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9/1/15 Managed Long Term Services and Supports Subcommittee Meeting.

>> THE SPEAKER: I think we will get started.

We do not have mics today. It is our first meeting of this newly-formed committee. We will talk a little about that. I will just do a sound check. Can people in the back hear me if I project my voice? Are you able to hear in the back? Okay. Great. Great.

My name is Jenn Burnett, I am the deputy Secretary for the Office of Long-Term Living.

I have been here for four months. There's been a lot going on in those four months. I want to talk a little bit about some of that, as well as things that have been happening over the past four years.

I want to thank everyone here for your interest, and passion. We have a lot to do in a relatively short period of time.

We really want to get it right and build on the system that we have today and make it better; that's really our goal.

As you know, the Commonwealth has embarked on a significant shift in ow we deliver long term services moving from a fee for service system to a managed care system is a pretty large undertaking. It is one that we want to do with all of the partners in the room. We don't want to do

this in a vacuum. So I am very heartened to see all of the people in the room. Especially the committee that we are surrounded by.

Today is sort of going to be an orientation for the committee itself. You will have to pardon me. He we have put this committee together so quickly and really have not had the time we needed to put in in order to orient people and provide the orientation of the committee.

The committee is really a subcommittee of the medical assistance advisory committee.

We formed it because we really see this as such a significant change is that we have to have a committee to advise the department and to advise the medical assistance advisory committee.

MAC is the medical assistance advisory committee that advises the department on changes in the medical systems program or the Medicaid

program.

The subMCAACs are formed and this one being a committee that is going to help us as we shape up managed long-term care services and supports.

This subcommittee is unique in that the Secretary asked me to make sure that we have 51% representation of people.

The role of the committee is to advise us. We have members on the phone, I believe. We do have a call-in number that public -- members of the public have been shared -- and so we recognize that this is sunshined meeting. We are open to your suggestions as well.

Because it is such a large audience, we will be handling our public comment period through papers that you all got to fill out and I will let Virginia talk about that a little bit.

Before we talk about our logistics and sort of the orientation for the subcommittee, I want to ask subcommittee members to introduce themselves.

Again, I am Jenn Burnett with the Office of Long-Term Living.

I asked Ralph Trainer to my left, here, I asked him to co-chair -- to Chair this committee. He will be our Chair.

Today he is getting orientation so we will teach each other how we want to run this meeting. Ralph?

>> Ralph Trainer.

I am an executive director for a center of independent living in Berks County, abilities in motion. I am also a consumer of long-term care services.

Hopefully I will be able to help and give the committee something

we have been looking for for a long, long time.  Thank you.

Jeffrey.

>> JENN:  I would like each committee member to talk about why you are appointed to this committee.  What you bring to the table.

>> RICHARD:  I am Richard Duckson injured in 1991 in a motor vehicle accident.  I lived with my parents for a couple years.  I had tenantant care services then.

After that, I moved into a nursing home for three years.  That worked out pretty well.

I transitioned from the nursing home into assisted living since 1996 and as -- that worked well.  I think I bring a unique knowledge to this.

After living in the nursing home, also living independently.

>> An Marie McLaughlin. The member of the subcommittee is Drew Neagle. We are on the brain injury committee, which is an advocate group for those with brain injuries. We want to represent their needs as we move forward in this discussion.

>> My name is Blair Borough from the united healthcare and community plan.

I have been working in Pennsylvania Medicaid for the past 16 years and prior to that about 8 years coordinating care in behavioral health arena for those seeking mental health, substance abuse services and other counseling services.

I am very grateful for the opportunity to participate on this committee committee to learn about services in the state as well as what things are working well that we don't want to see broken.

One of the few managed care representatives here. We have perspective on things that worked well and not on other states, we have a full appreciation of each state is unique as well as the counties. We are really looking forward to a productive discussion today in the weeks to come. Thank you.

>> Darryl -- Bayada. Provider of home and community-based services.

As a provider of those services, we are here to just kind of connect the dots with the processes in front of us.

>> Stew Sweatbury. I am retired. Currently serve as Chair Pennsylvania council on aging.

I am also a member of the board of managers for Lancaster General Hospital's accountable care organization in Lancaster City. My whole

career was healthcare, pharmacy, hospital administration. I serve 13 years as CEO and president of our international professional society the American college of healthcare executives. I finished my career as a professor teaching health administration and policy.

>> Hi, I am Scott Rifkip. A physician. I have seen every side of the healthcare world. I had major reconstructive cardiac surgery three times for congenital heart disease. I am thrilled to be here with you guys today.

I practice medicine for over 20 years in the neighborhood I grew up with and took care of a lot of folks with both acute and chronic medical problems.

About 10 years ago I purchased skilled -- a skilled nursing center that is -- Mid-Atlantic healthcare and are big proponents of the concept

of identifying patients and helping them get back out into the community. I have a mixed bag of medical experience.

>> My name is Richard Kovaleski a consumer of services. I worked on a couple committees. I am here today to speak about services that I received through long-term -- [indiscernible]

>> My name is Jennifer Howell. I been a part of the community for several years.

Linda Anthony and Dave have really just helped me to have my voice and I -- Ralph, Cassie helped me too -- I didn't mean to neglect you guys. I would like to do the same for other people.

>> Pam Amorella vice president of marketing and government affairs for Newport land senior services in Philadelphia.

My organization encompasses LIFE program we have experience working

in this arena.

Managed long-term care LIFE is an unbelievable model for seniors and across the country and non-profit nursing facilities.

>> Good morning. I am Jack Kane. I was with the Department of Public Welfare. In thinking about wanting to come on to the committee, I reflected on the specious I had as Chief council at the department. I was there at the beginning of the healthchoices program. I want to say I give a lot of credit to the department because it is not unusual that I am litigation against the department since I left.

[LAUGHTER]

This seems to be an opportunity to go back to the other side and to help promote what I think is really a fabulous idea.

I am very honored to be on the committee.

>> Hi.  I am Barb Dolzer, Liberty community connections, a service coordinator entity.  I am thrilled to be part of the group and hope to bring the perspective of sports cord nation agencies that serve under and over 60 population.

>> Ray -- I work at -- senior director for our Medicare plans including Medicare special needs plan which serves more than 20,000 dual eligibles in western Pennsylvania that I have been in that role for about 4 years.  Prior to that I spent 6 years in state government working on many of these long-term living programs in the Department of Aging.

I really look forward to the tint to be able to better integrate these services which today, you know, really aren't designed in a way that really has a whole -- [indiscernible]

>> My name is Neal --

>> JENN: Anybody on the phone, if you wouldn't mind muting yourselves until we open up for public comment; that would help at this end. Sorry.

>> NEAL -- president of healthcare -- Pennsylvania we are the largest union of healthcare workers in the Commonwealth of Pennsylvania including representing and -- direct care workers who work throughout the continuum of long-term living from skilled understanding facilities home and community-businessed services.

Our members and the direct care workers that we work with and represent have an incredible passion and vision for creating -- building on the system that we have and creating a long-term living system that works for everyone.

Unfortunately, the system today doesn't work well enough really for anyone, whether it be residents in skilled nursing facilities who would like to be in home and community-based setting or are in skilled nursing facilities not always getting care and support that they need there and certainly, the home and community-based services system it tell tremendous workforce -- stability -- it is unfortunate but true. Consumers, seniors, people with disabilities struggling to make ends make lacking the basics for themselves and their families.

Too often, unable to continue to sustain themselves in those jobs because of the challenges that they face.

We are really excited. We are partners already organizationally with a number of the stakeholders around the table and gallery, we are very excited to be part of devising and implementing a vision for

improved long-term living system that make -- in the state from no matter what relationship they have in the system as a provider as a consumer.

>> THEO: Hi. I theo Braddy, adjunct professor for Millersville University and director of central PA center for independent living.

I understand the needs due to being disabled since 18. And the need to have a voice; that's very important. I believe that managed care, long-term services is important. We need the -- to be actively involved in it; that's why I wanted to be part of this.

>> Cassie, here for James Holdsworth. I am Cassie and am controversial. I am sick, sexy and tired and old but I am still sexy. I am still an activist.

I have fought all of my life to just do anything. At first I

thought to go to regular school, which never happened. I didn't go to school I ended up getting my GED. I claim climbed up the steps to go to college. They told me because I didn't have a history in education.

I am a fighter and controversial figure. I am not stupid and understand policy quite well.

Right now I am in a situation because I worked -- crazy me. I always knew I shouldn't work. I have 100 operations when I was kick. I was supposed to be dead. I am supposed to be now. My worst disease is life. I have a beautiful daughter. She thinks she a princess.

Try a two-year weight with a live disease. My husband is not healthy. I still love him. He was forced to go back to work at 62 even though he has -- [indiscernible] which is $1700 a month by the way.

We are tortured by hospitals for co-pays by our own agency. I

wrote the proposal when I was 19 years old. I sat with my ideas with an older lady and those ideas came true. There was transitional housing in the beginning; that was wonderful because we got a lot of people out of the nursing home and a few disabled people off the street. I am proud of my legacy. I am 59 years old with liver disease. I have been around the world married an englishman. People give her trouble because she is small and came from me. You will never believe how old I was. I prayed all my life I was making good money at that point planned to get a job. I needed a lot of help. God got me pregnant. I don't know how it happened. I was told it couldn't happen. I was told I would be dead. Somehow I lived.

They told me I would be bed ridden. We are not supposed to be -- it took me a long time to have Monday. I started out as a peer

counselor college education I helped build Liberty now people sit around and talk to each other. Liberty is a great place and does good work.

Sometimes when you work you have to worry about your agency you are a commercial for them. I am really happy to be genuinely here to serve my community and tell them they can do whatever they dream of. Hey lookality the girl there. She was in Europe. She always asked me questions about it.

Our dreams can come true. Nobody tells us that. We may want to go to the shore and they don't have money to send us. We can get the money on our own. Figure it out and have our own businesses.

Integration is that. Integration isn't getting someone an apartment and sticking them in it. Integration is about getting people involved in their community and really consumer control is about working

the way you are supposed to.

I mean, it is about doing what you need done.

It's not about agency rules. It's not about the agency that doesn't give you a bath and you go around stinking in front of your relatives. I never wanted to be taken care of. My father wanted to take care of me. He was going to buy a store and I was going to be a cashier. I went to college. I was phi beta kappa. I didn't get my BA because of being sick. Nobody told me I was smart. Until I was in college I didn't have a clue. I understand policy quite well. Better than a lot of people.

I mean, I could be a bureaucrat but I am here to serve a -- I know a lot of good bureaucrats. Some of them here are good ones. They told me things I needed to know. There are people head of agencies

accountants and big people. I am just saying. Disabled people can do whatever they believe they can do.

