Date 04/06/2016 Event: MLTSS SubMAAC -Webinar for Office of Long-Term Living in Pennsylvania
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>> RALPH TRAINER: We're going to begin in a few minutes please.
10:00-1:00 OLTL Onsite Harrisburg Transcript
Thank you.
Good morning everyone.
Can I have your attention please.
We're going to begin with the -- roll call -- Pam is running late my co-chair.
If I may can I start with barb go around the table please.
>> SPEAKER: Barb liberty community connections.
>> SPEAKER: Rick Hoffman, sitting in for Tanya.
>> BLAIR BOROCH: Blair, united health care.
>> JACK KANE: Jack Kane.
Could have could have Richard.
Burp buffer Jenn BurnetT if you could, turn off the microphone, there's a limited amount of microphones. Deputy secretary for office of long term living.
>> RALPH TRAINER: Ralph trainer, co-chair.
>> FRED HESS: Fred Hess, disabilities rights advocate.
>> GARY SULLIVAN: Gary Sullivan.
>> SPEAKER: David gates as proxy for Jennifer Howell.
>> SPEAKER: Drew Nagele, brain jury association.
>> SPEAKER: Pam auer, I'm filling in for Theo he may be on the phone, Center of Independent Living central PA.
>> SPEAKER: Ray, UPMC plan.
>> SPEAKER: Diana, I'm filling in for neal.
>> SPEAKER: I'm stu, representing council on agencying.
>> RICHARD DUCKSON: Richard duck son.
>> SPEAKER: Zacharyry Lewis I'm filling for Casie.
>> RALPH TRAINER: People on the phone, please introduce yourself.
>> JENNIFER BURNETT: Tanya hello.
>> SPEAKER: Steve Williamson.
>> JENNIFER BURNETT: Arsen, who is the other one.?
>> SPEAKER: Estella Hyde.
>> SPEAKER: Terry Brennan.
>> SPEAKER: Brenda dare.

Consumer.
Employee of Tri-County patriots of independent living.
>> SPEAKER: This is Jen howell I'm not sure how long I'm going to be able to stay on.
But, I'm an advocate.
>> JENNIFER BURNETT: Okay.
Thank you.
>> RALPH TRAINER: Okay if I may let me go to housekeeping rules.
Committee rules for public comments, we will take them, please be patient.
Thank you.
If you can hear me I'm not muted.
[laughter]
I ask that everyone be polite and you use proper language if you you may be so kind.
The microphones as Jennifer said once you speak please turn them off afterwards.
The captionist is documenting the discussion so please speak clearly and slowly.
Your cell phones please turn them off, for those who are in need of substance, there's vending machines on the third floor we ask you clean up around your area before you leave.
And I'll go over the emergency evacuation procedures.
Run!
[laughter]
>> FRED HESS: Okay.
>> RALPH TRAINER: Okay.
In the event of an emergency or evacuation, please proceed to -- I'm sorry.
>> SPEAKER: Are you able to hear anything.?
>> JENNIFER BURNETT: We're muted.
People on the phone can you hear us now?
Okay.
Sorry about that.
We're just going over some housekeeping here in the room with Ralph, he is going over the evacuation procedures.
>> RALPH TRAINER: Again, everyone must exit the building.
If you require assistance to evacuate, go to the safe area located on the right outside of the main doors of the honors

Suites.
Frank or Janice,
>> JENNIFER BURNETT: Can you hear us?
>> RALPH TRAINER: Okay.
Frank or Janice will be there and stay there, until we're evacuated or permitted to return.
Take your belongings with you and do not operate your cell phones.
Do not try to use the elevators.
Please excuse the interruption please.
Bar the he veilers will be locked down.
Use stare one or stare two, to exit the building.
Stair one is locate open the left side through the main doors near the elevator.
Turn right and go down the hallway by the water fountain.
Sta ir, 2 is on the right side of the room or the back doors.
For those exiting from the side doors, turn left and stair 2 is in front of you.
For those exiting from the front, from the back doors, turn left then turn left again and stair two is ahead of you, please keep inside of the stairwell America to the outside.
Turn left, walk down to Dewberry alley to Chestnut Street, turn left to go to the corner of fourth, street, turn left to Blackberry street, cross Fourth Street to the train station.
All right.
Everybody have that, there's going to be a quiz.
And if I may, add one thing, I want to reemphasize the mission of this committee.
The mission of the managed long term services and supports subcommittee, is to be a resource to the MAC.
Enabling the committee to advise the department, of human services, on issues regarding access, to service.
With that being said, thank you.
And let me find my agenda.
We will turn to Jennifer Burnett for OLTL updates.
You have the floor.
>> JENNIFER BURNETT: Thank you Ralph, good morning everyone.
Ralph just went over on evacuation procedures and when we use

state buildings we're required we have a large meetings like this, we're required to go over them.
So, I say that because, I wanted to just call folks attention to the fact that next month's meeting is not going to be in this room.
It will be over -- be in the Temple University second floor meeting room which is in Strawberry Square.
I think this is the only other meeting we have outside of this room.
That room is not as big.
And we're going to have an overflow room for that room.
So we, once we fill to capacity we'll have people escort people to our offices on the fifth floor, 555 Walnut Street we have conference room A, B and C reserved we'll be live streaming it from there -- the meeting from there.
So if we get, if we fill to capacity in temple we'll have to move people down to the temple -- down to our offices on Walnut Street.
I wanted to mention in terms of going to temple, they have a new -- new security policy there.
If you have not been to a meeting electricity lately.
They do require meeting sign in for people coming into the actual building.
Or to the actual facilities at temple so you have to sign in and get a visitor's badge and, you have to wear that visitor's badge while you're in temple.
But this sign in does not replace our sign in, we need to do a sign in, if you could go ahead and sign in, when you get to the room.
There will be a sign in sheet, someone outside of the room helping people with that.
I mention all this just to make sure people a lot enough time to get through that extra layer of security.
Just give yourself enough time to go over there.
So I also would suggest that if you don't want to deal with going to an overflow room we get to capacity, if you're able to participate by webinar we encourage you to do that.
At the last meeting I already -- I talked about this once again I'm going to quickly go over the status of the RFP and draft agreement.

The proposals are due back May second.
And we did a bidders conference last month and the bidders conference brought many of the people who are -- many MCOs as well as other providers to several hour meetings where we went over questions people had.
A lot of questions we could not answer at the bidders conference.
QA has been prepared and posted on the DGS E-marketplace you can find by Google willing the DGS E-marketplace if you plug that in, you'll find that first one will be to our E-marketplace.
Also, we are posting things on our web site for your information.
If you find that easier to go to.
That is www.dhs.pa.gov and then, that front page of the DHS web site there's a link to community health choices.
Sort of towards the middle of the page.
And once you're in community health choices, to the right-hand side of the community health choices web page, you can see the RFP all the documents related to the RFP are posted up there.
We also -- there's a summary document as well if you find that easier to take a look at.
We also are in what is called the blackout period.
Which means we're not allowed to have private meetings or do anything that is going to jeopardize the offerers chance of continuing to be -- to bid on the project.
So we can't really do any kind of meetings that would give one vendor a leg up over another vendor.
That is sort of the whole purpose of, having this blackout period.
There is an addendum posted that got posted earlier this week.
It's posted to the RFP.
The addendum answered a number of questions that we have received since we posted the RFP.
Made some changes to the RFP.
There's a new definition for actuarially sound rates that's based upon the changes in the regulations we did some clarification, on the requirements of the home and community based settings per the 1915C rule that came out in -- I guess it was in January of 2014, from CMS.

Which provides information about what, or puts forth requirements of states as to what is in an appropriate settings for home and community based services so we put some language in there about that.
We revised the service coordination supervisor requirements to allow more MCO flexiblity to develop those requirements what will be administrative services.
We also revised exhibit A, the managed care regulatory guidelines and we are revising managed care regulatory guidelines has been added we did not have that in our original RFP.
So that's been put forth.
A clause has been added to exhibit EE making it clear that the 18915B and 1915C waiver, waivers are the authority Tatetive source for service definitions no the exhibit.
So the exhibit is not, you'll see that it doesn't have a lot of detail and service definitions in the actual RFP.
That is because, the a authoratitive source is our waivers.
We did that, we don't want to require a contract amendment every time, we change a service definition or add a service.
So that's part of why we did that.
Text changes were made to employment related services to reflect the newly expanded service definition changes included more benefits counseling career assessment and employment skills.
Text changes to therapeutic counseling services to reflect a clarification in the service definition.
And revised exhibit FF, participant rights and responsibilities this really brakes out the participant rights puts it in, readable format, format that moves away from the regulatory citations.
So those were some of the changes that were made through that a tend um.
We're also in the process of working very closely with our partners in office of mental health substance abuse services.
We've begun a process of meeting with them and discussing a number of things to help assure that the behavioral health and community health choices are coordinated and in sync.
We're looking at adding some depression screening types of questions in our clinical eligibility determination.
We're also going to be requiring memorandum of understanding between the behavioral health MCOs and the community health

choices MCOs and we're working on that right now.
That MOU will outline written communication plan for handle requesting individuals' complex needs.
We also, are going to be looking at what kind of data can be exchanged and we'll be required to be exchanged.
And the kinds of confidentiality requirements that those data exchanges will include everything from information about acute care episodes, information about medication regimes.
Those kinds of things.
Payment protocols for complex cases.
How to resolve standard disputes and payment responsibilities.
Those kinds of things will be outlined in that memorandum of understanding.
Currently, my staff and the staff at department of human services and beyond, even the Department of Aging as well and, many other partners that are helping us, are really focuses on participating for the proposal revi review for the readiness review.
And really operationalizing finalizing our, how we'll operationalize this.
The in terms of the preparing for the proposal review we're doing a lot of work to develop our evaluation components.
So those are the kinds of things my staff is working on right now.
I want to talk briefly about the MIPA agreement, which is -- MIPA agreement is the agreement that -- is between CMS Medicare, the State Medicaid office and the managed care organizations it's required under the dual special needs plans and special needs plans in general.
So little bit of background -- to improve -- we're getting ready to post it I want to make folks aware of it they can take a look at it and comment on it.
To improve the integration of Medicare and Medicaid benefits for dual eligibles.
The MIPA, requires the SNPS to obtain the 3 way contract I just talked about.
It requires CMS requires some basic coordination provisions to be in agreement, states can add additional requirements but we have not added a whole lot of -- we've been doing this for a number of years haven't had a really strong agreement, just sort of some basics.

So, it's met the minimum requirements of CMS but we're really trying to beef it up now to require greater levels of coordination and data exchange.
The new beefed up agreement is one way that we're promoting that Medicare coordination that I keep talking about in community health choices.
We are developing this MIPA contract right now we did extensive research on the MIPA cont contracts in other states.
We also had a lot of help from the integrated care resource center, which is a resource center that CMS makes available to states to learn how they can do better integration and better integration of care for dual eligibles.
So through the ICRC or the integrated care resource center, we did -- we were able to get a lot of information about best practices across the country.
So we took all of that and we put together -- we drafted a MIPA contract.
But in terms of what is new in this MIPA contract, although Pennsylvania's is willing to continue the MIPA agreements with all DSNIPS that has a new paragraph, that is going to be affiliated with the CHC, community health choices these provisions aim to make CHC to be a seamless experience for duals who also enroll in both.
Enrolled in both DSNP and the aligned DSN and the community health choices plan.
For example, it requires, CHC plan and affiliated DSNIP assign single point of contact for the member rather than one contact at each plan.
So that's the kind of thing that we're requiring in this new MIPA agreement.
The new agreement also, requires the DSNIPS to submit Medicare reports to the State, this will allow us to see how they're working together.
It will also give us a heads up if it has any problems with CMS.
The new reporting requirements should not add burden to the plans because they already have to submit these things to CMS.
We don't anticipate this will be an added burden to the plan.
I want to talk a little bit about consumer choice this is something that gets brought up whenever we talk about this whole

idea of coordination between the DSNIPS and the community health choices managed care organizations.
The CHHMCOs will require to have a companion DSNIP in the same region of the same, the service area must include the service area of the aligned MCO, CHCMCO as we have said before, we believe there are advantages to consumers, who choose to be affiliated DSNIP including better coordination and less hassle with Medicare copays.
But, consumers will continue to have the choice of the original Medicare, which is fee for service Medicare or, unaffiliated Medicare plan they can choose a totally different plan if they want to.
So that, we can't require them to be in the DSNIP in the community health choices.
So there's still that consumer choice.
If a CHC member does nothing about Medicare default will be to -- be whatever he or she has with Medicare.
We'll not switch them to CHC because they have not made a new choice.
Affiliated DSNPS will be required to work with the independent enrollment entity.
So, it can better counsel community health choices participants on the benefits offered by the DSN, we'll make sure there's information on the IE what the DSNP availability is.
Our next steps, we're working with CMS to approve the outdated version of the MIPA contract, since the new contract exceeds the minimum requirements we hope it will be a roved.
Because we have the minimum requirements what they measure this goes above and beyond.
OLTL, will be posting that revised MIPA agreement on the CHC web site and requesting feedback.
For DSNP want to operate in Pennsylvania, beginning January 1, 2017, their signed contract must be submitted to CMS by July 1, 2016.
So we have just a little bit of time to get all this in place.
The last thing I want to talk with you about, is some -- is, something, that has been brought to my tension there were a number of questions through our question -- the availability of the card to submit questions to us.
Regarding personal assistant services so I just want to go

