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>> RALPH: May I have your attention, please? We are going to start in about two minutes.

Thank you.

We are going to do introduction of the committee. I will start with Barb.

>> BARB: Barb, liberty community connections.

>> Darryl Andress, with Bayada home healthcare.

>> Blare, united healthcare.

>> Jack Cain.

>> Stu Wesbury, representing Pennsylvania council on aging.

>> Cassie Holdsworth, consumer.

>> Pam Mamarella, representing New Courtland Senior Services.

>> Jenn Burnett, Ex-Officio Chair, Deputy Secretary,Office of Longer-Term Living.

>> Ralph Trainer, Chair.

>> Fred Hess, consumer; and I represent Disability Options Network, Center for Independent Living.

>> Steve Williamson, from Blair Senior Services.

>> Jennifer Howell, consumer.

>> Terry Brennan for --

>> Good morning. Drew Nagele, representing the Brain Injury

Association of Pennsylvania.

>> Theo Braddy, consumer.

>> Ray Prushnok, UPMC health plan.

>> Arsen Ustayev, representing Sarah Care, home healthcare.

>> Richard Duckson, consumer.

>> RALPH: Thank you. I want to go over a few housekeeping committee rules.

>> Do you want introductions from folks on the phone as well?

>> RALPH: I'm sorry. Go ahead, please.

>> Brenda Dare, from TRIPIL, consumer.

>> Estella Hyde, AARP.

>> RALPH: Anybody else?

>> JENN: Is Tanya on?

[NO RESPONSE]

Any other members?

[NO RESPONSE]

>> RALPH: Okay. I would ask everyone to turn off your cell phones, please. If you leave the room and you have bottles or cups, please throw them in the trash. Try to clean up around yourselves. We were told we were a little bit unkempt last meeting.

The public comments, we really hope to get some. We are going to try to do that near the end of today's session, around 12:30. I will hopefully keep everyone on schedule.

Emergency evacuation procedures.

>> JENN: I have none. Let me find --

>> RALPH: Follow Jenn.

[LAUGHTER]

>> JENN: Okay. In the event of an emergency or evacuation, we will proceed to the assembly area to the left of the Zion church, outside and on the left.

It's on the corner of 4th and Market. When you get out of the building, it's sort of on the right here on the corner. If you require assistance to evacuate, you must go to the safe area, located right outside of the main doors of the honor suite. Right outside there, the large area. If you require assistance, go out there. The fire company will come and help us evacuate.

Everyone must exit the building. Take your belongings with you. Don't operate cell phones during that time. Don't try to use the elevators. They will be off.

We will use stair 1 and 2 to exit the building. When we go out, stair 1 and 2 are back here; that's the way we are going to go out.

You can exit through those two exits, but come around these hallways and go use those stairs.

Apparently, elsewhere on this floor there is a daycare and they use the stairs that are on that end of the building.

Let's see if there is anything -- keep to the inside of the stairwell and merge to the outside because a lot of people will be exiting in the stairwell.

When you go down the stairs, you will be turning left down Dewberry, left on -- the corner of Fourth you will cross right over there next to the Zion church.

That's the emergency procedures. We were asked, by the building

people, to let everybody know how we are going to be leaving in the event of an emergency.

>> RALPH: As you can tell, in Jennifer's previous life she was a flight attendant.

[LAUGHTER]

We have had another member join us.

>> My name is Marry Lou Brophy.

>> Neal Bisno, Healthcare Pennsylvania.

>> RALPH: Okay.

>> JENN: Barry Bowman. There you are. You know what, come right up here.

We have been getting asked -- Barry, I will do a little bit of an introduction. We have been getting a lot of questions about our

procurement process and the ability or the opportunity to review the RFP in advance of, actually, the 16th when publishing the RFP in November.

As you know, we have already -- we are in the middle of a review period on the concept paper. Previous to that we had the discussion document and each time we take into consideration all of the comments and make changes based on that.

At this point, we are receiving comments on the concept paper. Those are all going into the development of our procurement. The procurement has two parts. One is the RFP.

If you want to see what it looks like go to the DGS website. We are mirroring the HealthChoices procurement to the extent that we can.

In addition to that, we will be developing a draft agreement. The draft agreement really is kind of the nuts and bolts of how this is going

to operate.

I've asked Barry Bowman, who is very involved in helping us with the process. He is with the office of medical assistance programs. He has been very involved and has a lot of experience in the procurements. Barry is our state expert on these things. Barry?

>> BARRY: Thank you, Jenn.

Good morning, everyone. Good morning, committee members and audience.

As Jenn noted, I am Barry Bowman. I work with the office of medical assistance programs. I am specifically with the bureau of managed care operations. There I hold the title of director of program initiatives, contracting and communications.

We get the award I think for having the largest division name with

actually the smallest division.

[LAUGHTER]

One of the things I do there, I am the project -- my position is project officer for all HealthChoices procurements we issue over the years.

We are about 18 years into the HealthChoices program, the physical health mandatory care program.

Over that time we procured multiple times for multiple zones. We are very experienced.

We also have the ability from a delegation from DGS within the Commonwealth to -- we are solely responsible for the HealthChoices procurements. We do them in-house and get them out there on the street.

We don't have kind of a public presentation of our procurement

process. There's probably good reason for that. It's not a hot topic item. A detailed discussion would be dry, I can imagine.

I would like to give a quick overview of what it is, how we do it, discuss the agreements that result from it and then we will open it up to questions that you might have that are germane to the project you are dealing with here.

What we do with HealthChoices, we have an RFP, a competitive bid process.

Our process, we issue an RFP that is very much like you might see with other procurements for goods and services.

We try to parallel the process as much as possible because it is a familiar process for a lot of individuals around the Commonwealth, but due to the fact that we are kind of a hybridized grant agreement with the

federal government, we have differences in the way we procure compared to others.

The biggest difference it is normally within a procurement you would see narrative work statement that is detailed for perspective offerers, what they need to do to meet the elements of what they are trying to procure.

For us, we don't issue a work statement. We issue an addendum; that specifically delineates everything that an offerer must do and comply with to be a participant in our program.

That addendum is actually a draft agreement. It remains in draft throughout the entire RFP period.

We normally issue a 30-day comment/question period for the RFP within the 40-day posting period. About halfway through, we ask that all

questions and comments be issued in writing to the project writer.

At that point once we hit the 60-day period we use committees made up of individuals within various entities within DHS having specific knowledge in various areas.

Following the selection the evaluation period we make selections, and then we offer bids back out to the successful applicants to come and negotiate to be a member of our program; that is when the draft agreement based on comments and questions and things like that goes into the negotiation process. The negotiation process is what actually produces our final agreement; that's the final agreement that will be signed by the entities.

That final agreement -- with HealthChoices we issue multi-year agreement. In the past they have been up to 7 years. We are currently on

a projected time line where we will issue a three-year agreement with two-year option.

During the three years of HealthChoices agreement, we actually amend the agreement itself annually. We do it for various reasons. Partially it is rate setting, but we also amend annually to make changes during the annual amendment period that might be based on changes, DHS priorities, changes in the health system, issues, federal regulations and federal mandates, that sort of thing; so that's really kind of a brief overview of a very detailed and technical process.

At this point I would like to open it up to questions that you might have and how this might apply to your program.

>> THEO: You mentioned the negotiation portion. Is that similar to the readiness review?

>> BARRY: No. There are two things. The negotiation is conducted between the Commonwealth executivive -- the successful bidders go into negotiations. At the end of negotiations, if everything goes well for both parties, they sign the agreement.

After the agreement-signing is when we move into the readiness review period; that could be anywhere from an 8- to 12-month period where we have specific compliance teams working with the entities that have signed agreements with us to assure that they are capable of starting up on our go-live date.

>> SCOTT: A couple quick questions.

First is, this will be subject to the usual procurement rules of the state?

>> BARRY: Yeah. Actually, HealthChoices, because it is a grant

agreement, doesn't fall under Commonwealth procurement policy, but it falls under Commonwealth law. There are some differences.

The fact that we have actually delegated authority is quite a bit different from your normal Commonwealth procurement.

The differences really lie in not contracting to provide certain amounts of paper and office chairs. We are contracting to provide Medicaid services. It is a service-oriented agreement. It so it differs quite a bit from what you would see in a normal Commonwealth procurement. We parallel that process as close as possible because it is familiar. It is a good defensible process. It's legal.

>> SCOTT: That makes sense.

The same question is it possible to limit the amount of providers to a small number or look to the providers able to provide the services

within the financial rerestraints you are looking for?

>> BARRY: It depends on what you are looking to achieve with your program. You can do it either way.

We generally set a range of the number of providers that we think --

>> SCOTT: I think I am using providers differently than what you are using it, I mean entities to take on the program. Are you looking for a lot of entities that can achieve the goals or are you looking to limit to one, two or three?

>> BARRY: I am speaking of physical health and HealthChoices and the way we do it.

We are not looking necessarily to limit it to a specific number. We are looking for entities that can meet the elements of the program. From there, we would decide if the market share and everything we know about

the zone, how many of those that they could actually support.

Up front with the RFP, we are looking for the entities that can meet the elements of this program, which are considerable and -- so it's -- you need to find the folks that can actually do this up front before you can consider moving into notions; that's what the RFP does. Through its technical components weeds out entities that are capable of performing these functions versus those that may have just had an interest and wanted to bid on a Commonwealth contract.

>> SCOTT: Makes sense. Thanks.

>> DREW: Are you necessarily looking for entities that are already participating in HealthChoices to bid on the community HealthChoices if they meet the technical requirements?

>> BARRY: I don't know if it is necessarily an intent. I don't

want to speak for the long-term services program.

I think with what you see, we deal in HealthChoices we deal with some of the largest healthcare entities in the state and by vier tiew of their relationships nationwide. It wouldn't be surprising to me if you see entities in our program be interested and bid on the program.

From what I understand, there is no intent to give them a priority.

We actually don't do that in HealthChoices. We do it in HealthChoices through the virtue of every RFP. We bury the questions to the extent if you are what we call a heritage plan that is in our program, you might not be better able to answer those questions than a plan coming in from, say, Texas that wants to get into our market.

>> DREW: Can I just have a follow-up to that?

To the extent that the Commonwealth desires there to be coordination

between physical HealthChoices and community HealthChoices, would it be seen as beneficial to have some of the same entities in both MCOs?

>> JENN: I will answer that.

I want to do one bit of housekeeping and then I will answer it.

We need to turn off our mics when done using them. I was just told that if more than five are on, it will blow the system.

Just turn off your systems when you are done.

[LAUGHTER]

To answer your question, community HealthChoices is going to include physical health. Physical health is going to be part of community HealthChoices.

Really, it doesn't -- I mean, I expect just like Barry said, that there will be some existing HealthChoices, MCOs, that will bid on the

community HealthChoices opportunity, but it's not going to -- that really won't be taken into consideration in terms of rating them; that's just an independent question.

Kevin, do you have any other thoughts on that?

>> KEVIN: Jenn is correct. We are going to be managing the physical health services as well as long-term services and supports in our program.

We will be taking into consideration the possibility that a person may be eligible for physical health, HealthChoices and may move into eligibility for community HealthChoices; that will be consideration during the enrollment process.

If a plan is an overlapping plan between physical health HealthChoices and community health HealthChoices there may be some parity

in enrollment, but we are expecting regardless of whether they are in an existing program or not, they have to compete on the same playing field.

>> DREW: I'm sorry. One more follow-up.

Does that mean that the entities bidding on community HealthChoices have to meet the criteria for physical HealthChoices at the same time?

>> KEVIN: That is correct.

>> DREW: Thank you.

>> RALPH: Jennifer has a question. Use the mic, Jennifer. You won't blow it.

>> JENNIFER: Okay.

I am just trying to understand this process so forgive me.

When an RFP is in the procurement process, people other than the department and the MCOs bidding on the process can't be involved or see

the RFP; is that correct?

>> BARRY: They are issued publicly. They are usually on various websites. It's usually through the Commonwealth procurement eServices website. We often offer a link from our homepage. They are certainly open to all public review, public comment. Actually questions and comments -- there is usually a little eBlock for questions and comments. They are not reserved for entities that may not -- anybody can ask questions or offer comments.

>> JENNIFER: Once -- just to follow-up, once the MCOs are selected or they are going into the procurement process, that's between the department and the MCOs. Consumers will not have a chance to either see and/or comment on that; is that correct?

>> BARRY: After the procurement process, yeah, there generally

wouldn't be a public posting of the agreement until they are finalized and signed by all of the entities.

It doesn't necessarily mean that there is not any avenues for consumers to comment. You will have your subcommittee and various consumer subcommittees and there are communication avenues within the Commonwealth, within the DHS as well that folks can actually continue to offer comments on our programs.

We are open to comments pretty much 24/7.

