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>> RALPH TRAINER: Can I have your attention please, we'll start in a few minutes.?
Thank you.
I wanted to read what is in procure.

, people have asked me what that means, can we participate this is what it says in the procurement, from the issue date of this RFP until the department selects proposals for award, the project officer is the sole point of contact concerning this RFP any violation of this condition may cause for the department, maybe cause for the department to reject the offending offers proposal, if the department later discovers that the offer area -- that the offer has engaged in any violation of this condition, the department may reject the offending offerer's proposal or rescind the award, offerer's may not distribute, any part of their proposals offerer who shares information contained in the proposal with other Commonwealth personnel are competing officer personnel may be disqualified.
Doesn't mean we can't do public mealings continue will to do public meeting like this, we did take -- there was several, members MCO, members that we anticipate may bid on this, were on some of the subcommittees the working committees we've had, we've asked them to rescind themselves any managed care organization that was on one of our committees, we have asked them to rescind themselves we're going to be getting into more operational stuff, that may be putting them in an advantage.
What it is all about, putting -- not putting vendors, or bidders, at an advantage over other ones.
So that is what the blackout period is all about.
One of the -- actually, several of the members of the committee, asked us to talk a little bit, durable medical equipment and the requirements around durable medical equipment I know Richard on the phone was one of them and Fred you were another one.
So the language, from the agreement, is -- is that, CHCMO, community health choices managed care organization must provide exceptional durable medical equipment as defined in exhibit EE.
In the -- on the procurement, on the actual draft agreement, there are a number of exhibits and EE is the one where you'll

find the language around exceptional DME, that's especially adapted DME or other DME that is designated, as exceptional DME for the department over $5,000, that's an in existence in nursing facilities, what it allows for individuals who are transitioning for living in a nursing facility, continue to live in a nursing facility to have exceptional DME, so they are able to ambulate better so they have access to what it is they need to -- be able to participate in the community life of their nursing facility. However, that person decides to transition, wants to go home, that DME comes with them.
Belongs to them after, once that occurs.
So we've had this for some time and, we will continue to require it in the next -- in the community health choices.
I wanted to talk a little bit about work group participation.
And, first of all thank you for your ongoing interest in the work groups.
I have heard that there have been some concerns about meetings overlapping.
And that, the meeting times for the work groups, make it so you can't participate in multiple work groups.
We really wanted to have, to have the option to do the work groups around this meeting.
Because, so many people are in Harrisburg and, we cannot support people to come into Harrisburg for the work groups only for this meeting itself.
We really wanted to schedule them around this.
So some of them will overlap.
What I'm recommending is that if you find yourself in that situation, pick the one you're most interested in and get someone else to participate in the one that you can't make it to.
Because we're trying to make these accessible so people can meet in person.
You can find someone to represent you, that will probably be the best thing to do.
And we're also going to be having a work group report out at this meeting.
As again I just wanted to reiterate that the managed care organization participants on the work groups is no longer permitted. And they all -- they know that, I've made phone calls

to several of them.
All of them had that information given to them personally.
Talking about the clinical eligibility determination that's not something that is really associated with the procurement pro se, it is an activity that we are undertaking as we move into this new environment.
The first meeting was held on February 3rd.
And we had over 40 members participating in that initial meeting.
The group was presented with an over all strategy for a new clinical eligiblity process.
And they are, the plans are to design new clinical eligiblity tool, which included, the draft questions that were presented to the committee, at the time.
Over 100 comments were provided back to us in that process.
So, we have been sort of, analyzing all of those comments.
And they will be reviewed at the next stake holder meeting which is this afternoon and a number of you may be participating in that.
So we're taking questions and Honing in on them, what are the right questions to get to, a clinical eligibility determination as we're required to do for home and community based services.
And also, for nursing facility services.
The training committee, the first meeting also occurred on February 3rd.
We had about 12 people, participating in the training committee.
They discussed the charge and scope of the work group, they list -- came up with ally of priorities for training and ideas to be developed in determines of training MCOs from a stake holder perspective.
That is one of the themes that came out of that.
And, they really, they zeroed in on looking at the independent living philosophy as something we really need to embed with the managed care organizations.
And the communications group, will have the first meeting today, from 2-3.
Over in the forum place building, which is where our offices are located.
Right up on fifth and Walnut.

Members of this group include those who signed up for the communications committee, participant eligibility notices because that is a form of communication that we really have to get right.
And grievances and appeals, we really want to look how we communicate about our grievances and appeals.
I want to give you an update on the evaluation last month, we had, Howard Deigenholtz from the University of Pittsburgh come and talk to us about our evaluation.
He received a lot of input from this -- from our group.
Which is very valuable to him.
I want to just, explain to what the evaluation work group is, it's an internal OLTL group h meeting since last summer we have done a ton
of
work, to figure out the data sources as you can tell from what Howard presented the last time.
We've invited a member this is at my staff's request was to invite a member to be' a liaison to this committee he will report, Richard Kovalesky, Pat is he going to participate do you know.
He was going to give a report on the evaluation.
Maybe he will join later.
Yeah, that's -- Okay.
So we have not heard from Richard I really wanted him to report out on what happened.
Richard are you on the phone?
[no reply]
>> SPEAKER: He is not showing as logged in.
>> JENNIFER BURNETT: David, can you get in touch with him at all?
>> AUDIENCE MEMBER: I got a very cryptic email from him yesterday.
Someone else's name and phone number but it wasn't his.
>> JENNIFER BURNETT: Okay.
That's too bad.
He was going to report on evaluation work group meeting that he attended he has attended a couple of them so far.
And I think, what we did, at the meeting was really go through in detail, a discussion about all of the comments that we received from this committee.
It was very helpful.

Howard actually did -- you have a copy of it I don't have a copy of it.
Howard, put together a memo to our work group, that really, described the changes and revisions that he was going to make.
He is revising the PowerPoint presentation to reflect the change that's are made.
And we will be putting that up on our web site.
He is planning on interviewing nursing home residents.
That's a change he wasn't going to.
He was going to analyze administrative data and claims data.
And so, that was a big change for him.
So we are working on the design of what those interviews would look like.
We'll be reaching out to the associations, representing nursing facilities, to help us, figure that out and, we're really, looking forward to that.
So that was a substantive change that was made as a result.
But this letter to the sub MAC will be posted on our subcommittee web site, so that everybody can read the changes that were made.
Let me just go through -- I wanted to talk about the authority, CMS authority work we're doing.
Our policy office, has been working on finalizing the consolidated 1915BC w waiver applications that will make up the final CHC waiver
as I mentioned last month, we are going to be using our COMCARE waiver as the vehicle for the consolidated CHC waiver.
It's actually a concurrent BC waiver which means CHS will put us on track to be renewing at the same time.
That's what they do with the concurrent waiver.
The B waiver, allows for the use of mandatory managed care.
The C waiver, allows for the delivery of long term services and supports home and community based services.
We are also in the process of renewing our OBRA waiver, which has been posted.
It was actually published -- out for public comment right now.
It was posted in the Pennsylvania bulletin on February 27th just this past weekend.
We plan -- that particular waiver, expires on June 30th of

this year.
So we plan on submitting the waiver renewal to CMS in late March.
So it's out for public comment right now.
>> SPEAKER: Yeah I have a question about that on here.
Appear so transitioning youth from 18-21 under OBRA how is this going to happen?
What is going to look like?
>> JENNIFER BURNETT: Yeah. It will be be a seamless transition for them, but the individuals 18 -- if you recall, we were discussing and heard from staff, that people individuals that are 18-20 to the age of 20, were being included in community health choices and there was a concern that they would not get needed services, they received their services from EPSDT which is on the State plan.
There are a few unique services they access through OBRA that are important to them.
Some individuals.
It's not a very big number.
But it includes things like home modifications and vehicle modifications.
And so we have been approached and the department was approached, by coalition of groups who said you know what about them if they're going to be in CHC how do they access those services?
And one of the challenges in putting -- originally putting that small group of people into CHC is that our MCOs, managed care organizations would be responsible for bringing up pediatric networks we just tempt that was for such a small population, it just, wasn't really worth it.
So what we're going to do swerve them in OBRA continue to serve then through the OBRA waiver.
And anyone in OBRA, that is, determined clinically eligible for nursing facilities will go into CHC.
So let's see if I have anything else.
I think that's it for my updates.
So I just wanted to remind everybody the actual documents for the procurement they're all also on our web site, the community health choices web site.
You can see, you can look at all of the exhibits the exhibits,

the RFP, the draft agreement, as well as a summary document which is a very handy document that lists many, many of the changes that we made as a result of this open process that we've gone through so far.
It's very easy to read and user friendly.
We also have posted a frequently asked questions document that's up there as a PDF.
We're working to actually incorporate it into just a list of questions with pull down menus it's easier to follow.
So those frequently asked questions have also been posted.
But the -- what the managed care organizations will be responding to is what on the DGS web site.
The E-marketplace.
>> AUDIENCE MEMBER: Jen, Brendan Dare had a question where the RFP is located I put up the community health choices maybe we can point out to the folks on the phone they probably can't hear me.?
>> JENNIFER BURNETT: That's the DHS web site, right.
Go to the community health choices web site.
This is the click on the left.
Over on the right, down -- there's stuff you're missing on the far right.
>> AUDIENCE MEMBER: Should be a navigation Baron the right.?
Related topics.
>> SPEAKER: Related topics.
>> JENNIFER BURNETT: I don't know.
Yep.
>> AUDIENCE MEMBER: Sometimes it's on the right.
>> JENNIFER BURNETT: I looked at this morning, it's on the right.
Can you scroll over.
>> SPEAKER: Web site renders differently depending upon the size resolution on your screen.
>> SPEAKER: Look for related topics.
There it is.
Okay.
>> JENNIFER BURNETT: Third one down, there it is.
>> JENNIFER BURNETT: On my screen it was on the right-hand side.

>> SPEAKER: You're right.
>> JENNIFER BURNETT: The draft agreement is up there.
If you go to request for proposal March release, all of the March release ones are the documents you will want to look at.
>> SPEAKER: It's long, yeah.
>> JENNIFER BURNETT: That's how you get to it.
>> SPEAKER: I was wondering where are the requirements are? Are they in the draft agreement?
>> JENNIFER BURNETT: They're in the draft agreement, yeah.
>> RALPH TRAINER: You have a request Neal.
>> SPEAKER: With regard to evaluation other than Richard Kovalesky is there an opportunity for additional members of this sub committee to be participants in the evaluation process?
>> JENNIFER BURNETT: Well, it's an internal committee and, what we have decided is that, Howard will be making himself available we'll be meeting with his committee and members of his committee if they want -- as they want to.
It's really a working group where we get into very operational activities, looking at data, it's my -- metrics people that are really helping Howard with this.
So, we, we did not want to get into having a lot of more than one, representative of this committee.
>> SPEAKER: The question really comes down to methodology not necessarily the data.
>> JENNIFER BURNETT: Okay.
>> SPEAKER: How do we continue to be involved with examining the processes so that we understand what the researchers are looking for and actually doing?
Burp
>> JENNIFER BURNETT: Okay.
We can have come back the next time and talk about it.
Paul you may want talk about it as you want.
We have a adviser Paul is going to be speaking with you, who can -- who has been advising on the evaluation he can definitely talk to you about the methodology.
Okay.
All right.
Were there any other questions before we hand it over?
>> RALPH TRAINER: With that being said, Paul, please come up to the mic rephone here.

Introduce yourself please.
>> SPEAKER: Good morning I'm Paul I work with the Truvan health analytics.
And we have been, fortunate and pleased to be working with DHS, on the design of CHC and, this morning I've been asked to talk with you all about coordination of Medicaid and Medicare for dually eligible for beneficiaries what has been happening nationally and how that's being built into the design of community health choices.
This first slide, just gives you the big picture this might be surprising to people.
Of the 450,000 or so people who will be eligible for CHC95% of them are full dual eligibles.
And by full dual eligibles we mean, people who have a full Medicaid package in addition to their Medicare.
You'll hear that terminology a lot.
The partial duals are not included in CH CHC the partials are not getting any Medicaid benefits.
Subsequently there's not a lot to manage since the cost sharing and they're not included but 95% of the CHC target population, is full dual eligibles that includes the majority of people who are receiving LTSS today.
I have noticed in planning meetings and stake holder meetings and such that, the people who are receiving LTSS and dual eligibles tend to be described as two separate groups but in fact there's a huge overlap as you can see.
So 72% of the target group are dually eligible without LTSS they're not currently receiving LTSS.
23% are dually eligible and also, receiving LTSS.
So a big chunk of the people who are currently in one of the waivers are dually eligible for Medicaid and Medicare.
We look at the next slide --
>> SPEAKER: Excuse me Paul.
This is Fred, I have a question for you Paul.
The ones that are dually eligible without the long term services and supports, are they eligible for it or do they just not know about it?
Or do we know?
>> SPEAKER: We don't know.
So what we do know they're not currently accessing the LTSS

