MLTSS SubMAAC

August 3, 2016

>> PAM MAMARELLA: We're going to call this meeting to order.
Good morning everyone.
Our chair Ralph Trainer will not be able to make it today and he is asking me to fill in for him and Fred has his graciously accepted filling in for me I'm going to be ralph and Fred is going to be Pam we'll have a good time today, right?
>> FRED HESS: I'm not as cute as you are, sorry.
>> PAM MAMARELLA: I don't know about that Fred.
So let's start by, taking roll call.
Alice Stine. A
[roll call]
Brenda Dare is on the phone.
>> SPEAKER: Yes, I am.
>> PAM MAMARELLA: Cassie .
>> SPEAKER: Yes.
>> PAM MAMARELLA: Hey, hey Cassie Darrell.
>> SPEAKER: Linda is here for --
>> PAM MAMARELLA: Drew Nagle.
estella .
Fred Hess
>> ALFRED: Yep.
>> PAM MAMARELLA: Jack Kane. Jennifer howell, Michael Pelicano, Jesse wilderman.
>> SPEAKER: Here.
>> PAM MAMARELLA: Welcome.
Ray prushnock I was going to say I saw him.
>> SPEAKER: He is here he is in the hallway.
>> PAM MAMARELLA: Richard Dukson is on the phone.?
Scott Rifkin.
>> JENNIFER BURNETT: Who is here.?
Welcome Gail.
Steve Williamson.
[taking r roll]
>> PAM MAMARELLA: I totally butchered your last name sorry about that.
>> SPEAKER: It's okay.
>> PAM MAMARELLA: Terry Brennan.

>> SPEAKER: On the phone.
>> PAM MAMARELLA: Okay thank you Terry on the phone.
Theo Bradey.
>> SPEAKER: Pam Auer in for theo.
>> PAM MAMARELLA: William White.
Okay.
As we always do, I am going to -- well actually I'm going to ask a new member of the committee, to introduce himself right now tell us a little bit about yourself Jessie.
>> SPEAKER: Sure I'm Jessie wilderman I work with the service employees union which is, health care union here in Pennsylvania representing about 45,000 health care workers, big chunk of which are, home care workers.
Direct care workers and, really excited to be joining the committee, I'm replacing the Neil, who changed the roles within the organization.
And so, really excited to be joining and, I think we're really excited about the push to expand home and community based services and that understanding the work force as a really key element, of having a successful, you know, accessible low cost high quality system here.
Excited to be with everybody, thanks for having me.
>> PAM MAMARELLA: You're welcome, we're looking forward to your perspective.
I'm going to go over the housekeeping committee rules.
As always, we want to exhibit the utmost professionalism in our language and in the way in which we react interest every act with each other.
I'm going ask that everybody direct their comments to the chair, witness until you're called upon and, if possible keep your comments under two minutes.
The transcripts for the meeting are posted on a Listserv on your agenda.
Captionist is here documenting the discussion so please speak clearly, slowly and introduce yourselves so we know who is speaking.
At the end of the meeting if we could clean up ourselves and, take away any empty cups or bottles or wrappers.
We want to absolutely make sure that we give time for the people that have made their time here today to come and, listen to what is happening in the committee.

So public comments will be at the end of the meeting we'll work very hard to make sure we keep time so they have that available to them.
And now I'm going to read the emergency evacuation procedure chose is a technical compliance issue that we have to do every meeting.
Although I read them this morning I was really confused by them I have to be honest.
So --
[laughter]
All right.
But I'm going to, in the event of an emergency, or evacuation we will proceed to the assembly area, to the left of Zion church on the corner of fourth and market.
If you require assistance to evacuate, you must go to the safe area, located right outside of the main doors of the honors suitement office of long term living staff will be in the safe area and stay with you, until you are told you may go back into the honor's Suite or you're evacuated.
Everyone, must exit the building.
Take your belongings with you.
Do not operate your cell phones, do not try to use the elevators they will be on lock down.
We'll use stairs 1 or stairs 2.
Exit honors on the left side near the elevator, turn right go down the hallway by the water fountain, 1 on the left, for 2, exit the suite through the side doors on right side of the room, or the back doors for those exiting from the side doors, turn left and stair two is in front of you, for those exiting from the back doors exits, turn left and then turn left again and stair2 is ahead.
Keep to the inside of the stairwell merge to the outside.
I thought that was receipt interesting
[Laughter]
Turn left and walk down dewberry he's, to Chestnut Street, turn left to Fourth Street, turn left to Blackberry cross Fourth Street to the train station, does anyone have any questions about that?
[laughter]

I'm not sure who we're going to get to answer I'll turn the meeting over to Jen Burnett.
>> JENNIFER BURNETT: Thank you Pam, good morning I'm Jen Burnett the deputy secretary forever the office of long term living I have one more housekeeping request is for the people on the phone if you could mute your phone, unless you're speaking. That would be much appreciated we're getting some feedback.
I have to say, listening to those evacuation procedures, is probably an important thing there was a meeting held here about two weeks ago, Gail, there was an actual evacuation so it is something that actually, happens here and, it's best we know, and since we only use this room once a month, we're not likely to remember those procedures between meetings.
So thank you very much for reading those.
I want to talk about a few things I was not here at the last meeting I was, out of the office.
And, I want to thank Kevin Hancock who did chair -- did sit in my seat, last month and I really appreciate his being able to do that.
And I understand the meeting was pretty -- very well attended.
We had the folks from our press office come and talk about the communication plan and that was just the beginning step I'm going to talk more about it today.
I want to start out with talking about, readiness review.
And, what we're envisioning what we're working on right now in terms of readiness review.
And weave into that, the work we've been doing for centers for Medicare and Medicaid services CMS.
Later in the agenda you'll be hearing from Randy Nolen, who is division director at the office of long term living, who has been leading the charge with the readiness review process.
And, he is going to go over the work that we've been doing in regards to readiness review in much more detail.
So I'm going to, be covering in a very high level manner.
Moving towards community HealthChoices can't just happen, behind the scenes at the state.
It really does involve all of you and many more.
And we have -- you'll hear me say this over and over again it's sort of becomes my Mantra, which is our focus as we

transition in our working within all of the different offices within the Department of Human Services as well as some of our partners at the Pennsylvania housing finance agency and most certainly with the Department of Aging, we want to ensure that participants continue to receive uninterrupted services and providers get paid.
Those are two really important things that we want to achieve.
This will be sort of our Mantra throughout as we move into steady state tore community HealthChoices.
We've been in correspond answer and meetings with our Federal partners we've received guidance from our Federal partners.
This guidance is only for states that are going to manage long-term services and supports is called the gate way document.
CMS crafts this gate way document provides to states, individually.
So I think it's probably a template, most states have the same thing there are nuisances for each state.
>> FRED HESS: Can we get a copy.?
>> JENNIFER BURNETT: I checked with CMS to make sure it was a public, it is we'll share it.
We'll send it out of the meeting.
But I'll do some highlights on it.
>> FRED HESS: Okay.
>> JENNIFER BURNETT: Many of the best practices, that have -- CMS has gleaned from other state's implementations are included on the gate way document it's a pretty thorough document that really touches on all of the different, components of what we need to be paying attention to.
I'm going to talk about a few of them and, maybe, even help you understand what the State plans to do.
What first and foremost is row but stake holder engagement.
That is something that CMS advises states to do, I think Pennsylvania is doing much of that through the procurement process we had very robust stake holder engagement, having this committee, and having the committee being a public meeting.
Other ways we're gathering or providing, stake holder engagement but we also meet quite often with different groups, many of the State associations were meeting with on a regular basis when I'm invited to come to meetings I was invited to come to a meeting this morning I go to meetings.

