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>> For those on the phone, I just an announcement. We are going through a few technical issues to get our CART set up and we're going to be starting in a couple minutes.
>> Good morning, everybody. How are you today? Oh, look at that. Good to see you with a smile on your face, sir. Microphone ? Okay. Usually I project pretty well. I didn't mean to interrupt your meeting today, but I just wanted to come and say thank you for all the work that you've done. As part of CHE or community health choices, our goal is to serve more people in the community. That's what we want to do and that's our hope that we're going to get to through this process. But you're never going to get there unless we have input from folks at the table. I believe the committee is over 51% participants. I think that's a very important thing, because if we ever lose site of the folks would wouldn't receive the services, we'll have lost something and we'll probably screw it up. A lot of folks have probably heard me say this before. Where we are in

Pennsylvania right now is if you poll people in Pennsylvania or any state in the country, 95% of people are higher and prefer to live in the community. I haven't met too many folks in the five%, but right now we're at 50.9%, or I think we actually just cracked 51% that are served in the community, which is good. The number is going up and it's gone up a couple percentage points over the years. That's one level of progress, but if you look at 50% of the folks being served in the community and 95% of folks wanting to be served in the community, we're not getting the job done that we need to get done.

So lots of folks coming on. So our goal is to use this as an opportunity to get much you closer to that 95% and start moving that number. If you look at t we look at it every month and you see it stick up every month. It goes from 50.8% to 50.9%, which is better than being at 50.8%, but it's not where we want to be. Right? So for us, our hope is that through this process, we can get the input we need to make the RF P when it comes out, an RF P that will get us as far and fast as we can. This issue is something that is not just a goal for the administration or a goal for me. It's a personally important goal for me, but it's also one that's important for my boss, my governor. And when I first met with him to talk about this, I talked to him about why we were thinking of doing this and going through it, and the governor's response was, well, my mom and dad, they still live in the community. And I think most folks know he lives in the house that he grew up in. So it resonated with him right off the batted, and there were issues that [Inaudible] a big one and we talk about a lot of different things.

There are issues he gets at a policy level and there are issues he knows an admin administration. This one resonated with him personally and we have been following this one closely. If I have that and my parents have that, why shouldn't everybody in Pennsylvania have that? So for us, I'm not a dummy. That's what my boss wants. That's what I want by the way, too. They're going to get there one way or another and of course this will be a big step forward to us. But without the input that we've had here, and everybody knows all the stuff, along the way we've had discussion

documents, listening tours, position papers. We have draft RPs go out. We've had, I think, the federal government actually is using us now as a model. I think, Jen, you told me as a model of engagement with folks. We have gotten such valuable insight into what we might have wrong. This process is immensely powerful for us. We have made changes to the documents along the way, to the RF P, to the draft RP when it comes out, and there will be changes based on the changes made when the RF P is released. Happens without everybody trudge to go Harrisburg and going through what I'm sure sometimes is a very good meeting, but sometimes they can be a little dull, a little dry, some of the meetings. It's fascinating every step of the way. Good job. But for me, I just want to stop by, A, you know, and hopefully we can have a little bit of a discussion, just be talking here about where you guys are, what concerns you still may have, thoughts you have about the process. But also, just to say thank you for all the work you're putting in. It's not always easy. Some of it's, I'm sure, a lot to get through, but it may be where we're heading and it would have been otherwise. So first, thank you from the bottom six my heart on this, and I'd love -- of my heart on this and I'd love to have any general idea on where folks are in the process. So I can use that as I'm talking to Jen and some other folks putting the finishing touches on the art. So with that -- Jennifer.

>> This is periGillis. I would just like to thank you, because we have never had this opportunity before. I don't feel we have ever had this opportunity before to engage and to really feel like we're being listened to. So I want to thank you and your administration from the bottom of my heart that you would take time out of your busy day to come to the meeting and to listen to our concerns and to really make changes and really be serious. And you're not just giving us lip service about your commitment to us. So I'd like to thank you from the bottom of my heart.

>> That's very kind of you. I appreciate it. Theo? Good name. I like it.

>> I like it, too. I would like to also, like Jennifer was just stating how much I appreciate the fact what have we're

doing here. We have a lot of diversity. Sensitive opportunity be let me add this. A bunch of us, it's been talking outside of this meeting. One of the things that we're still kind of coming up with that we haven't seen yet is what is very similar to that than has been done with the Affordable Care Act is that we have people navigate through this MAIS of computers and healthcare. We see that something similar should be put in place with managed care. Right now, we are concerned that people might not be able to access some of the stuff that will be coming at him, and there will be some individuals who will be able to navigate through and pick the right plan, but not only that. It's something that goes beyond what is going to be happening with enrollment, but someone to really walk with people and help them make the right decisions. We had mentioned it before, but again, we want to bring that to be to your attention. >> First I'd say thanks again for the kind words, and also say that, you know, if I ever get out of line, Jen Burnett is not afraid to slap me upside of the head and say, you know, what is the matter with you? And I appreciate when she does, Especially she sort of eases upright before she hits me. That's good.
You hit on, I think, a really important point F we build the system, first hopefully when we're building this and you have managed care and you have the system a little less fractured than it is, that by itself will make it easier to navigate. I think one of the reasons why, you know, folks have said that there's a bias in Pennsylvania now for folks to go to nursing homes versus being in the community, I think part of the reason that exists is that the system a little fractured now. So you have physical health needs. They're addressed in one place. Behavior health needs are another place and long-term supports and services in another place. And having folks sort of this left to navigate that by themselves, I think that's one of the reasons if that bias exists. Right? If that is -- that might be one of the reasons. And I think the idea of getting the care coordinated and getting -- moving to managed care will help. Now, I know that I've had a lot of conversations with Jen about things that we can do to make it easier for folks to

navigate the system, by from the conversations you've had, I guess the question is what are the things that you think we need to add to get Thus? What are the things you don't see right there?
>> Well, there's going to be some confusion, too. Once you get under managed care and you get the service coordinated, you're set. However, when you get to the point of navigating through a whole bunch of information, getting assessment done through enrollment and then trying to figure out what plan is needed and understanding the different plans that is going to be offered by the different organizational things and regions, which one to go to, all of that, it's going to be very new and confuse to go a lot of participants. And so who do they call? I'm suggesting I went through the federal change and it's a process.
>> Sure.
>> So I think the mental health association has a contract and they are called navigators, and so we call them and they help you make the best decision and they walk you through that process. I'm thinking I know something in regard to a product test or something, but that is mainly focused on Medicare. So thinking something similar to that would help people make it through that.
>> You probably can speak better than I can about some of the things that they're trying to do to help make that process easier. We can always take a look at it and see if there's more that we can do.
>> Yeah. We've been talking with the Department of Aging about the roles of counselors, which is Pennsylvania's version of SHIP, which is the state health insurance program, which is required of every state to have to help them navigate into and make choices when there's open enrollment for Medicare. So they have a very specific role around Medicare, but it's a model that we can borrow and look at and really understand, and also, it's a network and there's some area agencies on aging in the room that could speak to this better than I go, but it's a network of experts who are highly trained on the inner workings of Medicare and that's a model that we would try to replicate or borrow from.

I'm glad to hear that you had a good experience with the navigator. I know that CMS has done a lot of money to put word out on the street to help with the health insurance marketplace for people to navigate into it. That's another place we'll have to take a look and see where it is in the mental health association. I know I referred to them on the radio talking about their role, so we'll definitely be touching base with them to find out what they do and how they've set their things up.
>> Tonya?
>> Tonya, can you introduce yourself?
>> Yes. My name is Tonya Higlo. I'm [Inaudible] but I'm here because I'm also a consumer of the medicate program, and I've been heavily involved with this kind of substance. The first changeover was CFM and [Inaudible] senator Wiley sent you a letter on my behalf for you to speak with me about six or eight months ago, so it's nice to finally --
>> I did not get that letter. Maybe some folks read it somewhere. I'm sorry. I didn't get that letter.
>> But I'm glad I have a conditions to speak with you now.
>> One of my biggest concerns about the system and reward is, okay, we're linking, like, the medical stuff together, which believe me, I could sit here and sort of blow your mind for half an hour. But I'm not going to do that. But more so than that is, like, NGOs are going to focus mainly on the medical aspects of things and making sure those needs are being met. But where is the intent going to be for people to actually get a chance to go out there in the community and, like, be [Inaudible] that they want to be? What's going to ensure that those goals are being met and it doesn't even apply to the future. It applies to right now. The overall communication to come between federal policy-makers, state you policy-makers, and everything thousand filters down through the system, because something I think that needs to be changed to is people have different levels of different disabilities that affect them all differently. And I don't think all the models that are in place actually work out for all individuals. Something needs to be done so we can boost everybody's potential.

>> So I think you've hit on one of the things that I think is the biggest failing of whether it's the federal, state, or local level for human serves agency. You get big, you know, bigger bureaucracies. Right? They tend to do black and white okay. Gray, they're not always so good at. Right? So unfortunately, most people's lives are different. Right? And they are necessity that gray area. Right? And you need to find out the issues that that individual person f you're really going to help them, you're going to help them get where they want to go. You really have to find a way to focus that. I don't think the system does that right now. I do think, though, that as we're moving to managed care, there is an opportunity and, in fact, an incentive for folks to do those things.
When you look at all the factors that affect people's lives and affect their health, there's only a piece of that is what happens when n a medical setting. Right? Your doctor's office and all of those things, that could be as little as -- I've seen some studies where it's only 13, 15% of your health is actually affected by what happens at a doctor's office. There are all other kind of things that affect other people's health and affect their lives, their environment, the relationships. They have all of those other things. So I think that when you look at managed care and you look at the incentive and you say what's the incentive for folks to have a shot to be in the community, I think there's the goal we're setting, the performance targets we're going to put into the RF P, I think there's also a financial incentive for the envelop CO to his put folks into the community. The truth of the matter is it's a hell of a lot more expensive to serve someone in the nursing home than it is to serve someone in the community in most indicates, in many cases. So for us, I think the alignment is the MCOs will have an incentive to get folks where they want to go. I think that will help with managed care, but I think the other piece of it, [Inaudible] with Jen as well.
Aim not sure what conversations have been heard here. We have to give opportunities for the NCO to address some people call it the social and economic developments of health or they call it population health or there's a whole

bunch of terms for it. What you're getting is looking at a person's life in full and not just, you know, this medical need or that medical need. So I think finding ways for the MCOs to engage on that and giving them the freedom to do that, and there's some MCO -- NCOs across the country who have done long-term managed care who get that and who understand that other component to it. That's the thing that we really want to unlock. Right? It's not just about any particular -- it's not only about, I should say, but it's also about quality of life. It's also about environment and all of those things and if we find a way to do that, then I think we'll be even more successful from 95, from 95 to 50, the speed at which we move. I think a big part of that will be understanding what you're talking about.
>> The one thing [Inaudible] done. Like when are we really going to brainstorm on things to put an effective system in motion and make sure that it works? Because see, I'm just using this as an example. If we take the changes in the over time system what have just been implemented, like the communication process wads totally broken during that period . Okay? If you wait until it's right time to do something or past the time when the law or something has already been enacted, it's not going to help anybody. It's going to create much more confusion than as if you did it already before it has to happen.
>> And I think that the process that we're going through now and all the other things we've done have been an attempt to get there. Right? I think one of the things that I became aware of, I actually had -- I worked for second Richmond when she was here under the report endell administration and I came back four-year later and I noticed one of the big changes in the department was it was more closed off from the people that served than it was when I left. And one of the things that we've tried very hard to do is send the message that we're listening again and we're opening the doors and trying to engage folks. Hopefully that message has gotten to folks along the way. Part of that process is doing 245. The draft agreement, the things they're doing there, we've had the benefit of 20 or so other states that

