurred within five years, of usually the application date and, if asset was transferred for less than fair market value money was given away that will mean the individual is not eligible for waiver services for a certain period of time or would be eligible for medical.

This provision does not apply to MAWD if you're applying for MAWD and, six weeks ago you get ten thousand dollars grave ten thousand dollars to your son we don't care we're not looking at that.

If you would later stop working need waiver go to waiver category or go into a nursing home need coverage then we would and it would become a issue I want to touch on state recovery does apply to both cat guys 55 years of age or older we would love to recoup Monday for long-term care too silt waiver services or any of those related prescriptions and

hospital care provided.

>> **FRED HESS:** That's taking the resource like the house or things like that --

>> **FEMALE SPEAKER:** House is excluded.

One vehicle is excluded --

>> **FRED HESS:** No what I'm saying is, when it comes time to pay back okay after we die or whatever, that's when they take the house and this --

>> **FEMALE SPEAKER:** If you're married and the spews would have to pass too we'll not take it.

>> **FRED HESS:** That's what I thought.

>> **FEMALE SPEAKER:** Okay.

Comparison, I'm sorry -- okay.

And slide 6, this is an example someone who is applying for waiver services Mr. A is applying for waiver, single, 60 years old and he is receiving gross wages of $1,800 a month.

And Social Security disability income of $1,000 a month.

So total grace income is $2,800 a month, and he happens to have $7,000 in resources.

So, first the is applying are the CAO is looking at the waiver, is he I will gentleman I believe, income of 2800 it is is gross over 2205, monthly income limit for waiver services.

So he is not income eligible for a waiver category they should be

looking at MAWD.

Resources are under $10,000, and resource eligible for MAWD let's look at income this is how we figured it out.

You CAO will figure it outer, take the $1,800, separate from the $1,000 under income.

Unearned income, the $1,800 we'll take a of 5 standard earned income deduction right off the top, then we'll take the amount left divide in half, that half that amount is what we consider the net earned income we count, we have the unearned income take $20 standard deduction off the top, and then the remainder is the net unearned income we'll add the two together, in this case, Mr. A has 1847.50 that we're going to compare to 250 percent of the FPIG for one person is, 2,513, he is income eligible before I got this -- there are other deductions we can give.

Deductions for trappings to and from work or telecommunications devices for someone who is deaf -- to work that kind of thing too.

Now we're going to determine okay he is income eligible and resource eligible let's determine the monthly premium so all we do there is we take his net income in this case was 1847.50, take 5 percent of that and round down to the nearest full dollar.

And in this case he has to pay $92 a month every month, premiums to paid via payroll deductions if the employer allows it or write a check every month.

They're going receive a payment statement once they're authorized

and the CAO is going to review income every six months to determine the premium for the next six month period, if income decrease ins that six month period they need to let the ACO know they should be decreasing the premium they're responsible to pay.

If it increases, however, this the CO should not be increasing the premium, until either the next semi-annual review or yearly annual review whichever comes first.

Before we go off this topic I want to stress al income is not used to determine a premium if you're married, spousal income is used to see if your income eligible is not used to determine the premium.

Premiums under $10 a month we don't collect.

And the last slide is just, how to apply for MAWD the application is the 600WD.

If you are not applying using a MAWD application let's say you're applying for waiver services or any MA you know or think your income is over limits I suggest you write maybe in red on the application I'm interested in MAWD or they comment section I'm interested in MAWD.

We have put a lot of information out to the COs six weeks ago we, we put out the second or third policy clarification reminding them they should be looking at MAWD if they're not income eligible they meet the other MAWZ requirements if that's the case they should be calling the individual and saying, hey this is what MAWD is involves a monthly premium are you interested.

I know that's not happening a lot of time, we're really trying too get out there with policy and trainings reminders they should be doing this.

If you find anyone that is rejected you she they would be eligible, have them or the representative, call the CAO.

And that's all I have does anyone have any questions.

>> **MALE SPEAKER:** This sin credibly useful information for those who work with people who are trying to get back to work and -- it's the stuff a benefits counseling we're all of sudden trying to do.

Can you make your presentation available to Pam so we can get to the committee?

>> **FEMALE SPEAKER:** They will put.

>> **JEN BURNETT:** We'll put it on the web site.

>> **PAM MAMARELLA:** I absolutely want to reiterate what drew just said that was really incredibly clear and at the end of your presentation I really feel like I understand how to kind of navigate, know how to navigate this process, so thank you so much.

Do we have any other questions from the committee or on the phone Pat?

>> **AUDIENCE MEMBER:** Nope.

>> **PAM MAMARELLA:** Thank you very much.

>> **JEN BURNETT:** Thank you so much.

>> **PAM MAMARELLA:** Sorry I forgot about you.

[laughter]

>> **JEN BURNETT:** Thank you.

>> **PAM MAMARELLA:** Okay.

Now we're going to attorney over to -- Jen to facilitate with our friends from CHC MCOs.

>> **JEN BURNETT:** We are actually, Randy Nolan is heading up our readiness review, process as I mentioned Kevin is -- erred with CMS today and Randy is with UPMC community HealthChoices in Pittsburgh doing an on site readiness review today.

And yesterday.

They did an on site readiness review with AmeriHealth Caritas recently and, we're finding them very, very valuable so we've asked Jill Navokas, who has been coming up here and clarifying things you know, Jill to facilitate the readiness review update.

>> **FEMALE SPEAKER:** Hi.

Okay.

So I have your community HealthChoices readiness review update.

And then we'll ask our MCOs to add any additional information that they would like to share with you today.

So as Jen said, Randy is on site today.

At UPMC the last -- yesterday and today they're doing readiness review on site. And AmeriHealth's on site was completed on August 22nd and PA health and wellness is scheduled for 9/14.

We continue to do weekly checks and meetings with the managed care organizations and continue to schedule additional TA sessions based upon subject matter items such as the housing initiative that we spoke of and encounter data and those types of items.

So we will continue to schedule those through the fall with the plans as the items come up as needed.

So with regard to policy submission approvals right now Pennsylvania health and wellness is currently at 43 percent, a marry health is at 37.74 percent.

And UPMC is at 17 percent.

Randy's group is currently working with all plans to get the policies submitted and our internal staff to review them.

And the network updates and I will stop there and I'll address your time line issue.

>> **FRED HESS:** Thank you.

>> **FEMALE SPEAKER:** So our go no go date is 9/29.

Now, with that being said, we have been working very closely with the Department of Health, Bill Wegman was here to talk to folks previously and we are identifying any gaps through out the network.

The next submission date for the MCOs is September 8th and at that time we're going to be aggression again addressing fully gaps we identify.

At this point in time I do need to say we're comfortable with the

physical health and the home community based network development and --
um, we continue to work with the MCOs to support finalization of any
gaps that we identify.
There is one area that currently we're reviewing as a gap that is
with the nursing facilities.
But we expect that will be resolved by the end of the month.
There's current provider negotiation and contract working done this
month so they're in the process of finalizing the agreements. And in
order to have providers included on our network reports there needs to
be a final agreement so that's why we're still viewing that as a gap
like I said the next submission will be 9/8 we expect that, additional
information will be finalized with the networks by the end of this month.
Keeping in mind, that any policy or procedures measurements we need
to receive from the MCOs, we expect that could drag through, next month.
Those items that would not be part of a go no go decision.
If there's some policy clarifications or something that is due from
the department.
So any questions on that information?
>> **MALE SPEAKER:** I assume go no go includes review and provider
enrollment readiness?
>> **FEMALE SPEAKER:** Can you clarify that I'm sorry? You mean the
network.
>> **MALE SPEAKER:** What is go no go base upon the policies or

whether they have providers to provide services.

>> **FEMALE SPEAKER:** Based upon provider network add wasly, the network adequacy has to be approved by the Department of Health for us to move forward.

So the go no go date is strictly associated with provider network adequacy.

>> **MALE SPEAKER:** So do you have any statistics on that yet.

>> **FEMALE SPEAKER:** Not at there point in time.

I will have -- we'll have, we'll have better numbers I think to share next go round, like I said the next submission, is due on September 8th.

So I don't have statistics for you.

But I can say that Bill Wegman's group with the Department of Health has been working very closely with the managed care organizations based upon our last meeting there weren't any major concerns, with the network, development.