As does secretary Dallas he is also spending a lot of time out on the road speaking to groups.
Also, testing of file transfers billing and payments.
That testing before -- through the readiness review process is something we'll be paying a a lot of attention to.
Testing of service plans to make sure they're loaded and validated.
That's another area we're going to be paying attention to.
That's outlined inned the in gate way document.
Outlining the enrollment functions including the use and training of the enrollment broker.
That will be a very, we will be doing a very thorough job of that.
I want to tell you that, it has been advised to us and, we have taken up the advice that we're going to share the procurement for the independent enrollment broker, before we put it out for bid.
That was input we received through the consumer sub-MAAC I don't know if it was suggested here I'm pretty sure it was.
So we will be doing that.
And then, the -- we will be creating with your help, provider network adequacy standards, including accessibility and instance requirements.
So those are two features we'll be paying a lot of attention to.
The distance requirements, speak to the how far providers are from a given population.
So, that will be one of the standards that we're going to be establishing.
I want to share with you something that we're reading and looking at and really, using as another way to learn how we make -- how we do this well.
But there was some of you may have seen a report published in July by the New York chapter of national academy of elder attorneys and, or a consortium of people in called W* New York called Medicaid matters they have a large group of various stakeholders, that have formed together, to really pay attention to how Medicaid is operating in New York.
And so they came out with a report on the inadequacieses of New York's over sight of managed care organizations.

And that's also to speak to the fact that this is a pretty recent implementation that New York had of managed long-term services and supports.
So we've read that report, taken a look at it.
And the purpose of the report, and what the elder law academy of elder law attorneys and Medicaid matters this report was actually brought to my attention the day after the report was issued when I had to speak at a conference of elderly law attorneys.
They brought it to my attention.
Wanted me to be aware of it.
The purpose this is a quote from the executive summary was to examine the prevalence and extent of reductions bying manied long-term care plans, and to assess plan compliance with procedural requirements for reducing hours of care.
So, they were looking at the complaints and grievances and, that's what the elderly law attorneys were doing and the Medicaid maters.
But they were really looking at the prevalence of reductions and I know that, that issue of reductions in plans of care has been something that's been brought to my attention in this committee.
Pretty much every meeting.
>> FRED HESS: Yeah.
>> JENNIFER BURNETT: Any ways the report reveals in New York, fair hearings for those reductions spiked by about 600 percent.
98 percent, of the increase was in New York City.
And, the 87 percent, of the hearings were against 3 plans and in New York there are 23 plans participating.
So there were 3 plans.
The other really startle willing fact of this report was that 90 percent of those hearings were won by the consumers.
So New York was doing something wrong this the way they were monitoring these hearing what was happening and in appeals.
So again, the vast majority was in 3 of these cases were in 3 plans.
That is an area that New York should have been focusing on it , reviewing the data, paying attention to it.
New York has also established some case law that places a

very high burden of proof on the plans, in cases of reduction.
So the plan, must prove that there has been a change in medical condition or, other circumstances that justified the reduction.
It's not enough to use a standard assessment instrument or norms for people with similar needs they really have to see a change in condition or circumstance that justified the reductions.
New York has historically had the first or second highest per person spending on personal care in all of the states.
Any ways for OLTL what we learned from this report what we're continuing to learn from the report, is that we are planning a monitoring system for community HealthChoices, that is, similar to the one that Department of Human Services we're adding additional components, we'll lift, mirror what health choice asks doing on the physical health side we'll add in long services and supports
>> FRED HESS: We will not have the problems of New York.
Burp bury sure hope so.
>> PAM MAMARELLA: Question from Pam.
>> SPEAKER: In that report, one of the things that really stuck out to me, why we need a specific type of navigator, for this change, is because -- of the high percentage of the hearings won by the provider the consumer didn't know how -- didn't show didn't know how to deal with the hearings and appeals they didn't know how to right, these navigators being specific, nonspecific to -- everybody, their brother under -- Department of Human Services, it needs to be, navigator, system specifically for we don't want to see what happened in New York, those cases won, more than not, because the people didn't know what they were doing or how to fight it.
>> PAM MAMARELLA: Thank you Pam.
>> SPEAKER: Brenda has a question as well.
>> JENNIFER BURNETT: Do you want to ask?
>> SPEAKER: I have a question and comment to back up what Pam said, are we going to have the same burden of proof on the plan, that New York does I really like that idea.
In order to produce reduction, a plan has to approve a change in medical status.
For the consumer my comment in regards to what Pam had to say I've been in touch with bill from Boston, Massachusetts if it's

okay, with Pam I would like to make a -- recommendation that this committee invite him to attend our next meeting.
I've been in discussions with him, whether he is available.
And it appears that he is, we will need to work out travel reimbursement for him, flying in from Boston.
I would like to make a motion of of this committee, to send an invitation to him for our committee to talk about beneficiary support and the way it works in Massachusetts.
>> FRED HESS: I would second that motion.
>> JENNIFER BURNETT: I would ask, does -- first of all, you don't have to make a motion because we're already doing it, we've Ralph put it on our radar, when we were planning for today's meeting.
And we've already invited him and he is confirmed to come in spent, I'm looking over to Marilyn to make sure.
>> SPEAKER: OkOkay.
>> JENNIFER BURNETT: I have not shared it yet.
For those who don't know bill Hen ning, he is a center of independent living director in Boston, who say long time, member of the disability community he has been a very active in Massachusetts implementation of managed care.
So he has got a lot of ideas, he also, was invited last month, I believe it was last month, that he attended our stake holder our work that we're doing with the Jewish health care foundation.
Fred was there.
And I believe, you were there as well Brenda.
But, bill --
>> SPEAKER: Yes.
>> JENNIFER BURNETT: Bill came to that, that's where we got the idea we should, go ahead and invite him.
He spoke very effectively, about beneficiary supports.
So thank you for that.
Thank you for that recommendation.
I talked about the additional components here are a couple of them we are thinking, we welcome your input we'll monitor the reports.
We will be monitoring those reports it appears that New York wasn't or they didn't take any action on them.
We will compare rates to what other MLTSS have experienced we will do some comparisons.

For other states what kind of hearings their getting.
Look for out liers among the Pennsylvania plans that may require further analysis we'll pay attention to that.
Just remember, that New York, it was only 3 plans that, really had the egregious problem of it, we can deal with that.
We can address that.
We'll also be monitoring the fair hearings process closely.
We'll know if there's a sharp increase.
Or if any of the appeals relate to service plan reductions.
We'll be paying attention to that.
So this is, these are lessons we learned from reading that report.
So if we detect any service reductions during the continuity care of period which I've also heard input in this process, we will definitely be following up with the plans on that.
Detect a sudden surge or unexpected volume after the continuity of care period, we'll follow-up with the plans.
We'll have processes in place with rapid feedback with all of the plans and, those are already under development.
And that includes, what we learned as a best practice from Tennessee, which is the daily war room calls for the plans we will be having daily, meetings with the plans.
On the daily basis, generally by telephone call.
With the right OLTL staff.
And we will really be using those daily meetings sort of like a stand up meeting that, many companies apply they come together to do a stand up meeting before the day gets going.
That will ensure issues on either side are front to the forefront and resolved quickly.
So again, members must receive services and providers must get paid.
That's just, what, what we are committed to.
I wanted to talk a little bit about the beneficiary support system Pam brought up one aspect of it.
But the release of the managed care final rule in May, came with many requirements for states, that are using managed care to deliver Medicaid funded services to participants.
In those -- in that rule, CMS is requiring a beneficiary support system that's what they call it for all managed care programs.

