>> RALPH TRAINER: Can I have your attention please -- can I have your attention please -- we hope to start in a few minutes.

We're getting set up. Thank you.

>> RALPH TRAINER: We apologize for the delay, technical difficulties still.

>> RALPH TRAINER: Can I have your attention please.

I would like to begin.

I would like to call of a call of order and -- the members of the committee, starting on my right -- would please introduce themselves -- can we use a mic if we can stretch it up here.

>> JEN BURNETT: Committee members can bring

their mics closer to them, that would be great -- and just -- -- a little bit of -- hold the button down, that's a red light it's on. Turn it off when you're done.

>> AUDIENCE MEMBER: Richard consumer.

Philadelphia.

>> RALPH TRAINER: Welcome.

>> SPEAKER: Tanya Tiglow.

>> SPEAKER: Fred Hess from New Castle Pennsylvania, Disabilities Options.

>> SPEAKER: Cassie from Disabled International.

>> SPEAKER: Theo Brady, CIL Central PA.

>> SPEAKER: Jennifer Howell consumer.

>> SPEAKER: Darryl.

>> SPEAKER: Steve Williamson from Blair Senior Services.

>> RALPH TRAINER: Can everybody hear well back there, raise your hand if you can't hear.

We'll try to speak louder I'm Ralph Trainer Village in Motion, chairman.

>> PAM MAMARELLA: I'm Pam, from Philadelphia, Vice Chair --

>> SPEAKER: Neal Bisno, president of SIU health care Pennsylvania.

>> SPEAKER: Russell Dade from the Pennsylvania Health Care Association representing Dr. Scott Rifkin, who could not be face-to-face. He is on the phone.

>> SPEAKER: Good morning

Blair, United Health Care.

>> SPEAKER: I'm
Drew Nagel from the Brain
Association of Pennsylvania.

>> SPEAKER: Good
morning, Barb Polser Liberty
Community Connections.

>> SPEAKER: Ray with
UPMC Health Plan.

>> RALPH TRAINER: Thank
you everyone, I'll let Jen
introduce herself.

>> JEN BURNETT: Good
morning I'm Jennifer Burnett.
Welcome to our second
subcommittee of the Managed
Long Term Services and
Supports.

We're asking staff to get
our call in information. I
apologize we're starting this
meeting without calling --
never mind. I've got it
right on the agenda. Okay.

Welcome to the subcommittee meeting I'm calling them. I'm going pass it back over to Ralph while I make this phone call.

>> RALPH TRAINER: Few items -- um, we would ask the members if they can, because of time, to try to limit their responses to questions, to three minutes.

>> JEN BURNETT: Okay. I have called in the members on the phone. Ralph, do you want to ask if any members -- we're starting the sub MAAC, if you are on the phone -- if you would --

>> SPEAKER: This is Scott Rifkin.

>> JEN BURNETT: Hello Scott. Anyone else?

>> SPEAKER:

[inaudible]

>> JEN BURNETT: Pardon me?

Can you repeat your name please.

>> SPEAKER: Stella from AARP.

>> RALPH TRAINER: Anyone else on the phone?

>> SPEAKER: Scott Rifkin.

>> JEN BURNETT: We heard you Scott and Russ is also here.

If people on the phone could please mute themselves while you're not talking that would be a tremendous help to us.

>> RALPH TRAINER: Could you repeat your name please?

>> SPEAKER: Tom and

Mary.

>> JEN BURNETT: Representing caregiver and -- um, we worked with Alzheimer's disease to recruit them.

>> RALPH TRAINER: Anyone else on the phone?

>> SPEAKER: Julia and Al, from Disabilities Options.

>> RALPH TRAINER: Katherine Holl.

>> SPEAKER: Yeah Holl.

>> JEN BURNETT: Anyone else on the phone?

>> SPEAKER: Terry Brennan.

>> JEN BURNETT: Got it, Terry. Thank you.

>> SPEAKER:

[inaudible]

>> JEN BURNETT: Okay. Anyone else on the phone?

>> RALPH TRAINER: With that being said, I would like to go over a few things, housekeeping things.

I said earlier before, if we can restrict our answers to the best we can to 3 minutes. Also, I ask that we respect one another and we respect the audience as well with the people in the public and we try to refrain from using profanity or any other language that may be inflammatory.

Also, if we keep our comments limited it gives us more time at the end for possible public comment and so forth.

So -- with that being said -- Pam, do you have

anything you wish to add?

>> PAM MAMARELLA: No. Thanks, Ralph.

>> JEN BURNETT: Okay.

Our agenda -- I wanted to talk a little bit about the committee member structure because we have had a lot of comments and, inquiries as to how the committee was formed, um, how we made decisions about the committee.

And I wanted to talk with the members about those decisions and then, also, to help members of the public who felt like they should be on the committee, who didn't -- weren't included on the committee.

We were instructed by the secretary to form an advisory committee for managed long term services and supports that included 51% of people

with disabilities, including seniors.

And so we said about -- we provided a nomination process which people were nominated to the committee, we had 150 people nominated to the -- to be on the committee.

We created sort of a decision process, we made a big chart of them and we, grouped people by geographic area because we wanted to have good geographic representation for the committee.

We also look at the non-disability members members who weren't representing disability groups thought of all the associations that -- and different stakeholders that are out there that are relevant and important in the -- in the future managed long term services and supports

delivery system.

And that included thinking about associations that we meet with frequently.

But, what I was really looking for is and -- the secretary was very much in favor of this is to have, members of associations be be the representatives. As an example we asked the Pennsylvania health care association to nominate a member and we asked for a slot we worked with them to -- get a member. The member is Scott Rifkin who is on the phone today and the association staff person here today with us is Russ McDade I wanted to put out there, the thoughtful process of really bringing members who have experience doing this work was to us a really important

thing.

This is a public committee. It's a sunshined committee as required by law.

And members of the public have been very vocal in providing us with feedback. We got a lot of feedback in our first round of documents that were put out for public comment.

So we welcome people to come to these committee meetings.

We are working on accessibility.

And -- accessibility across the board for example, there are wires that need to be taped down and that's our next phase. That's as we do these meetings we're adding protocols to the set up of them, so we start making sure we pay attention to things

like that. It was also pointed out to us that we sort of have all of the associations and people who are non-disabled here and people with disabilities over here.

We apologize for that.

I will talk to my staff about, making sure we set it up this a more integrated way.

But I just wanted to put that out there, um, as -- something we are working on.

Again, this is a work in progress we welcome your feedback on how we're doing.

And in terms of this meeting and the meeting, structure that -- and the communications that we have with the committee.

We wanted to hold this meeting today, because we believe that the concept paper

which was issued on Wednesday was going to be out last week which would have really compressed the ability for us to get the committee's input on the concept paper.

As it turns out, the concept paper we will have two meetings of this committee.

While the concept paper is still open. So we're actually in a good place.

We anticipated that this was going to go out the day after Labor Day and it got pushed back. So had to go through clearance with the governor's office which, sometimes, can take longer than we anticipate but it actually went pretty smoothly.

We had originally planned to do two documents. We compressed them into one which is what you see here.

Our original plan was to have -- some of you may have been in meetings where I talked about this, original plan was to have, a requirements document that was much more technical difficult about the requirements that we anticipate putting into the RFP for the managed care organizations.

But instead, we -- we really beefed up the concept paper to include many of those requirements.

I have heard good and bad things about the concept paper that got issued with a press release on Wednesday.

The comments I'm getting it's still not detailed enough. And in part, and the secretary really instructed us to do this in part that's because we really want to have

detailed feedback before we do issue the RFP.

So to the extent that we we're comfortable putting information out there and we're going to talk about all of the sections. Today I'm going to spend morning I would like to spend, um, really walking through this concept paper.

All of the elements of the concept paper.

You may have also seen there was a press release on Wednesday, actually two press releases that included information about the concept paper. The second one was a DHS specific concept paper that also talked about -- announced the procurement for health choices, Heather -- I want to point out behind me, we have created -- we're

moving away from calling this managed long term services and supports we're moving into calling it community health choices.

But while we do that, you'll see on our -- I'm sorry, can you just go back to the Logo?

Yeah. Back there.

The logo, community health choices you can't really read it you can't read it from there there is -- the bottom line underneath the logo it does say managed long term services and supports, we're still going to include it, but it really is not the focus. The focus is really on community.

As secretary Dallas said in the press release, we're calling it community choices because we want to highlight

community as really the -- one of the main focuses of moving to managed long term services and supports and he, when he speaks publicly, is always referencing our -- one of our main goals which is to move to -- move to a broader Array of community based services.

Can you move just to the next slide.

So this is the concept paper release.

The quote on the bottom, community health choices will allow us to serve more Pennsylvanians who need long term services and supports in the community" and that is a quote from secretary Dallas I hear over and over again. We meet with a lot of people that is one of his -- one of his Mantras.

How did we get here?

Which is the next slide.

I also, just -- before we get started I want to -- I would like to start by -- since we're getting started late, I may have opened up for asking for the public to also introduce yourself but we are half an hour, 25 minutes late. So -- um, we're not going to do that I do want to make notice of a couple of staff that have helped me, in working on managed long term service and supports all the work we're doing.

But also help with the meeting -- Janice is over there.

In the corner.

We have Marilyn Yocum on that side, behind me Peggy morning star our chief final officer, Elaine Smith policy managers and, also

helping me I think Sharon Johnson over there in the corner. If you need to reach me the best person to email is Sharon.

And I also want to make note that Heather Hallman from the Secretary's office is here with us today.

Heather was going to help me with these slides, but -- her voice sounds a little bit like Mickey mouse she lost her voice this morning -- I don't know if it's allergies or what, I'm going to try to walk us through the slides.

How did we get here? I'm going to go quickly over some of the things that we have done.

We -- yesterday, we actually did a managed long term services and supports community health choices third

Thursday Webinar some of this is covered in this, I if you attended that you'll be hearing some of the same things.

In February, the governor a announced his plan for making improvements to programs that serve people with disabilities and seniors.

And, he talked about managed long term services and supports. That press release is accessible from our home page managed long term services and supports community health choices. I have to get that word -- hoes words out of my mouth really start calling it community health choices.

It's available through the DHS community health choices web site.

If you go on the DHS web

site, main page, there are five big buttons and community health choices is one of those buttons.

So, you can just click on the but on, it will take you right straight there.

We issued the discussion document in June of 2015.

Several months ago.

And that was open for comment, public comment for 45 days.

During that public comment period, we did receive -- whoever is on the phone could you please mute yourself we're getting some feedback.

On the phone, please mute yourself. Thank you.

In June early June we received over 800 comments through the public process.

And those comments were all incorporated into the

concept paper in one way or another. If there are things that you commented on that you really feel strongly about, that didn't make it into the concept paper please give us that feedback.

We also held six listening sessions across the Commonwealth in the month of June.

We gained a lot of information through that process.

The transcripts of those listening sessions are available on the community health choices web site.

And then on September 16th, Wednesday, we released the concept paper. Which you have -- it was a handout here but it's also been emailed to all of the members.

Heather do you want to go to the next slide.

>> RALPH TRAINER: Can I ask everyone here, how many of you were on the webinar yesterday?

Raise your hands

[laughter]

Okay.

>> JEN BURNETT: Many of you were on it.

>> RALPH TRAINER: Keep us on our toes, how many of you have been state's web site for this committee.?

Goodness gracious

>> SPEAKER: Tried. Every time I tried to go on there and I -- pull up the LTSS on there, it goes straight to the MAAC, the main committee I haven't seen anything in there about the subcommittee.

>> JEN BURNETT: We are

working on linking the MAAC, the sub MAAC -- it's on there, there's a lot of material on there on the sub MAAC all of our archives, materials are on there you may have tried it before, we populated it -- if you tried it up to the first meeting, um, then, it was just a place for us to put stuff.

We had not posted anything but now things are posted is that correct? We'll check on it though Fred.

>> SPEAKER: I checked it the other day I could not get on it either.

>> JEN BURNETT: Can you go to the sub MAAC our sub MAAC page?

>> SPEAKER: Yes, I did.

>> SPEAKER: I could not find it I could not see it.

>> JEN BURNETT: Okay.

>> RALPH TRAINER: Fred

if you get a chance, give me a call next week. I'll help you run through it.

>> SPEAKER: Okay.

>> JEN BURNETT: Yeah I do want to make note we have two different web pages. One is the specifically for this committee.?

And that is a public -- on the DHS web site under the subcommittees -- the DHS committees area.

So that's one area. And that has sort of, all of the -- um, archives and artifacts from what we're doing as a committee.

In addition to that, there is a community health choices web site, which has all of the documents that we're publishing for community health choices.

I am in the process of -- I have asked our bureau of information systems to link the two.

So that if you're on one, there will be a live link to go to the other. If you're on the other, there will be a button that says take me to the community health choices web site. So, there's a little bit of confusion out there I -- I wanted to make sure, I think it if you call Ralph he has been navigating both of them. We're going to go through this very quickly and open it up for committee comments and, um, then, public comment when the committees finish with it.

Okay. Heather go to the next slide.

Our community health choices goals, we are

certainly, um, enhancing opportunities for community based living as one of the foundational goals of what we're doing with moving to community health choices.

And it is something we are always talking about when we're in the public.

We are looking at -- and looking for feedback on what kind of, things we can put in terms of performance of providers and performance of plans as we go into this procurement process.

So any advice you have around that, that would be great.

And we want to be -- well we don't want to in any way, hinder innovation we also want to make sure that we are covering everything because this, while we have had a rich

history of managed care in Pennsylvania, for the health choices program, that's been around for more than two decades, about two decades and we are going to be building on that infrastructure that is, that has been -- it's actually a nationally acclaimed health plan for Medicaid. It's one that many states look at as really a model of our health choices.

We also have close to a decade of behavioral health choices which is the managed care product for behavioral health.

We have staff in both those areas that are teaching us in the long term service and supports.

How to in OLTL to -- you know what they do.

As an example, what is --

what is a readiness review? How does it work? We have a small team that has been doing readiness reviews for years with our program of all inclusive care for the elderly life program, we're going to be learning from them as well.

But there's a lot of opportunity in Pennsylvania because of the rich history that we already have in managed care delivery system.