system.
And the fact that they are dually eligible tells us that they
are probably low income and have low income in assets they
financially qualify for Medicaid they have Medicaid we know that.
The fact that they're not receiving LTSS they could be
receiving state funded services through the Department of Aging.
They could be receiving nothing at all.
there's a large number of sub-groups within that 72% one of
the things I would expect MCOs to do is parse the member data e
to figure out.
That group is often referred to as well duals or well elders.
First of all they're not all elders they're not all well, we
know that.
I will show some slides in a minute about chronic conditions.
So that box needs to be unpacked a little bit, in part so the
MCOs can d decide, okay, here's a sub-group that has diabetes we should
have a diabetes management program for example.
>> SPEAKER: The reason I ask that question is if all 72% of
those people, that are eligible, if they decided to jump on CHC
that's going to entirely bankrupt the State wouldn't they?
>> SPEAKER: No they're already in Medicaid.
And so, they will be in CHC.
If they were suddenly to all receive LTSS that would bankrupt
the State.
But we believe that most of them are not eligible for LTSS
they would not meet the clinical eligibility criteria for LTSS
>> SPEAKER: Is that including the ID and in that --
>> SPEAKER: Which great.
>> SPEAKER: ID and DDL intellectual disability.
>> SPEAKER: No this is older people and people with
disabilities, people in the waivers that are being in the waivers,
but also W either either qualifying for Medicaid
through SSI.?
No, it does not include people with intellectual disabilities.
>> SPEAKER: Okay.
>> SPEAKER: Okay? So looking at the age break out the other
thing that you hear often in discussions is that, the duals are
are the elders the non-duals are the younger people.
That's just, to get straight, that's not the case.
It is true that there are more dual eligibilities, in the 60

plus group you can see here that 97% of the 60 plus group, are dually eligible and only 3% are Medicaid only.
But if you look at the under 60 group, 91%, of people currently, targeted for CHC, 91% of the under 60 group are dual eligibles.
So a slightly smaller proportion.
But still a very large majority in both age groups.
So
>> PAM MAMARELLA: We have someone on the phone that has a question.
>> SPEAKER: Okay.
>> SPEAKER: If medical assistance for workers with disabilities were utilized.
[very low volume]
>> SPEAKER: I'm sorry I can't hear.
>> SPEAKER: Speak up we can't hear you.
>> SPEAKER: Any better now?
>> SPEAKER: Yeah.
>> SPEAKER: My question is, do we think that Medicaid only number, from the last slide, would expand if medical assistance for workers with disabilities, were properly utilized I know that employment is being tauted as a priority for this administration, do we expect that number to expand?
>> SPEAKER: Sounds like there's a workers with disabilities Medicaid option in Pennsylvania and, that you believe that program is under utilized you're asking if more people would access that program with these numbers increase?
>> SPEAKER: Yes.
>> SPEAKER: So I don't -- I don't know the specifics about that program.
But it makes sense to me if more people, opted into that program, which is an option then yes the numbers would increase.
>> SPEAKER: Okay.
Thank you.
>> SPEAKER: Okay.
>> SPEAKER: So moving to the next slide.
So these numbers, that I just showed you, make it pretty obvious, that coordination of LTSS and other types of health care including all Medicare and Medicaid, services should be a priority for this program and as I'm sure you all

remember, it is goal number 2 in the five goals of the program.
And, just as a very simple glance at the numbers explains why this group is so important to CHC.
So why all the interest in dual eligibles?
Okay we know the vast majority of the people in the CHC will have both Medicaid and Medicare why do we care about that?
Why is this an important group to think about?
And to try to make things better for it?
Consumers with both Medicaid and Medicare navigate two parallel systems.
That in the normal course of events, are not well coordinated.
There are exceptions and Pennsylvania has a large LIFE program, that's a program that is designed to really coordinate Medicaid and Medicare.
But in the normal course of events, these are two systems that run in parallel to one another, with no natural mechanism to create coordination between them.
Medicare is the first payor for doctors whoms and skilled therapies, Medicaid is the payor for LTSS.
And so, if you're a dually eligible person, who uses all of these things as many people do, again you've got two different payment sources.
Those payors are -- don't have any natural way to coordinate across.
Again, I mean a particular program or MCO or payor might make special attempts around special situations but it's not the normal course of events that these payors are coordinating how they provide services to the person.
Most people transition through hospitals and/or skilled therapies which are Medicare reimbursed.
On their way to receiving LTSS.
So a very typical course of events is, someone falls, is admitted to the hospital, from the hospital, they have a Medicare skilled stay at a nursing facility.
When that visit ends, there is not a plan or there is not able to be a plan for the person to return home for all kinds of reasons.
The person ends up applying for Medicaid or already has Medicaid, becomes a Medicaid long term stay.
And by the time, that the LTSS system catches up to this

situation, perhaps, the home has now disappeared.
And there are all kinds of additional barriers to helping the person return home.
And that's because the two payment sources are not coordinating and, making the plan for how a person returns home together and early.
So moving onto some statistics I wanted to acknowledge I mean, yes.
>> SPEAKER: How are you doing.?
I'm confused because, the example you gave as far as how you know someone hurts themselves and ends up in the hospital and end up in a skilled nursing facility.
And, you know, sometimes most of the time their housing disappears.
What can you do to help coordinate that before that happens is this.
Is there an answer for that?
Because a lot of times that happens to so many people.
A lot of times those Thursdaying facilities you Noah sift in that.
Because you know, they're in a business to make money.
How does that -- how are the MCOs going to help with coordinating that, before it gets to that point.
>> SPEAKER: Right.
So the ideal situation, that you would like to see, in CHC is that MCO is responsible for both the hospital stay, the SNIF F stay and the Medicaid LTSS costs.
That MCO gets a care coordinateiator, service coordinator involved the minute they're aware of the hospital stay, before we even cascade down into the nursing home.
They -- if they're paying for the hospital stay they will find out about it, immediately, because the hospital is going to have to request a stay right, permission for a stay.
So it's all about the response, a responsible entity, accountable entity being there first of all the MCO.
Becoming aware of that hospital stay, immediately and then, getting their people into work discharge planners on the plan right from the start identifying whether there's a risk that the home is going to be lost, identifying there are natural supports that can help, all of though things.

It's about getting information, early and acting on it.
>> SPEAKER: I was going to say the reason why I ask is because, a lot of times like, I say if the person has some mobility issues and, needs assistive devices to get in their house, a lot of times the rule is you already have to be in your house, getting services in order to get that modification.
How do you guys combat that?
How does that change?
How do you fix that?
>> SPEAKER: So the transitional funds will still be part of CHC end people will stay have access to them and again I think, I may be over simplifying the situation but, from my perspective, it's about people, understanding there may be the need to transition back and there may need to be transitional services, to assist with that.?
And, having access to those and, arranging them so it can actually happen.
It's largely a -- a situation of, today there are so many different actors in the system they all have a piece, so someone has the hospital piece.
Someone has the home health piece.
Someone has the transition piece and, no one is responsible for putting that all together, in an effective package if that makes sense.
>> PAM MAMARELLA: I'm going ask the committee to hold the questions until Paul is all the way through his presentation so he can make those connections for us and then we can ask our questions in the end.
>> SPEAKER: Okay.
Great.
So I just want to acknowledge we presented some on other statistics in the third Thursday Webinar we've got the feedback that we shouldn't only characterize people as sick I completely agree with that I think there's room to also start talking about people, individuals, in case studies.
I mean, people who -- all the other aspects of their lives for today's presentation I think it is important for people to see these statistics so we understand that the so called well duals are not all well.
There are some of them who, apparently, from what we know,

have very little need and so, if you look on the left at this chart, 38%, of dual eligibles, have no ADL needs.
They have no need for assistance and activity of daily living and so that seems like a significant chunk until you compare it to the Medicare only which is the larger gold bar next to the 38.
So if you compare duals to the Medicare only group, the 74% of people with Medicare only have no need for assistance with ADLs.
But nonetheless there's a group of dual eligibles who probably need very little.
Again part of the MCO's job is going to figure out who those people are and what it is that they can benefit from, probably you know, at a minimum making sure they have annual visits with their doctors and engage in other prevention activities if you go over to the right, 40% P of dually eligible beneficiaries have a need with assistance in 3-6 activities of daily living.
That's a very large number.
It's very significant.
It's why in the earlier slides you saw that a significant portion of the LTSS folks, in CHC are dually eligible they're showing up here.
There's a large piece needing assistance with activities of daily living, opposed to only 9% of Medicare only groups, that have that need for assistance.
So, moving on, to some of the chronic conditions, the next few slides just to orient you, I have broken out by age.
So we can look at the under 65 group and the over 65 I recognize 60 is the important number in Pennsylvania, unfortunately CMS, looks at this from a Medicare 65 perspective this is CMS numbers you'll be looking at that's why the brake out is 65.
So, the first chronic physical chronic condition is diabetes.
And you can see that, dually eligibles are a bit more likely to have due bites under 65 than Medicare only, 27 versus 22%, hypertension, 43 versus 36%, heart disease just a smaller bit, more like 17% versus, 16.
Now if we go to the next slide look at the over 65 you see the gap is bigger these physical conditions do tend to be associated more with older people, so you see a much bigger gap.

So again, important to look at dual eligibles and the sub-groups and, age is one of the sub-groups that, definitely you'll want to look a at.
You can see 42% of older duals with diabetes versus 25% in the Medicare population and so on.
But the gap, the difference, between the Medicare only and the duals is bigger among physical conditions for older people than it is for the under 65 group.
Now, if we move to some mental conditions and, the one I realize people behind me can't read these slides because I can't read them either but I have them in front of me.
Let me outline.
The one on the far left is Alzheimer's and other dementias the numbers are small but the difference is significant. 4% of younger people, who are dually eligible, versus 2% in the general Medicare population under 65.
Depression pretty significant difference 34% for dual eligibles, versus 22 in the Medicare population, same page never 65, and schizophrenia and other psychotic disorders on the far right, very significant, 14% versus 4 in the general population.
And, if we look at the older people, in the next slide, with these conditions, you see that the gap is much larger, among older people for alzeheimers, you would expect that increases with age.
With depression, significant gap.
Not as high over all as with the younger group and schizophrenia, in other psychotic orderers not as high with the younger group, but still a significant gap so these two slides point out, how important it is going to be for the CHCMCOs to coordinate really closely with the behavioral health MCOs.
Okay.
So the impact of early MLTSS early duals programs just to give you a sense of the history here, there was a first wave, between 1989 and 2004, the results were encouraging which is part why you've seen such an up tick in activity in this area.
First of all, the first two categories nursing facility and hospital, the high cost services institutional services hospital services, were reduced in these programs so that was a -- that's generally a goal of these programs and it was achieved, almost always, there was one program, where nursing facilities

activities actually increased and -- um, in that program, the -- they have been carved out and left for fee for service the theory there was some cost shifting to the remaining programs that was left outside.
Similar situation, with hospital -- hospital increased in one program where hospital and other acute services were left out provided outside the program.
Physician services, have increased pretty much across the board in these programs, there's a real emphasis on getting people in to see their doctors.
And quality, has improved, although, there have not been a a lot of quality metrics and, there's a lot of work going on, both nationally and in Pennsylvania on -- measuring quality, in more ways than in different ways, but, slower rate of functional loss and lower mortality.
The lesson from these early programs, a big lesson, was that, programs -- if you're going to do this, and there are a lot of programs, don't leave
stuff, outside, in fee for service.
Because, you can expect that there could be a cost shift to that remaining, service that is left outside.
And -- this is certainly been taken to heart in the CHC, program, design, which is quite -- comprehensive for example, nursing home and CHBS are both in, you're not leaving one or the other out of the program.
Federal departments have accelerated since this early wave I think that's in part based upon the promising early results the balanced budget act of 1997 authorized the program of al inclusive care for the elderly PACE you know as LIFE here in Pennsylvania much offers a as a Medicaid option to encourage expansion the LIFE program started a year later in 1998 you have more sites than anywhere else in the country now, so Pennsylvania, is he certainly a state that took advantage of that.
The Medicare improvements for patients and providers act of 2008, MIPPA you've heard that term thrown around a lot.
Medicare, has -- a special Medicare advantage product, known as, a dual eligible, special needs plan.
DSNIPS you'll hear that acronym thrown around a lot too.
Prior to, the MIPPA, Medicare advantage plans could operate, these SNIPS in isolation from the State which didn't make a lot

of sense it is supposed to be about coordinating with Medicaid and yet, there was no, requirement that happen.
So MIPPA, required, health plans to have, a contractual agreement with the State, if they wanted to operate a dual eligible SNIP, Pennsylvania has a lot of them, people are enrolled in the SNIPS the MIPPA agreement is being beefed up I'll talk more about it in a minute the Affordable Care Act, in addition to creating Obamar care, it created the medicine cared coordination office which has been very helpful to DHS and thinking through the different options for coordinating Medicare and Medicaid in the CHY program.
It also, authorized a dual eligible demonstration which is called the financial alignment initiative, and there is, I'll talk more about that, in just a second.
So what is Pennsylvania doing? Parallel paragraph the CHC is going to use the MIPPA agreement which I just referred to, this required agreement between DSI P, S and the State to enhance coordination for the dual eligibles, to have on top is the CHC MCO, CHC-MCO to get a contract from the State, they're going to have to agree to have an aligned, Medicare MCO or a DSNIP by January of, 2018.
This will not be required, for beneficiaries, but, it will be required of the plan to offer it.
So, if you're enrolling in the, the program, you will have the option, if you want to, of having all of your Medicare also coordinated by the same company essentially.
Two products one company.
And, the result that we're looking for is the seamless experience for the beneficiaries so for example, you don't want two service coordinators one in each of these plans you want one service coordinator who is going to help you manage all of your Medicaid and Medicare, that's the general design.
So, moving on.
CHC-MCOs will also have to work to coordinate other Medicare options because the Medicare will continue to be whatever the consumer wants.
If you're happy with the Medicare you have today, you keep it that might mean that you have original Medicare over on the right.
It might mean that you have you're already in a Medicare MCO, Medicare advantage plan it's not one of the affiliated plans.