over some of the pointers on what we're thinking in terms of the personal assistant services.
The Commonwealth is committed to the success of the CHC and November in January and we held these meet and greets as I've talked about, with managed care organizations interested in providing CHC coverage.
Resulting from those meet and greets there have been a number of privately hosted meet and greets with different types of providers.
So we have received a number of comments and requests on assisting providers.
Specifically, personal assistant service agency we the transition to community health choices and we're committed to do that, to make sure there's -- that we assist entities that are moving to community health choices.
The active procurement process as I've told you earlier we're in the blackout period.
We cannot interact directly with managed care organization shall but I want to really emphasize that does not mean, personal assistants agencies or any other providers or individuals that are providing services can meet with managed care organizations and talk to them about what they do and, you know, work with them to engage in business with them.
So there is a list on our web site, where I just told you about.
The community health choices web site there's a list of all of the managed care organizations that have expressed interest in community health choices.
And they have agreed to put all their contact information up there.
So you can get that list by going on our -- DHS community health choices web site and scrolling down there's a place where we have a link that says -- managed care organizations.
I do encourage personal assistants agencies and other types of agencies to go ahead and really begin meeting with managed care organizations that have not already done so.
So you can better understand the expectations of those agencies.
And what managed care will mean for you.
With that I'm going to turn it back over to you Ralph, that's

my update.
Can I just finish one thing.
I had a question when I first got here about what kind of --
if there's a dispute between an individual and the managed --
decision made by the managed care organization.
What kind of recourse does that individual have?
We will have extensive rights and responsibilities as well as
appeal rights through our processes.
The first layer will be going through a dispute process
within the managed care organization.
The second place will be to come to community health
choices, OLTL and then of course we have the Bureal of hearings
and appeals standard process as well.
All of these will be well articulated within the managed
care contracts.
>> RALPH TRAINER: Jennifer I know a few people have some
questions.
I ask that you, identify yourselves so the captionist, can
get your name I'll start with Fred.
I'll go to drew and I think Pam you have a question?
Okay.
>> FRED HESS: This is Fred Hess.
J kept n a lot of people have come up to me and a lot of
people mentioned this, the Maximus took over the aging
waivers they're going to be getting all the CHCs, is there going
to be a readiness committee or something to make sure they can
handle all of this?
That's an awful lot of people really fast I don't want to see
what happened to these guys, that happened to like what was it
Christian financial?
On the FHS.
>> JENNIFER BURNETT: Yeah.
Yes Maximus did take over the enrollment of the aging waiver.
As of April 1st.
It is going very smoothly actually I have a little report
here if you're inte interested.
Okay.
Let me pull it out.
This is Amy Hyde, who is our staff person that's really in
the weeds working with all of the AAAs on this transition.

Because we are in a transition period.
As of let's see this would have been Monday April 4th the last report I got from her.
Approximately 25 email referrals have come in from area agencies on aging they have been dealing with.
Another one from, approximately 10 from service coordination entities and, Maximus is compiling information with regards to voice mails received people were going into voice mail.
I met earlier this week with the Department of Aging and the Pennsylvania association of area agencies on aging and we talked through some of the challenges that were in existence so far we really haven't had a lot of volume.
And we are working very close we one or two of the AAAs did have a very high number of people that were in their pipeline.
And we're working through how that will work.
So it seems like it's going pretty smoo smoothly at this point, we're working very closely with a
number of AAAs to make sure we have a smooth transition.
In terms of your other question of readiness, I had not considered any kind of readiness.
We will be going into a new procurement because there's going to be a lot more needed as you probably know, Maximus is a vendor for health choices and does a tremendous amount of work advising the hundreds of thousands of people that are in health choices on their options for managed care organizations.
So they will be going through a change because the department is in a active procurement for the new set of health choices managed care organizations.
There's actually an open procurement right now.
Maximuus will have to go through changes we'll go through an open procurement process to secure a new vendor for community health choices and, we're going to be calling it the independent enrollment entity and, we have a lot of experience mentioned Christian financial I did not have the -- I was not here for that process
[laughter]
But I've heard a lot.
It has quite a -- it has quite a reputation.
>> FRED HESS: Disaster.
>> JENNIFER BURNETT: I think we learned a lot from it, learned

whatnot to repeat.
So I think there's -- you know, sometimes when you make mistakes you learn from them and we're doing just that.
But we are going to be into a new procurement for it, we'll have an extensive requirements in there, with regards to training, staffing and expectations around volume and problem solving all that.
So we will, we're going to be putting those in our requirements.
>> FRED HESS: Okay.
>> RALPH TRAINER: Drew?
>> DREW NAGELE: Drew Nagele, timetable question more than anything, for the as you start to repurpose the OBRA the independence and the CommCARE waivers you're submitting for public comment the new service definitions and provider requirements.
So -- the period for comment on the OBRA submission ended, I think it was last Monday.
And then the independence came out last Friday.
So, one question is, was there any time to look at the feedback on OBRA to consider that for the independence?
>> JENNIFER BURNETT: Can I table that until, Virginia is going to go to do a presentation on the agenda.?
And she will be able to answer specific questions, such as the one that you just asked she is going to talk to us about what we're doing with our waivers and, give you, sort of some visuals about what that waiver transition is going to look like.
I don't think she is in the room yet.
>> CATHLEEN HOLDSWORTH: One of my concerns with Maximus is capacity, we should consider a capacity review or readiness review.?
Could consumers be part of that, who are members of that committee be part of that?
I'm concerned because, aging is an additional responsibility.
And then, they will be starting with the southwest which is a huge area, and it's not that I don't think that you've learned I'm sure you've learned a lot.
That's just an awful lot.
You know -- number of employees you know.
I do know there's still issues because my girlfriend I mean,

she is -- was in a pretty bad situation it took her almost 9 months to get services.
For me, my own experience of Medicare, it's very complicated. You know you could -- I would end up in CHC even if you wanted to be there, because there's a lot of people come at you to advise you.
Because you have your different brokers or insurance people and, I was hoping that maybe, we could think about navigators, some of the CILs have experience of doing this for almost nothing. But I think they could do a much better job if they were actual positions to help people get these processes.
So someone, doesn't end up, being on some lousey product of Medicare, that -- by default, when they didn't even know. Because it is very complicated process.
It's very complicated for me.
It's just starting to look better.
In the begin egg I thought it was a disaster the copayments were pretty huge but then they started to come down and, you know even reading the paperwork or, trying to get it together for the service coordinator, and I'm sure that, some of this is going to be very complicated to your average consumer I'm not your average consumer.
I just you though, would advise you to consider navigator positions.
Not a top dollar, I know the State is hurting you know -- the budget I know that.
Also, readiness review I think it's really important.
>> JENNIFER BURNETT: Thank you Cassie, all of us experience the difficulties, of navigating through insurance questions.
I know I'm working with my an uncle will of mine who has a lot of challenges and, it is so complicated and, he has normal commercial insurance and head care and even that is a difficult place to navigate.
I you know in hearing your feedback on you know, the independent enrollment entity I would not mind having you know maybe putting on the next agenda or a future agenda, a time for us to just get, you all can think about it between now and then, a time for us to get feedback and ideas for what should go into that procurement, because we're doing a new procurement, it -- your thoughts on how to make the independent enrollment entity

work smoothly would really be, much appreciated.
So maybe we could table that to put it on the next agenda and, you guys can come with your good ideas about how to really make that as -- giving us ideas about what to put into the contract, would be very helpful.
>> RALPH TRAINER: Pam?
>> SPEAKER: My question is what is the update on APRISE have been trained anymore?
Have they been hiring people?
We've been talking about the need to maybe APRISE would not be, us advocates have been concerned about APRISE taking over the education of consumers in picking the program.
And are they able to handle all of that, all of the new people coming in.
And what is their experience working with people with disabilities?
I know you said last time, some do but I've had people tell me they have been turned away, the never 60.
So, what is the plan?
What are they -- when are you moving forward with that is this what is happening with the APRISE counselors can we get other people to help with the system navigators.
>> JENNIFER BURNETT: APRISE the responsibility of the APRISE counselors we have a network of more than 700 I think I'm looking over to my colleagues at PDA is that right?
Network of 700 in the APRIS, approximately, they, they're responsible for advising Medicare recipients not Medicaid per se.
Medicare.
But we do also recognize that the APRISE counselors will run into duals, having to advise duals we intend to do significant training of APRISE counselors they have their annual meeting next -- I guess it's at the end of this month, yeah. Couple of weeks.
And we're going to be participating, doing a community health choices 101 at that, but in the future they will get additional information about it.
The APRISE counselors they're not the -- they're not going to have a responsibility for enrolling people into community health choices.
That's going to be the independent enrollment entity, they

will, have information, lots of information, on what how community health choices works how to get information on community health choices et cetera
>> SPEAKER: Maybe misunderstood, last month, you said they were the go to people, that's the way it came across at the last meeting we are really concerned there are educated committed people, able to handle, Medicare and Medicaid, especially when, the first go around I believe is going to be when people it's open for Medicare -- they can go into another program.
So open rolement.
So, we're really concerned about that population you know, getting these calls from people who are all new to the whole MCO stuff as well.
They want to know how do I pick this person?
They're also dealing with more people wanting information just on Medicare how are they going to handle all this, it goes what they say, is it capacity?
>> JENNIFER BURNETT: Yeah. I will say my experience with the APRISE program is that they are extremely, they are experts on Medicare.
They get extensive training through CMS and through other venues every year because every year Medicare changes.
And so, they have a lot of information about Medicare.
And I would expect that program will continue.
But, and what I said, I didn't mean to imply they would be doing the enrollment or anything like that.
>> SPEAKER: Educating people on choices.
>> JENNIFER BURNETT: Choices of Medicare, that's what they will do, yes.
Then they will know about community health choices and be, if they find, if they're with a dual they would be referring that person to the independent enrollment entity.
The independent enrollment entity is the one that is going to be doing the choice counseling for community health choices.
So, that you know, that's sort of the connection.
>> SPEAKER: It would be IEB is the one doing --
>> JENNIFER BURNETT: I Indepe ndent enrollment entity shall not IEB, procuring a new enrollment entity that will have a broader role, which is very similar to an expanded to the role

of the independent enrollment broker that health choices uses.
So that's that currently, they do enrollment into waivers.
In the future what they will do is is choice counseling.
Choice counseling into what plan you're going to go into.
That's the role they have been successfully completing for health choices for a number of years.
>> RALPH TRAINER: Pam, what I think you're talking about ties well what Cassie was promoting was we'll certainly review this and bring it up, in the future meetings for sure.?
I have a Tanya on the phone but, through technology Fred is going to read her question.
>> FRED HESS: Yes, this is from Tanya, she wants to know if a person is now able to order medical equipment under the waivers and it's independent of the insurance companies.
How will this work in the future the HCOs could be acting as the service coordinator as well.
How will there not be a conflict of interest and how will the process work?
>> JENNIFER BURNETT: We're waiting for managed care organizations to submit bids to us and they will describe how they're intending to do that kind of coordination.
That's sort of what the RFP is all about in the draft agreement.
We have been the expectation we will continue all services that are in all of our waivers in community health choices we will, we'll have an expectation that includes that equipment that you're talking about.
For people in nursing facilities, they are -- there's a program for called exceptional DME if a nursing facility has a resident who needs equipment that is more than $5,000, they can apply to office of long term living and receive a ten thousand dollars piece of equipment if they want to.
And that is a common thing that is happening with nursing facilities.
That program will continue.
So we're going to continue to make sure that we provide durable medical equipment to individuals.
I just wanted to recognize that Pam Mammarella had joined us she had a bought with traffic.

>> PAM MAMARELLA: Yes.
>> JENNIFER BURNETT: Bill white has joined and
Cassie James I'm trying to see if anyone else came.
>> JENNIFER BURNETT: Do you want to respond to drew's
question.?
>> SPEAKER: Brenda dare had a question.
My question is -- can Jen explain anything about what
consumer employers can expect or MCOs going to let us keep
current care workers will they impose any additional regulations?
>> JENNIFER BURNETT: We're not anticipating imposing any
additional regulations.
And, through the continuity of care period we've been pretty
clear that, people can keep the personal assistance workers that
they have currently and the -- we expect that managed care
organizations will be spending a lot of time looking at you know
reviewing that making sure that it's provided with high quality.
Appear
>> FRED HESS: Real quick.
If we, if my attendants go to someone he is, okay, so say for
some reason the people that I have now don't get in.
Are they going to maintain the exact same amount of pay or
the MCO is going to be able to change the pay low error do
whatever they want with it?
>> JENNIFER BURNETT: We have not really talked about a rate
floor but, I -- I experienced another states is that the
attendants get paid more.
So I don't know what is going to happen here.
So we'll have to -- that will be up to the managed care
organizations.
>> SPEAKER: Excuse me.
This is Jen howell on the phone.
I'm having technology difficulties is it okay if I just, ask
a question over the phone?
My question is to follow-up on that topic, what Fred was
saying.
Also, what Cassie was saying, the readiness for the consumer
members of the sub MAAC to be able to participate in the readiness
review for the new independent enrollment entities.
They're going to have so much more
responsibility as to what the independent enrollments have now.