have gone before us. There are things we've learned along the way. We don't have to create it from scratch and if you look at some of the things in the RF P or draft RF P, hopefully you'll start to see some of those things reflected in there. If there are things you don't see enough of, that's what I think this process is about. But I know Jen also wand to talk about it.
>> I just wanted to say one of our challenges was the timing of this, the implementation, which was very soon after the Circuit Court made its decision. We only had about a month and a half, two months to implement the additional over time pages for about -- for people who don't know about it, change requires individuals who are receiving [Inaudible] to individuals who are employees of people and self-directed programs for personal assistant services, and it also requires, the Fair Labor Standards Act requires minimum wage. We were already playing minimum wage, so that did not affect this. However, it did affect approximately 4100 workers who are getting over time today, who have been authorized to get over time. And so we had very little time period to make those communication. We communicated after the service coordinated indices in early December that this change would have to be implemented. They needed to go into the system to make some changes in the system and all of that took a little bit of time. So there were some bumps in the road. [Inaudible] so has left the conference.
>> Good morning.
>> Morning.
>> Now, there is a good example that you guys are actually listening to us. There was that 25% that the CMOs could drop us, that the insurance companies could drop us. And report it go to the state. Right? That was taken care of. It came from this committee and that's proof that you guides are listening and this is actually doing something that hasn't been done in a long time. Getting our input and actually using it. Okay? But there's still a lot of --
>> You could use the input?
>> Absolutely. Hey, I love to hear myself talk, but I do it for a reason. I've been having meetings with the Jewish healthcare foundation over in the Pittsburgh area and

everything, and there's a lot of concerns over there in that area. One of them is like an increase in services. The loss of individuality. The literacy of the content that's coming out. Can people understand it? One of the huge things is this change of age from 18 to 21. Now, I know, I know, I know APSDT takes care of it. It doesn't. It doesn't do home modification. It doesn't do [Inaudible] modifications. There's a lot of things it doesn't do. What it's going to end up doing is having these young people at 18 years old setting around for two years twiddling their thumbs because they can't go to college. They can't go to work. So if we goof up and push it up to the age of 21 it's going to be a huge mistake. A huge mistake. There's a lot of people out here that agree with me. You saw the letter we sent in with everybody that's back in this, and it's something that you're really going to have -- this is one thing I really, really want to you listen to very, very well, because it's just like taking these kids and throwing them away and saying, you know, who cares? And that's not what we're doing. The state does care and it's been shown especially in this administration. This administration really does care. So let's keep it that way. Let's not do that.

Some of the other things, people are worried that they're going to have to lose the providers that they have. Okay? That's a huge concern with a lot of people. And like Tonya was saying, the consistency of the message, if this department says this and this is something else that's not going to work, they all have to be on the same track. That's another one of the age things that we had.

While I'm in this meeting at the Jewish healthcare foundation, and Tim has been a part of it, we would be coming up with ways to get all the information about managed care out to the people it needs to go out to. Okay? And we've come up with several things from the billboards to newspapers to everything and anything. Even right down to taking it into the really rural areas to the feed stores, because if you think about it, you go out to a rural area and everybody has a cat, a dog, a horse, something. So they're always in a feed store. So that's one of the best

places to get permission.
>> Whatever works. Right?
>> Absolutely. So it's not just this committee. It's other committees that's reporting to this committee, that's reporting to you. And I do want to thank you for everything that you've done so far and I just want to make sure that we continue to do it and don't stop.
>> So a lot of stuff in there. Thank you. I appreciate it. For me, you know, we certainly -- the communication of it is going to be key in making sure that folks, once you know the system, that's hopefully easier and better to use, making sure folks understand that. Theo was talking about it. Other folks were talking about it. With regard to the 18 to 21 folks, we have heard on you that. I don't know that we're ready to talk about anything we can do differently. I'll just tell you it has been the subject of many internal meetings, trying to figure out something there. There's some constraints that we have, and I'm not 100% sure we're going to get to where you want to go, but I can tell you right now that we're having a lot of discussions about how we can find a way to do better than we're doing there. So we're having a lot of discussion on it and I hope that we'll be able to talk about it, have an approach that we can talk about soon for folks to react to.
>> Oh, okay. Even a compromise on the 18 to 21, fine. Don't give them something. I mean, they've got to have the home modifications. They can't move out.
>> Believe me. I completely understand where you're coming from. We are working very hard to try to find a way to get where you guys want to come.
>> We're here to help.
>> I forget. We need to be pretty for prime time. We just need to be ready for public access or something. Okay? We'll have our thoughts together on that.
>> Mr. secretary, let me ask. Is there any committee members on the phone that would have a question for the secretary? Are there any committee members on the phone that would have a question for the secretary? Okay.
>> Richard does.
>> Jennifer does, too. So with Jennifer and then Richard.

>> Has joined the conference.
>> I just want to, although it's already been said about approximate the 18 to 21 year olds. I know that employment is a huge part of the department [Inaudible] really appreciate that. But it's counterproductive you to take away services for people that are 18 to 21. If you can't give them waiver services, then at least work with EPSDT to take away [Inaudible] seeing that they can hire their own people.
>> Captionist: When people come and go from the conference, it masks what is being said.
>> Right now they have nurses that are coming in and half the time the nurses don't show up. The nurses can drive them places. They can't go to work. They can't go to school. They can't start college at 18. They have to stay and wait until they're 21 if the change goes through. Another change, they're very concerned about this first coordinator's name being changed to having a master's degree in education. Theo continues better at this than I go, but a lot of the centers for independent living employ people with disabilities to be you is ports. If you make the change to master's degree and it requires to have a master's degree, [Inaudible] because there's not -- I well realize that there's medical systems for people with disability which health law is very familiar with, and I used when I was working. However, there's not enough -- if you require a master's degree for support coordinators, there's not enough expenses that we can take off on the waiver. So it's going to cause people with disabilities to lose jobs and that's not the department's goal. So you're being -- with a lot of things that you're implementing, you're being counterproductive. You're saying that you want employment for people with disabilities, and yet you're going to take away services for 18 year olds and take away jobs for people with disabilities you if you raise the education requirements to master's degree level. Instead, education people on what they need to look for. If there's problems with support coordination, he had eye indicate providers on that. -- educate providers with that. Educate on what's happening, what they need to look for. Implement

training on how this could be done. There's a lot of ways to do that that doesn't require people to have a master's degree level of education, because what you're going to do as well, a lot of times when people have more education, they're further from the people. Not always, but a lot of the time. And people with disabilities understand what people go through a whole lot better than anybody. Because we've been there. We're going through it as well. So I would really ask you to please, please, please look at both of these [Inaudible] taking them out.
>> First, I wish we were [Inaudible] the issue for 18 to 21 year old so we could have a better discussion about it other than just to reiterate that we have had the concerns and we are taping a very hard look at it. For master's degree requirements or educational requirements, I think the goal is to make sure that folks who are providing services are qualified to provide services for you. Sometimes education is a proxy for that. Sometimes it doesn't need to be. It's one that we can certainly talk about what it is. I think our goal, unless there's some rule that I don't know about, our goal is to make sure the folks who are providing services are qualified to do so and can provide high quality services. If there are different ways to make sure we do that and it doesn't have to be a master's degree, there might be otherwise that we can get there.
>> There definitely is.
>> And I just wanted to also respond to that. We actually created a work group to work on this issue, hearing from many people that those kind of qualifications are kind of over the top. We heard that loud and clear. We created a work group. They met for the first time this week, earlier this week, I believe, or maybe it was late last week. Theo, you were at that meeting. There's a whole lot of good ideas that came through that process and we're going to be make something changes and putting out a new draft of what those qualifications can look like.
>> Theo, one more question to the secretary. His schedule is limited. I know Richard had one and Barbara had one zoom in if they're two quick questions, I can do two. I need to get back to health and welfare by about 11:00.

>> Can someone help Richard with the Microphone there, please?
>> Pull it closer.
>> Marilyn, can you walk over there and just hold it for him?
>> [Inaudible] information on how to go about [Inaudible] how could you make it so that if they limit [Inaudible] that there isn't one there, it could give them the proper information or the class that they need to be able to move out properly to make a smooth transition for them.
>> So I think that, you know be there's nursing home transition. There's efforts that we're going to, I think, announce shortly might help folks be able to move to make a transition from the nursing home to the community. I think with us it comes down to a theme that I've heard a couple times is the communication of what those changes are. All right? And we have a strategy for that. We have a strategy for outreach to the community and let us know how the system works. I think we can lawsuit us know better. Following you know on something Jennifer said, I think the folks be that receive the services probably are the best people to tell us what's the way to get the message out there. And Fred, you talked about the feed store. I don't know if I would have thought about that without you there, but we'll take a look at it. But I know my response would be we're going to try multiple ways to get that out there. If there's a way that you think we're not making that communication that you think might be effective, we're certainly all ears and willing to try anything. I think that changes like this, you're going to have to communicate multiple times in multiple ways, whether it's the feed store or whether it's in the nursing home. Whatever it is, I think we're going to have to try to get that communication out there. It's something new. It's going to take folks a little while to understand, and as we're doing that, whatever way we can do that, I just think it's going to have to be multiple ways, multiple times, and in areas that maybe I hadn't thought of before or again. I don't know if you had thought of the feed store before that, but we'll look for all of those possibilities. But if you have otherwise

that you think you can do that, we're certain all years on that.
>> Okay. Theo and then we have Cassie on the phone.
>> I just wanted to add in regard to the work group, in regard to associated coordination. We did meet that Friday and had a wonderful meeting. I think a lot of stuff got resolved. Jennifer Rogers led that and a lot of good people provided some input and those recommendations are considered updates that serve for nation requirement, issues that we had.
>> Hello. Cassie? Cassie James?
>> Cassie, are you on the phone? Did you have a question that you wanted to ask the secretary?
>> Okay. I guess not. All right.
>> [Inaudible]
>> So for community's first choice, I know that we've had some conversations with the governor's office, with Fred and some other folks. We are taking a look at it. I think we're not quite there in terms of viability n terms of the cost of it and whether we can do it given where we are in Pennsylvania, but we're having those discussions right now. We've agreed to take another look at it, but it's something that's under discussion, but it's not something that we think we can do at this particular moment, but that's why we're having the discussions, to talk about it some more.
>> All right. This will be the last one. I've got to get back and cause 134 more problems at health --
>> [Inaudible] from AARP. I just wish to compliment everybody for listening and I'd like to emphasize that aging, although we have similar feeds to the disability community, our needs are a little more unique and there is sensitivity to that and I would just encourage building on our aging system that we have in place, area agencies in the evening and the programs [Inaudible] and the transportation program. I do wish to talk about the staff.
>> I think we've done a great job. It's an important point. We did list minute sessions and other parts of the process. Folks living with disabilities made up a lot more of the audience than did seniors. I know we did a separate process there. We've got more feedback there I'm glad you're here.