The trick is going to be to make sure we get long term services and supports right. We look to all of you to help us to do that.

The next goal strengthen coordination of long term services and supports and other types of health care.

Right now, they have been completely running on separate tracks we believe there's

opportunity for sort of a nexus and an ability to provide better health care to people in the long term service and supports delivery network as well as to provide better long term service and supports and additional services and long term supports to people as they age or acquire a disability to really make those things more connected.

And we also recognize with the number of dual eligibles in the State, that there's an opportunity to connect to Medicare and Medicaid. We're investigating what is called our mipa agreement to see if opportunities of that, we're working with the integrated care resource center which has a really nice web site that

really highlights how states have integrated Medicare and Medicaid. We're really looking at that as well.

We are certainly looking at how we're going to be enhancing accountability and quality and the concept paper has a lot of detail about, at least our best thinking on that, please provide comments back to us formally and then through this committee process.

As to how we might measure some of those things a little bit better.

It's a challenge when you are talking about home and community based -- quality measurement is a challenge when you're talking about home and community based services because there are -- there is no nationally endorsed quality

measures for HCBS, they don't exist.

They're pretty much state home grown measures.

There is the State, I mean the Federal Department of Health and human service choice is where CMS is located centers for Medicare and Medicaid services is located, has a -- a national activity that's going on been going on for a year now, little under a year now which is to really take -- do an analysis of all of the gaps in home and community based measures.

That's a public forum, that's a public document they actually have the first report out which is really nice. We are looking at the domains in that report.

As to the things that he we want to measure in home and

community based services
around quality.

Advanced -- if you want
to really take a look at that
including their -- the report
that they issued, I guess
about a month ago, within the
last month, they issued a
report. And if you go to the
national quality forums web
site there's a home and
community based measure gap
analysis and a committee
that's actually been meeting,
the roster of the committee is
available to you if that's
something of interest to you.

I think when you look at
it, really look at the domains
much of it -- if you do home
and community based services
or use home and community
based services much the
domains are things that you
use every day, things that you

look -- that you, um, take advantage of and, would want measurement on, for manage the care organizations and to providers to report to the state that their doing.

Advancing program innovation, um, I am really interested in hearing about that. That section we'll go over that section but that section is very sparse and it touches one of the ideas of the program innovation around including how do we make improvements to and ensure -- make improvements in the direct care work force, in terms of supporting the work force. I asked for feedback in the concept paper we asked for feedback on that. So anything -- any ideas that you have, certainly working with your attendants and talking

with them is one way of doing it.

Also, talking with the home care agencies home health agencies. The direct care work force is a pivotal under pinning how we -- how well we do this. So we're really looking for comments and ideas on innovations in that regard.

I'll get into more detail, on that as we talk here.

We want to increase efficiency and effectiveness, we want to prevent eligible admissions to hospital and emergency departments we think we can do that by really connecting home and community based services and, health care in a more reverse way.

Participant considerations, I think I don't know how to do this,

because so many of you sat
through yesterday's webinar I
don't want to go through I was
planning ongoing through a lot
of what I did on the webinar
anyone here that wants me to
go through the detail that we
went through on the webinar or
would you like to start
talking and getting -- getting
advice.

From all of you.

So -- I don't have any
hands so -- I think we'll just
move on. Okay.

So we're going to stay --
okay. Go to that -- okay.

I'm going to turn it back
over to Ralph. We're going
to go through this slide, you
have it right there. And,
spend let's see. We have
about an hour and -- 2 hours.

So, how many minutes did
you originally schedule.

Okay.

Okay.

So we're going to spend 15 minutes on each of these, each of these items that are up here the participant considerations slide. That's really light.

We're highlighted okay. Great.

That's what you did Heather I could not figure that out I only looked at it in black and white. Okay. So the first one is eligible I'm going let Ralph lead this part of it. We're giving 15 minutes.

>> RALPH TRAINER: Okay.

Okay.

With the first one here, eligibility -- I adults 21 other older that require medical long term service supports whether in the

community or in the private or
county nursing facilities.

Because they need the
level of care provided by
nursing facilities, or --
intermediate care --
intermediate care for
individuals with other related
conditions.

Could you mute your phone
please.

>> JEN BURNETT: Those on
the phone please mute your
phone.

>> RALPH TRAINER:
Current participants of the
OLTL waiver programs who are
18 or 21 years old, and, dual
eligibles aged 21 or older
whether or not they need or
receive long term service
supports.

Clinical and financial

eligibility requirements, will continue for long term service supports. Is there any questions or comments or

>> JEN BURNETT: Advice?

>> RALPH TRAINER: Great.

>> SPEAKER: I have one. When I was reading the paper, you know, with one of the things that is sort of new to think about, in this model is that, there's going to be community health choices with MLTSS and then, community health choices you know for non-MLTSS duals primarily.?

And, in terms of the independent enrollment entity and the assessment process it would seem that we would want as families are in a time of crisis in a potential participant is going through,

the eligibility for many of these individuals who are already in the CHC program we know they're financially eligible how do we have an expedited system so we can engage that person immediately, while they're in that -- going into the crisis avoid the hospitalization sort of coming down the line and the potential you know, risk of institutionalization at the highest. We don't get stuck on a person who is maybe been with the CHMCO for a period of time so they don't get stuck and sort of a new set of processes when they really just need that, that care delivered promptly.

>> JEN BURNETT: Thank you.

Thanks.

>> RALPH TRAINER: Good point. Thank you.

>> JEN BURNETT: Heather asked if Ray has a suggestion how we can do that.

>> SPEAKER: I mean, it's -- it's really reading a line, you want to make sure that person is afforded the full range of choices for the other MCOs they may be able to choose from.

But the same time you want to acknowledge that they have already chosen MCO they may be satisfied with. So I think you need to have some sort of active step where that choice is acknowledged.

But it may not require the same intensive independent enrollment entity discussion.

>> RALPH TRAINER: Thank you.

Now I'm going to have Pam, do the next one please.

>> JEN BURNETT: Wait.

>> SPEAKER: Go ahead Jennifer.

>> SPEAKER: Currently, I was the transition coordinator for 9 and a I half years E united disability services, currently, young adults 18 to 21, receive services through EPET through Medicaid, but the waiver is able to cover services that EPSDT is not.

What is the future plans for those individuals when the waiver age goes to 21?

>> JEN BURNETT: We would like advice on that.

Um, we have not made any

decisions. So Jennifer if you have any suggestions, for us either state them here or, send them in to us or, if you want to think about it and, come back to the next committee meeting, we would just recommend that you give us what you think should happen in that case, that scenario.

>> SPEAKER: I've got a simple, drop the age from 21 to 18.

It's really simple. Everybody is in the rule, everybody is wrapped in.

>> JEN BURNETT: Okay. Duly noted. Heather you got that one.

>> RALPH TRAINER: We have a comment in the back.

>> SPEAKER: In terms of

eligibility you mentioned.

>> JEN BURNETT: I don't know if you can come up here -- microphone up here.

>> RALPH TRAINER: We don't have the receiving mic.

>> SPEAKER: When we talk about eligibility you mentioned people who are not using MLTSS, would be enrolled, and I was wondering if the payment that per capita payment would be tiered how would that work?

>> JEN BURNETT: What is your recommendation?

>> AUDIENCE MEMBER: It should be tiered I think the incentive to enroll people who don't use services, would be greater if the payment is the same.

>> JEN BURNETT: Thank

you.

>> RALPH TRAINER: Any others. Yes.

>> SPEAKER: My comment is on clinical eligibility were you going to cover that next -- can I go ahead with that?

>> JEN BURNETT: That's part of this discussion.

>> SPEAKER: Okay. So -- it notes here there's going to be a new standard or level of care tool. And, um, so, we would like to know what that tool is, and, make sure that the tool is able to pick up on clients who have cognitive impairment as well as physical impairments.

For people with brain injury they may not have awareness of the deficits if the tool is done in a typical

interview fashion you're
interviewing the person and
saying do you have difficulty
in any of these 3 areas,
functional areas of daily
living, the person may not,
they may say no, even how they
really do have problems in
that area. And, they may be,
therefore, deemed ineligible,
when they really might have a
risk of not being able to
continue in the community
because they have functional
impairments we really want to
see the tool we want to look
at the methodology of the tool
and help, design the tools, it
can pick up cognitive
impairment.

>> JEN BURNETT: Thank
you very much if you -- um,
recall, um, in the slides
yesterday -- and in these

slides as well the concept
paper, the section that -- um,
focused on stable engagement
we're going to be doing focus
groups around a bunch of the
things we're going to be
rolling out over the next year
and as we redesign the level
of care assessment tool we're
going to be reaching out to
and engaging interested
parties. So you'll have an
opportunity.

>> SPEAKER: Thank you.

>> RALPH TRAINER: Thank
you. Richard I would ask you
to use the microphone and
introduce yourself.

We'll get you help.

>> SPEAKER: Good morning
I'm Richard Copalesky, and
representing Pennsylvania long
term project good morning I

apologize for being late this morning.

>> RALPH TRAINER: Thank you.

>> JEN BURNETT: Richard represents the consumer of the advisory subcommittee.

>> PAM MAMARELLA: We have another comment.

>> AUDIENCE MEMBER: There are communities -- there are community based organizations that can do exactly what Ray is asking about.

CILS. Already talked to these consumers we know how to address the issues we know how to get the information and referral out. That is exactly the kind of transition that can make this smoother.

>> SPEAKER: As a matter of fact the center for independent have been doing it for the people, we have have been doing it way before that, the CIL we know our people better than the BAS coordinators do, thank you.

>> RALPH TRAINER: Thank you anymore comments please come up if you can.

>> AUDIENCE MEMBER: I'm Pam Walls from community legal services one group I'm concerned who are slightly over the income limit for the waiver program for long term. We frequently see people who are $20, little bit moreover and they're just completely, excluded from access to home and community based services.

And, they're only real

choice is often nursing home.
So, I would really, urge you
to consider ways of allowing
the group of people to qualify
financially via spend down or
some other mechanism like
that.

>> JEN BURNETT: Um, I
really appreciate that
comment, something we're
concerned about as well.

And, Heather has made a
note of it, we also have on
the CART.

But if you want to submit
additional comments for what
that might look like, um, that
would be very helpful.
Similar detail.

>> AUDIENCE MEMBER:
Thanks.

>> RALPH TRAINER: Next.

>> AUDIENCE MEMBER: Do I

need the mic?

>> JEN BURNETT: Only because people are on the phone.

>> AUDIENCE MEMBER: Okay.

I was wondering the -- the community spend down initiative that David Gates and I have been working on, which would allow people to spend down the medical costs, which then makes them eligible for other programs.

So, we'll put that in our comments but it would be a suggestion as a way for people who are just a little bit over.

They would be able to deduct their medical expenses.

>> RALPH TRAINER: Great. Thank you.

Anyone else?

Thank you very much --

>> SPEAKER: I think along with financial we should look at level of need, health wise because you can't buy your way out.

When you have chronic illness. It doesn't matter. I mean especially if you own a home you're under water whatever, there are a lot of situations where you just financially cannot buy your way out and the light at the end of the tunnel is not there.

>> RALPH TRAINER: Thank you.

>> PAM MAMARELLA: Okay. So if there's no other comments we're going to move our discussion to enrollment.

Enrollment will offer

choice of community health
choice MCO or the life
program.

Persons included in the
community health choices
population will be required to
enroll in one of the community
heal choices MCOs operating in
the region unless they choose
the life program.

And independent
enrollment entity will be
selected through a competitive
procurement process.

So I want to open this up
to questions? Or discussions.

>> SPEAKER: Yeah.

I'm sorry.

How many independent
enrollment per zone?

>> JEN BURNETT: Can you
tell us what you think that
should look like?

>> SPEAKER: Well, we want options for sure.

Often when you have less then you know -- one or two, that don't create options. So that's what I'm looking for.

>> JEN BURNETT: Thank you.

We're in an active procurement process right now for the independent enrollment broker. And that is our goal is to have more than one option so --

>> SPEAKER: You don't have any thoughts right now on how many that might be?

>> JEN BURNETT: Because it's an open procurement I cannot even talk about it I've said as much as I can.

>> SPEAKER: Okay.

>> RALPH TRAINER: All

right.

>> PAM MAMARELLA: Any other questions?

Comments?

>> RALPH TRAINER: Yes.

>> SPEAKER: I understand you can't talk about it I just wanted to clarify, that the independent enrollment broker as is put out in the RFP involves more than it has. It has some degree of service coordination I guess the question is, where the ID service coordination, cuts off and then the coordination by MCO would begin.

>> JEN BURNETT: Again we welcome your thought what is that should look like. As we move into the new procurement.

>> RALPH TRAINER: Pam,

could you come to the Mic please.

>> AUDIENCE MEMBER: My question on enrollment is, it already takes awhile to get through the enrollment process as it exists. There are going to be more steps are they going to still be able to stay within the 90-day eligibility process. Are they condensing some of the systems that already exist because, people are repeating themselves, 50 million I know I'm exaggerating through each pro dress they have to talk about the disability and functional eligibility, over and over again, giving information, is it going to be condensed and be more concise enrollment process.

>> JEN BURNETT: Yes.

I don't know
Jeanie Rodgers is here I don't
know if you want to talk about
it.

>> RALPH TRAINER: Can
you come to the mic please.

>> AUDIENCE MEMBER: The
RFP that went out that we
can't really talk about at
this point in time, did talk
about a condensed process that
would essentially, ensure that
people's -- through the
process within 60 days.
We're looking for a process
that will -- whatever ways we
can, um, essentially,
eliminate any large time
frames and, information that
is repetitive. So, um, in
terms of, we want to look at
tools we want to look at
systems.

And we are happy to take
your advice on all of that

information.

>> RALPH TRAINER: Any --
yes.

>> SPEAKER: I just -- I
just have a process procedure
question for this
conversation.

We're going through the
document, looking at each area
w is there going to be an
opportunity to have bigger
picture kind of comments
questions just about over all
processes I mean this you know
the comments on procurement
and where we are within then
independent enrollment broker
and the challenges that the
staff are having, in being
able to address detail
questions relate directly to
how this committee looks at
putting an RFP for community
health choices on the street,

and how that might show
conversation I do have some
thoughts on that and some
concerns about that and I
wonder when we raise those,
Mr. Chairman or madam chairman
or Jen?