>> JENNIFER: Just if I may, just a follow-up to that.

Once -- we are all offering comments and the state -- the department has done a wonderful job in making sure that advocates and other interested parties are able to enter comments; however, unless we see a draft RFP, my concern is that we won't know if our comments have been used

in developing the RFP.

For example, one of the things that the department pointed out in developing a concept paper is that -- or three things -- there was person-direction, consumer control and there was another big topic, which I very much appreciate.

However, they were also CMS directives there is no way for us to know as participants in the program, if our comments are being taken into consideration in developing the RFP unless we, as participants, get to see a draft of that RFP.

>> JENN: I will just respond to that.

As I said, the RFP is sort of -- is almost boilerplate language, which you can look at today -- is it on the DGS website? It is actually off our homepage as well.

>> BARRY: Afterwards, I can send a direct link to it.

>> JENN: The one that is out there for HealthChoices, we will use that RFP language very heavily borrowing from it and pretty much using it, copying it. It's the language we will use for the RFP itself; that's all of the legal information that is between the Commonwealth and the bidders.

In addition to that, there's a draft agreement that's going to be available. It's out there on the DHS website. We will get you the livening to it. It's that draft agreement where you are going to be mostly interested in looking for things like consumer control and participant-centered planning and participant direction, all of the things that you might -- that you are very interested in and want to make sure remain in the program. They are hallmarks of our program. Our interest is to keep those things moving along and in fact -- hopefully expand them.

When we do post in November post the procurement a taxed will be an addendum. That will be open for 30 days for comments.

If you see something in there that is missing or something we captured inaccurately, differently than you had recommended, you have the opportunity to, again, comment to us.

As Barry said, this committee is very much a part of the comment process.

In OMAP there are several like this. They are continuously providing input to the programs, monitoring the programs, giving the department feedback on how the programs are working.

We take these committees very seriously; that's why we formed it.

>> BARRY: Actually, to follow up on that as well, it's one of the benefits of the annual amendment process with the agreement itself too.

As your committees meet throughout the year with the Commonwealth, issues that -- an agreement goes live, you may have concerns with that, those are the things you can bring up during the year that can possibly be considered for change in each annual amendment.

The amendment really gives us the opportunity to alter the agreement in manners that do you think the directions of the department and meet the goals of everyone involved.

You have kind of a continual opportunity throughout the life of the agreement to be a participant.

>> BRENDA: During the annual amendment process, what happens if a particular vendor does not agree to one of the amendments proposed? Who holdings the power in that process?

>> BARRY: The Commonwealth actually holds the power in that

process.

If a vendor refuses. We conduct notions every year. Part of the notions is to work out any problems -- excuse me, I am getting over an illness and my voice is going in and out. I'm sorry.

The process of the amendment is to work through any serious concerns, get them worked out so that they can get the agreement signed.

If you actually ran into a recognition provision where somebody was adamantly not agreeing to the components, the department would terminate the agreement.

>> Brenda: Okay. Just one follow-up question. Jennifer, I hear that the RFP is just boilerplate language, if there are things we would like added to that language, are we free to comment on that before it goes out?

>> JENN: You can comment on it right now. We have the concept paper out there as an open document. If you look willed at the RFP, we will send you the link. If you see things that are of concern to you, please give us feedback. Thank you.

>> RALPH: Barbara?

>> Bash: Jenn, is it in the agreement where we will see specifics such as standardized assessment tool you said was developed the new service definitions, more detail on what is involved in creating a provider net work, address concerns like --

>> JENN: Yes. I just want to make a correction. We have not developed the standardized assessment. More to come, this committee will help us as we get into that next year. Right now we are focused on the RFP.

In the coming months, after November, we will be convening people to help us as we roll out a standardized assessment and there will basically be the assessment and questions that go along with it; that's to be announced. So it's not -- it's not ready right now. We don't have it ready right now.

>> BARB: Also, the service definition?

>> JENN: The service definitions will definitely be in there.

>> BARB: Thank you.

>> THEO: I think it's wonderful and great that DHS is seeking so much consumer input and stakeholder input; that's great.

I think one of the things that we want to get to as a subcommittee, specifically made of consumers, is can we have a more concrete opportunity to get with you all with the RFP this subcommittee of consumers minus

managed care bidders to have a real sit-down input regarding the issues that affect consumers?

Can something like that happen?

>> JENN: I think any -- DHS is willing to meet with anybody pretty much constantly meeting with people.

If there was a group of people that wanted to come talk to us, we would certainly entertain it.

>> THEO: I am talking about the consumers and members of this subcommittee minus any particular persons who would be bidding on it. Do you follow me?

>> JENN: Yes, I do. I don't see why we wouldn't be able to do something like that. If you have a dprowp of consumers interested in that kind of a meeting, please contact my office.

>> THEO: We would like to make that happen. I don't know if we need to follow the rules of anything like that, but does that need to be in a motion or do we need to just say --

>> JENN: I don't know that you need to have a motion. Just reach out.

After the meeting, Sharon is here with me. Sharon Johnson, Sharon, raise your hand. She will come and talk to you.

>> THEO: One last thing. This is to you, Barry, the panel that actually selects the bidder, is that restricted to Commonwealth staff?

>> BARRY: We have an evaluation committee and that's -- yes, that is restricted to Commonwealth staff. I think that we are legally prohibited to having contractors and things on it.

It is usually a multi-disciplinary committee, especially with

HealthChoices. We tend to have a clinician, policy specialist, folks -- actually from a financial background, executive policy, executive staff.

So it's kind of a multi-disciplinary committee.

Then what we also do is break down in subcommittees. We organize subcommittees based on the fact that some of the elements of the RFP are technical in their regard.

So the committee reviews those elements and then comes in and presents to the overall committee.

As one of our subcommittees, as for our RFP has been the consumer subcommittee through OMAP through their representation healthcare project they are selected, they go through the RFP, select the elements that they feel would be good for them to weigh in on and then during the evaluation

process they express things they have concerns with. The only thing we ask them is to sign a confidentiality, Commonwealth confidentiality form if they are going to participate on that subcommittee.

We have advocate and consumer representation in our subcommittees.

>> THEO: I'm sorry, everyone. One more thing.

I think I want to address something in regard to comments. Can I do it here real quick?

>> JENN: Uh-huh.

>> THEO: One thing we did was have a conversation with some of the consumers. One thing we agreed on is you mentioned in the concept paper an opportunity for readiness review. It's going to be scheduled sometime in March and December.

Can members of the consumer group of the subcommittee be part of

that readiness review?

>>: Jenn: I don't know the answer to that question, Theo. Legally I don't know the answer to that question.

Barry, do you have a precedent around HealthChoices readiness review? Are there ever any members of the subcommittee that participate in that.

>> BARRY: Not formal participation I know. I don't know offhand if it is legally prohibiteds. It is something we can investigate with the office of general council.

>> THEO: The issue is, during that period of time you want to demonstrate whether the providers are ready in a number of areas.

>> BARRY: Yes. Correct.

>> THEO: We don't feel, unless consumers are part of that, you can

truly demonstrate that.

>> Jenn: We will look into whether it is legally allowed and get back to this committee.

>> THEO: Okay.

>> RALPH: Cassie.

>> Cassie: Will you provide expertise providing long-term care to people with physical disabilities in provide ciewrmt will they have to demonstrate some sort of expertise?

>> JENN: Yes.

>> RALPH: Barb. What will be the criteria in determining that expertise?

>> JENN: Good question.

Kevin, do you have any response to that?

>> KEVIN: Sure.

I think that the expertise is going to be, you know, service-specific. There will be a list of different types of services in the RFP they will have to respond to and the criteria will be largely based on the service.

>> BARB: I will think our concern is -- this is a non-medical model. We struggle with how an MCO who has no experience in these services can demonstrate expertise.

>> THEO: Yes. Very much so!

>> KEVIN: I mean, I think it is a fair question. I think that the office of long-term living has enough experience to put the criteria to include everything we want to include. I think you as stakeholders are putting specifics what we need to include as requirements for the RFP.

As part of the evaluation process, the readiness review process, we can -- through the contract negotiation process we can evaluate the proposals and make a determination if they adequately commit to the level of services and the criteria for services that we are requesting; then the readiness review process, the 8- to 12-month process will allow us to work with the plans and have clear assurances with the plans that they are meeting the criteria for the individual services, but it's a good point.

Theo's earlier points, this is a point where we know that -- that's where we have to have a lot of concentration -- our readiness review process for community HealthChoices, compared to physical health health choilses will be different because we are not only looking for physical health services as part of the evaluation, we will also look at the community-based and long-term care services that plans in HealthChoices

may not be providing at this point.

Some plans, to be perfectly honest, some of the plans that may be bidding for this program, that may not necessarily be part of HealthChoices or may be part of HealthChoices providing long-term services and supports in other states and can demonstrate they have significant experience in this area.

Other plans, if they do not have that type of experience, they are going to have to demonstrate that they have the capacity through the proposal process and also through the readiness review process.

>> Jenn: I also want to remind folks that we have long-standing program of all-inclusive care for elderly which is a dual-managed program we are serving over 5,000 people in that program statewide. We do long-term services and sports and consumer direction.

>> RALPH: Cassie and nail.

>> Cassie: One of my concerns is, this is moving so fast and I am reading everything I can. There are places they are doing good stuff and not just cutting and rationing because they are in someplaces are making it difficult for people with disabilities to participate in the community.

The places that are doing the great stuff, they had a lot of money for start-up in the beginning. Savings were seen later down the line, not in the beginning.

We are not in a great financial state in Philadelphia; that's a huge concern.

I just came back from Utah. One of the girls there from -- she was from New York, Rochester, New York. She is not able to feed herself, not able the answer the door.

Managed care company went in and cut her, 75% of her hours just on paper. Didn't know her. Got upset because she didn't answer the door. Was going to fire the attendant that did the best care on her and was there and knew her the best.

It was the managed care company that dropped the ball, not finding out whether the girl could answer the door or not something that basic. She needed her hours. The state got it back but they had a lawyer on hand.

We all don't have lawyers at our side if we are being rationed.

A lot of consumers don't know who to call; that just scared the hell out of me. I know there are consumers. We might not even know they are having a problem for six months until we get with them and they finally talk to us and it might take listening about their life to find out.

Some consumers are just -- want to stay out of a nursing home. You know, if they think anything would jeopardize their freedom, they might not even speak up.

This is a huge concern. I am -- I need some assurances that there is going to be the start-up money. I am not getting them looking at the budget right now --

>> JENN: That is a problem.

[LAUGHTER]

Cassie, this has never been about saving money for the state. This is really about improving quality and able to continue the program.

We are experiencing unsustainable growth in the existing fee-for-service program that we need to pay attention to.

Our hope is through managed care, we will be able to expand our

ability to serve people by spending it in a way that is -- that makes more sense.

It's never -- this has never been about cutting any budgets. We are not anticipating cutting budgets. To the except that that start-up money will be there, we are using and working right now to figure out the first phase, which is in the southwest, what kind of funding we will have available there. It's never been about the budget. It has truly been about improving quality and serving more people in the community.

>> NEAL: Just -- we are spending a lot of time on the process, which is appropriate. There are a couple perspectives.

I would support maximizing the input of consumers in particular, as the process is moving forward.

One other important thing is stakeholders.

I think at the same time it is important that we protect the Commonwealth's ability to dive the program in the sense that, you know, let's be clear. This is a $5 billion procurement or something like that. I think physical health is 11 billion-dollar procurement. It is a big business opportunity for a lot of stakeholders. Let's call them stakeholders.

We want to make -- the whole point here is long-term living system we currently have does not work very well for enough people.

It doesn't work well enough for consumers. It doesn't work well enough for direct care workers; that's for sure.

Yet, we are spending the growth of spending in the program is, you know, growing.

How do we design a system that works better for consumers and for

communities and for the people that provide the care, which, you know, those two things are pretty aligned because we know in this sector, the direct care workforce has a huge impact on the consumer experience and outcomes.

We need to make sure that it doesn't become -- you know, the vendors who are vendors. Being paid to provide a service on behalf of the Commonwealth, all of us, somehow -- we need to make sure that we don't have a system likely to result in the status quo. The status quo is not working out well.

I think it is important that we both open up as this committee does. I can speak from experience DHS is very open to meeting with stakeholders, whenever asked to.

I'm sure many people in this room take advantage of that opportunity

at times.

I think we have the concept paper. We have this process. We need to open up other avenues.

At the same time, you know, we need to protect the ability to drive change in the system.

I think that is important.

>> JENN: Thank you.

>> DREW: To the extent that you are use boilerplate language for the RFP for community HealthChoices, I am concerned that there may be some terminology in there that is not exactly relevant for long-term services and supports.