If you have too many co-pays and the agency sick kicks you out and you are under water, I don't give a shit! I never asked to ask have money. I would give it away if -- I would be accused of fraud. I don't have much money it pays my mortgage, I will abouts I try to pay the hospitals. My daughter has a heart condition. Born without a valve. I have a liver disease. I have been in bed for a week.

They say, well, you are in consumer control. You will end up, you know, being in a program because if you -- I am my own social worker. Somebody told me it was consumer control. I learned about that from Ed Roberts. He was a genuous.

Maybe I didn't represent-him I was a lot Mader at them. He changed

everything. Just like Theo. Powerful guy. I respect you, Theo.

Bottom line, I did more than anybody said I could do. People are still telling me I can't do things. People tell me I will be dead. My doctor told me, your daughter is 15. At least she will be able to take -- I will live at least she is 21 and I might lifelonger if I decide to.

I will not ask for assisted suicide. I will be fighting hard for our community.

Thank you Kathy.

I will end it here. I know I can be dominate --

>> JENN: I think we knee you well.

>> KATHY: I just want to say one thing. I know why I am here. I am not here because of this but I think some people need to hear this. I'm sorry Jennifer. You will do know it. You have been my friend and

out there and fought yourself for disability rights. My three things are:

Consumer control. We need it back. It's not here. I hope we will make the system better. We lost consumer control under Corbett.

People have no choice. I am mad at everybody right now. I realize agencies are good. People are good. Community-based services I hope are the ones that do it.

I still belong to Liberty Resources I want to be a consumer. People cannot go without medical care for two years with liver disease. I am here to see if there is could be assumer control in the medical model. I am very sick right now.

I don't want to be rationed because I lived to be 59 and nobody expected me. I want to be treated. I find even medical care is broken

down. Now we are talking about managed care. I know it can do great things it has done great things in other things.

The other thing is to be sure the rates are carved in a way that will keep us in the community, no matter how sick we are, if that's our choice. I do never want to live in a nursing home. I will not kill myself. I am not a chicken shit!

I am telling you. I want to live and die. Maybe I want to do it in Philadelphia. I want to age in place! I want to -- I fought too hard to end up in a nursing home. Medical care is a fortunate. Because I worked for 28 years -- incentives are against us. Jennifer I know you are for us. I would be insane if I didn't work. I was one of the -- I am angry about a lot of things, especially because I am sick. I have been anier than ever. Working is good for us. We need jobs and to be

productive and make our dreams come true.

I want to make sure that that can happen under the managed care system.

They said it was going to happen. It will not happen if we are told by nurses who can be very controlling. My sister is a nurse -- nothing like a nurse when tick sick in the hospital and needing them. I don't want them coming into my house telling me I am not allowed to go out. I don't want to -- I don't want a chair that I cannot wheel out this is why I am here. I want it carved in a way that we cannot just exist, but that we can thrive. I have thrived. I love my own life.

>> JENN: Thank you, Cassie.

>> How do I follow that?

I am Brenda Dare. I worked in the disability services field for 23

years. I am currently employed by tri-county patriots for independent living. I am here first and foremost to represent the consumers that fight every day for the right for consumer employer option.

It is critical to me that that option be protected under whatever managed care contracts come forth in this committee because that really is consumer control at its heart.

Agencies might have the best intentions, but until we can choose who we hire and fire, what time they show up, and what they do in the course of their workday. It doesn't have to be written down on somebody's time sheet. Brenda had three beers. Brenda didn't take a shower. All the ridiculous things that get written down. We don't have consumer control.

I sit here amongst a group oval lies and advocates and friends who

have only themselves to blame for the fact that I am here.

How many conversations did I have with you to work for someone with support. I followed your advice.

I am here to be a mouthpiece but also a voice of reason. I don't expect miracles or policies to be changed overnight that were created over years of an absolute mess.

I left to live in Illinois some years ago. Pennsylvania was a hard place to leave. I came back about six years ago. Wondering, what the hell had happened?

Here we were in the middle of change and direct care services meaning Act 150 was closed. Don't make too much money to get on a waiver or you will not have services a the all. Had to rebuild my life in the midst of that chaos. I got lucky. I know there are hundreds of

people out there that don't get lucky every day; that's why I am here to shake policies for people who don't have the resources to be part of this committee.

>> Fred Hess: I am disability advocate for disability options network.

I was vice chair man -- I sit on three different transportation committees. I sit on the PA state voting coalition among many, many other things.

Because of the center for independent living, because of the waiver services that I received, I went from living in the projects to getting a job, to owning a four-bedroom two bathroom house. To being able to drive a vehicle again. To have that vehicle and be able to come here and sit here and try and help the people of this community with

disabilities this entire state.

The only way is for consumer choice. A hundred percent consumer choice. I know it will not happen. It is not possible to have 100% consumer choice. I would like a lot more than what we now have. Okay?

It's that simple. Imhere for the people with disabilities. I am here to represent them. Not just one certain disability. Every disability. Hidden. Not hidden. Plain view. It doesn't matter.

That's what I am here for.

>> Tonya author and historian. I just published my first article. It just came out in the West Tennessee historical society papers.

I am basically here today because at first I kind of thought I was on the wrong committee. I heard all of this talk about government managed care. I was, like, whoa! I am not here for this. I am on a

program through SCR in Erie, Pennsylvania. It is dualed Services My Way where you get to make your choices of whom you hire. Who you fire. What wages they get and how your care is structured and how want you to use your hours and what you need to use your hours for.

Now, if you ask me, we should be making that the consumer model of care in the State of Pennsylvania. Period. That is the kind of independence that needs to happen.

Now, granted, I just started on this program so I really don't know all the ins and outs of it yet.

I don't know the flaws and upside because I am experimenting with is it.

I think that is the point. If I can get it to work and make it work on a daily basis. Now, granted, I had to ask them for extra hours

to serve on this committee and drive, like five hours across the state and back to come do this.

[LAUGHTER]

It is causing a bit of an uproar. We are not even supposed to be allowed to have attendants drive us, which is absolutely assnine.

My whole thing of being here today is to kind of help try to make people see that there are other ways of managing your life. There are other ways of doing it so you can achieve the potential that you want to achieve and be the person you want to be right now.

What you have to get and what you have to be able to do is you have to, A, not be afraid to pester the hell out of your public officials; that's how I got here today because I have been bugging them for three years straight now.

I've also not been afraid to be on the front pages of my newspapers and everything else with the whole CFM mess and be on the news more times than I can count have news reporters in my house.

You know --

>> CASSIE: I like her!

>> THE SPEAKER: The way I look at my life is, I have Cerebral Palsy. It is inform going to go away. It is never going to really change -- well, that is debatable because I am working on that one. I will always have it and it will always be a pain in the ass.

Despite it being a pain in the ass, if we will unite and fight loudly enough, and I mean loud, then we can get this changed to where we don't need managed care in the State of Pennsylvania. We can, actually, be running it ourselves; that is what we need more than anything.

You do need service coordinating agencies to help you do that. There's bull shit talk -- sorry -- there's bullshit talk of the state talking about what they did with PPL and CFM now with service coordination agencies; that has to stop right quick before it gets started.

If they do that again, everything that we have worked through for the past three years to fix that mess is going to happen all over again; that is why I am here today. If we could get a couple technical glitches and funding glitches straightened out, I will be back for every meeting over the next two years.

>> JENN: Thank you. Thank you, everyone.

As you can see, there is a lot of passion around the table for our programs and services that we provide that keep people independent.

This is what we want to make sure that we continue to do that; that we do it better. Through managed long-term services and supports, we hope to get there. We will need a lot of help to do so.

Jack talked about the implementation of health choices many years ago.

I want to just take a moment to recognize a -- actually, she was -- she had been appointed to represent the consumer eye vet Long who was tireless advocate for health choices, representing consumers an unbelievable advocate for consumers of health choices.

Evette was not able to join us. She passed away last week. Yesterday was her funeral. Estelle Richman gave a nice eulogy as did other people who knew her.

I just wanted to share with the group that Evette was originally

appointed to this because of what Jack talked about because of her history in advocating and making improvements in health choices program.

We will turn to a little bit of logistics for a few minutes to kind of talk through what it means to be on the committee.

Folks in the audience, you will have to -- I am indulging in your patience for a few minutes. We did not get to do what should have happened for an orientation for the committee. We would normally do that by phone, but it didn't happen.

We all have a book. It is our new member and orientation book.

In the future, Pam Amorella will co-chair and Ralph is chairing. In the future they will do most of the talking. I will be here to report on things that the committee wants to see reported.

The first thing we have is the member list that is available to

everybody. It will be posted on the website we established a place on our web page where all of the advisory committees have a location on this. It is just a link.

Up until today it was not populated but all of this information in the consumer handbook will be made available through that link.

We have appointed all 25 members; that has occurred. You can see the kind of -- what people are representing in these various -- in the list.

The next thing we have is our meeting dates. I will tell you that an earlier publication had our sectioned meeting only the 14th. We change it had to the 18th. The 14th falls on rash a Hannah. We made the change September is the only month we are doing two meetings. It is mainly because we are taking time in the first meeting to do some

orientation. We will do a more detailed walk-through of where we are going with the next set of documents in the department.

Then we have the rest of the dates through August 3rd. They will be moving around. Most of them are here. A few of them are over at either the Rachel Carson building or 333 Market Street building, both on Market Street.

I also have a new member orientation slide deck in here. I will not go through it because it is just a little awkward to go through it.

The folks on the committee can look at it. It really does walk us through why we exist as well as what we do. I will serve as ex-officio member. I do not vote on anything.

If the committee decides to to medical assistance advisory committee as advise to MAC, you will either agree to it or have a vote

if it seems controversial that will be up to the Chair to decide whether or not to take a vote.

If there's consensus among everyone, there is no reason to take a vote, but if it seems like there is controversy over something to be brought forth, then it would be a discussion on that. I have -P attendants for the committee members. We expect people to attend let us know why you can't attend. As long as you let us know that you are not attending, we are/there is a pattern of not attending, we ask that you either resign or we do have -- we can remove you from the committee, if you are consistently not attending.

>> CASSIE: Can you attend by phone if you are sick?

>> JENN: April Leonhard is the person who keeps us honest. She is the one working to pull this all together. She has done a tremendous

job in a very short period of time making this actually happen.

We also Have A Description Of -- In Here And Our Calendar. another List Of Our calendars on there.

We do talk about a quorum. What our expectations are around a quorum. If members cannot attend but would like to send a substitute, you can do that.

