Managed long-term services and supports committee meeting

Friday, December 4th 2015

10:00 a.m. to 1:00 p.m.

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>> RALPH: We will be starting in a few minutes.

Good morning, everyone. I would ask that you take your seats, please.

I would like to start with the introduction of the committee

members and I would like to start with Barbara.

>> Barb Polzer, Liberty community connections.

>> Daryl Andress, Bayada home healthcare.

>> Blaire Boroch, united healthcare and community plan.

>> Tanya Teglo [unintelligible]

>> Jack Kane [unintelligible]

>> Bill White, AARP.

>> Kathleen Holdsworth, disabled in action.

>> Pam Mammarella, the LIFE program.

>> Jen Burnett, Deputy Secretary of Long-Term Living.

>> Ralph Trainer, Abilities in Motion.

>> Fred Hess, Community Disability Options Network.

>> Steve Williamson, Blair Senior Services.

>> Jennifer Howell, consumer.

>> Terry Brennan, PAC and CCAP.

>> Drew Nagele, brain injury association.

>> Theo Braddy, Center for Independent Living.

>> Neal Brisno --

>> Stu Wesbury, Retired, Chair Pennsylvania council on Aging.

>> Richard Duckson, consumer.

>> RALPH: People on the phone, please?

>> [indiscernible] AARP.

>> [indiscernible] Centers for independent living.

>> [indiscernible] voices for independence.

>> RALPH: Okay. Welcome, everyone.

I would like to make you aware of the housekeeping and our

committee rules, please.

For public comments, we will take them at the end.

I would ask that you respect others in the room, proper language, be respectful as you can be.

The microphone when you speak press button so it lights up and turn off because we can have disruption of the microphones.

There is captioning being done.

Cell phones, please turn them off.

There are vending machines cash operated, located on the third floor.

Please be mindful of your area. Pick up the empty cups, bottles and wrappers, please.

And, again, topics for these committee meetings, you are able to

submit them through a resource account email address and for the emergency evacuation procedures, there are emergency exits to the right for people that may need assistance, there is a -- I forget the name of the term for station where you wait if you are in a wheelchair.

Fred and I will make sure we yell and scream.

>> FRED: Fred is going down the stairs.

>> RALPH: I will be right behind him.

Well, thank you, and now we will have Jennifer give the OLTL updates.

>> JEN: Good morning, everyone.

I am actually going to ask Kevin Hancock to come talk about participant demographics first.

This presentation, is a result of one of the member's request to

understand better who's in managed long-term services and supports and understand the demographics of them.

Kevin is going to come talk briefly about demographics and then he has to go over to the health and welfare building for a couple meetings.

>> KEVIN: Thank you, Jen, and good morning, everybody.

Kim will be operating the PowerPoint presentation, and she is responsible for pulling the information together. I will punt any questions to Kim.

Dr. Wesbury requested this presentation to talk about not only the demographics of participants enrolled in Community HealthChoices but utilization data, data that describes the population and the cost of participants in Community HealthChoices.

A couple caveats before we begin, this data is estimated data.

What that means is, when we talk about the numbers, here, you may have seen these numbers before, especially the population numbers were included in the draft agreement information that we published in November.

This information is still estimated because there are a lot of different ways that this data could be pulled and we are still trying to finalize the methodology. We will end up using not only to identify the population that will receive notices for Community HealthChoices but how we will manage the rate-setting process.

Expect that it's quite possible that this -- these numbers you could see could change even for the same time period and also the way we describe the methodology could change in the future if we find a more precise way to identify the population.

That is my caveat before we begin.

With that being said, I am happy to answer questions either during or after presentation, as we go through it.

I will try to make what could be considered to be a fairly dry component of this presentation as brief as possible.

So the population itself, this bracket gives you a breakdown of the way we are looking at the population.

The overarching condition of the population -- we are not going to specifically talk about the individuals between the ages of 18 and 20.

Currently in home and community-based waivers, plan to be grandfathered into the program.

Just because we are trying to discuss population of the program it is truly fully operational.

The program is for individuals who are Medicaid eligible, 21 and

over.

There are subgroups within that larger population for Community HealthChoices.

The first is if they are nursing facility clinically eligible, if they are not nursing facility clinically eligible.

The nursing facility clinically eligible could be individuals receiving services in the community through home- and community-based waivers or individuals receiving services in a nursing facility.

Those -- Pam was kind enough to point out to me that they could also be receiving services in LIFE program, broadly considering LIFE to be home and community-based program it is separate because it is managed care.

Under that umbrella of NFCE they could be dual eligible for both

Medicare and Medicare or non-duals meaning they are eligible for Medicaid only.

Under non-NFCE or not-nursing facility clinically elimination I believe sometimes called NFI population, we have dual eligibles eligible for Medicare and Medicaid not needing lorve-term services and supports.

We also have non-dual individuals who are not CHC eligible but fall under non-CFCE.

We are taking into consideration this is non-dual non-CHC eligible but they are not part of the program.

>> Cassie: Just for clarification, can I ask something ask if they wept into the nursing home would they be eligible -- the way I read it in here, I thought if you were on Medicare and ended up in a nursing home and were on Medicare and I think it is the advantage --

>> KEVIN: If you are Medicare and Medicaid eligible, you are nursing --

>> Cassie: There is no way out for Medicare in nursing home, until they lost everything.

>> KEVIN: You mean if they are spending down into the program? I am not sure I understand your question.

>> Cassie: Do they have to become bankrupt or lose their house any assets before they could be --

>> KEVIN: For Medicaid Kara lone and not Medicaid eligible; that's correct.

If they are duly eligible, they would be part of the Community HealthChoices program.

Does that answer your program?

>> Cassie: Not really. I am just thinking, if they go into a nursing home, they are on Medicare --

>> Kevin: Right.

>> Cassie: They will end up bankrupt shortly.

>> KEVIN: Paying out of their own pocket for nursing facility services beyond the --

>> CASSIE: Yeah.

>> KEVIN: They wouldn't be part of Community HealthChoices.

>> CASSIE: They have to go through and take -- blah, blah, blah -- it's clarified. It's difficult for old people.

>> KEVIN: Agree.

This is a Medicaid program.

>> CASSIE: Just curious.

>> KEVIN: Very important policy question but just to be clear, this is a Medicaid program.

>> CASSIE: I understand it but I think in the long-run it ends up costing you more money if you pick up a whole person's life then.

>> KEVIN: Broader policy question. Duly noted.

>> KEVIN: We will talk about the nursing facility duals, nursing facility non-dulse, waiver dulse, waiver non-dulse, dulse not in a waiver, nursing facility or excluded facility code.

Those are the five populations we will touch on and give you numbers.

The methodology we will use to identify this population.

First criteria is age 21 and over. There is no clarification of person being deceased.

If they are duly eligible we identify this population as being eligible Medicare part A, B, D and eligible forked in okayed. We remove partial dulse, often called the -- supplements they receive for their Medicare and Medicaid coverage, not part of this question.

>> FRED: What if they don't have D.

>> KEVIN: Great question.

Often dual eligibles are only eligible if they are Medicaid dual eligible.

The way our program is designed Medicare part A and B recipients if they do not have part D will be part of this program, just to be very clear, though, we will take measures to encourage the enrollment in Medicare part D as well, for those individuals not enrolled in Medicare part A and D.

Medicare A, B and D will be part of the program. Thanks, Fred.

Additional methodology for background and the record, we exclude removed excluded facility codes. If you want to know what those codes are, we can certainly share them with you.

We included NFCE facility codes.

And non-NFCE facility codes as well to identify as specific as possible for clarification.

>> JENNIFER: Kevin, I'd like to ask a question and also raise a concern.

I was very disappointed to see age was raised to 21. Here is why: EPSTD only covers individuals in school and when if you graduate school, EPSTD stops and also for individuals who are in school and stay in school until they are 21, it only covers partial hours, so for me, myself, I had

no learning disability so I wanted to and had to graduate at age 18 the Governor has a huge push on for the employment of people with disabilities, and I think several things in the proposal, this being one of the main ones, you are basically saying you want to employ people with disabilities, but then you are telling 18-year-olds, I'm sorry, you have to wait until you are 21 to start college.

Basically, I used attendant care right after I graduated to go to college and be successful.

I can't imagine waiting three years, that would put off my employment journey and -- I mean, that just puts everything off until age 21 to even start. People would get very -- they could get very discouraged in the waiting.

I would ask for, if that can't be changed, at least an exception be

made for those who are looking for employment and need to start college or for those who EPSTD doesn't cover home modifications.

So for those in danger of going into nursing facility because home modifications are not covered, please consider at least an exception to that rule.

>> KEVIN: Okay. Thank you for your comment, Jennifer.

I am by no means a policy expert on EPSTD, but it is my understanding that prohibition for EPSTD services is not based on whether or not they are in school.

I hope you've submitted that comment as a question. It is something we should have to respond to as part of the process for the program requirements.

>> JENNIFER: I did. Even if the policy was changed and they don't

have to be in school to receive EPSTD, I know that the family has to be working, unless the policy was changed as welling about I also know not every service or not a lot of services are covered under EPSTD, hence the attend apt going with you to college; that would definitely not be covered under EPSTD.

Under EPSTD, attendants have to be nurses. They cannot drive you in your own vehicles.

Just something to consider.

>> JEN: Kevin I want to respond.

We are not experts on EPSTD. We are following policy on EPSTD have really encouraged us.

We had the 18- to 21-coverage in the original attendant care waiver.

We have been told EPSTD covers those people.

Let us go back using your comments to our colleagues in OMAP and talk this through. You bring up a good point around employment and also the capacity to be able to go to college, is that is it possible under EPSTD coverage. I don't know but we will find out between now and the next meeting.

>> KEVIN: Home modifications as well. We agree that they are essential for people to be able to maintain their ability to be able to stay in the community.

We will take it as a public comment, if it's all right with you and we will respond accordingly.

>> JENNIFER: Thank you very much.

>> KEVIN: Sure.

Okay. This slide gives you the estimated breakdown of the -- I'm sorry is there a question on the phone?

[NO RESPONSE]

No, there is background music.

[LAUGHTER]

We ask the people on the phone to mute if you are not speaking. We would appreciate it very much.

>> FRED: I think they went on hold.

>> KEVIN: The number of distinct number of recipients -- at any given time over the course of a year this number could be much higher -- a point in time number of strict number of recipient 393,693.

These are estimated numbers that are still Correct, but this is much more specific point-in-time calculation using methodology I us doesed

in previous slide.

Breaking down specific categories, five specific categories mentioned earlier, if a person is NFCE dual waiver eligible meaning they are dual eligible and receiving services in the community, total is 45,853.

The vast majority of these individuals are individuals either in the live program or individuals in the aging waiver.

The NFCE nursing eligibles are 77243.

The NFCE non-dual eligibles meaning receiving services in community 13,962; NFCE non-dual nursing facility eligible meaning in nursing facility are 7,524.

Obviously the non-dual waiver eligibles will be receiving services primarily in under 60 waivers; lastly, NFI -- which is vast majority of

this program to very clear, by far three-fourths or maybe two-thirds of this program are the NFI duals, the duals who are not enrolled in a long-term services and supports program.

A lot of data here, I will not go through each of these numbers.

It gives you a breakdown by region we will show you the maps for each category.

I will highlight the southwest because it is the first of the phases for Community HealthChoices going live in January 2017.

You will see in the southwest, specifically, individuals under the age of 60 who are considered dual over 60 is 4,032 individuals people receiving services in LIFE or aging waiver are duals who are most likely receiving services in those categories dulse in nursing facility, large number 16,951 are individuals over the age of 60, individuals under the

age of 60 is 1,084.

When you look at the two numbers for dual eligible populations, what this indicates is that in the southwest, even though they have a very rich array of home and community-based services, including the LIFE program but certainly what is available in home- and community-based waivers as well, there is still a lot of institutional services that people are receiving their services in nursing facilities/institutions.

Since this program is emphasizing home- and community-based services this provides an opportunity to look at those populations and see if there is an opportunity to be able to transition them to the community, if it is their preference.

For the NFCE non-dual waiver eligibles in the southwest, over the age of 60 is 715 but larger number here for individuals who are under 60

is 1,813.

So just in general, it is clear in the southwest, the population for under 60 has been very successful in looking for opportunities to have people to be able to maintain and receive their services in the community.

>> FRED: Thank you!

>> KEVIN: Fred is happy about that.