Specifically, in the concept paper I see reference to utilization management and utilization review. These are processes that are quite

appropriate for physical HealthChoices, where you have a disease process that -- you are treating it. You are expected to get better.

So that's quite common in the medical field.

In long-term services and supports, it needs to be a different process for the on-going review of a person's needs.

So those words, that language is problematic in terms of the RMP in our opinion.

>> BARRY: I think the element that maybe gets taken too far is that it's going to be an exact duplicate of HealthChoices RFP.

When we say it is a poiler plate it is across the board in Commonwealth. There are a lot of legal terms regarding ability to issue public statements that have to be in all prp FPs.

Along with the agreement as standard for what they have to voluntary

as contractors we have an element of technical questioning in each RFP we vary that based on procurement based on what we want to see in HealthChoices.

As I work with folks within MLTLS they are currently drafting technical questions that are more germane to the product that they want to get out on the street.

They are going through and identifying items such as do we need to have this level of kind of concentration on utilization management, which really doesn't apply to quite a lot of things you do.

I think what you will see, once the RFP comes out, there will be differences in the two RFPs and based on the goals of each program, the goals and services that are provided in each program.

>> DREW: Can we suggest some other types of review process in

place of UMUR?

>> JENN: Yes.

If you would just use the concept paper process. If you want to go out and look at RFP and give other ideas for doing monitoring and compliance which we are required to do for CMS and for the Commonwealth, quite frankly, the accountability is necessary in all of our programs. To the extent that you have ideas to achieve that; that would be helpful.

>> RALPH: Fred and then Jack.

>> FRED: It was just mentioned a little bit ago about out-of-state people being in on this RFP and getting the contracts.

I have a real problem with that. Right now we have PPL that is out of state. They have never even seen any of the consumers ever. Not one.

They won't because they are from out of state. Not only does that

mean that it will be bad for the consumer, very bad. It is also bad for attendants and bad for the Commonwealth because we are sending our money out of state, which I think is ridiculous.

I think we need to keep the money here in this state.

>> JENN: I don't know that it means that they will be out of state. They will be in the state but may come from other places where they have experience doing that. They set up shop here; that's -- many companies do that. It happens all of the time.

In our current system it happens, today, and it happens in the medical world where there is experience companies expand and they come into the state.

>> FRED: I understand that. If they set up something here they have to be localized branches. We have it broken up into three different

sections for this state when when they are going to be put out.

I think it is very, very important that they have somebody centralized and localized in that particular area.

I do understand, yes -- I mean, they have the experience. They have -- you know, they are going from state to state to state, which is perfectly fine.

I am mostly concerned about, will they have local representation to where they can come out and actually speak with a consumer instead of having to do it from another state.

>> JENN: Good point. That will be a requirement built into the draft agreement.

>> BARRY: In HealthChoices because we deal with national healthcare companies, they generally all have a big preference in the state

commercially they also require HealthChoices within each zone with which they participate.

Within those head quarters you have care managers and things like that it is not just a guy sitting by the phone. It is an actual headquarters.

>> KEVIN: We will be the same.

>> JENN: Yeah, we will be the same.

>> JACK: I think everyone recognizes and appreciates the openness and transparency that the department is looking to guide this process.

In that regard, I just want to go back to the process, however, a little bit.

Jennifer, you did talk about the addendum as being a draft agreement, which is going to be a key document.

So, as I understand it, when the RFP is released, the addendum will be released and open for comment.

Like any other RFP, you will take comments on the RFP, questions and comments on both the RFP and the addendum for 30 days.

Will we get to see -- will you -- will we get to see a revised addendum based on the comments received?

>> JENN: How does that work in HealthChoices, Barry?

>> BARRY: No, we wouldn't release a revised addendum.

In some respects, we are a different program we are very mature. People are very familiar with our product, including the consumers and all of the advocacy groups. I cannot speak for what they did earlier in the program. I was in a contract capacity.

Once again, I don't know that that is something that is prohibited.

>> JENN: Let me look into that, Jack.

>> JACK: Alternatively or along with that, typically, when questions and comments are raised to an RFP, there will be a document that is released are the agency will respond to the comments and questions; so that is another vehicle by which you can say, yes, this was a good idea or, no, you didn't want to accept it.

Again, it is the process so that everybody noise, if they make a comment, what was the department's position wrpt to that particular issue.

>> JENN: Yes. That is fair.

>> BARRY: Thank you, Jack. I jumped over that in my description. We release written responses to all of the questions that come in the process.

>> JACK: I can only urge you to take a lot of vitamin C over the

next several months.

[LAUGHTER]

>> BARRY: I am gearing up, Jack.

[LAUGHTER]

>> RALPH: Go ahead.

>> SCOTT: Thanks.

Just a follow on to that last question. During normal procurement processes, not only are there responses to questions, but the procurement -- the RFP can change based on that information that comes in; is that -- is the department open to considering those questions and making changes if it is in the best interest of the program?

>> BARRY: Yes, there is an alteration process for all RFPs they can make amendments during the posting. It could be based on a question. It

could be based on somebody reviewing the RFP really closely and saying, hey, this sentence doesn't make any sense. We don't understand what you want, here. We may have to amend the RFP to make it more clear. An IT link may not work; that sort of thing.

>> SCOTT: Two quick follow-ups:

Are you anticipating that they will be for all three regions in the beginning or just looking for western PA and central -- that RFP may be very different than --

>> Jenn. The. All three regions will be submitted with the RFP process.

As Barry has been describing, there is an opportunity to make changes all along the way. We will build language into the draft agreement that allows us to do what I have been thinking of as cycle

improvement.

Learning from the first iteration in southwest and also addressing, you know, regional differences between the southwest and the southeast, we will be very sensitive to that and looking for input.

You know, the Commonwealth has really vested strong interest in getting this right and it is -- all of you that are going to help us do that.

It is a huge change. We recognize that. We want this to be a process that involves people to help us get it right.

>> SCOTT: Thank you.

Are you expecting those MCOs to be bidding for all three or can they pick a region?

>> JENN: They can pick a region.

>> SCOTT: They will pick the entire region?

>> JENN: Yes.

>> Ravel: Cassie, before you go I have Ray.

>> RAY: As a health plan, I just want to express a lot of the same concerns that I think we are hearing around the table and I think we all know that we need to get this right.

I think we, you know, take quality incredibly seriously in our day-to-day operations, Medicare, Medicaid and satisfaction is foremost for us as well making sure that our members are healthy, keeping them independent today.

You know, from a sort of strong provider network, stable workforce, I think we all share these concerns.

I think the stated goal that this isn't about savings p but

improving the system in the long-run and quality of the system is incredibly important to us as well.

To be clear, I think the speaking -- speaking for he will Harrisburg plans MCOs, I want to make huer is he wet this right.

>> Cassie: I was hoping there could be incentives built into the core services of IL.

I can't imagine when I was a young girl being able to integrate into the community the way I had and my love for the disabled culture, community, history, philosophy which changed my whole feeling about my own identity.

I just don't think a medical model is going to be able to cut that. I think you need the expertise of the CILs.

I am hoping that there will be I object sentives built.

I know you say it behooves them to work together.

I am concerned about keeping IL alive, the core services, the places where disabled people were, the frontline jobs where they do peer counseling, where they accompany people to SSI, where they might negotiate with the managed care company on hours and have somebody help them, have the confidence to be able to do that if their life is not, you know, the same because maybe somebody thought they needed less hours, all of the things CILs do, all of the core services, helping them stay out of institution, helping them find housing advocacy, peer counsel, advocacy and referrals.

All of those things.

I don't think, typically, a medical model will think about that, or people coming in from that angle. A lot of expertise may be from the

medical-community based services sending nurses into the community.

I know Wisconsin has a great program. One of the CILs I just adore. Some of them are good but they all created jobs for disabled people.

Disabled people are, actually, integrating and helping people not only coming out of nursing homes, but a lot of people have been sheltered all of their life with disabilities.

Believe it or not, Kathy was. I don't know how it got so tough so quick. I wasn't so tough in the beginning. If it wasn't for role models, those counselors, I can't imagine what my life would have been like the last 30 or 40 years.

I just hope somehow you are going to build that in or create incentives, because I don't think it will just come out of their hat, necessarily.

>> JENN: Thank you, Cassie. It is great input.

We have no intention of rolling out a pure medical model here. It is not what we want to do.

Really, I mean, I think medical services are critical to every one of us. It is how we stay healthy and get healthy when we are not healthy. It is a component of it.

But the model of providing services that are just health-related, is not what this is about. It is about the broader social aspects of keeping people healthy and supporting integration -- I think you touched on something that is a very critical thing for us to make sure that we maintain is the focus on people integrating into the community.

To some extent, that means reducing isolation. People can get isolated in their home in their own independent home at times.

To the extent that we are paying attention to that and require the MCOs to be noticing that, be mindful of that and being required to address it, I think it is going to be important.

>> Cassie: Don't forget the right to risk. If they are overseeing long-term care services and medical services, we need more consumer control in our medical services. We definitely need a more aggressive medical model for people with disabilities.

I really believe we are underserved often. I think it could be an opportunity to make people better. We still deserve the right to risk in every aspect of our life.

>> JENN: Thank you, Cassie.

>> Brenda: I think that what Cassie said is very important.

I want to go back to the point about expertise in serving people

with physical disabilities when it comes to long-term care services.

I think we need to add some language there.

I think expertise is serving people with physical disabilities in a home setting and one-on-one setting is very important; that's where a lot of this stuff is going to come into play, recognizing isolation, keeping people involved and enveloping all of those concepts has to be part of the expertise that the MCOs have.

A lot of the consumers are not as vocal as we are in expressing needs. I think by adding language, but in a home and one-on-one setting I think is very important.

>> JENN: Thank you, Brenda.

Ralph?

>> RALPH: I have a comment and further down on the agenda to I can

add to it then.

The grievance and appeal process when I hear that, when my staff said this to me who does grievance as and appeals better than CILs? We are always advocating, advocating, advocating. I believe the MCOs and whomever gets contracted, there be a place for agencies and organizations such as CILs be part of the process.

I know I am plugging what I do, but that's what I am here for.

>> Richard and then Theo.

>> RICHARD: Just to go back a little bit. It seems like each year or a couple years, I am having to change my insurance because something they are not -- something they are telling me they are not going to pay for. It's costing me a lot of money.

Such as fleets; that's very expensive. If you figure -- everyone

has to go to the bathroom. You are telling me I have to pay for a box that's $4 a day for 30 days; that's a lot of money added up over a year.

The same thing like my wheelchair. If I need to go out and go to certain places and my insurance tells me, no, we don't think you need that for your chair, then how am I to get where I need to go if I don't have the proper equipment or things I need for my daily living?

If they can just say, we pay for it today, and then tomorrow they say, no, we don't want to cover that?

If you can change that quick. Do you see what I mean?

>> JENN: Yeah. Thank you, Richard.

>> THEO: I have to continue to reiterate this because it is violataly important. So important that I am probably going to get on all of your nerves with it.

[LAUGHTER]

It all goes back to this readiness review and managed care organizations not claiming things that they cannot do.

The training, you know, even establishing the consumer advisory councils. They can claim anything.

Do they have the training to go into the homes? Do they have training to know about durable medical equipment and life with a disability is more than just their condition, but the quality of life in which durable medical equipment provides for people.

You know, do they have that training? If we allow them to disclaim this without challenging them, especially with that medical -- that review, I'm sorry the medical review, the peer review the readiness review, I'm sorry.

If we don't do it at that time, we are going to miss out on something. It is violataly important -- you are hearing this from consumers, all of the things that we are saying, we hear from consumers. Just don't let them claim these things but allow an opportunity for them to demonstrate and those challenges and conditions in which they say they are really working with people with disabilities or centers for that matter, you have to do it at that time. You have to do it at that time.

>> JENN: Thank you, Theo. We will look into whether or not it is possible. If it is, we will come back to the committee and figure out how to do it.

>> Is Stewart: I have to apologize for missing the last meeting. I missed the webinars because of being out of the country. I have been able to pick up a little bit with regard to items recorded and available on

some websites; that's been very helpful.

That's the end of my apology. I should be around most of the time.

I do have a concern. The concern does deal with funding with cost.

I realize -- someone wrote somewhere along the line we were promised what is going on will not reduce financial support, on the other hand I heard the phrase unsustainable growth which means we cannot afford --

>> JENN: The current fee for service system is experiencing growth that we just unable to control; that's something we want to pay attention to, particularly with the I creasing number of people with disabilities and increase of seniors as the baby boomers start to age we need to be ready for it.

>> STU: By definition MTLSS will save us money in some respects by reforming care, streamlining care, by providing existing services in a

more efficient and effective and possibly a more economical fashion.

I connect all of those things because you can't disconnect them in a system right now with a Commonwealth that has no budget and we don't know what is coming down the line.