I'm glad you're part of the process, because we need to hear from all voices to make sure we get it right.
>> On behalf of this committee and myself, I want to thank you so much for coming.
>> Thanks so much.
>> You're always welcome.
>> All right. If Jennifer lets me, I'll come back another time. All right.
>> Have a good day.
>> Thank you.
[Applause]
>> If I now can, let me officially call this meeting to order. And introductions, as usual. I'll start with Barbara there and committee members, please introduce yourself. Say your name, please.
>> Barb Holter, liberty management connection.
>> You burned it out, Tonya. We'll start with Jack.
>> the mics aren't working. [Inaudible] from AARP.
>> Bill White from AARP.
>> this is not working. Must be on the same connection. Russ McDade representing Scott rip kin from Pennsylvania healthcare system.
>> There's too many mics on.
>> Pam [Inaudible] Philadelphia.
>> Half trainer, abilities in motion. We know who you are.
-- raffle
>> Fred mess from disability options network.
>> Steve Williamson from Blair senior services.
>> Jennifer house.
>> Drew Nagle [Inaudible]
>> [Inaudible] center for independent living, central PA.
>> Morgan Lindsay. I'm sitting in for knee Vincent [Inaudible]
>> [Inaudible] chairman of the Pennsylvania council on aging .
>> Arson from Sarah care, home health services.
>> Richard [Inaudible]
>> Disability in action. [Inaudible]
>> Okay. So we're going to pull the phone, and if Brenda dare is on the phone right now?

>> Brenda is. We're having a problem with the mute.
>> Okay. Darrell Andrus? -- Andrus? He stale hide? -- Estell e hide you? Mary Lou Brophy?
>> Yes. Mary is on the phone. Michael Pelecano?
>> Paul McCardy. Has left the conference.
>> Richard Paveleski?
>> Richard is [Inaudible] this morning. I don't see him.
>> He's trying to get on and he's telling us that whatever number isn't going. Just silence.
>> Pat, do you have his e-mail? >> Yes.
>> Okay.
>> And Terry Brennen?
>> Terry is on.
>> For everyone here, committee members and the public as well, when you do get a chance to speak, please try to be considerate and timely about the conversation. I will be able, I'm told, when I say a point of order, please stop so we don't move to the next topic, because sometimes we do get a little bit winded. The microphone, please turn them on when you speak, announce your name, and turn them off after you're done speaking, please. We have a captionist with us today and so I don't have a name for that person. Please turn off your cell phones. Clean up the area around you when you leave. And we'll do our very best to try to get some more public comments at the end with the secretary's visit here today. I'm pretty sure it's going to be tighter than usual. For those who are seeking nourishment, vending someone on the third floor. And before the evacuation procedures, frank, can you raise your hand? Frank over there on the left. Janice, you saw her.
>> She did might be out there.
>> All right. Well, those two people will help in the evacuation process. Everyone must leave the building in the event of an emergency. We will proceed to the assembly area. To the left of the Zion church on the corner at fourth and market and if you need assistance, Fred is going to help you. But seriously, frank and Janice will help us to the safe area of the honor suite here, and [Inaudible] evacuate the building, please take your cell phones with you. [Inaudible] and do not try to use the elevators. Use

stare one and stare two to exit the building. Stare one is through the main doors on the left side near the elevator. Turn right. Go down the hallway by the water fountain. Stairwell is on the left. And for stare two -- who wrote these? Anyway, we'll make sure you get out of here. Stay to the inside of the wall and the stairwell and assemble down by the [Inaudible] at Chestnut street. Thank you very much.
>> I just called in on the line. You can hear.
>> Yes, David. Is Richard on now, do you know? Fred just tested it and he was able to call in.
>>
>> Okay. Thank you.
>> I couldn't speak.
>> Well, we're trying our best with these phones. Every time we got a little close, something else delays it. But we're trying. She can give you the update. Thank you.
>> Thank you, raffle. With Ted's involvement, I didn't know that he was going to stay as long as he did, so I'm going to try to tighten up my remarks so that we can move onto what I think is going to be a really interesting presentation about our evaluation. And I think we really are looking forward to getting input on what we've done so far.
In terms of the [Inaudible] a draft RF P and agreement was closed earlier in January, and we received during these two RF P processes that we went to over 3,000 comments and over 350 people commented. Kevin is going to talk a little bit more about some of the comment things later in the meeting, but it was a very robust process. We got lots of input, and we really are -- we really believe we're going to have a much better product because of the comment process that we went through, and I want to thank the committee for really advising us to go through this process. We were somewhat resistant when we first heard the idea, when the idea was first proposed. As it turns out, it was a very useful process for us in terms of getting the product, the actual RF P to a good place.
I want to talk a little bit about the meet and greets that we've been doing. We held the second session of meet and greets on January 13th and 14th with managed care

organizations. We now have 12 managed care organizations. That's up you from I think there were seven or eight of them at the first set of meet and greets in November. 12 managed care organizations attended the second round, and that round included what we do at the meet and greets, we have a time period of about two and a half hours where they meet with very specific groups of interested stakeholders. These meet and greets included [Inaudible] human services administrate minors and various county governments, behavioral health providers was the second group of housing, work on housing, come in and talk about all of the different work that's being done to increase the amount of accessible affordable housing that we have in the state. We also had a larger group of current participants from some of the members of this committee were there. So we had a minute broader conversation. I want to thank CO for helping put tote the panel of consumers that came in. It was nice, because it did include consumers, both consumers, younger consumers to your point. Younger consumers and older consumers. We actually had several people who the nursing homes attend the meet and greet. Estelle Richmond facilitates * tattle the meet and greets and she asked every consumer to make some kind of a comment. And we have one older woman who lives in the local nursing home, get up and tell he is how wonderful -- she loves where she explosives she doesn't want to move. She absolutely moves her nursing facilities. I thought that was the 5% we talked about.

And we also have the same injury providers come four and talk with the managed care organizations. And then we did the debrief with the managed care organizations only. Got a lot of positive feedback with that experience. One thing we learned is because of these meet and greets, it really has opened the door for them to talk with providers, open the door to connect with a whole variety of stakeholders are interested in what we're going through, including many of the associations representing our provider entities.

We're going to be doing meet and greets in Pittsburgh, likely after the RSP blackout period. We're going to be able to do that. We're going to be -- Kevin, when do you think that would be? Meets and greets in

Pittsburgh? I'm sorry. I was asking when are we going to do meet and greets in Pittsburgh? We have to wait until after the blackout is over here.
>> The meet and greet will have to be after the end of April .
>> Yeah, after the end of April.
>> After April?
>> Yeah. But I want to work with the group there. When Fred alluded to the work at the Jewish healthcare foundation is doing, it's actually a network of Pennsylvania health funders that has never engaged and is partnering with us to do a more local conversation about thousand reach people. What do we need to put in place in and they've held a couple of meetings and we're very involved in that process, as is Brenda who is on the phone. And we'll continue to do those kind of things with other health funders and other parts of the state and a very useful process for us. We've gotten really good feedback through the process. The Pennsylvania health funders are also -- between now and the end of the blackout period in April, a meet and greet with housers local. Local housers. So we continue to work with them and partner with them.
I want to just say about the meet and greets, I've heard with several managed care organizations, we have never seen such a robust process of engaging managed care organizations , and they are the secretary mentioned looking at this as a best practice. So I just want to thank all of you for all the ideas that you've been bringing forward, because I think some of that sprung from other states recommending t but they only did one and approximate it was very small. It was just with, for example, I heard from New Jersey and they said, well, we did one and it was with area agencies on aging. So they've done a lot more and it's really proved to be a much more -- it's really helped to get providers connected with these managed care organizations.
I was also asked to speak about -- these are all items that came in with our request for items on the agenda to talk about the outstanding Department of human services RF Ps that affect community health choices. [Inaudible] enrollment broker. We are going to continue with maximus

for the time being. We did a procurement and the results of that procurement was to work with maximus. As of March 1st, we are implementing a different time period and requirement for people to be enrolled in the waiver. Our prior requirement was 90 days. We now had gone to 60 days. We are now going to be require them, and we've been measuring this and it's been slowly creeping down. When we first started this process before maximus even started about four-year ago, the average amount of time it took for somebody to get onto a waiver was over 100 days. I think it was something like 107 days. Today we're down to about 65 days. So we have been slowly improving this process and I think the results are in the data.

We will also start doing enrollment of the aging waiver beginning on April 1st, a communication to service coordination entities and area agencies on aging will be going out this week informing them of these two main changes, and then we will be doing some webinars to kind of walk through what the changes mean. So we're really committed to an open process to making the change and making the transition.

part of the reason that it was important for us to get the aging onboard and with the independent enrollment entity, part of the reason is that we did not want it to bump up against the rollout of the first phase of community health choices. So we wanted to get this transition behind us before we rolled out community health choices in January of 2017 in the southwestern part of the state. And then the other reason that we really wanted to look at -- move the aging waiver into the independent enrollment broker was because it creates a conflict be free place where people are getting enrolled. And so that was another important aspect of making this change.

So with that, I've been working very closely with the Pennsylvania association of area agencies on aging and our membership to adjust you to this change. I will also say in late spring, early summer, another RF P for independent enrollment entity, which is going to be critical for community health choices down the road will be -- we will be issuing that. The home mods broker RF P is expected to come

out momentarily. It's about the procurement people. It's cleared everything and now we've simply gone over the DGS and we wait 230 them to do their posting. -- for them to do their posting.
Do you have a question on that?
>> Yeah. I might as well ask that now. We're beginning January 1st of 2017. Now, when are the consumers going to get the information? Is it going to be before that or will it be actually January 1st and then after that how long do we have to enroll?
>> Well, that's a good question. Now, notices will go out in the fall and my goal in really doing a very robust communication and trying as many different things as we can in terms of communication, one of the areas of communication that's going to happen is our press office, our communications office for DHS will be on taking a vendor to help us develop materials, and those materials will need to be vetted by this committee, as well as focus groups out in the community. So that's one area of communications that we're going to be looking for help with. And my goal is really to have at least 95% of the people that are going to get one of those notices that Fred is talking about in terms of how to enroll or what you have to do is for people to be aware of it, to have some level of awareness that they are not getting that notice for the first time and saying, what is this? What am I doing? I don't get this.
>> I'd hate to get the announcement on the first and have to have it done by the second.
>> No. It will be coming out in the fall. The technical notices that we have to sign v to send out will happen in the fall.
>> so like three months?
>> Yeah. I mean, Kevin, is that about when you notice the start? Sometime in the fall? Like three months before?
>> September.
>> September?
>> Yeah, January 1st.
>> Okay.
>> Around that time.
>> So those are the official notices, but as I said, we

really want to have materials and information out to people before that so that they're aware of what's going on.
>> Brenda dare has a question.
>> Brenda dare? Can she ask it or do you want to just ask it?
>> Brenda dare asked the question, is PPL going to remain the FMS for now? Yes. We are not making changes before we roll out any other choices.
>> * when you say that, is that the whole state the southwest portion of the state?
>> The whole state, yes.
>> So that's years down the road?
>> Yeah. We're working very closely with making some improvements to our contract that we have with PPL right now, and we've taken a lot of feedback on what we might look at. You will be seeing some changes. Changes 230 the amendment in *ment in the next year.
>> In our -- we did -- an RF A, I believe it was, or some kind of request for feedback on our management service contract and the work that we're doing with that. We received a lot of feedback, and based on that feedback, we're going to be amending the existing contract to address some of that feedback. So that will be in advance of the rollout of community health choices.
>> Can I get [Inaudible] you on that? One question. Are you saying that once the contract is received with the NCOs that they can do some stuff contracting themselves or --
>> PPL, we will continue to have a contract on PPLs, which is a payroll agency. Maybe not forever. At some point. Meanwhile, you can start contracting. For now, at least in the first phaseout roll, first phase in, we are continuing to use PPL as our management services. We got a lot of positive feedback about PPLs. Some people may not feel that it is positive, but in our process, our RF A process, there was a lot of good stuff by consumers about how PPL has made improvements. So we're going to continue. We don't want to -- we don't have time. We don't have bandwidth to make any changes to that, so that will remain in place for sometime now in terms of fiscal management.
We want to continued to own fiscal management, because we