As well as, in the southwest, if I'm understanding it
correctly and please correct me if I'm wrong, the southwest is
starting with community health choices in 2017 in January, 2017.
And then you know, the dual eligibles and the new contract
for the independent enrollment entity, procurement is not
scheduled to come out until the falling
[inaudible]
And then until then, Maximuss, is currently going
handle all of the responsibilities.
And, one of the things that I'm very concerned about is
especially since people that don't have connections to advocacy such as other
people around the table like they're not going
to know what to do.
The practice is confusing, from the people I've talked to and
they will talk to me.
The practice is so confusing already.
I would like to know until the independent enrollment entity,
when the procurement goes out first of all I would like to really
you know, say again, the consumers, maybe on the sub MAAC you not
only need ideas but I think we need to have the respect of being
able to see the a draft of this before it comes out.
Much like UPMS you expect to see a draft of with health
choices I can't tell you how much I appreciate but what a
additional training is the they will get until the procurement
comes out to help people enrolled.
Because they're going to be in enrolling people that are on
that are not only not even on waiver services, but that are just
on Medicare are they not?
>> JENNIFER BURNETT: Okay.
Thank you for that question Jennifer.
As I said earlier, we would appreciate your ideas about what
to put into the procurement.
We have not done anything with it yet.
But it will be something that we're developing.
And this committee is certainly in a position to give us your
good thinking on what kinds of things we need to put, the
requirements we need to put into it.
What are the performance measures we have in terms of
expectations and turn around times all those kinds of things are

input you can give us in order to develop a statement of work which is our process.
We don't do a readiness review when we procure vendors for services like the independent enrollment entity.
But we could certainly take your ideas and come back with our best thinking of where we ended up with the draft statement of work.
And show it to you and ask for your feedback on it.
But we're not going to go through, a large open process, for every procurement that we do because if we ended up going through the kind of open process we went through for community health choices, we would not get much done, it would be very difficult to move forward and impact change.
But we're very interested in your good ideas about what we should be requiring in that contract and, as I said earlier, it would be very helpful we can set aside some time at our next meeting I'll make sure the right staff are here to listen to your ideas and have that interaction.
So thank you Jennifer.
>> RALPH TRAINER: Time for one more question.
Please go ahead
>> SPEAKER: Go back -- to go back on what you said about the 5,000 or 10,000 that will go towards a nursing home --
>> JENNIFER BURNETT: W Wheelc hair -- towards an individual who is living in a nursing home can -- yeah. They would get it, if they ever left the nursing home they take that equipment with them.
It's theirs.
That's their equipment not the nursing homes
>> SPEAKER: My understanding is the nursing homes keep the equipment, such as wheelchairs.
And, equipment such as ECU units, to help you control your bed your television things like that.
When you leave the nursing home, they keep that equipment.
It doesn't go with you.
And there's no one, when I left there was no one to tell me that, that the equipment that I could take that equipment with me.
And I just received that equipment, I've been out for out 20 years I just gotten my ECU unit when I left they kept that.
>> JENNIFER BURNETT: It, Richard, the equipment they keep, when they

leave the nursing facilities have to go through the process of durable medical equipment, it maybe your ECU was just equipment that belonged to the Thursdaying home not to you.
>> SPEAKER: They always use vendors durable medical equipment vendors that will come in, to the nursing home, and, you would speak with them tell them exactly what you needed.
And you would have -- it was a process.
But, you would never leave the nursing home with it.
It wasn't like, it was just someone saying well, you need this.
And, this belongs to us.
Or you reused it from another resident.
You know, brand new.
Always from a vendor.
Outside vendor, that would come in.
And when you left, the equipment would stay with them.
>> JENNIFER BURNETT: We would want to hear about that.
Let me go back to my -- the staff that does this program.
The exceptional durable medical equipment program find out what kind of notices they give when they issue the equipment but I know, for a fact that individuals, the equipment that is purchased, through the durable exceptional durable medical equipment we have at OLTL belongs to the individual whose equipment it is.
I have personally witnessed people taking the equipment home with them.
If we hear about that, we'll, I mean, I would want to know about that.
Either through --
>> SPEAKER: They consider it a loaner, like they consider it a loaner chair if your chair is not ready they reorder you another chair and then that chair is considered a loaner.
You've already paid for one.
The chair when you move out, they say that's their loaner chair, you have to give that back to us.
And the chair that you, we reordered for you which is basically the same chair, is yours.
>> JENNIFER BURNETT: OLTL wants to know about these things if that happens in the future going forward, please make sure, that you get in touch with us, you can call our provider hot line

I don't know, do you know what it is?
Does anyone know what the provider hot line number is?
We'll find out, I'll get it by the end of the meeting.
Okay.
>> SPEAKER: Okay.
>> JENNIFER BURNETT: Okay.
>> RALPH TRAINER: You can contact me as the chair.
I'll make sure it gets through to where it needs to go.
I can tell you, that equipment is yours.
So we'll do our best.
Please can someone turn the microphone off for Richard please.
Okay.
We have a guest here to speak about the managed care experiences.
We have Mr. Mark Gold, Gary Sullivan and patti killings worth, so I don't know how you want to do this
>> JENNIFER BURNETT: We wanted to invite some folks that have been doing managed care in other states to talk with us about their experience of doing managed care in other states.
And first on the phone, we have Patti killings worth she is with the Tennessee I don't know the name of the department, but it's the same authority as office of long term living in Tennessee.
She has been -- she has extensive experience in running Tennessee's managed care program.
And I wanted to patti to spend a few minutes talking about how they do it in Tennessee, then we have Gary Sullivan who is actually a consumer this Tennessee, to talk with us about his experience as a consumer so Patti are you able to pick it up?
>> PATTI KILLINGSWORTH: I am here.
Okay.
Great.
Good morning everyone.
So I'm going to kind of jump in a little bit but please feel free to stop and ask questions whenever, I'm happy to answer any questions at the end too.
Just to give you a little bit of level set, so that the Tenn care program, which say managed care program has been around since 1994.
We have been fully a managed care state since that time with

respect to physical health behavioral health services.
But all of our Medicaid populations have been in managed care for physical behavioral health since 1994, so, everyone, regardless of disability.
You know, in that spirit of the full disclose you're the first ten years of the program weren't prettiy.
We learned an awful lot about how to operate managed care programs and now, have a -- I think very well run managed care program.
But, you know, and we've learned a lot have benefited tremendously from those lessons in the first decade of the program.
The managed long term services and supports program is really a part of our second decade.
That's a good thing because all of those learnings came earlier and were brought to air as we began to implement managed long term services and supports we did that in 2010.
We did that for a number of different reasons.
None of which were really about savings.
The -- we were at a point sort of in our evolution of our program, where we were really looking at what is it that we need to do next.
For all those early years of the program long term services and supports benefits have been completely carved out of managed care.
Although, those individuals were in managed care for their physical and behavioral health.
What we saw, as a result of that, was just an awful lot of fragment taking and challenges with navigating this different service delivery system and some really, unintended misalignment I'll give you an example that.
So you know we had a section 1915C waiver for older adults and adults of physical disabilities that operated on the State wide basis.
And then, again, they received some physical health and behavioral health through the managed care program.
If a person was being discharged from a hospital and a managed care organization, arranged, to have help for them the managed care organization was responsible for paying for that home health benefit.

On the other hand that individual was going to go into a nursing home, there was no cost at all for the managed care organization.
So there was little incentive for health plans to really engage and really help to facilitate the transition to communities.
That's just an example of the kinds of misalignment incentives that we saw and just the challenges that of coordinating those benefits.
So we really wanted to address that issue.
We also wanted to address the fact that even though we had had a statewide, home and transitions services waiver program in place for a number of years at that point, participation in that program was still relatively, low, and we were spending overwhelming majority of our long term services and supports funding on institutional care for these populations.
If we look back you know around 1999, we were 99% institutional, actually more than 99% institutional.
At the point that we actually implemented the program, we were a little -- just to give you, we were a little under 10% hoax and community based services.
More than 90% institutional.
Really spending all of our dollars there.
If you looked at the rankings at that time we weren't just -- we were 51st because we were behind the district of Columbia, in terms of the percentage of money we spent in community first instead of institutions.
We really wanted to reframe our system to focus on community based services to find a better balance how we were spending dollars and to address those coordination issues.
So talking a little bit about where we started with respect to funding, we also were surveying a vast majority of people in institutional settings.
Again a long standing how many and community based waiver program we still had 82% of the people who were receiving long term service ises and supports in this -- in these two populations, who were receiving them in institutional settings and more than 80% of the time, someone came into a system, they were coming in in a nursing home.
They were not coming in the community.
So it was those, the front doors is where they came in.

Then they often tended to stay there for a significant period of time.
We really wanted to be able to change that.
In our home and community based waiver program, that existed before our MLTSS program came up, every time we wanted to be able to serve more people we had get a new appropriation to be able to expand the capacity of that program.
We really believed, there was there was opportunity within our existing long term services and supports budget to really be able to structure that to serve more people and if we could set the system up in such a way that people really understood their choices on the front end, and then we just let the funding follow the choices that people made about where they wanted to receive supports, that we would begin to be able to serve significantly more people without having to go back and ask for new money, basically spending our existing dollars better.
When we brought the program up we did have a waiting list of a thousand people who needed home and community based services.
We had a fairly robust benefits package we carried it forward into the new program.
So really a very seamless hears what your services were before, here's what your services are after.
But really we began to also try to think about how do we increase residential options that are available for people, who are in community, to no longer live alone, don't want to go into a nursing home how can we really begin to build the capacity of the system to do that?
And so, largely the same benefit package, with expanded or more intensive focus on building out the residential continuum.
We did not have any consumer directed options in our existing waiver program.
So that was another piece that we really wanted to build into our managed care program was for the ability for people to direct their own services.
Gary will talk to you a limb bit more about that.
Because he has been a champion of that program, component, really helping it work better for the people who are participating in it.
It's certainly evolved since the program we began.
Tennessee does have one small very small PACE program

operates out of east Tennessee, serving 300 people.
You know it just has not had a lot of impact on the State wide level because it has been such a small focused program within the State.
So a lot of opportunity to really begin to integrate services, and coordinate services and refocus the services on home and community based services.
That was really what prompted us to begin the effort.
So now we are fully, let's see, six years old.
And middle region of the state.
We'll be six years old in the fall as a statewide program.
We've seen some fairly remarkable changes since the program we began.
We have shifted from about 18% of our population being in community based services to between 43-44% of our population being in home and community based service he's.
We have increased just sort of, in terms of raw numbers from about 4700 people to about 13,000 peop people who they have their services
in community.
And a drop of 6,000 people off the Thur nursing home population we're down
from 23,000 to
a very flat 17,000 people in nursing home services.
And some of that has been achieved through transition, really helping people who want to move out of nursing homes and move into community to be able to do that.
And the year before our program we began we had 129 total transitions out of nursing home into the community.
And each of the years since then, it's been in the neighborhood of 600 or so one year we had 740. 740 people who moved out
of nursing homes and into the
community.
And then in addition, to that there's been a concertificatessed effort around diversion and really making sure people understand their options on on the front end.
So where more than 80% of people used to come into long term services and supports in the nursing home benefit that's now less than 50%.

So really changing that trajectory of how people enter the program.
A nursing home has declined when people do need to go in, they're staying there for shorter periods of time really having the help they need to be able to transition back home.
In terms of, expenditures we have more than doubled the percentage of funding that we spend in community and we made significant progress just in terms of how we ranked as a state with respect to the percentage of expenditures in institutions versus community.
So we are 23rd now from 51st over all, specifically for older adults and adults with physical disabilities we're 25th.
So we moved from very last to very middle of the pack.
And then the last two years of reports that have been done, we've been recognized among the top 10 states in terms of our programs increasing the percentage of funding for long term services and supports in community.
So, you know, middle of the pack not where we want to be, much, much better than where we were dead last.
Planning to continue working on that going forward.
So you know, for us I think, our managed care program, has accomplished many of the things that we set out to accomplish.
We have certainly been able to expand access to home and community based services no doubt about it from 4700 to 13,000 people.
We have certainly been able to reduce the utilization or target utilization of nursing home benefits to people who have more needs, more appropriate for that institutional level of service.
And to help people move out of nursing homes when they want to be able to do that and I think one of the statistics we love to talk about is our oldest person to transition out of a nursing home is 101.
So you are never too old to move back to community if that's what you want to do and our longest -- older adult to move out of an institution was there for 20 years before they moved out.
Back into the community.
And our IDD population, our oldest, longest institutionalized was actually institutional alizes more than

60 years was able to move into a community baysed setting.
So -- you know, some great successes there.
We also feel as if it we have a much more coordinated service delivery system.
Our care coordination, component is very strong.
Our expectations are very high and the care coordinator is really responsible for assisting people with their physical health behavioral health and long term services and supports needs.
We saw fairly significant up tick in behavioral health services in the very beginning of the program.
That's a good thing.
Because what it says to us is that, there were needs that had not previously been identified that really need to be identified.
So that people can receive the appropriate supporteds for those needs.
Also, needs with medical supplies with equipment, some of those kinds of things that we're able to address as you begin to coordinate service that's a holistic way.
We're really focused a lot on building expectations and planning processes around employment and community integration.
Making sure that people have opportunities for meaningful activities in the community and meaningful days.
Things that really give them purpose.
And which connect them with their communities so that's kind of the next, level of focus for us.
Clearly we have been able to align incentives in away that didn't exist in the system before.
Our health plans are paid a fully blended capitation rate for people who meet service home level of care they get the same payment for a person in a nursing home as they do for someone in community, that payment is really derived by looking at the historical expenditures for both of the services and then looking at the mix of populations that MCO serves building some expectation how we expect that to change over time but then really incentivizing them to want to put people in the community because they're responsible for the more expensive institutional benefit if the person doesn't have sufficient supports to really remain in the community.