So, if that's the case, then the CHC money MCO it's going to be harder for them, they're not in the payor in the case they will have to find other ways to coordinate, with Medicare providers who they're not paying.
And, or, with Medicare MC Os, in order to make sure that the Medicaid and Medicare are coordinated.
So I mentioned the financial alignment initiative.
And, the red stars, are the States where financial alignment initiatives have come up in the last two years.
Some of these have been operating for two years and some for one.
Lots and lots of activity this is an just an explosion of activitying in terms of stating really trying to get at the dual eligible I believe issue end try to improve coordination.
And there's some lessons that are coming out of those financial alignment initiatives.
And, we wanted to share some of them with you.
And, tell you how, CHC is taking these lessons to heart.
So the -- this by the way, is very early evaluation work and we hope to have a similar early findings from the CHC evaluations.
So this doesn't get to impact the outcomes yet it's too early.
But it's sort of what happened during the implementation, very important.
And very helpful.
So, lessons from the financial alignment initiative, use multiple methods to engage stakeholders that's really a lesson that's been around for a long time.
And, our presence here today is one of the examples of how Pennsylvania has taken that lesson to heart and put multiple stake holder methods, in place.
And also, you'll see in the -- if you have had time to look at the specifications yet, when you do, CHC-MCOs will be required to have member advisory committees to advise them in addition to the other processes that will be in place.
Medicare passive enrollment in the financial alignment initiatives was confusing for beneficiaries and overwhelmed MCOs, so, Medicare passive enrollment, means, in those demonstrations, that you were automatically enrolled for the Medicare.
So Pennsylvania, is not using Medicare passive enrollment.
Your default is going to be whatever Medicare you have today.

You're going to have to take an action if you want to change that Medicare, the hope is that many people will want to change their Medicare and go for a fully integrated experience.
That will be the consumer's option, no passive enrollment in Pennsylvania for Medicare.
Enrollment improved by community out reach organizations.
There's a lot of activity in this area there have been community meetings sponsored by foundations in Pittsburgh and Montgomery County.
We're hoping for more of that and also DHS is looking for specific activities to help with the out reach, really working locally to make sure local organizations know about this program and can reach people tell them about it, it's going to be critical to success.
Materials were confusing and improve with consumer input.
This is one of the issues that the communications sub-group that -- was described earlier today will take up.
So as we develop notices how do we make sure that we're putting it in front of the consumers and asking them how they pretty the information before using it and sending it out to 400,000 people.
Service coordinators were not always well trained, training requirements will happen.
That will one of the things that is is is going to be reviewed for the readiness of the plans.
Service plans were not available centrally, some of the States did not require automatetion and up loading of service plans which puts them in a position of -- having to do on site and file reviews to see what is happening in service coordination the plan is to have the MCOs continue to up load to up load the service plans in the system, finally, administrative alignment of Medicare and Medicaid has been challenging.
That's the big lesson from the early FAI the two systems are very difficult to align.
We knew that it's somewhat surprising a demonstration really designed to address that still founded very, very challenging takes more time and resources than anyone anticipated so the strategy in Pennsylvania, is go slow.
Don't expect there's going to be 100% of administrative

processes on day one it will take awhile.
So -- DHS will work with stake holders to pry orize
the most important issues to work on and pick them off one by one
and work on them over time.
So the first step, though is to have a platform, or a vehicle
in which to have that discussion, and that's where the
requirement that MCOs have a -- a DSNIP, dual eligible plan comes
in, so that's the platform, and then the discussion is about how
to make sure that CHC-MCO and the related DSNIP are actually able
to integrate the administrative and other things that they need
to integrate finally learning over time University of Pittsburgh
is conducting the evaluation you heard about the last time there
are 3 major parts of it, in each case looking for coordination
for dually eligible people is part of what look S* looked at this
terms of implementation, talking to a range of stakeholders how
Medicaid and Medicare are not working together.
And what some of the specific bugs are, so that they can be
worked out before phase 2 kicks in.
In terms of impact talking to a whole range of consumers over
time talking with them at several points in time over the life of
the program about their experience if you're dually eligible what
is your experience, with Medicare and Medicaid.
Does it feel less fragmented to you than it did before the
program, is it easier to manage, are you welcome less difficulty
with your copays than you had before.
All that kind of stuff, finally the administrative, analysis
-- on the right.
The hope is to create study cohorts in the data of people
that do pick the integrated option and the people who do not look
at whether they experience different utilization of services and
different outcomes there will be an opportunity to look
at the issue as part of the evaluation.
Pam, I don't know if you want to entertain questions or not.
>> SPEAKER: I have quite a few here.
And, I also have one from Tanya, she just texted it to me.
Now, as I was going to say to Rick before Pam said hold the
questions but, what he was discussing do you know here at the
end, would community first choice option, we don't have that yet,
but that is, you know, it is part of what we could have, as part
of the package that we could have.

Would the community first choice option make the transitions easier for getting people out of the nursing homes out of the hospitals and everything?
And -- stop them from losing the houses like you what the community first choice option help or something similar to work in the with the CHC
>> SPEAKER: I'm not an expert on the community choice, it's a special state plan option for home and community based services in my mind the services the service it's still becomes a question of how you manage it.
And so, I don't think CHC in and of itself would improve things it would all be in how you manage the CHC.
>> SPEAKER: Basically CHC it's to try and transition people to the home just as quickly as they would go to a nursing home.
And, we're having -- that's a totally different thing.
That is under discussion with the other people right now.
If you could take parts of what is at the community -- what's in the CFC, and integrate it into the CHC, would that -- would that be the answer to your question?
That might be a way to figure out how to get the transitions easier.
>> SPEAKER: It would be I know not many states have picked up, CFC.
>> SPEAKER: This is true.
>> SPEAKER: Yeah.
>> SPEAKER: Ones that have, are having problems with it.
>> SPEAKER: It would be interesting to see what their best practices have been you could potentially pick up the practice with or without the actual CCFC, and integrate into the CHC.
>> SPEAKER: Tanya wanted to know will be she is texting me instead of trying to get through on there.?
It's easier.
She wants to know how do these pieces start working together under the new system in order to ensure the best care possible.
>> SPEAKER: Great question, depends upon your situation if you decide to keep original Medicare for instance or you're very happy in your existing Medicare advantage plan you want to keep that, then, there's going to be a pretty big burden that falls on the -- on the CHC money HMC to reach out to Medicare advantage plan to reach out to those individual Medicare providers if you

have original Medicare, and, really coordinate and so, you know
one question, let's use an example, how will the CHCMCO know that
you've been admitted to the hospital?
Well, they might have to work on their hospital relationship
over all, and say you know, here are our members, I moon there
are systems where they can receive alerts for when their members
coming in the hospital, if they're not the payor for everything,
the question becomes how do they get information.
Then how do they act on the information and MCOs have
strategies for that, it's harder when they're not the payor.
If you choose, to go with the aligned DSNIP have the whole
package then it becomes easier, for the MCO because, they are
providing you with the services in both Medicaid and Medicare
plans.
They have internal work to do, to make sure they're not assigning you two
different service coordinators and
such.
But, it's easier for them because they have all the
information.
>> SPEAKER: Okay.
And the last question I have is, what percentage of people
with disabilities are going to be on the MCOs advisory committee.
Is it going to be just like this committee?
At least 51% or do you know?
>> SPEAKER: I have to look to someone who may be knows that
spec better than I do, I don't remember what it is.
>> JENNIFER BURNETT: We'll take it back and find out for you.
>> SPEAKER: Okay, please thank you.
>> SPEAKER: Okay.
After after I have Brenda on the phone.
Brenda, could you please ask the question.
>> SPEAKER: The question that I asked, can you hear me.
Question that I asked, does it look like the -- from the what
was said during a couple of the early slides in the presentation
is, involving hospital discharge planners, what services might be
needed, that we were looking to move more towards nursing home
diversion.
Instead of transition.
Is there going to be, funding allowed for that diversion
above and beyond the typical capitated rate?

>> SPEAKER: So I think, both thing are really important.
Diversion is, really important and should be enhanced through
better transition protocols when people are leaving the hospital.
And in my mind, that does not take away the need to also
emphasize on transition, back into the community from
nursing home when people have been in the nursing home for a long
time.
If the member is both in the aligned DSNIP and in CHC then
the MCO is getting revenue for both the Medicare and the Medicaid
and they should be able to figure out how to use those funds to
do the transition really well.
If they're not, responsible for the Medicare piece, it is
still in their financial interest to get someone to that hospital,
right away, even though, they might not, you know be paid for
Medicare to do that.
Because if the person ends up in an avoidable long term
nursing home admission, then the MCO foots the bill for that.
>> SPEAKER: Thank you.
>> RALPH TRAINER: Anyone else on the phone please?
I have Neal and bill, you win Neal.
>> SPEAKER: Paul thanks for the really -- thorough analysis.
And it's good to know that there is a plan for coordination.
Currently people with brain injury who
are served in the waiver programs, have the original Medicare
they don't have a DSNIP plan for the most part.
And so, what this poses for them is then, because the waiver
has requirement that TPR be used first for the therapies that
they may require, it requires, providers to use Medicare first
and then, to if there's still therapy needed after that, they can
go to the waiver.
But it puts the providers in a kind of a bind because,
Medicare has the therapy cap, which you know, they can bill up to,
there's certain exceptions to the therapy cap which they could
go beyond it's never quite clear whether that's going authorized by
Medicare
or not.
Seems like the solution you're proposing to requiring the CHCMCOs
to have their own Medicare DSNIP would address that, is that
your thought.
>> SPEAKER: If the brain with the brain injury picks

that integrated option the plan is responsible for both Medicare and Medicaid.
And my expectation, is that they figure out all that authorization stuff behind the curtain you know is this.
The consumer should not have to say you know, can I have this? Yes you can, for awhile, no you can't anymore, go to Medicaid.
That should be, part of the service coordinator's job who is managing the benefits across those two products.
Now, if the consumer chooses to stay with the original Medicare, my expectation again, would still be the CHC-MCO reaches out and helps with that coordination.
But, it's more limited what they can do, because they're not the payor in that case.
>> SPEAKER: Right.
So, is the requirement that, that when we hit the ground January 2017 that the DSNIPS the be in place.
>> SPEAKER: The requirement based upon feedback from the MCOs that was a heavy lift given the schedule of the procurement, because they -- let me take a step back, Medicare advantage issues a call letter every year they just issued the call letter for January 1, 2017, so plans are now reading the call letter interpreting it.
Trying to decide what their Medicare advantage products are going to look like and they have to have all that stuff together by sum we are.
Because the CHC procurement has just gone out it would be hard to do both things at the same time.
For the southwest bidders if they have a DSNIP in place want to put one in place by 2017 that's more than welcome they're not required to do it until 2018.
>> SPEAKER: January 2018.
>> SPEAKER: That's when the DSNIP requirement generally speaking goes into effect we'll also be in effect for the southeast, on January 1, 2018.
>> SPEAKER: Thank you.
>> SPEAKER: Sorry I called you Neal.
Bill is this bill and Jennifer and then -- Pam and Theo.
>> SPEAKER: I'm bill from AARP representing the elderly.
Excellent presentation I just wish to emphasize how complex how difficult my mother, which would be the good example would

not understand any of these acronyms that we're talking about.
Let alone 80 year old husband gets a stroke, then is he
cannot make decisions very well.
So then it is on the wife, or the next of kin, or someone.
So I want to emphasize out reach and education how important
it has to be timely also we have a very row burst, aging they had
work in Pennsylvania and I think, the more we can build upon the
existing system, which is county based, they know the providers
in the population the better off everybody will be.
Bullet I think the presentation showed just how complex
and difficult it is so thank you.
>> SPEAKER: I completely agree with that assessment.
One of the challenges with integrated care it is Jar goy.
We're talking and mo we more or less understand what the
benefit would be to choosing the DSNIP integrated option, but how
do you explain that to a person, that you know, here's -- here
are the advantages that's where the consumer testing all of the
messages testing all of the materials with consumers, is this a
clear message?
Do you understand what choice you're making?
Do you understand what you're get, what the benefits of doing
this are.
>> RALPH TRAINER: Jennifer?
>> SPEAKER: I just I have a question regarding enrollment
for dual eligibles.
A lot of people being dual eligible, and enrolling into CHC,
this will be completely new to them.
And in choosing their Medicare option and understanding what
Medicare options they have.
Currently in Pennsylvania, that assistance is provided by a APRIS
E volunteers however due to a letter that was received, by the
the cares of the aging community from what I understand a APRISE
volunteers have said that they are not able to provide this help
because, they will busy, in the fall, help helping people who
currently receive Medicare, to choose their plan.
So either APRISE volunteers need additional funding to hire
more or, something or there needs to be a support group or option
or something like that so that people, can understand Medicare
and what their options actually are.
Because as William pointed out it is very, very confusing