My real question deals with, at some point are we going to be provided with information about the costs and the sources of funds that pay for these costs that will deal with MLTSS?

I know we have Social Security, Medicare, Medicaid, we probably have state funds. I don't know where everything else is coming from, but there is a box with a dollar sign on it. Somehow I want to get the feel we are going to go with a box here to here that may be larger or whatever.

I have no feeling for cost. Coming from the Pennsylvania council on aging, I know what our costs are. I mean, I -- for example, I know

precisely what the income from the lotly is and that's where we get 75% of our money.

If you all want to help the elderly, go out and buy lottery tickets, man, we will be living like we really want to live.

So the bottom line is, I have many no fiscal viewpoint as to what we are doing at all. I don't know whether it is 5 billion, 10 billion or half the national debt.

I would love to get some focus on that.

>> Jenn: It's just about shy of 6 billion, the budget of for Office of Long-Term Living.

Peggy, I don't know if you want to say anything else. We have a variety sources of revenue. Medicaid is federally-matched program, that is how we are funded.

>> STU: I don't need an answer today. I am just hoping somewhere along the line.

>> JENN: If you want us to do some -- especially between now and the next -- I am really a PollyAnna. Maybe we will have a budget and we can do a presentation on our budget if that is something you are interested in seeing, folks, here.

Pegly Morningstar is our CFO attending meetings. She is sitting behind you and can give you more detailings.

>> RALPH: I have Fred here and then Kevin.

>> FRED: I got a question. This is just out of my own curiosity. How many people on this committee are going to be in the first region that gets transferred over to managed carat the end of the year? I know Brenda Dare is also. So three, four.

So the reason I am asking this is we are the first ones that will get hit with this mess. We are the ones who will have to work out all of the kinks.

I want to get it as straight as possible whether for good or ill, we are the first ones that will get it and make it better for the other two regions once they get started.

I just lost my train of thought.

Yeah, I -- it's -- our when it does hit our location, are we going to have -- what kind of say are we going to have in how the new contracts are redone? Is it -- I can't -- I'm sorry.

>> JENN: I think what Theo has been talking about with readiness review is the first thing I am going to be looking into.

I don't know whether it is possible to have consumers help us with

the readiness review process, but if it is, we will figure out some way for that to occur.

You know, as I have been saying all along, I -- we are really interested in seeing this work. It's a big initiative and I have seen it work very well in other states and other large states.

To that extent, I think there is an important opportunity for us to have consume Erin put on the process; that's what this committee is about.

We will be looking regionally as well.

>> RALPH: I think Fred's region will let you know whether or not it is working.

>> FRED: Oh, yeah!

>> RALPH: That process will come about one way or another.

>> Kevin: Thank you, Cassie or generously sharing your microphone.

One thing I want to say about readiness review is not just helping us with the process, Theo, is helping the plans with the readiness review process especially when talking about community-based services.

The plans, I think, will be looking for support to be guided through the process.

I think from AAA perspective, the advocates and associations, I think there is a real opportunity working with the plans and supporting their efforts and moving through the readiness review process and what the programs should be looking like from a community-based perspective as well as physical health perspective. Keep that in mind.

>> THEO: My experience is this: Everybody can claim stuff. There is always things to be learned. Very simple stuff.

Like what you all who is OLTL just sitting up this room. You would

have thought you knew that but you didn't.

Also in regard to counseling meetings suddenly that is people for people with disabilities.

It's okay for people without disability but it is terrible -- we have so many things attached to our planning ahead and going to meetings. We have to change attendants. We have to figure all these things out ahead of time.

When you suddenly cancel something it just puts our life in chaos in order to regroup.

You are not intentionally doing that, I know that, but you don't know how that affects people with disabilities.

So the same thing would apply to someone in managed care. They claim to know stuff and they probably do, but when it comes to living with

a disability is a whole other thing.

>> JENN: Theo, I meant to do this at the beginning when Ralph was doing housekeeping.

I apologize that we had to cancel Tuesday's meeting and reschedule for today.

I am glad to see a big group. The cancellation was due to the fact that we had scheduled it in an inaccessible room.

So when we went to find an accessible room we couldn't find one on Tuesday so we ended up deciding to continue -- I really wanted to have the meeting before the end -- before the close of the concept paper so we ended up with this.

I own that problem. I mean, it was a mistake that we made.

>> THEO: You get my point.

>> JENN: I do completely.

I hear you. We are working really hard to continuously improve the accessibility of our meeting space. So any input that you have, please give it to us. We are -- it's a work in progress, I will put it that bay, given the limitations of the amount of space we have in Harrisburg.

We are trying to keep it in downtown as opposed -- we have great meeting space outside of downtown but we are concerned if anybody is taking public transportation that that may pose a challenge for them.

>> FRED: I have a suggestion for MCOs when they get started up and everything. I believe that the MCOs need to have a person with a disability with them at all times to let them know if they are doing right, if they are doing wrong, to help guide them through it.

They are -- do not have disabilities. They do not know what people

with disabilities need. They are just taking good guesses.

If they had somebody with a disability not necessarily on their board, as an adviser for the MCO companies, I think they need to have somebody with a disability in that kind of a situation.

>> JENN: Thank you.

>> RALPH: Jennifer?

>> JENNIFER: I just have one more question. I hope this goes as well as everyone is expecting and hoping for.

My question and my fear is, I really feel that we have a lot of support with Secretary Burnett's review and Secretary Dallas. You are real advocates that will listen and care about making this work.

I hate going back to PPL, I don't mean to keep with begrudging that situation, but I was assured when PPL took over that it was going to be a

wonderful experience and that all of the concerns that I had were null and they were not going to happen.

When PPL took over FMS, I really feel like the department had kind of a hands-off perspective on that. PPL was given the contract and the department just sort of backed off and there was nobody that we could go to with our concerns.

I tried the Office of Long-Term Living's hotline several times.

There were no advocates.

I guess what I need to know and what other participants need to know in the room is that, if this doesn't work out as well as we hope, that the department's not going to take a handsoff approach or not going to bury their head in the sand -- forgive the expression -- because this was your baby and you wanted it to work.

If it doesn't, I need the assurance that it's going to be admitted to and reworked on.

>> THEO: Amen!

>> JENN: Yes, you have my assurance it will be. We do not want to repeat what happened with PPL. There are a lot of lessons to learn there. You just mentioned a couple of them. Things like making sure we have adequate hotline availability for an 800 number for people to call when there is an issue; that will be part of what we do.

There, you know, since returning to state government about five months ago, this PPL issue is something that keeps recurring and I am reminded how bad the implementation is.

We have a lot of reminders of things not to do.

>> RALPH: Kevin, are you finished with your review?

>> JENN: I think we are. I guess player -- we have gotten behind on our agenda, here. Kevin is going to talk a little bit about comparing -- going to what Jennifer asked about at the beginning of this meeting which is the question, you went through the process of a discussion document, what changed from the discussion document to the concept paper? Did we listen to anyone? Did we learn anything from that process?

Kevin is going to go through a brief slide deck that walks you through some of the things we learned in that process.

>> BLAIR: I don't know about the issues with the responsiveness in the past. I encourage the Office of Long-Term Living to look at the medical assistance program model for HealthChoices whenever concerns come up, they have a list of exactly who to escalate it to at the health plan

so that they get the request, same day they get it, the office is on the phone with us and we are resolving it the same day.

It is a responsive model. I would encourage something like that so we have that collaboration with all parties and don't have the types of issues where you don't have a very prompt response to a problem.

>> JENN: Okay. Thank you.

>> KEVIN: Good morning, everybody.

Can everybody hear me? Great.

I was asked to go through the discussion documents and compare it to how we developed the concept paper and talk a little bit about how we incorporated participants and stakeholder feedback into the concept paper and design of the concept paper. Key concepts we are hoping to make sure we are incorporating in the community HealthChoices program.

I will go through the feedback we received to date and talk about key focus areas where we are working on as we develop the RFP and the draft agreements and then I will leave it open for questions or we can -- if it's easier just asking questions throughout would be okay. Getting through the presentation would probably be a little bit more efficient.

So moving on to the discussion document framework.

If you remembered, we focused on these key objectives when we were developing the concept paper. These should all be familiar to you. We were focusing on person-centered program design and service program developments. Service coordination, access to qualified providers, emphasis on home and community-based services, perform Aprils-paced payment incentives, participant education and enrollment supports,

preventive services participant protections and quality and outcomes-based focus.

Those areas we framed out in higher-level detail we want to introduce the discussion document for what we were trying to achieve broadly to allow for a lot of room for stakeholders and research to help us inform what those objectives should mean for the program and for the concept paper.

So we presented the discussion documents, if you remember we presented it in early June. We had 6 listening sessions associated with the discussion document that took place in the month of June of this year, then we used that as a way to frame out the key areas of stakeholder feedback.

These are the areas that we know we included directly from

stakeholder feedback. There was a lot of discussion throughout the listening sessions and through the comments themselves looking for opportunities to streamline the enrollment process to build on the existing behavioral managed care system, to improve the process used for home modifications, to maintain and enhance directed services and budget authority; that was a big one that was discussed through every single one of the listening sessions and received a lot of comments on that as well.

Addressing limitations in the nursing facility transition, providing assurances for continuity of care and also employing continuous broad stakeholder engagement.

These are areas across the board the concept paper was framed -- it included components of stakeholder feedback and these were key areas we incorporated as part of the concept paper directly from what the stake

holiers provided to us in the discussions and through their comments.

So to go through these in detail, streamlining enrollments, it was requested that we look for ways to shorten the time frame from the point that people present they are in need of long-term services and supports and the point where they are determined to be financially and for lack of better term clinically or functionally eligible for long-term services and supports or LTSS.

Steps that we discussed in the concept paper and steps we are taking through this process, which are -- may not directly be part of the draft agreement in RFP but part of the program itself, reworking the level of care assessmentment tool shortening the time period and looking for ways to make the process more efficient for the participants and also using the indent enrollment entity to shorten the enrollment time frame.

If you had an opportunity to look at the request for proposal for the intent enrollment entity, you would have seen that we did have a shortened time period built into that contract and looking for opportunities throughout the process including opportunities to streamline the functional eligibility process and the financial eligibility to make sure that that time frame is shortened acknowledged to the paper and program itself.

In addition we are looking to build on the success of behavioral health managed care system. We, initially, when talking about community HealthChoices had an integrated program that included physical health, long-term services and supports and behavioral health services.

Based on the way that the dual eligible population currently manages behavioral health services and based on long-standing success with

behavioral health MCOs in Pennsylvania, we recognize that it's better to have a coordinate ated model to be using the existing infrastructure for behavioral health organizations and community HealthChoices and to maintain the system as it exists to limit disruption for the people currently receiving their services behavioral health MCOs and to augment the services for people who were not receiving services in behavioral health MCOs to make sure that those services are more broadly made available to them in the behavioral managed care product.

In addition, we know that we want to build in coordination standards with community-HealthChoices and MCO contracts and behavioral health. The physical HealthChoices program has the same objective and we know that we are going to be able to build on the contract language that they developed to be able to achieve that goal.

So we elected to have a carve-out for behavioral health managed care for community HealthChoices but to have a coordinated model where the draft agreements will reflect highly-coordinated language between the two programs.

We are moving to improve the process for home modifications. We are -- many of you know that they -- a discussion document or a concept paper was released on home modifications as well as -- for community HealthChoices and there's going to be a procurement in the very near future eminently in the near future that will create a broker system for home modifications.

The community HealthChoices program, as you saw in the concept paper will be required to contract with the home modification brokers to be able to make sure that the services are not only highly coordinated but made

more broadly available.

In addition, we will maintain enhanced participant directed services in budget authority. Tanya, who I know is not here today, in one of the meetings was advocating hard looking for opportunities to expand budget authority or services my way. This was recognized in the concept paper. We are looking to maintain significant opportunities for augmenting participant-directed services and services my way or budget authority.

We are looking for ways to improve the financial management services and going through in the near future for new procurement services for a policeman more localized and offers more choice for participants. Something that will be coordinated with community HealthChoices as well.

These are across the boards that we heard the most frequently in listening sessions and they were definitely highlighted in the concept

paper.

One point I will make, I am not sure if Jenn will talk about this later, but just yesterday New Jersey published a findings report on their managed care program. One of the key findings, which was interesting. We are absolutely convinced it will continue with Pennsylvania is that participant-directed services in New Jersey, actually increased under their managed care program.

We know that managed care is actually going to present an opportunity to increase these services and also to make them more successful for participants. We are going to look to the lessons learned in New Jersey to make sure that we are using a model they used to build on success.

Areas: We there is room for improvement. Program evaluation and

resign. We discussed continuity of care was a concern across the board. Can 180 continuity of care process will be required across providers. We are looking for opportunities and comments to make sure that that process in a concept paper, as described in the concept paper is as successful for participants as possible.