All that has worked really well for us through our money follows the rebalancing demonstration we layered onto our MLTSS program we have incentive payments around transitions, we have incentive payments around helping people remain in community. We also have incentivized participation in consumer direction and now, how about 10% of the population, who is in community actively directing some or all of their services in the choices program.
Some good things that have happened there.
The other thing, I guess, just kind of before I open this up to questions or however Jen wants to handle the rest of this is to say I think when we think about the main thing that's we have kind of learned through the process and we always try to pass along to other states who are on the front edge of implementing a MLTSS the first for us is that engaging with stakeholders in an active way in an ongoing way is just essential to designing to implementing to monitoring to getting it right.
And I know that this is an area where Jen and her team have done a really good job of just being transparent and putting a lot of information out giving people opportunity to review that's so critical, to hear from people in that design process where currently implementing a new program component with intellectual disabilities our stake holder process has literally been more than two years now in terms of getting ready for implementation.
And then, you know, building ways for people to continue to provide input through advisory groups, through regional forums through you know whatever kinds of mechanisms you want to put in place that just ensuring you can always be hearing directly from the people who receive services let them help to get to improve the program I'm grateful for members like Gary who have really you know, Gary doesn't hesitate to tell you when something is not working.
If he didn't do that.
We would not have been able to make some of the changings and improvements we've made over time.
We welcome that and appreciate that.
That is one of the things it's hard to know until you get in the midst of it, managing a managed care program is different than managing other long term services and supports programs.
So in the first ten years I think of managed carry think

one. things that Tennessee learned it takes, an investment in the State's capacity to be able to manage managed care well.
You do have to be integrally involved with what happens with the health plan on a day-to-day basis.
And have the expertise with the systems in place to be able to do that.
I guess, maybe the third and fourth thing all rolled together , that I would say, is that, really knowing what you want on the front end and, having detailed contract requirements and expectations, with enforcement mechanisms and incentives but all of those things still tend toe be really important, combined with a very solid readiness review strategy, to just make sure that, health plans are really ready to do what you want them to do, in the way that you want them to do it.
That is pretty key.
I know that's another area that again Jen your team have been working on it, we've exchanged materials with them I feel confident, that will be in place as you get started.
Jen other things you would like me to talk about.
>> RALPH TRAINER: Patti we're going to take questions after Marc and Gary present as well.
So please stand by.
>> JENNIFER BURNETT: Thank you Patti, we really appreciate your information about Tennessee and, your experience with managed care.
We're going to turn it over to Marc Gold from Texas who also is very involved in the Texas managed care roll out.
>> MARC GOLD: Good morning.
This is always great to be with you all.
I was here I think back in November, and we had a great conversation then.
The purpose of the meeting now is really to get to drill down after what Patti has talked about I've had the good fortune of doing national presentations with Patti she is as good as they come.
What you see with her is what you get.
Certainly the extraordinary job that Tenncare did with using managed care and using money follows the person to relocate individuals from institutional settings to community is nothing

short of extraordinary.
Now we're going to look at from an individual actually using the system it's one thing for state officials to talk about issues but we'll turn over to Gary.
I did spend 30 years in Texas state ten years with the Department of Aging and disability services, responsible for all the activities Texas created the money follows the person and we relocate over 35,000 people.
That was in conjunction also, Texas one of the first states I've been fortunate to be involved in that process, creating one of the first statewide managed care programs for long term services supports known as star plus.
The combination of these factors, work together because of that integration.
I have been with the stores.
So we're going to do today is we're going to have a greater opportunity of talking to Gary Sullivan, this is how we'll go through it.
He is going to give us a little brief review who he is.
Demographics services he is currently receiving.
And his experience where some of the advantages of managed care, attendant care at a very high level.
We'll at a minimum really delve down in the subject matter Patti referred to, service coordination, caregiver supports, enrollment process, consumer directed services, value added services, stake holder engagement, extraordinarily important, community integration and then, Gary is going to give us some of his own recommendations for over all enhancement to quality services and supports then issues raised by you all.
Again, I've done this for a very long time.
And what I know is, this is your meeting we want you to be engaged.
Some burning issue that comes up while Gary is referring we want you to articulate that.
We don't want to lose over the ability to lose the subject matter we'll come back to you in conjunction with Patti to respond to your issues again, we want to be very clear here, Pennsylvania has done such an amazing job, making sure this is your meeting that's the whole reason, Gary we thank him so greatly traveling all the way from Nashville to be here one

little asterics even though I live in Austin I was born and given my elementary education in Erie, Pennsylvania I know that's a lost part of Pennsylvania.
We thought of ourselves as Canada than we did of Pennsylvania my roots are definitely deeply here in the State.
So I would like to start having Gary Sullivan, who I've gotten to know very well.
Extraordinary man, very articulate as Patti said not shy in expressing his opinion, that's the whole point the you don't want to be shy expressing his opinion, Gary if you could sort of introduce yourself, give us a little bit of your personal background.
Program you're enrolled in, and some of the high level current services that you're receiving.
>> GARY SULLIVAN: Good morning, everyone.
I'm very honored to be here I thank Jen and her staff for enabling me to be here and to I have to tell you that, in my former life I was an attorney.
I apologize.
[laughter]
I hope no one holds that against me.
I sat on the appeals court, in Montana for about ten years.
I was their chief justice for six years.
And then one morning I woke up and, I'm on Medicaid program.
Which was a result of a primary rare form of muscular dystrophy I consider myself a constructive quad Dr. meanic I need help with
everything.
I look more able sitting here with my arms up, because, if I'm laying down, I can't do anything.
If my arms are on my side, I have someone come up and pick my arms up.
I do come at it from someone who is very, very disabled.
Basically, I'm a member of the Tennessee state choices program.
There's two phases that institutionalized and nursing facilities.
And, home and community based services.
I have a subset under that, consumer direction.
Which is marvelous program and Tennessee

has done a fantastic job in basically, advancing that program.
Making it, very, very very wonderful, for everybody.
It's really a win, win for everybody.
Because, it saves the State money.
It's actually cost them less to administer to me and gives me far greater flexiblity and control.
By the way, that's exactly what the LTSS community needs is, greater flexiblity and control did I answer any of the questions you asked.
Probably not.
>> MARC GOLD: We're going to get to that, deeper information. Patti is talking she said one of the great advantages of a managed care versus fee for service system, is that coordination, integration, across, what we've heard we've heard as long as old as I am the siloed community shall I would like to talk to you, about your your dealings with the service coordinator, how that process works how you feel perhaps that is, increased your quality of services.
>> GARY SULLIVAN: I did have services by the way under both non-managed and managed care and there's no comparison, the managed care is far superior.
I have one care coordinator, we call the service coordinator, care coordinator and, basically she does everything.
I have just, one person to call no matter what it's for.
I call one person.
Now, there is a -- there's a disadvantage to the MCO and I'll address that a little bit later as far as I'ming too much onto her.
As far as my position is concerned it's absolutely fabulous.
Anything that I need.
I got one person, one phone number and, she knows me, she has come out and initially she evaluated me.
She got to know me.
What my abilities, disabilities are.
Contacts me every month.
Makes a personal visit, every quarter.
She does an annual review.
And, basically, she becomes a friend, part of my family.
>> MARC GOLD: I know you and I had a lot of conversations

regarding I mean, there's certainly one thing that the State can do for you, or something certainly that the managed care organizations can do for you.
There's other activities, you have the other community based organizations for profit, not for profit, can help support you, but I know you and I had a lot of conversations you're real passionate regarding caregiver supports and, all that surrounding the both form form will a and informal supports, please, articulate your feelings about that.
>> GARY SULLIVAN: Well, you know, if I went out and interviewed all of the folks in the LTSS community wherever they are, whatever their condition.
I said if I am your advocate, if I'm going to go and speak for you, on your behalf, what one thing could I do, that would best serve you in the widest sense?
It would be a caregiver.
And yet, look at what we do to caregivers?
They are absolutely you know, the Federal government in its infinite wisdom, classified them as domestic workers.
Well how does society look at domestic worker.
Basically unskilled, uneducated and, unfortunately, they consider them unworthy.
That's the position that they put the caregiver in.
It's absolutely insane because she is is almost the important person, I say she, because 98-99% are women because they have the maternal inconstituent they have it in their heart to care for someone else they need that.
And fortunately I have one right here.
This young lady here to my right.
She has been with me for 3 years.
She becomes a part of my family.
She is, like I say she is the next most important person to me, than my wife.
I don't -- I depend upon her.
And I need to have someone who I can depend on and need to elevate that position.
They need to concentrate on it.
The NCO I'm with, by the way is spending all of 2016, exploring this because I have asked them and they're very responsive, they're going to spend a great deal of time and brain

power on this particular problem.
And it's a real big problem.
It's growing in this nation.
I mean, it's already crisis level it's going to become even worse later on.
Fortunately, we got at least one very big company going to work on this and I'm thankful to be apart of that.
>> MARC GOLD: You mentioned in some of your introductory remarks regarding consumer directed services I'll make the assumption that most people know what consumer directed services are it's a federal public policy.
Many states adopted it, early 2000s.
Where it allows an individual, to do their own hiring, firing of their attendants, some states have different payment structures, some states allow, the money up front, others give it a -- people have an individual budget.
It's different than the agency model that does all of the work and all of the functions and a lot of the supports you mentioned, passionate about consumer directed services and how important that is to you, can you talk about consumer directed services in general?
And then, how it's helped support you?
You mentioned, about caregiver issues, being an issue, everybody knows about finding an attendant all together direct services worker.
I know in Texas I'm probably sure it's true in all of the States in the United States, we say we have a turn over rate of 100% rate.
Turn over rate.
It's chronic and we're lucky to have Gary is lucky to have this young woman with him for 3 years you have this very, very personal relationship with this individual probably knows you better than your spouse does at some point.
So can you talk about some of those services.
>> GARY SULLIVAN: Well, the consumer direction program, is fantastic, in as much as, it allows me toic P my own caregiver, in all due respect to the medications who do a great job, vitally needed they are going to send out anyone, whoever. Whoever is out, whoever is available, sometimes, some of the agencies actually step, they can get a warm body that's good

enough.
Quite frankly, you know, just give you an example of that, one day, I had a young lady come out, she said I -- I said sit down let me explain what we're going to do I'm in bed.
I explained to her, started to explain to her how I was going to get out of the bed, sliding board so forth she said oh, I can't do that because I just had double hip replacement.
She came out to take care of me with a double hip replacement she is recovering from that.
That's the kind of nonsense you run into.
With consumer I haired katie myself I screened them.
One of the qualifications that you have to have, to be in consumer direction is you have to have the adaptation, that ability to screen them, you know to basically, treat them in every way that an employer plea employee would treat someone.
You have that relationship.
I could pay Katie more, unfortunate thing I can't give her any benefits.
You see?
She has no benefits at all.
She has -- she has singer song writer she does quite well on her own.
But she has this wonderful heart, that she is able to do this.
And she really doesn't make any money caring for me, but you see I can still pay her more than an agency could.
And, it's cheaper to the State.
That's the fantastic thing about consumer direction.
Everybody should be there.
They should be moving the institution population to the extent they can, over to consumer direction because that a perfect program.
If there's anything, if there is a utopia or anywhere close to it, that's where it is at, consumer direction.
>> MARC GOLD: That's the biggest endorsement we've been, let me drill down a little bit to that do you have a fiduciary I something to help you prepare the taxes paperwork and for some individuals, that's a very scary thing.
It's like I don't want to deal with that I want to hire and fire a individual, are there any other supports can you do consumer directed services?