Non-dual nursing facility eligibles, once again, here, the larger number is the under 60 population, under 60 is also larger number here but still opportunity here for -- it shows an opportunity here to continue to move with the Community HealthChoices objective of allowing people to receive their services in the community, once again, if it is their preference.

Once again, as mentioned earlier in the southwest, the vast

majority of this population and we are emphasizing this, it's the NFI duals, the duals not receiving long-term services and supports.

When we talk about this, we are going to talk about a lot of emphasis on the services in southwest no question about that the services are a broader array and also more complex.

We have to take into consideration this large population of people who are duly eligible but not in need, at least not currently in need of long-term services and supports.

So the physical health components of this program that reflect a lot of the services available in health choices are going to be a major part of Community HealthChoices architecture as well.

>> VOICE: Is this on the website?

>> KEVIN: Absolutely. That's the reason I will not talk through

all of the numbers. Not only would it be a very boring presentation, but it would also end up scrambling what we are trying to get to here.

I am hoping people are understanding why we are emphasizing the NFI duals. This is a very big program. It's a very complex program with a lot of different types of populations but the NFI duals are a big part of what the community health choice plans are going to have to focus on because of the larger numbers.

This will give you a map by category of individuals.

The first is the NFCE dual nursing facility eligibles, meaning individuals receiving services in nursing facility as of June 2014.

I think they are red on the slide. The red -- they are population centers obviously.

The population -- the larger of the populations and it continues to

green and to blue and to the yellow or beige.

We were not able to break these down by individual zones at this point, but as you see, the larger populations for these services are obviously for the nursing facility dual eligibles are in the southeast zone and southwest zones as well, as well as Lehigh Capital.

Similar to health choices those three is where most of the population for community health choices program.

It is still a statewide program and expectation for access and network development will be the same, it's just that this is the primary reason why we went to these zones first, the southwest and southeast first.

The next slide shows the individuals who are receiving their services in the community if they are duly eligible.

Once again, it reflects the larger populations are in the southwest, southeast and Lehigh Capital areas.

The third are the NFCE non-duals.

Again, southwest, southeast and Lehigh-Capital.

The next map shows NFCE non-dulse -- this is for individuals receiving services in community. They are again reflecting population centers for southwest and the southeast.

The last map I will talk about a little bit because of talking about the NFI dual eligibles.

You can look at this population across the board and population centers has vast majority. Philadelphia has 47,000 not receiving services and supports.

Allegheny County -- very large populations in each of these

counties. Luzerne is a very large county with 7,463.

The nursing facility ineligible are the individuals not receiving long-term services and supports are across the state. The distribution here for this population is a little different.

When you have a chance to look at these maps on your own when you go to the website you can see how the distribution is a little different.

Population centers are still very much the concentration but you can see this population is very much across the state.

When Community HealthChoices plans are developing their networks or designing their programs, they will have to take this into consideration. It's pretty important that physical health services will have to be in emphasis as well as long-term services and supports for long-term Community HealthChoices.

Just a little bit of data on utilization for these programs. This first slide is on Medicaid costs. This talks about -- also shows the federal and state shares. Acute medical is what we call the physical health services roughly a total of $575 million a lot of money spent for this program.

We pay a little more than 3 billian for nursing home.

Home and community-based waivers -- point to be made it is significantly less. When I started working with home- and community-based waivers this was a rounding figure for nursing facility figures. We are now spending billions.

It shows progress but shows we have a long way to go to reflect an appropriate balance of spending between home- community-based services and nursing facility services.

The total is roughly $5 billion for this program.

What this means from a national perspective is Community HealthChoices is going to be a massive program from cost perspective; that's the reason why we are putting so much energy and effort and how much we appreciate your support as we go forward with it.

Last slide we have on estimates here, that I am going to talk about just to make sure that we are saving time is utilization estimates based on the different categories by zone.

Just to highlight southwest total we are spending for each of these services is a little bit more than a billion dollars. We are spending significantly more, once again, for nursing facility services compared to home-and community-based services than long-term supports and services.

There is work to do to emphasize the balance effort and also to

emphasize that services will be provided to people's preference in the community.

The next two slides go into individual service types between long-term services and supports and acute medical care.

We have a slide here that talks about how Medicare services are paid for with these populations as well. These are also estimates based on 2013 data.

We do receive Medicare data as part of an agreement with centers for Medicare and Medicare services to help with dual eligible population and planning and a little bit with our LIFE program.

This gives you a sense of how much we are spending for -- or how much the federal government is spending for Medicare services for this population as well.

So with that being said, it was a quick rundown. I am going to leave it open for any questions before I turn it back over to Jenn and Ralph.

>> STU: I thank you very much being the person who requested this. I think you said it will be available on the website to get into it on detail.

>> KEVIN: This is just the beginning of the information available on the website. We will publish a lot more which will be a deep dive.

We are using this information as -- it will have to be part of the rate setting and also for planning -- program planning and deployment. This is just high-level overview of what will be available for this population.

>> STU: We received information about Medicaid about 5 billion

Medicare 5.3 billion; that's obviously 10.3 billion, but there are other costs and services that are also provided that are not included there.

Is there data on that?

>> KEVIN: If you are talking about the lottery-funded services, for example?

>> STU: Right.

>> KEVIN: There is data on lottery funded services. We didn't include it as part of this program we wanted to include Medicaid costs.

We will talk to our partners at the Pennsylvania Department of Aging. They do capture those costs, they do tie them to these types of populations as well, we can certainly ask to have that information made available.

>> STU: Eventually, all of this has to be put together because MCO

bidding on this process has to see some bigger picture for their organization so that there is a way for the managed care organization to describe their program covering this, and, of course, have hope that those are paid for.

We are, really -- what we are talking about is bigger than Medicare plus Medicaid. It is other costs as well.

>> KEVIN: I am going to agree with you, how the managed care plans plan around those other costs is a really good question. We are going to ask the plans to have an opportunity to propose to us how they would be providing what we are calling supplemental services for lack of a better term.

That's not going to in any way intrude on opportunities people will have to be able to receive lottery-funded services.

I am not personally going to speak for the Department of Aging, but I think that what we are looking to do, with all of these services, is to buildup a partnership with the providers of the lottery-funded services and managed care organizations to make sure that the best array of services are made available for the individual participants.

I think you are asking an excellent question. I think the managed care plans will be very smart to look at the entire array of services including lottery-funded services and others to get a whole picture of what is needed for this population and what it costs.

>> STU: Just one more comment.

Part of the RFP devoted itself to talking about AAA and better care lower costs.

Somewhere there has to be a definitive cost number. At some point

we can begin to compare to some baseline and -- so how will we know that we are achieving goals -- I'm still not certain that all of these costs funnel back to one point at some point we will have to be able to put our hands around this total package.

>> KEVIN: You are talk -- just for a point of clarification, are you asking for a goal that is being set for this program for costs?

>> STU. I would like to know if there was a goal. I am not sure there is. I thought I read the department may be setting the rates, so the bottom line is, I don't know how much flexibility will be there for an MCO to actually make their own proposal with regard to cost.

>> JEN: We are going to have to set rates they will have to be actuarially sound because we will be operating what is called a B waiver, which gives us the authority to do managed care.

We will actually do B/C concurrent waiver. The C part of the waiver gives us authority to provide long-term services and supports in the community.

The B waiver covers all state-planned services.

As far as, you know -- the package you are talking about, on the Medicare side, we don't have a lot of control, but we think this program will help managed care organizations, because we are envisioning this to be combined.

Medicare is run by the federal government, states are out of Medicare completely. It is really an arrangement between entity of either provider or managed care organization and Medicare, the federal government at CMS.

So when you talk about that package, it is kind of hard to -- for

the state to have any real control over that, but we and that managed care organizations certainly will have that and that will be in their best interest to be able to leverage both of those funds.

Blare or Ray to speak ton that.

This is a package that the state has responsibility for thinking of it that way it is a real challenge.

>> Scott: Jenn my apologies for jumping in, to clarify the goal is to set an actuarially-set rate for each service.

>> JEN: We must do that.

>> Scott: Got you. Good.

>> RALPH: I will have questions from Zach, Richard, Ray and Fred.

>> Ray, did you have a comment for Jennifer?

>> RAY: Sure. Excuse me. I think in response, I think the MCOs

have a great deal of familiarity with serving the 67,000 in the southwest duals because it is the Medicare population. I think we understand the subpopulations within that.

I think some of the open questions for us and some of the new interesting twists will be around the smaller population, the 5% of folks who sore that are participating in waiver programs or living in nursing facilities who don't have Medicare.

As we go through this process, being able to learn more about their experience and how they will fit into this program.

It is important, I think, that we look at them holisticcaly as we move all of the waiver and nursing facility programs into this -- you know, into this new system.

The other thing I would say on that is, from our standpoint, it

would be good to learn more about some of -- while we understand the sort of medical profile under Medicare A, B, D for dual eligibles, what we don't know as much about are the scope of services that are provided Medicare fee-for-service that wrap around that. We know there are therapies, durable income equipment. There may be some prescription drug related areas, over-the-counter drugs, things Medicare advantage and SNPs today will be part of the system as well.

>> RICHARD: The population will have Medicare.

In the RPF program requirements does not provides few references on med care.

Even though the Community HealthChoices program will change how dual eligibles receive Medicare coverage, it will not change the fact that Medicare will be continuing to be some primary coverage for Medicaid

paying second for most services.

Previous documents released indicate Medicare will remain separate and people will continue to have the choice how they receive their Medicare coverage originally Medicare versus Medicare advantage plans to include special needs plans.

Medicare coverage remains separate system, even if people choose joint Medicare it -- the question that I have is, what is expected of Community HealthChoices plans in terms of coordinating services with Medicare coverage and comments about the department's continuing highlighting the care coordination that the Community health choices program will provide and any comments on what is expected of Community HealthChoices in terms of coordinating benefits with Medicare or Medicare advantage programs.

>> Kevin: Great question.

The Community HealthChoices MCOs will have the requirements to working towards or already have a DSNP package or program available to them.

The agreement the state has with with the special needs plans we are going to be requiring as part of that NIP agreement that the the DSNPs the sister health choices plan to provide high degree of coordination between the two programs.

We think we have the authority to on the DSNP side to authorize a degree of coordination between the two programs, and to mandate Community HealthChoices or put DSNP or Medicare providers in general to provide services as well.

To be clear it will be in the interest of MCOs to work with

Medicare advantage plans DSNPs and Medicare advantage people in general full facilitation of services.

It will not only be more efficient and effective system of care for the participants but it's also going to be more cost effective and very much in the interest of program effectiveness and efficiency to be able to have a high dispree of coordination.

I really appreciate that participation -- if you think we were not clear enough in the agreement emphasizing what I said if you could submit a comment to that issue and then make a suggestion for where you think it will be added and we will take a look at it.

>> RALPH: Question from Fred and Zach.

>> FRED: Do those figures also include home modifications and medical equipment.

>> KEVIN: In Medicare they sure do.

>> Zach: I sh a question as far as individual service plan hours for the -- eligible consumers, are there averages on a daily or weekly averages for that?

>> KEVIN: You mean for the specific services themselves?

>> Zach: For the data you had up there?

>> JEN: We have it but that's not on those -- we haven't done an analysis on it. Of it's not included in those slides.

We do have average hours of work. The individuals get -- we have it but it's not part of what you've seen up there.

>> KEVIN: That's correct. If you are asking if we will make that kind of data available; A, we can; most likely it will be part of the historical utilization information that question will be publishing as

part of the program.

What you are asking is important data that not only wool stakeholders want to know but plans will need to know that as well.

>> Zach: Thank you.

>> KEVIN: Sure.

>> DREW: Could you go back a slide Kevin to Medicare and Medicaid buckets that you were showing us before? Since they are huge buckets, you know, over $5 billion for the Medicare and Medicaid, if the state can't just say we are going to leave it up to the MCOs to figure out the coordination, I think we need to give them some guidance as to how to coordinate the benefits.

The way Medicaid works is entirely different than the way med work.

If we are not careful we can have the MCOs pitted against federal

government in how the funds are distributed.

We need clear guidance about how the coordination of benefits should work.

>> KEVIN: I think we need to give guidance, certainly.

I think we are really open to suggestions on how to beef up the language on how you think that that should be presented.

>> DREW: We did submit that previously. I will submit it again.

>> JEN: That's great.

>> CASSIE: It's similar to the first question it's Act 150 all ages. I still care about the young folks even though I am getting up there.

Will there be coordination for people on Act 150 when they end up in the hospital or nursing home.