>> RALPH TRAINER: I
would say, certainly, bring
them to the now, if they seem
to be lengthy we can table
them and have further
discussions.

At a more appropriate
time.

But, one of the reasons
everyone is here is to get
your point of view, your
expertise and help guide us.

Is that helpful to you?

>> SPEAKER: That is --
can I have two minutes.

>> RALPH TRAINER: Go for
it. We'll give you 3.

>> SPEAKER: I shouldn't

need 3 for this. I mean, look you know we've reviewed the concept document, you know throughout and, and Jen kick it had off with some people seek details lacking I would be one of them that would be one of my first comments that I was hoping to see kind of a not fully flushed out version of an RFP that gave some of the types of details that an RFP would see. Not just the MCOs will bill provider networks and the department will monitor it, but, how they will build it, what those criteria may be.?

What a post queue provider, since that's who we represent might be in a network. Those details were lacking details on things like rate setting and rate cells and how someone acuity will be

factored in. How we'll handle rate setting for people who don't have MLTSS needs currently. Which is in essence new spend. They're out there now, kind of, anonymously going through life until, they have an event, understand the need to do some management on the front end so perhaps it's not as costly on the back end for the Commonwealth. Make no mistake you would be spending dollars you would not have spent otherwise on the individuals before they hit the system that's something we need to think through and figure out.

You know, timeliness standards, what the payments do not include, what the plans are I could go on, we will in our comment I think, all that

to say I think we need to be very clear about what the process is going to be, and, ensure that we have the opportunity to see those kinds of details before an RFP hits the street on November 16th whatever the date is, um, and -- then we all can't have these conversations with the Commonwealth, because I can't address that, you know, that detail we're in the formal procurement that is a significant concern to me, as I look at how the process rolls forward.

>> HEATHER HALLMAN: Can we talk about each of those as we go through, some of it will we'll be talking about provider networks.

>> SPEAKER: Absolutely I was responding to the

chairman, who said I should say it now.

[laughter]

>> JEN BURNETT: Heather made a recommendation, that as we go through these -- 7 houses I think, 8, um, our list of participant considerations that many of the things he is talking about are going to get covered in them, so we can have a more robust discussion during that period.

I just before we leave enrollment, because -- people have been bringing this up, can you -- can anyone give us or would you be willing to make comments on how do we ensure choice while also expediting the process?

So that is a challenge.

And so if anyone has any thoughts on how that can get done, um, that would be most helpful to us, because, we do want to ensure choice.

But we also want a short process and expedited process. So any thoughts you might have on that, um, I would appreciate it.

>> SPEAKER: This may sound stupid I really don't though how to the whole process for this works.?

But I would think, one of the biggest things, that could be done is, like, the State works with doctor's offices and the public all the time. Have different like have many brochures sent out to local doctor's offices an stuff so they know, that there's choices of providers because,

usually when people first get into trouble -- they don't know that organization like this exist, like it's not -- that is something that comes to the forefront of everybody's mind. So like, in the local communities the State would make up a brochure of, okay, here are your different like CILs for independent living, here's what they do, give like brief descriptions and brief summaries each one, and how each one is different from the next one, so when people have to start looking into these options they already know a little bit about it, guess what they're already working with a physician that knows who they are.

And knows about their medical needs, that can maybe,

point them in the best individual direction for that patient.

And maybe somehow, the doctors and stuff could coordinate with the CILs a little bit more to be able to get that person enrolled in the process faster and give them the services and stuff that they actually need.   But when the State is talking to doctors offices one thing, I notice is, you have to be very specific about what the individual needs.   A lot of times, that doesn't get done because you know, doctors are busy.

And when they write out prescriptions when they write out the stuff you need it's not, specific enough and if there's a way to maybe get the medical industry, the State

and the CILs working more together on the enrollment process, and doing it on more of an individually based mind set, it might work better that way. But, how to actually connect that all together, I'm not real sure.

>> RALPH TRAINER: Tanya, I know speaking from my Center of Independent Living we try to make as much information out to the public as possible. I know there's -- I'll turn to my left here look at the state I've looked at the state over the years to supply us with information.

Such as you're talking about. And, it comes in bits and pieces and my consumers in my area we don't have time for our bitses and pieces, we construct our own materials

and put them out in the
doctor's office as much as we
can, I'm sure there's not
anyone sitting in this room,
here that probably doesn't do
it, the same.

In their own way but
having the State provide us,
with such a process and a
document, I would say, would
be wonderful. Um, I will
just leave it at that.

>> SPEAKER: Can you
provide us with copies you use
so we can see --

>> RALPH TRAINER: I was
asked if I would provide what
we do. I see Stephanie
sitting in the back of the
Rome she is going to hold me
to it, make sure that happens
Stephanie is my nursing home
transition coordinator,
Stephanie we'll hopefully help

everyone.

Linda. Please come to the front if you may please.

>> AUDIENCE MEMBER: Um, Jennifer reminded -- I'm sorry, Tanya reminded me of the fact there is a role called supports brokers it is in services my way, and what it does is help the individual, navigate. I think there are a lot of people, even those that are self-directing that could use a support broker when you're sick, when you're down, when you -- if you don't have any formal supports to jump in and take care of all that, it is bad.

A support broker will advocate for you to get the things when you need them.

I would just urge you to

think about using that more broadly

>> RALPH TRAINER: Excellent.

>> SPEAKER: Just following on what Linda said I believe that it each person, no matter what waiver they're enrolled in, should have a circle of support and, that circle should be facilitated by whether it be a support broker or a peer mentor and, that peer mentor or support worker shouldn't necessarily be connected with an agency providing services with the -- they should be totally independent because, then they will have the best interest of the person. Because I know when I worked at united disability services, there was a lot of information still sent to doctors like,

brochures and things. But, doctors still -- got very confused in the process, themselves. So unless someone came in, UDS has a resource center and the doctors would call our resource center and someone would come in and walk them through the process. They would get very confused and they would not know what to tell people. So I think, that support broker or -- peer mentor, could help educate the doctors as well.

>> RALPH TRAINER: I agree. Supports brokers are certainly something that needs to be considered throughout this process.?

And it's -- anyone that is on the waiver service at any point in time, probably

will need a supports broker I'm looking at Linda ten years ago, 20 years ago, never had a problem directing any services.

Got ill, and, there is where it does help, having an independent one is certainly beneficial. Thank you.

Fred you had a question?

>> SPEAKER: No.

>> RALPH TRAINER: Okay.

>> SPEAKER: I'm sorry.

Choice is always connected I believe to people who are informed.

And trained.

And having a local face. That's important. I don't have the answers for you, but I do know often people with disabilities, when they just like, Jennifer mentioned, when they come into those these

systems they are relying on
the people to give them
informed choice and direction.
If they don't have the
training if your enrollment
broker doesn't have that
training, in regard to being
informed, in regard to just
being nudgable about
reasonable accommodation how
they can effectively
communicate with people, that
is not going to be informed
choice.

Rain train okay.
Richard then I'll go to you
Fred.

>> SPEAKER: Having a
system where you have --

>> RALPH TRAINER: Can
you get closer.?

Shout it out.

>> SPEAKER: Having an
organization that is in your
community, that if you have a

problem, you can go to them
and talk to them face-to-face
and address all of your
issues, few years ago, I ended
up in the hospital and, I
didn't have overnight care.?

I was by myself. I had
friends, family, different
people just helping me out
from time to time.

But, due to the fact that
my coordinator coming out to
the hospital, to visit me,
talked to me how I can get
overnight care, that was
available, I got the care and
my health all of the sudden
got better. I got staying in
the hospital as much, and, it
just worked out a lot better
if I think, that you have
someone that you can use, in
the community, doesn't take
too long to get to, quick
phone call, go visit them.

Talk out your problems and, get it worked out.

>> RALPH TRAINER: Okay. Thank you. Fred?

>> SPEAKER: Yeah. The first person that should be giving this information out, when someone goes into a hospital they have a baby that has a problem or if someone like me that gets into an accident one of the first people you talk to is a social worker in the hospital.

I believe that the social worker in the hospital is a very first front line of information and they definitely need to be able to tell people, about home and community based services what there is available out there and, they don't. I never found out about independent

living or anything like that, until almost 4 or 5 years after my accident.

And it would have been so much better if they would have come immediately to me in the hospital when it first happened, listen you can get on thing this thing and this thing, all they ever do is okay okay, we're going to get you hooked up on Medicare or Medicaid, that's all they say. They don't try to tell you about independent living system, nothing. And that's exactly what needs to be done that's our very first front line to get education out there.

>> RALPH TRAINER: Excellent point. Do you have anything?

>> SPEAKER: Throughout this discussion, I just kept

thinking disability
competence, we always include
rates and education and
culture we have a whole
culture of disability, based
upon Ed Roberts an directing
our own service and consumer
control and direction my fear
with this whole thing is, is
that -- the managed care
companies going to have any
competence training to know
what they're walking into.

And -- you know, it's
kind of scary if they don't,
then our whole world turns up
side down overnight.

I suggest that you really
have the big training a lot of
the trainers be consumers who
use the service.

As well as, some people
who living in the CIL, is.

>> RALPH TRAINER: Thank
you.

>> AUDIENCE MEMBER: I apologize.

>> AUDIENCE MEMBER: Back what Cassey was saying really, I know it's in the -- in this -- I got -- been going over the seminar, you talk about the training you talk about the -- you don't talk about independent living, philosophy, it has to be a core part of the training not just that the grass roots level at the you know the Center of Independent Living I'm talking about the managed care companies will probably need to go through some of the training.   And demonstrate they have been through it. And, through that, you can also do, building into that training is when you look at the improving the service those trainings can identify

action plans they need to
take, that we can come back to
you and, you can see that the
-- all aspects of the
companies are going to be
trained that we I think, I
would go out to colleges and I
-- I train social workers like
do speeches to social workers
my first question is, who
knows Ed Roberts these are
people that have been in
college for four years have no
independent about the
independent living philosophy
and come out and start working
for you guys and independent
living centers it's one of the
way you can really build in,
um you know, consumer control,
into the whole process I
really just think that's
something you should be
considering and should be
looking at an RFP and a whole

variety of disability
trainings going out doing this
work, at different levels
thanks.

>> RALPH TRAINER: Thank
you.

>> AUDIENCE MEMBER: You
were asking for specifics
during the written comment
period, following the June
concept paper, there were two
extensive proposal that's were
put in for this segment of the
process.

One was submitted by the
Pennsylvania Centers for
Independent Living, authored
by Tom Earle and one was
submitted from liberty
resources under my signature I
would suggest that you may
want to bring those up and, go
back through them there's a
lot of good suggestions in

there.

>> JEN BURNETT: Thank you.

>> RALPH TRAINER: Okay. Theo, go a ahead and we have one more in the back.

>> SPEAKER: I was reading briefly the RFP that was submitted for managed care organizations I saw within that, it spoke about demonstrating your experience in regard to working with health care systems.

It also wanted to know if you collaborated with any entity what that experience would be.

So I'm suggesting if that can be captured in an RFP why not capture, how you can demonstrate your experience in working with people with

disabilities.

And as well as the independent living philosophy.

As well as, demonstrating that -- um, your values advisory committee, is made up of you know, whatever you use, 51% of people with disabilities and that is important to capture that information.

Because any entity, any managed care organization can say I have this, I have that.

How do you know that?

You know, right now, only thing I am sure of, is both the Federal government and the State government, monitor Centers for Independent Living to ensure that they have 51% control and directed by people with diverse disabilities.
Any other organization out there, that don't have that

kind of level, of accountability, and, if OLTL wanted to capture that and any kind of accountability, I think, it probably needs to connect with organizations that already have that kind of compliance.

>> RALPH TRAINER: Thank you. I can't say I don't agree with you.

Jennifer then -- we do have to get to the one in the back

>> PAM MAMARELLA: I think -- our time sake we need to move onto the next bullet point and double back if we have more time.

>> RALPH TRAINER: Okay.

>> SPEAKER: I just wanted to follow-up on what Theo was saying, I think that, there are tremendous CILs in

certain areas. And Theo you're one of my mentors Linda Pam, but -- not everyone with a disability who is a disability advocate is connected to a Center of Independent Living there are a lot of other good providers out there, that have very good advocates. So I would just encourage you to not only look to the CILs but also, outside of the CILs to find advocates because, I just will be very honest some of the CILs, operate better than -- like any other organization operates better than others.

>> RALPH TRAINER: Dully noted.

>> SPEAKER: If I could say one thing before we move on. That is about the sense of community and, grounded in

the independent philosophy of
Ed Roberts every time I see
this succeed and work well is
around the community of
individuals as I look around
the room today I can recognize
many, when I see it not work
well is when people were
disenfranchised working
through cumbersome systems, or
-- being disenfranchised
that's all we'll see, sense of
community, grounding in the
independent living -- to
ensure that occurs.

>> PAM MAMARELLA: Thank
you.

We're going to move to
cover benefits.

>> RALPH TRAINER: I'll
make sure we get to your
comment in a minute.

>> PAM MAMARELLA: And
coordination.

>> RALPH TRAINER:
Existing services and delivery
models, will be included in
the community health choices.

Physical health and long
term service support services,
needs coordinated by the
CHCMCO, behavioral health
services will be closely
coordinated to ensure
participant needs are met.

On the left there's a
scale -- a graph, um,
indicating the different
perimeters.

Questions or concerns
comments, yes.

You get your chance.

>> AUDIENCE MEMBER: Hi
thank you I actually work for
a nursing home I just wanted
to touch on the senior
population as well, because
there's been a lot of talk

about the disabilities.

The senior population that's going to be affected as well our baby boomers age there's going to be more of them, um, actually the coordination of the benefits kind of segway to what I wanted to speak about any way

>> PAM MAMARELLA: Can we have your name?

>> SPEAKER: Marianne Brawley I work for the Jewish Home of greater Harrisburg. What we see in the facility is having difficulty getting the seniors back to their homes because of the coordination of benefits.?