>> GARY SULLIVAN: Consumer direction allows me to basically do all of the hiring and firing so forth telling them what to do.
I have no responsibility at all, the MCO and attendant care has a Federal employer agent.
It is usually a nonprofit organization, they come in, they take care of paying Katie, it's all online.
She puts her hours in.
Submits it to me I have an account there, all of my caregivers are there.
I look at you know, what they have submitted.
If it's agreeable, if it's correct, I approve it.
She gets paid no problem.
I have no responsibility I have to worry about any of that.
I do sign a service agreement that basically, eliminates any liability of anyone else, because it's really her and I.
Okay.
So she has any problems she comes to me.
If I have any problems I go to her.
We do not involve attendant care.
That's the way it should be.
Because they you know, they really aren't involved.
They didn't say, she was Okay.
Although, they did a background check.
They do have requirements.
She has to have a CPR, first aid card.
Issued by the American Red Cross or American heart association and they do a background.
I think that's about it.
Pretty much it.
So you know, if she is on a registry that eliminates them unfortunately.
>> MARC GOLD: There's a concept in managed care when we talk about managed care for those of us who work both on the State and outside of the State on these issues, one of the benefits of course is the service coordination piece.
The other piece that, we often talk about, there's value added services.
Value added services, the State as Patti described, attendant care program and Pennsylvania thought it wag going to be doing

the same thing, is known as Capita text ez rate, you do a service you bill for it.
It has the process to get paid.
In a capitated managed care rate what you have is, your actuarials go through the process, look at the historical data and managed care organizations are getting a per member, per month capitated rate, M apt rc gold, they get $100 they would have to take care of all my issues within that $100, whether I move from the community or institutional or, requires some additional behavioral health office ises they would have some certain responsibilities for that.
Some states layer some of the capitation, Texas has 3 or 4, different rates depending upon whether you're getting state plan amendments or waiver type of services, the idea is it's not a fee for service, type of structure.
That's what, in the contract of the State, with the managed care organization, that's what they're agreeing to to pay for all those services, under the capitation.
The managed care organization can provide additional services for the health and welfare of that individual above and beyond the capitation.
They're not getting state funds for that.
This is something they say this will improve the over all quality of the care, either help keep the individual independent, keep them in a community based setting.
They provide those services just to improve, over all quality of life.
So I'm going to address Gary and in saying what sort of value added services does your particular managed care provider, how do you utilize them and what benefit if any, have you seen from this value added service.
>> GARY SULLIVAN: You know I'm not absolutely sure what the you know, what value added services that I have received.
But essentially I have no wants, everything is pretty much paid for.
One of the nifty things about managed carry noticed was this I started getting a little catalog in the mail.
And it had my name and had credits on there.
I have so many credits from this catalog for nonprescription items for things that I would buy in the drug

store.
You know a knee brace, baby aspirin, very you know, cold medicine.
Just things that really, wind up costing a lot of money, could cost a lot of money, but they're free.
Because I have these credits.
That comes I think from the MCO.
My MCO also has a subsidiary pharmaceutical company, and then if I even, one time I ordered a drug there, that was not, was not covered by my plan, and I found out that it was like, $40 cheaper for the one -- I think it was 30 pill prescription -- than any place I could possibly get, Walmart or any other place, simply because the MCO wasn't trying to make money on the pharmacy company it was just a subsidiary, that they had so we could have that value added service.
So I got a very, very good deal even on something that wasn't covered on the plan.
>> MARC GOLD: I would suggest those are value added services because the services that probably are not offered to everyone, through the capitated rate you mentioned to me, please correct me if I'm wrong you also had had post control services.
They are value added services as well as eye glasses, gym memberships -- community integration sort of services.
Can you talk about the pest control services
>> GARY SULLIVAN: It was a great thing.
One of my care coordinators a few years ago, she had a little baby and she brought the baby in, my wife and I have a little place that we have, we live with our daughter and son-in-law.
And, we lived on the lower floor.
House built on a hill.
And the caregiver noticed that there were some sort of pest coming around the window sill.
She was afraid the baby may get bit -- didn't want the baby to be exposed.
She pointed it out to us we didn't know about it.
We called my care coordinator said we have pest control services, they sent someone right out.
Sprayed all around the house and everything.
Took care of it.

Never had a problem again.
Just great.
I mean, now, I don't know what other services are part of the managed care, I would not have gotten if I had not been on the non-managed care I'm not sure.
Gold gold probably big chance -- that's a sort of a traditional value added service, the managed care organization, usually works with the members and, tries to determine what are those extra special services that, individuals may need or, again, health in terms of quality of carry know you're very involved in stake holder engagement, Patti mentioned that the key to any successful new innovation from a state, really is very much dependent on people in the community, knowing what the program is about.
Having a voice.
Having a meaningful voice.
Again, I really do believe the Commonwealth of Pennsylvania has done a tremendous job you know with the sub MAAC meeting with the other meet and greets other avenues they have gone to try to make sure everyone has one, to be knowledgeable.
Two, have some interaction.
I know that you yourself sit on a committee in Tennessee could you talk about stake holder engagement, what Tennessee has done in terms of developing an advisory group ongoing advisory group, how that is structured.
How your feedback, how your issues are presented back to Patti and her staff and areas where you had a significant impact in terms of helping the State do what it wants to do, -- provide good quality services and making sure, individuals needs are met.
>> GARY SULLIVAN: Well, I, right away when the service or care coordinator came out I started mouthing off to her quite a bit, pretty fast.
I
>> MARC GOLD: I can't believe that --
[laughter]
>> GARY SULLIVAN: She said you should be on the advisory committee.
I said, really?
I would be happy to do it.
And so I started going to quarterly meetings that the MCO

held.
I basically what they wanted to do, they were listing you suggestions and anything that you had to say, they were there to listen, I let them have it full blast, they would take to Patti and her group and Patti and her deputy Michelle, both of those are just absolutely accessible to everybody all the time.
And so, we got a number of things changed by that group.
My MCO is a law, in the State of continue ten instituted that as part of their law that each MCO would have the advisory committee meets quarterly.
My MCO went above that, and said if it works here locally let's make it work nationally.
So they invited me to sit on a national committee, they have 3 meetings a year, two by teleconference and one in Washington, DC we meet there in November.
And they have a very, very sophisticated board national advisory board, they include, consumers, caregivers, family caregivers and all of the kinds of folks that work you know in the LTSS community as other stakeholders.
Wonderful.
Last year, for example, all yearlong we I think we focused on quality and how to measure quality.
In other words, that's something when you have a program, you kind of say well you have all these benefits and everything, how are theism packeting the community?
How do you measure that quality?
So they came up with a list of metrics, as a matter of fact I would like to share them with Jen and her group because we have just published a white paper on it.
Absolutely fantastic.
So that's the kind of thing.
That's the impact.
The advantage I think, this I would say, to those who are in the LTSS community, the members I was advantaged because an attorney you don't go into court with just your side you better know the other guide's side as well or better than your own.
So you know what is going to come at you.
So with that in mind, whenever I would come with a problem, I didn't just come from my standpoint.
This is how it's impacting me.

But also, I had to look at it from a standpoint how does it
impact them?
I try to come up with a balanced solution.
You know I would tell them, this is the impact adversely on me I understand what your problems are from your
vantage point I would let them know I knew that.
I would offer a solution.
And when they get that kind of information, they're far more
ready to respond and to react properly.
And in other words, give you what you want.
[laughter]
>> MARC GOLD: You talk about the managed care organizations
having their advisory committees.
Does the State have a separate like Pennsylvania has here,
advisory committee on a regular basis?
How does that work?
>> GARY SULLIVAN: Well the law is, that each MCO has to have
advisory committees that meet quarterly.
And they're educational and of course, you know, they have to
have consumers, they have to have members, that will participate
in it.
That's mandated.
They don't have a subcommittee such as this.
I'm very impressed with this.
We can only imagine that the LTSS community in Pennsylvania
is being served very well.
But the advisory committee, that the MCOs are required to
have you see every MCO has to report back what is happening to these advisory committees that
goes to Patti and her staff, they
get a lot of information from that, a lot of impact.
>> MARC GOLD: Couple more things and your recommendations
and then open up, I would hope, that the committee members have
some questions for Gary that we want to attach.
I would like to talk again, briefly, I'm trying to keep an
eye on the time for enrollment.
Do you remember you've been in the program for awhile how
that enrollment process was?
Was it easy?
Did you have the communication to make a good informed

decision?
Was it was a lengthy process, a lot of back and forth.
I probably said this to the group back in November, I recently had applied for Medicare and it was a disaster.
I mean, here I know, nationally, a health policy consultant, I thought I was going to lose my mind and, become a real Texas an when I had to deal with the front line person.
How was -- how was, I learned lesson was, you go -- you get to the first personally need to speak to your supervisor immediately I went up 3 or 4 levels I got the information I needed.
That's a drag.
How was your enrollment process.
How did it work for you?
>> GARY SULLIVAN: Well actually, it at the very beginning, that was 6 years ago.
And I got a pile of papers probably about half an inch thick I started going through them and my wife, looks over at me she says, well, what is it?
I said, well, I'm embarrassed because I was an attorney for a number of years and, I could not understand a word of it.
I said I don't know.
I just don't know.
There has to be some way, I think, that Patti and her group is working on it.
To condense it down you know?
On the consumer direction program, for example, you get a lot of information, you know, I'm going to hire someone like Kati kept but I think I got 64 pages.
But, most of that, say two thirds or three-quarters of that, could have been condensed into a little handbook.
It was informational.
I just gave it to Katie, said if you don't understand it, I'll go over it with you, whatever, but you know, what she had to fill out, was, relatively simple.
But you see when you get in mass like that, that's a big problem.
But, on the managed care just you know, even though I got half an inch of paper, the care coordinator said you know, no problem we'll take care of whatever you have to do here.

So as soon as she came out got on the job, I was taken care of.
Before that, it was so you recommend, simplify documentation, make it easy.
Were the people for assisting you and enrollment broker or some were they helpful do you have recommendation for is that obviously, a big concern for a lot of individuals here in Pennsylvania.
As it goes into the State -- that initial enrollment process.
It was --
>> GARY SULLIVAN: I didn't understand a lot what they were trying to tell me.
They were using a lot of acronyms -- you know, a lot of alpha bet soup.
I didn't understand what those stood for.
The process itself was not bad.
You remember now, I enrolled first, in a non-you know, in a non-managed care and then a managed care.
When the managed care came along, it was pretty simple.
Maybe it was because I had already gone through with a non-managed care.
But -- I don't think, I don't recall any particular problems, other than the fact that I think a lot of the information could have been condensed and separated out you know --
>> MARC GOLD: You talk about, of course which is very important for any individual, whether you're an individual with a disability or an individual with some level of disability you know, you all have some levels of disability.
Is to be able to be integrated within your community and you know, not only is there laws and requirements about that, the truth of the matter is, that's real life.
How has managed care, helped you to remain integrated within the community, help support the integration within your community, versus just being stuck at the house.
>> GARY SULLIVAN: Well it's opened up all kinds of avenues.
Unfortunately I don't use them because of a very active life otherwise.
I didn't know anything about adult care services.
Or, or -- many of the programs that go on in the community for folks like myself.

It opened up a lot of those, the advisory group, you know basically, has usually someone there, every single quarter, talking about programs that are available and, they pass out information all the time.
So, really would not even know, I would not have a clue what is going on.
Other than the fact that I do have a managed care program, that opens up the pathways to these communities for me.
You know?
I do have my own transportation.
And that kind of thing.
So that in that regard, I pretty much just participate like anyone else does in my community.
>> MARC GOLD: Transportation available to all of the individuals with attendant care?
>> GARY SULLIVAN: It is.
I would not say it's the best.
I mean, it's far better to have your own transportation.
But, if I need to get to a doctor or someplace, it's there.
It's available to me.
But you know, it's like anything you know.
If you order a cab you'll have to wait for it.
but it's certainly available.
I'm not, I don't think there would be anyone in my community that would not be able to go wherever they wanted to go.
>> MARC GOLD: Okay.
I'm going to ask you to sort of summarize and give your recommendations for over all enhancements to the program.
I mean no program is perfect.
Programs are always in a quality assurance mode trying to improve those activities so it's not a discourage Mena tendant care.
What do you recommend?
What do you see as issue areas right now, areas where for needed improvement.
Areas that you think the individuals from Pennsylvania, would benefit from knowing and what you know now, if you knew back then what would be important for the individual sitting here or called in, they need know, as they go forward with their program I though two things that tick you off, I certainly want you to talk

about anything that -- we have not discussed that you think is really important and relevant you did talk about service coordination and they have, two big of a case load.
Caregivers not enough RESPIT and services and supports there.
This is -- we like for you to talk about whatever you feel you need to talk we.
In terms of the improving the attendant care
>> GARY SULLIVAN: Are we going to be here for a month?
[laughter]
No, listen.
Seriously.
>> MARC GOLD: We know about climate change and things are speeding it up there -- so time is limited.
>> GARY SULLIVAN: I can sum it up, just this way if I had the opportunity to go to school, learn all about the LTSS community, if I had 16 PhDs I know everything there is I'm totally healthy I don't really know, what the help it is to experientially to sit in the wheelchair the way we do.
So here's what I would suggest and if you're a policy maker you take this to heart, you'll do very, very well come up with alongside of someone like me or Fred or Ralph, come up alongside look at things from our vantage point, understand all human beings want greater flexiblity and control.
That LTSS community, comes with a lot of limitations to begin with.
So when you set a policy ask yourself one question as your alongside of me -- how is this going to impact Fred?
How is this going to impact ralph, how is this going to impact Gary?
Is it going to benefit him?
Or is it going to burden him?
>> FEMALE SPEAKER: Don't forget the girls.
[laughter]
>> GARY SULLIVAN: Okay.
Fair enough.
What are their names
[laughter]
I may look them up later on.
>> MARC GOLD: That's another discussion.
>> GARY SULLIVAN: Yeah.