Meeting agendas are put together by the Chair and co-chair. Two to three weeks before the agenda. We will send out emails asking for suggestions. Ralph and Pam and I will have a meeting to discuss what the agenda looks like; so that happens at that time as well.

We will have the conference call-in number. Ralph actually mentioned and we are going to work on this for the next meeting to mic this so people on the telephone can hear to participate. I'm sure it is

hard to hear people -- we are planning on using open captioning.

>> Georgia: We are having trouble keeping the projector on. April went to find the IT guy.

We are committed to having open captioning, which is what we have had up there with communication access realtime translation. Apparently we are having a technical glitch. I'm sorry. I didn't notice that.

This will be posted -- this information will be posted on our website as well.

When we get into a period where members would have questions or you have any concerns along the way, raise your hand and Ralph will recognize you.

As we go through the process that we go through in terms of really getting to talk about policy and how with he are going to be

implementing this, there will be an opportunity for the public to raise questions as well.

We are going to try a different process. You will -- many of you have gotten a form, people in the public have gotten a form to fill out.

Virginia, would you ooh like to talk about how we will do public comments?

>> VIRGINIA: Good morning. For those of you who don't know me, we are going to try to do something different for this meeting. We want to make sure that we capture everyone's comments, participatants in the audience.

Jenn keeps talking about the forms, we haven't handed them out. We are getting ready to fill them out. We are calling them comment cards. They will actually capture your name and organization that you may be

representing. Your email contact information so that we can call you if we have questions about your comment and then an area for you to write your comments down.

Essentially, what we are going to do is have a section of our agenda every meeting devoted to gathering public comments. So as we go through the agenda, if you have comments on anything discussed, please feel free to write it down on the card and then during the public comment section of the agenda, participatants will have the opportunity to voice their comments or concerns depending on how many people have comments, we will be allotting three to five minutes forpeople to give their comments. Then we will have a record of what your comments are to keep track of everything. As I said, if we do have questions, we can reach out to you for further clarification.

So, at the end of each meeting, we will collect everyone's comment cards and we will have that record.

Unless there are any questions, I think April is passing out the cards. It looks like she's also putting our email address that's devoted to MLTSS up on the white board.

Ra-mltss@pa.gov.

If you think of something after the meeting that you didn't have an opportunity to jot down on the card or say at the meeting, please feel free to send us an email. Okay? Thanks.

>> RALPH: Virginia, do those public comments -- you may have answered this already -- do they go on the website as well?

>> VIRGINIA: We hadn't actually talked about that. I think it is a really good idea, Ralph.

I know for the discussion document that we sent out back in June we are finalizing the summary document of the comments that we received on that document and those definitely will be posted on our website.

I would anticipate that we would want to do the same here.

>> RALPH: Thank you.

>> VIRGINIA: Okay. Thanks.

>> JENN: I want to ask the committee if there are any questions or concerned.

>> I have a question. What is your hope of what comes out of the committee? What is the committee's -- what are we really trying to build here?

>> JENN: It's a great segue for my section and discussion which is to really talk about what we have been doing for the past few months and

talk about what the next steps are.

I will start by answering the question of what is the purpose of the committee?

The committee is formed to help the state, the Commonwealth, as it implements managed long-term services and supports over the next four or five years.

We are planning to move from a fee-for-service system, which is unsustainable to a managed care system in long-term services and supports.

So the vision here is that community health choices, which is what we are calling managed long-term services and supports, our vision is community health choices is an integrated system of physical health and long-term care, long-term services and supports, Medicaid and Medicare

service system.

Bringing together Medicare and Medicaid to the extent possible for those who have it. Many people -- there are many dual-eligible people, people eligible for both Medicare and Medicaid in the State of Pennsylvania in fact more than any other state in the country live here in Pennsylvania.

So we want to integrate Medicare and Medicaid to the extent we can as much as possible.

People with disabilities can live in the most integrated setting to live independently and to live in control of their lives; so that is the goal.

This committee is being formed because this is such a change moving from fee for service to managed care. We wanted to bring people

together to advise us on how to do that right; that's why we formed the committee.

Our goal in making this change to managed long-term services and supports is, first of all, to enhance opportunities for community-based living.

Pennsylvania is still a state that is unbalanced. We spend more money in institutional settings of nursing facilities we do in community-based services. We are hoping we can move to a more integrated system where people have choice and those who are in nursing facilities for end of life and rehab, the things that nursing facilities are good at.

We are -- we believe that many people have the potential to live independently and that's one of our goals.

>> What current numbers are you using to state how out of balance we are?

>> JENN: Our expenditures for 2014.

>> I just remember -- what percentage is spent on long-term care facilities versus --

>> JENN: 1ish on nursing facilities and 49ish with home and community-based services.

That actually includes -- I can get that number for you, Brenda.

>> Expenditures or the services -- the expenditures we spend 37.5% of our total cost on home and community-based services and 62.5% on is nursing.

>> JENN: [indiscernible]

>> With that rate there being home and community paced service it

costs a lot less. There are a lot more people being served in home and community-based services than nursing home for less price.

>> JENN: Number populationwise is more balanced.

>> The population is pretty balanced. 50/50.

>> The term "managed" scares the hell out of me. If you try to link this up too much with Medicare is you will end up having medical insurance companies try to tell you what people needs more than than people actually going out there and being able to live independent lives.

I will say it as many times as I have to and as many times as you have me come down here or I call you on the phone, because that is a very, very real thing and danger. Look at past history for one second.

Let's look at what happened with CFM, PPO, with the whole

changeover that the state has already tried to do.

I am telling you, you are walking a very fine line -- I understand how you are trying to get it to connect together and work. I see -- I can see the logic and the theory behind it.

But I am telling you, just because it works in theory, doesn't mean it's going to work in practicality.

The problem is, if you set this in motion too fast -- I have been told by a very reputable source, that this stuff is going to start in Pittsburgh in 2017. You are trying experimental model.

If you don't think about the long-term affects of it now, you will not be able to get people out of it because with the problem with CFM with employees not getting paid for how many months across the whole entire state, the system still hasn't recovered from that. And it won't

for a very long time.

Everybody has seen how much PPL can screw things up.

>> JENN: Tonya, I really appreciate that input; that's Part of why we are convening this committee is to make sure that we are aware of all of the potential challenges that are out there, that we identify them and that we make sure that they are sort of on our radar so we avoid going down the path that we need.

>> CASSIE: I think the system is broke for the same reasons she expressed. I hope it will be fixed. I hope we can come up with a vision that isn't rash and rushed.

I money is not there. I know there are issues in trying to everybody is people. I believe government serves people and healthcare should always come first.

It's working in Texas and Wisconsin. It's been done well in someplaces. I hope that is is what we are going to do. I want to say one thing: It is very important that the nursing home doesn't get paid more than us. That has to stop. Even if they don't have as many people. It's not about the numbers and what you pay them. I am not saying pay them less. I don't want my grandmother be rationed. Why can't they pay the same to the community as they pay to the nursing home?

Now, some people say I am wrong. I'm sorry if people don't like that idea because they want to stop the nursing homes from getting any money. I goes in those places I know people who live there. It is hard to see people not cared for living in their own muck.

I keep telling you, if you paid the community the same, there would

be no incentive to put me in the nursing home if I became terminal.

I don't think nursing home who don't do death well. They were understaffed, underpaid. Even if they had union they still might not be in that room when that person is dying.

The only wherein -- I don't like to watch people die more than anybody else. I worked -- I know it is part of life.

I am telling you right now, I want to die in my home and nursing homes suck at it. I don't understand why I couldn't die in my own home under a imagined care system. Consumer control and choice with my family.

>> JENN: Thank you, Cassie.

>> SCOTT: I was practicing medicine at the time that managed care really took over primary care in this country. When it was handed off

managed care took 10 or 15% off the top and there was no additional provision of services integration of care -- all that happened was somebody got between the source of the dollars and the providers and took 15% off the top and just said live with it. Live with it.

When I was working in Nashville, Tennessee as a turnality around doctor for bore doe, it was a hand off of dollars to managed care companies. It ended up having a lot of problems all over the newspapers with deaths occurring because services were not there to support -- just pushing people out of the facilities.

I am all for and been in the department's office to say this.

I am all for identifying patients in skilled nursing that don't need to be there and helping them get out in the community. I am 100% for that.

I don't believe it happens if you simply hand those dollars off to managed care companies who skim their 15% off the top and say to everybody else in the system. Tough. Live with it. Negotiate that provider down, and you will get less care. Oh, by the way, we need increases in what we get paid because we don't make profit.

We just have to be very careful that we understand how that care is going to be provided. Not just laying it off to the managed care company saying it is now your responsibility.

I don't think that as unresponsive as skilled nursing can be and government can be sometimes, the consumer concerns. I guarantee you that the managed care companies will be less responsive.

So that's a real Kevin to concern to be aware of.

>> Fred Hess: One of the main things I am also planning on doing

here, is making sure that basically what she was saying, the insurance companies don't take over.

As is, the insurance company tries to tell us what we need.

Okay?

Who knows better than what we need than us?

I have somebody that I work with who is attempting to get a wheelchair that will lift up so that they can cook for themselves without burning their arm.

It is a preventive thing in healthcare.

The first thing out of the insurance company's mouth. No. Not medically necessary.

They love to say that. They don't know about me in particular.

Just because I have this particular disability and this person has

the same disability, doesn't mean me and him are the same.

I may take five minutes in the bathroom. He may take 15. You can't sit there and compartmentalize this and say everybody with this gets this; that's one of the things imafraid of with managed care. I am afraid they will try to manage us. Instead of --

>> CASSIE: I am unmanageable. I am not worried.

>> JENN: Moving forward we will call it community health choices.

>> CASSIE: Thank you. Sounds a lot better.

>> JENN: I am really excited about that. It really places the word community in front of health choices.

Long after I am gone and when this program is operating on an on -- doing ongoing business. It will be called community health choices.

To your point, Tonya, we are intending that this committee will

continue not only help us bring up managed long-term service reports or community health choices, not only implement it over the course of the next four or five years but in an ongoing way have an advisory committee to the department that will really help us make sure that things are going well and make sure we are getting it right and make improvements.

There are -- there is a managed care subMAC that advises the department on the managed care program. There is a consumer subMAAC; this is a community health choices subMAAC to support the department's work in getting this right.

All three of you and pretty much everybody around the table, people in the room, believe in consumer control and participatant direction actual control of your services is really critical.

We are planning -- our intent is to have that be a highlight of how

we implement this program.