They actually have to provide -- apply for different types of Medicaid, as they go along and it's very difficult, we have actually had people go home and not be able to get on

their food stamps right away and, um, so that's where I'm really concerned because we do want to get them back to their homes. But when they come into long term facility, and they don't have the support out there, they don't know where to turn. They have the stop and start of benefits it's very difficult to transition them back and then unfortunately they do become permanent in our long-term care facility. That's not what we want -- either we want to see them back home.

So -- that's a big concern, um, that -- you know, again, that senior population is going to be highly affected by this. And, how we get the information out to them, how we coordinate the benefits so that, they don't loose as they

go every step of the way.

>> PAM MAMARELLA: Thank you.

>> RALPH TRAINER: Thank you very much and anything else you can add to that, please make sure we get -- any other questions concerns around the room.

>> SPEAKER: So wondering if we expect that any of the same MCOs who are currently in place under health choices and managing physical health services, would be some of the same ones that will be applying to manage long term services and supports.

If so does that represent a potential conflict? Or would it be allowed? Or encouraged or discouraged?

>> JEN BURNETT: Yes. It is open procurement anyone

-- any one with managed care
any managed care organization
will be able to apply.

>> SPEAKER: And their
consideration would be -- it
would be irregardless whether
they presently hold a
contractor health business.

>> JEN BURNETT: Yes.

>> SPEAKER: Because some
of the specialized long term
services and supports may not
be equally available, in all
geographic regions of state,
what would happen if an MCO is
selected by the client, MCO is
selected to manage long term
services and supports in one
region of the state, and the
individual who is served, by
long term services and
supports chooses a specialized
provider in another region of
the state, um, would that

require that all providers
have to contract with all of
the MCOs who are selected?

>> JEN BURNETT: If you
have ideas about how the State
would manage that kind of
scenario that would be really
helpful. So -- please
provide us with comments on
that.

>> SPEAKER: Sorry, Neal,
just asked me to go first --

>> SPEAKER: We both
raised our hands.

>> SPEAKER: As it result
relates to nursing services
facilities listed in an LTSS
supports and services within
that there are right now,
there's exceptional DME
payments there's special
payments for that kind of
individuals. Number of
things that are paid for

outside, the current per Diem system for nonpublic nursing facilities. What services does the department intend to include within the MCO's cap rate?

>> JEN BURNETT: All.

>> SPEAKER: Everything all those outside payments would be globals in a global cap rate, per month, per member, percentage of people that might utilize nursing services.

>> JEN BURNETT: Going back to Diane's question about -- Tiers it would be helpful for you to give us the ideas how that may work.

>> SPEAKER: All right. We can, it would be -- that be a comment later as well. Sorry.

>> SPEAKER: Just -- comment on the participant

directed personal assistant services sections -- couple of things just general comments and we will provide more details comments along the line. But, you know, very glad to see that part of the system supported in this concept paper, really important part, and I number of people here today, have a big stake in ensuring the preservation and growth and support of that system I just, mostly flagging that uniqueness of that model.

And taking account for that, with respect to the design of community health choices that you know, by definition, you know we're talking about seniors or people with disabilities Medicaid eligible being cared for, supported by a population

that is in many cases also
being supported by the State
in other ways.

Based upon you know the
off -- other significant
challenges that the work force
I'll save some of the comments
until we ghetto the piece for
work force. Obviously unlike
consumers and other models
even attendants or direct care
workers and other models they
don't have you know people
like you know -- big
institution that's pay
expensive support for all the
great work that Russ does and
others do, um, you know this
is a population that is you
know, has a hard time getting
their voices heard inside the
system and so, um you know,
that is a complicated with the
CMS providers I want to flag
that as the process moves

forward, that -- you know, the -- the administration take steps to make sure that system is continuing to work and grow and that the consumers and the workers, that are in that system, um, get the support they need and that the other goals that I know the administration has and taken steps to effectuate toward improving the services and supports and the stability of that system are -- that those goals are aligned with that process and not in diverging from this process.

>> RALPH TRAINER: I'll keep us to that task.

[laughter]

Yes, please.

>> AUDIENCE MEMBER: Diane again, I wanted to

mention that I was looking at the list of covered services and, one thing that is definitely missing extermination services which makes a difference between someone staying in the home or going into the facility, we recommend that is one of the listed office services. I also notice there's nothing that deals with acute services and, medical services and I don't know how you want to deal with that, but of course, you know, if we're talking about managing both the medical and the social needs of people we'll need to think about that and perhaps there's some way to put that in the language General it's in there, we mentioned that we're going to be providing the same state planned services that

are available through health choices.

>> AUDIENCE MEMBER: The services available through Medicare. Correct?

>> JEN BURNETT: Right.

>> AUDIENCE MEMBER: Okay. Thank you.

>> JEN BURNETT: For duals.

>> AUDIENCE MEMBER: Right.

>> RALPH TRAINER: Yes, please.

>> SPEAKER: Ralph I have to be excused I'll be calling back in by phone.

>> AUDIENCE MEMBER: Hello I'm a home care provider destiny, some of the things we were talking about the consumers in the -- no one is mentioning the home care agencies.

Because when the consumer transitions from home to hospital to nursing home, typically they have a home care aid that has been with them, knows their progress they actually know when they're down and when they're up. No one is talking about the home care providers can actually follow through with their clients from step to step. Typically they get lost once they get into the hospital the hospital takes precedence over the care they go to the nursing home they have no idea there's been a home care provider that's been there with the person we can't send our aids out to the hospital to look over the clients we can't send to the nursing home to look over the client, they get pushed off is

to someplace else, what are the home care providers for to be within the networks to be able to transition and stay with their clients. Because it's very important for the client to come back home to a person that is there, to take care of them.

>> RALPH TRAINER: We do hear you, we are trying to work that in.

The support broker, in essence is in part that person sometimes.

I understand what you're saying.

With working with your consumer and -- we will do our best to include that.

Thank you very much.

Appreciate your comment.

Yes, please.

>> AUDIENCE MEMBER: Hi I'm Ray Landis with AARP, one thing I notice that is not specifically mentioned in the covered benefits that I know there are a number of people in this room that spend significant portion of their lives reviewing and determining assistive living regulations and definition I don't see assisted living specifically mentioned and I would respectfully suggest that assisted living be a covered benefit in this concept paper.

>> JEN BURNETT: Thank you and, if you would submit that formally as well we have it for -- on the record here.

When I talked about innovative services and looking at the thinking about

Pennsylvania's assisted living regulation I think we have an opportunity because the assisted living regulations here in the state, align very nicely with home and community based regulations that, CMS published last year.

If you take a look at the Preamble to that regulation a lot of our characteristics are outlined, the characteristics that they talk about in the Preamble for CMS and home and community based regs are pretty much aligned very nicely with our regulations that came forward several years ago.

>> AUDIENCE MEMBER: But I do believe, we would have to specifically apply for the assisted living waiver, correct from CMS.

>> JEN BURNETT: We don't know what kind of authority we have begun having discussions with the CMS we don't know what kind of authority we're applying for, we hope to enable a lot of innovation we're talking about.

>> AUDIENCE MEMBER: Great thank you.

>> RALPH TRAINER: Cassey.

>> SPEAKER: Hospice is also something that I think, could be added I have seen in other managed care programs other parts of the country.

I can give you an example of it, when I put my written stuff in, I have it in my back/back I don't want to quote it, I've been doing so much reading I may give you the wrong quote. I would love to see that, a lot of us

live with families. And, others, arenas I've seen where people have been able, friends have been able to take shifts if the person lives alone.

And I don't think we all need to die in a nursing home. Okay.

>> RALPH TRAINER: Okay.

Yes. Jeff, Paul -- and I don't recognize the next person.

>> AUDIENCE MEMBER: Paul Fogle, just looking over appendix A, I'm from the Lehigh Valley center tore independent living that needs to go on the record as well.

Looking over appendix A the one thing I don't see on there, I have just skimmed this is, any mention of legal services for consumers.

All of these covered services, I know from the work

we do, with housing and other issues at least that people live with, sometimes referrals are made to Penn legal services and other areas they have their own systems of payment, reimbursement and whatnot I was just, wanted to inquire about any consideration of coverage of legal services for people that are covered under the DMLTS system.

>> RALPH TRAINER: I have my thoughts on that, perhaps my -- Jennifer can provide some clarity to that.

>> JEN BURNETT: I would just ask that you, we heard it today, it's on the public record but, if you want to submit additional comments on what that might be, um, that would be helpful.

>> AUDIENCE MEMBER:

Thank you.

>> RALPH TRAINER: Thank you Paul.

Let me have -- committee member first then you Jeff.

>> SPEAKER: When you -- go to the hospital they want to send you the record from the hospital to the nursing home, why can't the State pay for your bills, in home, instead of having you go to -- if I have to have -- IV antibiotics at home, in -- they say well, we want to send you it a nursing home the care is not all that great.?

I've been to a few.

And, my attendant has been with me for a year. She possibly could do it, do it very well. But -- you know, what is the training they don't want you to send you

home, they would prefer you to be in a nursing home for 2-3 weeks by that time, you have some sort of other issues.

So how could you, possibly -- have the State just pay for that and -- keep the help as best as you can.

>> RALPH TRAINER: I can't answer why the State does or does not pay for that help I believe Fred earlier said about about having a hospital be kind of like a point of information that when you're in there, as a patient, that you have resources given to you, made available, that will give you the best choices to make that decision to move. The cost certainly I would say something to Jennifer, might be able to help with it I don't know what else to say.

>> JEN BURNETT: Yeah one of the goals of our move towards community health choices is, that very problem you just described is to really reduce that to eliminate by having our managed care organizations being able to manage that, those processes and support as much as possible, your transfer back into the community, as you know, as -- quickly as possible. So -- one of our goals in this whole effort, to move to managed care, is to reduce those kinds of challenges that people experience today.

>> RALPH TRAINER: Let me touch upon a little experiment we tried, not experiment but an effort we tried with our LINK in one region was to

allow us to provide a somewhat supports coordinator, within the hospital facility, we met with about everyone who didn't cut a check per se, we welcomed that first but, our initiative didn't go anywhere because the hospital for whatever reason, resisted us being there.

And, it was very frustrating because the LINK dynamics the formula the way it's made would have been callous to twin in other areas, it kind of fell flat on its face we're not done trying. Thank you. Any other committee members?

Fred?

>> SPEAKER: Yeah I have something in here, um, no one discussed this yet on the participant directed personal

assistant services.

Now, as of right now we have an agency model and we have a consumer model agency models are -- they're all over the place, but there's only one consumer model that is PPL. And, my question is, when we do go over, switch over to the CHC, um, is everyone going to be able to supply all 3 of these because we have the 3 different choices in here? It's is everybody going to be able to supply all 3 or is it going to be just like it is now, only with the consumers getting consumer model getting these 3 choices and agency model staying agency model.

>> JEN BURNETT: I'm sorry Fred I don't really understand the question I will tell you that we will be re

procuring our fiscal
management services this the
next -- within the next year
and, um, we are looking at
more choice in terms of that
so any comments you have with
regards to that, um, we -- if
you -- if a consumer choices
the consumer directed model
they must choice, they must
use a -- that one of the
fiscal management services
that we provide.

The State provides.

So, but we're going to be
re-procuring in the near
future.

We're shooting to have
that procurement but don't
hold me to it, next spring.

And any feedback that you
have, on what worked and what
is not working with the
current consumer model that
will be very helpful I also

want to say that the third service that you're talking about, the third model that you're talking about, the service delivery model you're talking about, services my way, um, which is the budget authority model, is something that we are -- at least, today, we are -- we have included in the concept paper and we want to continue to have the budget authority model available for consumers. We actually heard that from a committee member last -- at the last meeting.

And it helped us to bring that forward a little further within the language of the concept paper thank you Tom.

>> RALPH TRAINER: Yes go ahead.

>> SPEAKER: Something I think maybe, Fred was trying

get at when he was asking his
question, was, the thing I
think in -- correct me if I'm
wrong, what you were asking
is, are people that use these
care models, going to have a
choice between which models
they want to use and like,
with PPL for example, are they
still going to be the only
consumer model there is?
Because, there's a lot of ways
that, their services could
definitely be improved
because, any time you have to
switch any thing with them,
for example, when I switched
over to services my way, my
budget is all screwed upright
now because, of what they did.
They can't even input a couple
of numbers in a computer
system right.

That needs -- that needs
to be -- that needs to be

rectified and then needs to be changed across the board.

I think, when you look at FMS providers someone in the State should be asking, do you guys really understand the gravity of what you're getting into, and, really how to do this efficiently. Because, dealing with PPL for, what, two years now, that is -- that is not done.

Example like you can call in and ask the customer service hot line, a really, really easy question that they should be able to pull that off of their computer screen no problem about, did you receive such and such paperwork for so and so and half the time, the basic person that you're supposed to talk to, under their direction, can't answer it.

They have to transfer you to supervisors, to get it answered.

Then by the time, they do that, like, there's no clear -- there's no clear or good way that they have been doing this business. I know, because I participate on call in committees with them.

And just the way they run it, is not clear and is not helpful

>> JEN BURNETT: Tanya that's why we're procuring we've heard of those comments from others we are re-procuring you're suggestions how to make improvements would be very welcome, um, and -- we will be reaching out to people who are in the current vendor for fiscal management, to provide us with feedback on what is working and what is

not working so we will be engaging in a process to make improvements to our current fiscal management services, and yes we, are planning on procuring it with choice, so that there are more than -- there will be more than one provider of the fiscal management.

>> SPEAKER: Can there be like an outline of criteria drawn up that these FMS providers have to --

>> JEN BURNETT: We do have standards and what we would want you to do is look at them see if they catch it, if they don't, please give us more comment what would work. But --

>> SPEAKER: Where are these standards?

>> JEN BURNETT: We'll get them to you after the

committee meeting. We'll send you an email, also send you, information on our provider hot line, which if you're having problems that FMS vendor is a provider if you're having problems with them, you should use our hot line and, let us know what those problems are and we'll do intervention. So -- you bet. Yeah.

>> RALPH TRAINER: They do get back to you I know I've called it, um, just to make sure that system is working may not work 100% but it works, most of the time.

So --

>> PAM MAMARELLA: I think we have another committee member that wanted to make a comment.

Is that right?