At this time.

Except for the nursing home agreements.

>> **MALE SPEAKER:** I just find that hard to believe based on my own experience so I'm not sure if you're looking at all the different types of MLTSS Freuders when you look at providers readiness.

I think there's been a lot of emphasis on position and, that kind of kind of provider development I will be surprised bit 29th of this month,

there was true readiness for MLTSS type services.

This group will not meet until next month.

So -- I guess we'll hear about go no go in the mail?

>> **JEN BURNETT:** No you'll hear about it at the meeting drew we're

working very very hard as are the 3 MCOs on engaging long-term services

and support providers both institutional and hole and community based

providers that's one of the main focuses right now we're seeing it on a

daily basis we get report perfection them, that's the primary thing that

they're looking at.

Two of our MCOs are legacy systems and HealthChoices and, they had -- they had adequate health care and physical health care

provider networks already.

So, we're working very closely with them on the development of their

long-term services and supports net work as I said both institutional

and home and community based services.

That being said, reports are going to them from the Department of

Health as to the requirements and the gaps by county I mean this is say

really biggen deafer it involves a lot of staff here at the state that

are very much engaged in it I don't know why you're thinking that

there's some kind of a -- a gap in it, we're never going to be ready by

the end of the month because we are pretty confident we're going to be

ready.

>> **FRED HESS:** I tend to agree with Drew we have UPMC, wants

17 percent?

>> **FEMALE SPEAKER:** No.

No that wasn't related to the network.

That was related to policy submission.

>> **JEN BURNETT:** Policies they submitted.

>> **FEMALE SPEAKER:** Policies and procedures and -- you know not to point out at UPMC, however, you know they -- it's not that they don't have the policies and procedures written and in place.

I think that, they're just behind in getting them all submitted for review.

So that is not related to the network.

>> **FRED HESS:** Thank you for the clarification I was looking that the 17 percent going there is no way they're going to be ready.

>> **JEN BURNETT:** All of that was related to policies that have been submitted to us.

>> **PAM MAMARELLA:** We're about to hear from the 3 CH MCOs about network adequacy in detail so perhaps we can ask our question about that again Drew to get more clarification and comfort.

>> **MALE SPEAKER:** Yeah I think, that would be -- it would be good to know, what percentage of coverage there is.

For providers that is -- the really important number.

>> **PAM MAMARELLA:** Understood.

>> **FEMALE SPEAKER:** And I do want to point out Drew, that there are network adequacy standards in place based on for the physical health side is based on, driving the time.

But for home and community based providers I think we have discussed previously about this I know Randy has brought this up multiple times for home and community based providers, there is a different calculation and we have actually put together information based on past utilization so past claims utilization of this population that will be moving into CHC for home and community based providers we've done those calculations to equate that to full-time equivalence so we're pretty confident that we have identified how many of those particular types of providers would be needed to meet the needs of the population and that's all based upon what has been previously used. And that's what the Department of Health is using as a guide for those types of particular providers.

>> **MALE SPEAKER:** Yeah I am aware of that calculation.

But that kind of, also imapplies a service that is one person to one person, if it you look at FTEs it really doesn't work for programmatic services.

>> **FEMALE SPEAKER:** We are we're -- you know for those types of particular types of providers, we have been gathering in the MCOs they have been gathering number of staff and that type of thing because you know, one agency is one agency.

But they could have many staff serving members.

And another agency might not have those same amount of employees.

So, we are gathering that information and taking that into account.

And the MCOs are gathering that information when they contract with the providers, to ensure that they have coverage.

>> **PAM MAMARELLA:** Perhaps we can also talk about this and think about this in terms of the continuity care of care period and how that will give us an opportunity for the CHC MCOs to experience what is being done right now utilizing those providers is there any barrier to them utilizing the providers in place through the continuity of care period?

>> **JEN BURNETT:** No we anticipate that they would, I mean that's our expectation that they will be using the existing providers if they're willing and able to provide services they will be using them for purposes of continuity of care.

So -- we do anticipate that but, do you want to maybe bring the MCOs up to kind of talk about what their experiences are with the network development.

>> **PAM MAMARELLA:** Sure.

>> **FEMALE SPEAKER:** AmeriHealth and PA health and wellness.

>> **FEMALE SPEAKER:** Who would like to go first?

>> **PAM MAMARELLA:** So perhaps, some people can -- two women, two that I'm actually I known your name -- hello welcome.

Perhaps can come to this microphone or, will that -- reach?

Okay.

Thank you Marilyn.

>> FEMALE SPEAKER: AmeriHealth.

>> FEMALE SPEAKER: My name is Patty write and Christopher with the AmeriHealth Chris is going to give an overview of the network update that we have been working on but -- the one thing I wanted to do is kind of reiterate and maybe emphasize a little bit more about the percentages because I heard the concern when someone individuals looked at numbers I just want to make sure everybody understands when they saw the percentage whether it's 40, 30, 17 what that indicates is, that -- those -- that is the percentage of the policies that the MCOs have submitted to our readiness review team.

That they have reviewed, and returned as finalized.

That does not mean that is only the over all percent what has been completed.

For example, for AmeriHealth we have submitted well over close to 500 policies.

So as the team looks at the policies our OLTL readiness review team they review them.

If they have questions or need clarification then they send that back to us and we continue to investigate and refine and redefine policies and then return them.

So that's just a work in progress so I just didn't want anyone to

get anxious to think that the MCOs have only submitted like a small percentage of policies, we've actually all submitted, several hundred policies that just reflects the process of the over all review process.

>> **FEMALE SPEAKER:** Thank you Patty.

>> **FEMALE SPEAKER:** I just wanted to reassure everyone and when you talked about the go no go I think, part of the readiness review is OLTL is really looking at the MCOs and for AmeriHealth I can speak we had our readiness review first.

What we had to do is demonstrate that we had a system that had the capability of accepting and defining service plans.

Obtaining and retaining all the information that was required in the agreement and the ability to then authorization the services and then we had to show that those services were then connected through the claims how claims would be paid.

So in addition to the network it's also really us being able to demonstrate to the State, that we also have a full system capacity to support the needs of the agreement and Chris do you want to give an overview of the contracts?

>> **MALE SPEAKER:** Thank you.

So I'm going to break it out into two different sections so the physical health providers.

There is a concern that it's really focused on the physical health providers that is not the case we have a team that is dedicated to

working together with the LTSS providers on the community basis and well
as the nursing facilities from a physical health network we've been
working with the Department of Health and OLTL submitting our provider
networks, receiving feedback, one of the areas that we have identified
as needing closure on health system is Armstrong County so we do
actually have a verbal agreement with the Armstrong hospital.

It's just a matter of getting the actual physical paper in house to
finalize that whole process.

So that's one area.

So it's continuing going back and forth looking at certain counties
and specialties.

The same process is happening with the home and community based
providers taking a look at the contracts that we have in house,
across all specialties, to be able to provide services for all the
benefits under the LTSS benefit.

We want to make sure this is an integrated model where the physical
health and LTSS providers are working together. And especially through
the service coordination piece there's a lot of outgoing, out reach to
the providers.

Physical health providers may have a little advantage weeking with
the managed care organizations they're acustomed doing the applications
going through the credentialing process the contracting reviewing that
-- so we're actually working and having daily conversations with the

home and community based provider that's are brand new to managed care

talking them through the different terms within the contracts.

Making sure that they understand and are comfortable with signing

those agreements with AmeriHealth.

So that as we move forward there's not going to be any questions on

that.

So we continue that dialogue.

On the LTSS provider side, we have all specialties contracted there

are -- we're working together to make sure of the counties they service

as you mentioned it's a different kind of measurement.

So in addition to saying their office is in Allegheny County they

may service green, Indiana and Blair how do we track that?

We're loading that and tracking that in our system so we can report out

to OLTL and the Department of Health so they can see the provider types

that we have in those particular counties to be able to service the

participants.

Jill had mentioned the FTE forms as well.

So we are gathering that, we did receive data from Randy Nolan on

the number of individual workers that it would take to be able to

service the population.

So we have actually been able to gather information, from over 30 of

the home health providers personal attendant care providers to be able

to say, okay do we have enough in our network to service this population?