Also, to make sure that we are -- I think that a lot of this has been highlighted through this meeting here today plus also some of the spopses we received here today to make sure that we have as transparent process as possible to make sure that we have continuous stakeholder engaining men requiring plans to have participant advisory dprowps, continuing with MLTSS subMAAC, and also maintaining third Thursday webinars.

All of these points were points taken and meant to address the

concerns and questions raised by the stakeholders.

Before I go on to the concept stakeholder feedback does anybody have any questions on any of those points?

>> CASSIE: I don't know 180 continuity of care process.

>> KEVIN: The word day is missing.

>> CASSIE: Okay. I know now.

>> JENNIFER: I have a question regarding FMS. Is that going to be conflict-free? I am asking because it was a lot more effective, I think, whenning as such as CILs and other providers ran it. We had local people to go to. People that we knew and knew us.

So is there any plans to take the conflict-free lapping out of it and give it back to the people do it well?

>> KEVIN: Just to be very clear, our federal partners have been

very clear with us that the service for financial management services has to be separated from any type of direct service delivery. It has to be conflict-free.

>> JENNIFER: Okay. Thank you.

>> SCOTT: I understand the need for conflict free even organizations. I think everybody understands and agrees with the need to have conflict-free situations even AAAs that are in that conflicted realm.

As we make these separations, I would just like to have folks be aware of what those impacts are from the consumer standpoint.

CMS and some of the law folks that have commented on these things recognize ways for some of these things to happen and what it becomes is a balancing act between conflict of interest and pulling apart a delivery system that then comprises the services that are provided.

I am in no way advocating that the conflict of interest is glossed over or thrown away. Everybody I think understands that that has to happen.

What I am advocating for is a common sense approach to how we do those things because the impact to the cop assumers while in concept they understand it don't have a full appreciatation for what it equates to.

The firewalls are put in place and barriers to meet conflict of interest, I would ask that we don't swing the pendulum from very far this direction to very far this direction and take a long time for it to land in the middle.

I would ask as we move the pendulum use a logical common sense approach to that. I think the federal people allow for that. Some of the legal folks who commented on this at both state and national level have

indicated there is common ground for that.

I would advocate when we land the pendulum land it in the common ground don't go too far from this side to too far from this side.

If I am conflicted organization and can say that, I think there is a lot of common ground in there that DHS, administration, Pennsylvania can approach it from that standpoint.

So find the right balance when we do it; that would be my comment.

>> KEVIN: I think we agree with you, Steve.

>> DREW: Kevin, you mention that you wanted to build upon the successes of the existing behavioral managed care system; and that the behavioral managed care organizations will be carved out, highly coordinated with the community HealthChoices.

So the people from the brain injury community are just concerned

there could be some misinterpretation about what might appear to be similar services offered by both the behavioral healthcare MCOs and MCOs under community HealthChoices.

For example, one of the currently available services under ComCare, OBRA and independence is behavioral services.

We think it is important that those services be maintained in the service definition under community HealthChoices because they are, in fact, different than what are offered under behavioral health MCOs.

>> KEVIN: Just to be clear, the services that are currently under the 1915 (c) whaifers including ComCare will be included as part of community HealthChoices.

Even if services similar, similar service description and services for contracts exist, those services under the existing waivers will be

part of community HealthChoices as well.

The services in general will be coordinated. Perhaps we will have an opportunity to be able to propose their approach to coordination to make sure that there isn't duplication in those services, but those services will be able to be made available in community HealthChoices.

>> DREW: Thank you.

>> RALPH: Barbara?

>> BARB: Question on home modifications. Is that service going to be redefined? Are you anding putting a cap on that service? Will there be any exclusions on home mods that currently are being done?

>> KEVIN: We are not talking --

>> JENN: Yeah, we are not talking about any kind of cap right now. We are, and have proposed to CMS, although it hasn't been approved yet

changes to home modifications because it was a very large definition. We had no granular data on what we were actually providing. P vehicle mods, home mods that is now being separated into four different categories; so that's going to continue; that's the way -- it will be once CMS approves waiver amendments and renewals.

>> BARB: There will be no exclusions on current home mods that are being done?

>> JENN: No.

>> KEVIN: If there are no more questions, I will jump to stakeholder feedback we received on the concept paper itself.

So many of you know that we released the concept paper on September 16th and as of October 8th, we had 89 comments from 38 commenters.

I would have to say that we are expecting to receive many, many, many more comments.

Like with the discussion document, we expect them to be -- we will expect them to be submitted towards the end of the comment period, which will be October 16th.

This is what we received so far. These are sort of the highlights of what we received so far.

We received a lot of comments advocating for services for the deaf-blind population. We are certainly taking that into consideration.

Incorporating provider standards as part of RFP and draft agreements; that is something we are definitely looking into, looking at models from other states as well as suggestions across the board.

Listening -- requests for lists for currently-participating

providers and service definitions, consider housing and homelessness as a barrier to address as part of the program design for community HealthChoices and we would, actually, love to have more comments in this area to flesh out specific ideas if people are willing to submit them to us.

Concerns about limiting consumer choice and questions about the enrollment process in the new Tim system.

We have had a lot of questions about the enrollment pro.

We will address the questions certainly and love to here opinion points and points of consideration and suggestions.

This is what we have heard so far and we know that we are going to hear much, much more. We are looking forward to all of those comments and looking for ways to incorporate all of them as part of the program design.

Moving on --

>> RALPH: I'm sorry. I have a real quick question on this.

I know that these comments, the 89 comments, those were from here during our MLTSS meetings. Correct or do they include some from beforehand?

>> KEVIN: Include comments made from this meeting but they are from a broader audience we received some comments from outside entities as well.

>> FRED: Before the committee started were the comments or suggestions woven into the 89 people or the -- I'm sorry. The 89 comments or is that just from the beginning of this committee?

>> KEVIN: O no no. The comments are part of that list as well.

>> JENN: We did a series of listening sessions around the state. A

lot of folks came to those. It was great.

We heard from over 800 commentators during that process and those were all considered, when we built the current concept paper.

>> Fred: That was the question I was trying to ask.

>> JENN: That was before the committee was formed a lot of the comments we received in that process led us to form this committee so this committee is really the result of feedback we received across the state.

>> Kevin: I'm sorry Fred, if I misunderstood you.

>> FRED: That's all right.

>> KEVIN: These are the focus areas we work on as we develop the draft agreement and RFP.

We are working on both. Have placeholders for concept paper comments and suggestions, of course,.

We are moving through framing out the boilerplate language and using the existing physical HealthChoices contract as a place to start, especially for the physical health services but also as sort of an outline for what we can use for community HealthChoices.

We continue to refine our data for the population and the people who are being eligible.

This is population identification for a population this big is always challenging. We continue to look for different ways to make sure that nobody -- no eligible person for this program would be missed as part of the process.

We are spending a lot of time on the enrollment process.

Part of the reason is the first bullet, the enrollment process in community HealthChoices is as much a technical process as it is a

technical process.

The communication -- the technical systems involved in this process will require significant changes to be able to accommodate the new program.

We are spending a lot of time mapping out how the enrollment process works and points of improvement for people who may be in need of long-term services and supports from the point of day 1 of their Medicaid eligibility.

Looking for ways to consider enrollment requirements for LTSS participate ants and nobody-LTSS participants and looking for ways to improve the functional assessment and opportunities to automate any steps for the financial eligibility requirements.

So the process -- we are spending a lot of time on this, as expected

because it is a new program.

>> CASSIE: I guess this a comment and question.

Seven states best practice I read in 2013 are looking at expanding enrollment to people on Medicare at risk of institutionalization.

I will be going on to Medicare and I have been reading a lot about it and I realize I am at risk of institution Ali am sick, old and sexy. It's not my fault. I realize Ralph will probably be at risk when he is not working at the CIL and Fred. I look around the room.

You keep talking about work, work, work. I keep telling my husband, we need to get rid of every dollar we have, maybe it will help.

We are in big trouble just because we did work. We are already living beyond our means because we are stuck in an underwater house and so are so many people that went out and built families and lived the American

dream. If you get sick or age -- it happens to older people too. We are not alone. It happens to older people who never knew they had a disability until they were old.

I am just saying, it is unfair. We are still working very hard. I hope you will look at people who are really at risk, to lose their life in the community, their family, possibly their children, their marriages. You need to look at it.

I mean, I was really surprised about my only option is a snip if I need skilled care.

I have had skilled care in my home three times in the last couple years because I had insurance, which I have decided to go on Medicare systematically because I am of age. I have not been working for two years. I want -- I am going to get healthcare lawyers and fight every

step of the way myself for freedom.

I hope that you will fight with us and consider it. I am not saying it is an instant thing you do on day one, but as you start to achieve these savings, same thing for Act 150, you could make it better down the line. I lookeddality the good programs like in Wisconsin. They put up a lot of money at first but when they started to experience the savings they did a lot of innovative stuff to improve state services even it was state funded for people like Act 150.

I just hope that you will look at that and look at how hard it is for many people on Act 150 to do the co-payments. Some of us are dlifng went and we are delinquent because we co-pay on everything.

I tell you my equipment comes first. I am not going to go around peeing myself to make anybody happy. Not the state, not the provider.

Nobody.

That co-pay has been big on every insurance including Obama care. It actually got bigger. I haven't bought a wheelchair I can't afford to buy half a wheelchair and take care of my daughter who I love deerly.

Then why should we work why should we go off 700 if we don't have the right to American dream. I think the innovation has to be built in and you have to look for providers that could achieve those goals. Some manage willed care providers already have a lot of money if they really wanted to help out the community non-profit providers, profit providers, whomever, they could off some of these opportunities and do Act 150 as a service in the managed care program.

I know some of these things will not happen in a day. I think they have to be built in somehow, looking for this long-term innovation or how

many years you expect the savings to be.

I know that all depends on how good the numbers are.

I am praying, even in my lifetime -- I am going to be 60 in November, that I see something to bail me out so that I don't feel like I was stupid to live the mesh dream -- I know it turned into a nightmare a little bit because of the recession.

I look around the table. Theo is at risk. All of the people that worked so hard. Pam might be at risk one day.

The advocates, the people that fought and shaped these programs now because they are only -- Medicaid eligible and some of them might be down the line dual eligible, but still they are at risk. It is ridiculous. It is a ridiculous system.

>> KEVIN: So when we -- I mean, as this program matures, there is

no prohibition for looking for opportunities to expand the pop layings if it makes sense to individuals who may not meet financial eligibility criteria for Medicaid. Keep bringing it up.

>> RALPH: Cassie, I want to say this. I wouldn't be on this committee if it wasn't for you being here.

When I was approached, the only name I heard was yours. I am sure that you are going to make sure to the best you can, to keep us at the flame, keep us on point. I will do whatever you can to help you maintain that.

>> Kevin: A couple other key focus areas to finish this up. I'm sorry.

>> BARB: In the concept paper, under the level of cave process, I was wondering if you could clarify something for us?

It states that the Commonwealth will contract with an entity to perform LTSS level of care determinations and redemptioners. Is the determinations what we currently know what is done in the waiver programs?

>> KEVIN: Broadly, yes.

>> BARB: Thank you.

>> KEVIN: Sure.

>> JENNIFER: Well, one of the questions that I have just commenting on what Cassie brought up, one of the things I was very, very impressed with Secretary Dallas on was that there is a huge push for employment for people with disabilities. It's just not talk.

He really implemented and tried to make it happen for a lot of people and really trying to figure outweighs to do that, which is, I think, huge.

But going on to what Cassie is saying, I think that the housing from HUD, I don't but I know a lot of people with disabilities do. You could lose housing food stamps for their families, Medicaid.

If they are at risk for health issues, I was working for 9.5 years, got sick my disability progressed and Social Security told me that my local Social Security office told me that I am putting myself until a bad risk because I was willing to work for 9 and a half years; that needs to be worked out.

I refused five raises so that I could work and stay on waiver and not go on Act 150. I was afraid of losing my spot on waiver services.

So all of these systems, along with the innovations, like the systems need to be coordinated, the housing, I really think that the employment income limits need to be raised for people with disabilities

who are trying to work.

I know that you can't have unlimited income, but I do think that the income limits are very low in consideration.

I think the health law project needs to work with the department to educate people on MAWD medical assistance for workers with disabilities.

Other innovative things that can happen so that initiative for employment is not lost because we are petrified for losing benefits, housing, food stamps, whatever it might be because we are afraid we are going to get sick and then lose everything.

>> Kevin: I hope you submit those comments in writing.

>> JENN: We have it on the record.

>> KEVIN: The last three areas we continue to focus on are the Medicare and Medicaid alignment. We spent a lot of time considering what

would be included in the MIPPA agreement.