The insurance companies that are represented here today that are your co-members, I think in talking to some of them, I see that they really do understand that the consumer needs to be at the center of how the plan gets to be developed for their -- both their healthcare as well as long-term services and supports; that really has to start with the consumer. And with the individual that is participating and in their world the member.

So there's, I think, that is a theme that will, I think, you will see in the documents that we put forth and to the extent that you think it needs to be stronger, please give us that advice. We are going to be issuing a public -- another public document in a few -- next week or two weeks early September.

I wanted to spend a few minutes and then at 11:30, because it is a three-hour meeting we will take a 10-minute break and we will come back at 11:40.

I want to walk us through some of the things we have done. I think when we are done with that we will be able to take a break. I see one question.

>> LINDA: I have a comment.

I would really wish this committee would take a look at the Wisconsin model of managed care. The reason is, they have an independent living philosophical organization as part of the whole process. I think they actually do the quality control.

>> JENN: Okay.

>> LINDA: The consumers of the services are telling them whether

it is working or not.

I think with sympathy element of independent living body, not just insurance companies or doctors, somebody that understands how we --

>> JENN: We will open it up for comment after our break.

We published a discussion document on June 1st. It was open for comment for 45 days.

During that time period, myself and the Secretary of Human Services Ted Dallas and the Secretary of Aging Teresa Osborne and in one location the Secretary of Health Karen Murphy went out and did six listening sessions around the state.

We went out and there were over 800 participatants in those listening sessions. We got numerous comments and information and recommendations from a variety of types of people.

Also, during that 45-day comment period had our resource account that is listed up there was open for public comment on the discussion document.

The discussion document was relatively open-ended. It was somewhat vague, to use Fred's word. It was intentionally done that way because we really were looking to get input from people. We didn't want to put something out there that made it seem like, this is how we are doing it. We don't know. We really do need input from experts around the state and experts in the field and we -- participatants and consumers that use our services.

There were over 300 organizations that submitted comment through the 45-day open period. We had a lot of input that way.

Stakeholder engagement is critical in this process. It's really of

value -- a personal value of mine, but it is also a value of this administration.Ize will say that the first step with the establishment of the new sub MAAC and availability of that and information put out to the public to make sure that you all can participate in today's meeting and future meeting. we have third Thursday webinars, listed out on our website.  They are updates on where we are in the process.

We are using webinars to put information out to the public on whatever it is that they would like information about.

The last webinar which took place in August was just 101 on how does managed care work?

We are still working on the quality of the webinar.  We heard a lot of feedback that the sound was not good.  We are working on improving that and using a -- exploring going to a studio to actually conduct a

webinar to have better sound. We are.

We heard a lot of feedback about the poor quality of the sound and are committed to getting it better.

We are committed to always using CART so that those webinars are accessible to people who are deaf or hard of hearing.

We launched new managed long term services and supports website. There is a button on the DHS web homepage, which was launched a few weeks ago. You can click on that and it goes directly to health choices website.

We attend naturally-occurring meetings, whether associations meetings or meetings of consumer groups.

Recently I went to a statewide independent living council meeting, as well as a Pennsylvania home care so, meeting, I believe it was last

week.

So we are responding to our -- this whole idea of being available for -- on invitations to go out and talk with people and let them know kind of where we are in this process.

In that vein there is a coalition of senior groups that has asked us to do a series of -- sort of listening sessions, like the six listening sessions that we did. They indicated that seniors had a hard time getting out to those and they asked that we participate in this series of listening sessions for seniors. We are doing that in September. I believe we got six of them around the state that we are participating in.

That's the kind of naturally-occurring meetings that we are out listening to and talking to people about.

We welcome documents along the way, discussion document was our first -- first go-around of public input.

Kevin Hancock our chief of staff will talk about what the second document will look like, but we are looking to solve and get public input on everything we are trying to do.

We are doing webinars. We are training our staff. They are used to the fee-for-service system and intricacies of making sure providers get paid in the fee-for-service system. We are teaching them what it means to move to managed long-term services and supports.

Tonya mentioned phasing in the Pittsburgh. It's actually the health choices counties in the southwestern part of the state. Will be phased in beginning with enrollment starting in January of 2017 southeast will be January of 2018.

The other three health choices regions, which are new west, new east and Lehigh capitol will be phased in in 2019.

So over the course of the phase-in, we will also be learning about what is working and not worthing and making adjustments as with he go.

We plan to be conducting over the course of the next few months and probably ongoing focus groups where we bring people together who have an interest.

I will just give an example that keeps coming up as I have been talking about this is the whole question of how do providers get credentialed?

The whole question of provider credentialing is a recurring theme I keep hearing about. We plan on focus groups bringing together organizations, bringing together providers, bringing together the MCOs,

as well as consumers to help us figure out how we do provider credentialing and how we make it something that is a true credential but it is not too confusing for providers and managed care organizations.

We also will be, as we move towards a procurement we are considering making sure -- this is a best practice -- making sure that the managed care organizations will be required to have participatory advisory groups. It is an area we see participatory input be part of what our expectations are around this.

>> LINDA: Jenn?

>> JENN: Linda, did you have another question.

>> LINDA: Given the Secretary asked you to make sure this committee was 51%, I would say the same thing for the advisory committees to the managed care.

>> JENN: Generally the managed care, those kinds of participatory advisory groups are made up of participatants, those that are ensured by the participating --

>> FRED: I would like to see the main MAAC have more consumer representation on it. A lot more!

>> JENN: We have been organizing and synthesizing information into buckets. Some of the themes we are hearing today are themes we read about and heard about through the public comment period.

So we are organizing it and sort of bucketing all of the different information. We plan on issuing a second document, which we will be calling a concept paper.

I have been talking to groups. I have said we will be issuing two documents, but that has changed.

We will, actually -- we heard that that would be confusing.

At this point, we will be issuing one document that pulls together some of the issues -- some of the things that we had laid out in what we were calling the requirements document. It brings it all together. There will just be one document. I think we are calling it a concept paper; is that correct? We are calling it a concept paper.

That document and Kevin Hancock will talk a little more about what we anticipate to be in that document, so that we can open up for comment here.

We plan on publishing that after Labor Day. There will be a new document with another round of public comment to really help inform us.

There will be a listserv.

>> The timing?

>> JENN: The timing of the next concept paper. After Labor Day -- I am not sure if it is the first or second week after Labor Day. Much will depend on how quickly it's moving through clearance. It's in a clearance process right now in government. So we have to go through some layers of getting it cleared and put it out publically. Any other questions?

[NO RESPONSE]

Okay.

>> CASSIE: I am am trying to follow this. Sorry.

I am afraid it is being rushed. I am excited about it. It is not an easy thing to do.

It seems like the time lines are really, really fast.

I mean, is that being talked about at all? If you have to slow it

down or it doesn't look like it will work.

Colorado took managed care and had it for a week and it didn't work at all. Consumers were getting hours cut. People were not showing up.

We have been through that.

I don't mean to -- I think it could be beautiful if we took our time.

If we rush into -- we rush into so many different models in Pennsylvania -- if we are flourishing with services and then get nothing. I am scared.

Even though you say there are good people here with insurance companies. I am trying to get Medicare, I know there are good people. I know people are trying to make sure you get medicine and things like is that but sometimes people do not know how to handle this population.

Even though managed care is supposed to -- a lot of people -- [indiscernible] I have a lot of black friends should have not died because they didn't do skin graphs. There was rationing going on. There are still allot of people with -- (inaudible) it is hard to know that as a consumer. Long-term care, I mean, being free in your own home and raising your own daughter. Having people in your personal life and then, also, looking at the medical needs, which I think has to happen anyway. I don't want people found dead. People are serving a lot of consumers with a lot less. I am just hoping --

>> JENN: Let's --

>> Jennifer Howell: [indiscernible] -- personally make sure that it does not go -- one of my questions is echoing following what Cassie has said, is it the Secretary's who is setting the time line? Is it

Secretary Dallas? When I met with you are Jenn and Secretary Dallas, I know that you were both very committed to making positive changes and it does seem very, very committed to keeping people first and foremost in the center of this process.

However, I am confused as to, are you setting the time line? Is Secretary Dallas setting the time line? Governor Wolf setting the time line?

If it is the Governor, then maybe this is not my right to ask, but I would really like to hear from him as far as -- I know he's the governor so this is probably a dream -- but if it is him that is setting the time line, then I would really like to hear from him as far as what his commitment is. Is it to save money because the system we have can't be saved. I understand the need for a budget. I totally do. I am not

working now. I am maintaining my own apartment.

I understand the need for a budget.

I need to know, though, the person that is realliy making the decision, what is the motivation? Is the motivation that he wants to see more people in the homes? Is the motivation that the State can't sustain the current method of care? Is the motivation -- for give me for the MCOs in the room is the motivation that the managed care organizations are very strong lobby organization and they don't see people with disabilities --

[APPLAUSE] --

>> Jenn: I can answer the motivation question and talk a little bit about the vision.

In terms of who set the time frame, that was a decision that was

made by the administration. I think the Secretary -- I don't exactly know who set the time line. It was here when I got here.

The Governor actually announced it in February. He announced this this in a press conference he had in Philadelphia. There is a link to it on our website.

So the Governor did announce it early on in his administration and the time frame -- just speaking to your question, Cassie, the time frame really -- the reason that we are phasing it in and starting with -- not with the whole state but with the region of of the state, is to really learn how we do, learn about how we are doing and to see -- to learn from our mistakes. To learn what works and doesn't work and to make improvements.

So, that -- the time frame is something that this administration

decided to do. I think probably the cabinet -- I don't know exactly if it can be pinpointed to a person. Brenda, can I finish on the other question, which is motivation.

I can tell you very clearly and heard the Secretary say this a number of times, this is about serving more people in the community.

One of the three metrics we have to report to the Governor each year is how we serve the people in the community.

The reason why we are doing this is to serve more people in the community.

It is also to improve quality.

It's to improve care coordination.

The coordination that happened between healthcare and long-term care, which is currently disjointed. It is to make improvements in

that.

It is not about saving money. I never heard the Secretary talk about it being about saving money. It is about improving quality.

>> JENNIFER: I know the Secretary has said it's not -- to him it is not about saving money. I just want to know that he does have the power to, indeed, stop this, if it doesn't turnout the way he does intend.

Please just remember and have the governor remember and Secretary Dallas and, please, you and everybody also that is working on this, remember that it shouldn't be about the numbers. If you serve more people in the community but the services that you provide are not good, then it doesn't matter anyway.

>> JENN: Yes. Quality and serving more people are the two

motivations that we have.

I just want to repeat what Jennifer said. The Secretary did tell her in a meeting he has the power to stop it if it's going wrong, similar to what you talked about, Cassie, in Colorado.