At there point, we actually exceed those numbers from a as you take a look at the individual providers required to be able to service the population on the home health the RN, LP New York City home health aid, we're breaking that down for Department of Health to be able to see those particular specialties in the counties they service, there's a lot that is going into our provider network.

And a lot is, focused on the LTSS side of that development.

On the nursing facilities, that was an area we have been working together with the department and with the facility groups as well as the individual facilities.

There were some questions, regarding how certain payments would be addressed.

We're making progress on that we have over half of the facilities under contract at this point in the southwest zone we're making tremendous progression in the areas there's still? Larger health systems working through the contract language we're having continued discussions with them as well.

>> **FEMALE SPEAKER:** I think the only thing, Chris if you -- just, kind of reassure individuals, the understanding that there were some of the provider types that were not Medicaid approved was under a procedure requirement we're working very closely with those as well.

>> **MALE SPEAKER:** We've met with the service coordination entities

in the southwest zone to identify providers to one walk through the service coordination expectation through continuity of care and how that will look after that continuity care period.

Part of that meeting was to gather information regarding service that's were provided on the OCBS process we're working together with those vendors that are not enrolled with MA currently.

Working together with the department to say here's some of the providers that have gone out, filled out the application.

Can we, somehow put them to the top so we can move their contracts through the system? So it is continued to work together with all of the stakeholders to make sure we do have adequate network but also increase the number of providers enrolled and able to contract with the MCOs.

>> **PAM MAMARELLA:** Thank you.

Before we move on Brenda dare has a question if you could turn that mic on?

Do you have a question?

>> **FEMALE SPEAKER:** Question this question is really in general for all MCO staff, I wonder if they can say what they're doing to make sure that consumers particularly very rural areas notes only have an adequate number of quality health provide home and community based services are they doing anything to make sure we have a choice of providers in those rural areas.

That's my first question.

>> **MALE SPEAKER:** So part of the our as we recruit and speak with providers is understanding their service areas.

If there's challenges in particular areas that's why we're tracking the counties to see -- if there's, potential items that we need to reach out to, providers to say is there capacity to expand your services into additional service areas.

So that's one of the things that you know working with the existing providers in that zone. And then if there's providers outside of the zone that may have an interest in expanding -- and moving into provide services into those areas having those discussions with them as well.

Not necessarily, do they have to be housed in the southwest area and in those 14 counties but they could reside on any of the bordering counties we have some provider that's are actually in the Lancaster, Lehigh CAP zone may have a satellite office that provides services in those areas as well.

So we are working together with those providers making sure that we have providers that can provide those services in those particular counties.

>> **FEMALE SPEAKER:** Okay.

And the second part of my question is can you tell us about what things will look like for consumers who choose to directly employee their direct careworkers rather than going through an agency?

>> **FEMALE SPEAKER:** I'm not sure what do you mean -- what things

will look like? I mean, you certainly have -- we have, services my way

of self directed can you provide a little bit more clarification.

>> **JEN BURNETT:** Brenda the -- we're not making any changes to the

self-directed model we'll continue to have services my way as well as

general self-direction and the MCOs are certainly going to be part

of that.

>> **FEMALE SPEAKER:** If I could just to kind of elaborate a little

bit more on what Chris is saying and I'm sure it's the same message that

tough T* you will hear from PA health and wellness and UPMC we

understand that there are services that are new that may not have been

in the current existing waiver packets.

Or, there are benefits that may not have been available to all of

the waivers so therefore, we really, while we have an idea of what

utilization may be, until we go out and begin to develop the new service

plans based on the new universal benefit packet, once we have and begin

to get utilization that will give us a better idea of other areas

that we need to be creative in look to expand origin to identify saying,

well, everyone that lived in the southwest, under previous waivers, not

everyone was eligible for meals we went into

what we thought was going to be now we see it's part of the universal

benefit packet wee develop new service plans we begin to identify in

Greene County there's actually now a 10 percent increase in utilization

and need for meals we'll continually be looking at that utilization the

service plan the feedback from the participants and the service coordinators to work with and go ahead and expand kind of think out of the box how to fill what may be future identified increase in needs for certain benefits.

So this is not -- a once and done we hand in a network in September, and then we're like okay, it's satisfied this is a growing expanding flexible network as we learn more about the needs and utilization.

>> **JEN BURNETT:** Right.

>> **FEMALE SPEAKER:** Okay.

>> **MALE SPEAKER:** Just to build upon that, in addition to just, working together with providers bringing them on board it's having discussions with them about, what is the capacity, what is their do they anticipate on growing? Can they increase to take on additional business so as Patty said it's going to be an going conversation.

So it is going to be evolving as we move forward.

One other piece I wanted to touch on is the training for the providers we will begin that in the fourth quarter run that through -- go live it's going to be, continuing education for all of the providers, physical health as well as the, LTSS provider types.

We will be meeting with providers in their offices holding provider forums and trainings with them we did go over a bit of that during the readiness review, big focus will be on the billing for providers because it will be new for the MCOs.

To make sure that they're comfortable and understand how to bill and also, that way, to tie back to the encounters we can submit the encounters appropriately to the state for them to have accurate utilization data.

>> **FEMALE SPEAKER:** Thank you.

PA health and wellness.

>> **FEMALE SPEAKER:** Good morning I'm Susan Christ vice president for the contracting management for PA health wellness.

>> **FEMALE SPEAKER:** Dee Dee PA health and wellness.

>> **FEMALE SPEAKER:** I'll give you a update we've been meeting with Randy and Jill and billion all of our details in terms of the contracts we provided so far.

And, they raise a couple of issues for a couple of counties we're working on that in participation for the next physician on 9/8 and 9/30 we'll additional information, as far as the LTSS bill goes we have touched, and contacted all of the -- providers sent to us on the State file we've had conversations with everyone.

Brought majority of those in under contracts.

Still negotiating with a few of those here and there and -- as AmeriHealth was saying it takes a lot of work getting providers to kind of up to speed for what it means to participate with the MCO, we have lengthy conversations in addition to just contract documents going back and forth it's an educational piece -- as far as -- a lot of

conversations about language and rates but also just how do you work with us what's the way we're going to interact going forward.

Making sure people are comfortable in this process in addition to just bringing them -- adequate network.

Adds everyone is stating this is not a one and done we'll continue to contract as we go forward.

There will be instances we'll discover a particular provider that we didn't either know about or -- didn't reach out to us, that we'll be contracting with on basically, as we find out about them as they're providing services what we call a single case agreement, we identify a provider that needs a contract we'll put one in place really quickly so the services are not disrupted going forward.

We're ready for our readiness review next week look forward to that conversation and -- answer any questions people have at that time.

>> **FEMALE SPEAKER:** Okay.

>> **MALE SPEAKER:** I have I don't know if UPMC is going say anything.

>> **FEMALE SPEAKER:** They will be next.

>> **MALE SPEAKER:** Okay.

>> **FEMALE SPEAKER:** UPMC is next, does anyone have any questions for PA health and wellness.

>> **MALE SPEAKER:** I have questions for all 3 of them, I'll wait for UPMC.

>> **FEMALE SPEAKER:** Okay.

>> **FEMALE SPEAKER:** Anyone else?

Okay.

>> **MALE SPEAKER:** All right.

17 percent, I think know I why Ray sent my today.

[laughter]

>> **FEMALE SPEAKER:** I'm terribly sorry.

OkaOkay.

>> **MALE SPEAKER:** I want to say thank you Patty for clarifying.

[laughter]

We have reached out we have submitted now over 70 percent of our policies and procedures.

So -- feeling good about getting responses back from those and continue to get the rest of throws in.

So in terms of our readiness review as I mentioned we have submitted a majority of those documents for the -- the desk review, mostly policies and procedures.

Network has been the big focus of our readiness.

We have submitted both our physical and the HCBS networks. And so waiting to get some feedback from those submissions.

We've also out reached all providers on the DHS list as well as any provider that's have been contacted through the email address, CHC providers UPMC.edu, in terms of network development our focus has been

heavily on continuity and, ensuring that there are no interruptions in
service.

We plan on using that continuity period to really, evaluate the
partners and T see who we're going to move forward with, in the interim
we plan unworking with everybody that is willing and able.

In terms of, estimating network adequacy we have been working
closely with our service coordinatetion partners to
assess the volume, that they're currently providing through the service
plans and our extrapolating that across the zone for the
partner that's we're not working closely with have exact data, to make
sure that we are, we're ready and Patty also said we're going to be
using continuity to assess utilization, and really, refine the network.