But, basically, that's you know, understanding now I this T* was Winston Churchill said ten thousand regulations and people loose all respect for the law.
You'll find yourself in this community working yourself around a lot of nonsensic call insane rules.
What has happened in continue ten is that, Patti and her group, they are very knowledgeable I think Patti, has some experience in her own family of someone who is in the LTSS community.
I know our deputy chief, her husband sits in a wheelchair just like mine.
They understand it.
As best as anyone possibly can, they live with it.
If I'm in this business I'm healthy.
But I know all there is to know about it I come in in the morning I say you know, what is my goal this morning.
Am I trying to prevent fraud waste and abuse?
Is that my primary goal?
Or is my primary goal serving the LTSS community?
I ask myself that question every single day.
Multiple times during the day because I think there's mission -- military calls it mission creep you know, your primary goal is to serve the LTSS community.
But all of the sudden, all your attention is on preventing fraud, waste and abuse.
That's important to do that.
But it's subsidiary to your primary goal.
So keep your focus on that, get alongside of me.
Look at this, and say, is this going to benefit.
What I'm about to institute?
-- the rule I'm going to lay down, is it going to benefit Fred or burden Fred?
That is what needs to be asked every single time
[applause]
>> MARC GOLD: Wonderful.
Before we turn it over, as a former bureaucrat, I appreciate those comments and, that recommendation.
Before I turn it over assuming we want and hope people have questions, both for Gary and Patti is still on the line certainly for patti, we did mention about service coordination you felt

they had the service coordinator had too much to do.
Do you want to just, briefly before that we'll turn it over to everybody else.
>> GARY SULLIVAN: I'm sure Patti probably knows that you know, what I think, I would do if I were in Patti's shoes is I would make sure that there was all of the support system for that care coordinator and make it very, very simple for the care coordinator to get whatever she wants she is called upon to do everything.
So, not to over burden her, she needs to have, access because that's basically what she is giving me.
I'm in good shape as a member.
But her she is not in such real good shape.
So I think getting her support system, now I don't whether that would be go to Patti or the MCO itse itself to have a real good support system for that care
coordinator.
Gold goal Okay.
Great.
So we certainly hope that this has spurred on conversation or thought or issues for Gary and again, P P Patti, is still on the line.
>> RALPH TRAINER: Pam and Cassie just the girls now.
[laughter]
>> FEMALE SPEAKER: Thank you.
We're good.
I have a bunch of questions but, one of the ones that Theo asked me to ask and Jeff at the same time, who are the subcontracting MCOs, CILs active in Tennessee?
Are they part of?
Are they contracted or subcontracting and are they doing assisting with transition and diversions the contractors --
>> JENNIFER BURNETT: Patti that question is for you.
>> PATTI KILLINGSWORTH: Can you hear me?
Okay.
Awesome.
So I heard the question about the CILs, did you also want to know what managed care organizations we contracts with, is that a part of the question as well?
>> FEMALE SPEAKER: Basicall y, what MCOs you're using are the CILs contracting with them?

And the CILs working with you all for transitions and diversions?
>> PATTI KILLINGSWORTH: So we rather than the CIL contracting with the managed care organizations we actually have the direct cont contract.
With the centers for independent living.
And they do assist with transitions, but a big part of the role they play is providing peer-to-peer support for people who are transitioning.
So they actually provide some education and some support in terms of helping people who are in that process.
In our new MLTSS program component, we actually are including some several benefits that are really focused around self-advocacy and including peer-to-peer support benefit that is broader than just transition.
It's also about employment, it's also about more independent care living and directed care centered process.
Those sorts of things we're currently working, the health plans are working with the State wide independent living center to as a potential provider for those services.
>> FEMALE SPEAKER: Can I ask another question.?
>> RALPH TRAINER: One more, we want to get everybody else in.
>> FEMALE SPEAKER: Trying to figure out the biggest one.
I guess, one question that I have and Cassie may want to ask this, I'm wondering if you have community first choice option in Tennessee?
And if so, has this made a difference -- part of the improvements in 2010.
>> PATTI KILLINGSWORTH: As an authority we don't have a community first choice program. In terms of a funding authority.
In terms of what you, the services that would be available under community first choice and how those benefits are administered we offer the availability of the same things essentially within our managed long term services and supports program.
So not surprisingly the most widely utilized benefits that we have in the program is personal care visits or attendant care depending upon the blocks of time that you use.
They can receive those benefits through a consumer direction

model if they choose to do that.
And we also, when Marc talked earlier about in lieu of services, cost effective alternative services one of the things we allow health plans to do in the MLTSS program is to exceed what are otherwise benefit limits for those services when that's determined to be more cost effective than institutional care, that would be required for that individual.
We have a number of people who receive attendant care services, above the level of support that they really need to maintain in the community.
>> MARC GOLD: I want to add in Texas we have community first choice.
Community first choice it's been an year in implementation like all programs it's in the process of being implemented.
The biggest benefit there is, Patti mentioned is the attendant type of service what the program has helped is for individuals with intellectual disabilities, have state service and individuals with IED had never a state IDDE and that type of service before.
And hopefully, that will help get individuals off of our interest list which is about 10-12 year interest list.
Can I ask one question of Patti that was brought into one of the members could not be here --
>> PAM MAMARELLA: Can we hear Cassie's question,?
>> FEMALE STUDENT: I just I like so many things you said, he especially the out-of-pocket, I spend a lot of money out-of-pocket I have 3 disabled people in my family that would be a great benefit to lots of people.
But, one of the things I wanted to ask you --
>> PAM MAMARELLA: Can you move your microphone closer people one enhancement might be if the MCOs pulled together an insurance pool which would allow people that cost more in the community than in the nursing home to remain in the community.?
I know, they're few and far between there are people I've had a few friends very closely living this the community for one they could not position themselves in a wheelchair if they didn't have someone around them they may be under a seat people other people may have been sick on a ventilator I've had people on ventilators have done fine in the community don't cost that much as all.
There are people when they start to get infections they

really need more skilled care around the clock.
Because we had a long history now I mean at least 30 years of taking people out of nursing homes, we often hear from people I would rather die than go back in a nursing home.
And, you know, New York has 24 hour care we don't really have it I mean, we managed to work things together kind of, mostly by the activists by doing what they're not supposed to do, by giving it to someone and seeing what happens.
The bottom line state being kind enough to allow it to happen because it happens.
But that's going to happen for everybody.
You know, we've been really good, we have a systematic way of ensuring that when people, do cost more in the community they can still remain in the community.
It would mean a lot to me, to see that in my life time not for me personally but for the people that you look in the eye and say well, I hope you never go back in the nursing home, don't think you'll ever going back in the nursing home you know, in your heart of hearts that is not always a -- level playing field the other thing I would like that Tennessee did, that I feel very strongly about, that I don't think is happening in Pennsylvania, yet, not because of that but because some of the politics we have in town we really do need to make sure that Thursdaying home and community have equal pay.
Because until that happens, it's almost like sometimes you have to go in to get out.
To get the service package you need sometimes you know, I mean although we're doing good, we have got 51% in the community it is still not perfect.
Until you know, you could be in that SNIP unit you get stuck in the nursing home to get services you need, which is ridiculous.
We've been doing this for 30 years, we could do better I think a real good enhancement would be if the MCOs pulled together, some sort of insurance fund, to make people at risk of being back in the nursing home, not have to worry.
It allows all the MC Os the flexiblity of caring for people in the community because I mean, I'm sure the MCOs have a heart there's nothing more heart wrenching than what you see someone who doesn't want to go in a nursing home, whose been there, go back.

And I don't think that should ever happen
>> PAM MAMARELLA: Thank you Cassie.
>> GARY SULLIVAN: I was going to make one really quick anecdote I have a friend who is a registered nurse she has Multiple Sclerosis she spent 13 years in nursing facility, she is in Tennessee.
She came to our advisory group and she said that she wanted to live out in the community.
And I said, got to be kidding me.
You have to have 24/7 support.
You can't -- she doesn't have the ability that I've got, anywhere near it.
I said you can't possibly want to do that.
And, yet, the MCO, through community living services and this is something that attendant care basically has advanced, they're very bold and they basically made it possible, for she moved in, with another gentleman they got -- they have an apartment and, they have supports not a group home.
But they have support for it and I think if you rather than combine it, the MCOs make them compete against each other.
That's exactly why you have the goods I think the good result from it you have competition.
You have a reason you know to be a little bit better than the next guy.
Keep that going.
>> FEMALE SPEAKER: We had developed clusters here we call clusters what you're talking about.
Maybe you put one high cost person into a apartment, with a person that may need more emotional support, rather than, skilled care support.
Where the other on person needs skilled care so -- in the end they don't look so expensive.
Whatever you can support them all.
And that works very well too.
It's just harder now, in public health I'm from Philadelphia not a rural area I'm from the far area where we have a lot of people living in poverty and stuff, housing is a major issue for everybody affordable housing.
It's harder and harder to get the clusters I mean I used to be, the manager of the developing them I was younger.

It was hard then.
It was like, we did it, somehow we did it I think it could be done now especially with some of the partnerships in housing.
And, I know that Jen Burnett is experienced working with the CILS you've seen the clusters being developed you know the recipe that's a very good recipe.
There might be those people a few people I know, who will never move in with anyone.
And they won't move into probably a subsidized housing.
Not me I don't care where I live as long's got a roof over my head.
You know.
There's those people that you hope would be accommodated one way or another, however people could think it, we need to think about it more I lover the cluster, it work work works.
>> RALPH TRAINER: One more question Tanya is on the phone I would ask anyone other members now if you have any questions please submit it to us we'll make sure Gary gets them.?
>> MARC GOLD: We've got some questions writtens in the text if I may.
One question really did go back to the competition area and the questions so really for Patti.
We know that attendant care CMS requires would be multiple managed care organizations competing in any one local region that is not okay to have one managed care organization, unless you have a certain authority for it.
How is that worked?
In Tennessee where you've had multiple managed care organizations, competing for member services, how is an New Hampshireed?
What sort of assistance are they given to navigate the system to make the ultimate choice.
>> PATTI KILLINGSWORTH: Sur e.
So I will say this is an area from the early years of our program where we learned a lot in the beginning of our program.
We wrote, what was probably not a very robust contract in any one who was willing to sign it, could see a managed care organization and there were lots of them.
Some of them weren't very well equipped or very good at being managed care organizations.

That was not a good thing, either for members or for providers I think, now the place that we have gotten to, since that time, as we do attempt to have a procurement process we're very clear about our expectations.
We have a 600 plus page contract which we, routinely monitor and enforce and we only pick the top 3 plan he's from that procurement process.
So, we want a small enough number of plans operating statewide we can work very, very closely with each of those plans on a day-to-day basis and can monitor and oversee the work that they do on a continuous basis.
So that is very important to us from a quality perspective.
There are also areas where we don't allow the health plans to compete where we really prescribe how things are going to work because we want, the things to be consistent for members regardless of the health plan they choose.
You know, so for example, we don't allow health plans to offer benefits, extra benefits if you will, all of the health plans don't offer, we really want a member's experience to be seamless across the system.
And consumer direction, we prescribe how that competitive program needs to work with all the health plans an develop informational materials standardized to ensure it looks like one experience across the delivery system.
At the point that a member is coming into the program really needing to make a decision about what health plan they want they're coming in through an area agency on aging and disability which is an aging and disability resource center and provides information and assistance to them in making that enrollment decision, we don't use enrollment brokers we utilize what is a local advocacy organization that helps that individual think about some of the things that they may want to think about if they're selecting their health plan.
You know, are your providers in the health plan's network, let's look it up, let's see, do you have Medicare? Do you have a health plan for Medicare?
There are some advantages to having the same health plan for both your Medicare and Medicaid benefits.
Really just kind of helping people think about the things

they need to think about and make that decision.
Then, of course, there's always a period after a member enrolls to change their mind and choose a different health plan.
So, you know there's a period of time afterwards where, they can just call in and make a simple request and change.
There's an annual period every year where people can change or, they can change if there are hardship reasons they need to change even in you know, in between the year period.
So for us we like that process better than enrollment brokers if you will.
We just feel like having an entity that is much more of an advocacy organization helping that person with that decision -- is a place that we're more comfortable with.
>> MARC GOLD: That came from Steve Williams son, there's a question from Brenda dare.
She said that Gary said that, attendant care has a background check for Katie did the MCO have any involvement in the hiring process at all with the background check with any aspect of that and, is the care coordinator, employeed by the managed care organization or is he or she independent?
>> GARY SULLIVAN: Well the --
>> PATTI KILLINGSWORTH: In terms of background checks for people who actually provide supports for workers providers are required to conduct background checks of all staff, obviously health plans don't play any role in that, other than it is a requirement that must be in their contracts with all providers to participate in the program.
And they do, monitor, compliance with that requirement as a part of credentialingly and recredentialing process.
With respect to people who participate in consumer direction, the fiscal employer agent is the entity who actually is contracted to perform that background check on behalf of whatever workers the member elects to hire so, it is a function of the fiscal employer agent not the managed care orga organization.
To perform the background checks.
Yes the care coordinator is an employee of the managed care organization.
I know there are feelings about this across the board.
I will say we feel pretty strongly that's the only model that would work here.