I will take one more question from Brenda.

>>BRENDA: Just a comment. As a proud representative of southwest if it isn't working there we will slow it down by hook or crook.

>> JENN: I talked a little bit about the concept paper. We will get more detail on it and timing on it from Kevin Hancock after we take a break.

I did want to mention that we have made a decision, the department has made a decision based on a lot of feedback that we received, which is that the behavioral health managed care will be carved out in our

original discussion document behavioral health was part of it, we made that decision. It's really in response to significant public comment and the health choice -- the behavioral health choices contracts and our contracts going forward are -- community health choices MCO contracts will have requirements in them that connects the two systems so that we have expectations around communication, around coordination and some of this work is already getting -- some of this groundwork is already getting laid by the behavioral health choices system and the physical health -- there is some work getting done to really encourage coordination between the two systems.

I wanted to make sure that you were aware of this carve-out.

One of the arguments we heard is that the significant population of dual eligibles who receive their behavioral -- health choices through

their -- behavioral healthcare through behavioral health choices programs, and there are some significant changes happening under behavioral health choices that may get lost at some point.

We made the decision to carve out behavioral health and just work collaboratively with the behavioral health system.

We are working very closely with our partners in OMHSAS office of mental health and substance abuse services, who oversee behavioral health choices program they are helping us all along the way to make sure that there is that connection coordination and communication expectation in our contracts.

I just wanted to pass that along to you and open it up for questions if that's way okay with you, Ralph. Two more minutes.

>> NEAL: I just had a clarifying question on something you laid

out in your presentation, Jenn.

You laid out a schedule of -- by region for health choices, maybe I missed it.

>> JENN: We will be doing procurement for managed care organizations to submit bids to us then we will go through a readiness review. Kevin can talk more in detail about that.

>> NEAL: I have the impression that there will be a unified procurement for the whole state in the near future, not consequentially.

>> JENN: It is. Procurement is unified. It is the roll-out phase of the regions that is going to be (coughing -- inautomobile).

>> NEAL: I see.

>> Are you limiting that to MCOs that can cover the state and making it -- it's something we talked about before -- allowing the

providers to create MCOs and bid on this procurement?

>> JENN: I will have to ask Kevin to answer that question.

>> KEVIN: They have to be licensed managed care when bid and have credentialing standards they will not have to bid statewide but for each individual bid for one zone, for three zones or five zones but they are not required to be statewide providers at this point.

>> Do they have to cover entire zone.

>> KEVIN: They have to provide they can provide network services in the entire zone, yes.

>> RALPH: We will have Kevin speak after we come back from the break. If we may, let's take a five-minute break right now. Probably be ten but --

(Break.)

>> Ralph: Can I have your attention, please?

>> KEVIN: Good morning I am with the Office of Long-Term Living. I feel like I am coming down with the cold. In the middle of the discussion I may lose my voice. I will try my best.

As I go through with a bit of the more worth -- before starting that, I wanted to talk a little bit about the -- sort of getting background on the questions that were raised for the time line and also for how we got here for managed care.

Starting with the time line, one point I have to say about what serves with the time line is that we are moving very quickly to a procurement process. We are moving closely to move it up to bid. It is an aggressive time line. I don't think it is too quick.

What we are trying to achieve is to have this managed care service

go up to bid in November. Go through the contract negotiation process so that the managed care companies and the long-term living providers have close to a year to be able to adjust to this new system and also to go to other networks, specifically, in the southwest, which is the first phase.

It is aggressive for the procurement process, but the purpose of that aggressive time line is to really build it --

(You are currently the only person in this conference -- automated voice from phone).

>> FRED: Seems like more to me, but --

[LAUGHTER]

>> KEVIN: There is a method to this time line, which is to build out the program and provide enough time to be able to buildup the

infrastructure to so that it will be successful launch in 2017; that's the rationale. Another point of discussion about managed care itself, Pennsylvania is -- has been a leader in managed care for a really long time. We have been a leader in managed care in long-term care as well. It was mentioned earlier I will actually emphasize it a little bit.

Pennsylvania has a very mature physical health managed care entity in health choices. It has been viewed nationally as a successful program.

There is a lot of reason why Pennsylvania knows it can be successful in managed care for long-term living services as well. Health choices has been in place since the mid- to late-nineties across the state. It has demonstrated that Pennsylvania has committed and strong managed care organizations as well as providers that are

interested in making sure that this model program works successfully.

With long-term living, we are also a well-known state for being early -- the two programs where we haven't -- Pennsylvania case program or life program and in --

(You are currently the only person in this conference).

>> Blare: I can call in so that stops.

>> KEVIN: Thanks, Blair!

[LAUGHTER]

We were early adopters for PACE and autism called ACAP program.

We have two long-term services and supports managed care supports in place already. LIFE program is national mold. We have more participatants and now have more participatants and more providers than any other PACE program in the country. Talk about -- it is Pennsylvania

LIFE program.

We are proud of that. We know thats that an example of why we know that managed long-term services supports works in Pennsylvania as well.

Before I get into the paper I want to answer Linda's question.

>> LINDA: I was someone who was around when health choices was implemented. I don't want to rain on your parade but it was a little bit of a nightmare for consumers when it first came about.

I would certainly hope that we have a quicker mechanism to correct some of the problems that we saw with the implementation of health choices.

No providers that are accessible, things like -- I mean, I have a list but I'm sure you might too. I just want to avoid the things that we went through with health choices many years ago.

>> KEVIN: Just full disclosure, I was not part of health choices in southeast.

[LAUGHTER]

I I was part of roll-out southeast and hee high capital.

I can say lessons in southeast were adopted in southwest. Health choices roll out was pretty smooth and Lehigh capitol because of the lessons adopted. You are making an excellent point. We have to adopt -- if we can adopt health choice lessons learn and adopt lessons learned from the 22 other states that have engaginged in statewide managed long-term services and supports, which include Wisconsin, which include Colorado, which include Kansas, Kansas and Colorado are two areas where they have had a lot of challenges.

Wisconsin, Arizona has the longest managed long-term services and

supports in the country. Minnesota.

>> LINDA: They put more dollars in community than any other state.

>> KEVIN: Arizona's model is a wonderful model. We will learn a lot from them. We learned a lot from Texas, which is a big state, we learned a lot from Tennessee, Massachusetts, Wisconsin has a wonderful model. Minnesota and Wisconsin have wonderful models.

We have a lot of national lessons learned. Pennsylvania is not the first in the program. Long-term services and supports.

In Pennsylvania, we have a lot to build on from what other states have done. We intend to adopt it as lessons learned.

To the point that you are making, Linda, we know -- part of the reason to be perfectly honest, it has nothing against the southeast, but we are going to the southwest first because we know in the southwest the

dual-eligible infrastructure is different we know we can borrow it there to be able to build on managed care program for dual-eligibles.

We also know in the southwest, they have been working -- a lot of managed care organizations have been -- a lot of infrastructure.

In the southeast they are in full flight for building out that process in the southwest they are more mature we are taking the lesson from health choices that's the reason we are -- it is not because I am from personally the southwest.

[LAUGHTER]

So, all of it being said, a little bit of background, I will jump into the content we are planning to ininclude.

As Jenn mentioned we are releasing concept paper.

It is different from what we released in June, the discussion

document.

It is the framework of what we are planning to procure.

I am using the time frame early September for me early September is before September 15th we will release before September 15th but it will most likely be at Labor Day or second or third week of September before September 15th.

It's outlining what we are doing in procurement itself.

We are putting it out for public comment not the least of which is we need your help.

We want to make sure that the way we are characterizing common components of the service we are characterizing them correctly. We didn't miss anything that was majorly big.

People have come to me and asked me whether or not the Commonwealth

of Pennsylvania -- they've already made the decisions for the framework for what community health choices will be.

I can say with all sincerity we have not.

We know what we want to achieve. We know for sure what components we want to have included in the program, including participant direct services in a heavy way.

We want to make sure that we are characterizing them in the right way and not missing anything.

So that is really the high-level focus of what we are trying to achieve with this comment period and we are looking forward to hearing what you have to say for what we included in the RFP. Linda?

>> LINDA: Are we going -- is this committee also going to look over that RFP before it is finalized for release?

>> KEVIN: We are working on that process.

The way the consumer -- there was a process where they had a review that was really during the RFP process itself. We are planning to duplicate that process as close as we can.

You the mechanics of it, how that will work, I will say, yes, we can work out the pro success -- it is the different concept of the concept paper which is open to public comments. The RFP will -- we are working out the lodgist Iics of how it will work. Thank you to for asking that question.

The concept paper is going to be divided into three sections:

Participate consideration.

Managed care organization components.

Stakeholder engagement process.

The participant considerations are focusing on obviously -- they will be obvious to everybody eligibility community hellth enrollment process into the program. Covered benefits will talk about physical health, as well as long-term services and supports and then key services such as home modification, participate directed services, nursing home transition and behavioral health services.

We know that we are -- behavioral health services are not a direct part of community health services but they are a maim or part of the coordination effort. We want to call it out in this document as well.

We will talk about the coordination of benefits, which is a major roll in managed care organizations. From a needs assessment and service planning process.

As well as how we will coordinate services between Medicare and

Medicaid for the full dual-eligible population.

It's one of our major goals, to make sure that Medicare and Medicaid systems are highly coordinated.

We will also talk about what the providerred in work composition is going to look like, and also the way that we will be supporting participants in this program including hotlines -- nurse hotlines, for example -- as well as participant information materials.

Then he will be talking about continuity of care. Continuity of care will mean different things during the transition positive process compared to the ongoing continuity requirements that will exist when people are switching between plans in the program.

We know that we have to have a very robust and longer -- for lack of better term -- couldn't fewity of care during transition as we

implement community health choices, but we know that in the ongoing operational role there has to be continuity -- we will talk about quality assurance for participants what that means for us and there is detail in what we are planning to do to measure planned performance and provider and planned performance to meet our objectives and the objectives of the members of the program.

Then we are going to talk specifically in innovations we plan to propose as part of the program, including housing-related innovations, integrated employment services, direct care worker services and expanding the use of technology in the program.

That's participatant focus.

Any other questions?

>> On Linda's point of review of the RFP. You said the committee

would review. I would like to make the point that there may be people bidding on it and would it be customary --

>> KEVIN: It is part of the logistics we need to work out.

>> I would suggest that it may be a good idea to put it back to the consumer subcommittee.

>> KEVIN: That's been discussed. I appreciate your suggestion very much.

We would love feedback on to you to make that process work. We want a transparent and inclusive process at the same time we don't want to include any type of organization to be able to bid and participate in the program.