We're final icing our systems configuration as well.

The focus on that again, has been streamlining the billing
authorization we want to make sure there are no hang ups in our system,
that stop people from getting services.

That will not be a bottle neck for us.

And as been mentioned a few times DHS is on site today looking at
the system and ensuring that it has all of the capabilities needed to
deliver on this program.

We're moving our focus now from those critical readiness components
to the more kind of nice to have looking at value added benefits
alternative models for things like assisted living and trying to be a

little innovative and creative around those areas.

Also initiatives aimed at addressing the social determinants of health we're now starting to shift our attention as we feel more comfortable having those critical capabilities in place.

We have submitted and sent the ID cards to CMS on 8/25 that's a 45 day review.

So we are, planning to hear something back on mid October.

And in terms of that, I think we're going to learn a lot from the on site review and we're feeling confident moving forward.

Thank you.

>> **FEMALE SPEAKER:** Thank you.

Any questions?

>> **MALE SPEAKER:** I do have a question.

I'm most interested in the brain injury providers in the southwest region and -- I know that they have submitted to each of you enrollment packets but I'm not aware that they have received back contracts from you. And there's 23 days left.

So it's hard to turn around a legal agreement in 23 days.

Because it has to go through the lawyers all that stuff so I think there may be some things being missed.

>> **FEMALE SPEAKER:** I know that we have sent out contracts.

I think one of the areas we're trying to navigate right now is, what we're trying to do is direct, directly contract with providers.

So we can build that relationship.

But I think there are other entities that are coming into play that

with very intentions are trying to advocate for some of the agencies and

as a result, some agencies have now informed us they want to go through

a third party.

And I believe that the third party is trying to develop the ability

to be able to be a single signer but I'm not

100 percent that exists today this is information we just received

within the past day or so.

I'll be reaching out to some individuals after this meeting to try

to understand because again, we have providers that had initially

indicated that they were going it to sign and now we're indicating that

they want to go through a third party.

It has to do with brain injury.

>> **JEN BURNETT:** Can I make -- I really strong plea to brain injury

provider ins your network.

Providers have to contract directly with Medicaid and with the MCOs during

the continuity of care period.

(Correction) However, providers may use a third party as their signatory agent so long as those providers understand that they are accountable to the MCOs for the requirements of their provider agreement.

also have to be enrolled in Medicaid.

So I don't know Jill if you have anything else you want to say about

>> **MALE SPEAKER:** Yeah.

I don't think that the providers that I'm talking of are necessarily waiting for that to happen, I don't think that's offered.

>> JEN BURNETT: I have to give specifics our MCOs are working day and night to bring in provider contracts.

And, we're not, they're not singling out any provider type.

They are working very hard to get contracts through with this providers it's their goal is to get contractors with the existing providers especially through the continuity of care period.

>> MALE SPEAKER: Okay.

>> FEMALE SPEAKER: We would certainly do specifics after this, I'm sure.

>> MALE SPEAKER: I would love to get to you.

>> MALE SPEAKER: We would happy to sit down.

>> FEMALE SPEAKER: I think there's that little bit of confusion that -- that has just kind of reappeared within the past day or so.

>> MALE SPEAKER: And additionally, we have actually sent united agreements and, if they didn't make to the correct individuals we would definitely like to know that and who to send that agreement to so it gets in the correct hands.

We have sent agreements out to all of the provider that's are enrolled under the same file under the -- with the OLTL.

So we'll definitely like to speak with you after the meeting.

>> **MALE SPEAKER:** I'm aware you sent out enrollment packets but have you sent out actual contracts.

>> **MALE SPEAKER:** Yes.

>> **MALE SPEAKER:** So two of the providers are Remed and main line health.

Main line rehab.

>> **MALE SPEAKER:** Yeah. I would love -- because I actually just received an email this morning about main line rehab I would definitely like to speak with you regarding that.

>> **JEN BURNETT:** Why don't you, take that -- can you T with take this offline if you have specifics all 3 of these MCOs that are here today want to hear what they are, so they can mitigate whatever going on that is not getting that contract to signature.

>> **PAM MAMARELLA:** Carrie.

>> **FEMALE SPEAKER:** Carrie Bach these are tan why's question on the are theness review one she would like to know what happens, when a participant uses a provider who is not in the network?

And also, following the September at the timeth date, when are we going to get a look at the provider networks.

And will the committee see it before the general population.

[29th]

>> **JEN BURNETT:** I don't know the answer to the second question I'll find out.

Do you know the answer to the question.

>> **FEMALE SPEAKER:** No.

>> **JEN BURNETT:** I don't know the answer to that question.

>> **FEMALE SPEAKER:** Can you do the first one.

>> **FEMALE SPEAKER:** The first question, so this is, if I understand the question correctly, she is already using the particular provider who is an MA enrolled provider.

And then in turn, finds out that the managed care plan that she selected does not have that provider in network.

During the continuity of care period, all providers, will be working all MCOs will be working with all providers to make sure that services are continued.

So during the process in which a member is looking to choose a health plan, they may want to look at the provider network that will be available with the enrollment broker. And determine if her particular provider is part of the MCO's network she would want to use that information to choose her health plan.

The entire directory will be available online. And, also, the managed care plans will have online provider directories so participants can make an informed choice when they choose their plan.

>> **FEMALE SPEAKER:** So is it -- would it be correct to say that after the continuity of care period if a participant use's provider out of network they would be responsible for the payment of the services?

>> **FEMALE SPEAKER:** No.

[laughter]

I don't think that would be -- accurate.

The participant would want to work with the managed care plan and their service coordinate you're to make sure their services continued.

If in fact it came down to a participant needing to change their MCO, that is their option a member can change that at any time.

Okay.

>> **PAM MAMARELLA:** Does that answer your question Carrie?

>> **FEMALE SPEAKER:** I think so.

But -- if I could read Tanya's mind right now her next question would be, she uses services my way.

Which gives her that flexibility in her budget.

If she had a provider who was out of network in her chosen MCO, would she be able to uniteddize her budget under services my way, to work with that provider of her choice.

>> **JEN BURNETT:** I don't think she would have a problem, service misway will continue as it is today.

We're not changing services any way it will continue, but she will have that budget authority to purchase things or purchase services if she chose to, that are help her meet her service plan, services my way will not be changing.

Tanya is such a good spokesperson for services my way we need to get

some kind of video going of her because we don't have is a lot of take

up on services my way, but she is definitely, knows how to use it.

So thank you.

>> **PAM MAMARELLA:** I believe we have another question from Tanya I'm

not sure if this came into to you also the one I have in front of my

asks -- can you ask if the fiscal agent will still be PPL or, someone

different and if it's different how would the transition work?

>> **JEN BURNETT:** We do not, we are in the procurement right now we

have not made a final decision on the procurement it's eminent, and

announcement will be made.

We put out for bid put out a request for proposals got companies to

come in and we went through the whole procure scoring process we're

ready just about ready to make an announcement we're waiting for approval

from the Governor's office.

So yeah.

There will be a transition between if it's two different vendors.

>> **FEMALE SPEAKER:** I can add whoever that selected vendor will be

all of the MCOs will be working with that selected vendor because that

vendor will be submitting claims to each one of the MC Os so there

will be a collaboration between all 3 MCOs and whoever that vendor

selected would be.

>> **FEMALE SPEAKER:** Do you have fu any other questions.

Okay.

Thank you.

Have a good afternoon.

>> **JEN BURNETT:** Thank you to all of the 3MCOs for participating today.

Pam Nam brings us to Ben ladder political being that will give us an update on housing plan.

>> **BEN LAUDERMILCH:** Hello.

>> **PAM MAMARELLA:** Good afternoon.

>> **FRED HESS:** Come sit by me.

>> **BEN LAUDERMILCH:** Good afternoon everyone.

It's nice to see folks who managed care organizations, we met last week.

So if you don't know me my name is Ben Laudermilch I'm the executive housing director at the department of human services I'm special advis er to the secretary on housing.

And we're living in exciting times under the managed care environment we have had a lot of discussions about housing.

I wantedded to give you a brief update of the housing strategy as we sit today.

I would like to see more getting done in the coming year, 12016 was a great year and I think, by the simple fact we reduced and released the housing strategy.