Most young disabled are not starting out on high salaries where they become dual eligible very fast with illness and bills and things that come in, especially today. Nobody is starting out with great salaries, no young people, especially with disabilities.

How are you coordinating with Act 150? I have not seen any reference.

I know it is not in the program. It would be nice to know that when you are in a program that deals with the state, you know, it is so close to everything else you end up in a nursing home, that that will be picked up on.

>> JEN: You know, coordination with state-funded programs like Options, which was mentioned earlier and Act 150 are all areas that we will be seeking input on from this group and from the public.

We are to the really sure exactly how we are going to coordinate with them, but we have it on our to-do list over the next year to really figure out how we do a good job of making coordination not only with Act 150 and Options programs if you are he will I believe for those you are not generally eligible for Medicaid, but expectation around coordinating with other benefits like SNAP and other benefits that are available, housing services housing availability --

>> CASSIE: One thing that would be helpful is if it was mentioned -- like, you know, that people on Medicare and advantage mentioned in the nursing home, if the provider were responsible to either contract with people that are familiar with this or -- such as CILs and things to do spend-down for consumers when in the hospital. Usually they are losing everything. Especially in they are in hospital long-term or get caught in

SNP unit and lose their apartments needlessly because they are not considered. They are not making frontline staff at CIL is not making a million dollars.

So I am just saying, these people become impoverished, dual eligible and often missed and often not picked up. In fact they can be the silent dual eligibles they don't know they are dual eligible.

I don't know how many people found out haphazardly they are dual eligible in this community.

I think that that needs to be looked at and I don't think it should be that hard to do since you have all of the data right there in your office on Act 150.

Up and down of disabled people on Act 150.

>> JEN: Thank you, Cassie. We will definitely take a look at

that.

>> RALPH: Tanya?

>> TANYA: One thing that scares me a little bit in reference to the RFP, maybe not solely in reference to this presentation up here but I think it has to be said, is the part where I was reading about the service coordination and the MCO.

From what I understand and this could just be my understanding of it and I believe I emailed several people to get different versions of this feed back over the past week about whether the MCOs have to coordinate with those that already exist or whether they will be able to take it on themselves.

I got mixed reviews on the answer to this question.

I am going to suggest something, that you give the consumer the

choice.

What I mean by that is, yeah, we know certain stuff is going to be switched under the MCO, but give the consumer the choice whether the MCO keeps the local service coordinating entities going whether they will do it themselves.

You are saying that this whole new model is supposed to be about Community HealthChoices and consumer participation and consumer direction.

I think that is something that should have to be strongly considered and to my next point on that, I mean, we are talking about employment for disabled individuals, well, with the CILs, I mean, that is how people with disabilities become employed and service coordinators.

I didn't see anything in that RFP that said anything about the MCOs should have to employ a certain number of people with disabilities to make

sure that the services that people with disabilities really need are being thought of when they distribute this care. Is there anything that the State of Pennsylvania is prepared to do to make sure that that happens.

>> FEMALE VOICE: Excuse me! Hello.

>> RALPH: Hold on a minute, please.

>> FEMALE VOICE: I don't know what is making it unbelievably hard to hear.

>> RALPH: I believe everybody on the phone mute your phone, please. Thank you.

>> FEMALE VOICE: Can anybody hear me?

>> JEN: Everybody needs to mute your phone. If you mute your phone you will not get feedback while on the phone.

>> FEMALE VOICE: How will I get feed --

>> CASSIE: The qualifications are not helping us any either. The qualifications are just too high.

You know, some of the best service coordinators I ever saw in my lifetime were in the early days, before we even put associates agree on it.

The turnover was less. The turnover is very great for service coordinators that are not being paid a decent salary in hospitals -- disabled service coordinators that come in because they care about their community.

I mean, I cannot tell you how much I miss the days when we had people who were there because they were -- they loved their community and I had to change -- every time we changed the qualifications and now we upped the qualifications one more time and it is downright scary.

To go along with her question because I think it does tie in.

>> TANYA: I mean, I know what I asked is a really loaded question, but it was meant to be that way.

[LAUGHTER]

The reason why, though, is if it's about people with disabilities and elderly people that are eventually going to need these services or are already do, then the voices should be represented equally.

I mean, because here is the thing.

I am not really trying to speak bad about anybody in this room or even insurance companies because, actually, I have been rather blessed so far with being able to get what I've needed to live, you know, an active and productive life. I would like to do more, anybody would.

What I need to make sure is okay. I have chosen to take on the

responsibility with services my way. I've done so of my own doing. I get that.

The reason why I've done it is to prove if things are set up right, a disabled person can do that in their lives and make decisions just like anybody else in this world.

I am afraid that if it goes to a bottom line with an insurance company, that whole angle of this and people with disabilities wanting and needing to be employed to be a regular part of society, forget about what we do in this room for a second and think about, you know, our regular daily lives and the things we want to do and the goals that we want to have, I am just afraid that if nothing is mentioned in the RFP about how to keep local service coordination agencies alive and how to make MCOs work with them a little bit, they will never discover who the full

individual is.

>> JEN: Tanya, thank you for your comment. I want to point out that there is a continuity of care provision in the RFP, which requires that your service coordinator or your -- any service you are getting, there is a continuity of care period for six months.

We have met with the managed care organizations and a number of people in this room met with the organizations with different -- I will talk about it a little bit later in the OLTL update, what we heard and this was pretty much across the board with every single managed care organization, the question that was asked, it was asked by our facilitator, you may know her, Estelle Richman. She was the former DPW Secretary a few administrations back.

She asked the question in every one of the sessions, do you ever

terminate a provider at the end of the continuity of care period. The answer was, not just because it is the end of the continuity of care period.

We terminate them because of quality issues, fraud, because of other things related to poor service, but we do not terminate services at the end of the continuity of care period, that six-month window just because it's the end of the continuity of care period. It was pretty much across the board the MCOs told us that.

I just want to -- I mean, in trying to help you not be so anxious about it. If you have a good service coordinator, there is a good, solid relationship between you and you feel like you are really receiving person-centered care from that service coordinator and want to keep that service coordinator on, you work with your managed care organization to

make that happen.

They wouldn't want to disrupt that because it would be disruptive to your life.

Unless there were other issues, if there were issues around the quality of the service and, I'm sure the managed care organizations will be talking to you about that if that's the case.

>> Tanya --

>> Brenda dare. I would like to ask a follow-up question in light of what you said.

>> Brenda: If they are saying they won't terminate a provider because of just the end of the continuity of care period, the quality include service coordinator not needing those qualifications? There is a service coordinator -- I will use myself as an example -- I have had the

same service coordinator for 20 years until just recently. He was someone who did not have a master's degree or is not a licensed RN.

Would that be a quality issue with the MCOs under the current RFP.

>> JEN: We are still seeking comment on the qualifications; that's the whole purpose of RFP being put out for comment. It's an unusual procurement process we are going through in this process and we are accepting comments on those qualifications so please, by all means, if you have comments on them, get them to us.

>> RALPH: Barb?

>> BARB: Jen, question. The current FC qualifications in [indiscernible] if what is appearing in the draft RFP is what the department goes with, do you not have to promulgate those changes through a regulatory process?

>> JEN: We asked our general counsel that they said we don't have to. We can go above. We need to put the requirements in our waiver.

>> TANYA: So unless I heard you wrong, I am not trying to start an argument here, I am just trying to understand it in laymen's terms because I still don't understand the government Bible speak and I may never because it's not my area.

In fact, what you said, as long as your service coordination agency or entity wasn't in violation of anything, then you should be able to keep them under whatever MCO you go with. Right?

>> JEN: As long as they are meeting the quality standards set forge in our contract where managed care organizations and the managed care organization's understanding of what those -- Kevin, do you want to help?

>> KEVIN: The continuity of care period -- service coordination service itself, they will have to be part of -- in some configuration they still have to be part of the managed care plan's network.

>> TANYA: I get that part, but let's say, like, with these requirements that are there that they have to follow, if they are not currently within those guidelines, are they given a certain amount of time to be able to be within those guidelines?

>> JEN: We would welcome comment on that. Any ideas you have behind how to go about doing that we are looking forward to it.

>> Tan ya. My biggest concern is if you have a way of life and you have done the best you can and you have done everything the State's asked you do do and then some to live your life as independently as possible at, like, the lowest cost possible and have, you know, done your job as an

employer in running your own workforce and budgeting your own stuff, it's, like, if all of a sudden that gets changed, then it's, like, I don't want to be the one penalized --

>> JEN: We have contemplated services my way.

We are continuing to allow for services my way, so that budget authority you have under services my way, we are not anding that going away. That will continue to be part of our requirements in our new FMS system we have, that's not going away.

You will continue to be the employer who has a budget and that's not going to change.

>> TANYA: I just hope I am doing it in conjunction with an agency who knows what they are doing on how to run it when issues come up.

>> JEN: Thank you.

>> RALPH: Tanya, real quick, I would recommend that you talk to your service coordinating agency to find out if, in fact, they are going to go after this. Keep in contact in conversation with them. They will let you know real quick whether or not they have a possibility. Barbara, you had a question?

>> CASSIE: Can I say something about the qualification issues because it ties into her stuff. I bant to thank you for the stuff you have included. We give you hell and you will it continue to get it you included a lot of our thoughts and suggestions. I read it three times. There are services and things that have been included that we have talked about around the table.

What people forget so often when they are writing these things and get caught in the bureaucratic world is that disability competent is about

our expertise and a lot of us know how to waive and do this paperwork and serve the community, especially when they are young, God knows I stopped working there when I couldn't fill out forms.

The bottom line is that, you know, this is why the qualifications shouldn't go any higher.

You cannot at one point say you want disabled people to work and then put at risk the very businesses that have always hired them; that are regulated to hire 51% of them. It is about disability competent, culture and everything else.

I am thinking of all kinds of ways to save jobs for the disabled people that are working as service coordinators right now.

We have changed so much CILs. They are much more professional than they used to be. They have quality managers, chief directors for

controllers. They have bent over backwards for the State.

This has been going on for 15 years!

Changes, changes, changes.

It is very political. It is based on money.

Don't kill our CILs!

They are almost -- they could be fried just from all that they have been through in the last 10 years.

They are still serving huge number of people. They are committed. They don't go away.

Ralph has been here how long? Theo has been here how long. Tom Earle, I watched him get old working at CILs. It's not a bad thing. I am old and proud.

[LAUGHTER]

You have to give it incentive; that's the bottom line.

It's hard for us to know if there is incentive.

I almost asked you to grandfather the people that are there, I think you need to go further and look at those qualifications and consider things like cultural competent, consider things about the future of disabled people with the cost of college today, because a lot of people have been going to college in the last couple of years, but that has been at no phenomenal -- not very many people have been encouraged -- it is hard to get OVR to pay for a social work degree for a disabled person.

They fought with me left and right. You have a disabled. You need services. People who need services are not good at serving others.

I fought all of my life.

When I went to Hanneman. I was no dumby. I was phi beta kappa.

People get the bullshit of wanting to be on the computers.

>> JEN: I appreciate what you are saying.

>> CASSIE: I am pouring my heart out for her.

>> JEN: What I want to say it we have not only centers for independent living, we have a rich array of home- and community-based services delivered under our fee-for-service -- we have a rich history in this state of good and home- and community-based whether it is AAA or CIL.

The managed care organizations that come into this state or country participating in health choices maybe they want to expand and become part of this network, they are going to have to depend on these agencies. They have to edge gauge, contract and work with agencies. They don't have the bandwidth to do the services the direct care, the home modifications that Fred keeps talking about, the requirements for durable medical equipment.

They will depend on our infrastructure and they are going to have to engage.

Now, there is a possibility that our infrastructure failed in someplaces.

Our data shows there are pockets of failure.

Managed care companies will probably weed those failures out and not want to contract with them.

For the most part, we are looking and expecting that they are not going to come in here and say, I want to do everything from soup to nuts. They can't! They are going to depend on our rich, local entities, whether they are CILs, AAAs, home health agencies or companies that do home modifications that have put up maybe community action program that does great home modifications in Luzerne County. I don't know. They will be

looking for that infrastructure and depend on it.

>> CASSIE: Jennifer, I understand what you are saying. There are disabled people who will be unemployed who are service coordinators right now in our CILs right now at a time you keep talking about jobs.

We have lost be.

LEFT2: S under FMS, we lost jobs under -- [indiscernible] -- I mean, disabled people have been the ones.

>> JEN: That is why we put the RFP out in draft. It's a draft.