>>BRENDA: Perhaps what we could do is put it back on the consumer -- at this table as well. Create -- [indiscernible]

>> JENN: I also wanted to mention Richard is here as consumer subMAAC, who is our liaison. It is the logistics we will have to work out. Thank you, Brenda for the recommendation.

>> TONYA: The one question I have, everybody keeps talking about how Medicare and Medicaid have to work together to supply the services. I get that that needs to change and be more proficient. I completely understand that.

The question that I have about this is, okay, while looking at this from the medical dollar funding standpoint, what happens to the idea of the consumer getting to live like an independent life in the community? Who handles, like, the community supports so we could go out and be the individuals we need to be?

>> KEVIN: Okay. So -- I will answer the second question first if

that's okay.

>> TONYA: Sure. Fine.

>> KEVIN: I fully expect the participants have the primary say in coordinating the services in the participatory model.

Even managed care participate ant-- front and center. The participant has to take responsibility for coordination of their care and services.

To your point about the coordination of Medicare and Medicaid it is not so much dollars coordination it is service coordination.

The services are often managed in silos. There is not a lot in the fiscal health realm that makes the services seamless for those who are duly-eligible. There ends up being gaps that exist causing problems for participatants.

There are countless stories of dual-eligibles who have had a lot of -- at the minimum headaches but the maximum real risks rent presented to them because of lack of coordination between Medicare and Medicaid programs. That's the objective of service coordination.

>> TONYA: I have a preliminary follow-up to your response.

Another problem I have noticed and seen over the years is when a consumer needs an increase because of something medical going on, why does that usually take up to a two-week process for that to go through?

>> FRED: Or months.

>> TANYA: Or months even.

If you get something like a script from a doctor that says, okay, patient needs X, Y, Z starting now from this duration to this duration, why does it take the State so long to set it up to make it happen?

>> RICHARD: It shouldn't take that long.

>> TANYA: It does.

>> RICHARD: We are trying to fix that.

>> JENN: Do you have experience in the disconnect that you can put more of an example to the -- on the table?

>> RAY: One of the stories I have shared with Jenn after leaving service at the Commonwealth and going into managed care organization where we work with dual-eligibles, one of my first questions out of the gate was, how many of our members are waiver participatants?

The hard answer was that information isn't readily able available or transmitted.

What appears on a Medicare claim is diagnosis. It doesn't indicate that a person's participating in a program.

The State to plan data exchanges are virtually non-existent.

Over the course of the last several years made a commitment to making the matches. Even when able to, we have a great system with Allentown County, for example, when we are able to see when one of our members is participating in a waiver program, we don't always know who their service coordination is. Those things are made more difficult because of HIPAA rules.

As a HIPAA-covered entity we cannot share information with a non-HIPAA covered entity.

There are a lot of complications the way the system is structured.

In most cases, one of our members may be hospitalized. We know that. We are work with them on a transition home.

What we don't have the ability to do in real time is say, we flow

this person is participating in a waiver program.  Here is how becan September up a more effective plan.  That's really one of the men fits in the future that the come from this.  By having even the basic transmission of information we can have more successful outcomes.

To Tanya's point, those are the concerns we have.

If we are able to participate in this future program, key features that we are looking to have are the ability to ramp up services at the point where it is most critically needed.

We want to make sure that we are catching people before, you know, they enter into a stage of crisis.

Those are the pieces of current system that gets closed down by financial eligible, all of the pieces that the folks in the room know well.

The plans most of all have an interest in that.

We also have more of a stake from a customer service standpoint, as well as being responsible for total cost of care and keeping the person independent. Fred: Are you trying to tell me between Medicare and Medicaid they do not discuss anything to do with HIPAA?

>> RAY: Not at all.

Personal care services are not HIPAA covered. The information is not always easily transmitted.

In addition to that, we don't know with whom we would need to establish a business associates agreement, we may have a person who chose us for insurance who, you know, may be participating in a waiver program, but we don't know who they have chosen as service coordination.

>> JENNIFER: Actually, I have a few questions. I think the

communication between managed care and Medicare is very important. I was wondering, does the committee have any plans to -- do the Chairs have plans have plans to talk to or conference with any people, participants in other states, who do have a managed care organization and are working under it successfully what they like about it? What they don't? Bumps in the road were?

>> JENN: The short answer is, yes. If the committee would like to hear from individuals that are currently receiving their services under managed lock-term services and supports system either from Texas or Tennessee or one of the states that we know they have done it successfully, we can bring consumers here.

>> FRED: I would like to hear in every state doing it successfully.

>> RALPH: As Chair I would like to say about Wisconsin and so forth, yes, they are the folks we should be listening to. They are the most up-to-date on what we are trying to do in this state.

Hopefully we can get some of the problems solved they had going into this.

The more the better.

>> JENNIFER: I have another question, if I may. Managed care organizations are used to working with medical care and a lot of us -- well, as you know, home and community-based services are designed medical model. In the RFP, is there going to be sufficient training to make sure that the MCOs know that the providers that they are dealing with are not medical models so that -- I know that in medical models are certain benchmarks that they have to meet in order to be a medical

motion denied.

Where a medical model won't be able to do that either expensewise or -- we want the controlwise -- participants.

Is there plans for that to educate the MCOs on person-centered planning and on establishing a whole new set of benchmarks and not using a current system that they already have in place?

>> RICHARD: So answer your question, absolutely yes.

In terms of education and also requirements for managed care organizations to demonstrate and validate that they understand this -- for lack of a better term social model requirement versus the medical model requirement. Absolutely, yes.

>> BLAIR: I would add that I not only agree 100% that it should be part of the requirement in the RFP, I know in other states we worked a

lot with the providers themselves on education and working in terms of any differences in requirements very sensitive that they are not -- this is not -- things are different with home and community-based providers a lot of sensitivity to that. I appreciate you raising that.

>> RALPH: We have Kevin for 10 minutes. If we can, can we have him continue and members have your questions, please, for the public, we will have public comment right after he is finished. Thank you.

>> KEVIN: Great. The second key component to concept paper will cover managed care organizations and it will focus on what the network requirements need to be and that includes provider transitions provider services and components of provider management including training, education, manuals, et cetera, et cetera.

We are also going to include a concept that we are asking for

response that includes accreditation standards as well as performing improvement projects and a lot of other key features to demonstrate successes.

Other key program integrity issues that fall under the umbrella -- confidentiality, HIPAA sort of led into consideration to that and also united disguisation management and review.

>> FRED: Quick question. When you said provider transitions, does that mean, I am with A services do I have to change provider or keep the provider.

>> KEVIN: The providers -- there is going to be a transition period, obviously it is part of the continuity of care component.

The providers will have the responsibility to talk with area work with -- contract with them.

>> FRED: We will be able to stay with the same one as long as they qualify.

>> RICHARD: If you are in a plan -- it's hard to a hard yes to that question, but if you are in the plan, the provider has contracted with that plan and you are happy with that provider, most likely, the MCOs and you will, as part of your person-directed service plan and processes will be able to -- [indiscernible]

>> FRED: I wanted to make sure I will have a choice.

>> TANYA: Doesn't this come down to a bid with who stays and who goes?

My other question is will a program like services my way stay intact or will it be disman he willed?

>> RICHARD: Services my way is a different question than provider

--

>> TANYA: I know but --

>> RICHARD: Providers in the area where their geographic region, they should be working with managed care plans -- [indiscernible] -- providers are actually -- they are going to be part of the network development. The managed care plans are the -- bidding for the program. The providers will be contracted with the managed care -- does it make sense?

>> TANYA: Here is the thing. I've been with my service coordinating agency since I started this program in 2006. I would prefer the choice of keeping that service coordinatingent city because I know who I need to work with if something goes wrong with the service coordinator. I know what I need to do to manage my care that way.

>> KEVIN: Sure.

>> TANYA: If you make me or other consumers switch to someone elsewhere they don't know who to talk to and what they need to do to get things done, you will have a whole system of a bunch of screwups everywhere.

>> FRED: It was the problem with PPL.

>> TANYA: Exactly.

As far as -- what I am asking about services my way, that's kind of a newer program that does implement this whole idea of independence that you guys are talking about that you want to see happen.

If the service coordinating entity that you pick doesn't know how to manage it, guess what? The idea of independence goes straight out the window.

Now a consumer like me that has worked very hard to build that and demonstrate that they have the necessary skills and necessary means and whatever have you to manage that, should not lose that right to have that service coordination under whatever the government is going to implement.

>> KEVIN: My answer to you would be, if you are in one of our plans, pick the plan that provides service coordination.

>> TANYA: Will I get the choice.

>> KEVIN: If it contracted with MCO, you will get the choice.

>> THEO: I am trying to follow her train.

How would an entity like services my way be part of that provider? How can we assure that -- is this an organization like services my way be part of that? In that network?

>> JENN: Services my way is a model for consumer direction where the -- it's actually built on what used to be called cash and counseling model, where an individual has a certain budget and that budget is negotiated with the service coordination entities so that they figure out, okay, this is worth this and they have a budget.

And then they manage the budget based on when they need services as opposed to managing hours.

She is actually got a budget that she works against and it is managed that way. It is really a delivery -- it is kind of a tweak to the consumer-directed model where it is actually -- she has a consumer budget as opposed to -- what is it called? ISP. She has a budget instead of ISP.

>> TANYA: I feel if the State has given me the power to do that

now, because I've demonstrated the ability to manage workers and everything else over the years without any real hassles or problems, except for when PPL and CFM took over destroying everybody's lives for a while, then I feel like because I've worked hard to be able to manage it, to do it and be able to do things like come mere today, then I should have the right, no matter what the State does, to keep that service plan. So should any of the other consumers out there that are under consumer-directed models.

What cares me is, the state will say, the Best thing for you to do, the best thing for the state to do is go under agency. What will happen is we are not even going to have the choice over who comes in and out of our homes, what we get to do, what they get paid, anything.

That will not be good.

>> RALPH: Is that a real fear for her?

>> FRED: It is for me too.

>>BRENDA: I have a couple questions:

One might sort of allow some of Tanya's fears.

Will a particular provider be able to contract with more one MCO? That's my first question?

>> JENN: Yes.

>> KEVIN: Certainly.

>> SCOTT: I didn't hear the answer.

>> KEVIN: Historically, yes.

>> SCOTT: Will they be required?

>> Kevin: No. At least I can't manage a scenario they wouldn't.

>> SCOTT: It would be a nightmare. It would be difficult to have

a lot of MCOs in one sniff and 15IT systems to connect to all the pieces that go with that. That's a concern that talk about.