But, there's a lot of work to be done -- so, without further ado --

we queued up?

>> **MALE SPEAKER:** I'm afraid not, we're having technical difficulties.

>> **JEN BURNETT:** We've been having difficulties all day year.

>> **BEN LAUDERMILCH:** I'll replied you the five year strategy is designed to address issues of connecting Pennsylvanians to housing in particular accessible affordable, integrated and supportive housing.

We added accessible based upon the advice we received from the groups like MLTSS that is missing from the first draft.

The 3 core populations we focus on, faux folks homeless individual whose are living in an institutional setting or some other state center that could be living more independently in the community and then finally, rent burden individuals paying more 30 percent of their income towards rented.

So that is where we are today with the core populations.

We have reimagined the housing strategy a little bit so the last time I was here you were nice enough to invite me I did go over the lowing strategy and I have to be honest, I stumbled over it as it organized each and every time.

So if you walk away with nothing else today, remember that I'm primarily interested in we're primarily interested in the pipeline connecting people to housing.

Services.

How do we support people pretendenacy and tendency sustaining in

their housing.

Production -- by the latest estimates we're some 278,000 units short

in Pennsylvania for the number needed to make housing affordable.

And finally the metrics in reporting that.

So those four things.

That nice and easy I needed that simple to remember it.

So, that I can talk about it when I'm in elevators with different

secretaries and -- legislators and so forth.

In thinking about the strategies then, if we, dive down a

little bit, let's talk about the connecting people or the pipeline.

We need to build that local referral network we really struggled

with that I can tell you as someone who worked locally, hourses

speak a different kind of language than service providers.

So that's evident in almost every meeting including one I had last

week with our managed care organizations.

We Matt we were talking about you attended a low income tax credit

you thought we were making up the Jargon I equally feel when I attend a

Medicaid discussion that you guys are making it all up as you go along.

So,.

>> **FRED HESS:** We are, we are.

>> **BEN LAUDERMILCH:** All of the acronyms we're trying to -- housing

is learningly done at the local level, long-term services, are largely

done at the state level.

Behavioral health largely local.

OMAP a lot of the services Medicaid services in the physical side
are done in the State perspective.

So we have a whole bunch of different mishmash of systems we're
trying to find the best practices located across the State some of the
promising things we're seeing, your way home in mounted gomer I county
we pair up a social worker and someone who understands real estate help
someone through the process of exiting homelessness and getting housing.

Another one is connector services out in housing connect you're out
in Allegheny County.

Talked to folks in the local jurisdiction rural areas.

So we have promising practices we have systems that are hungry for
information.

So we're hoping to be able to share that information.

The second strategy is arrange strengthing housing needs, we're
hoping to maximize Medicaid funding last time we didn't have the great
information we found out that, early win the centers for Medicaid and
Medicare services approve the office of developmental programs
housing services definitions I think this is really good news for long
term living.

So there we tested some thing that didn't really run through our
internal process.

So we sort of, shoved something out there a year ago and, the public,

commented on it and then, centers for Medicare and Medicare services
reviewed it and felt comfortable they identified Pennsylvania as a
potential best practice that's really good news bodes well for the
fought we really want to see this happen under the MCO system as it will
exist January 1, in the southwest.

So we're already in discussions with the managed care organizations
we want to also see, across the department.

So it's crucially important that, we take a look at Medicaid, OMAP
services and as well as the behavioral health services the other area
that we're hoping to -- in strong alliances there is, criminal justice
system we know a lot of our folks are -- familiar with that system.

And, we have a real problem in the State of Pennsylvania both at the
state level and at the local level whether folks are, rere-entering society.

We're taking a close look at that.

The one that is near and dear to my heart say former housing
developer is the expansion of funding opportunities for housing.

Next slide.

Please.

Absolutely critical here is the development of public private
partnerships and again that's how we see that the managed scare
organizations we see developing partnerships there we see a
strong partner in the housing finance agency I don't see anyone from PHFA
here today.

But they're a very strong partner talk about that in a moment we need to target, existing DHS resources and we've already done some of that I'll talk about that in 2016 successes we've had.

We also want to redirect homeless efforts, more towards housing if we're able to pay for some of the services currently being paid for by other sources could be paid for through Medicaid we're looking to really team up with the home also continual of care across the State.

16 of them including our suburban and rural areas.

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

We need to measure, and communicate our progress.

So we're tracking metrics that is absolutely more difficult than it sounds.

I thought it was easy when I came up just track our successes the fact of the matter we don't have the systems to track our who needs housing, who could be living in the community but is living in an institutional setting.

Again we're looking towards our managed care partner those try to develop those strategies as we move along so that we can tell the story.

One of the promising interventions that we're looking at right now is, something is that we call the data match where we actually Medicaid data, encounter data against data collected by the homeless management information systems across the State.

Showing basically how much someone cost, when they're home also,

versus someone how much it cost after they secure housing the human services, side of me says that, that's the right thing to do.

Provide housing for individuals who need it.

For some of our more economically minded individuals across the Commonwealth, we also want to tell the story of how much it cost.

I think, people, heard the story of million dollar Murray, we think that's the promising area that will show in new Haven, Connecticut states out west have told that story it's far cheaper to have someone with appropriate level of services.

Finally we need to communicate the progress, so I'm hoping that you'll invite me back I'll be able to tell more great stories as we move forward.

Let me talk a little bit about 2016 if we advance to the next slide.

So some of the accomplishments, well on the way I like to think that the housing team, at the office of social programs, helped to move them along, but one of the promising inventions is the fair weather lodges I encourage you to take a look evidence based model shared living but it has ownership interest presential aspect of it.

It's very interesting model some models across country, people have been able to purchase their own homes we have 5-6 individuals who have similar issues that they face, in similar challenges.

The one that I'm, intimately familiar with is in Perry County just north of us and they started a business transportation business

transportation is a major issue in Perry County help people get to their
appointments and a grocery store and other services that business is thriving
there's an evidence based model it cost less than some of the more
traditional models TANIF rapid rehousing is a taking funding and
directing in a different housing we looked at the rapid rehousing model,
we served 22 families in a Philadelphia neighborhood, who would not have
gotten housing that's interesting we'll look at the second year here
we'll serve 28, the goal is to serve 50, we under shot the first year
we'll under shoot the second year we're working with the Philadelphia
office of home also services the crown jewel, demonstrated how housing
works in the human service, section 811 project based rental safety
answer program some of you may know we got that, award back in 2012 it's
taken a long time to get off the ground I'm happy to say last spring a
year and a half ago we got it off the ground with the help of folks like
the south determination project and regional housing coordinators the
numbers are a little bit steal, we right now have a waiting list of 338
individuals across the State of Pennsylvania.

That, doesn't sound that great.

But if you consider a year and a half ago or a year ago we were at
0, and numerous challenges we're doing really well the other thing you
should know we have community needs that number 310, we have more than
doubled the committees since I wrote this, we filled 63 units.

So some of the challenges that we face with housing finance agency

partners is that we get the units committed they're not necessarily
empty when they're committed.
So we have to wait for it empty out, the other challenge by some
counts it takes as long as 150 days for people to transition out of
their institutional setting whether it's a state center or nursing home
to actually get into housing.
The landlord on the housing side, is required to hold it for 60 days.
So we see some missed opportunities in the system.
But is this is say great learning experience for us it really shows
demonstrates what I talked about earlier housing, human
service questions don't really talk the same language.
So -- a lot, that we're learning there.
One of the other things to focus on is the success is the
Pennsylvania housing finance agency has been added to the qualified
allocation plan guidelines they send developers in building housing some
points on their applications if they include section 811 that's really.
QNews because what it does, is prioritize the development of 811
units units for have disabilities.
So, PHFA has been a great partner.
Other efforts and there are probably too many to list, nearly
$80 million in housing services and supports through transition back to
the community, we really focused and MFP dollars on that area.
I wanted to share some of those 2016 successes that we had, some of