So in Pennsylvania that not only applies to community HealthChoices it would apply to HealthChoices behavioral HealthChoices and ACAP a small program for people with autism and is a managed care program.
So the beneficiary support system, must provide choice counseling, educate participants about their grievance and appeals rights speaking to what you were talking about Pam.
Within managed care environment, and then, also, how the State's hearings and appeals process works.
Both the managed cares, grievances process as well as the State process.
Again, all of those programs are administered by the Department of Human Services all of the managed care programs in Pennsylvania are administered by the department that OLTL is part of.
And that does give us an opportunity to streamline and, standardize some of the requirements of the final rule.
So we are looking at a number of options and, the possibility of using community partners, existing community partners but we have not settled on a solution yet.
The implementation of that is not required until the after community HealthChoices gets started.
But we are committed to a department wide solution with each office having it's nuisances for us the nuisances would be the long-term services and supports.
>> PAM MAMARELLA: Pam?
>> SPEAKER: This is a quick question I just wanted to know when CMS mandated that the rules say that, you have to have it for all of the health -- do they say you have to have one for everything.?
Or, each plan at least have one?
I just want to be clear.
Maybe because we can have one for this and a couple fit together and -- something like that.
>> JENNIFER BURNETT: No.
They didn't tell states how they needed to operate it.
They didn't tell states to do it.
For efficiency and economy and scale we're planning to do, one DHS wide one.
Then each office, will have its nuisances for the things that

don't apply to them.
For example, the behavioral health MCOs will have different perimeters that they're looking at in terms of beneficiary support system.
But there are things that are very common and so, we don't want to have to go out and do four procurements or even 12, because, choice counseling and educate requesting consumers about their grievance and appeals rights, are two different things and maybe provide by two different providers.
So, we will be doing something DHS wide we're starting to meet on that.
And then we will have, each office will have their own component
>> PAM MAMARELLA: We have a question from Cassie.
>> FRED HESS: And from Tanya --
>> SPEAKER: Any money for the consumer needs to help represent themselves say a lawyer?
Or, I mean, how is that going to work?
I mean they're going to be up against MCOs they're probably going to have, paperwork I want to make sure that the consumers, have some kind of a tool to fight you know for themselves.
>> JENNIFER BURNETT: I don't know if the money to pay for a lawyer it's obvious that, consumers, are who we're trying to protect here and what the beneficiary is the consumer.
So that system is set up for them.
I don't know the nuisances of how it's going to be set up.
It's just in the early stages of the development as we're, looking at what the requirements of the rule have.
So, there will be resources, I can't say, that it's going to be cash in hand to hire a lawyer.
>> SPEAKER: I I just hope there's the community for the consumers to get the help.
>> JENNIFER BURNETT: That's the whole point of the beneficiary support system we must implement one.
>> PAM MAMARELLA: Tanya.
>> SPEAKER: This sort of a follow-up comment to this I guess I would think, if there needed to be a appeals process instead of, going through all of the mumbo Jumbo of getting lawyers everything else involved to make things take forever, if the consumer had, legitimate reasons, like, documented, from a doctor,

documented from somewhere, stating that, yes, they still only need this and this -- why won't each of the MCOs or the Department of Health and human services, have someone on staff that could handle that or a couple of people on staff that could handle it.
Look into it make it efficient and get it done.
If there's still something wrong, with the consumer services, have someone like whoever their service coordinator whoever it's going to be, sit down with them and, like, explain okay.
This is why this was.
This is what you need to do.
And, just make it easier, more efficient because, if you get, the law involved in this constantly what you're going to have is, a whole like a whole backed up system, where people are going to be needing these services but the one thing I don't understand is if they're appealing something, are they still getting services while they're appealing it is this
>> JENNIFER BURNETT: Yes.
And just to answer your question, the service coordination function is, really a lot about what you just talked about, the service coordinators, going to be responsible for providing information on changes and certainly P if the doctor has documented that the services are needed the managed care organization is expected to provide those services, that's how our contracts with them will work.
And then, if they find that there's still a problem, something that just isn't, they're unhappy with a decision that's gotten made they have an appeal right.
>> SPEAKER: Okay I understand that part.
What I'm also going to maybe, bring this up, too, if the service coordinator is working with the MCOs, are they going to be more prone to do, what the MCOs are asking them or what the consumer needs?
Where is the line between the two?
>> JENNIFER BURNETT: They're going to want to serve the consumer as best as they can.
They're going to want to prevent higher levels of care such as hospitalizations or emergency room use and if that is, something that they work out with the consumers, so the service

coordinators are going to be responsible for making sure that the services that consumer, that beneficiary or this the case of managed care, that member needs, then, they -- it's going to be incumbent upon the organization to provide the services so they don't see a further decline in the person.
They have a very strong interest in keeping people, as healthy and, independent and integrated into the the community as possible.
>> SPEAKER: Is that going to be like, a written for sure thing with whatever MCO like, signs on or gets the contract?
>> JENNIFER BURNETT: That's pretty well outlined in the draft agreement, so if you look at the draft agreement, that we put out for public comment back in December, maybe -- it was the one in November, onive those two, you can find information about that.
>> SPEAKER: Okay.
>> PAM MAMARELLA: You have another question.
>> SPEAKER: This is a comment that I know Theo would want on the record too, that we're asking that, somehow this navigator system, be independent of the MCOs in the enrollment broker completely, you know, there for the individual, to help serve them.?
So there is no conflict anywhere.
>> JENNIFER BURNETT: Thank you.
Pat do you have a comment
>> SPEAKER: Brenda has a question I wanted to let you know Scott Riffkin is on the phone.
>> JENNIFER BURNETT: Brenda, do you have a question?
>> SPEAKER: Yes, I do, actually.
I like to request that, members of this committee, be able to participate in the process of designing the beneficiary supports and, overseeing the implementation I know you said you're not sure how it's going to be set up I think we can have some valuable things to offer
>> JENNIFER BURNETT: Thank you.
>> FRED HESS: I have something.
You may not be aware but we have a consumer members MLTSS subcommittee meeting, between us every Monday.
Okay.
Before the meeting.

And we do have some recommendations here.
Okay.
We have beneficialry supports Federal regulations require the State to establish a beneficiary support system, that provides, one, an access point for complaints and concerns about enrollment access to covered services and other related matters.
Two, educational enrollees, grievance and appeal rights within the MCO, the State fair hearing process, enrollee rights and responsibilities and additional resources outside of the MCO.
3, assistance upon request, sorry, and navigating the grievance and appeal process, within the MCO, as well as, appealing adverse, benefit determinations by the MCO to a state fair hearing.
This system may not provide representation to the enrollee at the state fair hearing, but may refer enrollees to sources of legal representation.
Four, review, over sight of LTSS program data, to provide guidance to the State medicate manage on identification.
Remediation.
And resolution of the systematic issues.
Here are the recommendations -- OLTL has stated that they intend to work with the OMAP and OMHSAS to create a single beneficiary support system for individuals and physical HealthChoices.
Behavioral health HealthChoices and community HealthChoices given the difference between these 3 programs, in terms of covered services MCOs providers, assessment, and authorization process, administrative over sight we do not believe it is feasible to have one system, for every one in these 3 programs.
There should be a navigator, system specifically, for people seeking HCBS through CHC.
Second recommendation, people need a place to go, to get help when they are denied services, or their services are reduced we believe persons in CHC should have access to an attorney, or, trained paralegal to assist with grievances and DHS fair hearings, we realize the such assistance would be outside of the scope of beneficiary supports, under the Federal regs, but separate contractor contracts, should be done to ensure that the availability of legal representation.