process.
>> JENNIFER BURNETT: Can I respond to that?
Thank you Jennifer.
Yes, there was a letter that was received from the chairs of the aging house and Senate committees.
And it did point out that APRISE volunteers are going to be very busy I can tell you we're working very closely with the Department of Aging, for those who don't know APRISE is our state health insurance program required to provide information on Medicare and Medicare choices for individuals, every state has one.
It's called a SHIP in other states.
And our APRISE program we're working with the director of the Pennsylvania Department of Aging and have a lot of ideas about how we make sure that the volunteers are very educated about community health choices.
And, the APRISE volunteers have been telling the State office, that the department, that they're very interested in learning more and getting trained on community health choices.
So I'm not sure how that concern came into the chair's letter but we have responded to it.
>> SPEAKER: Follow-up question.
If I may, what plans are being made to the APRISE volunteers don't become overloaded?
And inundated with all of the people that need assistance?
>> JENNIFER BURNETT: Well what we're doing is, their primary role is, providing information to consumers.
Providing information about Medicare that's what their function is.
We're going to be training them so they understand what community health choices is.
And they understand, what our processes are.
But, that you know, that's going to be you know, they're probably going to be asks we want to make sure they're armed with the information.
And in addition, to APRISE we have a lot of other ways of reaching people.
And including through the independent enrollment entity that independent enrollment entity is going to be actually be the one responsible for supporting the individual to enroll into

providing choice counseling for them to enroll into community health choices.
That will not be the responsibility of the APRISE counselor.
>> RALPH TRAINER: Pam?
>> SPEAKER: This is Brenda --
>> JENNIFER BURNETT: Hold on we didn't hear you hold on.
>> SPEAKER: Will that independent enrollment entity be the MAXIMUS?
>> JENNIFER BURNETT: At the beginning yes, because we're going into a procurement process but right now, we're going to be using MAXIMUS as the independent enrollment entity.
>> SPEAKER: Okay.
>> RALPH TRAINER: Pam?
>> SPEAKER: Jennifer spoke well, Theoa's Yes, sir has been about navigators, if it's going to be someone that can assist the person from the beginning making the decisions and taking through the process I hope we'll be able to really handle that as well as the enrollment for their other responsibilities.
The other question I had was, taking it slow, what does that mean?
Because you're talking about people starting in 2017, and, are they going to be like Guinea pigs do we know what service they're going to get, people's lives depend upon this?
>> SPEAKER: Taking it slow means there are certain administrative parts to the integration, that we know are not going to magically happen just by having a DSNIP and CHC-MCO let me give you an example, enrollment card if you choose the integrated option, the idea would be you get one card it covers both your Medicare and Medicaid services, the reality, is that you're probably going to start, with two cards.
Here's your DSNIP card and here is your CHC-CMO card when you go to the doctor please present both of them that's an example, we're not talking about the service coordination, the expectation is that the -- the MCOs will have their care coordination model in place.
And they will be able to start helping people, immediately, navigate the two systems.
But some of the administrative things, let me give you another example.
Appeals.

Medicare appeal process is different than the Medicaid appeal process.
It's going to work against consumers you have to wait out one process before you can access the other.
But it's going to take a bit of work with stakeholders to look at how can we integrate appeals.
So that will not be true on day one.
So those kinds of things really administrative things are going to take awhile.
>> RALPH TRAINER: I have Neal -- Stu, I'm sorry, and Neal.
>> SPEAKER: Stu, over the last several years, accountable care organizations have appeared and are being created almost, regularly now.
And those organizations, include, patients who are dually eligible.
What's the complication there, assuming that the accountable care organization is not part of MCO, that those patients get withdrawn from the accountable care organization and become part of the MCO?
Or is there a continuing dual responsibility for their care?
>> SPEAKER: So the CMS requirement is if you're in a Medicare let me reverse it.
The YMS requirement is that if you're in a Medicare advantage plan, you may not be assigned, to a Medicare ACO.
So CMS is looking at it from the Medicare side which is what they're responsible for, and saying you can't be in both.
If you choose, Medicare advantage plan so if you choose a DSNIP , then, if you have been assigned to an ACO, that assignment would lapse you would not be that is right.
Exactly you can only be in one or the other.
>> RALPH TRAINER: Any further questions.
Pam?
>> SPEAKER: Another question.
Sorry I left it on.
Service coordinators are going to have a lot to do and, I'm just trying to understand, how they would be able to do service coordination and if they have to do, nursing home transition, are they just going to be the ones who arrange the nursing home track significance or doing it, nursing home transition is, very lengthy and very hands on and very personal job and, I want to make sure

how that's done.
>> SPEAKER: I can't speak to how CHC money CMOs would address that here, I can tell you in other states the number of other different arrangement Social Security emerged, some MCOs have transition specialists, let's say I'm your service coordinator today but you end up in a nursing home you need transition assistance, I would -- I would bring in the specialist and say, my you know one of the people I'm helping needs assistance with transition.
And there would be a hand off but then continuing over sight that's one model.
And another model is that the service coordinator, realize on an existing transition agency to do that, it becomes a referral to that end coordination so the transition agency then might become part of the interdisciplinary team for the period of transition.
So, there are a lot of different ways to approach it.
The service coordinator, should continue to be responsible over all for that person's will being.
But then who they work with who they bring in, how much insensitive they have with the person for the period of transition, I think different MCOs use different approaches to that.
>> RALPH TRAINER: Fred.
>> SPEAKER: Actually centers for independent living, their fifth core is transition, it would be good idea to go to the cent centers.
Well, actually, David Gates answered my question for me on the -- the percentage of, people that are going to be in the pack.
Now, it says 60% of participants, will be, someone involved with dual eligibles.
Okay.
But that's not meaning anything.
What is got me worried right here is, 25%, of the total membership, are going to be people receiving long term services and supports.
So that's only 25% that are going to be on the participant advisory committees for the MCO.
25%.

That's an awful low number and, if they want to get it right they have to step that number up, anything way above 25% I would have to say at least 50, 51% just like we have right here.
That's just a big concern of mine.
There's,
>> SPEAKER: You're referring to the MCO advisory committees you found the language it's 25% consumer membership.
>> SPEAKER: Correct.
It says the CHC money MCO must provide the membership including designation of the pack, the pack membership must be composed of at least, 60% of the participants, with 25%, of the total numbership receiving long term services and supports.
And in addition to the individual diversity the CHCMCO should seek to have geographic including urban and rural, 25% is extremely low, considering if you want to go to the experts, the people that are already on LTSS are the experts.
So, why would you go to someone who has no idea I think the 25% needs to be upped dramatically
>> SPEAKER: The spec is currently written is 60%, members speak 60%, which could be, a family member or someone that is just dual eligible and never even heard of long term services and supports.
>> SPEAKER: Right.
Burp buffer who cares about their health care.
>> SPEAKER: Yeah.
>> RALPH TRAINER: Jennifer.
>> SPEAKER: All right.
I had another question for the secretary burnett I was just wondering, since, it's going to be ultimately the independent enrollment for accessibility to ensure people have the training that they need to choose the Medicare plan that they want, is there any plans to educate the independent enrollment broker on Medicare options?
>> JENNIFER BURNETT: Extensive training of the independent enrollment entity in more than that.
So -- yes.
We will be doing extensive training with them.
Which is why the training committee here is so critical.
>> SPEAKER: Sorry if I go back.

One of the questions I had is, one more than one advantage plan?
For people to choose on Medicare?
>> JENNIFER BURNETT: Yeah,.
>> SPEAKER: Okay.
The other thing I want today say is, you know, Fred let's think about that.
How that's comprise because, when we did the managed care committee in Philadelphia, managed care first hit, we sat with the MCOs and the people at the highest level it really helped to change things.
It was disaster when it first started.
And being at the table, with the MCOs the executives, along with the special needs people, it was a lot of nondisabled people at that table, but if they weren't at the table, we would be just talking to each other, making stuff up.
So I mean, the thing is I want -- you know, it was many disabled people and input but we want the input with most powerful people, that are going to make the difference in it.
That's the only thing we should think about the percent and make up the make up the managed care companies and the roles.
Otherwise we'll be talking to each other we don't want that, we want to be talking to the people that can make a difference.
>> JENNIFER BURNETT: Sure.
I'll just respond to that by saying, Paul mentioned that, we're doing a lot stake holder engagement in sort of public private partnership with the Pennsylvania health funders collaborative, so these are, foundations that, provide, that fund, health related activities, like the United Ways of Pennsylvania.
And, they have really stepped up to the plate and said we would like to help you -- get the word out about this.
So, we held our first meeting in Montgomery County for the southeastern part of the State on Monday.
And one of the recommendations that came out of that meeting, there were about I don't know maybe 100 people at the meeting, it was a very diverse group.
People who didn't know, some people didn't know anything about community health choices is the first exposure to it.
And others that, were pretty well versed in it.
So, we, onive the things we heard was, the model, that

was used in the roll out of the original health choices, 15 or 20 years ago, is really good, which is what you're describing Cassie it is in terms of recognizing issues early on and making quick adjustments to them, we'll be working with our colleagues at the office of medical assistance programs to try to
replicate that same model of having a local, local advisory committee, and in addition to, the managed care organizations having to have the advisory committees we'll do some kind of a local advisory committee in each of the zones.
>> SPEAKER: That's great I just wanted to reiterate I knew ralph that said the CILs the ones that are good, taking people out of institutions are really good.
And, they're hands on I mean, they take them out to get used furniture or new stereo I mean they budget everything with them. To the t it's a lot of work you have to go shopping with them and fill the refrigerator you have to go shopping with them to teach them, they grab all the Oreo cookies they haven't been out in awhile, they may need protein there's some education that goes along with that.
I'm telling you the CILs are great at it and I am putting an advertisement for the MCOs to consider continuing on -- to do it. Because, we're not getting paid much for it, when we do get paid we've been very late I don't know about
this add minute I know the last one, this isn't about this administration we hardly got paid, people were going bankrupt, but we were still taking people out.
Because you know, that's our community.
And you know, that's what we fight for, at the CILs to get our community out.
And to keep it out.
I think they're both very important too to keeping people out is just as important as getting people out.
Both of them are hard to do.
>> RALPH TRAINER: Thank you Cas is sie I have a question from Tanya, Fred is going it read it and one more Jennifer we have to move on.
>> SPEAKER: This is a suggestion from Tanya, there should be a way so that the service coordinator can have clear access to the person's medical records in order to keep communication between doctor and service coordination entities clear,

exception, I keep up, I keep my SC up to date on medical appointments and, necessities there is
no question going on this should be be made a standard practice.?
>> RALPH TRAINER: Jennifer?
>> SPEAKER: Just to comment on what Cassie was saying about nursing home transition.?
One of the things that I think is very important, is not letting people be isolated.
Because once a person gets out of the nursing home, what can happen is, it can lead to isolation.
They don't know people, they don't know places in the community.
And, one of the ways to -- I found to prevent against that is to have a circle of support or, have a support broker, do a circle of support.
And bring in the natural resources, so that it's not just paid resources we're not looking at the state for everything.
Introduce them to the faith community a sports team, get their howdies let them be the person to lead them to the meet meetings and back yourself out and let them them form that natural relationship.
That's a really important for the State.
To look into.
>> JENNIFER BURNETT: Thank you Jennifer.
I appreciate that.
>> RALPH TRAINER: Any other members have questions.?
>> SPEAKER: One more quick question.
Just about the APRISE counselors are they going to be hiring more, become paid?
Because they're going to take on a whole lot more, especially the in southwest starting it up, they're going to have a bigger learning curve right away.
Also is there an opportunity to expand the APRISE not from aging but for under 60 a lot of people don't necessarily, who are under 60 don't go through the aging or don't understand you know are it's a whole different -- the system is not going to be different but that's a different culture and atmosphere some people may be used to.
Is there a way to expand on the APRISE for navigators.
>> JENNIFER BURNETT: We're in conversations with the