>> KEVIN: The hospital is an example of entity.

>> FRED: If they want to keep their consumers they have to go with more than one. If they have a consumer base of 600 people. They have to go with multiple if they want to keep what they have.

>> Kevin: These are all comments we need to receive on the concept paper. It will help us flesh out the requirements.

>>BRENDA: My follow-up question is, for those of us who are under consumer employer model now, will everything end up -- service coordination particular MCO do you have any idea what the accreditation --

>> KEVIN: We are working on the accreditation process for consumer

employer.

There are standards that are being looked at nationally right now.

>> JENN: As we flesh it out, it will be something we bring before the committee and ask your input on.

>> KEVIN: One follow-up to your point Tanya about services my way.

We have participant-directed services front and center in the program. We are looking for every possible way to expand the opportunity for consumer-directed services.

Budget controlled -- proposal for budget control would be -- [indiscernible] -- in response to this program. At this point I am not looking for any opportunities to limit any kind of -- [indiscernible]

>> TANYA: I am glad you are not looking for it as I fear with anything governmental -- I will just say it -- it ultimately usually

comes down to what can we afford to do a with a -- we should be doing everything we can to build that independence up.

I mean, okay, we have a system now that, you know, allows people with disabilities to go to school, go to college and all of that is great.

If you still look at the unemployment numbers in this country, it's something like 70%. Do you know why that is? Depending on what state you live in, there are different requirements that every state does.

It shouldn't be that way. My own personal example of that, I got accepted for a PhD program at the University of Memphis three times for three years.

I could not go because I could not get everything I needed to get coordinated to move to that state and get it done.

So as a result of that, I am I dependent scholar and author and write for their historical journals but I am not doing what I was born to do. Maybe it is this stuff. I don't know. I think the history stuff has more to do with it.

[LAUGHTER]

I am just saying, it is just an example. We need to make this country so it is more open and free for opportunity.

If we could do that in Pennsylvania with committees like this, I am all for that. I've got to make sure, first and foremost, that that is truly what the aim of this is.

>> RALPH: I think your being here helps us stay true to that.

We all don't have all those experiences where you are right now. For you, Cassie and others around this committee, keep us to that flame.

>> TANYA: I will try.

>> NEAL: Yes. Process question, clarifying.

The procurement process you described that we were talking about on the side on health choices, physical health and the MLTSS community health choices procurement, are those happening in an inter-related way or a separate?

>> KEVIN: Right now -- [indiscernible] they are processes but separate returns.

>> NEAL: Thank you.

>> CASSIE: I want to know why we have to use the SNIF or split system? When I was a little girl we had two organizations top in the country if you needed rehab and you really needed it, you got [indiscernible]

Now we have the SPIT units everywhere. We are filling their he had abouts every time the hospital doesn't want us, which is managed care, they will get us out because they will not keep you in the hospital too long if you are sick. They want to put you in a SPIT unit it is openly adapt member or savvy -- sign themselves into the nursing home for three months. I have seen many of my friends fight their way out of there and friends call me up and say, they are in the nursing home they went through rehab they feel good and were told they cannot live in the community they will always need help. Don't we take good care of you.

I don't see it monitored enough. They are everywhere. I'm sorry, sir, you might live in a good one.

>> SCOTT: I agree with you.

>> CASSIE: Why can't we go back to real rehab? I think it will be

cheaper. It has to be cheaper than filling beds.

>> KEVIN: I would argue that that situation is part of an unintegrated system. The more integrated a system is between physical health ware and physical lodge term services and supports, the more you will find that those types of situations will not arise.

>> CASSIE: A lot of people could use rehab. They are not asking their doctor for it. They are trying to go to GNC on fixed income to find something to make them Strocker because they are so afraid offending up in SNIF and not getting out if they don't get well fast enough.

>>BRENDA: I think a key part of what we need to make sure of on this committee is each educate doctors. I have been in the hospital and nursing home I have been in the hospital four times in the last five

years. Every time I am told physical therapy won't really help you. Your functioning is maxed out.

The doctors don't believe me. They need education. They don't take the patients somebody has to stand up against them.

>> KEVIN: Brenda, I will say again the lack of education in the physical -- It is not integrated system. The more integrated it will be -- for that type of education.

>> THEO: Can I go back to something I think I heard earlier did I hear a percentage needs to be -- on the advisory --

>> KEVIN: On this advisory committee?

>> THEO: MCOs.

>> KEVIN: Jenn made a point participant advisory committees so most likely there will be 100% made up.

>> THEO: Is there anything we can do to clarify what that means and not leave it into the happens of the managed care organizations to determine?

>> KEVIN: I would welcome that as a comment to the concept paper.

The reason why is, we for some of these components I have talked about, we have to make a decision as to how descriptive we need to be with the MCAs, it sounds like you think we need to be more prescriptive? Very much so.

>> RALPH: There should be a criteria defining what 51% is. You can't leave it in their hands.

(Multiple speakers.)

>> RALPH: Thank you very much, Kevin.

Can I open this up to public comment?

>> JENN: Fist, do any committee members have anything?

>> STUART: With regard to reaching out and studying successes in other places, thank you.

At the earlier stages of this meeting, I was getting a little bit depressed. It sounded like managed care was an incredibly maligned concept and I thoughts I was reading magazine articles and is not getting a feel for what it really is.

Managed care, in many places, is extremely successful. Arizona is one. I will mention Signa as an insurance company that handled most of the care for Arizona State employees, including faculty, Universities and everywhere else.

While I was there, I lived there 10 years. I was a Cigna patient along with my life. I was there. I was 100% happy.

What encouraged me even more was the fact that whether they polled all of the resip yaps of care under Cigna and other companies that provided care for state-related employees, the Cigna staff model HMO was by far the highest rated program in the state for those employees.

I kept hearing disparaging remarks around the country because too many people were looking at single anecdotes and coming to the conclusion about managed care.

So I encourage you to look for successes. Whatever it is. Wisconsin, California, here is there or wherever. There is a lot of success in managed care. Those programs are effective in dealing with their patients.

As a side issue, in many situations, savings of significant dollars were an outcome.

Why let's ratchet down the words "managed care" and look at the models we maybe able to introduce.

>> RALPH: Thank you.

>> BLAIR: I would add that, generally what we see in this case is implement ace of LTSS has ultimate ared in a higher level, greater level of increased benefits per participant receiving home and community-based services than what they had previously. It is not about taking things away but with the -- more independent living shift because that is more cost if I in many cases than nursing facilities it frees up and loosens uptight resources in the state budget.

>> SCOTT: It's running between 95 and 97% -- it may not seem that way because if you are a person having trouble finding that transition back to home but we run between 95 and 97%. We would like it to be

higher. We would like to get folks home quicker and serve the hospitals with short rehab needs. The beds stay full with long-term care patients; that's not what we want. The small percentage of patients that stay make it difficult for us to pay short-term rehab patients going home to the community. We are not against that concept. The issue is transitions. Brenda?

>>BRENDA: I want to put this comment on record we heard yesterday that Act 150 is going to be carved out of managed care. I understand why the decision is being made at this time, I think it is critical that we look at a way to protect services for people who have the potential to use increased services under managed care to gain employment.

We are mandated to poverty in this state if we are not lucky enough to be on Act 150 even then affording co-pays is untenable for us.

We need a way to look at Act 150 or changing the statute if necessary to allow people to really benefit from the independence we are giving them.

>> KEVIN: Just to be clear, we agree across the board with the need to increase opportunities for employment for participatants; that's one of the plan innovations we are planning to propose with this program.

>> JACK: So I am correct, the concept paper drives the drafting of RFP and stakeholder comments.

>> KEVIN: Yes, it will.

>> JACK: In that regard, the concept paper is like a proposed rule that everyone gets to comment on, and then that along with the comments will get rolled into the RFP, which, if you think about it, becomes the

final ruling.

There aren't going to be regulations here. What will control access to care and provision of care, the payment of care enrollment in the MCO is all of the good issues that are being raised here, really will be set forth in the RFP.

In that regard, picking up on an earlier comment with respect to who should be looking at the RFP draft? It seems to me there is nothing to hide. It should be transparent that everybody is on a level playing field; and that it would be, I think, in the department's and the Commonwealth's best interest to release the RFP in draft so that everybody gets to see where you ended up on certain issues and so that if there was -- we can at least raise our hands or people can raise their hands and say, you might have missed something here. Think about

redoing it.

There is no question, at the end of the day, the department gets to say what is going to be in the RFP. There is no question at the end that once the bids come in, and there are contract negotiations, none of us in this room -- well, some of you will be involved in contract negotiations, we are not going to be able to -- so what we have to go on is, what is the structure that you set up for purposes of entering into those contracts and the contracts in turn will govern day-to-day provision of service and payment for services.

So I am just suggesting that -- consider, although I know it's usually not done that, an RFP is released in draft. In this instance, given the nature and scope of the services that we are talking about, given the type of services that we are talking about, given the change

that you want to bring to the systems, this might be an instance where letting everybody see the RFP after the comments come in, it may be to your best interest.

>> RALPH: Are we prepared to take motions?

I would say, Mr. Kane, if you can put that in the form of a motion we can vote on it to have review the draft as you shared.

>> JACK: Well, well, I will make that motion. There should be other comments on it.

Just given my experience, regulations don't matter much they will not control this system. The contracts are going to control the system. There's always going to be regs coming down but on a day-to-day basis, with respect to assuring the providers that can contract with MCO and there are guidelines that the MCOs have to follow with respect to who

can participate in their networks, what happens when there are issues between a provider and consumer, a provider and the MCO, consumer and the MCO, everybody knows you will work in absolute good faith to make this program the best program in the country.

I have no doubt about that.

Given the concerns that get raised from people who have to live in the system every day, it seems to me that if that RFP could be released, that that help the concerns or keep from doing a redo. It will be in everybody's best interest.

I will make a motion.

>> RALPH: With the motion being heard, I would say the ayes for the motion vote aye and nays nay.

>> THEO: You have to have a second on that before it gets voted

on.

>> RALPH: Any dissention until we have further comment on the motion?

>> CASSIE: I know -- it's not Robert's rules but it's Ralph's rules.

Okay. Ralph, I don't agree. I think it should be up for a little bit of discussion. I think it's important that the consumers know that the rates will protect them -- I do believe it should be transparent. I just believe that, transparency for the people bids for it comes at a different time.

It's very important to me that those rates protect us; that we will be cared for in the community and not rationed; that their rate system is really thought about.

I read a lot about managed care. There is no one answer.

I try to make it as simple as I can for my community and say, why -- [indiscernible] -- that's not enough. There are other answers. People who do cost more in the community that want to be here. They have been here all of their life.