The special needs plans that currently serve Medicare, high-level they have a agreement with the statement to provide the services in the Commonwealth.

We will use that agreement as a way to build in assurances that there will be coordination.

We are looking for ways to frame our CMS authority for our community HealthChoices program itself and also looking for opportunities to develop data exchanges or infrastructure that would support health information exchange with providers.

Also continue to look at opportunities for standardizing credentialing with all of the plans to make it easy for the plans and providers who would be seeking to join a plan network and last but

certainly not least looking for ways that we can meet our quality assurance standards and program evaluation standards through data transactions with the plan and the Commonwealth with different types of reporting and different types of contracting monitoring and standards.

These are key focus areas right now.

The primary focus right now is to have the RFP and draft agreement ready for the release on November 16th and also to highlight key areas we know that are going to be particularly challenging in this new program.

With that being said, are there any more questions or comments for me?

>> CASSIE: Did I hear that you are going to have the RFP ready by the 16th?

>> KEVIN: Of November.

>> CASSIE: I got confused for a minute; scary.

>> DREW: Kevin are the MIPPA agreements available online. I am interested in the coordination with Medicare.

>> KEVIN: The if me are not we can.

>> DREW: We are concerned that providers are unable to get exhaustion letters from Medicare. There are Medicare caps on the services and the language needs to be understood that it is impossible to get a letter of exhaustion.

>> Kevin: The MIPAA relate to the managed care plans. You may be experiencing some issues with the Medicare fee for service plan which falls outside of that.

>> DREW: I see. We still have the comment about coordination needing to reflect the reality of what you can or cannot get sought of

Medicare.

>> KEVIN: I think it is a very fair comment.

>> RAY: Just curious if there is an update on your CMS conversations regarding authority and your current thinking as we move towards the RFP?

>> KEVIN: We have another conversation scheduled later this month.

We have had a lot of -- we have had a lot of suggestions froms CMS contractors specifically about the MIPAA agreement we had a session that tbheent a lot of detail about different opportunities for us.

I think that CMS has -- they received the concept paper. I think that they have questions about the concept paper. We are hoping that they provide specific guidance to us when we talk to them later this month.

Broadly saying --

>> RAY: How about financial alignment? Three-way contracts? Is that contemplated? Have you reached a decision on the mechanism?

>> KEVIN: I think we are still open to talking about demonstration waiver 1115 (a).

Jen, you can correct me if I'm wrong 1115(A) is off the table.

What authority is 1915(b)(c), 1115(a) waiver we are hoping CMS provides us some direction. We have a suspicion which direction they will point us to.

>> JENNIFER: I don't mean to be monopolizing the conversation but I do have a question as built in with the time period the department still seems to be very open to comments and taking our comments into consideration and changing the RFP if need be, which is wonderful.

Thank you again for the openness of the administration, it's a very

welcomed change.

I have a concern on the time period and on whomever is in charge of this, whether it is the Governor or Secretary Dallas or whoever is driving this to be done by a certain time. Have they allowed time built into the process for the comments and the changes that need to be made as you see there are changes that need to be made and it is not working exactly as you may have hoped, can you go back to them and say, this needs to be changed, but we need more time or is the time line set in stone?

>> KEVIN: I mean, you were asking two separate questions. Incorporating comments, stakeholder comments and stakeholder feedbacks on the documents that will be released.

We think at this point that there is certainly enough flexibility to make -- the concept paper as mentioned earlier was framed in large part by

the suggestions made by stakeholders in Pennsylvania.

That being said, we have -- with the comment period for the concept paper ending by October 16th, we have more than enough time to be able to incorporate those comments and suggestions and key components the stakeholders are promoting for a November 16th release.

We have enough time for that. As Jenn had mentioned earlier, we are releasing the RFP with draft agreements. We have a 30-day comments that is available on the draft agreements.

We have enough time before the contracts are negotiated to make significant changes to the draft agreement or the agreement that eventually turns into the actual agreements, based on those comments and key points.

I think that we have also committed -- we have -- we are going to

build into the contract itself the opportunity to be able to make changes based on, as Jen mentioned earlier, rapid cycle evaluation or any other risk areas we see are not working in the program.

We have mechanisms in the contract itself, once it is live, to be able to make changes to the program and make sure that we have multiple fail-safes to make sure that those changes can be made for the new program.

>> JENNIFER: Just a follow-up question. Will we as participants have a department -- an exact department contact, not a recorded message but an exact department contact, whether it be Secretary Burnett or whomever, who is committed to seeing this work, if we are seeing this problems on a day-to-day basis, will there be a department contact that we can contact you.

>> KEVIN: I can say that you do. You are on the committee.

[LAUGHTER]

You definitely have contact information. There will be a representative for issues that participants are raising, there will be representative/entity that will be able to hear those concerns, department sponsored, actually part of what we are looking forward to hearing comments on how that participatant entity should be framed for the program from the stakeholder feedback but a participant entity that will take those contents on an individual basis and problematic basis.

>> JENNIFER: Thank you.

>> STU: From what I read before coming today and certainly from what I have heard during the meeting today, I can see that we are going to be busy over I don't know how many months with regard to the balance

between what is managed care and the other phrase being personal directed care.

I have had 30 years' experience with managed care in a healthcare system and what makes it successful, if you think it is successful, is that it is managed; that there is a person or persons who deal with what care is to be provided and caring for individual patients.

On the other hand, I am fully aware that Temple paper that was included have somewhere in our paper dealt with especially directed care.

We are on two tracks. I inconvince continuous conflict as we go down that line.

My appeal is that we understand that things can change with time. We can learn with time.

Not all HMOs or managed care healthcare organizations were perfect

on day one, and are not in fact perfect today but they are a lot better today than at another point in time because there was a learning process and a balance.

I have always felt in my role as a healthcare executive that patients don't know everything about their care but our physicians don't know everything about the care so there is a real opportunity to make sure RFP or whatever there are ways of adjudicated indicating these differences and that hard work can take place now to smooth things as we go down the line.

>> Jenn: So I would just like to amend your comment and ask that rather than saying there is going to be conflict there is a nexus. I think the nexus is really about person-centered, person-directed care being at the center of how they get their care deliver the to them.

Certainly medical care, physicians know more and can offer a lot to all of us. We don't know what they know.

We have to figure out what that balance is. I think that's sort of what this whole committee is here to help us do.

>> DREW: Kevin, I think I misunderstood what you said about authorities considered did you say 115a is off the table.

>> Kevin. There are two. One is capital A and one is small a; that is bureau drat speak. The small a is -- the large A authority was use in the Affordable Care Act and are currently closed as they exist now.

The (a), 115) a) demonstration waivers are still available.

They have a higher standard, like, for example, budget new tralt, all of this stuff is onlipe and don't want bore you to tears but it is flexible type to have waiver.

>> DREW: That is what I understood, you know, that is what the state was most interested in going for. I guess I just wonder if in the RFP and for our, you know, remaining week of comment period, whether there is any relevant defenses in what would be going into the RFP if you go with one authority over the other?

>> KEVIN: Great question. I would have to say at this point we have to write the RFP and draft agreement with program framework that would be eligible for both.

>> DREW: For either. Okay. Thank you.

>> KEVIN: To be honest of the two different waivers we were discussing, 1915 (b ?ie. c) the program would have to qualify for that or 115.

We want to make sure we have enough flexibility to meet requirements

for more flexible waiver as well.

>> JENN: As an example in 115 (a) the state can ask for what are called costs not otherwise matchable the secretary of health and human services can grant us that authority to actually use our Medicaid dollarss for costs not otherwise matchable. It gives us flexibility but budget neutrality is a very big challenge.

However, as Kevin said, just to put a little bit of, you know, making this practical, even though -- if we were to go down the 1115 (a) path, we still want to align with the current regulation on the 1915) c) INK which describes -- going back to the question about person-centered planning and person-centeredness speaks to that and requires states to have person-centered systems, as well as as pretty clear definition of we want to align with this regulation whether we went for bc or little a.

>> DREW: CMS has to approve either one; is that right?

>> KEVIN: That's correct.

>> DREW: So do they actually look at RFP?

>> KEVIN: They look at RFP, the rates that are submitted, pretty much everything submitted to the program.

>> JENN: They have to approve the managed care contracts. They have to look at everything.

>> Ralph: I will go over the recommendations. Some of the members are here. Some unfortunately were not able to make it today.

Richard's concern was consumer protections. What is what is the state going to do to assure that there are consumer protections in this process. My conversation to him again was -- there has to be a way for easy appeals ooh and grievance processes that are tangible you I will

never understand long after I leave my position awe -- when on one hand -- I have seen it. They are on the phone at a consumer's home and they are whispering some things to the consumer. It just seems to be a bad process. My service coordinators are -- they are on board for consumers almost 99% of the time. If there is a way down the road that the process can change and make it fluent and speedy, that would be wonderful lastly, I think you answered this some way some how. This subcommittee, do we get a position on the concept paper? I think you've answered that already. Will this committee have a position on the concept paper?

Again, some of these questions we have here, we have already answered today.

Moving forward, I will ask Jennifer and Cassie, if there is anything

more you want to add to what you spoke about today?

>> CASSIE: I am all right for now.

>> JENNIFER: I am good for now. Thank you.

>> JENN: Anyone on the phone have any questions in regards to that?

[NO RESPONSE]

Tanya submitted questions to us. I will just read them.

What Medicaid -- who Medicaid providers will be and how they will provide services going forward. Do you have any response to that?

>> JENN: I mean, they will -- the providers -- I am not talking about the managed care organizations, the providers will have to be actual Medicaid providers. They will have to have registered with Medicaid. They will also have to have gone through our process for authorizing the ability to provide services as a long-term services and supports provider.

So those things will still be in place and so I would imagine many of the providers that are already providing services here, will engage with managed care organizations to contract with them and provide services.

>> RALPH: She had asked, What is the department going to do about increasing the standards for service coordinating agencies as well as FMS providers going forward? Do you have any plans in place?

>> JENN: Yes. We will be going out eye -- Kevin, correct me. Is it a concept paper with FMS? We will be starting a procurement process for new FMS vendors.

>> KEVIN: RFI.

>> JENN: That will be coming?

>> KEVIN: Eminently.

>> JENN: We will put out for comments for FMS, the concerns over the past couple years and certainly since I returned here will be welcomed in that process.

Service coordination, we will have very -- those stand standards will be laid out in the procurement process.

Again, going forward, again, I think you pretty much answered this in a sense, I am looking at Fred and Fred's area going forward, that smooth transition period. I look to Jennifer in having her have that special hotline to the department to answer the questions from consumers.

>> RALPH: There will be a lot of concerns. Trust me.

>> Thank you.

Barbara, comment?

>> BARB: Question. When you talk about the service coordination

agencies and standards, does Act 22 still play into this?

>> JENN: Yes.

>> BARB: Regarding the network of providers, I just get a little concerned because I am not sure that consumers are aware of the potential change of choice of provider under this new model.

Currently in Philadelphia, you could run a list for PSA agencies and come up with 65 to 70PAS providers.

The likelihood of all of those providers being available, I don't think that that is true. I think we really need to educate and make consumers aware of this that there is a potential change in how they access their services.

>> JENN: Thank you.

>> RALPH: No further questions?

>> JENNIFER: I was just wondering, is there any plans to take out of the RFP that it is the managed care organization's decision with what they do with supports coordination in response to making it more person-centered?

Could it be up to the participant as to whether they choose the managed care organization's method of supports coordination or providers are contracted with the managed care organization?

I think that is a huge part of person-centered planning. I think it's very important.

Some of us have relationship with supports coordination agencies -- I am not exaggerating here blood, sweat and tears.

Those relationships have been forged. We finally get it right and the idea that someone is going to have the authority to take that away

from us -- if the MCO has a supports coordination entity that they want to work with, then make them represent it to us. Make it well worth our while to switch, but make it our choice.

I really strongly believe that.

>> JENN: Thank you.

>> RALPH: Now we will have.

>> RAY: I just wanted to talk about FMS and the role. I though it's an important subject with the current provider.

I am curious how it's evolved in time it was more independent-living focus with training and education and more comprehensive than simply just the payroll function that is being performed in currently and future state will look with service coordination and FMS will come together maybe differently than the current process but maybe differently than the prior,

you know, process as W.

>> JENN: Kevin, you can correct me if I'm wrong.

Recognizing that problem, we are putting in the RFI the opportunity for the FMS provider to have a support broker for consumers who need it.

If the consumer were to need a support broker somebody to teach them how to hire, fire, train, all of that kind of stuff, that support broker is going to be available to them.

Then, maybe the consumer might say after a year of using support broark I know how to do this I don't need it anymore, maybe down the road they have a changeover in direct care worker and might want the support broker to come back into their life to do recruitment again.