>> CASSIE: I am glad. This is why I am adamant. It is not against you.

I am amazed at the stuff you have added. Please, I mean, we are begging for some support for the CIL's infrastructure and the jobs disabled people hold in them now.

>> JEN: We are looking for alternative, thousand do we demonstrate quality and expectation that there is qualification for a person?

I had a meeting with a group of providers yesterday and it was loud and clear is that those qualifications are going to put people out of business. They did some kind of survey and figured -- not out of business but people will lose jobs and they are disabled people that will lose jobs.

We put this RFP that was issued on November 16th out for comment and we included those higher standards. The feedback that we are getting is all stuff we are taking -- we have been taking into consideration feedback all throughout this process.

So if that's an issue --

>> Cassie could it be a performance standard instead -- audit it,

look at the paperwork, look at the work that's done. CILs will have to support their staff with disabilities too.

The bottom line is, I do think they hang in. A lot of times they get people out of the nursing homes because of commitment.

I think if it was a performance, what you do on the job, day-to-day, how many calls you take, how many people you are dealing with in nursing homes trying to get out, how many people on SNP relocating back to the community.

>> JEN: Let me just say that we have serious issues in our current service coordination delivery. Very serious issues that are -- people are dying, people are ending up in nursing facilities because service coordination -- we have data on this.

So my staff, when they looked at Community HealthChoices and

knowing that we have pockets of service coordination where there is real failure, they wantedded to address that. The way they came up with addressing it was to add qualifications.

If there are other ways of getting at that same problem and addressing that problem, we welcome it. That is the whole purpose of putting the RFP out in draft is we are welcoming comments on a different way to do it.

If you think that it's a false qualification to say you must have a bachelor's degree or an RN, that doesn't really get to what our goal is, which is to have high-quality service coordination, give us the feedback. Tell us what to do I stead; that's sort of the whole purpose of this open RFP process.

Please, we welcome it.

>> RALPH: Barbara.

>> BARB: So, Jenn, excuse me, you are aware that these requirements have a devastating affect on current FC network.

Are you willing to share what kind of deficiencies you have noticed so that we can respond on positive ways to keep the qualifications at the current level, but build in performance measures or training or certifications or whatever, but we are at a disadvantage if we don't know what you've found that made you go to a higher level.

>> JEN: I will give you anecdotes, but we are going to put together the data on it.

Part of this -- Act 22 went into place, the chapter 55 or whatever, 52 went into place. Tom just let me respond.

>> TOM: I am trying to get Ralph's attention.

>> JEN: Do you see him?

[LAUGHTER]

And since that time, you are probably aware of the implementation of adult protective services which is the -- for -- between child protective and OFSA.

Through that process we are seeing a lot of people in waivers, large number, coming through the protective service system.

They are being referred to our staff.

When we go into the service notes that the service coordinators are supposed to keeping on it. There is nothing. We see nothing.

Yesterday we met with a group of providers and Ginny Rogers part of my staff who couldn't be here today. She was impassioned. There are deaths. They have a lot of hours and are covered with decubidi.

When we see the referrals to adult protective services we are getting and the volume of that, we know there is a problem with service coordination.

The next time Ginny comes to this meeting, we will have some data on this so that you can see what it is that -- that new window of looking at what is going on in our system, that we are -- have been made aware offing I don't know maybe it has been going on all over.

We have over 100 service coordinatation agencies, maybe 120 of them since that Act 22 took askt.

We are challenged by it. We want to address it.

The way the staff came up with addressing it, is as I said, to add the qualifications.

If they are the wrong way to address it, we need your feedback on

what is a good way to address it.

>> BARB: Those instances, are you going to say that that's the norm or the exception?

>> JEN: The norm is poor service noteses we don't know what is going on.

>> BARB: Just trying to get to the bottom of it. I would hate to see us throw out the good with the bad.

>> JEN: Absolutely.

Like I said, when we go into HCSIS, there is no information.

>> BARB: So can the department reach out to the providers.

>> JEN: We are going to be doing that.

>> RICHARD: I just have a quick question and I have to say about the outstanding job that everyone has done since Act 150 and keeping this

going.

As far as improving the system, I think that is a very good goal and vision.

I understand emp's anxieties, but I agree with Cassie that a personal system that we still have a face-to-face relationship, individuals that understand the area and culture. It changes a lot within geographical territories and such.

I agree, we don't want to throw out what we are doing very well and lose it.

It takes me to the next question about evaluation. I am just going to hold on that for a minute and I know Theo has a question.

>> THEO: Thank you. I hear what you are saying, Jennifer, and I agree that the department of services have to do something.

Increasing the qualifications to RNs is not the solution. It's just not the solution.

My experience often and we see this a lot with what we do in the agency model of attendant care who require RNs to come in and look at people with bed sores and so forth, they just miss those areas. They don't have time, they don't spend time on that.

Sometimes they don't even come to the consumers' homes.

I don't believe increasing the RN as a qualification for service coordination is going to do the job.

As a person with a disability, I don't want an RN, which is going to be the key to any managed care in regard to service coordination because service coordination is going to play such an important role in this. I just don't see RNs as a person with disability being in charge of

that.

I would rather have someone who has long-term experience in regard to independent living philosophy and knows the kind of things that really increase my ability to live well, versus being made majorly concerned over my medical condition.

I see that happening with increased qualifications with regard to RNs.

>> JEN: RN or licensed social worker.

We don't know what the solution is. It's why we put it out in the RFP to get feedback on what could work in terms of how we improve the quality and expectations.

>> CASSIE: Jennifer, we are -- people coming to work as social workers than we ever had. It hasn't improved service coordination at all.

It really hasn't. The turnover has become more rampant. The commitment -- they never think they are being paid enough. I'm sorry I don't know what they think they will get paid when they get out of school. It is much more than the CILs can pay.

We will not give up the right to risk. If this is big brother in our life telling us we are too sick to get out of bed. We will toss that managed care right out of our home.

Imtelling you. We have a philosophy and disability culture and dependingcy we should be training on. Not aging. Aging should be training and are not doing it well.

Aging can't really talk about Ed Roberts I will os if I or culture we have gone out and reached out to our community and, exactly, we don't want nurses in our home telling us what to do. We may want a nurse if

they listen to us.

Can I just say one more thing. This is is the truth. I have a lot of chronic issues. My daughter in the beginning was tube fed open heart surgery, was in intensive care for months.

The medical model has neither saved her -- even around feeding her.

They said she had to be pumped with a certain amount of liquid she could never digest.

It wasn't until I started giving her less liquid. She is first generation to George the oldest person with her disability was 19 when she was born. They don't know anything. They are learning.

Because I am a mom, have basic -- I learned how to feed her.

She is doing so much better than a lot of the Degeorge kids in these special areas they only get to go out. They are not integrated at

all with a doctor and nurse because, you know of the heart conditions and they have risk.

There are anesthesia like he's gist. I want her to have a cardiac anesthesiologist. I didn't see any specialty -- I will bring that up there. The right to risk, the right to know about your community, the right to know about Ed Roberts on a ventilator that came out and lived in the community.

I do believe it should be based on performance. I've always believed it.

When I thought I wasn't performing best for my community. I loved it enough to leave my job.

>> Jeep: Cassie let me stop you and reflect on what you said.

>> CASSIE: The committed people that stay for years, the

commitment came because they were allies to the community or they lived with a disability.

The more we have change for the state, the less we have been able to cultivate it in everybody.

>> JEN: Let me reflect on a couple things you said.

One is -- I want to put to rest this -- the qualifications we put out on service coordination was our best thinking. If you have better ideas please submit them to us; that's what we asked you to do is it the whole purpose of putting this out there as a draft, it is very rarely done by DHS, in fact it was very hard for us to do this. It was a challenge but we did it.

It is out there as an RFP, draft RFP and we welcome comments.

If we could stop talking about the service coordination. It was

our best thinking.

We know from fed back we got not only today --

>> CASSIE: Can I say them they will be brief. Some of the ideas are based on performance. Another is if training could take place within CILs to bring up the performance capacity or certifications like Barbara said, but they could be done internally.

These are just things I am suggesting so that our infrastructure doesn't get more shook up than it has been in the last 10 years.

>> JEN: Thank you; that's helpful.

>> RALPH: In the interest of time.

>> TOM: Ralph, general, may I say one thing --

>> Ravel: I want to limit further questions on this topic. We need to move the agenda along. Anybody else real quick from the committee

here?

>> Brenda: This is Brenda dare there are simple ways to allow for exceptions add language that says "or equivalent experience".

>> FRED: Yeah!

>> Brenda: I will add it and expand on it in my comments. I just want to put it on the table.

>> JEN: Thank you.

>> RICHARD: I appreciate everyone's anxieties. It is difficult moving into this phase.

The question that I have is about evaluation. So what measures that can be used by CHC choosing MCO and long-term service plan seems particularly important for PA consumers able to choose MCOs on a month-to-month basis. Am I correct?

>> JEN: Yes.

>> RICHARD: If they find it is not working to be able to choose someone else; and that --

>> KEVIN: Just to answer that, you can make a plan change at any time in Community HealthChoices.

>> RICHARD: I think that may address some of these concerns about changing providers that do understand the social and cultural aspects of disability.

The other one is, healthcare evidence data and the information -- what kind of information will be provided entities and participants and network could make informed choices.

The second one is what does success look like in 12 to 18 month inwoe on health choices or specific plans.

>> JEN: Reflecting on the second thing you asked about, we do have an evaluation plan it's actually a five-year evaluation plan which CMS requires under the 1115 chort we will not go with that we will go with bc con currently waiver but still do evaluation.

We can have evaluation -- if you are interested in hearing what the questions are what success looks like, we can have them come at a future meeting and do a presentation.

We are actually under contract with the University of Pittsburgh working very hard with them to develop our evaluation criteria looking at what does success look like. We put together a lot of questions on what does success look like.

If that would be of interest to you, we can certainly have them come and talk.

>> RICHARD: Yes, most certainly.

I know that University of Pittsburgh is very good at assessing and working around disability issues; that's great.

>> KEVIN: I want to add one point about your first comment, Richard, we will be publishing plan-level criteria to help inform participants to be able to make choices; that's a standard that we are adopting from the health choices program; it's also a standard that exists across the country in many long-term services and supports managed care as well.

Be assured, you will will see that data and we will make sure that when it is developed it is meaningful and this subcommittee will have a chance to comment on what makes the most sense to be able to present that.

>> RICHARD: Excellent.

I think that that would -- due to development and active participation, so we don't lose the good that has been acquired over the last many years integrated into this program and be able to have these assessments to guide the program. Yes.

>> RALPH: I would ask the public to please wait until we are done to have your comment. I am sure that many of the committee members around here are vigorously addressing some of your concerns as we speak.

With that being said, we will have the OLTL comments A Len and Tom will be speaking at the end of the meeting I'm sure.

Georgia will help me with a few slides. I have five or six of them.

I will go through them quickly. It was brought up at the beginning of the meeting (Jenn)ing this agenda doesn't leave much room for

discussion of RFP. I can see it has become a coppic we are talking about throughout the day and throughout the things we do present.

I welcome that but I do want to go through these quickly so that we have a chance to first of all do public comment and fist of all hear from folks about their concerns about the RFP as we have been doing on an on-going basis here today and also to hear from the public.

So my quick -- I have a quick update on CHC. I wanted to talk about the managed care organization meet-and-greets we talked about.

We will be scheduling some more of them next month.

We would welcome one of -- let me just talk about what the meet-and-greets are, and then talk about what our plans are for the future meet-and-greets.

We broke out two days in November, earlier in November, 4th and

5th.

We invited managed care companies from around the country. We had about 11 of them attend. It was about half health choices for managed care organizations, half managedded care organizations that don't participate in anything in Pennsylvania, but they do participate in managed long-term services and supports in other states.

It was -- they don't know much about Pennsylvania. So it was a very interesting dynamic to have those two types of MCOs together. I think it really provided for a very rich experience.

We spent the first half of the first day educating the managed care organizations on the as-is -- what is going on in Pennsylvania today? What do we do? Our history. How long-term services and supports, home- and community-based services have evolved over the last 30 years.

We spent sometime doing that.

Then we -- it was sort of MCO-specific information.

Then we invited home- and community-based services providers.

We had probably 150 people in the room. It was a very large convening of any kind of provider.

We invited home- and community-based providers to do a presentation to the managed care organizations about what they do.

It was very helpful for them to hear about the rich array of home- and community-based services that exists in Pennsylvania and they got to ask questions.