Entities providing that assistance, should be independent of the MCOs, and, the enrollment broker.
Another recommendation, enough time to choose a plan, since choice of plan is largely dependent upon the providers in the plan's network, consumers will need enough time to find out which providers, are in which plan in order to make an informed choice of plan.
Sharing of information among consumers.
It's said word of mouth is the best advertising could be assumers should be identified with the means by which they can share experiences both positive and negative, regarding plans of providers with other consumers like maybe a Facebook thing or something.
MAXIMUS, consumers remain concerned about both the time lines of the application processing and the limited amount of support provided to individuals in navigating process.
Especially regarding financial eligibility we would like updates on corrective actions being taken, by MAXIMUS on their current performance.
>> JENNIFER BURNETT: Thank you Fred.
>> FRED HESS: I'll give you a copy of that.
>> JENNIFER BURNETT: I thought you would.
>> FRED HESS: Absolutely.
>> JENNIFER BURNETT: We'll have an update of little bit of, an update on where we are, with that so --
>> PAM MAMARELLA: Steve?
>> SPEAKER: Can you share who the 3MCOs that had the big issues?
>> JENNIFER BURNETT: I can't off the bat but I will, I'll get you a link to the report.
>> SPEAKER: Thank you.
>> JENNIFER BURNETT: Okay.
>> SPEAKER: I want to make a comment, the department does have an independent entity within it, the Bureau of hearings and appeals.
That's been in place, for over 20 years.
That hears, grievances and appeals.
From all types of consumers whether it's an issue of eligibility or whether it's an issue of denial of service, there is a whole process, that the department follows, whenever notices

are provided by the department or frankly under the HealthChoices program.
I at least am not aware to date of any problems, of people can disagree from time to time with the outcome of the process, any problems with the current process, while consumers enrolled in the physical HealthChoices program, or in the behavioral health programs.
So I'm assuming, that the department is going to use that same process, and rely on that same process.
That's not to say it can't be, any process, can be improved upon.
But there's a very good process in place.
Secondly with respect to, to access to legal services, there are legal services -- there are legal services organizations across the Commonwealth.
That will be available and, had been available to help consumers.
That is not to say, that more funding, perhaps, could be earmarked to help those organizations and this could be, an opportunity for everyone to advocate on behalf the increased funding for legal services.
>> JENNIFER BURNETT: Thank you Jack.
And yes, we're in close contact with that bureau, they're very much aware of the development of the community HealthChoices the board of hearinged April appeals.
I have two other thing I wanted to share with you.
And -- the first one is, the update on our communications strategy.
I have -- I personally have a very strong commitment to making sure we do very robust, thank you
[laughter]
So, I really feel like, I really feel that there's a tremendous need to have good communication with all stakeholders that includes stakeholders in this room, but it also includes, all of the people who are going to be affected by this, in terms of, their either participating as a dual eligible or, receiving long-term services and supports in the community.
Or receiving long-term services and supports in the nursing facility.
>> FRED HESS: Jen, how do we get the information out to the

regular consumers not sitting at this table, are not aware of this meeting how do we get that out to them.?
>> JENNIFER BURNETT: Yeah. I'm going to cover a little bit of that.
Yeah.
Last month you heard a high level communication plan from the press office and our press secretary Keith Gillis, came and did a presentation on the communications process.
You gave them, Kate and Heather some feedback and that feedback it was very helpful.
I think it had to do with making sure we're open captioning the video that we have available which is a very high level video that is now open captioned and available on the from the CHC web site.
You can look at it there.
>> FRED HESS: Is that the one we looked back?
>> JENNIFER BURNETT: At the last meeting yeah.
We're continuing to kind of fine tune that strategy and, really making it much more robust and that includes some of the timing and we'll come back to you with the sort next iteration of the plan of the strategy.
But it includes, more detail on when we're going to blast, do email blasts when we're going to be issues letters and other notices.
When we're going to be, posting things on our web site.
And then, all of the out reach we plan on doing.
And, we are going to use we are just about in the final stages of bringing on a firm that's going to help us develop materials and I think at the next meeting we'll have more details on the communications strategy.
We're in the development stages of the developmental stages of materials and have set some benchmarks to engage this group in September and October in the September and October meetings.
We'll come to you with some drafts of our best thinking.
And ask you for feedback on what that would look like.
Should look like.
And then, certainly, at a high level, our communications strategy, includes, communications with you.
It includes, communications with the providers.
But, ultimately, it includes communications with beneficiaries

and how we effectively communicate.
And, we also know, that the provider community, is a trusted source for getting information out.
For the providers and MCOs we'll really engage them and provide them with talking points those kinds of things so they can start responding, last month, I met with the Pennsylvania medical society because, we believe that, that the -- this is feedback we heard from the consumer sub-MAAC that people who are dually eligible are not yet in the long-term services and supports system won't have, for example, an attendant to ask or a service coordinator to ask and likely they will go to their primary care physician.
So we are in communication with PMS and doing strategy with them around, how to get the word out to physician offices.
And also, we think that the service coordinators are really going to be armed with information, so we'll be doing some webinars to update them and get them, well informed about, how they talk to people when they get that note, when someone gets the notice what are they going to say if the consumer calls them?
Our service coordination, our service coordinators, and then we also need to, really make sure the direct care workers know about it, so we'll be working with our Pennsylvania home care association.
We have SEIU at the table but really getting the word out to in addition to direct care workers.
And, for example, just as an example the Pennsylvania home care association, has a newsletter they have offered to put, information about community HealthChoices as we time it, as we want information to get out, when we think it's best.
Right now, at this point in time it's a little bit early.
I don't want to make you know, start getting the word out almost you know, we have about 11 months before we launch this.
So, we are in the process of developing those materials, we'll be sharing them, vetting them actually with you.
So providers and service coordinators, will need to be informed before we actual
send out those letters to the consume ares so they're able to respond to, if they get calls.
Butlers out reach to participants will follow
that, again those will be vetted here and those will inform, be

over time be informing individuals that a change in this delivery model, or how they receive their services, the way they receive their heal willing care is on the way.
So for those dual eligibles who are not in HealthChoices currently they will have to pick a plan and they're going to be informed of that, in the very basic level.
So, information is being developed to help the participants and providers alike.
And, we need them to understand the steps that they're going to take in order to get enrolled and make choices.
I want talk very briefly about quality and then I'm going to turn it over to Kevin Hancock I've used up --
>> PAM MAMARELLA: Pam as a question before you --
>> SPEAKER: Last meeting drew Nag the le, asked when they talked about, this everything was cognitively accessible do you have someone working on that, make sure the video had some larger terms in there, too, that might be difficult for some people.
Burp
>> JENNIFER BURNETT: Yep.
We will be, thank you.
Did you give specific advice to Kate and Heather on the video terms that you thought were a little bit --
>> SPEAKER: I'm not sure.
We gave an idea, we saw maybe harder to
>> JENNIFER BURNETT: Can I ask this committee to take a look at it, make sure we captured the recommendations you had, if we didn't, get the feedback to us through the MLTSS resource account.?
If you go on the video make sure that it's account -- we have accounted for the things your recommendations we can make changes if we need to.
>> SPEAKER: Jen as a clarification it actually is not live yet it's supposed to be live this week.
Secretary Dallas is sending --
>> JENNIFER BURNETT: We'll send out a notice when this is live with a link to it.
>> PAM MAMARELLA: Ray?
>> SPEAKER: Okay.
So Jen I had one question in terms of you know, especially in the western part of the state, we have you know, many individuals, majority of, Medicare beneficiaries are already in Medicare