>> SPEAKER: I wanted to just comment on Mr. Dutson's comment I think that moving back to that one of the most exciting and powerful things that come from a new system like this is, that in the current system, with the hospitalization there isn't an MCCO is aware of just as the home care representative, mentioned -- there's not a formal connection there.

Being able to implement the services, as you suggested by having a safe discharge to home, and having the MCO being able to work you know across the system in that way I think this also, um, is closely and that ultimately it's better for the participant and it's more -- it will be a lower costs and ultimately a better

for the health care system
over wall. I think we also
need to be careful for people
that, um, who have had a
disabling event in that same
hospitalization or, whose
frailty has moved to a stage
where they're clinically
eligible not also limit that
person's ability to move
through the system, quickly
and have those same types of
options afforded to them, so
they're not in a situation
where they still need, if they
can bypass financial
eligibility like is suggested
this the concept paper that's
a great first step but then
also not to slow things down
with you know, a level of
care, follow by having to
choose your independent
enrollment entity and
interacting with that chosen

independent enrollment entity
and then, you know, choosing
your MCO be the same or a
different one and then you
know if it's a different one
you have to wait until the
first or 15th of the month and
then, you know, then choose
your service delivery model
and then choose the agency or,
you know, et cetera, et
cetera, et cetera I think it's
a matter of something some
process so these things can
move quickly so that an
example that Mr. Dutson can
exercise that choice to have
services following them home
when they need it.

>> RALPH TRAINER: Thank
you Neal.

>> SPEAKER: Point of
clarification, to secretary
Burnett did you say that the

FMS re-procurement is scheduled for the spring?

>> JEN BURNETT: I did and Heather just reminded me that we're doing a request for information on the FMS procurement this fall.

So the opportunity to give us the kind of comment that Tanya is giving us.

>> SPEAKER: Procurement would start sometime next year.

>> JEN BURNETT: Yes.

>> RALPH TRAINER: Okay.

Jeff?

>> SPEAKER: Okay. My name is Jeff Eisman Pennsylvania with the State independent living council or PASILC also work with the transportation alliance which a few folks are members of

that.

On page 35 you have a list of under appendix A, covered services and non-medical transportation listed.

I was curious is that transportation within the OLTL waivers -- and also, what is going to happen at this point, I brought this up before with medical assistance transportation program or MATP, how are folks going to be affected in MLTSS or I guess CHC is the term we're using now.

>> JEN BURNETT: We would ask you to make recommendations what that might look like the larger MATP program is big DHS program it is not, we're just going to be connecting in however they end up doing it,

I am not sure Heather do you know anything about MATP in terms of where it's going, but we're sort of, um, following along in a larger DHS effort around MATP reform, um, and, as far as the non-medical transportation, we look for ideas about what that might look like, currently we do have non-medical transportation available in -- I think most of our waivers.

But, and it's used for a whole variety of things but we would look for your recommendations on what that might look like.   Thank you.

>> AUDIENCE MEMBER: Okay.   Also had -- someone mentioned durable medical equipment earlier from what -- talk to go folks in the other states that have done managed

care that's been a bit of
concern, other places they
have accessed the durable
medical equipment has become,
more limited and when you add
that in with some of the
stuff, the CMS competitive
bidding which is, active in
some regions of Pennsylvania
eventually will be in all
regions of Pennsylvania,
that's a life time keeping
people employed, I have the
and out of the hospital and
nursing homes and
institutional -- it looks like
it's pretty limited
information on it, is it
pretty much you want us to
fill in the gaps -- or what
are your thought on the DME?

>> JEN BURNETT: Well I
agree with you, I think DME is
a really critical -- I would
say, most managed care

organizations, at least the
ones that I've been speaking
to, recognize the value of the
good DME and, durable medical
equipment that works for
people.

It helps keep people
healthy you said it helps
people participate in you
know, in life, it helps people
get to work all of those kinds
of good things, so -- I in
agreement with you, if you
have thoughts what we should
require around DME please --
provide those to us.

>> AUDIENCE MEMBER: Last
comment someone mentioned
hospitals earlier and social
workers.

Any out reach efforts
Pennsylvania has a social
workers association any
targeted efforts to those

folks and also the folk that's are in medical school right now to change because we all talk about the medical model how it is, people trained in that, they're going to make referrals based on, the presuppositions and recommendations what they know. If you can get to people earlier when they're getting trained they're going to think more in terms of, community based and non-medical and social model, so -- I would be curious to hear your thoughts on that.

>> JEN BURNETT: I thank you for that suggestion.

>> RALPH TRAINER: Kathy and Fred.

>> SPEAKER: I would --

>> SPEAKER: I would like to see a wheelchair durable

medical equipment a functional need rather than medical need.

Because, there is a functional need, to get to work and indoor chair is not going to get you to work very long. Right now, chairs are like disposable we have them for weeks and then we go try to get some other use chair because the crap that they are putting out, is just pathetic since they have been cut and there's more limitations on them federally. It has hit us right in the back. I've been here for 8 years and have no decent chair I have one decent chair he was evaluated for it keep and I had an ulcer and was in bed two weeks they would never assess me again at the main place where they assess because I would not take the chair back.

But I had not had an ulcer since I was a child, to me that was a trauma worrying about that skin thing I had not done that since adolescence I think there's needs to be a lot of functional needs stuff if you expect us to integrate and live, one thing the medical model has never been good at, is figuring out our functional needs. They only see us when we're sick.

They don't see us as super people like fast wheelchairs running through Washington trying to lobby, no matter how sick we are, we have a spirit in us.

That medical necessary has never captured that.

And if you really want this to be something to improve our lives, it's got to

be more functional assessments on everything.

>> JEN BURNETT: Thank you.

>> SPEAKER: One more thing about the durable medical equipment we need a better process, to take for -- what do I want to say -- um, an appeals process we need a much, much better appeals process for it.

Because there are a lot of times that someone says hey listen I need a chair that will let me do exactly what my peers do, my peers, work on cars I would like to have a chair that would stand me up so I could work on my own care too, that's not going to happen they're saying that's not medical okay. I'm not looking for anything like that

that's just an example or someone might need one because, they're in their house they have things that are up high or they're cooking they need to have a chair that will raise up, okay. So they can cook without burning their arm.

All right. Things like this.

We need an appeal process that will work in favor of people with what they need and what they feel they need to get along in the community as best as possible.

>> RALPH TRAINER: Okay. Thank you.

Lady behind Faddy. That's you in the blue.

>> AUDIENCE MEMBER: I'm Bridget Lowery I'm a provider

for services for people with
neurological disabilities.
I'm wondering -- on the list
of approved services, you list
home health PTOT and speech
and, I'm wondering if this is
different than providers who
have their licensure as a home
care provider since the
majority of the brain injury
rehab providers are licensed
through home care.

>> JEN BURNETT: That's
an over sight thank you for
pointing that out, home care
definitely needs to be on this
list.

>> AUDIENCE MEMBER:
Thank you.

>> RALPH TRAINER: Okay.
Thank you.

Faddy.

>> AUDIENCE MEMBER: This is a question rather than a comment.?

There are four segments that are indicated to be procurements in this concept paper. One talks about nursing home transition providers.

Doesn't explain what that is or how those will be identified. There's the FMS procurement that was just mentioned.

There's the independent enrollment broker.

And, then there's the VME or the home modification broker.

All of which, have tremendous impacts on how this will work.

From a process perspective, I don't expect an answer today, I would ask that

you can see how the flow of these four key aspects of making this work, is going to work.

>> RALPH TRAINER: Thank you.

Linda and then the lady behind Linda.

>> AUDIENCE MEMBER: I'm sitting here getting a little panicked. I'm remembering back when health choices was being implemented and, some of the problems, that were happening, was -- ridiculous.

Parents going to drug stores to get their child's prescription and they're told amoxycillin is not on the formulary it is the most common antibiotic ordered how cannot be on a formulary.
But, um, I really hope that if

once is implemented there has to be faster ways to fix the problems.

I heard at the last meeting DME provider say that the managed care company won't contract with them or if they contract with them, they don't use them.

And, when problems like that are going on, people need a way to voice it and get it worked on.

Health choices just went by months and months with people in trouble.

And, and I don't want to see that happen again here in managed care since we know what we went through with the health choices. So -- all I would say is, there has to be some fast remedy way to address problems, was people bring them to our attention.

Thank you

>> JEN BURNETT: Thank you.

>> RALPH TRAINER: I'm Diane Peggy with service coordination limited my question has to do with the 3 models of service you mentioned agency model participant directed model and a combination model under services my way we have a number of people that are using a combination model, who aren't on services my way.

Is that an over sight or that will be --

>> JEN BURNETT: Give us feedback on that I would think that, an individual, wants to use agency model on the weekend and consumer directed during the week, we're not changing that.

We would expect that could continue.

>> AUDIENCE MEMBER: Maybe on the same day. You know --

>> JEN BURNETT: Potentially on the same day and so, that's an over sight, the concept paper, um, let us know.

>> AUDIENCE MEMBER: There will be a straight combination model?

>> JEN BURNETT: Combination, services my way is not a combination model it's a budget authority.

>> AUDIENCE MEMBER: I understand that, but the combination model is only mentioned in conjunction with services my way.

>> JEN BURNETT: Okay. So -- yeah.

>> AUDIENCE MEMBER:

Thank you.

>> JEN BURNETT: That was an over sight.

>> RALPH TRAINER: Yes.

>> SPEAKER: The MCO, I want to find out why are they allowed to take for hours for to decrease our hours for the 25%. Is it 25% and/or before 25% they reduce our hours if so, that an hours they are decreased, what am I to do if I have say 10, 15, 20 hours you know, in my condition I cannot get water, medication, it's a lot of things I might need, if my hours are decreased.?

>> JEN BURNETT: Yeah the concept paper does say, once the threshold of 25% reduction is occurs then the State intervenes that's how we've

written it, if you think
that's too high of a threshold
and you think we should shrink
that, give us the feedback.

>> RALPH TRAINER: Fred.

>> SPEAKER: That is a
major concern because if they
-- they can drop everybody
they want to up to 24% without
even informing the State
they're doing it.

And no one -- there's no
recourse to get your hours
back, none I see nothing in
here, about any kind of a
recourse to get it back.
That goes into what I was
talking about, with your
appeals process.

Because -- they can -- if
they decided to after 160
days, if they decide listen
we're just going to drop
everybody, 24%, not have to
report it, that way we're

going to make a little bit
better profit or something
like that, it's just -- it's,
ridiculous, they shouldn't
even be able to do that.

>> JEN BURNETT: I give
giving us that feedback is
helpful I would tell you that
the managed care
organizations, have been in
their their best interest to
keep you healthy if dropping
your hours, is going to make
you unhealthy, like Richard is
talking about, or -- effect
your health or effect your
ability to participate in life
then that, they're -- we won't
you know I mean I don't think
a managed care organization
will do that, if it effects
your health you'll end up in
the hospital. And, that
costs them.

Remember they're under a

capitated payment and so --
they're going to want to do
everything they can, to wrap a
care plan around you, with
your support and your -- with
you in mind and you as part of
that planning process to
figure out, what is the best
level of service for you.

If they say, um I'm going
to drop you by 25% and you end
up in the emergency room, that
comes out of their pocket so
they have every reason, to
keep you healthy.

That's the whole model.

So -- um, I think, I hear
you you're worried about the
25%, please give us feedback
as to what threshold, we're
not going to but I will tell
you that if there's a pattern
like you talked about, there's
a managed care company that
does, 24% for a 50% of the

consumers -- of the population, we'll be looking at it, that -- we'll be monitoring it, we're monitoring those kinds of things and trends with the managed care organizations that's an area we would definitely be monitoring and working on.

>> RALPH TRAINER: Cassey and Jennifer we'll take two in the audience and we have to move on then.

>> SPEAKER: Managed care is an insurance company basically I mean -- managed care is an insurance company.

In Texas -- in Texas -- in Texas, the consumers actually, had this happen where one provider cut almost everybody.

And in that capitation, if that capitation is off at all, they're going to -- they're going to cut us I mean what else are they going to do, that's what managed care companies do, they deny people, all the time, things they really need and if you don't appeal, you're not going to get it.

I mean, it happens all the time, with the managed care companies even now.

Appeals are very important especially for disabled people we're denied basic basic things sometimes.

>> JEN BURNETT: You'll be pleased to know we have several former employees of the Texas who went through that process and they are part of our advisory group they're giving us advice on the kinds

of pitfalls we're looking at all of the States, one of the things Pennsylvania has to its advantage is there's so many states have gone to long term manage services and supports we're learning from them, we're in weekly or -- few times a week talking to other states to find out what are the pitfalls that's one we heard about and, we will be doing things to mitigate those kinds of challenges.

>> SPEAKER: I just think, I just think that people -- when CILs were doing it they were involved with people, they were in the hospital with people and they still didn't have the -- the leverage, to have that much control to cut or increase anyone.

So why I think the State needs to be more involved because, giving them 25% is almost looks like we're being private advertised until a crisis hits it's scary I do understand that some people may be taken advantage. That's should be looked at I'm not suggesting that if someone has some huge package that doesn't make any sense, that you don't look at that.

But, also I think you need to look at when they cut, did they really cut for the right reasons because, if they do it by diagnosis, they will get it totally wrong.

We will have different chronic health problems different issues.

They cannot do it by diagnosis, they have to do it by function to get it right.

>> JEN BURNETT: Thank you.

>> RALPH TRAINER: Yes.

>> SPEAKER: Um -- secretary Burnett the one of the things that impress medicine when I met with you and the secretary Dallas the commit for the person centered planning although, I was reading through the document for community health choices, and I must be honesty really think that it, in in ways is contradictory, to person centered planning and giving people with disabilities control, I think it takes our control away and in many cases and give them toe the managed care organizations.

One of the examples that was already brought up was a

-- 25% drop that they can do.

And another example that I have, is the supports coordination. It is up to the managed care organization whether or not they will be willing to share supports for services with the current providers.

And I'm not sure if you want me to we get to that coordination of benefits, I can definitely do that, but I have -- comments on that as well.

>> RALPH TRAINER: I would ask you to wait until then, please.

Two from the audience, the gentleman there -- in the yellow shirt.