know that rolling out long-term services and supports, managed care programs is a lot of lift, and for now, we don't want to ask managed care organizations to also then have to contract with a fiscal management entity.
>> And again, committee members, please turn your phone off after you speak and announce your name when you do speak. All right?
>> Okay. I think I made up about ten -- I'm still about ten minutes into the next part of this, of the agenda, but I really would like to make an introduction for evaluation. This is going to be a good use of information about the evaluation you of choices. We actually commissioned, the department missed an independent entity, the University of Pittsburgh, to help us with this evaluation. Work group and committee health choices, evaluation work group was established a long time ago. I think in the summer we established it.
it's an internal work group that really knows it's made up of a lot of our program analysts to really know how our data works, including how the Medicare data works. And so we started talking about what the evaluation would look like. Recently, our committee must have recommended that this internal committee recommended that we ask somebody from this group to join the committee, and that occurred at the last meeting I was at, which was in November. Richard Coveleski asked me about evaluations. He seemed very interested in evaluations, so I reached out to her. [Inaudible] he went head and did so. And he attended his first meeting earlier, I guess in January. That happened in January. Unfortunately, Richard is not here or I would have asked him to talk a little bit about his experience. We received very positive feedback from Richard about the work that we've done so far on the evaluation, but Richard is going to be asked to report. We have the capacity for Richard to say anything?
>> [Inaudible]
>> Is Richard on?
>> Richard, are you on the call?
>> Yes, I am. I am on the call now.
>> Hold on a second, Richard. I'm going to put the mic over

to you.
>> Before University of Pittsburgh Howard Gigemholtz speaks and presents what we have, I'm going just to ask Richard to give you feedback on what his experience was with the evaluation.
>> First, thank you. First of all, yes, I do have an interesting evaluation. And I would like to thank the deputy secretary for that. From my experience in January, the first meeting, I attended online. It was a very positive experience looking at various types of markers that would align with long-term support services and I really felt that the University of Pittsburgh senior researcher and members of the committee are interested in making -- assessing and evaluating, reporting back to this committee. A lot of social and various types of assessments, but I was very pleased with the meeting and believed that the members of the committee will be as well. That's been my experience thus far is what I can say for now. Anything else, Jennifer?
>> No, thank you, Richard. That's great. So with that, and I just wanted to point out that I said this before to this committee. The state will be seeking a concurrent [Inaudible] waiver from CMS. And that will be occurring in April. You'll be hearing, because we have to go through a public process in order to actually make an application to CMS for a BC waiver. You'll be hearing, actually the public will be hearing about what our goals are and what we're planning to do, sort of the structure of what that BC [Inaudible]
We are not seeking [Inaudible] waiver that requires fiveyear evaluation. The long-term impact of pulling out community health choices is going to have on the participant population.
>> Captionist: There is an echo on the line.
>> So we have [Inaudible] very general delegates -- sorry about that. This behind me kind of shows the types of input they're getting that's going to go into our continuous learning and improvement, which is what we're committed to here. So stakeholder feedback certainly this committee, but in addition, a lot of other stakeholder committee, stakeholder

feedback, and we're very interested in feedback all in general. We also will be doing our quality monitoring and oversight. This is a really key part of our role as DHS is the quality monitoring and oversight [Inaudible] for the purpose of evaluation. And we're looking at program evaluation both in the short-term through sort of kind of the continuous quality improvement process which would get information from monitoring, but also in this longer term program evaluation.
So with that, I'd like to introduce Howard Degenholtz, who is here to provide us with sort of the structure of what the evaluation is going to look like. Howard, do you want to come up here? I'll trade places with you.
>> Okay. I can't see the slides.
>> I need to get my steps in, so it's good.
>> You can take the one in front of Zach just move Zach's mic over there. He won't hit you.
>> You'll move to the next slide. I'm Howard Degenholtz. Very brief outline, what I'm going to do is share with you the purpose of the evaluation, overview of the evaluation design, and I have a whole bunch of extra slides at the end that everybody will have access to. So I'll have additional detail and be more than happy if you look at it after the meeting and provide comments and feedback after the meeting. That was kind of the purpose of having some extra slides in there.
Okay. So first of all, be I want to thank Jim Burnett for really, and DFS for really making the commitment to having an outside evaluation. The other states that have been pursuing these types of policies have either done it through the 1115 waiver mechanism which obligates them to do some type of evaluation, but oftentimes, and there's a federal national evaluation going on with the 11: 15 programs and other similar demonstration programs. However, not every state has really made a substantial commitment to internal within the state legislation. What Pennsylvania is doing is Fantastic. It's a lot of solid information about how these programs can be drawn and approved and it really is going to be a national model for general rating information that I think will help people in Pennsylvania

and other states as well.
What we're planning is a statewide -- it's going to be about a seven year evaluation of the implementation process and outcomes of community health choices. We provided the evaluation around the papers and documents, and I'll review those, each one in term. You can see them up on the pored. The key point about the evaluation, everyone involved, multiple data sources and multiple methods, and we only just looked at one source of data that administrative records were just focus groups. Then times you miss the big picture. So the idea around having much typical sources of information try an eye late on you what's going on and have a reach picture of the experience . Program. We'll be conducting [Inaudible] what we'll call the participant caregiver experience and interviews. We'll be analyzing administrative data.
And just a note to the rollout, this is external and independent evaluation. There is a working group which Jen referred to at OL it TL that's made up of program analysts of longstanding expertise and which are called [Inaudible] to Join that group as well. 245 that provides the oversight of the program and on a monthly basis to provide updates on the program and they also collaborated on the design as well.
the role of this committee is to -- will provide you with updates on the evaluation you and how a program is rolling out, and I'm also here to get feedback from everybody on this committee about what we should be doing and what we should be looking at. But we'll be having formal ways of gathering information and input from program participants and caregivers, providers and other stakeholders, but also this committee is an important aspect of having a good and strong evaluation that addresses the needs of the community.
I have to apologize. I have a really bad cold. So what I've done here is provide a summary of the major research questions under each of the program goal areas. And I have this information repeated several times as we go through it. We have greater detail. Research questions. Some of these are directional, hypothesis driven, and some of these are more descriptive and exploratory, and I can explain what the

difference is as we go on if anybody has any questions. I'm more than happy to address them.
The major goal of community health choices is, number one, to enhance opportunities for community living. And the directional goal is whether it increases the use of home community base the services, delays or prevents institutionalization, and I didn't have space, but also facilitates running to the community for people who are living in an institution or nursing facility.
Number two, under improving service coordination, Sarah would con sensualize it as both the coordination of care. So within the medical care system and also within the home and community based services and LTSS systems, but also you between those two systems. So is CHC improving coordination between the medical side and the social side. And then also between the Medicaid and Medicare funded services, because historically, those two programs don't talk to each other and are often at cross purposes.
Number three, enhancing quality and accountability. This one is, for me, I hold this in my research in quality of life. The question is what is the impact of community health choices on the quality of life and well-being for participants and caregivers? And I want to point out that here we're talking about, as an outcome here, we're talking about unpaid and family caregivers. There are an parts of the evaluation that look at the impact on the paid provider systems. And also impact on quality of care across the spectrum of acute and long-term care services. Sometimes I say long-term care instead of LTSS. Just force of habit.
The fourth goal was advancing program innovation. This one was more descriptive you and exploratory. I think there's a lot of optimism that the program will, by reducing some of the regulatory and structural [Inaudible] to the way programs are financed and delivered that there will be innovation, and as with innovation, you don't know what it's going to be. If we knew there was, it would be [Inaudible] but it wouldn't be an innovation. So there's an expectation there might be new models of care. New ways of doing care coordination, new technologies, new combinations of housing and services, new opportunities for employment

and, by definition, we don't know what those are yet. We can make guesses, but this is where we're taping a more descriptive and exploratory position coming with hard to the evaluation.
and then finally, increasing efficiency and effectiveness. And this is where the focus is on the utilization of acute you long-term services and supports. Somewhat different than goal one none this is the renouncing goal falls under number one and the overall cost system goal falls under number five. So there's logically some overlap there. Number one is increasing home and community based services and number five is monitoring costs.
This one is a little bit hard to read. I feel bad about this because of the contrast. What I'm going to do in the next few slides is talk about the different data sources, and there's three major date collection processes we'll be going through. The top one, which is in play, is key informant focus groups. And we'll be using purpose of samples and I'll explain what that means. At the lower right in the Greenwich box, it looked good on my computer screen, so I'm sorry about that. Participant and caregiver interviews. And this is where we'll be drawing [Inaudible] statewide examples, and I'll explain that in greater detail. And then the third box, which is the LL, analysis of administrative data, and this is where we'll be able to analyze the data from the entire state. Next slide?
So just to give a quick very high level summary of what we're doing, if you look down and see the comments of red on the left, these are the major population groups that are going to be [Inaudible] community health choices. And I want to recognize the 18 to 21 group is not shown. We can discuss that, how the evaluation is going to approach that population. But holding off that issue for the time being.

We had a lot of meetings with OLTL to think about what are the major categories that we should be thinking about in terms of impact, and we divided it into 21 to 59 and the 60 plus population, then we divided it into people currently living in the community receiving LTSI, people living in facilities receiving LTSI. So that, of course, is a much

larger group of people who are duly eligible and not receiving LTSS currently. So that's a group of 300,000 eligible for older adults who are also covered here and also target of these evaluations.
If you just look down the blue column, you can see that for each population group, you can see multiple sources of data, and then the two boxes that are blank is where the participant interview design is focused on people living in the community and not, for design reasons, we'll be talking to care give minors and people who live in facilities, but we're not planning to interview facility 12 participants as part that have component of the study. I'm confident we'll have a lot of questions about those. Yes, there's a question?
>> Is there any reason that cutoff is 60 and not 65, which is when Medicare kicks in?
>> Yeah. So that's a very complicated issue. The waiver, the aging waiver program covers people 60 plus, but the dual really kicks in at 65, so we've defined it as 60 plus for the purposes of the evaluation. Some analyses will be restricted to 65 and older. It's a quirk of the way the aging waiver is designed and that kind of falls through.
Rather than overly complicate all of the slides, to have 60 to 64 and then 65 and older, I just you combine that together. We're cognizant of that. Yes?
>> Brenda wanted to know why there's no participant interview for nursing facility residents?
>> We feel that there's quite a lot of information about nursing facility residents that's available on a lot of important [Inaudible] and for a lot of those population, we really want to focus on using MTS data, understand strengths and weaknesses, but the major impact is on community health choices for people currently living in the facility. It's twofold. One, reducing the probability that a person who is living in the community becomes a permanent resident, and two, for people currently nursing home or facility residents, increasing the probability that they return home. And we're going to be spend ago lot of attention on trying to answer those two questions using the extensive data that are available for administering data systems.