As I earlier, we had Estelle Richman facilitate a conversation with the MCOs so home- and community-based providers got to hear how the MCOs are envisioning doing business in Pennsylvania, reflect on their

experience in other states and just kind of talk about what this could look like, what the future could look like in a managed long-term services and supports delivery system.

So -- that's where we heard that comment about Tanya -- to speak to your question -- where we heard the comment Estelle asked the MCOs, Do you ever terminate a provider at the end of the continuity of care period? They said, No, not because it is the end of the continuity of care period, but we could terminate a provider due to other reasons such as fraud, poor quality and those types of things.

We did the same thing, that same setup where we had a presentation by the different employer groups or consumers and then did the MCO kind of conversation facilitated by Estelle with other provider types.

Current participants, we had two members of this committee come,

Richard and Jennifer came and talked about their concerns, their worries, what is on their mind how we roll this out.

We want to expand that, when we do the next round of meet-and-greets in January, we would like to do a broader consumer conversation.

We would ask -- we will be getting notices out to you to let you know how you can register if you would like to come to it in January.

Look for that. We would like a larger group of consumers come and talk about concerns.

You two brought about concerns you've heard and things you've brought around this table. It is always good to have --

>> Brenda: Jennifer are there plans for meet-and-greets in the southwest area?

>> JEN: Yes, there is. We will be doing the same thing in the southwest in the coming months.

>> Brenda: Any idea of a timetable on that?

>> JEN: No.

I don't know -- we are, actually, you know, just a little sidebar, here, the Pennsylvania's network of health foundations is very interested in partnering with us as a state to help us kind of convene and get things moving in various areas.

We have one of those scheduled for the southwest.

Brenda, I don't know if you've seen that, it's December 16th. I am working on getting permission -- although I don't know if I can, because of the budget impasse, I am working on getting permission to actually travel there.

If I can't, I will have -- we have regional staff I can send to that meeting.

The idea is to really get -- begin to have a conversation in the southwest specifically where the roll-out is the first phase --

>> Brenda: I don't think I seen the notice. Could you forward it to me.

>> RALPH: Me too.

>> JEN: I will have Marilyn send it out to the whole committee so you all can see it if you have partners or know of people in the southwest, please, they are trying to get the word out.

It is the Jewish healthcare foundation is convening it.

There are a number of healthcare foundations in the southwest putting it together for us.

We are envisioning it really as a public/private partnership. We are excited about it.

Area Agencies on Aging, we did the same thing convening the AAAs, this was on November 5th.

We did the same with service coordination entities. Those of you who are involved with service coordination had an opportunity to come and present Ed Perkins in the audience put together a really good presentation with his partners talked about the rich experience of service coordination we have in the state.

That was presented as well.

As a matter of fact, after that presentation, some of the managed care companies talked to me about how wonderful the experience of doing meet-and-greets were, in other states they rolled out, they were not

familiarized with what service coordination might be available in the Community; so this was a really good education process for them.

The last group of providers that we invited was nursing facilities. We had about 60 nursing facilities come to that meeting.

We really decided to hold these meetings. We will do another set of them in January, weather allowing. It was a combination of what we learned from other states, a combination of talking to CMS and some of the national associations that support this work like CHCS or the integrated care resource center. These are resource centers we look for for advice that is a good idea to get managed care organization even though there is not a procurement in place but beginning to get them to talk.

We had a total of more than 800 participants, all very positive feedback.

Participants found the opportunity to learn about each other and make introductions. Those introductions were very important.

We also have heard feedback since then, we have done a survey and then also did a post-meeting with managed care organizations that it has led to a lot of follow-up discussions they have had with providers throughout the state, various providers. It was really a great opportunity for us to begin a dialogue, even though we don't have a procurement in place.

I think we are fortunate in terms of our timing.

I want to talk a little about some of the changes we have made.

If you could hold your questions just in the interest of time.

The concept paper led to the RFP that is out there in draft.

We made a number of changes based on the concept -- based on the

feedback that we received in the concept paper.

I would just highlight a couple of them.

I probably should have done it at the last meeting, but I neglected to do so. I think I got a question that helped me highlight one of these but -- so the concept paper closed on Friday, October 16th.

We received over 1500 comments from that process, over 250 -- nearly 250 commenters. We have been doing -- we did analysis of that, which really led to the RFP.

We had about -- a team of about 20 people looking over those comments, helping us organize them, helping us analyze, and put them into -- a lot were similar. We had a lot of repeat comments, put them in buckets and really considered them -- Cassie mentioned this before the meeting started, that we reflected on a lot of things that we heard or

that we received in concept paper comment period.

>> CASSIE: I think I thanked you for it. When I read it I was quite surprised there was a lot qlud. I want to thank you publically. We always tell you the things we are concerned about. I thank you for the things that have already changed.

>> RICHARD: Yeah.

>> JEN: We will continue to do that in this new era of being able to put RFPs out and be able to comment on them.

I think this kind of partnership between public will make a stronger system for us in Pennsylvania.

We already have, like I said earlier this vast array of home and community-based service delivery and nursing facility delivery.

We are still in imbalance state we spend more funds in nursing

facilities than home-and-facility based services. Our goal is to help people in-home, which I think is Pennsylvania's future.

The concept paper comments. The three things I wanted to highlight were: The procurement timeline, which changed and we are in the middle of that change; some of the housing options and service delivery; education and outreach that we heard.

These are some of the highlights that we heard but the ones I want to talk about are the 25% change.

Here in the concept paper we talked about a 25% service plan change threshold. We heard loud and clear from the public that that was not a good idea. Why would you limit 25% could send me to a nursing home; these were comments we heard. We did change it. We received many comments on it, like I said.

We really were looking for a threshhold on which to base an automatic review.

Of course, we always retain the right to review any change. The state has -- can do that. We can take a look at any change at all.

We were looking for a threshhold just in terms of our own capacity to look at changes.

It sounded to us like 25% changes was not helpful and could be very devastating to people, so we removed those thresholds all together. We have no thresholds. Instead we will just do random reviews.

We have the right to take a look at changes at any time.

So that was one change. I think I did mention that last time but it wasn't because I was proactive, it was because somebody asked a question.

And in terms of continuity of care, we have also heard a lot of feedback. We have already had a lot of discussion on that, concerns about losing existing service coordinators, concerns about losing existing providers.

We, again, there are both participant concerns about this, provider concerns about this and we understand that it's a very strong concern of people.

As Ralph mentioned earlier, if you are concerned as a consumer, talk to your service coordination entity. Make sure that they are aware of this change that is coming down the pike, help them understand what they need to do in terms of reaching out to companies, get them familiar with them if they are not already doing so.

These are the provisions of continuity of care.

We are really looking to continue that and have that continuity of care period. We have to. CMS will be looking for it.

Any comments you have on that, please let us know.

The procurement time line, I think we might have heard it here first from one of our members, that an RFP process is not the same as a regulatory process; and there is not the same amount of public input and concerns over putting the RFP out in November, which was our original goal and then having a blackout period.

So this was the original procurement time line that was in the concept paper and thanks to not only comments we heard here but comments we heard through the concept paper process, we have changed that procurement time line and this is really what it looks like today.

This is the new time line. We issued for public comment draft RFP

and draft program requirements and some of the comibts.

A week remains in the community period for that. December 11th is when we are looking for public comments to come back to us. If you haven't made comments, you will probably want to make sure, if you are interested, give us comments on that.

Then following that S that's the beginning of a weekend. The following Monday on December 14th, we are going to be releasing the remaining materials that we have, again in draft, for comment.

Those will be additional draft materials that include in a lot more detail on eligibility and enrollment process that we are -- that we've come up with.

Again, we are looking for comments.

In addition to that, we have much more detail on quality and

oversight in that process, when we release on December 14th and we are going to have several -- a number of other exhibits, including information on the changes to what Kevin was talking about earlier, which is the MIPPA agreement. The MIPPA agreement gives us the tie-in with being able to coordinate with Medicare.

The comment on the December 14th release are due back on January 8th.

We will be receiving all of those comments back, and those comments come through our resource account, but you can also call in if you don't use the internet, or you can mail in hard copies of the comments.

All of that is available on our website.

We and a release at the end of January, early in February or the final RFP, the actual RFP. At that point we do have a blackout period.

I don't have a a date for that final release of the RFP because I don't know how many comments we will get back in these two comment periods.

We really have taken a very hard look at the comments and we are very committed to making sure that we do review all of the comments that we get, consider them and analyze them and figure out what we can use and what we don't think will be practical for Pennsylvania.

So we don't have a firm date on that final RFP, but we are thinking late January/early February at this point in time.

I also want to talk briefly about a meeting that was held -- it wasn't a hearing. It was actually called an informational meeting. It was convened by the House health committee. It was also a joint committee meeting of the aging and older adults committee and the committee; that

was on November 23rd.

I want to get back to hearing from all of you so I will not belabor the point.

>> Georgia: I looked. I couldn't find it. It was not posted yet.

>> RALPH: I will send it.

>> JEN: Ralph will get out to everybody.

All of the testimony was there. I will say that secretary Dallas and Osborne did presentations at that committee and I did one at that committee as well.

There were a few panels. The first panel was government, the three of us.

The second panel was a number of home- and community-based representatives Joan Bradbury Life alliance who was well represented. We

had two AAAs talking about different aspect one urban Philadelphia corporation of aging Holly -- as well as [indiscernible] Hoyt who represents rural AAA Bradford, Sullivan and tie ole owing a.

And [indiscernible] who came to us from liberty resources he came and talked about Centers for Independent Living.

Ralph will get the actual testimony. It is on the record and you can see what was said during that process.

The next panel was a combination of nursing facilities as well as the Pennsylvania homecare association, and then all three nursing home associations presented the leading age representing the not-for-profit and really a larger array -- actually the whole continuum of long-term care servicing p Kelly Unintelligible representing the county's affiliated homes and Russ McDade representing Pennsylvania healthcare association

for-profit.

There was submitted and written testimony from a number of consumer advocates; those are all also available on the record.

I warranted to talk briefly about the level of care determination which is something we are working on.

Pam will talk about subcommittees we will be forming. One is on the level of care determination. We will invite members of this committee, a couple members of this committee to be identified.

Before I get into that, I wanted to talk about our interest in -- some continuity in how level of care determinations are made, but then also some significant changes to how we administer it and how we manage it.

We are contemplating moving into a contract with aging well, which

is a limited liability corporation, knowing that the Area Agencies on Aging have been conducting level of care assessmentments for the last -- I don't know -- 20-22 years starting with early lamp program and going from there; that was even before we had an aging waiver, but really looking at their rich experience in doing this, we have asked if we could enter into that contract with aging well.

Aging well is a limited liability corporation formed under the Pennsylvania association of Area Agencies on Aging; however, the difference is going to be that Pennsylvania -- us as a state, as the Department of Human Services -- will have a direct contract with one contract with aging well. The expectation will be for them to conduct the level of care determinations.

We are entering into a new process of looking at those

determinations and how they are done.

We have done a lot of research on this, including research on the current process. We have had a -- more than 12-month assessment of how level of care determinations are currently being done by the University of Pittsburgh, looking at that and then looking at our medical direct or has been doing a lot of research, actually intonational research. They looked at British healthcare assessment for how they make these determinations and -- anyways, we are going to be convening a small workgroup. Again, a couple -- when Pam talks about these committees we want a couple volunteers we can't have more than two from the committee we don't want the committee to get unwieldily.

We expect the person, whoever represents this committee, to come back and report back to this committee on how the process is going.

We are hoping to by spring of this year -- next year of 2016, to have a new tool to test. We will be testing it in five counties. Then by the end of the summer, we are really hoping we have a new process in place, people trained on that process, we will be looking for -- life providers will be helping us. We expect brain injury providers, centers for independent living to provide input on making these decisions for these populations we know there are distinctions to make a level of care determination based on -- sort of what the population is.

We are very sensitive to that. And thank, Cassie, earlier for bringing up disability competency; that is what we are bringing into consideration as we do this.

And -- let me see if there are any other things to update you.

Real quickly, I will not harp on this. I want to mention we have a

new website.

If you gone to it it's a lot easier to navigate and get to.

I want to point to where our information is in case you have bookmarked the old website and no longer getting it to work, because it no longer works; this is ow new website.

We migrated about a month ago to the new website.

You can see on the right hand column the second link -- the first is health choices the second is live link to Community HealthChoices.

If you just go there, you will get to everything that we have on our website.