And you know, in order for someone to really be able to effectively coordinate physical behavioral health long term services they need to have knowledge of the services and they need to be able to access the services they need to reach out and access resources within a health plan.
There's no hand offs an opportunity for people to sort of get lost in the process.
And so, we built in lots of requirements to ensure that is objective and fair.
We have monitoring processes that we do people can request an objective assessment if they feel for any reason their assessment has not been appropriately conducted.
But we find that supported coordinators care coordinators who work for health plans are very much the same advocates they are, when they work for other entities who are in the community.
They are there to make sure the person needs are met and they are getting the services that they reality I do need and want.
>> GARY SULLIVAN: Can I just add the Federal employer agent was the one who clears all of my caregivers.?
And I think, it is incumbent, Jen, if the State of Pennsylvania makes sure that in their contract with the Federal employer agent, make sure that they have a specified amount of time to clear that caregiver to pay that caregiver.
Because I know of some plans I've talked to a lot of different states.
Some plans allow 3-5 weeks to clear the person.
Now I can send, if I had 100,000 I could send it to Hong Kong overnight, but they can't clear an American citizen you know, for care giving you know, in what -- a week or two?
They have to understand these young ladies a lot of times, are single moms, they don't have 3,000, 10,000, $20,000 in the bank, they're living paycheck to paycheck.
They have got to be qualified, very U ve very, quickly.
The payroll, by the way, also, can you imagine starting on the first of the month getting your first paycheck on the 30th of month?
I don't think so.
Build in those limitations with whoever is going to screen

the caregivers.
I guess, it would be the Federal employer agent, the FEA.
>> JENNIFER BURNETT: Thank you.
>> RALPH TRAINER: Thank you Gary, very much, very much.
A round of applause for this gentleman please
[applause]
Also, Patti on the phone Killingsworth worth thanks for doing a great job, a round of applause for her as well
[applause]
And Marc, we'll give you the regular send off a round of applause for you too
[applause]
>> MARC GOLD: It's my pressure I certainly hope that everybody learned a lot I know even after all these years I learned a lot.
Pattti thank you.
Gary drove 2 days, two days to go only, Gary you promise to send that white paper to the committee and the committee can help dispurse that information.
These meetings.
Really are, incredibly valuable you're very fortunate to do it and par take of it, thank you very much to everyone who participated it.
>> RALPH TRAINER: Thank you.
Now, because time is getting crunched -- we would like to hear from Jonathan McVeigh, to give us -- sorry.
No.
Virginia?
Come down.
She is going to give us a summary on the CMS authority.
>> VIRGINIA BROWN: Am I on now?
Okay.
And Joergia, -- Brian is.
Okay.
All right.
So -- I guess it's good afternoon everybody.
Thank you for allowing me to come in and give you all a brief update on where we are with the CMS authorities and the waivers that we're planning to submit to CMS for community health choices.
Just by show of hands did anyone here listen to the third

Thursday webinar a couple of weeks ago?
Okay.
So for those of you that did listen, this will be a repeat performance but it will be a fast performance, in *E because of the time.
So Brian why don't we just, move directly to slide 3.
Okay.
So I'm going to skip I think everybody knows what our current system looks like which is, the slide that was directly before this.
OLTL is going to be, operating a concurrent 1915B and 1915C waiver for community health choices.
The 1915B waiver allows for the use of managed care in the Medicaid program through managed care organizations.
And makes the program mandatory for individuals who are eligible to receive services through the program.
The 1915C waiver, allows for the provision of home and community based service on top of those state planned services provided through the 1915B waiver, 1915C waiver services as I said allow for the provision of home and community based services for those individuals who need, otherwise need institutional care.
So those individuals, who are determined to be clinically eligible for the waiver program.
It is also really our goal to have better coordination of care, so the department is planning to use our current statutory authority under Medicare section 1859 the social security act to allow Medicare advantage plans to create specialty plans targeted to individuals with special needs who are duly enrolled in both Medicaid and Medicare and using under the authority the department would use our DSNP contracts also known as MIPPA agreements to link both the Medicare and Medicaid services.
So that's how we're planning to do the coordinatetion of both Medicaid and Medicare.
Through existing statutory authority.
So just a little bit more about the 1915B waiver.
So health choices which is Pennsylvania's statewide managed care system for children and adults, currently operates a 1915B waiver.
It's known as the Pennsylvania 67 waiver or, health choices.

OLTL modeled the community health choices 1915B waiver after the current health choices waiver.
So we took the current health choices waiver, used that as a starting point and made the necessary revisions to that waiver to reflect what we wanted to do in community health choices.
So the provider network standards for community health choices will mirror those that are currently in the health choices program.
The 1915B waiver application requests the authority from CMS for Pennsylvania to mandate participants in community health choices to obtain services through managed care organizations so community health choices MCOs will provide wellness care management and other services that are not available to other Medicaid participants not enrolled in CHC.
So these are services that will be above and beyond what is currently offered through health choices.
And then, waiver participants, in the community health choices regions may only receive services through their CHCMCO.
So that will be different than what our system currently looks like today, where we have, many different providers enrolled in what we call fee for service to provide waiver services, those -- the same waiver services, and in fact additional waiver services will be offered through community health choices but those services will be provided through our network of providers, through the managed care organizations.
And then just I think this is -- this is information you already have, with regard to the populations that are included in the 1915B waiver application.
So, it will be adults, age 21 and older, who require Medicaid long term services and supports.
That's whether the individual requires them or wants them in the community or wants to receive those services in nursing facilities.
And then the other population that will be covered are all dual eligibles age 21 and over, whether they need long term services and supports or not.
So with regard to the 1915C waiver, as we said earlier the 1915C waiver, allows for the delivery of the long term services and supports in individuals homes and their communities.
During the 3 year phased implementation of community health

choices, Pennsylvania will operate a 1915C community health choices waiver in the community health choices regions.
The existing 1915C waivers, aging attendant care and independence and OBRA will continue to operate under what we call the fee for service delivery system, until community health choices is implemented in the respective regions.
I think, this can get a little confusing so I have some pictures in a couple of slides which hopefully will illustrate the what we're talking about a little better.
OBRA waiver will continue to operate as well.
We will continue to operate the OBRA waiver in its current form to accommodate those individuals in the OBRA waiver, who will not meet the nursing facility clinical eligibility criteria for CHC or for individuals who are aged 18 through 21.
So beginning in the spring of this year, individuals that are living in the southwest region of Pennsylvania, who are receiving their services through the OBRA waiver will go through a level of care assessment process.
And those individuals who are clinically eligible we say individuals who are nursing facility clinically eligible, will transition to community health choices.
Those individuals who do not meet that level of care, criteria will continue to receive their services in the OBRA waiver.
And also, individuals that are in the age group that cannot be transitioned to CHC, will be transitioned to the OBRA waiver.
So there will be no loss of services for individuals.
I think I said everything we have up there I can move along.
This is a, just a slide around the HCBS settings rule.
The reason why it's here is that we are choosing to repurpose an existing home and community based waiver to become the community health choices waiver.
The reason why we're doing that, rather than just starting a community health choices waiver -- is because of the HCBS setting s final rule.
Any new waivers that are -- after March of 2014, have to be fully compliant with the HCBS final rule.
If we repurpose an existing waiver, we preserve our transition period through March of 2019.
So we felt that it was probability in our best interest to

preserve that transition period to work through our transition plan that we have approved with the CMS around our HCBS transition plan.
And utilizing an existing waiver.
So in the CHC1915C waiver, there will be a CHC waiver specific transition plan and it will be based on the current OLTL transition plans already approved by CMS.
Just part of the whole compliance with the Federal regulations, we are requiring the CHCMCOs to ensure compliance with any OLTL policies that go out, regarding the HCBS settings final rule as well as the Federal regulation.
So that being said, we have made the decision to repurpose the commcare waiver to serve as the vehicle for the community health choices waiver.
That decision was made for several reasons.
The COMMCARE waiver, first for those who are not aware the COMMCAR E waiver is the waiver that serves individuals with traumatic brain injuries it's our smallest waiver.
It's currently serving just over 700 individuals.
So it has the fewest number of individuals that will need to transition.
When I talk about transition, since we're using the COMMCARE waiver as the CHC waiver, that means, that the COMMCARE waiver cannot operate as it currently operates in the non-managed care counties.
So individuals who are currently served in the COMMCARE waiver in those counties that are not going to be immediately transitioned out into managed care, will need to transition to the independence waiver.
So in the South Western part of the State, individuals in COMMCARE will transition to CHC directly and the rest of the state he is individuals in COMMCARE will transition to independence.
So let's just get back -- move back a little bit.
I was talking about the reason why we were choosing the COMMCAR E waiver it is the smallest waiver, fewest number of people to transition.
The level of care criteria is the same.
So individuals in COMMCARE already meet the nursing facility clinical eligibility criteria.

So they will be very easy to transfer to either CHC or to the independence waiver.
The service package, in the independence waiver is very similar to the COMMCARE waiver with the exception of two services and then, COMMCARE was just renewed last year the time frame, allows us
to line up the 1915B waiver with the C
waiver.
As I said there were two services that are not currently, provided in the independence waiver that participants in the COMMCARE those are residential and structured day services those two services are being added to the independence waiver.
And I'm going to talk more about that
and that amendment in a moment.
Here we have the pictures.
Here's what we're envisioning January 1, 2017.
The 14 counties in the South Western part of the State, which will be the first roll out of CHC.
The two waivers, to OLTL waivers that will be available are the CHC waiver, which will be operated concurrently with the B waiver so it's paired with managed care and then the OBRA waiver will be also operated it will continue to operate the way it operates now.
Individuals who are in the OBRA waiver who are duals, they can receive their physical health services through the CHC managed care organization.
But if they don't meet that NFCE criteria they will continue to get their waiver services, their long term services and supports through the waiver, as they do today.
And the rest of the State, you'll see, we'll continue to operate the aging attendant care independence and OBRA waivers again the same way we're operating them today.
So the next slide shows what we anticipate in January of 2018.
Similar situation of the 14 counties in the southwest.
And then the counties in the southeast that will transition to the managed care delivery system.
The CHC waiver and the OBRA waivers will be operated in those two regions.

The aging attendant care and independence and OBRA waivers will operate in the remainder of the state.
And then in the next slide, you'll see in January of 2019, we'll be down to the CHC waiver and the OBRA waiver and obviously the act 150 program will continue to operate as it is currently operating as well.
It's not paired with community health choices.
So going back to my comment about the independence waiver, we are planning to submit some environments to CMS, to add those two services.
We're also planning to submit amendments to the aging and attendant care waivers.
Those 3 amendments, a notice was published in the Pennsylvania bulletin this past Saturday, and notification went out to our Listserv about those 3 amendments and we have started the 30 day public comment period for those 3 waivers the amendments on those 3 waivers.
So we're currently in the public comment period for those.
I'm trying to remember off the top of my head what all the changes are.
There aren't that many, primarily for independence it's adding the two services.
For the aging waiver it's ating the enrollment broker as the entity that is assisting participants in the aging waiver.
Navigate the enrollment process.
There's a transition plan in each of those 3 waivers outlining how individuals in those waivers will be transitioned to the CHC waiver when CHC comes to those particular counties.
And there's probably something that I'm for getting.
So those waivers are out currently for public comment.
We are anticipating at this point I think we had actually anticipated that the CHC waiver would be out for public comment as well.
That has been delayed and at this point we're anticipating that the notice will be published in the Pennsylvania bulletin on Saturday April 23rd.
Which would again start a 30 day public comment period for both the CHCB application and the CHCC application.
And then our time frames for submission to CMS, is to submit