Department of Aging as to the role of the APRISE program.
I will tell you that there are a lot APRISE counselors that counsel people under the age of 60, that is happening, today.
And, we'll continue to work with them, to figure out what that role it and figure out how to equip them make sure they have the infrastructure, there's no decisions or, initiatives right now, except for the fact we're having the -- the significant conversations about it.
>> SPEAKER: Can some people be involved with those conversations you know, to be consumers know, how it's going to be run how it can help?
That way other volunteers can be involved?
>> JENNIFER BURNETT: I'll bring it back and "Tulsa Talks" to Darlene Sampson, she is the director of the program she is doing a lot of good work ash APRI, is E I will bring that back to her.
>> RALPH TRAINER: Okay.
Paul I want to thank you very much for your presentation.
Thank you.
Okay.
Moving along, we're going to have Jen and Pam, do a quick overview of the dual eligibles.
>> JENNIFER BURNETT: Picking up on the great presentation that Paul just provided us which is really more about the -- what the State of the situation is for dual eligibles, which we're very fortunate to have those data sources.
There's a new data book that was published I think in January by MEDPAC the payment and access commissions for Medicare and Medicaid and CHIP and they are -- they meet quarterly and they report to Congress and they're very important opportunities for us to get information but that latest thing on the duals has been helpful for us.
We're always talking about numbers and, I thought it might be a good idea to talk a little bit about the impact in a person's life.
And because Pennsylvania does have a dual eligible managed care program which Paul referred to as LIFE, living independence for the elderly which is known as the program of all inclusive care for the elderly.
And because we had a dual eligible life member, come and talk

to us early on she was here about 4 months ago, I don't remember her name.
AnAnnie she was talking about her experience at new Courtland one of our LIFE providers I would like to turn it over to Pam to talk about sort of, little more context around the presentation that Annie provided and talk about the day and a life.
>> PAM MAMARELLA: Sometimes talking about stories rather than facts and facts help people understand what it is that integrated care is more substantial way.
Just to contextualize that, so everybody knows, that LIFE, PACE across the nation was the first fully integrated care model in the United States.
95% of the people that receive their CARE in the LIFE program are dual eligible.
That when we talk about the service coordination, when we talk about LIFE we're really talking about it interdisciplinary team made up of doctors and nurses and social workers and dieticians and transportation coordinators all of that comes to a hub through the a social worker that does the service coordination it's done by a team, so keeping that all in mind and recognizing that LIFE is able to decrease hospitalizations institutional care, quality of life, satisfaction is really through the life.
I'm going to talk about a composite person, that was put together by the interdisciplinary team and talk about what LIFE looks like when she was receiving care, that wasn't integrated.
And then, what LIFE looked like when she was receiving care that was integrated.
And in this instance, we're talking about the LIFE program, so today we'll take about MABEL80 year old woman living alone in a service enriched affordable housing unit, her family has since pasted she has many friends she lives with in the same housing complex member of her church, she attends Sunday services regularly.
She volunteers at the food pantry monthly.
And she attends Bible study and tried to do that a least once a week she suffers diabetes and hypertension as well as severe arthritis which requires her to use a Kane and a Walker she has been a patient of the same primary care position physician for many years, resume followingist, endocrinology and a eye doctor

and foot doctor, she receives care from a special doctor she is unable to follow through with all of her appointments pain from her arthritis leads her to her local emergency room, and this can occasionally lead to hospital stays, while her using service coordinator, helps us as much as she can, there's absolutely no mechanism, in place to notify the coordinator where she goes to the ER or admitted into the hospital.
Each of her 7 medications, that she takes daily including insulin for diabetes are prescribed by different physicians, they're only reviewed in total once a year by her primary care physician and then, even though she believes that she is taking her medication properly she is becoming confused about her medication, edge meant how often she should take her pills how much she should take no one notices that.
Attending service, and Bible study and working at the food pantry starts to feel out of reach for her she stops going completely.
During her latest admission to the hospital, work up showed that she had elevated blood sugar her insulin dose was increase was because her team was not aware she had not been taking her medication properly the team discovered blood pressure was elevated, added additional unnecessary medication to control it she did feel better, she was discharged with a visiting nurse and new instructions.
But unfortunately, because the initial problem of taking proper medication was not doubt her blood sugar and blood pressure dropped, causing her to become weak and dizzy found on the floor after a fall in pain confusion, she was admitted to the hospital with a fractured hip what's next?
Nursing home placement, hospital and rehab, does she loose her apartment?
Is there any way she can return to life, where she is able to go back to church which is so vitally important to her.
So that's nonintegrated care this is put, together by a team of people that really experienced people coming to our program, with issues that look like this, very often.
And, that team put together like 20 pages I've tried to reduce it down as much as possible.
I want to talk about Mabel, 80 year old woman, who lives in the service rich community she no longer has family but she has

friends, she suffers from buy beat, hypertension as well as severe arthritis which requires a cane or Walker she joined the life program in 2014 and she attends the center two days a week. Where she takes part in activities, and has made friends with common interest while at the enter she was regular follow-up appointments in the clinic with her health care team.
Her arthritis gives her occasional pain and stiffness but she has easy access to a wellness program at the RIFE center which can target programming specifically for her, that includes exercise, heat and massage.
3 months ago during a visit to the clinic is it was identified that her blood sugar and blood pressure, were elevated. And a home visit evaluation by RN was scheduled to review her medications and her diet.
Where it was discovered that she was confused about her Regime, immediately the teamworked with her to create and put a new plan in place, to remedy and monitor her situation subsequently, her blood press you're and her blood sugar were control, within weeks, and she was able to continue to do the things that she loved, with assistance.
It's worth noting that when she first joined the LIFE program she went to the ER in pain but this time, the physician, in the ER spoke with a LIFE program physician, for complete review of her status and no medications were made instead, a LIFE nurse was deployed to review her medication at home she was seen by her primary carry
physician the very next day, the Sunday in
the following week she went to Sunday services, and completed her volunteer work at the food pantry.
And that's the story MMabel, in the
integrated carry found myself, last year, in the ER, I have a condition, that makes all of my blood levels abnormal.
But abnormal for me is my normal and no matter how many times I would try to tell the people in that hospital, that this was the case and they kind of understood my condition, they didn't know my personal condition, and they kept trying to treat me.
They admitted me into the hospital they gave me medication that they probably shouldn't have.
One thing led to the other and 15 days later, I came back out, but, had they had my medical records, had they been able to

coordinate with my doctor, I would have been in that ER and back out that day.
>> SPEAKER: Had they listened to you.?
>> PAM MAMARELLA: Had they listened?
>> SPEAKER: They don't.
>> PAM MAMARELLA: They go by a book you know, professional professional and records and -- I think, probably a lot of people, say things that maybe are wrong.
So -- you know I understand how it goes.
As I was saying --
>> SPEAKER: Disabled people don't fit into the norms they don't listen it can escalate quick I've had it happen to me.
>> PAM MAMARELLA: It did, through that process if I had that coordinated care if I had someone who was, helping coach it, it would have been a really different experience and so, you know, professionally I've watched this work for a long time.
But then, personally it happens and you get a whole new kind of passion for moving that direction and making sure that education is in in place and away that people really understand the opportunity that is in front of them when it comes.
So -- thank you.
>> RALPH TRAINER: Any questions.
Go ahead.
>> SPEAKER: Finally.
I think that's I just want to say that's a really helpful narrative to share and, to Jen's point take it away from the statistics an the pie charts to the actual experience of participants I just have a comment about it, which is, I mean, this is exciting because when we have two really really important programs, have been the difference in the huge populations in this country that it can mean, prior to Medicare and Medicaid these populations didn't have the support they need.
The idea they're operating and we're not reaching the realizing the full potential of coordinating between those two programs is obviously a huge gap in the system that everybody is struggling to fix.
I think the stories really do point to how the virtual use, sake will to get created when the programs are working together. When they are integrated rather than siloed.
The one thing I didn't get from either whether the person has

a home care attend and -- didn't sound like
>> PAM MAMARELLA: In in case she would have X amount of home hours us about ad upon her particular case that would be an agreement between the participant Mabel and the interdisciplinary team.
>> SPEAKER: Right just want to highlight this is something that I know -- that attendant or a tentents are hugely untapped -- huge resource in driving the integration of care.
That work force as we know is whatever the model is the participant directed model or agency model or whatever model, you know, unsupported, well enough, but there's, growing evidence that, if we invest in that work force, that -- those attendants that work force can be a key in making sure the integration happens there's been a study that's been going on pilot program that's been going on, about ready to I think in the next two weeks release publically the results of the work that is happening in Los Angeles through a CMI innovation grant.
That -- I have seen, some of us have seen the early unpublished data it's really striking -- that agree to which, enhancing the skills of those front line workers, and giving them some, skills and some baitsic technology, to make sure the flow of information among the providers is actually happening and, in realtime monitoring -- conditioning this those terms -- the excited Regime, can have a hugely game changing impact in terms of lower, ER visits, lower hospitalization and ultimately lower cost and better outcomes is very, very striking.
So I think as we move towards this model its a work force that often gets overlooked, not that other providers on the team, whether the registered nurses or social workers are not important, but the baitsic, that person that is with that, what consumer whether it be 10, 20, 30 hours a week or whatever, is really the front line of chronic disease management and prevention in the system and, it needs to be seen that way.
>> RALPH TRAINER: Thank you.
I have Jennifer and then Scott.
>> SPEAKER: Just following up with what Neil, one of the reasons why I'm very scared to go into a integrated care model I do have a excellent work force does know me very well.
I also have an excellent supports coordinator, under the fee

for service model, that follows up with me every couple of weeks.
If she doesn't hear from me, she calls and checks on me.
She advocates my attendant advocates with my doctors if she needs help my supports coordinator steps into that role.
So that's very important to me.
When we have issues that, perhaps, my supports coordinator, doesn't understand, the agency that I'm with, has a structure in which there's supervisors, to which I can go to, and my supports coordinator, can go to to understand the State regs and understand what is going on in my situation.
I have a whole support team within my supports coordinator.
And the agency in which I work for, that communicates with the State and daily basis, to push things, through for me.
Whether it's my my need for home modifications, my need for more hours I'm just afraid, because I have that experience.
In the fee for service model, I have that experience.
I Noah lot of other people do too.
I think one of the fears that we as consumers have is our supports coordinators, besides our attendances are, are our biggest advocates when it goes for the integrated care model and that goes under the insurance company or the MCO, what is going to happen.
This is not only the supports coordinator that's our advocate, but it's also, we become very comfortable with the agency in which they work.
So we know that chain of command we know who to go to.
For support if they're not available.
We're always encouraged to go like -- there's a supports coordinator on call, 24 hours a day, if we have questions.
So I'm, I have that fear that with we go to an integrated care model, that will not be the case there will not be be that advocate, for me, because they're working for the insurance company and not for an agency, that I've been working with, for the past 20 years have my best interests at heart.
>> JENNIFER BURNETT: Well first let me just say Jennifer I appreciate everything that you said I understand, how important service coordinator is in your life and, the life the lives of our people in our long term services and supports home and community based program, service coordinators, we recognize

they're very, very important.
We also recognize and -- I reinforce, what neil said about the value and the importance of, direct care workers and the direct service work force, in the daily lives of individual whose need long term services and supports at home.
In their nursing home facilities I think they're a work force that really is, across the board, that the work force that teach es the lives of people who need long-term care, on a almost -- usually a daily basis.
So I think it's really important that we pay attention to and, support their jobs as well.
CHC has continuity of care provisions in it for the service coordinator.
And, service coordinator to continue with individuals they for six month continuity of care period, during the -- the managed care organizations are going to need to contract with your service coordination entities in order to continue, to provide, that same service coordinator, over that continuity of care period.
Once the continuity of care period is over, that doesn't mean your service coordinator goes away.
In our meet and greets we did with the managed care organizations over two sessions one in November and one in January, we heard loud and clear that if the service coordinator is working well, is a Dish of value to the individual, they would change that.
That's not something we no disrupt that, that would be very disruptive in a person's life.
So -- we have already know, know that -- it will occur.
And it's going to be up to the service coordinate nation entity and the service coordinator to provide high quality services if at the end of the six months, the MCO, you know works with the individual and finds out that service coordinate entity is not of high quality and, not doing a job the way that they, the individual expects them to do, they may not continue to contract with that service coordinate entity that is going to be up to the MCO.
>> RALPH TRAINER: Let me go to Scott please.
>> SPEAKER: Hi there I want to repeat something I said at the one of the earlier sessions I have heard a lot of the

concerns about skilled nursing centers I understand them I really do.
I think, everybody needs to recognize that the progress I have skilled nursing operators out there, see their roles changing.
I mean very rapidly changing.
90 of our patients go within 20-25 days.
I think the progressive, operators bother for profit and nonprofit out there, understand that the role down the road is going to be short stays, rehab getting people home.
The number of baby boomers that will need skilled nursing is only going up and, we're always skilled to have better coordination to have, the ability to get folks home and, Jen and I, we've had some discussions around how we get folks that really don't need to live in the nursing facility how we get them home and create the insent tips in the system to do that, there's really great opportunities particularly when we start to talk about dual eligible programs.
So, it is something that we actually encourage and, I think we're going to need to look more and more at it, the number of skilled nursing beds is not going to go up and the number of people that are, getting into that, that 75 plus ranges, rapidly going up.
And so, it's -- I think there's a real willingness within the industry to work, make this all successful.
And, understand the goals of getting everybody home and, it's a good thing, coordinate with home care and, and such, so I think that from the skilled nursing facility perspective, I think there's an allias, for it, and not a group pushing against it.
>> SPEAKER: I have two questions one is about -- I have two questions, one to follow-up to Jen's, if the service coordinators that we like, they go through the continuum of care, or continuity of care, if they go through and, they're liked, what happens if they don't meet the qualifications the eligibility to be a service coordinator they don't have those --
>> JENNIFER BURNETT: Incumbent service coordinator they already meet the requirements if they're incumbent service coordinator that is currently working with the individual they're already meeting our qualifications.