>> AUDIENCE MEMBER: My name is Zachary Lewis I'm

representing disabled in
action Philadelphia I want to
comment reiterate on some --
of the the questions the board
members asked, Richard in
particular about the 25% cut,
I just -- the comment on that,
that's like a -- that could be
domino effect for some people,
that you know, they may not be
able to like I say give
themselves a drink of water or
turn themselves which ends up
leaving you know, skin issues
and ulcer issues which means
it's going to cost more money
to be in the hospital more
money to have people, nurses
come out or whether or not you
know they're in the hospital,
or at home.

To train someone to
figure out how you know, to
handle that information, but
I'm sorry, how to you know,

handle and deal with that person, so just like you guys said that you know, you will take that into advisement and you've done some things already to look at that, like what exactly have you done that could be a huge domino effect which leads someone back to it the nursing home or back into a nursing home, they have already been in there once before.

Which costs them more on the State but I'm here to help like, what are you guys going to do to deal with that

>> PAM MAMARELLA: If I could, so -- one of the business lines and service lines that I work with is the life program, which is a managed care product.

And integrates both everything that happens on the

Medicare side, which is any hospitalizations and also on the Medicare Medicaid side which is the long-term care services and supports.

And what the goal of the program both from a financial standpoint, from the insurance company, and, from you as the individual, are aligned in that model. That is to say that, in a model like this, it will cost an insurance company, so much more money, if they don't get the fundamentals right. Because you're right, it will lead to anennstitutionalization or it will lead to a hospitalization. So, pore the first time, you have to keep in mind, that the financial really incentives are also people's incentives and they're aligned. And so

if it's inherent and they will
attend to the this system,
which isn't to say there also
shouldn't be other
accountabilities and processes
put into it, but, remember,
alignment is what is going to
keep the MCOs also accountable
for the money for themselves
also.

>> AUDIENCE MEMBER: I
say that because, the -- the
reason why I say that is
because, if you guys are here
as far as the people, that
it's like you're giving up
your -- you're tossing out
dollars versus peoples lives
at stake, because like I said
it's a domino effect that
person ends up in a nursing
home, and he has been in a
couple I've been to a couple
also as an advocate and I've

seen some of the things that happen. Bed sores get worse, people are laying in urine like no one should have to be subjected to those things.

>> JEN BURNETT: We agree. Managed care, as Pam just described and I have mentioned earlier, the managed care organization, has a fundamental interest in keeping you healthy and keeping you as healthy as possible keeping out of the hospitals, keeping out of more costly --

>> AUDIENCE MEMBER: Also have a fundamental interest to cut cost and save dollars?

>> JEN BURNETT: They may -- that may be a -- that may be the case but they're under a capitation and under that if you're more expensive to them they don't get anymore money

from the State they have -- an interest, in deeping you healthy because when you get, unhealthy you end up in those more costly, sick saidings end up in the emergency department end up with the hospital, end up with ulcer that Cassie talked about, they have a tremendous incentive to keep you as healthy as you can be and support you, to live in independently.

>> AUDIENCE MEMBER: I don't want to -- I want to say also, so if someone is -- if managed care decides to cut, that 25%, what is in place for an appeal process.

>> JEN BURNETT: We'll have appeals process, as soon as initiate an appeal -- you can continue to get your service.

>> HEATHER HALLMAN: It's

not just about 25%, because if you get any services cut you still have an appeals process. It's just 25%, where we say, we will definitely review it. No matter.

So that's -- you always have that appeals process.

>> JEN BURNETT: Appeals process exists across the board doesn't matter if they cut you 1% if you're unhappy with something in your service delivery package then -- you have the right to appeal.

Once that appeal, is initiated, things -- the managed care organization will be responsible to maintain your status quo your original status quo and, while we go through the appeals process.

And, so -- the 25%, is just a threshold at which the State is going to say, whoah

this is not, there's something going on here.

We do see care plans that are extremely extremely high and, when we do take an investigation, into what is going on, um, with that particular provider, we end up cutting those services we do this now, today.

And if the case is that they have you know, 120 hours a week, in those situations, we're going to look at it we're going to say, wait a minute you've got 24/7 and maybe 24/7 is justified, depending upon your condition and your functional needs, um and that happens. So, it's -- you know, it is already occurring it's just that, we -- the State is doing it today.

>> AUDIENCE MEMBER: I want to say this and I'm done -- I just you know, hope that I can charge you guys with making sure that appeals process and/or other tools are out there, so that you know, whether that process is written on the wall so people can have the tools to make sure they're getting the best quality of care.

>> JEN BURNETT: Thank you very much I appreciate that.

>> RALPH TRAINER: Absolutely.

>> SPEAKER: Just want to augment one thing that -- that Pam said, not only the managed care organizations financially independent, to keep our members well and healthy, but -- just wanted to remind

everyone with this program,
everybody has a choice.

It is -- we also, um, as managed care organizations, are competing with each other, to provide the best services to people we serve.

And realize that you have the choice to go elsewhere if you feel that services are inadequate. So just wonder if we can talk too much about that choice wanted to remind everybody that choice will continue to exist.

>> SPEAKER: Yeah, I just want to point out, the -- I mean, totally agree that's why we're all here, we understand that we're trying to align the incentives, in the system, with the outcomes, for the consumer and for taxpayer and also for the over all

community and there's a lot of experience around the country with this model, you know, it is you know, no model aligns with the incentives perfectly and you know, there is a degree to which there's a -- as the speaker spoke to there is also an incentive to reduce service because that also, reduces costs which creates more profit within that capitation so, so along as the reduction doesn't lead to other costs, it's actually in the MCO's best natural interest to reduce the service. So, if it leads to discomfort and, you know, personal problems with the consumer but not necessarily, medical problems that result in other care setting you know, there might be an issue.

It's also true that, in

the real world, let's say if this distracted system or others like that person is getting provided care by a consumer who is also trying to string together hours to have be able to deal with their family budget and, if their hours are reduced for a consumer by 20%, then maybe that consumer doesn't work for them anymore they have to go find some other job, you know, that provides more consistent hours and therefore, the whole relationship between the consumer and the attendant, might be disrupted, so, I'm just, pointing to the fact that there is a degree to which this over sight of the system is being handed off to some degree to MCOs under the supervision and, with the over sight of the State.   But

little less directly in some
cases than a traditional model
and, so it is, really
important that those, systems
be put in place, to make sure
that the real life impact on
consumers and attendants and,
therefore, on consumers, are
you know, are accounted for
finding the right number which
it's 25% or 20% that triggers
automatic intervention be I
think those kinds of things --
you know, having an appeal
process that is efficient and
fair and you know, attune to
real life circumstances is
going to be very important.

>> RALPH TRAINER: Thank
you Neal. There's a person,
raising their hand in the back
-- please come up.

We'll get to you then --
I agree with you Neal I think

that appeals process, also, has to be timely.

I mean real quick.

Because people lives depend on the decisions. Thank you.

>> AUDIENCE MEMBER: I'm my name is Patty Wright with health partners plans I wanted to say you know as Blair and Ray have said, to offer some reassurance to the participants all the MCOs will have care plans, that because the DHS has really insisted that this is person centered, those care plans will be created with the participants and they will have the ability and the right to sign those care plans when they're being developed.

And the care plans will contain information, about the appeal process, and I think

you'll also have the MCOs commitment that those services, would not be reduced or changed until you went through the appeals process.

So it's not as if someone is going to move you, from 10 hours to 5 hours and then have you go through an appeals process.

So the hours will remain intact, while you go through the appeals process to enable either you or the physician to provide more information.

>> RALPH TRAINER: Okay. Can you stay there a second because I have -- I have a feeling Fred is going to grill you?

>> SPEAKER: Actually no, what I was going to say is -- the post way I can see to do this, if they want to cut you

down to 20% or whatever it might be -- they have to come to you, tell you listen we're going to cut you 20%. Do you agree with that? If you say no, then you immediately start the appeals process because if they just step in, and, drop you the 20% by the time you get around to even filing an appeal, which could be 2-3 days you've just lost 2-3 days worth of the attendant care you need.

So, I think, that they have to give an announcement and give at least one week for you to appeal before they start dropping it.

>> AUDIENCE MEMBER: Fred I think what is important is I think there's a commitment, that we would not change or drop or remove any services,

until an appeals process
decision is reached.

So, if you currently have
ten hours, and it may be that
the care plan, the functional
assessment that's being done
between your service
coordinator and the
participant that new
functional needs assessment
indicates that perhaps there's
8 hours, instead of 10, and
the member says I'm not going
to agree with this care plan,
I want my right to appeal.
The ten hours would remain all
the way through the process
until resolution. I think
that's a commitment that we
should have and I also think,
that as DHS again continues to
reinforce that this is person
centered, that -- as part of
the reporting and the thing
they're going to be looking at

for MCOs one of the things they're going to look at, as the MCO's will be looking at internally, we'll going look at our service coordinators. Number one, the State will receive information on the Commonwealth, number of appeals that each MCO has and internally each MCO there should be a commitment that we're continually looking at each service coordinator and, looking at his or her record of reducing services, within a care plan and, look for trends.

And if we begin to identify a trend way certain service coordinator that's a indication of reeducation is the service coordinator really using the functional assessment tool, does he or she truly understand it, do we

need more education, or is it that, that these reductions are appropriate and supported in the end by a fair hearing. So there should be things that are look add and monitored all along the way, not just waiting for an appeal.

And I think that's -- part of what the State, DHS and the Commonwealth will be looking for, from us, again, just to say, are you -- are you fudging trends are you seeing something, are you being aware and not just waiting and waiting for a 25%.

>> RALPH TRAINER: Thank you very much. Thank you.

One more in the back and then Linda.

>> AUDIENCE MEMBER: I'm going now.

[laughter]

>> AUDIENCE MEMBER:
Okay.

I -- I am just at a loss here.

MCOs will cut hours. Does that mean that if I'm getting 10 hours and my MCO says I can live with 8, does that mean I've been committing fraud or something I was assessed and state said I needed 10.

And, an insurance company, is saying I need 8.

Well, does that mean the other 2 hours you guys were giving me shouldn't have been given to me and here's what I really came up here to say -- some people cannot survive another emergency room visit.

They will go in the hospital, some will die and I

-- I not willing to let consumers, go that long and if they start cutting hours say they say we're going to take five hours some of the consumers they won't speak up about that.

They will just take it.

And, eventually get sick and then I guess we find out that they, have been cut.

But, I -- any hours you cut, is someone getting ten hours a week you all know that's very very little.

In terms of, getting yourself ready and going for the day and maybe even having a job but you can't -- cutting hours to me, I don't understand.

>> JEN BURNETT: We do it today, I'll just say, that we do it today providers do cut

hours on occasion. We do go through appeals processes those things are not changing.

I will tell you, that -- I believe very strongly that managed care organizations, have -- in their best interest I think you've heard from a few managed care organizations to do what is right for you.

Person centered planning is a big part of this, so if -- you sit down with your service coordinator and service coordinator talks about well, you know, you have ten hours but -- and ten hours is a small care plan, you're right.

But -- um, do you really need, two hours, to whatever it is you're doing for the two hours can't you do that in one hour.

That is the kind of cut

that is happening today,
happens with our providers
today.

It does.

And --

>> AUDIENCE MEMBER: I go
-- but up to 24-25%. I mean,
allowing them that leeway is
way too big. Way too big.

>> JEN BURNETT: Give us
that feedback we've heard a
lot here today if you have a
better -- that's what I'm
asking I asked Cassie in the
beginning if you -- if you
have a better idea of a better
threshold, is it 10%, 5%, give
us that feedback.

So we're really looking
for it, I will tell you that
-- to some extent, we do have
individuals that as Cassie's
mentioned there's not -- that
they do have an attendant
that's not really doing

anything, during a period of time.

That's -- those kinds of things are happening. And that's the kind of conversation, that the service coordinator and the consumer has during the person centered planning process.

>> AUDIENCE MEMBER: I'm not worried about the consumers that can speak up like me Cassie Pam or me, or Zach, I'm worried about the consumer that doesn't do that, doesn't speak up for themselves. If you don't make it clear to them, if any of your hours are cut you can appeal, immediately.

So that your hours stay.

But not everybody is going to know that or do that.

Because -- you know, the

whole process. They --
they're a little intimidated
by it all. So, they're not
going to bring it up.

That's the kind of people
that I am worried about, not
being informed, of what their
rights are under the system.

>> JEN BURNETT: Okay.
Thank you.

>> RALPH TRAINER: Thank
you. Lady behind -- Cassie.

>> SPEAKER: In tight
times the money is tight,
consumers get treated like
crap.

All around.

I mean, yeah there might
be cuts now but some of them
may not be for the right
reasons if you talk about
integration, you have to look
at some of going out, during
the day, someone participating

for me, I used to be fine participating without attendant care.

But I try to do it now, and you know, even trying to pack my bag everything takes longer like I always think I'll have breakfast before this meeting I barely, I got a Smoothie that's progress from the last meeting I don't function like I used to. And that functional need thing is something really disabled people came with I believe.

You know, discussions with CMS, if I remember the early days of talking about functional need.

And, I'm just hoping that there can also be an education level, about functional need, it's not just medical I mean, unfortunately a lot of you guys see us at our worst and

sickest. But you don't see
us trying to live our life and
even that is a struggle.

Without the right
assistance so I mean I do take
the cuts very seriously.

But I also take the
stories that I hear from you,
Jennifer about someone having
the huge package that I've
never heard of or seen in
Philadelphia no one has ever
had that kind of package in
Philly that I know of. You
know. Everybody is in the
aging organization, it just
doesn't happen.

Especially, sometimes we
don't even ask for the hours
we need, that's a learning
curve, especially as your
disability is getting worse.

And with age, disability
progresses.

And, this is for a lot of

people, I'm not even in this program, I don't know why Act 150 is around.   I want to say one thing I have not said it it's not -- there's no room for me to say it.

But why isn't the ED in here, why isn't act 150 in here if you put the most vulnerable and physically disabled in here why can't you put those loud parents, who have the parents March in and make a difference.

In the holes of the capitol, because we March in the halls of capitol what I hear from some people we should wear suits able bodied people to do it they like talking to them more.

Sometimes that is very true in that capitol it all depends who is sitting in those room U.S. know.