I just want to show you where we are now, in case you've tried to get on to the old website and haven't been able to find us.

This -- when you click on that link this is the page you get, there

is a whole array of links, all of our artifacts, archives, these archives of these meetings, all of them are accessible from our new Community HealthChoices website.

I have resource information. This PowerPoint, as well as the one that Kevin presented, both will be put on our Community HealthChoices MLTSS subcommittee work group suk committee website. The links to these documents -- they are all live links you can a voil yourself of.

Those are the things that I wanted to talk about for my update.

I saw that there were a few hands while I was speaking.

I think that I will turn it back over to Ralph.

>> RALPH: For anyone who goes on to the link, that will be sent out regarding Jennifer's testimony before the House committee, I would encourage everyone to speak to those committee members that gin fer spoke

with.

Certainly some are very educated about these issues and some are not.

These are the folks that may have a definite hand in how this thing plays out.

So speak to your leg tores. Get them educated.

So for committee members, do you have any questions for Jennifer? Jennifer has one and then Fred. Thank you.

>> JENNIFER: I, actually, have a question going back to something else. Should that be addressed now in the interest of time or --

>> RALPH: If you believe it's going to take up some more time let us address this and we will make sure we get to you -- as well as the people in the audience.

>> JENNIFER: Thank you.

>> FRED: Actually, what I will bring up it has something to do with this but it also has to do with what was said earlier.

There is a lot of problems with the home modifications. I need some clarity on home modification discussions with documents and brokers. Where are we at on that, one; how will this work with Community HealthChoices, two; I haven't heard a thing about any transportation issues whatsoever throughout this entire proceeding. Where are we at with that do MCLs take over transportation? Are they going to -- what are they going to do? How are they going to deal with that? How are we going to deal with that? These are just -- without housing and without transportation, without home modifications, this is all a waste of time because nobody can do anything anyway.

>> JEN: On home modifications, it is in limbo. I don't have an answer for you on that.

It, actually, the secretary's office is handling it. I can get information and get it out to the committee if that will help you.

>> RALPH: Very much.

>> JEN: I don't have the answer about how -- we know we will provide home modifications in the Community HealthChoices; that's a given.

>> CASSIE: It's in here so it better be.

>> JEN: It's a service that will be provided. Actually, we are expanding it, how we are envisioning the waiver to be made available to long-term services supports a waiver to include home modifications; that's one thing.

On transportation, it is addressed. We are going to be required --

MCOs will be required to provide non-medical transportation, non-medical transportation is currently a service in at least two of our waivers, maybe more.

We are just going to carry that over into this new waiver that will be available and we will be paying for non-medical transportation.

Medical transportation, on the other hand, is provided through MATP.

We are waiting to see what happens with MATP. It is in the secretary's office. It, actually, is in office of medical assistance programs, the conversations about that.

I don't know exactly how medical transportation is going to be handled, but we are envisioning following along with MATP does.

People on the phone, would you please mute your phone. We are

getting feedback.

>> FRED: Mute the dog.

>> JEN: We are hearing the dog barking.

>> FEMALE VOICE: I am hearing dogs barking.

>> JEN: I am asking to mute the phones. We all are. Go ahead.

>> FRED: Actually, real quick.

>> JEN: Anybody on the phone, please mute unless you are a member and have a comment.

>> FRED: Also, with the home modifications, are we going to remove the cap or are we going to put a cap on it? We don't have a cap on it now; that's a big, huge concern. There are a lot of places that need a heck of a lot of work to make it liveable to a person with a disability.

If we put a cap on home modifications we will hinder people from

going home.

>> William: I am from AARP I heard good feedback in coordination with AAAs, coordination of services and acknowledgment of people in nursing home and emphasis should be on community-based services.

I know there are a lot of technical details, but I like what I heard today. I wish to complement you.

>> JEN: Thank you.

>> RALPH: In Jennifer's testimony before the house, one of the legislators that serves the large AAA area in the northeast, one of her concerns that she hears all of the time is transportation again, it is another reason why you need to be speaking with your legislators to make sure that they do the funding for the transportation and my links that I get this information from is always attributed to Jeff Eisman from the

SILC.

For all of you folks out there, if you want to know what is going on with some of the issues revolving around our topics, here, it is an excellent spot it is an unpaid political announcement.

[LAUGHTER]

For, again, the matter of time, we need to have follow beings from the LIFE program, Jonathan Gago join us, thank you.

>> PAM: During our last meeting, you got to hear from a consumer in the LIFE program Annie. We like to call her Miss Annie B. There were a lot of technical questions about how the LIFE program worked.

We would like to put context to her story, but I did also want to just let you know Annie's journey more articulately from a continuum of care standpoint.

Annie B. was a waiver consumer. She has a waiver consumer for about 20 months.

During that time she received home care, home healthcare three times a week. She had meals on wheels.

Unfortunately, the waiver was not able to support her in a way that could keep her in the community. She ended up in the hospital and from there she ended up in a nursing facility.

Annie was in that nursing facility for 15 months during which time that facility helped her really regain her strength from where she had come before. About a year into her journey there, we -- in the LIFE program met Annie from our efforts to continually make sure that whoever can get out of an institution is out of an institution.

Annie transitioned into a housing opportunity through the state's

nursing home transition, and was in that unit until July 2015 where at that point in time annie has found affordable housing for her.

So we met her and her big personality last time we were together, but that's technically her journey and her story.

So, again, I am now going to turn it over to my colleagues to describe in a little bit more detail what the LIFE program actually is in the State of Pennsylvania.

>> JON: Thank you for the opportunity. My name is Jonathan Bowman the division director for the division of coordinated care in the Office of Long-Term Living. We oversee the LIFE program in Pennsylvania.

So just a little bit of background about what LIFE is. Nationally LIFE is known as PACE all-inclusive care for the elderly.

LIFE is in Pennsylvania because PACE is a Pennsylvania pharmacy

program.

In this regard, when we talk about PACE in this conversation we are talking about the federal program for all in-inclusive care for the elderly which in Pennsylvania we refer to as LIFE.

The first PACE program began in California around 1960, 1973, I believe in California's Chinatown there was a growing demand, need for community-based services and so they developed a program that they referred to as on lock.

After successful waiver demonstration, this demonstration was approved through the balanced budget act of 1997. It was made a permanent Medicare program and Medicaid state option.

Immediately following Pennsylvania took this opportunity and we opened two PACE programs in 1998. The first of the two were in the

Philadelphia region and the Pittsburgh region.

Pennsylvania is actually a leader in the pays model. We have the largest provider network in the nation. We currently have 19 providers operating 34 centers across the state soon to be 35 and over 5,000 individuals enrolled in our program.

We are one of the largest provider networks in the nation.

A little bit more about what the LIFE program is. This is -- the LIFE program is Pennsylvania's first fully-integrated Medicaid managed long-term care program.

What that means is, the program integrates both Medicare and Medicaid services and funding through monthly capitation payments. This allows the provider to pull the payments from both Medicare and Medicaid into a risk-based pool to provide the best services to the participants

and how they feel they need served.

The LIFE program is a little different than traditional Medicaid fee-for-service programs, in that it provides acute care, long-term care, pharmaceutical services and also behavioral health services.

The goal of the program is to enable older adults to live as independently as possible in their homes for as long as possible. The services are focused around adult day services. Everyone enrolled in the program has access to adult day services and Joann will probably go into more detail about that, but participant has access to, like I said, adult day services. There they can get services such as meals, socialization services, physician services, therapy services, et cetera.

On the next slide I will go into a little bit about the eligibility of the LIFE program and what is it takes to be enrolled in the program.

In order to qualify for the program, these are federal guidelines, you must be age 55 and older; determined to be nursing facility clinically eligible; you have to reside in a service area or a county or zip code that is served by a LIFE provider. And the provider needs to determine you are able to live safely in the community at the time of enrollment.

The next slide talks a little bit about what the LIFE population looks like. In Pennsylvania 95% of our participants are dual eligible individuals. This means that they are enrolled in both Medicare and Medicaid services. Nationally, according to the national PACE association the average participant was 80 years old, 75% of them are if he maim, 90% live in a community-based setting, the average participant has 7.9 medical conditions and 47% of the participants have some form of dementia.

The next slide here, I guess -- I don't know what colors they are.

The green areas, actually, represent areas across the state where life services are currently active and available. Those counties shaded in green are where the services are currently available.

The counties in yellow are areas where we are currently developing LIFE services and hope to have them in the near future.

In addition to the counties up there, we are also looking to have services in Montgomery County and Perry County very sortly.

The areas that are white and a pink color, those are areas that we are currently -- the office long-term living is strategically planning to best get paid services into those areas.

The last slide on my piece of the presentation here is just for a little more information.

We have a list, like I said before, there are 19LIFE providers.

Here is a list of the providers that are currently operating across the state.

This information can be found on the department's website at www.dhs.pa.gov if you do a key word search for LIFE the program website will come up.

Like I said there is more information about the LIFE program including eligibility requirements and a list of provider and areas that they are currently serving.

I will turn this over to Joann she will talk a little more about from a participant and provider perspective.

>> Joann: I am Joann Gago like Chicago for the future.

[LAUGHTER]

I am the oldest one. I I know I don't look it but I am very old.

I wanted to say my passion around this is to keep people home all the time if at all possible.

I want to describe a day in a life in our LIFE.

One is determined nursing facility clinically eligible through our systems in the county an assessment by a team of people, physician, nurse, social worker, therapists, both PT and OT, diet ition, even personal care will do a complete evaluation of this -- of the person looking for enrollment in the program, then they develop a care plan.

The care plan that you are aware of through service coordination program and this care plan are a bit different in these drill down on the problems this person has with very interesting inter-disciplinary perspective so that this is all one thing working together with the participant at the table making sure that that plan of care is theirs.

It is very individualized and that document should be found in every LIFE program.

So in the morning, for example, the person rises at the time they want to. Not necessarily the time we want to. They allow that to be part of their plan of care. Our personal Kara siftant will arrive at the home prior to the van coming.

In terms of transportation we provide that within the program.

The personal Kara siftant will either -- whatever it is, help them get dressed, get a bath, shower or whatever it is, help them get themselves ready. It could be a light breakfast might not be.

Again, this is completely driven by individual plan of care, there is no broad brush, here.

At that point, the participant is transported to LIFE in my program

in Pittsburgh the LIFE Pittsburgh program we have 560 participants in the program today covering half of Allegheny County.

We are pretty clear it is door through door. Nobody thought you could greet and meet your driver at your door. Most people need more assistance to do that get to the van. Door through door is our service.

They arrive at the day health center they may get breakfast or shower. The activities are therapeutic. If you talk to somebody who is a certified therapeutic recreation specialist, that is CTRS it is a little bit different than activities person it is therapeutic and specifically meant to help rehabilitation for the person.

Then the activities there are several happening through the day. They get to choose.

On the next slide, here, I just want to make a few really important

points; that is participants have full access to physician, nurse, social worker, dietician, therapist both occupational and speech and a physical.

The recreation therapist and personal carat their home and in the center. It is not designated as home care service it is wherever the person needs the help that is where they get the help.

Medication management is provided within that program. We obtain, set up, educate and assist in taking the meds and these services are provided throughout the program.

All physician services include all of the subcontractors like your dentist, eye doctor, your glasses. It is a comprehensive beginning to end LIFE program means your life. It isn't just an acronym although clever, it is not just meant to be a clifer acronym.

The most important point I put if you didn't walk away with

anything we don't relinquish -- centers that exist in Pennsylvania if you go to the hospital you may have a different doctor if you go to a nursing facility you may have a different care service. We never relinquish care -- on my note -- ma might mean your home Cleveland if visiting your daughter or son nursing facility, hospital.

At the present time that person's enrolled in the program we do not relinquish their care.

Very, very important point to say that addition -- last slide, I think, meals. I was impressed by the fact when I went into the program 30% of the persons that were living in the community were undernourished. We found that they could afford the food they couldn't prepare or obtain the food.

Just as a point it is such a basic need and right for a person to

have.

So we provide all meals in some cases three meals a day seven days a week, depending on the need.

All harm services we serve a lot of high-rise and mid-rise buildings we have schept relations with those folks they want to keep residents in their apartments they don't want to turn them over and have people go to nursing facilities.

Our goal is very strongly written to be home- and community-based and not to change it.