advantage plans.
How is that going to be part of the communication, sort of acknowledge choices that have been made and -- not to sort of confuse and unintegrate things.
>> JENNIFER BURNETT: Yep.
Good thing you asked that Ray I forgot about that piece, that's why we think dual eligibles are likely to -- we need to really speak to that issue.
They will be coming out of open rolement.
You know, at the end of the year.
And, they will have made their choices.
So we are working with our partners at the Department of Aging to craft that message to make sure that message gets to them.
We'll be informing the APRISE counselors they will be getting some education as well on community HealthChoices we don't expect them to be experts on community HealthChoices but they should be aware of, when those will -- we'll be notifying the APRISE counselors in advance before the notices go out, if they do get called about it, we know they're a trusted source of information on Medicare and their choices in Medicare.
But we do need to make, we need to make sure there's some kind of a statement in there, this is, feedback we heard from other states, I think California gave us this feedback, pretty sure it was California.
That, one thing they did not expect, they didn't expect it, but it happened.
That is, the confusion by Medicare beneficiaries.
So, we're looking at those lessons and, we'll be figuring out how to best communicate that so people don't get confused.
When it's a statement, this is not about your Medicare choice or Medicare plan choice.
So we'll have to figure out how to do that.
But, when we come, with information, that is going to -- when we come with the, examples of, communications, can you make sure you look at that for that purpose as well?
Thanks.
Quality, I wanted to talk briefly about quality.
Because in Pennsylvania, we are very fortunate, to -- first let me back up for a second.

The national accreditation by the NCQA, they have been testing home and community based measures.
And they have been testing them for purposes of, putting out an accreditation for providers.
Accreditation on long-term services and supports.
Home and community based long-term services and supports.
They we actually had one provider here in Pennsylvania, that participated in their pilot to really kind of, tease out what these would look like, the provider was abilities in motion, in Berks county they participated in a pilot of this.
Ralph Trainer who is not here is the executive director of that agency.
So he, had a lot of vision around the NCQA role.
So they have, there was a press release that came out on I think it was the 25th of July, announcing their new accreditation and distinction program.
To improve the quality of long-term services and supports.
And establishes standards for nonmedical services for our populations, populations with complex needs.
And so, the accreditation piece is they're going to be, they have an accreditation for case management, so that service coordination in our state, and then they have a distinction which supports, NCQA accredited health plans and behavioral health plans and their ability to effectively coordinate long-term services and supports in addition to, physical health and behavioral health.
So those are the two things, and accreditation and the distinction.
And, we are very fortunate in Pennsylvania, to have 8 providers that took up this and they are going to be early adopt ors of this accreditation.
Actually one is is he sitting at the table, liberty community communications barb Polzer's agency, she works at is going to be -- early adaptor of the accreditation there are 8 other providers, throughout the State.
I can get you the press release and, the press release actually lists out all of the early adopters of accreditation including Pennsylvania's 8 we actually have more than any other state except Michigan.
So I'm very excited about that.

The other thing I wanted to mention is the consumer what successment of health care providers which is, accreditation that is, bestowed upon -- a tools by the agency for health care research and quality.
Which is, so the consumer assessment health care providers is CAPS tool as it's known out in the community.
There are many, many caps tools there's a whole Suite of Caps too many, AAHQ, had accepted the CAPS tool for the trademark for the homant community based tool, Pennsylvania will be taking advantage of that, you'll be seeing more about that, but, we're very excited about those two standardized processes for quality, that are going to be, in the national arena that we can take advantage of.
The CAPS tool was actually the -- it was done through a pilot with about 7 states, through a CMS grant out to those states they participated, in similar to what AIM did, basically, trying out testing, that CAPS tool, but I recently learned that it was, accepted for the CAPS trademark and, for the AAHQ trademark you'll be hearing more about that as well.
Those are my updates.
And, I don't know if I want to open it up for questions or we
--
>> PAM MAMARELLA: For sake of time, we could, maybe take one or two questions but that was it, if we have any.
We did take them as you went along Jen.
I think we can move along.
I think -- the next on the agenda, so thank you
Jennifer as always.
Those last two items sound pretty exciting a big move forward.
So the next on the agenda is procurement updates from Kevin Hancock.
And a new member just showed up, William White welcome.
Good to see you.
>> FRED HESS: I thought I was late.
[laughter]
>> JENNIFER BURNETT: Okay.
>> SPEAKER: Interstate was m messed up.
>> KEVIN: Is this microphone -- okay.?
Good morning, everyone.
I'm Kevin Hancock from the office of long term living I'll be

giving you a very brief and quick update on the procurement process for community HealthChoices.
Just as a matter of background as many of you know, we released the request for proposal and draft agreement for community HealthChoices on March 2, and received proposals from 14 bidders on May 2, and from May 2 on through today, we have continued through the scoring and proposal review process.
We are still in that process.
It is completed the cycle at this point we're planning to release the selected offerers, within the next two weeks.
>> FRED HESS: Okay.
>> KEVIN: So the next step in the process is notifying the selected offerers.
And then beginning the conversation with them about moving forward with the procurement process.
And really that is, my update.
I'm not really in a position to provide more information than that because we're, while we go through the process we're still in a blackout period.
But I will happy to answer any of your questions I can answer
[laughter]
>> FRED HESS: As he looks side ways to me.
[laughter]
>> FRED HESS: Okay.
>> PAM MAMARELLA: Does anyone have any questions on the committee with Kevin with regard to the procurement process?
You've left them silent for the first time I think.
>> KEVIN: I can give you a couple other updates on the active procurement that is are up coming.
We will be we will be relosing RFP as well for the independent enrollment broker as many of you know, we had procurement process that went, that was, -- that was executed last year.
2015.
Due to some irregularlies and also the, the movement to managed care for community HealthChoices we recognize that, that the procurement vehicle we used, was no longer appropriate.
The requirements for the program changed.
So, we entered into an emergency procurement with the existing enrollment broker MAXIMUS.