Sometimes, the very open to
us, and sometimes it's hell to
go through it, it makes sick
so few people carry think it
has to be mentioned we're in a
tight time.   There's a budget
battle going on and this can
only work if the rates are
right and the capitated rates
this is the first time I
really, really hate myself for
not liking that more I really
-- I am -- reading everything
I can about -- rates so I can
actually at them have some
analytic call view I've never
saw a population more
dependent upon the damn rates
of everybody from the service
coordinators to the IL
agencies, to big cap Tated
rate that the managed care
companies get.

It scares the hell out of
me, because we're in tough

times and that is one reason why I think, you know, I really am afraid for this population, and I'm 60 it's as long as I'm alive I'm going to be to be watching what happens here because I mean, it could be the greatest opportunity in the right time, but I hope it's going to be with the greatest innovations in mind, even in these tough times.

>> PAM MAMARELLA: Mr. Chairman I want to mention we still need to get through provider network continuity of care and quality assurance for participants so I'm not sure if at this point, perhaps we move on and then -- um, --

>> RALPH TRAINER: Let me take that one lady in the back before she jumps over me. And then we'll definitely have

to move on because we are very limited.

>> AUDIENCE MEMBER: Hi, I'm Pam Walls again from the community legal services currently because of the aggregate cost gap people can get served in the community even if the care is more expensive than a nursing facility we've been been talking about it being a protection that managed care organizations are going to want to serve people in the least expensive setting which will generally be the home, what protections will there be for more serving at home or more importantly being currently served at home?

>> JEN BURNETT: I -- I would, recommend that you give us, give us some thoughts in

what kind of, protections and when you talk about protections we should be, um, engaging in, we are talking about our at least the concept paper, articulates continuity of care provisions in there.

And then, um, I mean, we certainly are not going to be looking at -- that's parts of our rate setting process, Cassie talked about how important rates are and -- Diane mentioned, Tiered we're going to have to really look at how you know take a look at what that -- what the volume of that is, and -- um, figure it out.

So --

>> AUDIENCE MEMBER: Can you have rates that are set specific to?

>> JEN BURNETT: We'll have --

>> AUDIENCE MEMBER:
Individual's needs.

>> JEN BURNETT: That's
what Diane was mentioning
about, rate tiers right.

>> AUDIENCE MEMBER: It
would have to be you know,
very specific to the level of
to each individual.

>> JEN BURNETT:
Functional need, yeah.

Yeah.

>> PAM MAMARELLA: Okay.
So we can take one more
comment from Tanya we'll move
on.

>> SPEAKER: Um, I have
what I believe might be a
common sense suggestion about
this 25% deal thing.

And A, can we layout
something that would tell
consumers like when you would
be in danger of possibly
getting your hours cut, so

they would know like what criteria they had to follow and what criteria they didn't. B, in terms of people needing hours and stuff, something that I tried with my CIL last year, is we had a thing set up, for me, where like, okay, I had a minimum level of hours that I used every week and a maximum hours that I was allowed to use when I had like public functions or, doctor's appointments or something like that.

We, I think, in every consumers plan, there had to be a minimum amount of hours, and a maximum amount of hours set up you can do, some sort of budgeting to manage your own life.

But then, if something like -- medical comes into it, where -- it's going to be more

of a permanent thing, that you need like more hours per week, that has to be able to get through the system faster, but what the other way does is it gives you, it gives the consumer more responsibility to lead their own lives, it gives them a budget to work with.

And it gives them some freedom that they can make different choices that they want to make. Now, like a big commitment like this, with the subcommittee, that I'm going to be working on for the next 3 years -- four hour a week -- increase doesn't even cover halfway from Edinboro to Harrisburg, so in that case it doesn't work.

For like my normal like, community functions like to go participate in an event that

the senator or someone invite
medicine to, yeah.   That
works for me to be able to get
to Erie and back in that week
to do that and then through,
like -- different weeks
throughout the year, if you
don't use all of those hours
in that if you need to pull
them from the next week you
should be able to call your
service coordinator and say,
okay, you know, I'm using them
here I'm using them for this.

And I mean, we -- we did
that.

We did that all year it
worked out beautifully.

And, I think, if more
people, were given that sort
of option, to be able to do
that, then you would not
necessarily have to worry
about all these like, 25% cuts
and everything.

But here's -- here's part of the problem that I see with this system.

You don't have enough -- people -- people are going to throw things at me, I'm just going to say it, you don't have enough consumers that are willing to engage in the system like the people in this room. So many people they get health issues or get something they go through they just say oh, God that's the end of my life. But I think if we really want to change that perception we have to open, we have to open that up because -- the funny thing about what happened to me at the end of last year, at the end of the fiscal year last year I -- had a foot injury, I was able to manage that injury through like, I don't know,

the last two months of the fiscal year before I had to ask the State for an increase to imagine in the next fiscal year the only reason I had to ask for an increase then is because the hours, that I still had banked from the previous one, didn't carry over.

See, so like -- yeah. Consumers have to be smarter but the State has to be smarter with how it does its budgeting.

>> PAM MAMARELLA: Thank you we're going to need -- thank you. We're going to need to move on and the next topic I believe is quality assurance.

We partnered with comprehensive services, rather than did read through it, everyone can see it -- and for

the sake of time, why don't we
open this up to questions.
And discussions.

Diane.

>> AUDIENCE MEMBER: I'm
going to go to the appeals
that's part of this section
actually I wanted to mention
that -- yeah I'm on two
appeals committees for the
life -- two different life
programs and, we are
independent, members of that
appeals committee.

And I think, that the --
what we need to do is spell
out what the appeals process
looks like and who does -- who
hears those appeals.

I think you know as Pam
very well articulated, managed
care organizations have an
incentive to give as many
services as possible to keep

someone in the community.
However, you know being on the appeals committee I know that sometimes, um, we hear appeals where services are cut, services are denied. And they can help the person stay in their hone home. So they need a good independent appeals process. To -- look at that.

It could be more -- it's more than just cutting hours by the way. It could be denying equipment it could be many other facets of the care plan.

The other thing I wanted to mention is that, this is something we did not read in the concept paper in any -- I don't think it's in it at all. Is that people people need an advocate, Linda talked about those people because certainly

there's people here in this
room who are very good
advocates for themselves.

People who have very good
family advocates and then
there are people who don't
have anyone they don't know
what their rights are. And
they cannot speak they don't
speak up for themselves or
they cannot speak up for them.
We very strongly recommend,
there be an effective
independent, I mean an
independent um buds man
program, not an um buds man,
that has ties to a service
provider that -- is going to
be critical for many of those
people who don't have a voice
here. Who are not able to
pick up the phone, don't know
where to call. They need
someplace to access that
advocate. I should be right

at the time of enrollment they learn about that person.

>> PAM MAMARELLA: Thank you Diana. Thank you. Fred?

>> SPEAKER: Diane by the way, my job title at my Center of Independent Living is I am a disabilities advocacy coordinator. I am the advocate in a lot of places a lot of the centers for independent living that's what they do is advocate --

>> AUDIENCE MEMBER: I will however, just mention that -- CILs also provide -- coordinate services and so that I'm no the taking away from your -- I'm sure you're wonderful advocate I'm sure many of them are, I do -- want to stress that we need to make sure and we have also,

ombudsmen programs AAA area agencies on aging many of them are very good advocates I'm not -- I'm not saying they're not. But they are not independent.

And I want to make that distinction of what independent means.

It means that you're not tied to a service provider in any way.

Thank you.

>> SPEAKER: I do have one other thing we skipped this over really badly.

On 2.5 the provider networks -- and this is one of the major things I wish to discuss in here.

CHC will mirror those of existing health choice programs for -- this is what kills me, hospitals, specialty clinics trauma centers

facilities for high risk
neonate, specialist,
pharmacies emergency
transport, rehab nursing or
the dentist, there's one --
home care provider.

Home health provider,
certified hospice, durable
medical -- this is -- is as
medical as you can possibly
get.

One of the things we
don't want is medical model of
anything.

This is not medical we're
not in the hospital we're in a
home and community based
service. Not a medical type
service.

Okay. That's -- this is
just, it can't mirror medical.

It just can't do it.

>> PAM MAMARELLA: Can
you tell us what page you're

on?

>> SPEAKER: 2.5 on page 15.

Provider networks.

>> PAM MAMARELLA: Thank you.

>> SPEAKER: That's a really important fact to realize there's a medical model charity model and a social model there's a number of model those include the independent living model I know originally I asked the question, when it came to home and community based services, what that would look like. Living independently in the community or independently independent model good point. Yes.

>> SPEAKER: Yeah.

>> JEN BURNETT: I just -- the -- the sentence that you didn't mention at the end of that is, for covered long term services and support services which are -- in the appendix in the back, including nursing facilities services community health choices must demonstrate to allow choice of providers accessible to them have expertise in LTSS so what you just read, medical side that -- the community health choices will -- be covering, health care.

That is going to be part of this, this is a broad array, that connects health care and the social model that you're talking about. So -- if you go to -- um, in terms of provider networks, appendix A is the long term services

and supports that we have listed but, we welcome comments for what additional long term services supports so there's a -- the CHC benefit package will include that's on page 35.

So -- if you see things that are not there, that are in your idea and the realm of how many and community based services let us know.

If it's missing.

>> PAM MAMARELLA: Mr. Chairman I need to be excused -- thank you.

>> RALPH TRAINER: Two more questions we'll take Pam first and then you.

>> AUDIENCE MEMBER: Just wanted to say based upon what Fred said that, we understand there's medical side and

there's MLTSS we just want
assurances that, the medical
philosophy doesn't bleed into
the non-home and community
based services of it, what are
the assurances what are --
consumers going to have to
protect themselves, to make
sure that they're, um, MCO is
not looking at them as -- a
diagnosis and not, a person
with a disability.

Is that --

>> SPEAKER: Basically
yeah.

>> RALPH TRAINER: Before
I get to you I have win member
over here.

>> SPEAKER: Yes.   Thank
you -- sorry.   Real quickly,
um, as we look at the list of
-- of -- performance measures
here looking to see is there a
-- you know, we'll make some

recommendations obviously in
our complements to your point,
Jennand others you want to
hear from us, what you think
it has to be I think the
Commonwealth has a list
performance measuring you're
considering, financial
incentives there's some hints
in the document they're not
clearly laid out to the extent
that, um you know, we can
start to put some meat on
those bones, heading into next
time I think that will be very
helpful, um, for everyone who
is going to be covered under
the community health choices,
um, but -- then in particular,
for a group who we have not
had much conversation about,
here today that's our seniors
with multiple occurring health
care needs whose challenges
and needs are much different.

Who are -- in chronic need of pretty high level care in some ways, some way, shape and form we try to care for them in the least restrictive and most community based setting possible, but for some of them, they're at a point where it's not possible.

Given everything that they have got going on around them and we want to make sure those are conversations that we have, on this task force. And there are comments we look at as well as we move through the process.

>> RALPH TRAINER: Okay. Surely they will thank you. Yes.

>> SPEAKER: I have a comment on quality measures but -- um, we did skip over in the continuity of care one

point that is in the concept
paper, um, I wonder about
thinking about the six months
in terms of, the 180 days in
terms of, whether that will
allow sufficient time for MCOs
to transition existing care
plans and to negotiate new
person centered plans, with
clients and providers and, in
New Jersey's MLTSS transition
I believe they allow two years
for that process.   So I would
just wonder you now, is that
-- is six months enough.

I think we need to
lengthen that.

>> JEN BURNETT: Thank
you for that comment.

>> SPEAKER: On the
quality for, people who have
brain injury, there's already,
some very well established and
existing quality standard
that's are mapped out and

abided by the Commission on
accreditation of rehab
facilities for brain injury
and, I'm hoping that, when we
get more meat on this, that --
um you know, you'll consider
doing those standards, for
outcome measurements there's
already outcome measures that
are being collected, for
people who have brain injury,
um, and, that allow
benchmarking of providers
against the entire group.
Which is a core standard
requirement. There's also
the national institute of
health, patient reported
outcomes measurement
information system. It's
called promise.

I'm wondering if you
could also consider looking at
that.

>> JEN BURNETT: Sure.

Any ideas for quality
measurement systems, that you
are aware of, that you want to
point us to, please do so,
right now we are, certainly
looking at the NCQA work but
in the home and community
based world there are just not
any real -- there are not
enough standards that are
nationally recognized that are
you know, for us to really be
using.

So, yes and there is also
quality measurement
significant quality
measurement that's done in
nursing that silt that we're
going to be taking a look at
as well thank you.

>> RALPH TRAINER:
Jennifer and then Cassie.

>> SPEAKER: I'm looking
at quality measurements --

>> RALPH TRAINER: Put

your microphone on.

>> SPEAKER: I'm looking at the quality measurements I understand they came from nothing but they put all the populations in and a lot of times they have it looks like 18 million in payments for quality based adjustments for the first four submissions -- um, this was about -- I think, that's not properly stated I think the idea is, to pad people at least enough, that they have leeway when people's needs deteriorate they can increase the hours or move them around, you know, we used to put them in risk pools and I see the need for risk pools in this but they're setting the rates all over the place here I understand that some people may choose a nursing home but, to me I would rather

be dead than go in a nursing home and I have liver disease. So -- I mean, I'm just saying personally there's a lot of people I know who peel the same way.

With disabilities who have chronic issues that, they might have to face that decision one day.

Um -- and, I think, there needs to be something to keep us in our home, if we want to stay there.

We're not asking for a big package deal or anything.

Or not even anymore hours the right to die with your family and loved ones and the right to live.

And, integrate I'm really concerned with the whole word integration is not against you guys, but you guys are used to working with hospitals and

sick people, and times of
crisis.

You know, you've done a
great job on the special needs
end from where you started.

Because I was very there
when you start I I was at the
table with the MCOs in
Philadelphia there were a lot
of people dying of bowel
obstruction they would say
it's related to the disability
in the nursing home it had
nothing to to do with the
disability, it had to do not
with cleaning them out
improperly, a lot of things
can go haywire I've seen and
experienced the word
integration I'm hearing from
the people who want to live
they don't have chronic
problems I talk like old lady
I don't mean to, but when I
was young I wanted to get out

in the world, I had
spina Bifida I had a lot of
obstacles to face if I had not
gotten attendant carry don't
think I would be the person
that I became to be sure, how
can we apply that risk pool to
the integration, pad it so
people can have a life because
-- you know, it's everything
that is so medically necessary
to the point to the endth
degree that integration will
get lost trust me they always
have.