We are envisioning having this support broker function within the RFI.

>> KEVIN: The RFI doesn't go to that level of detail we are looking for --

>> JENN: I have it fleshed out in my head what it will look like we want to ask people to comment what it should look like.

>> RALPH: Cassie, question?

>> CASSIE: The maintenance of effort piece I just wanted to bring up, I hope we will not lose Medicaid protections and I was thinking of a way to track people's utilization is just look at HCSIS and the last two years some of PPL's stuff because they have documented it.

Although I don't like PPL I have get something about my utilization.

I just don't want to lose any protections that Medicaid has offered to this community and when people make decisions about utilization of hours.

None of us in this room I don't think would want to see hours abused, either, because we want people to come out of nursing homes. We want to see new young people served, but at the same time, as you age, people's disabilities change and, actually, people's lives change as when -- a lot of people were afraid that Medicaid would cut our hourses saying people were eligible actually a lot of us were available and got more hours which opened up a better life to us, despite the rumors.

I don't want to lose any of that with the budget neutrality, the language.

>> JENN: I was around when that happened when we had our Act 150. In fact our lottery system in aging didn't want to use, you know, take advantage of Medicaid. We had a nice robust lottery program. It was a battle to get Medicaid in the aging waiver. Same thing happened on the

Act 150 side. It was a battle in the 90s to get people to accept the fact that they could have Medicaid and maybe even get more services from Medicaid.

So it's an interesting conundrum that we find ourselves in when we make change. It is never easy.

Just to your point, Cassie, and I think I said this at the last meeting, managed care organizations have a responsibility and sort of the inherent responsibility to keep people as healthy as possible and as independent as possible.

To that extent, I can't imagine that they are going to come in and put protections into the contracts where we are going to be looking at if cuts get maid we will pay a lot of attention to that.

I don't and that they will, when cuts are -- unless there are

situations where the care plan is really inflated and doesn't make sense it creates dependencies which are not necessary and never healthy for people.

So those kinds of dynamics are all at play in this.

>> CASSIE: Also --

>> Brenda: I would like to make a comment.

>> JENN: Please hold Cassie is finishing her comment.

>> CASSIE: I don't want to see our system privatized I feel the state/Commonwealth will always have a responsibility to monitor that, we are getting the best care and the care we need.

>> JENN: Absolutely. CMS requires us to do that and we know it is the best thing to do.

>> JENN: Brenda, I am putting the mic down to the phone. Go ahead.

>> Brenda: One thing that really concerns me in the concept paper to piggyback on what Cassie says on not losing protection.

After the 180-day period, once the tool was developed, it says that state review is only required when a -- wants to review a service for more than 25% cutting my hours by 25% would be the difference between me working and literally -- [indiscernible] 25% is human.

It can be -- why is that cost number there at all [indiscernible]

>> JENN: Thank you, Brenda.

We have had comment on that and we are reviewing it and making consideration of changing it. Actually, the state has the right to review any changes at all. We put 25% in there as -- because of knowing what our capacity is, we do have concerns.

We have the right to go in and any change at all in a service plan

or care plan can be reviewed by the state. We are considering, Brenda, what you just said, was also mentioned we actually went into detail on it at the last meeting so we are looking at that and taking consideration of it. Thank you.

>> THEO: Can we ask that when the state review, if the state review, that that information is then brought to our attention, so that we too could understand and work with you on those appeal cases?

>> JENN: Well, on an individual basis, no, it is protected information.

But we could definitely and we will be aggregating our data and looking at it and talking with you about what we are learning in the system; that's part of --

>> THEO: Provided reports?

>> JENN: Yes. We will be working with you to develop provider reports, develop the type of reports you want to see in these meetings. Fl.

That's something to think about in the future.

>> THEO: Okay.

>> PAM: Fred?

>> FRED: I want to let you know I keep hearing it over and over and over they don't want 25%. They want 0%. They don't want a% of anybody's hours getting cut. Period. Right off the bat.

It can happen. We know it can happen. They say it won't, oh, well, they want to keep you healthy and giving you hours will keep you healthy. They also want the pocket pook healthy. I am afraid it will happen. If they drop everybody by 25% without a review there shouldn't be any

percentage it should be straight up. Zero!

>> JENN: Thank you. We are hearing that from other sectors to. I think I got that.

>> THEO: Can I add one more thing to do that?

>> JENN: Yes.

>> THEO: If the state looks into it and a case does present itself and has the warrant for changing another part of it is did something in the person's life change enough to warrant a reduction.

If that is not the case, a reduction should be put in place anyway.

>> JENN: Yep.

>> PAM: If there is no further comment from the committee. We will open it up to public comment.

>> My name is Mark Saltis from MSI, a member of Pennsylvania

association medical suppliers.

I made take comment about a month ago regarding my concerns about the network adequacy and contracting with providers.

Kevin mentioned that we can reach out to those managed care companies that we may not be contracted with. So I did that.

We have basically, also -- there are three managed care companies that I am speaking with currently. Each of those three have multiple recipient of theirs that we know of that are going without medical supplies.

We said to them, we want to discuss two things with you: One, current situation where they are not getting supplies; two, the MLTSS expansion.

One of them base irkaly said talk to us in a year.

What about existing consumers, they said our network is closed but if you talk to us in a year we may discuss it further.

One of them did not respond to multiple attempts to reach out to them. The other one said, our network is closed. End of story. Network is closed. We already told you for the last several years when we tried to contract with us, the network is closed.

We have a different administration now. The deputy secretary Burnett and deputy secretary Lisa Allen are aware of the situation and I believe they are concerned about this. Just know that it is going to be a difficult battle for them. I think the managed cares, despite the mission statements that we hear maybe in these meetings and other places how they care about their recipients. If they care about it yes is concern about the dollar and they are going to basically take providers and slash

reimbursements and all of the things -- there will be a challenge for the department and we thank you guys for being so receptive to us and talking to us about the issues.

I just wanted to follow up on that. I know there were things said to managed cares, hey, you need to work with the providers as well, that's what I am hearing. Hopefully I will reach out to them again within the next month or so and hopefully have a better thing to say to you about that. Thanks for taking my comment.

>> Jenn. Thank you.

>> PAM: Russ?

>> RUSS: I want to first thank Jenn and Kevin and others for the presentation today. I think it is very helpful. Jenn we recently had a conversation about the extent to which, you know, we could kind of clearly

see how comments are being used or not and appreciate the dialogue and you sharing it and letting us all know how they are woven in.

I want to expand upon the conversation earlier about the RFP process and the provider agreement, because I am still confused. I think it is an important piece that we all understand as we go forward.

I have been a member of many advisory committees for many years. When there is an act of procurement on the street, oftentimes it limits the ability, whether it is your ability, Kevin's ability or another administration official's ability to really engage in dialogue around any details.

My question is, we may not have an answer today it may be another go-check with lawyers and procurement experts.

If the RFP hits the streets as planned and draft agreement is out

there and we are chewing on the detail and see a detail we would like to discuss with the department, do you know if there would be any limitations to us being able to go back and forth on those details during open procurement or do we have to wait until we come out the back side of the RFP? If it is, it presents concerns we can't have open and honest dialogue with you, Kevin and other members of the administration.

>> JENN: Legally, I don't know whether -- what the situation is, but I would like to be able to do that. I think that dialogue is always better than just a written comment to really understand and drill down on what the concern is.

>> Can you commit to trying to get an answer from somebody in procurementland.

>> KEVIN: So there are two documents that will be released on

November 16th: The draft agreement and then the RFP.

If you your comments are about the draft agreements, there can be that back-and-forth because it is a draft agreement. It is not final agreement. There could be a lot of negotiation.

If it is about the RFP itself it might be trickier --

>> There is nothing that links those two. If we talk specifically about the draft agreement and I can pick up the phone and call you or we are together, there is nothing that will prevent you from endpaijing in a dialogue detail because there is an RFP on the street.

>> Kevin: The first thing I will do in that conversation is encourage you to submit your comments in writing. We want this to be as transparent as a process as possible.

They may be helpful for other people --

>> RUSS: We always submit our comments in writing for part of the process. We don't want to lose the time between a 30-day comment and get preliminary answers so that we can get that information to inform other companies.

>> KEVIN: Absolutely. We are open to that.

>> RUSS: Thanks.

>> KEVIN: Sure.

>> PAM: Hi, I am Pam your Auer with CIL of CPA and ADAPT I was around when trying to redraft an assessment tool when you were still with us, which was a horrific specious.

The big problem it was a medical model it was a huge debate and argument.

My concern is what that assessment will look like? Are people going

to be involved in the development, people with disabilities?

>> JENN: Yes. And an existing provider (s).

We are looking at MDS home care as a potential to be looking at. We are talking about the needs assessment and care planning tool or service planning tool whatever it ends up being called.

We are -- we want to find some kind of standardized document then we will require managed care organizations to have those available to be able to do care planning and then reporting to -- figuring out what the reporting to us looks like.

>> PAM: My impression is that -- we have been asking for years and years and years and we are excited. One part we are excited about the opportunity to have people based on functional needs. We want to make sure that that assessment tool is seeing the whole person and making sure

that any of our needs are going to get us what we need serviceswise.

For years, I always called it the haves and have-nots depending which waiver you are on.

I hope it is an opportunity for a level playing field to get all of variety of services out there.

Is it people from this committee to bring people to the table? There are a lot of us Ang us to see what it looks like and be part of it MDS makes me think of nursing home.

>> Jeep: It is MDS home care. What it does is actually allow us to start comparing the individuals that are in nursing facilities with individuals that are in the community and a little bit more of a rigorous way which we cannot do right now. The argument often is people in nursing homes have much greater needs in the homes. We know in waivers we are

serving people with high need.

It is one tool we are looking at. If there are other tools out there that people know of that you want to recommend, please let us know. There is -- a lot of work has been done in this field. So, you know, we will be adjusting it for Pennsylvania.

>> PAM: My last question, instead of the enrollment tool, and then the you meet with enrollment and meet with service coordinator and approval from the state it is all rolled into one tool, one assessment is that what this is designed to be? I just want to be clear. There are so many steps people have to go through that's what takes so long.

>> JENN: Can you address that, please?

>> Ginny: There will still be a level of care processes that part of determining if someone has long-term care needs. Jenn is talking

about, specifically, the piece where the needs, functional needs of the person and what they need to terms of the service coordination the domains, the MCOs will be using to do a needs assessment and service plan process.

>> PAM: There is the same old level of care and then this is another piece?

>> JENN: Pam, it is a requirement, CMS requires the level of care, yes.

>> PAM: All right. Thank you.

>> RALPH: Thank you.

>> My name is Lisa Robinson, owner and CEO of my independence at home home care agency in Philadelphia.

I have a few comments.

One on the consumer side. I think one of the things I am very concerned about is the confusion I think will be belt my consumers -- I am really concerned that there may be a chance that some of them will be lost to us and placed with agencies -- I know we all try to do our best but placed with agencies that don't provide them with the same level of care that we do or place them with agencies in individuals who they don't know; that's something that really concerns me.

In the concept paper, I noticed that they were going to be sending out materials to the consumers but as you may well know, a lot of consumers either don't check their mail.

I want to know, are there going to be other things put in place whereby people will go to the consumers home to speak to them and educate them on these changes?

It's going to have a huge impact on them?

The other question is regarding the rate. I haven't been able to get a firm grasp on whether the rates will stay the same for what providers are currently getting as a PAS service provider or if they will be reduced. If they are reduced, I think a lot of providers are going to have hard time sustaining themselves; that concerns me as well, because that will also impact the care that the consumers will receive.

I just wanted to put that on the table. Thank you.

>> JENN: Thank you.

Continuity of service provision for 180 days, we will maintain what the status quo for rates. After that, there would be negotiations between managed care organizations and providers and, you know, we are working right now on some -- we are doing a lot of work on rate-setting process

and that is -- that does involve looking at what the currently rates are.

>> May I ask one, please?

In that regard, is there anything set in place whereby they cannot come in less than what we are receiving now? I think with PAS you are getting 19.52 an hour.

If they come in less it qo be difficult for a small provider such as myself to maintain what we are doing right now.

Is there anything in place for that? Are they taking it into consideration what position that will put us in?

>> JENN: I don't think we have anything in place at this point, but you can certainly make that Kent in writing to us.

>> RALPH: Can you wait a minute, please. I don't know if we answered whether consumers stay with you or goes elsewhere. That goes

back to consumer choice. They have the choice to remain with you, absolutely.

>> In the concept paper, I know that as a provider, we have to bid on becoming a provider within the network. My understanding was if we have Mr. Smith who was in one provider network and we haven't -- we are not in that network, then, essentially, he will be placed with somebody else, unless I am missing something; is that correct?