And we will be procuring the service we're planning to release the procurements, as early as, September.
But, just this is, you are hearing this first.
Because we have, had such a successful experience in stake holder engagement with community HealthChoices procurements, and releasing it for public comment, we're planning to do the same for the independent enrollment broker.
So, later this month we're going to be reduce leasing a draft request for proposal, for the independent enrollment broker we'll be releasing it for public comment for 3 week time period.
The reason this is unusual it's an unusual step the reason we are doing this, is because, we recognize, that the independent enrollment broker role is for community HealthChoices, unique.
It is not, a duplication what is done for HealthChoices, it's certainly not a duplication for what we do right now with the home and community based waivers.
It is, unique role and we want to make sure we get it right.
We want to make sure we hear from a cross section of stakeholders on different components of the service to make sure we're meeting everybody's questions, concerns and program attributes.
Are there any questions about that?
>> FRED HESS: I do have one question for you.
You knew I would.
How many have -- can you tell us how many have signed up for the southwest region?
How many have made the proposal for the southwest region.
>> KEVIN: How many managed care -- submitted a bit.?
At this point we have not been able to share it, we have not shared it at all.
>> FRED HESS: Can you give me at least a number.?
>> KEVIN: We can't we have not shared it anywhere else yet.
But -- title 14, some portion of which, applies for the southwest
[laughter]
>> FRED HESS: Really.
[laughter]
>> PAM MAMARELLA: Thank you very much for that Tanya.
>> SPEAKER: Kevin something that scares me a little bit

about this whole process, is, you guys want it off the ground and running in 11 months, right.
You wanted it started up in 11 months, correct.
>> KEVIN: Correct.
>> SPEAKER: Okay.
My big concern is, like, within that 11 month time period, how are like the service coordinating entities, the physicians, the doctors, all of that, the other pieces, that go into this, that are not in this room, how are they going to make informed decisions like procedure to the launch of this to know which MCOs, that they're going to still deal with and know enough about the programs to tell their patients or whatever have you, that are going to need the information on this, on this stuff, I just don't see, how that's going to be done, you know, in an 11 month time process, if the procurement process is still going on.
>> KEVIN: So that's a terrific question Tanya I'm going to reward it make sure I'm understanding what you're asking.
How are the program providers, mean egg, the long-term care providers and the physical heal providers are going to know how they're going to enter into a contract with a managed care organization, to be part of the managed care organizations network is that what you're asking.
>> SPEAKER: Yes.
>> KEVIN: So it's a particular question for the long-term care providers.
A lot of the physical health providers for a very long period of time have been participating in the managed care networks whether their commercial or HealthChoices network, especially in the southwest which is the first zone that's going to be going live.
So, they do, in this process they have been part of, contract negotiations and network development effort on the the part of managed care organizations for a long time.
So, that sense that is not going to be new to them for the long-term care providers it will be new.
The expectation will be that, I believe it's safe to say that this is already kind of taking place.
That managed care organizations, will be and, long-term care providers will be, reaching out to each other, to find out about the type of relationship they could be developing to be able to

establish that type of network relationship.
It's, I think it's, we have been talking about this now W we had meet and greets earlier this year with managed care organizations, and long-term care providers, there's already been a lot of conversations that have already taken place.
There's, there has been a lot of opportunity for that conversation to start.
So, and, I think it's probably safe to say it's already occurring now.
What, we have to assure though is that, also something that has to be assured on the part of the Department of Health the managed care organizations supporting community HealthChoices have in that network in place before they go live.
That's part of, the Department of Health certification for managed care organizations.
It's also part of our readiness review process that Randy Nolen will be talking about in a few minutes.
There's a clear way that we can verify that the networks are going to be adequate before they go live.
But, there are already I think it's pretty safe to say there are already conversations already taking place, and it's also on the part of the Department of Human Services, also the Department of Health to make sure that, that all of our providers are very well educated on what community health, what it means for them and, what they need to do, as quickly as possible to make sure they're engaged with this selected offers of the managed care organizations.
>> SPEAKER: I'm glad the conversations are going on, but I guess I'm a little bit confused as to how they're going on.
If you don't -- if you don't know, what MCOs are going to be available in what area, do you just have them, all just talking to all -- talking among east each other right now, hypothetically.
>> KEVIN: Providers are smart they're talking to all of the managed care organizations they know --
>> SPEAKER: Okay.
So like once this rolls out if I contacted, my primary care physician and I asked, asked him before him or her before I made my choice of which of the MCO's are you going to work with, would they be able to tell me that, or are they going to be confused

>> KEVIN: Primary care physician I'm assuming your primary care physician won't be confused by that question.
They may be -- they may be confused, they won't be confused about which managed care organization they should be able to answer that question.
They may be confused about what is community HealthChoices.
>> SPEAKER: Are they going to recognize it though when I say, managed care organization are they going to know what I'm talking about, go by the insurance.?
>> KEVIN: I agree with you, primary care physician will most likely know which managed care organizations they participate in.
They will know, what managed care is.
Managed care, has been -- especially just talking in terms of the southwest, managed care has been pretty saturated in the southwest, commercially for 25 years if not longer.
The HealthChoices has been in existence in the southwest since, since the 1999-2000 time period HealthChoices has been around for a long time as well.
What they will need to be educated on, and, what they will need to learn more about, is, what is community HealthChoices, because it's the new program.
And that's going to be on the -- responsibility of the department to make sure that education is, is broadcast as widely as possible.
It will be on -- the responsibility of the selected offerers to make sure that they're reaching out to network potential network provider participanttion.
And, it's certainly going to be on the part of providers that are interested in participating in these types of programs to educate themselves and to know, to know this is something that is going to be coming their way.
Great questions.
Thank you.
>> JENNIFER BURNETT: I also want to reinforce Tanya when I talked about our meeting with the Pennsylvania Medical Society, that was the beginning of the conversation to start strategize with PMS.
There are he especially in southwest PA for starters, there are county medical societies that we're going to be reaching out to, we'll be working with the Jewish health care foundation who

is helping us facilitate these meetings.
We'll be working in southwest PA to make sure those physicians are informed moving to the southeast we'll do the same thing on the southeast we've already engaged with all of the five counties in the southeast, we just need to get to the medical folks and PMS has been really helpful in partnering with us on that.
>> SPEAKER: Just a heads up one of the most difficult areas, you might have is with physical therapists.
Because a lot of them out there, already do not September Medicaid the way it is.
So, when you're doing your procurement stuff, you're rally going to want to reach out to them hard core, because, allots of physical therapy providers especially in my area, if you tell them, that you have Medicaid they will not, accept it.
So, that might be -- that might be an issue.
>> KEVIN: I agree.
And, they're one class of provider that will present a challenge.
The most -- the most common example for network issues in the Medicaid program is normally dental services.
So, a lot of dentists are, do not participate in the Medicaid program as well.
A lot of, there have been innovative ways to address these gaps in networks but you're absolutely right.
Certain classes of providers, will have to, they will have to be a lot of communication with certain classes of providers to encourage a them to participate in the community HealthChoices.
>> SPEAKER: Okay.
>> KEVIN: Okay.
Thank you.
>> SPEAKER: I know this has been brought up before, people -- I know people have worked on train -- I think one of the important things is, to have consumers train some of these managed care companies on independent living philosophy and the social model because, leaving some of the stuff coming out of England which is going to a lot of managed care and other places, they had a totally different model they were trying to implement and it kind of counter active to everything consumers have been putting together for the last 30

years about their life.
We don't want to be medicalized we don't want to be told we're not allowed out by our managed care providers because we're -- you know we're taking risk which we feel we have the right to do.
I just don't think enough is really being done in that area.
Because you know, we could go I don't want to see this community go backwards when it's going forward.
>> KEVIN: So I mean, I think that's a fair point.
Just, speaking generally, if you look at the request for proposal the way we published in March, you'll see that, there were pointed questions that were asked.
Regarding the community living model and, the cultural differences between a medical model versus a community living model.
So, it was definitely a c consideration.
>> PAM MAMARELLA: For the sake of time right now any other comments, or questions if you could submit them, because we're going to need to move on.
So we have enough time for the people that have joined us today to also, make comments, so thank you very much Kevin.
Next up is a budget update -- from Peggy Morningstar.
>> PEGGY MORNINGSTAR: Hi my name is peggy morning store I'm the chief financial officer for the office of long term living.
So -- we wanted to, just give you an overview of our -- high level overview of our current fiscal year 16-17 budget that was enacted this month.
Last month, it's already August where did July go.
So on the next screen, you'll see that, for 2015-16, the past year our actual funds spent, to date 1.8 billion-dollars.
That's just state funds.
It's broken down by our five appropriations which the office of long term living, currently there are the governor's request, was -- for, 2 billion, whereas, what was enacted was, 1.9 billion.
So you can see, just based upon the different appropriations, that each each appropriation, received a bump but not the bump that we were requesting.
On the next slide, that -- the one point, let me check my slides.