the 3 amendments.
The aging attendant care and independence amendments to CMS by the end of May and to submit the CHC waivers to CMS by the end of June.
We're hoping for an effective date of September 1st for the 3 amendments and then at the very outset, an effective date of January 1, 2017 for the CHC waivers.
So that's where we're at.
Any questions?
>> SPEAKER: Bill white from AARP I hope there's not going to be a quiz on this Virginia.
[laughter]
>> VIRGINIA BROWN: Someone accused me of speaking a foreign language I'm not very proud of that, I'm sorry.
>> SPEAKER: I know it has to be done but it is, a little complex.
>> SPEAKER: Yes, Virginia on the amendments to OBRA independence and ultimately CHC, what we're noticing is the OBRA comments that were submitted, they were submitted like a week ago Monday.
And then, Friday, the independence came out.
And a lot of the changes that were proposed in the OBRA service definitions are carried over into the independence.
Things like cog rehab and voc resources, they're going to be carried over into the CHC as well?
>> VIRGINIA BROWN: Well here's the thing is that the turn around time for the comments, for the OBRA renewal which was submitted to CMS, last Friday, and the comments that we received, we may -- we did make some changes based on the comments we haved from the OBRA renewal, to get the side-by-sides changed reflected in the side by sides it was -- just impossible.
You're right.
There are some of the same, like for example, I can tell you one of the things that we did make an adjustment to based upon stake holder feedback was around the -- time limitation in some of the employment services.
And we did make that a longer period of time.
I expect that we'll get similar comments on those waivers, that are currently out for public comment, that have employment

services in them.
And we will make sure that any revision that's we make are consistent with what we have submitted with the OBRA waiver.
Or any feedback that we get from CMS.
>> SPEAKER: Right.
Good.
So, any -- so as we're making our comments on the independence waiver amendments, proposed, it will be helpful for us to know what was actually submitted on the OBRA?
Can we see that?
>> VIRGINIA BROWN: We can certainly post what we submitted to CMS on OBRA.
But I would just encourage you to make the same comments that had for -- if you have the same comments.
>> SPEAKER: If you change something we might have a different comment.
[laughter]
>> VIRGINIA BROWN: That's a fair point.
Okay.
Thank you.
>> RALPH TRAINER: I would say --
>> SPEAKER: Same thing happens again when you post the CHC waiver, right -- for the public comment.
>> VIRGINIA BROWN: I think when we -- we have the lag time now between the 3 amendments that are out and the -- well, no you're absolutely right.
Drew, I'm sorry I'm getting confused keeping all this straight.
>> DREW NAGELE: It's hard the comment appeared is the end.
>> VIRGINIA BROWN: CHC waiver will be, will be put out for public comment in the middle of the comment period for the 3 amendments.
But I do hope that we'll be able and I'm pretty sure we have already done so, make the -- made the changes in what we're planning to put out for CHC, so that it reflects what was, submitted to CMS on the OBRA waiver so any of those changes.
Does that help?
>> DREW NAGELE: Yeah as long as we can see what you put out to see it.
>> VIRGINIA BROWN: Yeah we can do that.

>> RALPH TRAINER: I'm going to wrap up with one more question from David here.
And then we'll get to the subcommittee reports.
>> FEMALE SPEAKER: Thanks Ralph.
Virginia you noted that you anticipated there are folks in the OBRA waiver who will not meet the nursing facility clinically eligible criteria, it they will be assessed, there will be a prediction that some folks will not meet that criteria.
I'm going to predict that many of those folks, may will be people on the autism spectrum who have been in OBRA for some years.
I also know that there has been efforts in the past, to move them out of OBRA, is there any anticipation of once again trying to remove the folks who are on the autism spectrum out of the OBR A waiver
>> VIRGINIA BROWN: At this point in time, as we reported, that we're primarily looking at we'll be a reassessing as CHC rolls out across the State, for with the purpose of transitioning people to the CHC waiver.
>> SPEAKER: I'm not with those who don't meet NFCE.
>> VIRGINIA BROWN: They will continue to be served in the OBR A waiver.
>> RALPH TRAINER: Thank you very much Virginia.
>> VIRGINIA BROWN: Thank you Ralph.
>> RALPH TRAINER: To my subcommittee chairs if it's okay with you, could you just send me a report of your progress on your subcommittees for the benefit of time because we want to allow some public comm comment to take place is that okay with everybody.
Okay.
No occa objections.
Thank you very much we'll open the floor for public comment, please use a microphone at the front of the table there and if people are in a wheelchair, please move that chair for them.
Thank you.
No comments?
No questions.
Go ahead.
You're up Jack.

>> SPEAKER: It's a fight for the the microphone.
>> AUDIENCE MEMBER: Two comments.
One on the Tennessee model.
A lot of people are getting out which is very welcome.
Where do they go and how did the people in Tennessee create the housing for those people to go and live in.
On the second one just a very quick one on Act 150 how are they going to be enrolled in the roll out area?
>> JENNIFER BURNETT: We made a decision after the discussion document, was issued in June of 2015, we got public comment on that to eliminate Act 150 in the community health choices it's going to continue to operate as a fee for service as it operates today.
So, it will not be -- Act 150 will not be changing.
On the housing -- how did Tennessee create housing?
I'm not sure.
I don't know, Patti are you still on the line?
I think she has left.
So I will ask her though and I'll bring it back to the committee the next time we come back.
I'll talk to her about what they did, to stimulate housing.
I know Pennsylvania is very actively working the department of human services very actively working with our partners that make affordable housing available such as Pennsylvania housing finance agency the department of community economic development and the public housing authorities across the State and to that end on Monday, in terms of that goal of creating affordable accessible housing for people, the secretary appointed an advis er on Monday, Ben Laudermilk, who started in the secretary's office his job is to coordinate housing for consumers in the department of human services programs.
And the secretary is getting ready to issue a housing plan that Ben will have responsibility for overseeing.
So you'll be hearing a lot more about housing we can bring Ben to this committee if that's of interest to folks?
And he can kind of talk us through this housing plan that has been put forth and, so housing is very much on our radar.
>> AUDIENCE MEMBER: Just to be clear, how does someone who how does someone become eligible for Act 150 next January let's

say, who helps that person, you know, you know, how does that person enter the Act 150 scene if it's not going to be part of this new thing?
>> JENNIFER BURNETT: It will be, I think they will continue to Ginny, independent do you want to respond to that? I'm sorry?
>> AUDIENCE MEMBER: Someone going through the process will continue through the enrollment broker, if they're eligible for Act 150 they would then be enrolled in Act 150 and, receive choice of service coordination and receive those benefits.
>> JENNIFER BURNETT: Just for people on the phone. Ginny Rodgers indicated Act 150 will be enrolled through the independent enrollment broker as it is today they will be enrolled into Act 150 and receive service coordination services from the service coordinators that are available.
>> RALPH TRAINER: Zach?
>> AUDIENCE MEMBER: Add I liked having Gary here we had Gary couple months ago.
So I kind of heard all that stuff.
But, I got a better understanding it seems as though Tennessee was moving more towards where Pennsylvania already is or where our focus on the social model of disability and, one thing that I didn't hear, because I asked him before was, did he have choice on who his service coordinator, could be if it wasn't through the MCO?
So I definitely like to got more answers on that one, as we're bringing in the MCOs, you can see that we are already, where other states are trying to get to.
I want to make sure we don't go backwards towards the medical model where we're still getting input, from our consumers as, Gary said you know, stakeholders this is what we're already doing, as long as we continue to move forward, I think we'll be just great.
So make sure that they say shall oh, I think two MCOs per region is not enough I think we should have a lot more maybe 3 or 4 that's not enough choice.
Thank you.
[applause]
>> RALPH TRAINER: Agreed.

Jeff?
>> AUDIENCE MEMBER: This is Jeff Eisman from PA SILC one issue I didn't hear addressed is what is going to be the role of the MCOs in terms of supporting individuals with employment? That's something to consider for a future webinar and particularly since the governor announced the employment first initiative and there's going to be legislation I think to help show what that looks like it might be something for this group to consider.
Particularly with the move towards community and integrated employment thank you.
>> JENNIFER BURNETT: I would just say that we are including expanded services in our waiver, as I said earlier the waiver for the a authoratitive source for the definitions.
We would have expectations in the innovation part. document, RFP document the draft agreement document we asked them to describe to us how they're going to deal with employment.
>> RALPH TRAINER: I can say personally the MCOs I've talked with, have met with me, employment was certainly one of the topics they were interested in so forth, how we're moving consumers into that.
Okay.
Pat has a question.
>> AUDIENCE MEMBER: I have 3 from folks on the phone, first is -- will the proposal review evaluation component, include evaluating MCOs, LTSS performance in other states.
>> JENNIFER BURNETT: I will put that forth as a suggestion. Can you send that to me.
We'll put that forth as a suggestion we don't have, we don't have definite evaluation criteria, that's one of the thing we're working on, those kind of suggestions are very helpful.
>> AUDIENCE MEMBER: The next question is from Peter, what agency is overseeing maximus distribution of new cases to supports coordinators, who is watching for a fair distribution of new cases?
>> JENNIFER BURNETT: Oltl is.
>> AUDIENCE MEMBER: Then from Dennis Kane, what trek recording capabilities will be required for medical skilled nursing, shift care nursing home care providers?
>> JENNIFER BURNETT: I'll have to ask the people that are

really in the weeds of operations.
I don't know.
>> RALPH TRAINER: Okay.
Please come forward.
Please.
>> AUDIENCE MEMBER: Hi, I'm shape Covach, health partner plans in Philadelphia I want to thank everybody for all their commentary it's great Marc, appreciate all the work you're doing one thing I've been noticing as a big part of the conversation is the initial enrollment into the program through the office of income maintenance.
And, I have experience with the DHS that was my previous job in Philadelphia.
I know how difficult and confusing it could be for individuals to get enrolled to get the coverage that they need.
So, maybe a big topic of conversation at the next meeting or a webinar could be how an individual actually goes through the steps of you know, where they go to what office, who they talk to, if things change who they need to contact, because one minute someone can be healthy and fine the next minute they can be you know, bedridden or in a wheelchair that's very scary if you don't know who to reach out to, who to contact, so -- that's just a recommendation.
>> JENNIFER BURNETT: Thank you.
That's a great recommendation.
>> FRED HESS: I got a real quick comment.
At my Center of Independent Living I'm not sure about all of the centers but at my Center of Independent Living we actually do have someone on staff that helps with transitions.
Okay.
And I'm hoping that is going to continue, and not get taken away from them, because they really know what they're doing and I heard conversations earlier about well, you know, we didn't know who we were going to you know, not who, but -- some earlier about not you know -- enrollment brokers doing it and the MCOs doing it and this and that and the other.
Just leave it alone, leave the CILs to do it.
>> FEMALE SPEAKER: Whatever happens it's a core service it's a Federal mandate.
>> FRED HESS: It's not just the transitions okay for me I

wasn't in a nursing home.
I was in my own -- and it still had someone come out and talk to me got me hooked up with Maximus, that's what I'm talking about
>> FEMALE SPEAKER: Are you saying --
>> FRED HESS: It's not a transition.
>> FEMALE SPEAKER: You're saying benefits people people know it all, that lady from the county you were talking about.
>> FRED HESS: We've got someone on our staff that will go out, they came out and signed me up and showed me, you have this, this, and this -- that you can get services from this company, to that could be your service coordinator she explained the whole thing to me, she helped me sign up through Maximus the whole bit we have someone at our center that does it, everybody should have one and, that would help out a lot and -- it would help out the consumers.
>> FEMALE SPEAKER: Nice to be paid for it, but it's a core service.
>> FRED HESS: She gets paid for it but she is not getting compensation from the State or feds.
>> FEMALE SPEAKER: Exactly.
>> JENNIFER BURNETT: I think she is you're a Center of Independent Living, your funding comes through OVR, OVR does require you to do -- five core services INR that's nothing -- that really is that will be your case you'll get your funding from OVR and do, INR, peer counseling, skills training, transition services, I can't remember the --
>> FRED HESS: The thing -- I was in a conversation the other day, with one -- **>> FEMALE SPEAKER:** Advocacy.
>> FEMALE SPEAKER: I have to say something real fast my consumer connection -- has made this a major -- sorry I thought I had it on.
Consumer connection adapt, DIA, everybody, has said if you're going down there you better be fighting for he me, we would like to ask for a resolution that we brought up over and over, we do not think it takes a degree to have be a dedicated service coordinator.
We do not want it left up to the MCOs not that we don't like MCOs or anything, nothing personal.
But they just want it to be part of the what is written in

the contract, and, I hear it over and over.
So I'm going to ask that there be a resolution at this table that it's been repeated several times and noted.
I'm asking you, Ralph.
>> RALPH TRAINER: Making a motion.
>> FEMALE SPEAKER: I don't know how to do that, Roberts rule.
>> RALPH TRAINER: I need a second on that motion then from the floor.
>> FRED HESS: I'll second that.
>> RALPH TRAINER: Okay.
Is there any discussion in regards to that motion?
From the members?
>> PAM MAMARELLA: I'm not clear what I'm being asked to vote on.
And we have no time left, but I think we should open the next meeting, perhaps if this is important and clearly it is, we can open the next meeting --
>> FEMALE SPEAKER: Could we just, kind of clarify it I don't think it will take that long.?
>> JENNIFER BURNETT: Yes but the meeting is over.
>> FRED HESS: Already 5 after.
>> FEMALE SPEAKER: I don't to get beat up.
>> JENNIFER BURNETT: Yes.
Next meeting we'll start
>> RALPH TRAINER: I'll table the motion until the next meeting and thank you everybody meeting adjourned.
[meeting adjourned]