I am sick of the committees that look at our costs like we are cash cows or maybe our cash cow has gotten too expensive, let put them away.

I want the rates to protect us in a lot of ways. It's not an easy answer. Rates are always hard.

Look at the thing that happened before, our whole system blew up because people didn't prepare for it. I didn't like that it happened and seeing all of the disabled people that didn't have jobs anymore and decisionmaking power in anything any more.

I tried to work in that system too. I couldn't sleep at night. The young people that should have taken over our systems were the first to go. They were the cheapest too. I don't know why that happened.

I have a 16-year-old daughter. I need to go into busy am going under financial care. I think there should be a movement for people going under. We are stuck with this money that we can't buy our way to health. We can't buy our way out of our house unless we want to default and not have any kind of credit, which we worked for all of our lives; that's not easy to get with a disability.

I want to make sure that those rates, whether I am in or out, I am here to serve my community. I thought Act 150 was in and will be disappointed if it's out.

I am here to serve disabled people. The bottom line S when you

start serving the bidders, I get scared.  I just have to say that passionately and will stop now.  They are not bad guys, but when it goes up for bid they can read it.  If there are problems there should be another meeting and negotiate it out, maybe we screwed something up or they will not do well under it.  I don't know.

I want to make sure the rates protect our lives.

We saw devastation like we never saw before.

We went from being a national model, talked about all over the country with a Governor that was very generous to having -- being afraid and hours were cut we had to go to CMS and had to sit in rooms, document everything, most people got their hours back.

You know, now consumers are so scared.  They are so how longary if you take them out to lunch they may speak up.  They are not speaking up

lately. Once things go backwards, people get scared.

We saw our whole system dissipated and ripped up into threads. The CILs have changed. I'm sorry. They have.

They suffered from it.

People don't look happy anymore like they used to. We have to get over that. We are in another time. We have another Governor and are here to build a better place.

I like this model. I know it could be better. I don't know that it will be better. I plan it will be better. I think everybody here wants to make it better; that's the intention.

We have to make sure that that happens. I don't think that that happens by having people that are going to bid involved in the whole process.

>> NEAL: I appreciate the concept of the drop-off Act -- [indiscernible] -- I want to express some concerns about that and about the way this process could go.

I mean, it's very interesting for somebody who would know from direct experience, regulation matters, but contracts govern in a lot of ways.

I think, you know, the end of this -- MLTSS -- I think the state needs to get used to the idea that that provides the taxpayers of this state and policymakers of this state and administration of this state leverage to drive positive change in this system. The system doesn't work very well. The status quo is not sustainable for a variety of different perspectives. It is not good forconsumers not getting what they need.

The caregivers that provide those services are not getting what they need. There are a lot of winners and vested interest doing fine relatively fine in the status quo.

Input is really important. Feedback is really important. Like the sort of iterative process. Initial document comments summary of comments you know more -- subcommittee concept paper. At the end of the day, the state has to make choices. If we -- I think through this whole process, if everybody gets feedback on everything and we end up with no stakeholder interest, you know, it is much easier in this state, many, many years of proving this to stop positive change happen and make it happening.

We have to make sure the vested interest that are preserving in status quo, profits or business model, you know, don't end up preventing

real transformative positive change from happening.

This system needs really significant change around quality, outcome, access, around independence and around justice for the people that depend upon the services and the people that deliver the services; that justice doesn't exist too often today.

The people in this room in the state we stand in the way of that.

So I am not sure that everybody getting to markup every document along the way is actually going to get to the best outcome.

>> FRED: I agree.

>> CASSIE: I agree.

>> RALPH: We have a motion on the more --

>> FRED: It's not been seconded.

>> RALPH: I thought you did.

Sorry.

>> JACK: Before we vote, is the motion that the department will release the RFP or is it a recommendation to the department consider releasing it? This was not obviously talking about prior -- it is to consider releasing.

Let me just in terms of, you know, there can be too much back and forth in terms of comments. I very much appreciate that.

Everyone does have to realize the RFP is going to set the rules for the contract. There will be no regulations. It's what -- the contracts have to be consistent with the RFP.

We will not be part of a contract negotiation we should not be part of the contract negotiation; that's for the Commonwealth and the managed care organizations; that's how that process works.

This is guiding that process. So to me it seems like although it is not typically done, in this instance, the department should consider -- not for a long period of time, but to give everybody a sense of -- you can publish the comments. We know that. What did you do with the comments? That's going to be the key. How did you incorporate those comments into the RFP document itself and the RFP document is going to control so much.

>> RALPH: Do we have a second on the motion?

>> PAM: I am seconding that a draft release of the RFP be considered before the final release of the RFP.

>> RALPH: May I take a vote now, Theo?

[LAUGHTER]

>> THEO: I would suggest a show of hands.

>> RALPH: May I have a show of hands for those in favor of the motion?

(Show of hands.)

It is almost unanimously defeated.

Thank you.

We have a few minutes left for public comment so Linda have at it.

>> LINDA: Jack, I was with you there for a minute. I liked it better when it was stronger than just consider. The devil is in the details. We all know that. It's our details. It's our lives. Not the people that don't use the services.

So what I -- I have two questions. I've heard rumor that services my way is going to end; is that true?

>> KEVIN: I am going to be honest with you, we haven't talked

about services my way in context of the RFP. We need help figuring out how it is going to work.

Budget authority and budget service is part of service directions. We have to figure out how it will work. We haven't talked about services my way in terms of --

>> LINDA: Okay.

>> KEVIN: It's an area we need help.

>> LINDA: We will give you help. We believe the program is important. It serves people who can't get served with our usual system.

My second question is, are nursing homes going to be in the mix to keep people out of nursing homes would be an incentive if the nursing homes are in there, they will not want to pay the higher price either, the MCOs.

Are nursing homes in there or are they not?

>> JENN: They are in. It is the next iteration that is coming forward.

>> KEVIN: During the meeting with the Secretary --

>> LINDA: I wasn't.

>> KEVIN: I am getting --

>> LINDA: We all look alike after a while.

[LAUGHTER]

>> During health choices expansion, we had someone from the state, from the bureau of program integrity come to our group, we are a group that represents durable medical equipment provides wheelchairs, supplies, incouldn'tment supplies and the like.

We were told that basically, all we needed to do was -- we wanted

to contract with one of these managed care companies, was call this number on this list.

What was handed to us was a piece of paper with eight managed care companies.

I had already seen this document and called every one of them and only one of the eight had an open network.

This was prior to, during and after the expansion.

All the networks were closed to new providers.

Unless there is some provision in this that is going to say, hey, if you are a willing provider, you are willing to work with a certain rate that we are going to -- we give to other providers, we will have a lot of situations where unless somebody was -- unless your provider was contracted with that managed care a long, long time ago, you will not be

able to work with them; that is one of our biggest concerns as an organization for our company.

We service over 4,thousand recipients that are dual-eligibles currently. How many people have to switch to another managed care plan or hopefully try to work with some of these managed care plans.

Some of them -- some of the managed care plans have slashed reimbursements very, very significantly.

A lot of providers are dropping out. These are the type of things we would just ask the committee to keep in mind when going through this. We believe that any willing provider provision in the RFP would do that.

>>BRENDA: If I can speak to that, I can tell you from the comments submitted from the southwest it was a key point of our comments thus far that managed care organizations need to be willing to work with any

qualified provider.

We can make adjustments to what qualified means. We can definitely, you know, work with them not to say you have to take anybody that comes through the door. We do recognize that broadening the networks and making sure at the time the contracts are implemented, networks are open to new providers and don't close people out it is a priority.

>> Thank you.

>> SCOTT: Be careful with "any willing provider" clause just because they put a provider in a network they will use it. We saw this on the primary care side and medical specialists.

They put anybody in the network but the case management of the MCO would not use 90% because they were only going to use the group they

negotiated better pricing with.

>> CASSIE: That's why people can't get wheelchairs and are recycling them.

>> Coming from the aging side, I just wanted to know on the committee, how many members are aging specific? How many? I know Stu and art is back there he is representing Steve Williamson. Is there any other?

>> JENN: We have one caregiver not able to be here today. She is representing an individual with early stage dementia.

>> Do we are have more than one caregiver?

>> KEVIN: Members on the phone, would you mute the phone while we continue the discussion? Thank you.

>> May I ask the same question about brain injury; that is what I

am here about.

>> JENN: A representative from brain injury providers?

>> FRED: During my accident I sustained minor brain damage.

>>BRENDA: It's not my primary disability.

>> FRED: Because of that if you notice I wrote write notes after notes my memory not here because of brain injury.

>> I am glad you are representing.

>> FRED: A lot of consumers I work with are also TDI.

>> Good. Thank you.

>> RALPH: One more then we have to wrap it up. The kids will kick us out.

>> Okay. In the successful states, I am wondering what they did when a waiver, as in Pennsylvania, is being used to provide medical care

that is not provided under medical assistance?

>> KEVIN: Can you give an example.

>> Cognitive [indiscernible] therapy only provided medical assistance if under 21.

Then tailored OT/PT/speech. You cannot go to a community provider if you have a significant brain injury because they really are not used to working with that population. The rate of improvement will not be fast enough to avoid termination.

It is a very different things. I am concerned that if people are sent out to the community to receive the generic OT, PT, speech and cognitive then the whole purpose -- [indiscernible] -- there is also a provision under independence and [indiscernible] some people have non-traumatic brain injury. The whole purpose could be defeated; that's

the reason why we needed the ComCare behavior.

>> KEVIN: Just to clarify your question the service is not in the state plan and it is currently received in a waiver for people who are over the age of 21. It is currently received in one of our waivers age --

>> 18 for -- that would be [indiscernible] up to 21 is official independence in will ComCare.

>> KEVIN: You are asking what happens to those services in this program; is that correct?

>> The MCO has no experience in praying for brain injury rehab. Doe don't do it.

>> KEVIN: It's most likely they will contract with providers who are specialists in those types of services.

Speaking generally we are not planning on cutting services in this contract service. The waiver of services package that currently exist, will be part of this program in the way we have it listed. When you look at the document, please let us know if you think we need some clarity.

The MCOs will have a vested interest in making sure that they have qualified providers to be able to perform the services.

>> RALPH: Let me ask, was that question on your public comment card? If it was, can you make sure you email it to us?

>> Okay.

>> KEVIN: That would be great.

>> RALPH: That is a good way to segue into sorry. We have no further time.

Virginia Brown will stalk you outside of the door to collect your public comment cards.

>> We didn't get one.

(Meeting concluded at 1:04 p.m.)