1.9 billion, plus lot write funds and our Federal funds our
total budget for the office of long term living is approximately
6.4 billion.
Which is an increase over 14/16.
And this is showing again the break down by the different,
the five different appropriations.
So that 6.4 billion on the next slide will be broken down by
those 5, appropriations.
And the different, waivers within each appropriation.
The first long-term care, which is where we pay our nursing
facilities and our operating grants and contracts totals
4 billion.
And, there you can see the difference between the State funds,
the Federal funds and, the other funds that total the
4 billion.
>> FRED HESS: Where do the other funds come from?
>> PEGGY MORNINGSTAR: Other funds are the tobacco funds and,
lottery funds.
Different areas there.
>> JENNIFER BURNETT: And assessment -- program.
>> FRED HESS: Okay.
>> PEGGY MORNINGSTAR: Human and community based services is
a aging waiver that's almost a billion dollars in total funds
until you add the State funds, Federal funds and other funds.
Our long-term care managed care, which is our life program,
appropriation, is 274 million, once you add, the
Federal match.
Services to persons with disabilities, which is, Commcare and
independence and OBRA waivers, 749 million and attendant care
which is our attend and care waiver, Act 150 state program, totals
344million, so that is the 6.4 billion, broken down by
appropriation and waiver programs, at this point in time.
Again high level view, hot off the press.
From our budget office, this morning.
So -- I want to thank Ben for pulling these screens together
he has been my assistant for the summer.
Any questions?
>> SPEAKER: Can you tell us whether it has gone up or down,
has attendant care stayed the same, decreased Act 150, um, you
know, are we losing people I'm not seeing how this is effecting

us.?
>> PEGGY MORNINGSTAR: So, this just on the -- from the State funding.
This is the State funding side you can see that, long-term care, which is in the nursing facilities operating -- operating contracts.
Has increased.
From what we spent, to date for 15-16 to what they're projecting we will spend, this year.
Same with the other, four appropriations.
But what you're talking about, more detailed review we're currently doing what we call rebudget for 16-17 because, they didn't give us what we wanted.
So -- we have to sit and actually reconfigure the budget.
On an office level.
>> SPEAKER: That will let us know how many people can be served?
>> PEGGY MORNINGSTAR: That's what we're currently working on.
I have I think, until September to come up with that.
Thank you.
>> KEVIN: Just to add, Pam I mean, the appropriations -- just to add what peggy is saying the appropriations increased, but always keep in mind, so are the enrollments, so, yes we're seeing increases in our appropriations, but, the real question is whether they're matching the ARC of increase for the enrollments that's what peggy is in a rebudget process she is focusing on right now.
So, that's a question we do have to answer in terms of being able to make sure that the programs are funded appropriately.
>> FRED HESS: I have a question.
Kevin, when we get the increases in everything, of people, is this going to be able to keep up with the amount of people?
Because once we go in managed care you know as well as I do -- you know as well as I do, the -- it's going to increase, almost double, okay.
The amount of people that are going to be on services, so, is this budget going to be able to handle that?
>> PEGGY MORNINGSTAR: I'm not sure why you think it will double?
>> FRED HESS: Well maybe not double at least, it's going to

increase, phenomenally, okay.
It is going to increase massively.
Is this budget going to be able to handle that?
>> PEGGY MORNINGSTAR: Well, I can have Virginia talk to our CMS waivers are you know, they have certain numbers of enrollments that we protect but go ahead Kevin.
>> KEVIN: You're basing that on what you're seeing as demographic changes.
>> FRED HESS: Yeah.
>> KEVIN: Okay.
So we're recognizing, we have not seen numbers double at least in the near term.
Thank goodness as all I can say to that.
But we're seeing pretty dramatic increase newspaper some programs
>> FRED HESS: Is it going to be able to handle it?
That's what I'm wondering are people going to have to be denied getting services, because of the budget?
>> KEVIN: So we'll answer your question cautiously.
Peggy's rebudgeting process, will evaluate, how it will be able to handle it.
We're worried
>> FRED HESS: Do we have a concontinue sequenceacy plan in case we get more of an increase than --
>> SPEAKER: If we don't get enough an increase it's our job as community to get in those services start making demands of these guys.
I'm sorry but I think, there's not enough to serve the number of people, we need to get inside those offices at that capitol and tell them we need more money for our community
>> FRED HESS: Yeah.
>> KEVIN: And as objective governmental employees we could never.
[laughter]
>> SPEAKER: I don't work anywhere.
I quit.
>> PEGGY MORNINGSTAR: We do look at the increase in the enrollment.
And services to protect our requests.
So, them under funding us, does pose, a difficult situation

for me to rebudget.
>> SPEAKER: William White, bill white from AARP we have not talked about inflation and the increase in medical costs so it's probably a wash just looking at the figures probably the same amount last year as this year let alone any increase.
>> SPEAKER: That's true in medical.
>> PAM MAMARELLA: It's important we wait to see the September report you'll put together that translates these dollars into service to people.
So that we have an understanding of what it is that we're looking for and, what kind of input you'll need from us, as consumers and provider in the system.
So do we have any other questions?
For the sake of time, it would be good if we can move on so thank you very much peggy.
>> PEGGY MORNINGSTAR: Thank you.
>> PAM MAMARELLA: We look forward to your next report on this.
>> PEGGY MORNINGSTAR: Thank you.
>> PAM MAMARELLA: Okay.
Next on the agenda is, Randy Nolen, he is going to talk to us about employment services update.
>> RANDY NOLEN: Readiness review.
>> PAM MAMARELLA: I apologize readiness review.
Thank you Jennifer.
>> RANDY NOLEN: Good morning everyone my name is and owe Noelen with the office of long term living and, among other things I'm overseeing the readiness review process.
As we move towards managed care, so I have a couple of slides for you.
I'll go over them very quickly if you have any questions, please ask.
Basically the purpose of readiness review is to measure the readiness of the managed care organizations prior to, CHC going live in all 3 phases starting with the southwest in July of 2017.
Readiness review, criteria and benchmarks are set by the department we'll do readiness review through two processes desk reviews and own site, a lot of policies on desk review, policies and procedures we'll go on and go on site reviews to make sure

those policies and procedures and things actually work.
So that would be part of the process.
Readiness teams we'll have one team responsible for each MCO.
And, that team will have, 3-4 staff, plus, a host of subject matter experts from different areas.
People from OHMSAS, third party liability.
Our bureau of informational systems, that we'll look at the IT systems.
So we'll have a number of, subject matter experts that will be assisting, with the readiness review.
The readiness review will, CHC will review all the LTSS components and work in conjunction with HealthChoices to review physical, components, that's if we're using the same MC Os, if there's cross over MCOs, if we're using an MCO that physical HealthChoices isn't, then we'll do the physical health part of it also.
So there's a lot of work to do, in regards to that.
This slide is showing a little bit about the readiness roster who is going to oversee the process we'll have a supervisor of the process in a number of staff under them.
And then we'll have some subject matter experts, that will look at following areas member materials, member services, staffing training, provider materials provider services, quality management, covered services, the IT systems, contracts and subcontracts owned other administrative services financial reporting and records retention and operations.
We're also looking at value based purchasing so we'll have, a number of people looking at it, this is not an all inclusive list what we'll be looking at, these are some of the main areas we'll be reviewing and monitoring.
The MCOs must, demonstrate to the department, the compliance with specific policies and procedures.
As outlined in the CHC agreement and, through various CMS recommendations.
And we have a list of things here, we'll be looking at the administrative functions they're enrollment related functions anything to do with member services, service provision, network adequacy, couldn't knewity of care, grievance and appeal and fair hearing process, critical incident monitoring and reporting quality assurances, systems testing program integrity and