The goal of interviewing people directly is to measure important concepts that are not captured in administrative data systems. Functional status, informal support networks, quality of life satisfaction with care. And while I completely agree that those are important constructs for nursing home residents in terms of focusing the evaluations, we had to make a judgment that we're not expecting community health choices to have a major impact on those outcomes, for those participants that we expect choices to really impact those populations, mainly through running to the community or avoiding in the first place. If there's any response to that, I'll pause.
>> This is Zachary Noyse. I guess my question goes to I'm confused about that. When [Inaudible] gave an example of how to reach people, like he said, you know, because of the situation where he's in a rural area, you have to go and, you know, feet people to, I guess, inform them and find out information for where they are. People that are in nursing homes and facilities are kind of confused about how to get a better understanding of what's going on or what their goals are in order to stick it out or to transition out or to do whatever they're going to do. I guess the best way we want to say that. What we're trying to do is enroll, this is just one component of the site. We feel we're going to have a lot of information about them.
family caregivers, tell us about the experience of those and people living in the facilities. From the point of view of our resources and evaluations, we're going to get more bang for the buck and talking to a family member or representative for those people, and again be that's one small source of information. We'll have a lot of information about their experience under CHC. Is on
>> Again, this is Zachary Lewis. That's like asking my attendant how was [Inaudible] the other day? I would not want to you talk to any of my caregivers or any of my family members without talking to me first or at least asking me, is it okay if we do that? And giving me the option to say yah or nay [Inaudible] some of the system that you don't ask. The way I'm going to to be able to give it to you. By not including that population. I'm a little confused.

>> I think you're slightly right. I've done nerve my year that and you know the importance of quality of life and experience as an outcome for people who live in facilities. I'm not undermining that. I also know how well and how poorly, if you ask staff about nursing home resident and then asking ask that nursing home resident the question, they would correlate very poorly. What effect do we think community health choices is going to have in major health impact? [Inaudible] receiving services in the community. People who are currently living in facilities, their daily care is really determined by that nursing facility. So we don't see that changing very much. Just a change in the way the payment [Inaudible] is going to help people return to the community in the first place. So we've directed our evaluation towards looking at some very specific questions for those population. So I'm not discounseling the subjective experience, by we're trying to focus our research in terms -- resources in terms of the research we can do.
>> Excuse the Microphone there, please.
>> You might be asking, hair family member they may only see once a westbound, once a month. So the information you might get from them might not be correct. They might see them and see them in good shape. And then you ask them more questions. I think my family will take it very well. But once a family member leaves and the residents accident there and there's no one to check on or see some of the things that's going on, then you will slip through the cracks. So I would think that you would point to firsthand information, a residents that facility. I think you would really need to talk to the president and think that it gives them a more comfortable -- make them more comfortable about talking. Seems you can't go there and see to them in the setting. They might feel -- if they say something, it could jeopardize their prayer.
>> I fully appreciate that.
>> Richard, for point of order, that's duly noted and for our time constraints, we would ask the doctor to proceed with his presentation, please.
>> Thank you.
>> Before you move on, Howard, this issue of interviewing individuals in

nursing
facilities is something we can revisit. The purpose of coming to this committee is to be getting feedback from the committee and if you feel strongly that's a cohort we're missing, we can figure that out. So thank you.
>> Absolutely. That's what I was going to say, Jen.
>> Okay. Sorry.
>> So what I'm going to do -- can we, Georgia? So what I'm going to do now is talk a little bit about the methodology for each of those pager data collection efforts to give you a sense of how we're going to go about doing it, * and get your feedback on what we're proposing here. So the first major setback is what we're call key informant interviews, and the goal here is to monitor the implementation of the program for multiple perspectives. We've been asked by OOTL, this is our goal, to provide early and independent and ongoing insight into how the program is rolling out, and we're actually planning to start this in the fall of 2016 and then we coacted a statewide basis where we'll be interviewing stakeholders from across a wide range of categories. We're planning to use a semi structured open ended interview approach. This is what we're calling qualitative and just to identify specific things that are mentioned from the perspective of different stakeholders, the chance, the main part of the evaluation where key informants will be able to tell us in their own words what's going on, what challenge they're facing, what's going well, what's going poorly. And I'm conduct this go on an ongoing basis. We'll be able to provide feedback to OLTL through the evaluation work group as early as the spring and summer of 2017. This is really important, because OLTL wants input and independent input on the program rollout in time to make course corrections for January 1 of 2018. So we're going to be conducting these interviews, like I said o an ongoing basis, and we'll be providing preliminary reports and updates to this committee as well on an ongoing basis. Just to go through, we'll be talking to a wide range of [Inaudible] and expanding this list and also very importantly, working with this committee and other similar groups to identify and get people to actually enroll and

engage in these interviews, reaching out for the next few months to start setting up these interviews for people. There's some debate on my team as to whether we enroll key informantsing and back to the same people again and again over the course of the rollout of the program, and we've left it open in that regard. There might be some people that we go back to multiple times in regards to the NCOs. We'll be reaching out to the same individuals and informants from the NCOs over time, because there's only 12 of them or however many there are in each area, two or three in each program area. But then we also want to make sure that we cast a wide net so that we're not limited and only talking to certain people.

So if you've seen the list, we're looking to talk to housing providers, nursing home providers, facilities, home health agencies, personal assistants, and also [Inaudible] adult data living.

>> Captionist: Speak up, please.

>> Home modification, habilitation, respite, service coordinators, service care providers, hospitals. One thing that -- I don't know if it was -- our last working group meeting, the point was made, the goal of talking to two to three informants of these categories might be too low in some of those categories, for example. In terms of primary care providers. If we talked to one or two people in the community be we might not get a whole picture of what's going on in let's say a rural area or in a different network, different M C O. So we're attuned for that and we're planning to talk to acute and LTSS providers that have a range of contact with CHC.

We're also, of course, including some government informants, additional county officials and area agents on aging [Inaudible] let me pause and see if there's any comments with regard to that question.

>> Bill white from AARP. I just waive to caution about release of medical information. It just dreams me that you can't go around talking to everybody about the care. Let's just say if I'm in a nursing home, you need the patient's release, so I just wish to caution you on this. I want to include that in the slide.

>> One issue is that in this component of the study when we're talking to key informants, we are talking to them about their experience with CHC and not about specific residual program participants. That's one. When you talk to individual program participants, you're talking to them with a consent process, and we offer confidentiality when we speak to those people.
Now, technically, this gets into some of the technical IRB regulations and functions under what's called evaluation of public benefits so that grants -- that's a special tag under the IRB regulations. And it's stream lines are approach to interviewing people and engaging people, but we always are very clear to participants that what they tell us is confidential and that their name is not linked to the -- any reports that come out. In order actually execute it, the University of Pittsburgh will have a lot of identifiable [Inaudible] under the framework agreement.
>> Thank you. Once again, I just caution you because of licensing law and other considerations. So I hope you have a good comfort level, because my background says it's going to be problems. But thank you.
>> Sure. We have a lot of experience doing interviewing of patients and nursing home residents and providers who a range of different studies, and one of the most important points to handle this is training of our interview staff and also in our procedures in handling the data.
Can we have the next slide? The next major activity about how to get information about how the program is operating is the participant and caregiver experience . I'm sorry. Participant and caregiver focus groups. This is a task that is closely related to the key informant interviews and was recommended by the working group. And the goal here is to really counterbalance the one-on-one information that you get by talking to somebody on the phone or in their office, talking to [inaudible] participants one-on-one versus talking to people in a group. Sometimes you get different information when people are in a group setting and they have shared experience that helps them articulate better what's important to them. So we're planning to conduct some focus

groups early in each program I implementation year. This would be Winter of 2017, 2018, and 2019. So it gives us another methed for finding out what's going on from the perspective of participants.
Our role here is to, for example, in Phase I, 2017, southwestern Pennsylvania will be conducting focus groups a more urban area and focus groups if a more rural area, adjacent area, and focus groups with participant groups of different ages, Poe focus groups with caregivers, because they're a major constituency in this program. So again, the rationale, then, is to get another source of early information about how things are rolling out.
How are we doing on time? We touched on this a moment before. This was a larger activity for the evaluation, which is the participating caregiver experience issues. We're putting together a very comprehensive interview guide that has primarily categorical quantitative questions, but also open-ended opportunities for people to tell us in their own words what their experience is. We'll be using as much possible validated measures of satisfaction and quality of life. We'll be conducting these interviews prior to enrollment so that in the fall of 2016, and then again repeat that go in the summer of 2017. In 2017. I'll show you the next slide and how it works to get complicated, but the general idea is that we want to interview people before they are enrolled in the health choices and that after they're enrolled in community health choices and also follow them up for three years, because we think that the impact on people's lives is not going to come right away. Actually, the impact right away is going to be in terms of disruption and confusion prior to the enrollment process itself. So certainly changes in the service plan, and as things get smoothed out, then that's when any actual been fits to I know proved service coordination might start to have an impact on pep's lives. So it was very important to follow people through time. Otherwise, impacts on policy and satisfaction might not show up for 12 or 24 months. So the plan here is to do all people in a [Inaudible] study and continue for up to three years. And then as you can see, it's broken down into four different categories of people

we'll be interviewing.
Let me go to the next slide. It has a little bit of detail.
This one is a little bit complicated. Let's see if I can talk you through T so for the people, one of the complicated things here is benefit, and I'll a challenge. This is that the way things are being implemented in Phase I will have a comparison group in Phase two and phase three that are -- that we can use to find out if changes we're seeing in southwestern Pennsylvania are due to the program or if there are changes that are happening statewide. This is very important. When we enroll people, we follow up with them six months later and 12 months later. But we want to know if that change is due to the community health choices or if that's just ordinary change that's going on. So we have a comparison group of people from the other parts of the state that are not going to be participating in the Phase I in 20176789 and then we repeat that model in 2018, so we'll have, using the fate three group comparison for these two groups. I know it sounds very complicated. But the most -- the thing to bear in mind is that the strongest evidence that we can put together on the impact of community health choices is what we call before and after study with a contemporaneous comparison group. That tells us if the changes we are seeing before community health choice and after community health choices are different from what we would have seen if THP had not gone into effect, and that's what we designed this part of the study to capture.
I know that's complicated. In the interest of time, I want to move on.
The third major part of the eval situation, this is where we'll have the most information about use of community based services, institutionalization rate, acute care, cost, and of course we'll be able to construct measures of quality of care that are sensitive to the interface between LTSS and acute care. As an example of that, there's a lot of attention nationally towards measuring pressure ulcers in the HCBS population. It's an important issue, and being hospitalized for pressure is deceiving. Acute care is considered preventable. So the question is under THC, do we see lower rates of bad outcome going forward? Well be able

to look at that using the ex-be at the present time of administrative data that the commonwealth is giving us access to. So we'll have medicate data, Medicare data [Inaudible] also have access to a level of care of determination data, service plans, as well as a range of different performance spectrums and quality measures that were reported directly from the managed care organization. the rest of the slide gets into some flexion at thises.
The main thing to bear in mind is we won't know what happened in 2017 until sometime in 2018. So it takes a long time to get the results from this part of the analysis.
It's very important, but we want to have, basically, a full year of experience before drawing conclusions and it takes about 18 months in get all of that data completed. So we won't even begin to -- we won't be able to start analyzing it until sometime in 20186789 that's what's shown on the pock on the left. For Phase I, we'll be able to start analyzing in 2018 and two years of data in 2019 and two years of data in 2002, and because the Phase two and phase three zones start later, we want three years of outcome data until 2022. So because that takes a long time, so the important thing to note here is this is really a very crucial part of the evaluation and it addresses some of the questions that are -- that are important to the community amongst, you know, in a numerical way. Like how many people died? How many service did people get? Did they get more service or less service? Do people have lower risk of going to a nursing home? And those are the really hard outcomes that are very, very interested in and knowing the answer to, and it's going to take a lot of time before we have enough data to draw solid conclusions about those findings.
So I put it last, but another thing to bear in mind is because it takes a lot of time to get these answers from administrative data, that's why we also have early insight from the other two components . Study.
Let's go to the next slide. This is just --
>> I have a question, if I may. This is Ralph trainer.
With the information you're collecting, how are you and the state going to distribute this information to the relevant folks that affects?