you may have seen Governor Wolf's press release maybe five or six months
ago.
If you advance to the next slide I want too talk a little bit about
what we've been doing in 2016, I would like to list to be longer and meaty we established
important group of bi monthly housing stakeholders across the
department, recommended individuals up to 10 individuals I do
invite you if you're interested contact me that's been great we ran the
using services definitions to that group we really talked it through, we
added homeownership and other things to look at assistive technology, so
we've got some really good advice from the housing stakeholder work
group.
We drafted in May, reboot of our 2 year housing strategy so take a
look at that, we're hope to go see that improve sometime in November.
Again I mentioned the Governor Wolf picked up the release of our
housing strategy review, that is a pretty good thing if you have not had
an opportunity to review that perhaps we can send that out.
July was a little bit of a busier month we completed a release of
the permanent support I have housing needs assessment we looked at
permanent supportive housing we have good data that supports the need
for extreme low income individuals who are rent burdened we have pretty
good data on the homeless side this is more about persons with
disabilities that required housing.
We published a little web page about six resources on our housing

web site but I've gotten a great deal of positive feedback about that,
so lists six ways you can sort of guest connected to housing.
That's helped folks in the department to refer people -- sort of
understanding from a broad state level perspective, how do you get
connected to housing we secured CMS approval for the O darks P lowing
services definition, that's a huge milestone.
In August we developed high level interactive guidance tools we're
really trying to give the tools, trying too take local lessons bring
them up to state. And then provide those lessons to individuals across
the State who are interested in housing best practices so again that's a
work in progress I wish I could say that, we begin that process we
didn't end it, if you advance to the next slide what are we doing right
now?
We're creating releasing educational materials and resources for
program offices to share with their staff and provider networks.
So that sounds simple, but it's been very difficult task, because so
many services in housing are local.
So I can't tell you, that an intervention that works in Philadelphia,
will, equally work in Erie that's become more apparent as I've
done my travels across the State we also are developing in-depth
training to help consumers access housing that's a critically important
part we're looking to reconstitute the regional housing coordinator
summit and provide trainings at that summit some of you may have

attended that several years ago.

In October we're looking to finalize the year two stray housing strategy so I can easily remember it when I'm nonin an elevate you're with an important person and then we're also looking to assess the TANIF rach I had rehousing first year data we received from Philadelphia.

And November we're looking at training seminar for the State it wide I mentioned the RHC summit and finally I think, one of the most important pieces moving forward is, the long term living Medicaid housing services definitions.

So we really do have tentative approval, Jen if I'm not mistake, CMS is signaling?

>> **JEN BURNETT:** Virginia, have you gotten any feedback on those?

>> **AUDIENCE MEMBER:** No we have not submitted them yet they have been approved in the CHC waiver but they have not been approved yet, we have not submitted the other four waivers.

>> **JEN BURNETT:** They have been approved in CHC waivers. And what we'll need to do is submit them for the other four waivers that has not been done yet.

>> **BEN LAUDERMILCH:** Still very promising.

>> **AUDIENCE MEMBER:** Submitted this month.

>> **JEN BURNETT:** Okay great.

>> **BEN LAUDERMILCH:** I brought a -- I don't know I don't want to run over my time, but -- I did bring housing services definitions rescap if

nine is interested in talking about those I discussed them the last time

I was here.

>> **JEN BURNETT:** Go ahead bring that up up.

>> **BEN LAUDERMILCH:** Think about two buckets of support that we can

provide individuals one we're relatively good is a system across the

Commonwealth one we're no so great, pretenantedacy, you think about prep

for integration into the community.

Developing housing assessment plans which includes budgeting and

includes housing needs assessment, preferences locations barriers, to

getting into housing.

And informed choices absolutely critical.

So a lot of times folks want to stay with they are, inertia in being

a certain situation if we can provide that level of education,

connecting the individuals.

Crisis planning.

You know what happens, if -- is this happens? What happens if I

have this situation occur?

The housing search itself, that's pretenantacy service, supports

likes deposits utility and security furnishing first month's rent, home

modifications and first cost, those are the supports we can

provide apartment home and inspection this is absolutely critical we

want to make sure, A people are living in high quality safety and

affordable housing.

But B, that the housing inspection is done in a consistent way with the housing choice voucher program so we want to, actually, gain a little bit it make sure we can work with the public housing short as well as thousanding private developer that's the pretenant say stuff we're doing, the crisis planning I don't think we always think about that. And the informed choice is I know say system, especially I don't think about the housing choice we think of the units individual.

Tenantacy sustaining we talk about community integration and resources and behavioral issue that's is where it gets interesting.

We need to retain the housing.

So I self-determination housing project, the regional housing coordinators have done a lot of work about hew to be a.

QTenant.

Reduction behaviors this is something I Robbed from the behavioral health harm reduction across the board, how do you reduce behavior that's are more likely to get you evented? That could be any number of things from drug and alcohol substance abuse, disorders all the way to housekeeping.

Pets, huge.

Sustaining relationships with landlords neighbors, tenant and landlord law, absolutely crucial people know the rights one of the things I mentioned T evening NIF rehousing and eviction in New York City they have increased many times their contributions to eviction

prevention and by my calculations, 100 dollars of
prevention represented by a legal aid attorney is worth thousands dollars
of housing safety answer, that's my rough numbers don't quote me.

Housing plan monitoring and update so -- as things evolve for
individuals we want too make sure we have a relevant plan.

So, these two ideas I think, again the first one connecting people
to housing well-worn path in a behavioral health work we've done a lot
of work in the last decade that's how I got into housing for persons
with disabilities we've done the greatest job it's far cheaper to keep
people in the housing delay, going into some sort of institutional
setting for as long as possible.

Absolutely.

When we talk to our managed care partners last week some of the
thing that we were talking about didn't sound very simple it's something
we want to keep our eyes on the transition, we want to decrease the
number, but also the length of time it takes to get people into housing.

So that 150 days we need to get that down to 90, to 60 days if we
can.

We want to change our default thought process, and again I have not
vetted this --

[laughter]

But we currently defaulting to nursing home and I think we want to
think about housing setting can someone live in a housing.

That should be a question we should ask early and ask often.

Diversion.

We need to increase the number of people diverted, from these higher costs, more restrictive settings we need to decrease the length of time people are residing in these we need continue crease access to housing for as res denteddal options I have a note to say our home and community based compliant I don't know what that means, we need to divert people a way make sure it's compliant with the regulations as they exist today.

So the MCOs are really focused on some questions.

How will your organization identify individuals who need housing I think that's easier said than done? Right? We know that a certain number of people need housing but we don't really know how to get it I had a slide that I showed you the last time that showed the 54,000 people that are in institutional setting if we move 500 of them out we can save the State 15.5 million-dollars how did we identify those 500 people it's harder than we think.

What are the organizations strategies to meet housing needs how will they be implemented we're very interested in implementation strategies and we only just started that conversation.

It's very exciting.

And how will your organization measure the housing strategies in innovations as successful.

That's absolutely critical I think, if I can go back in time I would

love to talk to former deputies about setting up systems we can easily counted success, failure, numbers and, unfortunately they have evolved over time we don't have the best systems to count all that.

So -- that's in a nutshell I don't know if folks have questions about that.

>> **FRED HESS:** --

>> **BEN LAUDERMILCH:** Slide with resources.

>> **FRED HESS:** Not that just -- I'm a probably mentioned this one or two thousand times.

Why are we not getting houses that are on the tax rolls and for each county and just going in there and doing a home modification on them and then turn around sell them and rent them to people with disabilities.

All these houses are sitting there, doing absolutely nothing they're not creating any income for the city the county, the State, nothing.

So why are we not doing this yet? Still?

>> **BEN LAUDERMILCH:** I think the short answer is communication.

Sharing the best practices so -- when I was at the local level, I struggled with the necessary resources to bring a house up to code.

I'll give you an example if you have a source of funding that is Federal, you can't make the house move in ready to expectation that you and I might think would work you have to get it, completely code compliant.

You might be able to do that with the number of units the scale we need, we need more systemic change I believe.

>> **FRED HESS:** Only get 5 out of 100 houses on the tax rolls that's still 5 percent.

>> **BEN LAUDERMILCH:** We need the local partner those agree to the approach there's resistance the not many my backyard, syndrome that seems to play in of our communities we have systemic issues we have communication issues the department community economic development and -- department of human services needs to communicate better, about priorities.

So that's what the housing strategies hopes to improve we're looking at best practices I was just in Erie I was just there, within the last month, and the folks that I was talking to -- the human service providers were not aware of any first time home buyer or any sort of activies to rehab homes.