I have spina bifada, go
to their world, rehab doctors
every day all they talk about
is being sick I'm forced into
that because of my liver
disease but not my
spina bifada my whole life is
-- I fight every member to
integrate not to have a
patient I've gotten up on my

feet to despite how sick I
feel some days, because
integration is the key to
happy -- well rounded life.

>> JEN BURNETT: We agree
thank you.

>> RALPH TRAINER:
Jennifer.

>> SPEAKER: I actually I
have two comments.

As as far as the quality
assurance, are you guys
familiar with Jim Conroy from
the centers for

>> JEN BURNETT: Yes.

>> SPEAKER: Out comes
analysis?

He -- does an incredible
work as far as creating
measurements and with
community outcomes.

He does good work with
that I would also like to go

back to -- coordination of benefits because, we did skip that.

And -- that is, very important to me.

I really do think that it needs to be up to the consumer as far as the person's plan if they decide to use the provider as long as the provider is contracted with the MCO I believe that it should be the participant's choice, to use the current support person, that they're with or to go with the MCOs supports coordinator and here's where I have been in the last year and a half, I've lost my job because of my health, has deteriorated like Kathy said with her spina bifida I had CP all my life it never stopped me I was involved in in my community I

wasn't in pain, I -- in the past year and a half, my left hip is dislocated they can't do anything.

They can't do anything about it, my back, there's problems with my back.

That we just found out that there's problems with me hands and, now, my hands aren't working either.

But I will do anything I can to stay out of the hospital.

And I know that that's, um, that's the same for a lot of other participants they will do whatever they have to, to stay out of the hospital, they will go to the hospital fighting and screaming they will get up in there I get up every day and in excruciating pain and other than the people closest to me, people don't

know that.

And one of the people that are the closest to me and have really helped me through all of this, is my supports coordinator.

And, she is very familiar as to what is going on and, has fought tore me, in several situations.

when all this stuff was going on with PPL and forgive my words when I said that, but -- when all of it was going on with PPL, a lot of us turned to our supports coordinators, and even though, it wasn't billable hours for them, they helped us because, they care about us. We built up a relationship with them, and those that don't have good supports coordinators, we have always been encouraged to switch but, just the -- the

idea of getting how do we start with a new supports coordinator for an MCO that's -- doesn't know me that's going to know me as a number, going to try to save money by end to end keep me out of the hospital, while I should have been in the hospital, several times, my doctors are fighting with me constantly, to get morphine pump and, so that I don't have to deal with pain.

But I'm doing everything I can to keep myself out of the hospital, so that's -- what they're looking at, um, I am afraid my services, are going to get cut.

Whereas, my supports coordinator, is going to go to bat for me, as she always has, since I have had her she is going to go to bat for me with the MCO and tell them how

important it is, for me to have this services that I need.

So -- I consider us like a team. And, she has been very important to the success of my continuing my every day life. And I know that's -- true for a lot of consumers.

>> RALPH TRAINER: I agree with you Jennifer, my supports coordinator and in my life is too, very important person. Thank you.

Okay.

>> SPEAKER: If I could say something really quick. Something I recognize in the population, a lot of people do not want to go to the hospital, people with disabilities. And where I do understand, there's other populations that do consumer

wide services that's an
important distinction to be
made.

>> RALPH TRAINER: Few
more questions from the
audience. And we have Fred
first and then -- a gentleman
with his hand up.

>> SPEAKER: By the way
I've had a lot of people to
say, we transfer and we get
the new MCOs now I'm going to
change out and get someone new
for this and get a new sports
coordinator and this I'm not
going to know anyone.

That is a a huge concern
is there any way we can make
it to where, somehow can be
able to keep the same people?

Or is it going to switch
to whoever, whatever whenever.

>> JEN BURNETT: We're
encouraging all kinds of

problems from home health to
home care to support
coordinator organizations, to
reach out and start working
managed care organization it's
not going to -- I mean,
managed care organizations
will have the responsibility
for supports coordination but
that's not to say we're not
imposing what that model look
like. So they could,
essentially, contract, with
the support coordination
entity if they wanted to. So
we would really encourage
those sports coordination
entity and community based
organizations around the State
who want to participate in
this, to start getting to know
and building your
relationships with your
managed care organization,
with the managed care

organizations in your area so
we're really encouraging that.

There's some really good
information for community
based organizations how to
make this transition, on the
foundation web site that
really talks about business
Acumen and what, what kind of
things you should be thinking
about for the future in terms
of -- um, working with the
managed care organization,
being able to contract with
the managed care organization.
So -- if you have not looked
at that, that's an area for
any of the individuals that
want to participate going
forward, which we certainly
hope they do, because we got a
lot of expertise out there,
across Pennsylvania, with our
provider community.

To -- um, to get to know,

to build those relationships.

>> RALPH TRAINER: Jennifer.

>> SPEAKER: I have a question, Mr. Chairman, as far as is -- is the fact that, um, the supports coordination piece, and the decision to contract with providers is that a definite? For the decision, um, to be, up to the managed care organizations.

And then, I have a follow-up question --

>> JEN BURNETT: If you have an idea how we should do it, please provide us with that input.

>> SPEAKER: Okay. And -- my other question is it's just really a comment I mean no disrespect, I'm just trying to learn.

If the MCO's are the ones

trying to get the -- the current RFP, why are the providers supposed to be doing all of the work to connect to the MCOs

>> JEN BURNETT: Happening both ways talking with managed care organizations around the same thing I'm sure managed care organizations want to participate in this -- are already reaching out to providers I know it.

>> SPEAKER: Okay. Thank you.

>> SPEAKER: This is Zachary Lewis from disabled in action again I have another question, since the day -- since the State has already submitted the concept paper those CMS will they resubmit

the concept papers to CMS -- with any changes based off the comments and feedback from the consumers providers and out reach? Which is due on October 16th. And if not, why?

>> JEN BURNETT: The concept papers is just the beginning of our process, it's not an application. So -- we have a lot more work to do, with CMS and certainly that's part of -- that's part of why we're doing what we're doing here is to get input on what we've -- we have issued here so we can zero in on a more fully baked product that we would go to CMS and in terms of asking for an authority we have not done that yet we just submitted a concept paper and told CMS this is what we want

to do, this is just the first step and now we're out doing public meetings trying to get feedback on what this looks like, so we can -- zero on in exactly what we want to apply for, with the CMS.

There's something in here, that I want to bring to people's attention to -- which, has a funny name I really consider it to be innovation -- it's a very small section, it used to be much bigger but it got smaller through the process.

Called comprehensive services, it's on page 19.

This is where I really am seeking comment on, um, opportunities for innovation in our system.

Um, we were really looking at the whole question of affordable and accessible

housing and, ideas around how do we expand the affordability and accessible housing we believe housing is a social determinant of health, good housing, matters and so, we are looking for comment on that.

We want to -- expand access to community based and integrated employment how can, the -- the managed care organizations what can the managed care organizations do, to make connections with the employment, resources, um, currently we do have employment services, in our waivers, they are highly, highly under utilized. And, we would like to really want to beef that up I will tell you that, expanding employment I can't remember the exact wording Heather maybe you know

it, is -- the whole idea of improving and expanding employment is one of 3 performance measures we report to the governor DHS reports to the governor, on a quarterly basis.   Is that what it

>> HEATHER HALLMAN: Increasing opportunities.

>> JEN BURNETT: Increasing opportunities for employment I believe the employment of people with disabilities is one of them the third one is an -- development of skilled long term services and work force. We're really interested in innovation of that.   The fourth expanding technology supporting long term services and supports if we're going to move into the 21st century we really need to pay a a lot more attention to technology

that doesn't just involve
information technology but
that involves -- like things
like -- interoperable health
information technology but it
also involves durable medical
equipment all the technology
that can help people remain
independent.   So those areas
are for four areas we thought
of that -- that we could get
ask for comment on innovation,
but if you have other
requestedsplease submit them
that's not a closed list.

>> RALPH TRAINER:
Cassie.

>> SPEAKER: One of the
things I was -- if you could
give this to the people who
would, hire people with
disabilities, especially into
the intake and FMS old times
that's how a lot of us got

into the work force she did it in the CSPT waiver.

>> JEN BURNETT: Suggesting in --

>> SPEAKER: Procurement there should be incentives to people who give jobs to people with disabilities and decision-making too that's at least a percentage.?

We're all those funky jobs so easy to get, also some of the barriers have to go away like in Kansas they said you could make up to $50,000, and still keep Medicaid.

That made a world of difference. It also makes a big difference um, there has to be, some thing in the two year period where you can't get Medicare.

Luckily, you know my husband was able to go work so we could get insurance. All

that work did was pay for our insurance for a family he also is older gentleman, with some issues I mean it's reality I like kind of a sad thing you have to force them out to a day-to-day job when he is a musician, there's so many things he does creatively he doesn't get to do.

Not every family can do that I was out on a ledge if I didn't have someone love me enough to do that.

I don't know what I -- I would be dead quite frankly I have autoimmune liver disease I would not be able to get my drugs.

I'm in a house under water I have a 15 year old I have to make her think life is wrong just like every day. And there's so many things that don't get taken, into

consideration.

And -- that is going to ruin employment, a lot of people have chosen, very smart disabled people, not to work, because of barriers the

>> JEN BURNETT: I agree. That's something we're looking at today, and -- um, another very under utilized program and on medical assistance for workers with disabilities.
So -- those are areas that we want to be, really taking a look at dusting off making -- more available, making more information available, et cetera we are just about out of time, Neal do you have?

>> SPEAKER: Before we break up, I just wanted to -- take a moment, um, you know, and really recognize the process we're in just because I know, you all, have been

doing a lot of meetings and a
lot of public interactions
we're very good picking out
all the problems but -- um,
you know, we're -- this is a
really exciting process, I
think we when you think about
the public -- the round of
public meetings the department
did, this process, you know,
already had two meetings and
just, fundamentally the
concept paper with all of the
need for more detail, I think
is a really -- pretty amazing
road map for much informed
long term system particularly,
points that you addressed at
the end the opportunities to
-- really innovate and drive
change. Because -- if we
just, change the way the thing
is organized, um, without,
fundamentally, you know,
transforming the -- the nature

of the system to really get to
the outcomes we want,
obviously, we won't get there
quick enough so I wanted to
recognize the department and
this whole process.

>> JEN BURNETT: Thank
you.

Thank you.

>> RALPH TRAINER: If I
may -- let me wrap up with the
two questions there in the
back -- the lady first the.

>> AUDIENCE MEMBER:
Thank you.

I was about to burst I
have a couple -- a couple of
things -- um, it's -- it's --
I'm getting a lot of anxiety,
listening to this -- and,
listening to all of the
questions thinking about all
the things that are not
flushed out on paper at this

time.

I really worry about not requiring a shared service coordination model and not requiring the -- the existing service coordinators, see this process through for a period of time.

Worry about -- um all the things that we don't know about.

You know, that we are going to come up and that are going to come up, in one month, our opportunity will be -- will end, and -- the RFP will be developed and I think about something that Fred said at the last meeting, um, that -- we are allowed to see a draft of the RFP, before it actually goes live. Because I -- I really think that would be a very valuable thing, to make sure that people's needs

are being met.   This is too important of a process --

>> JEN BURNETT: Can I just interrupt you because we really are out of time -- I have another -- engagement.?

Um -- I want to make a comment on what you said that -- in a month your opportunities are over, it is not over.

You need to work on -- developing relationships with managed care organizations, they are going to depend on our fantastic network of nursing facilities or a fan or the network of home and community service providers we have infrastructure in Pennsylvanias that these managed care organization railroads going to have to tap into, I would argue that your opportunity is just beginning.

And -- in terms of what you don't like, in the concept paper, I -- I urge you to give us feedback on those things, to provide us with more detail, the detail you want to see.

>> AUDIENCE MEMBER: But I have you know I sent pages long letter back in June or July -- after the public meetings, you know --

>> JEN BURNETT: Reinforce those.

>> AUDIENCE MEMBER: I'm frustrated there's not more meat, on this -- and you know worried about -- you know the things that you're still looking for input on, I just wish we had another opportunity, another round of this.

Because I feel like we need it.

Just to make sure that we just need --

>> JEN BURNETT: This is -- this is a this meeting committee did vote to not have the RFP?

>> RALPH TRAINER: Can we have quiet please. We are not going to be doing that.

This is your opportunity to -- um -- please, provide us with as much detail as feel you need.

>> AUDIENCE MEMBER: Thank you.

>> RALPH TRAINER: Zach?

>> JEN BURNETT: We have to break up I have to get going.

>> RALPH TRAINER: Zach you're up.

Okay.

>> AUDIENCE MEMBER:

Okay. I'll take it.

You made a comment you said something about good housing you said it was -- important.

>> JEN BURNETT: Yes.

>> AUDIENCE MEMBER: What exactly do you mean by that I've done a lot of advocacy work and in Philadelphia especially as far as, housing and I did there's a big need for you it you would be surprised how many people, will take any type of housing as possible so they don't have to be homeless on the streets on shelters especially people with disabilities they will take whatever possible so -- what do you mean by good versus like I'll take any opportunity possible so I don't have to be out in the

streets?

>> JEN BURNETT: We would like for your comments on that, any kind of innovative ideas that you have around -- the issue of affordable accessible housing is welcome, so -- whatever you -- however you want to -- whatever you want to tell us --

>> AUDIENCE MEMBER: I'll give you comments by what do you mean by good housing.

>> JEN BURNETT: I mean that's a real person centered question it's -- really up to the individual.

>> SPEAKER: Affordable safe integrated housing --

>> RALPH TRAINER: Yeah. I would like to thank everyone.

Again take a look at the web site and submit your

comments. Thank you very much.
The next meeting date is
October 6th and it's on --

>> JEN BURNETT: Across the street at the Rachel Carson building -- across the street.

[meeting concluded at 1:12 P.M.]