>> SPEAKER: The ones they're talking about with having a bachelor's degree and -- --
>> JENNIFER BURNETT: Do you want to talk about that now?
>> AUDIENCE MEMBER: Not really.
[laughter]
>> SPEAKER: My other quick question.
>> JENNIFER BURNETT: We made some changes to it.
Based upon the work that was done by a committee, that met with Ginny recently she is going to be talking about that later on in the agenda.
>> SPEAKER: The other question is for the LIFE program, is that just for over 60?
Is that for any age?
>> PAM MAMARELLA: Over 5 but, the PACE innovation act was, passed, recently.
But now allows the program to be designed for under 55.
I know there's a Pennsylvania provider really itching to get in.
And is going through all the hoop those do that.
LIFE for under 55 soon to be -- hopefully in the State I know it's supported.
>> JENNIFER BURNETT: I would say, in LIFE for under 55 is something we'll take advantage of, but it -- CMS has to go through the regulatory process, to give us the guidance that we need, in the program, outline, that we're going to need, in order to participate.
>> PAM MAMARELLA: Jennifer and Zach.
Then Brenda again on the phone.
>> SPEAKER: My apologize I have to leave to take my daughter to an interview.
>> SPEAKER: I just have a follow-up comment for second Burnett and her staff, I would like to thank the secretary for allowing the 18 to 20 year olds to go into the OBRA waiver even though that's a small population now, it's going to be growing and it will -- it will be -- it is congruent with the governor's goals for employment.
And providing people, the opportunity to go to college, so I I thank you very much for that.
And I would just, really encourage you and your staff, to please I know the RFP is in draft, is still, it still says draft

there's a comment period for that.
I would really encourage you to please not leave the supports coordination decision in the hands of the MCOs, you have our best interests at heart.
Secretary Dallas has our best interest at heart and, you're really committed to he is really committed to allowing us to control this process and really listening, to us.
So I would really encourage you to please consider allowing the supports coordinators who are currently, enrolled in PA, to be supports coordination to be an allowable enrollment with MCOs and for that to be not the MCOs' decision but the decision of the office of long term living.
So that we as consumers, participants, can make the decision, whether to go with our current supports coordinator or, to go with that of the MCO.
If they have a better supports coordination agency or way to do things, then, they can convince us of that.
But until they do so, I know that I would feel a whole lot better about the change if I knew that my supports coordinator, and the agency that she works for, could go with me and I would still have them as an advocate for me and they could still be an enrolled provider, under the MCO.
And that it wasn't up to the MCO, because currently, it feels like, that's a huge piece to me and have it be up to the MCO, is incredibly scary.
>> JENNIFER BURNETT: Let me just respond, the RFP is no longer draft we issued it yesterday we put in the DGS marketplace it's up there it's also on our web site I navigated you to the point where you can take a look at the documents that we have up there.
In one the documents, is called, summary of the request for proposal and agreement.
And that's a pretty simple description what we're talking about, in the large document.
Which is the draft agreement, or the draft agreement and the RFP.
it does describe service coordination, it's going to be the administrative cost in the capitation rate it's going to be what the MCOs are going to be responsible for they have a continuity of care period built in there, service

coordination, is one of the most important services, that they provide and, what Pam was describing earlier, they have a very critical role in the success of the life of the member, their members.
So, um I think they're going to be taking service coordination very seriously.
Again I mentioned the couldn't knewity of care period the service coordinator will stay with you during that period of time you can make the case to the MCO, that is really working well since it sounds like it is.
>> SPEAKER: Jen I put the RFP in the section where they have to talk about service coordination.
>> JENNIFER BURNETT: We asked them to describe what they -- how they would do service coordination these are some of the questions, that we have.
These are all in the RFP you can see those.
What page is that on Pat?
>> SPEAKER: It is on --
>> JENNIFER BURNETT: I can't read them.
>> SPEAKER: Page 21.
>> JENNIFER BURNETT: On page 21 of the draft agreement.
>> SPEAKER: This is in the RFP.
Burp buffer okay.
Page 21 of the RFP, gives you, the information, we'll be asking -- we have asked MCOs to provide to us to describe how they are going to be doing a service coordination.
>> RALPH TRAINER: I have Tanya text and then I have Brenda Dare on the phone.
>> PAM MAMARELLA: And Zach.
>> SPEAKER: Tanya just wanted to second Jen's thoughts and, I -- I agree with the statement too, that the -- in order to find out, from the MCOs if we're going to be able to keep our service coordinators we out there in the western part of the State, which, have yet still to meet with any of them which is odd because we're the first ones that is going to be going through all of this process, as soon as -- I said this every single meeting I'm going to say it again, we need to have a meet and greet with the MCOs, in t western side.
>> JENNIFER BURNETT: Pat that's a take away.
>> SPEAKER: We'll coordinate through the Jewish health care

foundation.
>> JENNIFER BURNETT: Let me say what I talked about at the beginning this is the blackout period, the State can't participate in those meetingses in a meeting like that.
But -- we can ask the Jewish health care foundation to convene it it's a take away from us.
We're in the middle of planning a meeting on housing housing for the South Western part of Pennsylvania.
That Jewish health care foundation is helping us put together.
>> SPEAKER: Do you have a schedule on that?
>> JENNIFER BURNETT: Pat is there a date yet for that?
>> SPEAKER: No.
>> JENNIFER BURNETT: Okay.
>> RALPH TRAINER: We have Brenda on the phone.
>> JENNIFER BURNETT: Brenda on the phone hold on a second let me set it up.
>> SPEAKER: All right.
One of the things I just wanted to reiterate Pam did a really good job of, letting us know what integrated care might look like, I really am concerned about protecting choice for the people who feel like they can't advocate for themselves.
Make sure we have a choice not only of MCOs, and -- Medicare coordinating Medicare plans for enrollment, do we protect our choice to change doctors when necessary?
People need change, if we, if we loose that ability to choice, we depend too heavily on the system, and the MCO to provide for us and not, have the ability to make informed choices ourselves I think we'll be losing soming in terms of quality of service.
Coordination is good, but it's note the end all be all.
And, the other thing I wanted to say, is that, do we have a guarantee that each Regal have at least two MCOs to pick from and what do we do if there are not two that are acceptable after the end of the 60 day, bid process.
>> JENNIFER BURNETT: Yes, that -- we are anticipating, two to five per region.
Or per zone for health choices per zone the minimum is two.
We'll have to go back to the drawing board if we don't get t t two?
>> SPEAKER: Okay.
>> JENNIFER BURNETT: Richard do you have a comment?

>> SPEAKER: I wanted to reiterate, about our a attendants and how they important they are,
to our attendants we have the ability of having the same attendant, or attendants and then, go to the doctors with us and -- go to the different appointments and if something happens for one of those they would be the ones that would be advocating for us, stars getting information to our service coordinator or a doctor or -- whoever we may need to speak to.?
If -- I'm unable to speak someone is unable to speak they can speak for us, they are with us all the time.
I think if you think about them and, how much that -- how important they are and the pay they're getting then, you know, it's important that you know, the pay they're getting should be thought about also in some of the agencies.
Because they're getting like $7 an hour, $8 an hour, you will not get the quality of care moving out you know, you're suggest to getting you know, inadequate help.
>> JENNIFER BURNETT: Thank you for that Richard.
>> PAM MAMARELLA: We have a question from Zach.
>> SPEAKER: I have a question.
The gentleman that just left that was talking about, nursing homes and, how you know, they're trying to work on transition more and more people out.
I didn't want to throw jabs or anything I -- the nursing home industry like they're bottom dollar is have people fill those beds that's what they're in business for, that's how they get paid my question is, how -- what are the centers that will be given if this he they are truly sincere as far as working on getting people out, what would those incentives look like now and when the MCOs come in, what would the extensions look look they're holing people back from doing that.
They're -- I can go for you Noah while and give, plenty of examples how, you know, people want to get out, but there's always, the most honest barriers for them to continue.
>> JENNIFER BURNETT: Yeah, well, you're touching on something that's been -- it one of my career -- something I've tackinged many my career since my first days when I was in college and doing -- being a nurse's aid in a nursing facility I know, I -- I think you just touched on exactly why we're doing what we're doing.

Because, we need this to be better coordinated because people do get stuck.
And, while Jennifer you have things and many of the folk that's are sitting around this room there are people in nursing facilities today, that can't get out because they're stuck.
And, we believe, and -- as Paul said in the research, that has been done in managed long term services and supports we believe in the new e environment managed care cop companies have an incentive to keep people and serve people in their own homes in the place where it's going to be less expensive for them it's going to be better outcomes for the individuals, so managed care companies have a very strong financial incentive, to support people, in their own homes.
>> SPEAKER: What about the barriers that the nursing home industry or nursing homes are going to put up with that?
How do you combat that is this what do we do now?
What are we going to do?
Or are you what are you going to do as a governing body over this?
>> SPEAKER: The barriers, I think, the managed care organizations will have lots and lots of tools, to work on, one of the things we've been doing is really, connecting them, with housers this the State.
We did meet and greets in January and, managed care, we had 13 or 14 managed care organizations there.
They have shown an interest in bidding on CHC and we brought together, folks from the Pennsylvania housing finance agency, housing authorities, developers, who are into housing, and then I just mentioned to Fred we're doing the same thing in the South Western part of the State, something more localized that's just one example how we're expecting anticipating that managed care organizations will begin to work on removing barriers.
>> RALPH TRAINER: Zach I think it's a responsibility of everyone here, to and I don't put a lot of faith in my government a lot, but it's up to me, to make those changes, I see Snickers,.
[laughter]
But -- you know, I've gotten to know you a little bit I can't imagine, you not being vocal in those instances not only for yourself but for the consumers you work with and the people around you when you find that there is a problem, you certainly

met a lot more people in the last few months with this group, that could help you along that way.
So, it's my hope that you'll do so.
Barb you had a question.
>> SPEAKER: Well maybe a comment but a question that I don't think that can be answered.
We have consumers in the community who are scared, particularly, consumers who have high budgets 200, $300,000 a year when they hear nursing home and you have to be -- you're in the community to the point where your costs don't exceed nursing home, the fear they're expressing is, I'm costing more and am I going to have to go into a nursing home they need to have that assurance, somehow, it --
>> JENNIFER BURNETT: It's in the RFP we have language in the RFP off the top of my head, anyone that is in the community, at the implementation of community health choices the managed care organizations are going to be responsible for keeping them in the setting of their choice.
That's in the RFP I don't have the exact language here.
>> SPEAKER: Okay. Thanks.
>> JENNIFER BURNETT: Here it is, okay.
The draft agreement is in section 5 program requirements A, covered services participants living in community of the time of implementation of the CHC in the zone, and who chose to remain in the community, the CHCMCOs must support that choice and support the participants in the community.
>> RALPH TRAINER: Any other questions from members.
>> SPEAKER: This is Brenda I have a follow-up are they going to be required to get people out, who are going to be more expensive once they're in the community?
>> JENNIFER BURNETT: I would think that would be something that they will be working on.
>> RALPH TRAINER: And our job as well.
Burp buffer that's right.
I wanted to just say that the same provision which we call grandfathering exists for nursing facilities for residents of nursing facilities who choose to remain in nursing facilities they will have the same choice we do not want to displace people, through this process.
One of the meet and greets that we had, was a meet and greet

with consumers, and, this was in January and there were a number of consumers that came from nursing if a signatures who were concerned they were going to be kicked out of their nursing facility and one, older woman got up and said I really love where I live infer my community there I don't want to go anywhere, we reassured her she is not going to be required to move.
>> RALPH TRAINER: Jennifer.
Bam max ma'am it happens.
>> JENNIFER BURNETT: Five percent.
>> RALPH TRAINER: Jennifer?
>> SPEAKER: I just wanted to ask a question.
I have not been able to read the RFP yet or, see it and by draft when I said before I just meant that the State is able to make changes to it until the implementation.
But I have a question regarding support brokerage is there any language in the RFP regarding support brokers
>> JENNIFER BURNETT: Not in the CHCHRFP we're contemplating puttest support brokers into the FMS it's something we were thinking about, to support people, to support individuals who are new participant direction don't really know how to hire you know, how to manage, so participants who are new or if a participant, this is an area that we have heard a lot of feedback is missing, so those, those supports brokers were envisioning as someone that is important to, individuals being who are, not used to consumer direction not used to participant direction.?
That's where, that's where you -- you will see that language.
>> SPEAKER: As a follow-up to that.
I would just, really, encourage the State because you can make changes until the implementation, from how I understand it, that's what I meant by draft, to put the language, in that form, for the support brokers because, again, and I'll just echo this again a lot of us are looking for that advocate that is not hired by the MCO.
I see, that being a conflict of interest, if we're going to the MCO, they're the ones that approving our hours we need that advocate whether it be, a support broker or, a service coordinator, that's not connected to the MCO, to provide advocacy won our behalf.
And, I know that you said that, Ginny will be discussing the

new Regs for service coordinators, but I do have the page in the RFP, that addresses that.
That's a little concerning for me as well but I'll wait until Ginny speaks to bring that up.
>> RALPH TRAINER: Okay thank you.
Pam and then we have to wrap it up move on please.
>> SPEAKER: I have a follow-up question to what Jen was saying about, putting the supports brokers in with the FMS.
Would that be a conflict?
Because I see the supports broker is someone who is independent or I don't know how you have it designed.
I guess I need to know how it would be designed because, I see a supportings broker someone who would be a liaison or an advocate between the people who handle the finances and, had the consumer helping them, work together.
So would that be a conflict if it were the --
>> JENNIFER BURNETT: Model of support broker is something that we heard from I believe it was Temple University early on when we first started, when I first started they came in and talked about this idea of having a support broker.
And, actually David Gat es as with him he may be able to speak to it better than me.
We're at the very beginning stages of -- of contemplating this and, but we, would like to make sure that individuals, who are going into the participation -- we're envisioning the support broker not as you're describing it Jennifer, but someone to help a person, who chooses consumer direction to be successful.
That is the role, that we're envisioning a support broker to be in.
So, I don't know how else we would pay for it, but, we were thinking that it could go into a contract that we would have, with our FMS that would be available because it supports the idea of a having a fiscal manager over here dealing with payment, for your individual and then someone over here that helps the consumer be successful in that participant directed model.
David?
Do you want to respond to that is this.
>> SPEAKER: Yeah if I could.
Thank you ralph if I can answer your question Pam.
Actually the person driven services and supports coalition,

support the idea of having supports brokers in the FMSRFP rather than in the community health choices in order to minimize the conflict if it's in the community health choices RFP, then, it would be the managed care organizations who would be hiring and paying the supports brokers which is absolutely not what we wanted.
So that's why, we have supported having it in the financial management services RFP it's got to be in one of the two, in order for supports brokers to get paid.
We felt it would be less conflict, in the FMS, RFP.
>> SPEAKER: Thank you David.
>> RALPH TRAINER: Thank you David.
Okay.
With that being said, thank you both Jennifer and Pam.
For the subcommittee work groups, we did do some discussion about that.
I'm sorry we will have more.
Any members of those groups would like to share their experiences so far?
Except for Fred?
[laughter]
>> SPEAKER: Gee thanks.
Okay.
>> RALPH TRAINER: Okay.
>> SPEAKER: I have -- I would give a further update on the, clinical eligibility determination tool at the next meeting.
>> RALPH TRAINER: Yeah because we'll be further --
>> SPEAKER: When we discuss that feedback today I'll be ready to report out more then.?
>> RALPH TRAINER: That will be great burp buffer okay thank you.
>> RALPH TRAINER: Drew.
>> SPEAKER: I had a question about that, because the -- there's a group that is sort of working more nationally, through Intery, to come up with a supplement to the clinical eligibility determination tool specifically for brain injury and, we have meetings scheduled through you know May.
I think.
And yet, the comments are due March 14th, so there's a mismatch there.