>> JENN: He will have to choose somebody else in the network; that is how managed care works.

>> Okay.

>> RALPH: Thank you.

>> That is a great lead-in for my comments.

I am Lorraine -- I am commenting on behalf of the medical equipment

suppliers.

One of the concerns, of course, is the 180-day continuity of care provision.

I keep listening to multiple providers in the room, service providers, durable medical equipment providers.

In some cases we are a little different than many other providers because our equipment is already in the home or the person is already using it. As I look around the room, many of these individuals have more than their power mobility devices or manual mobility devices.

What it would require is, if there is 180 days, depending on how the primary payer works, and if we take the situation with Medicare, the primary payer has what they call capped rental categories.

Many products fall into that category. They pay providers for a

certain number of months before that equipment is owned by the beneficiary.

So when we start looking at dual eligibles, we have to look at the Medicare rules and what we are dealing with. Does that mean taking that product out because the previous two -- couple speakers mentioned the fact that the networks are not open. We have concern that the networks don't have all of the specialty DME providers they need.

Many of the DME providers have specialized over the years and provide different equipment. Theo couldn't get his power mobility device from just anybody in the Harrisburg area.

So, you know, again, the concern is, how do you handle this? What do you think? How can we do something different?

Even looking at what Medicare has done, of course, in certain areas

of Pennsylvania and we have competitive bidding, where the primary provider has been chosen because they have competitively bid on a product; that means that the Medicare recipients have to go to the select group or providers.

So, again, your choice is limited as a Medicare recipient in that way, other areas it's not.

What Medicare did with bidding program they allowed for a grandfather clause. I think it may help with the consumers or state if they consider something along that line.

If an scried already had a personal service provider that both the provider would have to agree that they would grandfather and the consumer, that they want that, the same way with DME. If I have a product in somebody's home whether it is oxygen, ventilator, power mobility device, a

bed rather than disrupting that care to that patient, what we need to do is think about how we can continue to provide that service.

I don't think 180 days is appropriate for a lot of reasons. I'm sure everybody around this room has different reasons for that.

If you just take a look at the medical equipment and say, do we want to pull that product out? Do we want to set up a whole new system? If that patient is already at home on a ventilator, already receiving those services, you will disrupt everything from home health to DME to service coordinators.

So I wanted to bring that up. We certainly have a lot of concerns with that and also on the dual eligibleses someone earlier brought up regarding Medicare coverage and denials if there is a way to have standardization, where you don't need a denial, there are certain products

that are not covers for DME and they are statutorily uncovered items that are published.

Why would we have to go through a denial process? Why would the state have to go through that? The consumer and have a delayed process and even with the prior authorization process and the MCO process, what items will of ours would be required to have prior auth?

The problem is we can't provide the product and get denial until there is an authorization on the MCO side.

Again, we are experiencing that right now. Many of our consumers have months and months of delays in getting product as we work through the technicalities. If we can get around the you red tape would be helpful.

>> JENN: Lorraine, you have an in-depth knowledge of something that is very complicated. It would be great if you can put recommendations in

writing as to how you see that kind of thing occurring. Of.

Because I probably can read it, I will be able to read it later, ut about the noances are important to get at and help us frame it out right.

>> Lorraine: Thank you.

>> RALPH: And in the spirit of keeping this timely, I have two more people and then we will go into the committee member suggestions for the agenda items next.

>> Roy: I am Roy Zimmerman from -- I currently serve as president of Pennsylvania association of medical suppliers.

It was mentioned earlier that the concern was on the durable medical equipment side if the individuals continue to have access and that there would not be deterioration or clause in there that they would provide less than what they currently have access to today.

I do want to ask if what the protection will be for the provider community and also for the recipients in the fact that currently in the State of Pennsylvania, there was an MCO earlier this year that arbitrarily cut their reimbursement prices by 353% of Medicare's fee schedule.

It put a lot of providers in a bad position to be able to continue to provide.

Not that the product is not available or providers are not available and have the ability and expertise to provide, but that they could not provide at that kind of rate.

So now you put an at-risk and accessibility issue to beneficiaries.

Will there be protection in any MCO contracts that they cannot do that to the provider and make the beneficiary at risk ?r.

>> JENN: We will be putting those kinds of protections into the

contracts. If you have any specific ideas or thoughts about how that might look and be written, that would be very helpful to us.

>> Thank you.

>> My name is Quinn. I am speaking on matter of law of cedar woods care management.

I actually have several questions.

My first question is, I know that maybe the first meeting you had it said you would be doing I guess a Samableing up in Pittsburgh when it rolls out the first time and that's supposed to happen and work out the kinks and those types of things.

Is there an assurance to say, I believe if it is not working we will pull it? Is that still happen willing or --

>> JENN: We will make adjustments along the way if we have to.

I have heard the Secretary say that. He has said it to Jennifer Howell.

>> Okay. And then there was a credentialing at the end of September and it said that -- I just wanted schair fiction if you have any information waivers would be consolidated under CHC if not it goes under RFP. I am not sure if it was understood correctly, written correctly? That is not clear at all.

>> JENN: I am not familiar with that. Make Hale, do you know anything about that?

>> MIKE: Credentialing will be a big part of --

I am Michael Hale with the Office of Long-Term Living.

As far as we have had discussions, credentialing will be a big part of the process that the MCOs will be credentialed as will the service

coordination and the provider entities; that's all going to be part of the process of readiness review as well as in the RF -- in the RFP documents them selfs.

>> Okay.

>> JENN: We have started those webinars and they were intended to get information from all kinds of providers, nursing facility providers.

>> Those will just continue?

>> JENN: Those were our first step at getting feedback on what a credential might look like. We have an interest in developing some standards for credentials to make it so that providers could be credentialed in a state sanctioned/authorized credential so that managed care organizations could providers could operate in different managed care organizations with that same credential.

We are looking at a standardized credentialing process. Whether we get there, I don't know. The webinars were were meant to get.

>> Thank you. The next question is the deadline for RFP is in November. The MCOs, once the RFP is released -- I just want to understand the process. Once the RFP is released in November, that's when the MCOs will based off the document will start bidding, if we are informed to reach out to MCOs to try to contract with them, we don't necessarily know who will be accepted and won't be. Who we reach out to may not make the cut.

>> JENN: I would advise you to reach out to as many as you can and begin having a conversation with them, developing relationships with them, understanding what their requirements are going to be in terms of what they expect providers to do.

I ask you to reach out to as many or all.

On the DMS website I think we sent it out to the committee, it's a public document, which is all of the managed care organizations that are currently participating in HealthChoices by zone; that's just one kind of -- there is also Medicare special needs plans across the state.

I would definitely be reaching out to the ones that are in your region and begin conversations.

>> Okay. And then we don't know if they are selected. The deadline for us to know who will be MCO or will not in this process is that March or next year or --

>> KEVIN: Early spring.

>> JENN: Can I stop you for a minute? I will tell you I was at the managed care subMAAT and they asked for a list of providers. The managed

care organizations are also wanting to reach across the line and figure out who you guys are and start dialogues with you.

>> My last question, I think it was said earlier by you guys. I think I might have missed the details of it.

I know it's split up by region and someone asked if it would be one MCO over one region or several MCOs --

>> JENN: Several.

>> That's all. Thank you.

>> RALPH: Zach, before you start, can I ask the committee members if you have any topics for the next upcoming meetings?

>> JENN: Please send them in or if you want to --

>> STU: I would love to see the financial -- what are the dollars associated with this whole thing.

>> JENN: Yep.

>> Fred. Jerve.

>> JACK: Is there a time line for when you will be deciding which type of waiver you will submit?

>> JENN: We will -- I will table that until after we talk with CMS. It will either be concurrent bc or 115 (a).

At least until after the RFP goes out we will not engage in that full-fledged -- as you know, it is a very public process. We will not be coming not only to this committee but going out and doing focus groups around the state in order to begin that process.

>> JACK: All right. Thank you.

>> FRED: Four things: Community planning for community-based services, social workers and everything.

The second one would be home care and ins takingsal care, eligibility equality ooh durable medical equipment and appeal process. We need to discuss these things at our next meeting.

>> JENNIFER: I will would really like to hear from a state that is doing managed care effectively and hear from some of the participants because despite the assurances, I am very scared so I would really like to get some assurances from people who will be using the services.

>> JENN: I am glad you mentioned it Jennifer, we are in the process of recruiting consumers, I believe we have one potentially coming from Texas and possibly Tennessee. We are currently working on some of the states that have been doing managed care, managed long-term services and supports.

So that is on our agenda. We are thinking maybe November, but we

might have to table it until later in the year.

We are working on that right now.

Thank you.

>> CASSIE: I would like to recommend Wisconsin Zach had his happened up for a long, long time for public hearing.

>> CASSIE: I would like to recommend Wisconsin there is a lot going on there and I don't hear complaints from consumers or people working at CIL with disabilities.

Also, I would like to -- Tennessee and Texas had nothing until they got managed care. We are more like Wisconsin who had things and the system changed.

>> JENN: Okay.

>> CASSIE: And I hope for the better.

The other thing is, I would like to analling in place and managed care discussion, I would like to hear from managed care perspective on that as well as what our perspective and our comments might be on that.

That word seems to disappeared suddenly and it scares me. I hope I am sustainable until I die; that's my plan.

[LAUGHTER]

>> JENN: Thank you.

>> Brenda: There are two topics I would really like to discuss at the next meeting. One is that I think I would like to clearly delineate the differences as this committee sees them between what MLTSS will look like and what senior life looks like, there is a lot of assumptions that we might be modeling after them and while that is

true -- [indiscernible] -- it is not an across-the-board -- another thing

I would like to talk about consumer employers and what it is actually going to look like under managed care for the people who want -- [indiscernible]

>> JENN: Thank you.

>> RALPH: Zach?

>> Zach: Hi, everyone. I just had two quick questions. What assurances can you guys provide or guarantee that if, like, a consumer or even myself you know gets -- is denied through our insurance the denial letter is like gold when submitting it to our supports coordinators and possibly get it through our waivers.

I don't know how -- I am dual eligible and I don't know how to get that piece of paper to say that you are denied this whatever -- this product or is this service through your insurance so that I can submit it

to my supports coordinator to submit through my waiver.

So I guess the question is, like, in order -- how can we get that piece of paper; that's one.

How do we, you know, get it through our waivers.

Is there managed care all going to be grouped up into one big lump?

>> JENN: We can require it in the contracts for the first question that there's a timely notification of change or denial so that you will have something in -- you know, in writing that you can appeal.

We are going to -- in managed long term services and sports and in managed care in general, we will have one waiver whether it's 1115 (a) 1915(b)(c) waiver you may be receiving services under but we will do a concurrent (bc waiver.

We have a big challenge in doing oversight and management of those

programs we are very interested in just having one.

When dealing with FMS what checks and measures will you darn tea us as consumers that we will not, you know, go through a lot of, you know, of what happened with PPL regarding dealing with not act able to speak to someone face to face when our attendants need paid they provide essential service for us it is so necessary.

If they -- we cannot talk to anyone because, you know, whether -- I don't know who the new provider is going to be, but if they, maybe, submitted the facts and we have a list -- we have a piece of paper staying, we went through but no one is et gooding back to us or we need to see someone face-to-face for that or if the time sheets is read incorrectly through, you know, a system through provider -- like the provider might have to scan it in or during the issues of availability,

the time of day cause some of us -- I plan ongoing back to work. If I am at work 9 to 5,000 how will I take care of FMS if they are open during the times that I am at work?

>> JENN: I think Kevin mentioned the RFI we will open on new procurement FMS give your comments back to us, your suggestions on how to make improvements, how to address issues that you are facing right now and specifically address issues that -- I mean, whatever issues you are having, those kinds of specifics will really help us get the new FMS procurement and contract right.

>> Thank you.

>> JENN: Thank you.

>> Good afternoon. Director of Bucks County AAA.

I have two very quick questions. The concept paper mentions the

telephone needs assessments and analysis to be completed by the managed care organizations; is that separate from the current options counseling completed by the aging and disability resource centers?

>> JENN: I don't know.

>> KEVIN: Yes. You are talking about the functional needs assessment? Yes, it is driven options counseling the aging disability resource centers complete right now.

>> Excellent. Thank you.

The second question is, just for point of clarification regarding level of assessment tool to be created, did I hear correctly that you are considering a tiered eligibility? One for institutional care and another one for home and community-based services?

>> JENN: No.

It's a level of care for clinical eligibility for nursing facility care which is the currently standard. We will probably rename it but it is a requirement by CMS in place whether in home and community-based services or in nursing facility. So it goes for both.

>> Okay. Thank you.

>> RALPH: Okay. I thank everyone for coming. I thank everyone for their comments.

The meeting is adjourned. Thank you.

(Meeting adjourned at 1:05 p.m.)

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