>> **FRED HESS:** When I first moved here in the State I was living in an apartment building, once I hung united with the center for in the living they got a house off the tax roles I used my -- um, my waiver all right for a home modification.

What did that, they increased the size of the bathroom all the plumbing got restrike youred I had to have expert plug ins and more power only 65-amp system, all paid for it got it 100 percent, accessible right now.

So, I just got a $15,000 house, which is now worth $25,000 okay.

Because -- of the improvements so when it gets turned back over to the State they will be able to make some money off it, or be able to sell to someone with a disability that can use all of this.

I really really think it would be a fantastic and greatest idea would be to try to just if you have to, it's the State.

Take a couple of houses off the tax rolls you know and just -- create them, make -- housing for 3-4 people in a house.

You know I mean it's pretty simple.

>> **PAM MAMARELLA:** Thank you fled Estella?

>> **FEMALE SPEAKER:** It's a long time advocate for AARP and get people out of nursing homes that are eligible to go into the community be supported and very interested in this 150 days, why is it taking so long to move someone from -- that type of a facility, to a community based facility?

>> **BEN LAUDERMILCH:** I think what it's not a community based facility it's using.

So I think, part of the problem is, new housing we're seeing the bottle neck on both sides of equation I won't name the housing developer for one of our early adopters took a long time to get the paperwork going we developed a system called prescreening assessment intake and reserval which is San online system or at light I thought it was online system.

Up front, the service provider can load in information about the
individual and sort of determine early on if the individual is eligible.
Then there's -- waiting list administration that's oughted mated
then a wait list administrator ask dig deeper.
Where it becomes old school after that a letter is mailed or faxed
or emailed to the housing provider and, so -- couple of first times the
message about the 811 program didn't get to the leadership down to the
property managers who is managing that apartment we had delays there and
strays on other side where we didn't have people who necessarily fit
into the units another problem that we faced is we -- identified units
that were available that may have been housers vacancy problems if you
and I don't want to live there, why would we assume anyone would want to
live there? So if it's not located we had a property that was maybe
located further away from services and the individual who looked at it
said no.
So we're seeing, it is not the cycle of a service coordinator delaying
150 days it's all of it.
From soup to nuts we may be have people on waiting list for one
region not for another one, we don't have unitness this one region but
we have them in this region we're seeing people sit longer.
>> **PAM MAMARELLA:** If I may add my organization actually has housing
completely dedicated to nursing home transition and so we have no
barrier to units.

And rather extensive waiting list but there are so many barriers to
try to comply with the housing qualifications that need to happen which
includes an ID which is one of the number one barriers we see.
To working with nursing homes who, are not necessarily incentivized
to help the participant leave the nursing home so I would be happy to
directly talk to you about our experience with that we've done close to
200 nursing home transitions now.
And, have no traditional structural barriers to doing it, yet the
time frame to accomplish it is longer than we would like it to be for
people.
>> **BEN LAUDERMILCH:** I don't have good answer fors you think that's
my thing we're trying tolane through the 811.
>> **FEMALE SPEAKER:** Sounds like the ba basic problem is housing.
>> **BEN LAUDERMILCH:** Housing is scarce and the number of individuals
the supply of individuals is much higher than the supply of housing.

>> **JEN BURNETT:** It's housing also the service delivery system and
eligibility for waiver services.
Which is different than eligibility for nursing facilities services.
So some people fall through the cracks that way.
That's another thing that happens it takes time to get that
eligibility to happen.
I think, it's not only housing side but it's also a service for each

side.

>> **FEMALE SPEAKER:** Thank you.

>> **FRED HESS:** Question?

>> **FEMALE SPEAKER:** This is one of Tanya's questions she has a whole paragraph of questions here so I'm going to try to sort through them real quick to find the ones have not been answered.

>> **FRED HESS:** Got to love Tanya's questions she is as bad as me.

>> **FEMALE SPEAKER:** She is a very thoughtful person.

So -- all right.

Let's see here.

I think this is one in a is very applicable.

Are you aware of any special grants or low interest loans that may be available to landlords and/or realtors to do some basic accessibility type of things to their properties outside of the home modification program that is more of a one-to-one specific? So that they could have it already you know, doors widened and it would not have to be done under the home mod program.

>> **BEN LAUDERMILCH:** Only area it's very little amount of money it's probably the only flexible pot of money I'm aware of is the PHFA administered reality transfer tax fair which stands for Pennsylvania housing affordability reininvestment enhancement fund.

So FARE there's been P flavors one is national thats one is the RTT repeat transfer tax and one is the realitied to the Maclellus shale and

flexible how they can be deployed I will tell you the core problem with that, is landlords, most grants that can help people with home mods and other assistive technology are based upon income.

So, landlord property manager is not necessarily low income and not necessarily, eligible.

I think it's something we really like to take a look at and our housing stake stakeholder work group has money promising practices I don't know if.

>> **JEN BURNETT:** I also would put out the Pennsylvania assistive technology foundation which is another resource for getting low in interest loans.

Also there is a program through the department of community and economic development we don't know a lot about.

That may be another area to be looking.

That's funding that goes to local municipalities for doing home modifications.

>> **BEN LAUDERMILCH:** Still tends to be attached to the video posed to the property which I would love to -- now on the other hand, Pennsylvania housing finance agency, has done a great job of including that, in the low income housing tax credit guidelines the problem it's no in there to pleat the deplaned unit has to become available at the right time for an individual.

>> **JEN BURNETT:** Going back to the first goal the pipeline.

>> BEN LAUDERMILCH: Here's another problem with the pipeline I don't want to belabor this, if we get thousands and thousands of people on a waiting list that's disa appointing that's discouraging, for the provider but also for the individual, so I'm language wishing like public housing wait list, some of them outside of Philadelphia are five years long.

So Languishing on a waiting list isn't good either we want to demonstrate there's a need we want to get people queued up for units available.

>> JEN BURNETT: Pennsylvania housing finance agency has been for the last at least maybe 15 years really, building accessible affordable units, through the low income housing tax credit program and as they build those units, they get people who need, accessibility features and the affordability features into them.

When someone moves united of them, this is where the pipeline is so important, a tenant doesn't need the accessibility or the affordable feature could move into that unit and they -- it's no longer available to us.

This is actually I think, people may remember secretary Estelle Richmond this is something she worked with PHFA to get that qualified allocation plan to include incentives to do these enhanced accessibility affordable features from the builders the pipeline has been a vexing problem there's no just way, no way -- there's into direct availability of

someone to fill the unit when the unit goes vacant.

So we have a lot in PHFA can did come and do a report if we want to invite them to tell us, how many of their accessible and affordable units are into the getting used by the people who need the features.

They do track that.

>> **JEN BURNETT:** Is that.

>> **BEN LAUDERMILCH:** Is that the full paragraph?

>> **FEMALE SPEAKER:** No but -- some of the other questions have more to do with how the MCOs how CHC is going to effect the qualifications for these different programs my understanding is that it's not going to?

>> **JEN BURNETT:** CHC and one of our requirements for all of MCOs that apply to be part of community HealthChoices is they have a whole description of how they're going to address housing so housing is definitely on their radar it's part of their part of our agreement with them is -- you know they came back to us said we need to do the things we're doing, kicked off with the last thing, in a included some of the PHFA and other housing partners and all 3 of the MCOs our next steps is -- our plan to meet individually with the MCOs to really talk through the strategy is.

Housing is definitely part of the community HealthChoices it will continue to be be so.

>> **FRED HESS:** Homeless people are not very healthy, so -- yeah.

>> **FEMALE SPEAKER:** There's a strategy to assist with that, it will

not effect with qualifications for current housing programs is that --

>> **JEN BURNETT:** I'm not sure I follow that.

>> **BEN LAUDERMILCH:** I think --

>> **FEMALE SPEAKER:** The HUZHUD

qualifications.

>> **JEN BURNETT:** No.

Yeah.

>> **FEMALE SPEAKER:** Thank you.

>> **PAM MAMARELLA:** Thank you Ben.

>> **FRED HESS:** We have ten minutes.

>> **PAM MAMARELLA:** Ten minutes for public comment and we have a long list on people on the phone why don't we go -- is there anyone here today that wants to has a question or wants to make a public comment.

>> **PAM MAMARELLA:** I'm going excuse myself and turn this meeting over to Fred.