I don't know what to do about that?
>> SPEAKER: Are you on the committee?
>> JENNIFER BURNETT: The comments to the intery tool are due March 14th.
>> SPEAKER: The comments on the CED.
>> JENNIFER BURNETT: CED.
>> SPEAKER: Which includes the intereye tool?
>> SPEAKER: Are you talking about the level of care then you're talking about assessments.?
>> SPEAKER: Yes.
>> SPEAKER: Are you on the committee?
A
>> SPEAKER: I am.
>> SPEAKER: I'm on the committee too I did it by phone I don't know.
Yeah.
>> JENNIFER BURNETT: I don't -- I'm not sure, I'm not really following what your concern is.
>> SPEAKER: Well there's a group that is working on trying to make it the best possible tool.
And, yet the request for comments, has been -- has been asked for by the end of business on 3/14.
The group won't be done its work by then.
>> JENNIFER BURNETT: It doesn't mean that we can't, make adjustments along the way we've got to keep this moving and I this I that was, made clear the first meeting we've got to, we've got a short time frame to turn this around so I mean, I don't -- the questions that you're talking about, I'm not really sure, exactly, so -- but you're saying that, you're in a committee that is looking at best practices assessing for brain injury that committee's work on a national level is not going to be done before the March 14th, is that correct?
>> SPEAKER: That's correct.
>> JENNIFER BURNETT: Okay.
All right.
We'll maybe -- maybe you can think about that.
>> SPEAKER: Going.
>> TOBIAS: Amendments through the years through the weeks through the days of all of this like always but -- is there -- sorry.

There's going to be amendments through the you'res through the weeks through the days as always, some things never change. But --
>> JENNIFER BURNETT: Or they change a lot.
>> SPEAKER: Or they change a lot.
And, I'm going to -- you know, Jennifer I know you'll kill me for this request, but everybody is talking about it I didn't hear anyone bring it up but everybody thinks it's running too ramped we're real really not going to be ready for southwest I'm just telling you what I'm hearing on calls, and discussions.
And I'm hearing it from everybody.
And -- a lot of people I thought would show up and say slow down the way they have been talking I'm telling you is there any way we can slow it down to assure people it's not going to be haphazard it's the last disaster we've experienced people are not trusting that.
It's all going to be worked ow.
>> SPEAKER: Okay.
At this point, there's no slow down we're going to continue as we go.
However, we will have go no go dates along the way, really assessing whether our systems are up to being able to do this. We have safeguards along the way and we will slow it down as secretary Dallas told Generaller if in a private meeting he had with her five months ago, we won't, we won't continue if we're not ready to do it.
>> SPEAKER: Will there be a hot line other something with the State one thing that happened in New York is managed care company just fires someone attendant without all the wrong a assumption sent someone the girl not answer the door it turned into a big disaster and the girl had been with that attendant for years she was a great attendant.?
Managed care company had no familiarity really with the case.
And I'm not saying it's going to be like that, Jennifer I'm sure there's going to be, that one person or that one indent and, that's a pretty serious incident.
>> JENNIFER BURNETT: We will continue our consumer hot line and our provider hot line.
>> SPEAKER: Okay.

>> RALPH TRAINER: Okay.
Fred you had a -- comment.
>> SPEAKER: I was looking at the subcommittee work groups on here and we have the four it seems to me because of the problems that we're having with the timing and everything okay.
Everybody is wanting to do this at 2:00, 2:00, 2:00.
But, I'm looking at this and we have the training work group, the communication work group, with eligibility notices and grievances and appeals, I am thinking that actually, all of those, could probably be put into one because they're all basically -- they're not the same but they're within the same line if you know what I mean.
Is that a good idea?
Badded in W* idea?
>> JENNIFER BURNETT: I think it's too much.
I think we have to have, the communications work group really is going to have a responsibility to help us craft our message.
That is a big job.
And, just to step back for a minute and talk a little bit about, what DHS is planning, for communication -- around communication, thus far, so you've heard a little bit about what the health funders are doing, they're already helping us to convene at a local level they're sort of the, the boots on the ground they're at the local level, we'll also have the DHS, the department of human services press office is in the process of procuring a vendor to develop materials, like they did for health choices.
So that will be developing video, we'll be developing, you know brochures all that kind of stuff, that describes what health choices is we're going to need a lot of help for that and that communication work group is going to help us and this group is going to have to help us when we get this message we'll want to do focus groups with particular kinds of groups Bill white was talking about the message to seniors we would want the message to seniors maybe to be a little bit different than the message to people with disabilities I known.
I don't know what the case is.
But we will be looking to have -- that, communications work group be one of the hubs for helping us to do that, down the road we have not started doing this yet, but our participant

eligibility, currently is very confusing we want to help at least to articulate, what they, what they mean in plain English and sixth grade English opposed to getting just a plain participant eligibility notice that gets generated out of our, our office of income maintenance system we want to have some kind of, explanation what those notices, we won't necessarily be making changes to the notices they have to be approved by CMS but we'll have messaging to explain what it is that you're receiving.
So that is a really, really critical thing.
Training, also, is really critical I don't think that we want to have, one committee that is responsible for both those different things because I think there are different skill sets if you will, and ideas for it.
I would say because the overlap happens because we're trying to make these meetings accessible to the members of the committee, and so we're, scheduling it for the days that you're in Harrisburg, and, overlap is happening, that doesn't mean you can't have a voice.
If you choose to go for example to the clinical eligibility determination work group, because that is really critical right now you want to have, a say in that, but you don't, you can't get to the -- you're also really interest in the training work group, that doesn't mean you can't communicate with the training work groups chair and say hey, I -- these are my ideas what was covered , you can have a conversation with them.
We're trying to be really open about the process and, but, we are limited in the logistics I guess you could say, I mean we could do all our meetings virtually, that's another opportunity that would help, with the timing so we can do them at different places.
But at least for these initial meetings we thought, doing them in association with this is the right way to go abou it
>> SPEAKER: I I didn't understand communications whats so extensive I understand, yeah.
>> RALPH TRAINER: Okay.
I can tell you as chair a lot of emails come by my way I always send them onto the right people of these committees.
So I will try to do my part as well as everyone here, as a committee member, if there's something that comes along that you think would be beneficial to any of these subcommittees please

make that happen.
Okay.
Durable medical equipment -- Jen touched on that earlier.
So it is our great pleasure to have Ginny Rogers to give a presentation on service coordination.
>> GINNY ROGERS: Hi everyone.
I know there's a lot of interest in this topic.
So I just came prepared to talk to you about the process that we used -- to end up with the information, that is in the agreement, that you will read.
There was originally a work group internal work group that met and came up with the original proposed service coordinator will qualifications that you saw in the draft agreement.
That went out I believe in December or November.
So based on that feedback reaction to that, we actually did set up a very small committee made up of individuals from this group we met on January 29th to talk about the qualifications and, alternatives to those qualifications.
We did make some changes to the qualifications, we I think, took away some of the experience requirements.
From what we have proposed I believe there was a five year experience requirement and one we would changed that to 3.
We also, made some additional added some additional information about social services health care related settings.
That kind of information, and -- in addition, the work group had recommended that for the individuals who are currently providing service coordination, who would not at the onset of CHC be able to meet those qualifications they recommended more or less a certification program that existing individuals could participate in, to -- basically become I'm using the word certified but, credentialed to enable them to continue providing services as a service coordinator or a supervisor.
We took that to the steering committee which is made up of DHS and OLTL executive staff who reviewed that information, the group had recommended an example it was a credentialing program, professional service coordinator program which is actually through the American association of service coordinators Ohio State University office of Geriattics and Gerintology, I'm putting this out, this is what was recommended originally and, what the, the steering committee

decided was, that they thought this was also a good idea to allow this opportunity but we weren't going to necessarily adopt one program.
So the language that you see in the agreement, the RFP or the agreement I'm not sure exactly where it is.
But basically, I'll read it.
Service coordinators hired prior to the CHC zone start date must have the qualifications and standards proposed by the CHC-MCOs and a roved by the department.
So we're actually, for those individuals who don't meet the qualifications as described, we're actually, allowing the MCOs to propose what they, the qualifications that they will require, for these service coordinators, and then, present that plan for OLTL approval.
So that is the recommendation of what you will actually see in the document.
Hi cassie
>> SPEAKER: Is there any language -- I don't usually have a mic.?
What I wanted to say is there any language around life experience, for instance, maybe, person who coordinated a lot because they had a family member with a disability or a person with a disability, themselves?
I think, life experience it would really, some sort of language it give credit to to it
>> GINNY ROGERS: There's not actual recommendation to the current recommendations it is pretty specific as it currently exists.
We are assuming that, individuals who -- I'm quite certain that individuals who will be part of this, will obviously have that kind of experience as well.
The people who are currently in the field, that will continue to provide services -- -- who is doing that
>> SPEAKER: There's a ghost we didn't like what you were saying.
[laughter]
>> GINNY ROGERS: Sorry guys.
>> RALPH TRAINER: When you said about the 3 year experience, what is that experience?
Maybe that's something that can help Cassie.

>> GINNY ROGERS: Thank you for that.
At least 3 years of experience in social service or health care related setting.
>> SPEAKER: It's a little different though I mean we did, originally, and the way we were able to hire disabled people, was through life experience.
And -- we want to -- it would be great if we all got an education went to college.
It was head that had way I mean most of it -- had college education but it's going backwards because of the recession because poverty, less people now with disabilities are going to college.
And, they're going to want jobs.
And they're going to need jobs they're probably going to -- many of them are attracted to working in their own community and I just, was hoping that it would be some sort of language safeguarded, directed towards people, like that.
And parents too I know many of the really, really good parents that are great advocates they work out here too.
And they would like jobs.
For instance, we have done an awful lot for many of us before we ever saw our first jobs so you know.
>> GINNY ROGERS: Thank you for that.
One of the things we did hear from folks that participated in one of the last meetings, was, actually from the MCOs who did express that, the experience of individuals that are currently working in the field, and wanting to potentially maintain or keep those that are experienced and are able to do this work, and, I think, that by allowing the CHC-MCOs to propose standards or qualifications and then, submit that to OLTL I think, I'm expecting that we're going to see that an allowance for the individuals that are currently being you know, serving as service coordinators and service coordinator supervisors.
>> RALPH TRAINER: We have Pam and Jennifer.
>> SPEAKER: So that's only, the allowance they can create is only for people that are existing service coordinators, they will not be able to do that for people that would like to bring in?
They have to be the social worker was 3 years experience or --