The last pint another point I want to make sure that I drove home was, we remain with that person or that participant remains with us -- unless they choose to disenroll which they have the right. They stay with us regardless of the progression of illness or disability. They are ours

until they are not ours; that means they either go somewhere else, move somewhere else, decide not to be with us, which by the way let me say we are somewhere under 1% total of disenrollees. They don't do it often. Once they get into the plan with richness of the benefit and type of service they get they don't typically disenroll.

We were given a few minutes. I could go on. I want to just clarify one tiny thing. Jonathan use the term adult daycare. I don't use that expression I use day health center.

Adult health center people have more of an opportunity to have services provided in a center. So this is a complete range of services available in they are really very rarely finding somebody to come in just to be supervised.

Some days that's part of it, but it's important to say that.

Let me say isolation for the elderly is lethal. It shouldn't happen.

There should be opportunity for them to socialize, find friends create a social network.

One of the horrifying things about aging you lose friends, social support and that's why the centers is are so very important; that's why we call them day health centers. We don't give anybody a stigma that adult daycare, I must need baby-sitter.

Many days I need one but that is not who our participants are.

So that was my quick rendition.

>> PAM: Actually, if I might just add one other thing; that is that unlike other plans, we are able to do things that are not traditional and more driven towards, again, people's individual needs.

If you have a beloved pet who is your best friend and that pet needs to go to the vet and you can't do it, we will do that for you.

If you -- trust her, she's done it many times.

If you have an instance where your health would be impacted by the fact that you don't have an air conditioner, we are going to be able to get it for you. We are going -- so the essence of this is people to people that look each other in the eye, then really get to know each other and then are able to cover not just medical or traditional social needs but really, how do we keep people where they are? And do that with them.

>> CASSIE: Have you ever dealt with an older parent of a teenager, for instance?

Seriously, being a disabled mom, few people -- people are amazed all the time even I am amazed I have my daughter. That was God. He sent

her to me.

The bottom line is, have you ever helped somebody in their own house to stay together. I don't think my daughter will always be with me. She is 15 and in high school.

She said to me I have no intentions of leaving unless I marry. I love being with you, mom.

I was a little shocked to hear it and don't get it many days.

In case she meant it.

>> JOANN: As long as the person immediates the criteria they could be anybody's mother. They can come into our program and we have 55 and older is the age limit.

So we have many people between --

>> CASSIE: I don't plan to come in until I am impoverished which

could be any day now.

>> PAM: Fred.

>> FRED: I have a a quick one. I am on services right now. About 30 years when I finally hit 55, would I be able to switch over to LIFE is it beneficial because I still work and continue to work until I can't do it any more.

>> JOANN: We don't have a lot of people who are working. Part of it is because of their level of disability and their concern is significant enough that that's no longer possible for them.

Income, there is financial criteria for eligiblibility as well. It is low income. You could argue it is not so low they need to maintain residence in the community it is not for straight Medicaid if you understand it is typically low income in terms of eligibility, you need to

support a residence in the community so it is higher.

The answer to that question is, yes, except I don't know about the work.

You would have to stay below a certain -- if it was a certain job it would have to be below a certain amount. Typically it doesn't meet the clinical criteria for us.

>> FRED: There is a clinical criteria.

>> JOANN: Nursing home critical --

>> FRED: I am dual eligible and work.

>> JOANN: You are not old enough. Clearly you are way too yuck.

[LAUGHTER]

>> FRED: Like I said in 30 years.

>> JOANN: In 30 years come on over.

[LAUGHTER]

>> Brenda: I heard you say, Joann, that services can follow someone. If they go out of town to visit family members. What are the criteria under which that can happen and how long can that traveling stay with a person.

>> JOANN: Traveling assistance is defined slightly differently for you than I am describing.

What I mean by that is that our services in terms of medical coverage and our management and coordination of your care continues to go with you.

We don't send staff with you on a trip. That does require some assistance from someone else.

Understand, mostly we have served the aging community.

So, again, we have many disabled people that are in their 50- to 60-year-old range. The criteria, you have to be fairly disabled.

>> PAM: Tanya, did you have a question?

>> TANYA: Yes.

What are the income income criteria for this? Would the State ever consider raising income criteria.

I know just from my own personal experience, my grandfather passed away of Alzheimer and dementia a few months back.

They needed, you know, help coming in and out of their home to take care of him, but we couldn't afford it.

My grandmother and my mother were basically kind of stuck not having the skills that they needed for him.

>> JOANN: Right.

>> TANYA: To do his care. As a result he ended up dying in a nursing home because of a bad fall because knop of their staff were watching him.

>> JOANN: Sure.

>> TANYA: When you have a program like this I believe it is one of the most life-saving things the elderly population could have, but usually -- I may be stereo typing here a little bit, if the person's not already, like, disabled before the aging process happens to them, of course, they are going to have money, you know, put aside for themselves later in life.

What do we do as a state and as a government to make services like this eligible to more people?

>> JOANN: I think financial -- Jonathan can talk about it. It's pretty Hi.

>> Jonathan: LIFE financial eligibility is a little bit different than waivers. It is traditionally 300%. The LIFE model it does allow a federal benefit rate spend down manage your income can be higher.

>> CASSIE: What is 300%.

>> Jonathan: Federal poverty level.

>> CASSIE: You don't know what it is?

>> GEORGE: It is different for different families.

>> JOANN: I will give you a range of [indiscernible] understand the point is to answer the earlier question, the reason for that was really designed so that people could maintain a residence. It wasn't hardship for them.

>> TANYA: I mean, the more I hear about this is if my grandparents would have had the right connections to be on something like this, there

is a good shot my grandfather may still be alive today.

When you do have a program like this maybe something I am going to suggest how I've suggested with, like, pamphlets for people knowing about different service coordination before is that this also would be mentioned in those handouts that the subcommittee is going to make so that people know about this.

>> JOANN: You won't get any of us to agree with you.

>> TANYA: So deaths don't have to happen, needless deaths.

>> RALPH: Thank you for your presentation. Fred has been playing with my mic.

>> FRED: Yes, I have.

>> Zach: I have a question about LIFE --

>> FEMALE VOICE: [indiscernible]

>> Zach: Besides meal preparation --

>> JEN: Please hold off on the phone. We have a question in the room we will get to you afterwards.

>> Zach: Besides meal preparation, you mentioned that you would help with personal care either at home or at the health center.

What examples would that be? It struck me as, what?

>> JOANN: I might have said the same thing.

The concept is you have activities of daily living you need assistance with. Our personal Kara siftants -- the care plan will determine how much service you need.

We don't do it exactly the way, I am aware of other waivers in the community. We do it based on this care plan.

You have access to our full team but our personal Kara siftant will

probably arrive in the home early in the morning, help out of bed, help get bathed, help get a meal.

It really moves with the day, according to the need.

We have a lot of chairbound, bedbound folks. We have some -- it is a very small number, but all of the people that we serve need significant assistance to do their daily life.

It is really described by you or by your need, basically, the person enrolling as to the amount of service they receive in a day.

There is the housekeeping, Pam is reminding me of in services.

With the limited time, we will get you some information. We could bring a pamphlet for you all or I could bring 700 pamphlets for the committee, no problem.

I would be glad to do that because it describes all of the

services. We don't like to say that everybody gets that. Everybody gets what they need. If you don't need housekeeping services, you don't get that. If you need them, you get that.

>> RALPH: Jack, you have a question.

>> JACK: Question and comment. First, it was a very good presentation, but it raises the question, I guess, why are we not expanding the LIFE program.

>> JOANN: Well, I am expanding.

>> JACK: Well, in terms of -- this will be an alternative, I realize that, but why not look to expand LIFE generally?

>> JEN: Jonathan mentioned the tray teamingic planning around all of those places and don't do will LIFE.

>> JEN: On the phone, please, could you mute, please.

In order for LIFE to be viable in every part of the state we need to expand LIFE.

>> JEN: We will take a question from the phone. Did you have a question? Are you asking the question?

>> FEMALE VOICE: Yes, I do have a question. Can you list essential aspects -- do you proper skills, etiquette?

Please, I am trying to speak. Would the people be quiet so I can speak? The question is why chiropractic care is in there. Eye care, dental, allergy shots, diabetic shoes; a lot of this stuff is not mentioned, you know, people h people are concerned. I think it is a great program if you address all of the aspects of the care of the person.

>> JOANN: We absolutely do that. I'm sorry you probably are in a garbled --

>> JEN: We are providing an answer. Mute your phone and Joann will provide an answer to it.

>> JOANN: Yes, on the phone, I want to say that every service a person needs is provided. When I say every, it means according to the need. It is a social program. It is social medical program. It produces everything you need. If you need an eye doctor, health exam, you need cataracts removed, if you need eyeglasses twice a year because your vision is changing, which doesn't change but anyway.

The point is, we do everything that needs to be done. Dental. All of it is in there.

Again, I would suggest you go to a website, look up LIFE in Pennsylvania. It is, actually, the correct acronym of the website would be life -- I am afraid I don't know the exact website.

We will explain every single service that could be possibly provided.

>> Jenn: On the phone, could you please mute your phone we are conducting a meeting here.

>> TONY: Good afternoon, I am Tony Brooks from Philadelphia, disabled in action. I am an advocate also.

It was back before LIFE started, we talked about transportation, housing nursing home transitions.

I lived in a nursing home.

I want to ask a question, like -- I got out of a nursing home. I am living in a community, which is affordable and accessible.

In Philadelphia, we have a lot of homes which are abundant. Has the stakeholders, the Department of Human Services ever got in contact

with city council, the state council, representatives and talked about the housing issues where, yes, we need to rebuild homes. We need to build affordable accessible homes.

The transitions, like we were talking. You said we have over $3 billion in nursing homes a lone, community-based services is less.

Why not transition that money into providing services for people outside and building more homes which are more accessible and more affordable.

We talked about modifications of homes, yes.

We can put that money into that.

Transportation.

I am wheelchairbound person. There is the issue about going to a hospital. Sometimes you have to leave your wheelchair at home and go to

the hospital.

Transportation. Provide services where you can have your wheelchair to take you to the hospital when it is an emergency instead of just ambulance come and carry you up and leave you in. Hospital without a wheelchair?

We have transportation that will take us back home, but wouldn't it be best when we have a transportation system that takes us with our wheelchairs.

>> RALPH: They are schept comments, especially about the wheelchair. I have been there. I lost my chair. The issues about more housing and so forth, I will let Jennifer take that.

I can tell you this, I know they are constantly working on home mods and so forth. Hopefully you will get an answer that gives you some

hope we are going in the right direction.

More importantly make sure you send these comments in to us.

Trust me, we review them.

Thank you.

>> JEN: I wanted to address your question about housing. The answer to whether or not DH staff has gone to the City of Philadelphia and met with housing authority and met with the agency within the city that works on housing locally and also HUD, there is a HUD office in Philadelphia.

We actually had a meeting I went to with about five of my colleagues, including two other deputy secretaries about two months ago with those folks.

Calvin Jeremiah was very helpful and hopeful in terms of thinking

about what the future could look like and what our partnership could be with that housing authority.

We plan on doing that with housing authorities around the state, but I will assure you that housing, the issue of housing and the question of availability of affordable accessible integrated housing is one of the top issues that secretary Dallas is thinking about today.

He has asked his executive staff and assigned, he actually appointed a housing coordinator for his office.

Also, he has delegated his authority to be a member of the Pennsylvania Housing Finance Agency to Joann Glover. There is a team within DHS that is working on housing strategic plan, which we will be issuing in the next three or four weeks.

Please look at it, comment on it.

Housing is a community issue and is something we are aware of.

We are looking at the resources that all of the DHS offices -- housing isn't just an issue for people with disabilities. It is an issue for tannive population, homeless population, aging -- children aging out of foster care. It is an issue across the board in DHS, which is why he brought it to his level in the secretary's office, there is this office called office of social programs and have a housing coordinator within that.

When the housing plan gets issued, we can bring John PAY who is housing coordinator to secretary Dallas and have him walk us through what we are planning to do with it.

One of the things the secretary told us to do, we have been working on this plan for several months now, he really wanted it to be action

oriented. He sent us back to the drawing board when we brought it to the drawing board because it was not action enough.

I think you will like what you see. There will be opportunities for local communities to participate.

>> Thank you.

>> CASSIE: We are in all of those populations too. They always forget that. They start saying like we are up against them.

So many homeless are disabled. Everybody in that population --

>> JEN: That's why the secretary really took it to his office. He didn't want it to be Office of Long-Term Living office of investmental programs mental health and substance abuse competing with each other so to speak.

We are a unified.

We are entering into a unified housing program for the state under DHS.