>> **FRED HESS:** Okay.

>> **MALE SPEAKER:** Hello Lester benefit with supports coordination I have two.

[Be for example net]

I have two simple questions this time, what is the day the consume everies must choose a MCO for the community HealthChoices before they're auto enrolledded so I can let them know hey you better do

this, by this date or you will be auto enrolled without your.

>> **JEN BURNETT:** It's in the third week of November I don't have the exact date I'll get it for you.

>> **MALE SPEAKER:** Okay.

The third week of November.

And then, we were talking about the trainings.

Right now, our service coordinators have to do trainings regulated to chapter 52.

But I -- as we hear we want the service coordinate you'res to inform our consumers, what isshipping with the community HealthChoices.

Can my, can these trainings that these service coordinators go to, can they count towards the annual trainings?

>> **JEN BURNETT:** I don't think they have anything to do with the clap interpret 52.

>> **MALE SPEAKER:** I know, then I have to have training for that.

For chapter 52.

>> **JEN BURNETT:** I'll take it back for consideration.

>> **MALE SPEAKER:** Thank you that is where I was going -- I don't needed two today.

Thank you.

>> **FRED HESS:** Do we have any other questions here?

If not, let's go to the phone.

Do we have anything on the phone?

>> **AUDIENCE MEMBER:** I sent you a text.

About 8 questions.

>> **FRED HESS:** Okay.

Okay.

I don't have them.

Is that it?

Nope.

Okay.

Thank you.

Question text one.

From Davis Menya, for your information, he is a home care provider.

How will CHC effect current providers?

>> **JEN BURNETT:** All providers who are currently participating in any of OLTL Office of Long Term Living programs will need to contract with the managed care organizations.

>> **FRED HESS:** Okay.

From Neal Brady he is with the transportation company.

Will transportation for health care access and service appointments for care, et cetera, be coordinated independently by each of the MCOs it will be handled by statewide over sight? Secondarily, then, how will charges and payments for medical transportation be managed? Again through the MCOs directly or through the State?

>> **JEN BURNETT:** I don't have the answer to that, do we know? MATP, we have medical assistance transportation for that -- that the MCOs are going to be tapping into and using.

Those are county by county offices do you have anything else Jill.

>> **FEMALE SPEAKER:** I think the managed scare organizations themselves,.

>> **JEN BURNETT:** MCOs will want to coordinate for medical care.

>> **FEMALE SPEAKER:** Through service coordination, activity.

>> **FRED HESS:** Okay.

From Susan Weary is autism -- yeah, is autism provider what is the time line for providers in southeast to complete applications with respective MCOs?

>> **JEN BURNETT:** Generally autism provider would be contracting with the office of developmental programs not with the Office of Long Term Living.

So but in the southeast, next spring, people are going to be hearing from the managed care organizations if you provide services under the Office of Long Term Living which generally OLTL, defers to autism service those the office of developmental programs the autism bureau.

>> **FRED HESS:** Okay.

From Kathy Cubid the network add wayacy guidelines developed by the ALTL work group be released to the public?

>> **JEN BURNETT:** We have already talked about them and shared them

in this meeting.

So --

>> **FEMALE SPEAKER:** We have a follow-up meeting with --

>> **JEN BURNETT:** Follow-up meeting.

>> **FRED HESS:** Come to the mic.

>> **FEMALE SPEAKER:** Sorry.

>> **JEN BURNETT:** Before Jill starts we have talked to a number of states around the adequacy standardses for long term service an supports last week when I was at the conference I talked to many states about this.

There is -- just not a standard process, no state has a standard.

>> **FEMALE SPEAKER:** Right.

So we were working with Pennsylvania health law project.

>> **FRED HESS:** Right.

>> **FEMALE SPEAKER:** We have a follow-up meeting with them scheduled on 9/15.

So that -- that, the discussions with the Pennsylvania health law project, were how we arrived at that full-time equivalent calculation for LTSS providers.

So we will be having a follow-up meeting with them next week.

>> **FRED HESS:** Okay.

This is from Jennifer Molluch, NF provider.

Question from PSC south facility when can we expect the Concierges

from the 3 MOCs to be on site here facility to answer any questions.

>> **JEN BURNETT:** That's a MC by MCO.

>> **FRED HESS:** That's the answer, from Ashley Hensky, what is the update whether or not having NPI numbers for all providers, including non-skilled home health aids is it moving forward? If so? Why and what are the dates as associatedded with it.

>> **JEN BURNETT:** I have not heard about it in awhile, my understanding the managed care organizations will not be required to implement this on January 1st that's all the update I have.

>> **FRED HESS:** Okay.

Let's see from Pam Walz, what is the status of the requirements for the appeal process? Where is the final version of available?

What is the status of planning for the beneficiary support system?

>> **FEMALE SPEAKER:** Being finalized with legal.

>> **FRED HESS:** Being finalized with legal.

>> **JEN BURNETT:** Being finalized with legal, as far as beneficiary support system, there will be a procurement at some point in time as we move forward with that.

But I don't have any specifics.

>> **FRED HESS:** From Ne environment l Brady if the M creek Os require medical transportation providers will they have to use them district itly or can they organize them through a broker?

Since a broker would not necessarily be a direct contract provider to Medicare or Medicaid, will there be an exception, will the MCOs contract for transportation on a individual or collaborative basis?

>> **JEN BURNETT:** All of the above.

>> **FRED HESS:** All of the above, okay.

Kathy Cubick, if time, please pose this question.

Who will complete the initial assessment of the services of the service coordinator, I'm sorry.

At the MCO or, the service coordinator, the new enrollee is still getting to use during the transition continuity of care period?

>> **FRED HESS:** Would you like me to repeat that?

That who will complete the initial assessment.

>> **JEN BURNETT:** Service coordinator.

>> **FRED HESS:** Service coordinator at the MCO or the service coordinator that the new enrollee is still getting to use during the transition.

>> **JEN BURNETT:** Service coordinator that the -- during the continuity of care period the service coordinator as long as they're -- as long as they are in agreement that they want to participate, will and are qualified to participate, it will be the service coordinator developing with the consumer with the participant with the service plan.

>> **FRED HESS:** Okay.

That's all the questions we have on the phone do we have any -- we

have a question over here.

I'm sorry.

Go ahead.

>> **MALE SPEAKER:** Fred I had a question about people who have brain injury, who may be over 60 years old, during the transition during the phase in period, may not be able to access brain injury services.

Because they would not be covered under the independence waiver.

Is that correct?

>> **JEN BURNETT:** No, they will -- if they're 60 years or older in COMMCARE they will go into independence.

>> **MALE SPEAKER:** Right what if they're a new applicant during the phase in period.

>> **JEN BURNETT:** I don't know.

>> **FEMALE SPEAKER:** Drew we talked about this before I think we'll have to be -- sorry.

>> **FRED HESS:** Please come to the microphone.

>> **FEMALE SPEAKER:** Sorry.

So during the transition period, when the in the southeast and the rest of the State, where individuals will be going directly to the independence waiver if they were trying to access services in COMMCARE, for those individuals over the age of 60 we're going to have to dot best we can to meet their needs in the aging waiver.

>> **MALE SPEAKER:** So they will not be -- they will not be, able to access the brain injury services that are in the CHC waiver?

>> **FEMALE SPEAKER:** They will not be able to able ResHAB or structured rehab.

Right.

What do we do about this? I believe Cog rehab is a service in the aging waiver.

I'll -- I'll double check.

But -- I think it is.

>> **MALE SPEAKER:** Okay.

That -- there's a gap there.

So --

>> **FEMALE SPEAKER:** The decision was made not to -- to open the independence waiver up to individuals over the age of 60.

So we're going to have do the best we can pleat those individual's needs.

>> **MALE SPEAKER:** Okay just want to point out that the -- one of the highest incidents and prevalence groups for brain injury is the over 60.

>> **FEMALE SPEAKER:** Already.

>> **MALE SPEAKER:** Age group because they fall hit their heads.

>> **FRED HESS:** Okay we have the same.

>> **AUDIENCE MEMBER:** Same question.

>> **FRED HESS:** Do we have any other questions from anyone?

Okay.

All right, our next meeting is going to be October 4th, right here.

At same bat time same bat channel this meeting is now adjourned.

[meeting concluded]