>> We have monthly meetings with the evaluation group. We are all providing quarterly reports on our findings, and we haven't worked out yet the process for releasing those findings more broadly. But that's a part of our ongoing communication with OLT.
>> Yes. Maybe one of the things the committee will be able to do is put together a communication strategy for the evaluation and bring it to this committee and get your feed book it and city that works. We haven't given -- we're still concentrate okay what the evaluation looks like, as you can see from this presentation, that we haven't thought about how we're going to be public bely releasing the information. So that's something that we'll have to consider going in the evaluation. But thank you for the question, Ralph.
>> That's been on our mind, on our radar.
>> And I had a question on the previous slide. Can we go back to it? We're going to be studying Medicaid and Medicare, especially on the dual eligibles. There may be what appears to be a blip there, because the department had not, until recently, implemented the requirements using third-party resources first before using waiver services. Now that people are doing that, it may appear that there's more services venues, but that's just something you should be aware of. That's a really good point. So what we're doing right now, currently right now is get ready for this. You're looking at updated data we have on hand under the university, we'll call it a faster contract arrangement, the commonwealth to do research. So we have data on Sunday. So you're basically looking at the 2013 date to develop our analytic strategy, and then as we get closer, we really provide appropriate baseline and that conversation [Inaudible] you to be aware of program managing. Data systems, there's a bunch of different changes that are going to be [Inaudible] coming down the pike. That will make that very challenging. There was one I was going to mention. So some of the challenges around each of these, in terms of the key informant of the computer [Inaudible] up here today, in order to really accomplish this, participation and cooperation of stakeholders, we'll be networking to to feel

identify stakeholders [Inaudible] as groups and consumers to participate in interviewing people views and [Inaudible] a level of trust in our method and recognizing the importance of what we're doing is going to be crucial to getting this done well. Just as an example, there's been a couple mentions of some efforts [Inaudible] foundation. They're doing a very nice job competing, provider and advocacy. And connected with that group to build up our network of [Inaudible] a big challenge there. It's going to be recruiting and retaining the sample. It was very complex work we had done before. We had experience doing this, but it's always a challenge when you go out to interview people in their own homes [Inaudible] and physical challenges. So I don't know what we're getting ourselves into there. I can tell you more about our approaches. There's some best practices to reach people, as well as to engage people in study and to participate over time. We're asking people when you recruit them to participate you in three years of interviews. So that's very important. And we don't want people to drop out, because that undermines the data. One of the challenges we've also recognized, Phase two, Phase I, phase three. Phase two, Philadelphia, primarily you are been and suburban. [Inaudible] adjacent areas. And phase three [Inaudible] experience with LTSF, with primary care and healthcare varies in those different types of communities that propose [Inaudible] comparison groups. So again, that's a challenge. You want to choose communities that are representing people [Inaudible] comparison data. and then finally, with the administrative data -- I'm sorry.
>> Drew from the VIPS. [Inaudible] and there are changes to the systems.
>> Captionist: Very difficult to hear.
>> There are always quality concerns with building data for [Inaudible] and managed and sometimes it looks like there's a lot of good information there in terms of data outside there. [Inaudible] analysis, then again, we have the same problem that we're looking at tonight, administrative data. We're comparing the Phase I area to the Phase two area to find out what happened during 2017. So to the extent that Phase two is different systematic ways from Phase I, then

that raises some challenges for that. We have some statistical techniques we'll be use to go try and control it .
Turn to the summary slide. So let me just review the highlights and then I'll stop for questions. [Inaudible] rigorous, independent analysis, THC on multiple outcomes from multiple populations. We're taking advantage of [Inaudible] multiple -- I'm sorry. We're taking advantage of the phased implementation. We talked about that a couple times. 20 construct comparison groups and estimate causal effects, because that provides the strongest evidence of the impact of CHC on people's lives. Multiple perspectives, we'll be talking to a wide range of provider types, advocacy groups, stakeholders, participants in different living arrangements, health conditions for using multiple methods, because you find out different things if you ask different ways. So having participants and providers, interviews, focus groups, administrative [Inaudible] to what's going on big picture. And then also, this is very important. That we'll be providing both early insights and long-term findings. [Inaudible] on what's happening as early as possible. If they need to make course corrections they'll be hearing the periodsers, hearing it from this community, and also an independent course of information from the University of Pittsburgh about what's going on out in the community.
And then longer term outcomes will be important to the question of doesn't it work. I think there's another slide, just the team that we're putting together.
>> Anyone have any questions, committee members? Please. Announce your name, please.
>> This is stew westbury, I do represent the Pennsylvania council on aging. I'm also listed [Inaudible] because I live in a continuing care retirement community. One of the you words I really dislike that's used around this table is institutionalization. I do not live in an institution, yet that's the category that I apparently am in because of the way he is eve structured, which really leads to my question. One of the goals of CHC, the whole operation, is perhaps hopefully to reduce institutionalization of

using the term I don't like to use. And it increased the ability of people to live in their own communities.
I'm well aware that there's a very large gray area with regard to whether an individual should be in an institution versus in the community. And I like to know what element within your total plan will look at that, because I'm sure cost is an issue, but also isolation is an issue. And this is one thing we looked at with Pennsylvania council, and that concern the question of someone might want to live at home, but that isolation ultimately contributes to bad health or worse health, and so -- and I know we can't get into the details of this process, but is that interface between the community and institution going to be a focus of a part of your research?
>> Thank you very much for raising that. See if I can address it in a couple different ways. One is that, and this is something we're grappling with at the design stage, there's different parts to the evaluation. So when we're looking at the total [Inaudible] everybody regardless of their living arrangements *ment. Now, some of those living arrangements are visible in the data. That is, we can tell if somebody is living in a nursing facility or other type of facility. We can tell to some extent that they're living in a personal care home or assisted living facility, but there are other types of living arrangements that are not discernible through the data, like an independent living component of a CCRC or senior housing or other types of housing.
So there's a little bit of a dark care. Right? So when you just use administrative data, so when we go to the participant interviews, there we'll be able to sample people who are living in community settings, and we're not planning to stratify by type of settings, but when we go out you to their homes to interview them, we'll find out what kind of place they're living in, whether it's a single family home or an assisted living or perm care home or whether it's a senior high-rise or a community living. So we'll be able to incorporate that into our analysis through that.
The key informant component, that's where we're going to be talking to different types of stakeholders from different

types of housing arrangements. So a representative from [Inaudible] personal care home, for example, to find out what's their interface with community health choices, what does that look like, one of the interesting questions that we don't know the answer to is whether the health choices will [Inaudible] managed care, organizations under CHC will provide LTSS. Those types of settings. [Inaudible] as I look to before under innovation, whether there are new combinations of housing and services for people. Now we get to the other under lying portion, overarching, and where I'm really, really interested in feedback from this community, this committee, which is what terms in the literature, and you have to forgive me for my ivory tower approach to this, but the jargon is community engagement. And I don't go what that muling -- I don't know what that means. I want you guys to tell me what that means. I know how it's measured you and defined in a lot of surveys and stuff, but to me it's part of you getting to do the things that you want to do. And for some people, it's working. For some people it's going out. For some people it's a ball game or family involvement, but we want to measure that, so that's what's important to people. It's a component of quality of life and it was something for people with physical disabilities and something you rely on other people to facilitate that. And the services need to recognize that's a part of your daily experience that is a part of the care plan, so with we want to talk to people directly about their experience with regard to their level of community, because socialization is [Inaudible] some of the five% of people want to be in a nursing facility are people who are socially isolated living at home and when they love into a facility, they now have the ability to have social reach than they would otherwise. We always hear the exception of how it's being referred to people, but I don't want to have to question, well, why were they socially isolated in the first place? Where is the system failing them? The question here, [Inaudible] changing the finances, because it's making it impossible for people to have a better experience in their preferred setting.

>> Well, I can tell you this. Members around this committee

will do their very best to make sure you address that those dark areas and gray areas must be historic.
>> I appreciate your comments, your sensitivity at that you've expressed makes me feel more comfortable about your evaluation process. I did vowel I know tear for the communications committee. I hope that got to somebody. But I don't know. You've got to tell me about the status of that committee.
>> Yeah. As I mentioned, the evaluation committee and the part of the action is also participating and other parts of the Department of human services [Inaudible] and evaluation committee. -- at your last meeting or two [Inaudible] the last one I was at Richard asked questions about evaluation and concurrently with that [Inaudible] can you represent the committee on the evaluation commit any these meetings, we do a lot of meetings. It's just they were long meeting. They're very intense. We were thinking that Richard could represent this committee on the evaluation committee and communicate back with you as to what the status is each month, but I need to talk with the committee itself to see whether or not members from this committee, because the original idea was to get one member from this committee that would then report back, and we just haven't explored you or somebody who was interested, and we have a member on the phone, Brenda has also expressed interest. So let me go back to my committee or to the committee, the internal committee, and have that conversation before and then at the next meeting we'll have another conversation about it.
>> Did we got agree that there would be an evaluation committee of this group necessarily necessarily supporting and being part of the research group, but separate? Because there are over three or four or five potential committees that we're offering an opportunity beyond. >> No. It was the same committee. It was our internal committee that we wanted a member for. So I don't really know what a separate evaluation committee here, what its role would be. I welcome your rolls on what you could do. And maybe Richard would like to convene an evaluation committee to get more input on when he goes to the meetings that are the OLTL meetings. I don't really know. The committee that showed

up on the [Inaudible] it shouldn't have had evaluation, because we already had identified Richard on the evaluation committee. But I welcome your feedback on what an evaluation committee here would do and maybe it's a conversation we should have with Richard when he's here next time.
>> Just to throw a suggestion out, if there were a smaller working group you, whether formal or informal, you would be able to reach them maybe in advance of what we have -- like it's appropriate timing. [Inaudible]
>> And then get feedback from that group? Yeah. Stuart, let us think about it and we'll talk about it at the next meeting. Thank you.
>> Are these groups in person or in person by phone or both?
>> I attend in person as available or somebody from my team be there in person. Unfortunately, I have a time conflict with the March meeting. We'll be represented.
>> Dough we do have the potential to do a conference call. We have a member that's been advising on [Inaudible] and Richard as well.
>> And lean okay Stuart's side here a little bit, I think it is important to have input from these committee members on basically our committees in one way, shape, or form, and I would hate to hear that Stuart's point of view or insight would be mixed through an evaluation process that missed that darker gray area.
>> We're more than happy to review comments and suggestions, and I'm not sure of the best way to filter that, but anything that gets us through Jen's office, we work really hard to take that into account. I didn't get into the nitty-gritty of this, but we'll be doing some -- we'll be starting our process with some focus groups, primarily in southwestern Pennsylvania, with the primary goal of informing the interview instrumentation for the participant and caregiver interviews. So we're going to be start that go process of recruiting people to come in and tell us what's important to them and what we should be measuring. So we've got both formal ways of doing that and also oversight ways of getting information into the evaluation.
>> In terms of comments to us, you can use our resource