>> CASSIE: Thank you. Great idea. Tony's points were great.

>> RALPH: Jonathan and Joann thank you so much.

>> JOANN: I wanted to add one more thing, I happen to be the incoming Chair of national PACE association board.

One of the things we are working on that just got passed is PACE innovation Act allowing for broad ebbed definition to whom we serve.

And many other things about it to innovate interesting and new models within the PACE model.

I want to throw it in because of the concern.

>> JEN: It was passed by Congress and signed by the President.

Look for change in the PACE program.

>> RALPH: Allen, do you have a question about LIFE program.

>> RALPH: I knew you were sneaking up.

>> JENNIFER: I do. I would like to thank the presenters for their presentation and secretary Burnett I would like to thank you and your staff. I imagine it is really hard to put your heart and soul into something and come before our committee and hear criticisms.

I would like to thank you for taking our comments to heart. I would like to thank you for all of your hard work of you and your staff.

I do have concerns, however, with housing. Please, please, please, please don't just work with HUD and PHFA. It needs to be mainstreamed landlords.

What is happening is, if there is not an understanding of how the systems all work together, you are pushing for employment, but a lot of us

can't -- if you get housing through HUD or PHFA and then you become employed, you lose your housing or your food stamps or your transportation.

I think it really needs to be reconsidered for the waiver limits to be increased for those of us who can work because when I was in the population of people who can work, I literally refused five raises because of not being able to -- needing to stay in my waiver and not wanting to go into Act 150 because it was state-funded.

There is talk about master's degrees for people with supports coordination. I don't want to bring that issue up again. I know it was discussed, but for those of us with disabilities, if we would -- I would love, love, love to go to school to get my master's degree. I was advised against it because starting salary for someone with master's degree would

put me right out of the waiver.

>> Jenn: While talking about employment let me make a comment about that; that's a very important issue for the secretary both in terms of implementation of WIOA, technical difficult, Is on the phone -- please, on the phone. On the phone, would you please mute yourself. Please mute yourself on the phone.

I don't want to hang up because other people will get disdetective connected on the phone.

Empty o for people with disabilities is important to us at the department.

Across all of DHS employment is one of three performance measures that are reported to the Governor's Office on a quarterly basis by DHS. Employment is really important in DHS.

So to that end, I recently appointed one of my staff members to become really involved in employment.

One of the things he is looking at is working with the office of income maintenance on MAWD program. It is under utilized we want to see it utilized more.

My staff person is digging into working with the office of rehabilitation, working with the workforce innovation board, just all of the different employment activities that are happening in the state and getting into those mainstream employment areas.

So you will be hearing more about employment as this kind of develops, it's really new. Just started.

Rest assured the secretary is interested in the issue of employment.

When you met with him he mentioned his adviser on employment Steve Suroviec, I think he may have reached out to you. He asked for your contact information and I gave it to him.

Rest assured we will be working on employment, but it's new, relatively new for us at DHS.

>> JENNIFER: I appreciate that. That is why I was saying, with all of the changes in housing and things that you are making, please don't make good changes and then make changes -- if you make it in housing, then -- everything is request HUD and PHFA, even if you are pushing for employment of people with disabilities and helping people with disabilities get employed, it could cause them to lose their housing.

>> JEN: Let me just speak -- I think there is a little bit of misconception.

PHFA provides affordable housing at many housing, including way higher than people on SSI.

They have mixed-use housing throughout the state that they are funding.

I don't -- PHFA is a great partner to us. It is the only way we can get affordable housing in Pennsylvania through that or the money department puts towards housing, which we don't really do.

PHFA is a great partner to us.

We also have been and will continue to and expand our work with landlords. You mentioned landlords. There is a lot of work we do out in the community through our regional housing coordinators to educate landlords.

We have a program called the prepared renters program, which

provides information to people looking to get into independent housing particularly those coming out of nursing facilities how to be a tenant that succeeds what your responsibilities are, landlords like tenants who have gone through the prepared renter program because they know what their responsibilities are.

We are trying to in many different angles work on housing issues.

>> JENNIFER: Can I ask another question.

>> RALPH: We are running really late. Not to usurp Pam, these are work group ideas, subcommittee ideas that I am going to have Pam talk about in a little bit.

In regards to my portion here, talking about participant discussion and reflection of what we have learned from consumers, I can tell you, it's the same topics, transportation, service coordination, employment,

housing and so forth.

I think with effort of subcommittee work groups, we might be able to move the department in a way that will help them give us these things that we are very, very concerned about.

For saving time on today's meeting, it is pretty much the end of my discussion session.

I will use Tanya as an example.

She sent as many members do sent me some emails about this, that and the other.

I try to answer them as succinctly and correct as I can; that's probably why she said earlier she got responses that she wasn't sure of.

>> FRED: She picks on me as well.

>> RALPH: It is a value of this committee and members of the

audiences. We do try our best to answer these things.

We are not always the experts at your that you send us but we really, really try to get you the right answers. We certainly encourage you when you here to bring them up again.

Barb sent me a big thing about service coordination. We threw that topic and she leaving with sol lace.

With that being said, -- I've been encouraged to have a little bit more public comment from ail.

>> CASSIE: Tom has had his hand up since we got he here.

>> Allen: I got here first.

I don't want to beat to death the social work stuff.

I said before, I actually went to speak well social workers -- a degree does not guarantee you will be able to coordinate and do service

coordination. In fact, it might actually be a detriment, depending on what they have been taught.

I do feel, though, however we could provide training for all of the independent living model on independent philosophy and on the language not just people-first language but how we talk about disabled people and also some of the history; that would help them understand what they are getting into, both MCOs and service providers and service coordinators.

Just one question I would like to ask, I would love to see this as a subject, what has changed over the last, say, five years in terms of nursing home population and people living in the community?

What have we identified as barriers to moving that further? That really is the tasks, isn't it? The task is to find out the barriers that keep people going into nursing home and what population is increasing what

ising that.

The last thing I want to add is about employment. I think one of the biggest barriers to employment is the eligibility requirements to get into the services that you need as a disabled person.

Decent wage. You have to start applying again.

How will we overcome that for lots and lots of people.

I think if you did a study eligibility requirements just getting us out of bed in the morning, let's face it everybody gets out of bed and doesn't have to pay for it. We have to pay for it. Why is that? Where is equality.

Those are questions you will be looking at and be coming up with as barriers to employment. Thanks a lot.

>> PAM: Mr. Chairman, for the sake of time I think we should table

the discussion around -- I think we need to say something, because it's one of those things where, if I might just say, Tonya at the last meeting did a call to arms to all of us. She said, let's really make this committee do something. It was at that point that Jenn actually turned to me at that meeting and said, we have to do that. She came up with ideas of how to do it.

>> JEN: Where is the list -- okay.

I just want to talk a little bit about a couple subcommittees we are forming and could use help in.

One that has been consistently talked about here is the whole idea of training. We want to put together a subcommittee on training about independent living philosophy is one aspect but there are a lot of other things we need training on.

Sensitivity to brain injury.

I think there are a lot of different opportunities for training.

I have to say because of budget limitations OLTL has been very neglectful in terms of being able to provide training but going forward, we are budgeting for training. I see Peggy over on my right she is our chief financial officer. She is nodding her head we have money for training speak need your help.

People who would like to participate -- I guess what we will have to do is send around some sign-up sheets for people who are interested.

Keep in mind, if you sign up for -- we are a little bit challenged by the logistics of this, we think we could maybe do a meeting around this meeting but we also think we have to work harder. Things like better telephone connections and through webinars doing some of our committee

activities through technology.

Training is one. Another is the level of care determination. We are looking for a couple members to help us with critical care determination.

The third is grievances and appeals. We have ahead a lot -- Fred brought this up -- I'm surprised he deposit bring it up today. How we do grievances and appeals are really important. We will be convening a work group next month to help us kind of map out what that might look like.

And then eligibility notices. Somebody mentioned this earlier, but we are going to -- we need to make sure that our eligibility notices and the notices that we put out are readable, understandable, will resonate with the people who receive it.

We are going to be doing more and would like to engage the

disability providerred in work and the aging provider network to help us do education and outreach.

That is more -- my goal is to make sure that people know this is coming before they get the first eligibility notice.

We want to do a robust outreach and education process.

We will be looking for some feedback.

The actual notices and working on the notices, how they read and what they look like is going to be important.

Those are the four committees I have come up with based on feedback I have been hearing throughout this process.

We will send around some sign-up sheets.

We have about five more minutes -- that was our quick and dirty conversation about committees.

If you have other ideas for.

>> FRED: Transportation and housing.

>> JEN: Okay. Well, actually --

>> PAM: There is a gentleman who has wanted to ask a question.

>> JEN: Any other ideas, just put them on the notice -- Georgia do you have pieces of paper?

We will be putting sign-ups here or send them around and you can sign up.

>> RALPH: You can email us to let us know what committee you want to participate in or other subcommittees you think would be good.

>> PAM: People have had their hand up all day. There is a gentleman --

>> RALPH: Tom, we will let you come first.

>> TOM: Thank you, Ralph, Mr. Chair.

Just want to highlight a couple things that I have heard today and a couple of the priorities.

One of the overall things we have done is integrate two systems that have not worked together.

We have heard OLTL talk about anecdotal evidence suggesting supports coordination, improper supports coordination has led to problems of neglect or abuse.

We could spit in the wind all day about that. We could also come up with a lot of anecdotal evidence hundreds of not thousands of people who have been abused in nursing homes. We don't hear that coming up.

So to base the credentialing requirement on raising the bar, which I think is implicitly an insult to the disabled community that implies the

bar is not high enough right now and that the people with disabilities and supports coordination in place right now is not doing the job, I agree with Ms. Polzer you don't throw out the baby with the bath water, here.

I would say, overall supports coordination in Pennsylvania has been done very effectively. The QMET process has been effective in auditing those results.

Let's please be careful with that.

We have now an adult protective services program in place to help with that.

My comments:

One, there seems to be a lot of deals being made behind closed doors.

The purpose of this is to do it in around open and transparent way.

If we are moving towards an integrated system that begins to break down the silos in Pennsylvania that have existed for decades, why are we continue to sole-source and exclusively give local work to the AAAs and not all of the providers who would be doing this work so that we begin to break down the under-60 versus over-60 dilemma that playinged the state for years.

This could be done for every provider that partners with an MCO and keep it within just AAAs under a contract that was sole-sourced and not put out for an RFP is not transparent or in a good-faith manner for what we are doing here.

Also, the training and outreach work and teaching consumers who may not be familiar with self-directed services, asking the AAAs or P4A to give them a proposal on that and not asking Centers for Independent Living

to do it who have done it for citizen aids is also non-transparent.

That work should be opened up to everyone. We need to do that.

I don't know what is going on, but you keep asking for comments and suggestions and you are getting them ad nauseam. Over and over. Written testimony. Public testimony. Minuscule amount of what is being suggested and recommended, based on years of experience is being widely ignored.

S one last thing, I promise, this issue about the continuum of care and the continuity of care and safe guarding consumers who value their ISP, their lives depend on ISP hours and to not insist -- we have the ability to design system on the front end, we should do it right and insist that there be a safe guard period where ISP hours cannot be reus dod unless they are demonstrated to be reduced as they are now where consumers sometimes need more hours sometimes and their ISPs are adjusted

upward if they needless they are adjusted downward.

That should remain in place.

There was a question asked earlier about the utilization data on people's ISPs; that's in the HCSIS system, in the SAMs system. This data should have been in that report what the average utilization per group, per waiver per day and per week. It's there. That can be used for the benchmark that we mention -- that we use for the implementation of this program.

So I really hope that some of these ideas get traction. We have heard announcements about how you submit ideas and comments. Let's get these comments and revisions in there.

Thank you.

[APPLAUSE]

>> RALPH: I would like to thank everyone for their participation today.

Again, much to Tom's chagrin, please send in your comments. I see Jeff back there raising his hand; that's the best I can tell you, unless you have a real quick one.

>> JEFF: Yes.

>> RALPH: Less than a minute.

>> JEFF: I think a lot of people saw CIL being's state plan for independent living at CIL CP from 11 to 20 and Wednesday December 9th class in Pittsburgh 11 to 2.

Any issues CIL k works on long-term care, housing, employment, we work on because of public comment on our state plan.

If you are interested in commenting on our state plan we have

information we take comments until December 31st of this year.

>> Pam: Happy holidays, everyone.

(Meeting concluded at 1:03 p.m.)

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