>> GINNY ROGERS: For people that people in the future, yes. The difference is, the exception we made are for existing individuals that are currently service coordinators or supervisors.
Yes.
>> SPEAKER: You just grandfathered the assisting the people in.
>> SPEAKER: Just one thing, with the -- having the social work degree and 3 years experience it's going to be people that are going to need a higher salary too because you'll not get people right out of college, because you need that 3 years experience.
You'll have to pay a higher rate.
I just don't -- I am having a hard time having to have that high of a degree.
>> GINNY ROGERS: So let me just read for service coordinators must be RN or bachelor's degree in social work psychology or other related fields, and at least 3 years of experience, in social service or health care related settings, except the service coordinators hired prior to the CHC zone start date, put have the qualifications and standards proposed by the CHC-MCOs, and, approved by the department.
Okay.
So, the -- the service coordinators supervisors, this is where I think you were speaking specifically, must be RN or PA licensed social worker or PA licensed mental health professional with at least 3 years of relevant experience except that service coordinators supervisors, hired prior to the start date who have a masters degree but not a license must obtain taken a license within the first year of the agreement and two, must have the qualifications standards proposed by the CHC-MCOs approved by the department.
So, we do have that language in there, for both supervisors and service coordinators for the existing work force.
>> RALPH TRAINER: Jennifer.
>> SPEAKER: I Ginny I want to echo both Pam and Cassie, in saying that when I met with secretary Dallas one of his -- one of the goals for his department one of the thing that he is very concerned about as well as apparently the governor is very

concerned about, is the employment of people with disabilities.
And, one of the things that as Cassie pointed out, one of the things that people with disabilities people with disabilities, have done, is become, supports coordinators, are able to share their life experiences with others.
So, in some ways I think these qualifications are counter productive, to what the secretary is trying to achieve with the employment of for people with
disabilities I know OVR funding has been cut and people with severe disabilities always they saw are not the f focus.
In helping them to get jobs so -- a lot of the people that, could qualify, to become supports coordinators, are not going to have the finances to attend college without the help of OVR.
They're not going to be able to a lot of us are on waivers as well.
So so if -- if there's a requirement there, for a masters degree, and/or bachelors if they stop a lot of people, it may stop a lot of people from achieving that supports coordinator's position, I know from myself, the agency that I work with, has a wonderful supervisor.
She is one of my most favorite people in all of the world.
And she has about 25 years of experience.
in the BHCS service system she came over to the physical disabilities side, she does not have a masters degree.
If you can see here these are requirements come to be I can see her, taking the retirement and instead of going to get her masters degree.
But yet you'll not find a more knowledgeable person to answer questions on either side, she has developed, team approaches, when I I was working she made me part of her team.
She explained waiver regulations.
Unlike anything -- anyone else, I really really encourage you to take another look again I know this is not, a draft RFP in that it's a draft, but, secretary Dallas had assured me that it can be changed.
Up until the date of implementation.
And I would, I would encourage you really, it's hard to go back and take another look at these qualifications.
>> RALPH TRAINER: Jennifer for point of order let me ask this it question to Ginny here, would that individual be one that

would would be grandfathered in.
>> GINNY ROGERS: Sounds like that would be the case she sounds like an excellent service coordinator.
>> SPEAKER: She is grandfathered in, she would not be let in, if the person came in, I think Jennifer's point is, if a people came like that applied today.
>> SPEAKER: That is -- exactly my point.
>> SPEAKER: It's that kind of dedication, 25 years.
>> SPEAKER: Right.
>> GINNY ROGERS: Thank you Jennifer I appreciate it.
>> RALPH TRAINER: Neal and William.
>> SPEAKER: I just -- I guess I'm a little confused.
So the language in the RFP talks about the MCO's is it an understanding that what the MCOs are going to D it doesn't talk about grandmother egg and grandfathering the current service coordinators.
I mean we've all seen I mean, some of us were copied on a letter from NCIL and SILC, there is a large portion of the service coordinators would be displaced an not -- it if those standards were applied and, if -- it sounds like the intent is to grandfather, is that the case?
Or I'm just, I'm just totally not getting it.
>> GINNY ROGERS: The intent is to have the MCOs propose to OLTL, in their RFP how they will essentially decide the qualifications for that group of people.
And --
>> SPEAKER: It's up to them.
>> GINNY ROGERS: That will be submitted to OLTL.
>> SPEAKER: Can I see if I got this, it's up to them, but they have -- it's up to the MCOs they can grandfather people, am I getting that correct.?
>> GINNY ROGERS: Yes.
>> JENNIFER BURNETT: They will.
>> SPEAKER: Or they have to or they will well I'm not sure I understand.
>> GINNY ROGERS: For the first 180 days nothing is going to change with your existing -- providers Okay.
But, following that time period, the MCOs will, be either hiring individuals, that meet these qualifications or proposing and having a aboved, their own qualifications and standards that

they're proposing that OLTL will review, and agree to.
>> SPEAKER: Where is the certification?
>> GINNY ROGERS: Or subcontractor.
>> SPEAKER: Where is the certification that you talked about?
>> GINNY ROGERS: The certification would potentially be one of the options that MCO may choose.
So they may be looking at the existing field and the experience that is out there, and suggest to OLTL in their the RFP they would someone participate in this service coordinator program complete those modules and receive this certification.
>> JENNIFER BURNETT: A certification.
>> SPEAKER: You would be monitoring that real close even their service coordinator, I should just leave it on
my fear is that, like, if there was a shortage of money you know, the MCOs, could just use the hospital service coordinators, they're overwhelmed they're not very good at all.
I mean I've had a million hospital coordinators that is a medical environment and just to assume, that they're going to be great because they have RN degree or they're a social worker that is nuts.
Most of us end up in a nursing home because of their people.
I mean even me I mean I had to fight my way from going in a nursing home even when I had my own apartment, had no intentions because my mom was down at the shore I was 30 years old in rehab the social worker was bent on putting me away I kept having people come to my room I thought I had to go out the fire exit and escape the hospital we've had the experience as disabled people, I'm hoping that someone is going to be looking at their backs, because only reason I'm just saying if they kept it in-house they can keep the money and the money doesn't go out.
And managed care is very good at that.
I just want to make sure you keep a good eye on that.
>> SPEAKER: Once again I think, it is bill from AA, are P the differences between the elderly and the, disabled community the medical model, that qualifications, and RN or LPN or social worker, with a degree, is kind of just standard.
Once again for the elderly community you want to have the best educated qualified people for this very important position.
So I think you struck a good balance you gave the option, to

have current people, grandfathered, but, you're going to have high standards for new people.
And we realize it's not a perfect world.
You know, Abraham Lincoln didn't have a law degree, he did very well.
So, there's no magic bullet but I think you did have a good balance.
>> GINNY ROGERS: Thank you.
>> SPEAKER: Just real quick this is going to be quick we need to have a discussion here, when the MCOs are at the table, on dignity of risk.
Because that is something that young people should never have to give up or old people.
Would know about the right to risk.
>> RALPH TRAINER: Thank you we have Brenda on the phone.
>> SPEAKER: It's Richard.
>> SPEAKER: Richard on the phone.
>> RALPH TRAINER: Still there Richard?
Hopefully you will email us we'll get to hear it.
One pore question, here from Fred.
>> SPEAKER: Yeah.
Yes this is brought to me, about service coordination.
We need, someone suggested that we have someone with experience in independent living on the board who chooses the service coordinators and, to pass and an IL test I mean a -- you know, to -- someone has to be on these boards picking the service coordinators that knows independent living, very well.
And, that would be the type of person that would make a good discussion on the service coordinators.
>> GINNY ROGERS: Thank you.
>> RALPH TRAINER: Okay I'm going to -- I'm sorry Jennifer, we're running out of time I want to let the public have an opportunity to speak.
>> GINNY ROGERS: I am, I do very much appreciate the conversation and I do think that, as we go along I think that there's certainly a role for evaluatetion as well, of -- service coordinators and, look how this precedes.
So we'll look forward to having that conversation further.
>> RALPH TRAINER: Thank you.
Okay.

For the public, if they have any questions, please use the microphone down there at the empty chair.
This is Zachary again.
Basically I'm trying to understand, the gentleman he mentioned how, that the difference between the elderly and the disabled.
I think, like, who would not want the same quality of care in the same education as far as, information that is given.
Whether or not, someone has the degree doesn't necessarily mean that you know they're going to be able to give that information or be able to communicate that information to a consumer.
As long as supports coordinators whomever is going to pass on the information well, that's going to be the deciding factors whether or not they have a did he good owe not I have a degree in busy work in -- you know, IL community.
The two, don't matter but -- two don't add up at the same time, we will give information well you know, advocate well helping people get out of nursing homes and stay out of nursing homes you know just improve their quality of life.
Period.
My I had indication has nothing to do with that my life experience does because I know where -- I know where people are coming from you know, I've been faced with going into nursing home myself I'm eligible like other people are, the education part you know, I don't understand why it has to be such a quality of education versus you know, making sure that people can disseminate the information.
>> RALPH TRAINER: Duly noted.
Okay young man.
>> SPEAKER: Hello, it's a question from awhile back, while one saying about service coordinators having you know, there was poor service coordinate nation in areas and needed more training I was wondering, is there anymore analysis particularly as I'm a member of the training panel, what would like to look at what those gaps are, so we can start to think about it I mean, is it that -- they don't have social work degrees or, or is it some the other aspects of the lack of knowledge or training they need to have.
I hope we can continue to discuss what the qualifications

should be.
And that we don't just see it now as it's done.
I think, I agree with what Cassie, sorry, Zach and everybody else has been saying about this it's not, about you know, at the moment, President Obama could not be a service coordinator he is probably a qualified lawyer he is not going to pass the social work degree you know, this whole lot of people out there, to make some decisions in life, to become excellent what they do.
So, I think we we're closing down the number of people who are going to be, you though look for this job.
We're raising the salary at the same time we don't know whether there's enough people out there, with bachelor's degrees who want to be service coordinators how many, do we know, how many service okayed naturors at this moment in the State have met those qualifications do we have that number?
We have not, why are we making decisions like this, we need to know how many service coordinators we're talking about, it has to be grandfathered in when they leave leave then of course you have to have that social work with the bachelor's degree coming in and we don't know yet, how many people that would be, and I'm just wondering how we make these decisions without, all of that information.
Otherwise you could find that you have no service coordinators or, service coordinator with extra work we can see what we'll have, some of the extra work they will have more clients because there are not enough to go around at that point the quality goes down.
Thanks.
>> RALPH TRAINER: Thank you.
David?
>> SPEAKER: Thanks ralph.
I have a request and a question regarding the work groups.
It appears that a lot of the detailed work on community health choices will be done through these work groups.
I would, I would think, it would be a very useful if we could have reports from the work groups at this meeting as to their progress and exactly what their recommendations are, because I mean I've heard that there are work groups when they're meeting but, I haven't heard much about the actual, results, or the product of those work groups and I think it would be really

useful to hear back of that.
>> JENNIFER BURNETT: We agree.
We're just forming them, I mean it's the formative stages once we have sort of, an ongoing process, that will definitely be coming back to us some of the work groups will be ongoing for years, because, for example, training which Allen just mentioned is going to be something that, evolves and, we're going to recognize the need for training in different areas as this thing gets going.
>> SPEAKER: I appreciate that thank you Jennifer and then, one other specific one, work group question.
There had been a mention earlier on, about a work group, kind of near and dear to our heart on grievances and appeals not specifically the notices but the rights and process how that will work and how that will be attempted to be intergreated with the whole Medicare appeal process which is quite different I have not heard anything more about that whether that work group exists whether there's a chair because we're very interested in that.
>> JENNIFER BURNETT: It does.
It has not gotten formed yet it's on our list of things to do, we wanted to get yesterday's RFP out that's where most of our focus has been.
Seek spooky understand
>> JENNIFER BURNETT: At this point we'll be relooking at some of the thing that have been brought to the table, of interest to people.
Either through this process or, through the questions we receive, or the comments we received in the open process we had for the RFP or the questions that we received and in the MLTSS and the CHC Thursday webinars we get a lot of questions through that process as well.
So there's a lot of ways that we have been learning about what people are interested in immaking improvements to, grievance and appeals is one of them.
I think, we have talked about grievances and appeals, as a subcommittee of the communications work group.
But it's got a lot of nuisances to it.
>> SPEAKER: Right it's more than the notices, okay.
Thank you.

>> JENNIFER BURNETT: Okay.
>> RALPH TRAINER: Neal.
>> SPEAKER: Drew.
>> RALPH TRAINER: Drew.
[laughter]
>> SPEAKER: We look a look that's ok.
I just wanted to raise a separate issue that has not come up today but which we have on the Grange association has written to Jennifer that concerns the access to the waivers during the interim period between now and next January first.
The contract that OLTL has with Maximus has now changed and, imposes a bit higher standard upon Maximus for getting people in the program, which may make it harder for some people who have cognitive impairment to get into the waiver, during this interim period.
So, we would like a special review of the people who are not accepted into the waiver and, with hope that people are not going to be excluded during this period where we're trying to work everything out.
>> JENNIFER BURNETT: Thank you.
>> RALPH TRAINER: Drew do you have any questions you feel?
[laughter]
>> SPEAKER: We have some -- yeah we have some folks from the phone.
>> RALPH TRAINER: Okay.
>> SPEAKER: Okay.
Let's see.
>> JENNIFER BURNETT: Are you going to say them?
>> SPEAKER: Yeah. It's -- it's from the public.
Other than I know that, Richard had some comments I thought I would do his first.
So his comments were related to service coordination, that he feels it's unnecessary for a service coordinator to have a degree when you have qualified and caring coordinators have been working in the system for many years.
It will make it very difficult for people to want to move out because they won't have the service coordinators possibly more than one or two years.
Because they don't pay enough, to keep something, -- keep someone with a bachelors or a masters d degree.

In the supports coordinating agency, like in the Philadelphia area, you may have many people, that have been service coordinators without a degree, that have done a great job for their consumers and a the system seems ton working well, without e stipulatetion, such as a degree.
When I moved out I didn't have the right resource, it took me 15 years to get myself together and I still don't have all of the right information, because I'm still learning as I go without my coordinator.
I would not have made it this far, they play a big part in my life and, OLTL should provide some kind of support team before and after, they move out, although I have done well with my service coordinator.
I think those all from Richard.
And then, Jennifer Pool, had a comment from working with the waivers and then with the LIFE program for over 15 years I see that many eligible folks could qualify, for one of these programs, but won't enroll because of the State recovery program.
Many times an older individual, lives in their home, and sees it as the only thing between their family and won't give it up will the State recovery still exist in the Commonwealth, with CHC and if it does, state recovery needs to be expanded fully to those signing up for HCBS.
>> JENNIFER BURNETT: That's not changed.
That is out of our control.
>> SPEAKER: Federal requirement.
>> JENNIFER BURNETT: Federal requirement.
>> RALPH TRAINER: We have to wrap this up.
>> SPEAKER: Also has a question, when the IEB been Joeling the aging program?
>> JENNIFER BURNETT: April.
>> SPEAKER: Okay.
>> SPEAKER: This year?
>> JENNIFER BURNETT: Yeah.
>> RALPH TRAINER: Okay.
Everyone.
Thank you very much for your a attendance have a great day.
[session concluded]