accounts. The RA mailbox, at the bottom of the agenda. So if you have comments on what you just heard today and are not able to talk about them right here or wanting to back and think about it some more, this will get posted to our website. So you'll be able to take a look at it and give us feedback on what you heard today and how we might make improvements to the process.
>> is there a question?
>> Keep it short, because we're running late.
>> Okay. I'll keep it very short. I just wanted to [inaudible] to our coming in to be interviewed so that they can be honest and they don't feel that they're going to lose services on what's working and what's not working, and also, you did a really great job on the evaluations. However, There are a lot of things that you were saying that I'm guessing a lot of people [Inaudible] because it was research jargon. I'm not being disrespectful to you, sir, but there was a lot of things that people didn't understand, so I also wanted to be sure you that when [Inaudible] are interviewed, they're interviewed in such a way that they understand what you're saying. And David had no idea that I'm going to say this, but you might want to utilize Pennsylvania health law for that, because he can understand what you're saying and then he can break it down for people like me to understand what you're saying. Pennsylvania health slaw a very good -- health law is a very good source of that, because they can talk research jargon or legal jargon and they can also break it down for participants to understand. I call them often.
>> Your main question to Professor degenholtz is how do they ensure when they're talking to a person in the nursing home that that doesn't reverberate to other staff in the nursing home and there could be consequences Queens. Could you answer that, please?
>> Sure. Not to drop another point, yeah, I will, you know -- I take full responsibility for the presentation today and for going through it quickly and sometimes being very technical. So I'm happy to answer any questions via e-mail, and there will be a summary, I mean a more narrative summary of this presentation available in the next few you weeks. And

then there's also one of the reasons why we are conducting focus groups in the early part of the [Inaudible] because we have, so that the language that we're using and the out comes that have been identified, so again, I'm using jargon again, the goal in the plan, as parted of our planning process is to address that very concern. So we will be talking to consumers and caregivers and finding out how do people think about these issues and talk about those issues so that when we conduct our surveys, we're using the right language. And the language that I'm using today is like the behind the scenes design language for the way we talk in a natural interview. Interviews are designed to be at the right level of detail and also literacy for the people that we're addressing.
now, to get to the other point, confidentiality, an interview with a conversation with an interviewer from the University of Pittsburgh is between the University of Pittsburgh that participant. So when we start every interview, and when we recruit even before that, when we recruit people to participate, so that means you get a letter in the mail and a call on the phone, would you like to participate in the study, that is always accompanied by the statement that clarifies that anything you say will be completely confidential and the research team and that the results of that conversation when you tell us is to summarize before reporting publicly so we don't teal anybody at the commonwealth [Inaudible] who says you what. What we do is we report numbers of the statistics, but we analyze [Inaudible] in terms of broad themes. So now the assurance that we give is basically inviting and [Inaudible] and way tell people the steps we're going to take to ensure their confidentiality. Because we're working with the commonwealth, we give us access to names and address. We're sending information to our people, but it comes to the University of Pittsburgh. We get into more of that. There are some circumstances that are alert -- that we're alert to, but we recognize that we might identify situations such as abuse or neglect, so we'll have protocols in place for if we might you have something [Inaudible] to identify potential situations. If somebody goes into your home and

talks to you and tells you something about approximate something going on at home, we're also going to leave behind phone numbers and contact me and we're also something to [inaudible]
>> one more question. Fred promised me it would be very short.
>> I speak Jr. high, so you definitely have to tone down. If you need somebody in southwest approximate PA to have discussions with, that's where I'm from, so please get ahold me.
>> They find him at the feed store.
>> absolutely.
>> Did you have something?
>> Professor Degenholtz?
>> Real quick. One question that you had to the committee about what would you guys want to see, I think it has to be explained to include [Inaudible] from place Holder communities. No more of this, well, if you're in the car with your attend Dan, they get paid, but they condition get paid for bringing your vehicle back to your house. I mean, it stymies the whole effort of independence that way. We have to be more realistic and more up front and more fair as individuals get the whole thing moving forward, and to get community integration taken seriously, not only are you going to be out in the community [Inaudible] but you're going to be out in the community to [inaudible] and that's a step that needs to be taken.
>> I want to thank you very much for your presentation. As you can tell, you'll be getting a lot of conversation about it.
>> I'm looking forward to it. Thank you.
>> Thank you.
>> Kevin? I'm going to do a brief draft agreement comment.>> Thank you. I'm going to see if I can do this in five minutes or less.
>> We're at a table that's dual eligible for the next meeting, so you have time.
>> Ten minutes or less. I was asked to present on some of the -- sort of give an update on some of the community health choices procurement processes and also talk about

some of the key themes we heard in the release of documents from December. We released a series of additional documents F you remember just studying back a bit, we released the draft RF P and draft program requirements, including definition in November. And the comment period for those documents closed in the middle of December, and at the same time, in December we released a number of additional components that would be part of the draft agreement, including some additional exhibits. And we closed the comment period for those documents in the beginning of January.

So we had lots of documents out for public comments. They weren't overlapping, but we wanted to have as much opportunity for people to be able to review and give us suggestions on the structure of the documents. Dem's documents themselves were criteria well criteria at least from the structure in the draft agreement, those documents released were more of the legalistic, for lack of a better term, structure of the program, but we did have [Inaudible] direct impact on participants, not to mention rights and responsibilities. And of those documents that were released, we received about 860 comments. A lot of comments on a lot of different topics, and I'm just going to go through on seven of the areas where most of the comments were talking about * upon and just talking about what was contained.

we received a lot of comments on the program's terms and conditions. A lot of those comments came from the manage care organizations. Most were questions as much as comments. And we had our you legal team look through those in and determine if any changes would be made to that section. We had a lot of questions specifically clarification on applicable laws and regulations, and there was -- the applicable laws and regulations were part of an exhibit on the physical health choices program. Since we do have bloodies of regulations that are really specific to long-term services and supports, we had to make changes to that, although there were certainly a lot of overlaps. But that section creates a lot of questions and a lot of points of clarification as well and we are taking a pretty

aggressive approach to make that information more tangible not only to the managed care organizations who would be bidding for the program, but you also to providers and certainly to participants.
We received a lot of comments on reporting and encounter data reporting, also largely from either providers or the managed care organizations, and most of it was about what data would be required and what were the responsibilities for all of the above, and we think we addressed some of the concerns and questions that were raised in that section as well.
[Inaudible] a lot of comments. The point that required a fair amount of clarification was the actual time period that would be associated with prior authorizations and also the different types of services that would be covered. We think that rewriting at least one of the bullets of that section will make the requirements clear, but we are following standards that I think the people who had comments or concerns about the time frame and the length of time it would take for a prior authorization will be certainly relieved by the prior [Inaudible] but I think that the comments in general represented a lack of clarity in the language that was creating some confusion, and we're hoping to be able to clarify that.
Received a lot of comments on our proposal for quality assurance and [Inaudible] it's now going to be exhibit K. A lot of suggestions for what should be included or how to refocus some of the ways that we're going to be providing those assurances, and we've included a lot of those suggestions. A lot of those discussions were very helpful, especially for people who have concerns about specific questions for their types of services. We received more than 50 comments on rights and responsibilities, we are still actually working through those comments at this point and how we're going to clarify that information. In general, it was a lot of different types of questions about the rights that we published or were raised. Some suggestions for additional rights were also presented by the commenters, what the responsibilities actually mean on the part of the participants, and where those rights and

responsibilities are going to be published and how frequently. All were the types of comments we received in that area.
And last on this list where we received the majority of the comments were on the performance measures themselves. That was an exhibit we called GGG. Since we had so many different data attributes, there were specific questions on what those attributes meant and what would be the requirements? And those questions came across the board from participants, from providers, and from managed care organizations, and certainly from advocacy groups. And we are, just speaking in general, I think we're going to try to be a little bit more creative in the way that we end up publishing the performance measures, because I think we're probably going it need flexibility. Based on the comments we've received, we're going to look for opportunities to follow what [Inaudible] choices does in the way that they manage their recording and their data collection, and look for opportunities to make changes based on ongoing operations. That was multiple suggestions we received from [Inaudible] themselves.
So those are the teams. For the procurement process itself, we're planning to publish the RP and additional draft agreement. It will be -- the date we're talking about at this point will be February 27 or February 24, and we're expecting that the RP itself will be a final document. The draft agreement will be going out at the end of February and we'll still be a draft document, which means that through you this process, we're still expecting to be able to make changes to that document and we're going to ask a lot -- if the committee members, when it's published, look at it again and see if there's anything in this discussion that we've missed or that you're still concerned about. A lot of the questions and concerns raised, like service coordination, have been addressed in the document or will be addressed with final language and we're thinking people will be happy with the outcome once the language is finalized.
Please do look at that document again and especially from this commit I are. If you have questions, please make sure that we know it and we'll handle it, we'll get back to you

or we'll make sure that we'll make the correction if needed. That being said, Ail leave myself open to questions if we have any.
>> Any questions from the committee members? Jennifer has one. Go ahead, Jennifer.
>> I'd just like to make a comment. I think secretary -- I thank secretary Ellis, but Jen, I'd like to thank you and 11, I'd like to thank you and all of the staff that's been involved in this. I love that [Inaudible] and you're coming back to us for more and more comments and be a taking our comments into consideration. So thank you from the bottom of my heart. There's no way to say thank you enough to what you're doing. I know it takes a lot more work on your parted and a lot more meetings and a lot more headaches. So [Inaudible] a lot more from everybody. So thank you from the bottom of my heart.
>> Jennifer, thank you. The suggestion, multiple people in this committee made the suggestion to put out the draft documents for comments. We had concerns in the beginning, mostly because of the time line and the fear that we wouldn't have had enough time to be able to set up the program. But the reality is that we really did need to send them out for comment. A lot of questions and issues helped us clarify it. That will make it a lot better and in the end, it is [Inaudible] the right thing to do. So thank you. This was meant for timing when we first were concerned. So thank you.
>> and I don't necessarily say from the bottom of my heart. Jennifer is a super organizer, but I want to say thank you you to everyone for setting I hope it was a precedent for contracts going down the road, that they do get vetted properly instead of here you are. This is what's going to happen and so forth. When you first started with this process, you get the blow back from members of this committee and others around the state loop it was delayed. But that's okay. Let's look at this in the future as a boilerplate on how RPs and contracts should, in fact, be presented. Thank you.
>> I will take your suggestion back.
>> You can share you that with procurement.

>> Gladly. From the bottom of my heart.
[Laughter]
>> Ralph? Cassie had a question. She wanted to know if cost will ever be a factor?
>> I'm not sure I understand the question. I'm glad to answer it the way that I think --
>> I think it's probably yes.
>> We live with' appropriation. Because we'll always be [Inaudible] we have a budget and we always have to be a responsible state agency. We always have to take cost into consideration.
>> I believe she may have been referencing the location of service.
>> If she's referencing the location of service, I'm not going to get [Inaudible] the secretary on this, but we are making sure we have language in case that presents the requirement that a person's location is not -- if their preference is to stay in the community or their preference is to stay in the city where they're receiving their care, there will be protects in place to make sure that continues. So [Inaudible] will not be a consideration.
>> So you'll see language to that effect when we issue the EERP .
>> Cost was mentioned, and you described appropriation. Is the potential source of that appropriation state funds or are they lottery funds?
>> For this program, our program is a Medicaid program, so it is federal and state match. In our current appropriations, there are some lottery funds. So to answer your question completely. There will be a lot of refunds in the program, but the source of the funding are not expected to change. There will be blends with state funding and federal fund to go cover the cost of the program.
>> Just to make my point, the vast majority of funds available for services for seniors in our commonwealth comes from the lottery. And the Department of Aging, as well as the Pennsylvania council on aging, will continuously monitor and be very concerned about uses of those lottery profits, so to speak, especially in view of the impact that it may have on senior citizens in the commonwealth.

>> Sure. We can give you the assurance that there will be no expected change in the way that the configuration of funding -- this program will not represent a change in the configuration of funding in terms of the lottery. [inaudible] services in the lottery program.
>> Thank you. I want to thank you. Anything else?
>> If no more questions, then no.
>> Appreciate it. All right. Pam, would you want to go over the committee in his and then we'll have Jennifer wrap up afternoon that. -- after that.
>> So I'm going to walk through this briefly. Currently we have six subcommittees training clinical eligibility determination, evaluation, service coordination, communications, and participant eligibility notices. So we've already heard about the evaluation committee from Jen today and from Richard also, and we've heard about the service coordination committee from Theo, as well as Jen whose preliminary meeting was last Friday. So let's talk about the groups that are actually meeting today and that's the training workshop committee. It's going to happen today. I'm not sure exactly what time. At 2:00 o'clock. And that's great.
>> You want to stand up?
>> The Chair of the committee, Greg Ness, is here with us today. Hi, Greg. They'll have a brief conversation and presentation about the cope and expectations of the direction of the work group. I know there's one committee member that might be talking to you you who might want to join, so whether or not you still have room on your committee, you'll let them know at that time.
>> Where is this meeting?
>> Where's the meeting criterias Greg?
>> Actually going to be across the street at seller Dorsey's office. If you don't know where that is, come see me and I'll give you directions.
>> Okay. The clinical eligibility determination, this work group includes more than 25 members, four of which are from this committee. The meeting is also occurring today. Anybody want to shout out a time? Go ahead, Jen.
>> Wilma, do you have a place?

>> 2:00 o'clock.
>> Two clock and where? First floor here. Room B.
>> The ground floor of this building. Groups that will be starting communication, which will now also include participant eligibility notices. They had not started yet.
I think there's a lot of people that have been interested in that committee and then finally, grievance and his appeals, and the Office of long-term living has combine the interests of eligibility, as well as grievances and appeals to reside under this umbrella committee that's now Pope communication. This work group will meet next month to discuss logistics and responsibilities of the group, and you'll be receiving an invitation in an e-mail from project lead Shannon Baker and more detail sometime next week.
And Shannon, can you stand up? And again, please note the work group chairs determine the amount of work group participation, and so any questions about that would be directed towards them. Thank you.
>> I'm going to wrap it up. I want to touch briefly on service coordination, because that was one of the topics that I was going to cover, and I'll make that just very quick. I think CO and I kind of provided a bit of an update. A small stakeholder group met on January 29 and this discussed the service coordinator qualifications. I think Jennifer made mention of them being maybe not the right proxy when the secretary wads here. So the session was very productive, as we heard from Theo. He felt it was a good meeting, and we're actually in the process of putting together what we heard on the 29th, and it's going to go back out to that committee for their comment and feedback to make sure we captured it accurately. We came up with a number of ideas [Inaudible] master's degree for service coordinators.
These talking points give me a little bit of feedback.
More information than I have in my head. Highlights of that meeting, including ensure adequate access by existing providers into the CHC program through the implementation of a skills competency course. That was one of the things that was discussed at the meeting and we were intrigued by that idea. We would also be maintaining enhanced qualifications

for new service coordinators in the future. What they are is we don't know quite yet what they are, but they'll be looking for feedback on that as well.
And then I know Theo has left today's meeting, but Barb was also at the meeting. Did you have any comments that you wanted to make about the meeting that I haven't captured?
>> We also were discussing the requirements for supervisors.
>> Okay. Good. And those will come out as well? Whatever feedback Jenny got in terms of that meeting, it's going to be coming back out to the committee for comment. So you'll be hearing more about that. And as we re-vice this, our concept of service coordination qualifications, the feedback, the reason we're doing this so quickly is we want to get it into the RF P or into the draft agreement language. We're really on a fast track to make these changes so we can get different than than the language we heard that people are comfortable with. .
>> And the last thing I wanted to discuss briefly with you before we end this meeting is the state is going to be applying to CMS for new authority. It's called the B C concurrent waiver authority. And we'll be developing a B, this is which is our authority to do managed care, along a C waiver, which is all of our home and community based services, and those will go into and be considered concurrent by CMS, which is so they haven't combine the two yet, even though many, many states are coming in with proposal to do managed long-term services and supports. C MS has not combined those authorities, so it's still a concurrent waiver. .
>> One of the things we'll be doing in the near future is putting together a stakeholder engagement for the waiver application. We actually have, are required by the new regulation that went into effect last year or in 2014, we're required to do an extensive public comment process on the waiver application. So you'll be hearing more about that process, but I wanted to share with you one of the decisions that's been made around that application. CMS has informed us that if we deciding to after a brand new C waiver, we run the risk and they will be looking at compliance with that 2014 regulation. We have providers today that may not meet

the settings regulation. And so that is a big risk. CMS has adviced us heavily to seek or use one of our existing waivers for the vehicle to make our application for the C part of the waiver.
After extensive consideration, whatever their might be, we have concluded that the best vehicle for making our single application for a C waiver, which will include all services that are currently in our existing waivers, is the come care waiver. So we will be, if we are in the process, we will have to amend the independence waiver to include the services that are not available in independence, but are in come care waiver and at that point we'll be doing back office work to con I go people. It should be completely seemless to the composers, because many of the services that are in independence are in come care, on already an independence waiver. So thinking a lot of it is going to be the waiver for independence to add services, and then
>> Captionist: I have lost the audio. Dialing back in. We will have four waivers, including the independence waiver with this expanded butted to serve people that were in the come care wear. I wanted to share that with all of you, just because if we do -- we are going to be going into some public announcements about this it. We'll be doing a lot of work-around the transition of a lot of work with the brain injury association and others around the transition of the consumers to make sure that it's seemless, and they will continue to get the level of services that they have today.
I guess I would open it up to any questions. We have about five more minutes here.
>> Yes. Any committee member questions? Pat, are you getting any information from the [Inaudible]
>> Not a question, but a comment that Cassie had. She wanted to just share that older adults adults on Medicare should be able to stay in the community.
>> Duly noted. Jennifer and fled
>> Believe it or not, I'm good.
>> I had a question. Is that going to be the same for those of us who are only [Inaudible]
>> The over waiver is going to remain in place. Eventually, people on the over waiver will go into community health

choices and BC concurrent waivers.
>> Okay.
>> All right. We have Jeff eyes man chomping at the bit.
>> I got to hold.
>> Okay. Can you temperature he is when the governor's housing plan is coming outs for human services populations?>> I know it's in
clean, so I don't have a date on it. I
can check back with the [Inaudible] see if they have a sense
of it, but it is right now, actually, it was discussed at
the CHS executive staff meeting yesterday. It is with our
-- in our Office of legal [Inaudible] for their [Inaudible]
>> Okay. Thank you.
>> Thank you. I was confused by the come care and independence and want to make sure I'm understanding. So you're using the come care as the kind of waiver vehicle for community health choices, which means everybody in come care commute and and then what happens with the other favors waivers?
>> In the remainder of the state until the southwest next year.
>> thank you.
>> [Inaudible] I just had a question. Nothing about what you guys stated today. I just had a question at FMS. I missed the last meeting. I don't know if there were any updates about that. I know in previous meetings you talked about changes that were supposed to start in maybe the springtime. I just wanted to know if there were any.
>> Can you just tell them to update on the [Inaudible]
>> I didn't hear the question.
>> She wants to know what the update on FMS is and whether there are any changes. We had a request for information out on the street. I think it receded when I arrived here in May. We got a lot of good feedback from that, including a lot of feedback that people, that consumers are satisfied and attendants are satisfied that they are [Inaudible] service right now that are actually working pretty well. So
we got a lot of feedback on that. So based on the feedback that we received, we are going to be making changes to the existing contract that will continue under an emergency

procurement through the rollout of the first zone of choices. And Mike has more information.
>> There were a lot of comments, as Jen said, a lot of pro comments, but the ones about any changes that were necessary or things that participants would have liked association in this current contract, we are going to be looking at all of those. We have a committee that's set up to look at those comments and we will be including several different comments into an amendment of the emergency procurements. So that will be taking place after implementation, because like Jen said, the lift for this project is going to be such that we're going postpone doing anything [Inaudible]
>> Right. So we'll make the changes, make the amendsments, and use the amendments vehicle for making changes now or, you know, soon or in the spring, and then no procurement will go out next year after the first community health choices.
>> For the matter of time, the Chair recognizes the next two people after you, sir. Give us your name. >> Thank you. Mark Soltes, I'm here representing Pennsylvania association of medical suppliers. We've brought a couple issues up to the committee's intention and secretary Burnett's attention regarding DME, durable medical equipment and supplies issues. What we would like to do is request either a workshop or an opportunity to meet with the managed care specifically about some of these early complex issues that we brought up, such as their rental cash issue and that sort of thing. Would that be possible for us to have a specific meeting with [Inaudible]
>> I'm not sure. We have a very short -- it happens within the next couple of weeks. What's difficult is bringing in the managed care organizations. We might be able to use kind of a webinar base on that, but you we'll take it back and get back to you. I think that's a good idea. So sort of like a meet and greet, but with [Inaudible]
>> yes. Appreciate it. Thank you.
>> And if we can't do it, we can ask the Jewish healthcare foundation. After the blackout program, we cannot talked to managed care. The state couldn't be involved, but you I think we could ask for partners at the Jewish healthcare to

convene some kind of meeting where you get to talk to [inaudible] organizations.
>> We also you have all of the interested managed care plans listed out on the website. So you, in fact, could reach out for them directly and try to do something.
>> Lester Bennett, [Inaudible] coordination. When I lockdown to some of these MTOs, they've said stuff like we're going to keep some of those cases and they said they're going to keep some of the high cases and they said they're going to go with the high [Inaudible] can you give us a definition of which cases they're going to keep and why? Are they going to be focusing on the needs or going to be focusing on some of the things that I'm starting to see, like request for high service coordination units? So I need them to define, basically, which cases that they've already said to me we're going to be keeping some of these cases and they said it will be the high cases [Inaudible] duds that make sense to you, anything -- M I recollect ss Jennifer
>> Not really, but I'll try to responsibility.
>> You're going to the contract with certain support coordination entities. Which one are you going to keep [Inaudible] what does that mean, high cases?
>> I don't know that Jen can answer that one.
>> [Inaudible] which case they decided to keep?
>> They will have to do that as they make their application to us. That would be described and we'll [Inaudible] rates and evaluate their application to us you based on that kind of a description.
>> Thank you. That's what I need to know.
>> All right.
>> I have a few that came in through the webinar. Real quick. Mark gram wanted to know if life providers will be invited to the meet and greet and if they will also be included in the University of Pittsburgh evaluation.
>> I don't know about the evaluation, but we'll talk with them. I don't even know. I think Howard left. Shannon, that's a question that you've been asking, too, so it's on our radar, yeah, but as far as meet and greets, again, we're going into the blackout period very soon. I don't see us being able to pull off another set of meet and greets. Okay

? And we already had one for life providers. That's right . Life providers already did do a meet and greet. Forgot about that.
>> And the last question I had was from Kathy Kubit. She wanted to know if other stakeholders with participate you in committee * * committee work groups you and if so, how do you feel you about doing that?
>> The chairs of those groups can select who they want as their members. They're only going to limit you it number wise as best they can handle it. That's the best I can say.
>> Yeah. And we can receive people's request to be on a subcommittee through our in mailbox. You can use the RA mailbox to send in the committee that you might be interested in.
>> You don't have to have a committee member sponsor you?
>> That's true. Somebody from this committee has to sponsor you.
>> That's what I thought.
>> Thank you, Fred. Forgot about that. Yes.
>> Okay. With that being said, meeting adjourned. Thank you, everyone.
>> All right. Thanks
STUDENT:
(end of call.)