encounter data and financial functions.
We'll be looking at that stuff, we'll have guidelines when we want things submitted we'll have guidelines and benchmarks when we want a certain percentage of things completed.
We'll work with the MCOs to make those dates.
We do have a process in place, to look at the MCOs make sure they're going to be ready by a certain date.
To provide services.
And we'll be continuing to work with them to meet those dates.
The MCOs must also demonstrate they're going to coordinate with various entities that including the behavioral health MCOs the independent enrollment broker and financial management service broker and, maybe other entities that they're also going to be required to coordinate with.
And then once we're done writing the review the results of the readiness review will be providing to the contract monitoring teams we'll set up contract monitoring teams sort of patterned after what HealthChoices does.
And their responsibility will be to monitor the contract ongoing basis looking at any changes that may occur with the MCO as far as policies network, is going to be a big thing we monitor, continuously.
So all issues that we identify, from readiness are he view will be part of the ongoing monitoring process.
And then, there's also a, process we'll put in place that's called early implementation evaluation.
That will be learning from what, happens in the first couple of months.
When the southwest and then we'll be implementing things to correct that or identify issues as we move across the rest of the zones.
We also will have, a contract with the external quality review organization.
That will also, provide us review the data that comes in.
They're currently, entityity that HealthChoices is uses, it's the same process that they go through.
And this slide, is just a little bit of a southwest time line.
We're -- the hope is we'll identify the plans, and announce them in August of this year and then we'll be begin readiness review in September.

What we'll do, is we will have a meeting with all of the plans that are identified.
We will walk through with them, what we expect in the readiness review process.
How we expect to be done.
The tools that we'll be using to perform readiness review.
And then, encourage them to start submitting stuff to us for review.
And then like I said the early implementation function we'll be looking at that early November we'll be looking at it, the lessons learned and trying to evaluate that.
We will be -- continuing to monitor, all of the outstanding items through readiness review all the way up to implementation.
And afterwards.
There are a number of things we need to have done by a certain period of time to ensure that the MCO are goes to be ready to go July 1, and we have established a go or no go day of March 31st, some of the things that we're really going to be concentrating on that need to be in place at that point in time, is the network, provider inest work.
The IT systems and systems that need to be utilized to ensure that care plans can be down loaded.
That providers can be paid appropriately.
Those are some of the major things we're really going to be looking at.
Plus, their call centers and how the interaction is going to be with participants so there's a lot of issues that need to be done and we need to be comfortable with it by the end of March to ensure, satisfactory us to the MCO is going to be ready to go by July 1.
We'll be establishing monitoring teams in the spring.
So they are ready to roll and July 1, comes up, we will be activating what we're going to you will call the SWAT team that handles a lot of issues and problems that come up they're going to include, deputy secretary and chief of staff and all of the bureau directors in OLTL that will handle, immediate problems on a daily basis.
That occur.
And then, we will continue to review, one of the biggest

things we'll have to continue to review after the 180 day continuity of care period we'll have to continue to review to ensure, that network add quadacy continued to be adequate that we have enough providers and, monitor how the MCOs will continue with the networks as they move into the future.
And then we did throw a southeast time line in.
Some of the stuff is similar on that, it's just to move the year out.
It's the same steps it's just, move the year out in regards to that.
Then the slide that, we probably you know we always love to put in, the one that asks for questions.
>> PAM MAMARELLA: We have a couple of quiz, Fred do you want to start?
>> FRED HESS: Yes.
With this go or no go -- does that mean that, you know it's possible that, this may not be implemented?
I don't understand the go or no go
>> RANDY NOLEN: Not the whole program a particular MCO may not be ready to go July 1, you may need network adequacy we'll not allow you to start until September 1 it's not in regard to the whole program itself.
>> FRED HESS: Okay.
So if they're a no go, and, say there's only two per -- for that region, that means there's only going to be one for that region, correct?
>> RANDY NOLEN: We know there's going to be 3-5 foreeach region we'll have two of them if one of them is not ready we're going to work very hard with them, we realize, the networks the MCOs realize, one of the questions you asked earlier about was, how, providers are going to get into the network and things like that.
The MCOs are currently, discussing, and talking with all of the providers out there, they have a lot of letters of intent with the providers, that if they are picked as an MCO, they're going to start the contract process with them immediately.
They have already got a lot of providers that say, hey if you'll be part of the program we want to be part of the MCO a lot of the MCOs have really moved forward on identifying providers already.
>> FRED HESS: Okay.

>> PAM MAMARELLA: I had a question about the early implementation function I'm a little unclear what that actually is.
>> RANDY NOLEN: It's part of our, part of the quality review area that we will be putting into place to really take a look as the MCO comes up, and starts providing the services how we'll monitor them.
And is there lessons learned things they did wrong we can correct as we move to the southeast it's gone to be the first up front look at, we brought the process up.
>> PAM MAMARELLA: Any other questions, Pam?
>> SPEAKER: My first question, or comment is, any representative from this committee, going to be part of any of the readiness review that's been a recommendation ongoing from the consumers on this.
And you said, different experts well, consumers are experts in the services.
So, is that going to happen?
>> RANDY NOLEN: At this point in time we're in the initial phase of what we're doing with ready any review.
We're looking at the tools at this point in time trying to create the tools that's been our first look at.
Part what we need is, probably need feedback from you guys how you see yourself involved in the process.
And how you would like to be involved in the process.
>> SPEAKER: A lot of things that you had up there, really hard to see, I'm sorry, on your PowerPoint.
The letters are small and not good contrast but any way.
From your PowerPoint I did identify some areas that consumers definitely, should be part of, could comment I'm going to give that to you.
The other question is, some of the definitions, of the first list of areas, that you would be looking at, do you have definitions?
One the first PowerPoints when you were talking about the teams and,
>> JENNIFER BURNETT: This one?
>> RANDY NOLEN: Probably this one.
This one here Pam talking about member services member materials -- staffing and training.

>> SPEAKER: One more list before that, I'm sorry.
>> RANDY NOLEN: That is that.
There's one about definitions.
I asks --
>> SPEAKER: The things you'll be basing the categories you're basing them on, you'll be he will vale waiting them on, definition of those, there's another area listing how you have guidelines, are guidelines we can see in advance?
>> RANDY NOLEN: Well, what we're doing is, the readiness review is based upon the agreement, everything that we're asking for in the agreement, we'll be looking at in readiness review, we'll be measuring everything we expect in the agreement. So that's where the, guidelines is based on, and where the categories are coming out of.
>> SPEAKER: With the agreement, is that out for public to see?
The -- did I miss that.
>> KEVIN: Absolutely is it's on the CHC web site.
All of the terms are broadly or specifically defined in the agreement
>> RANDY NOLEN: Same agreement that was put out when we put the draft of the RFP out.
They were put out together
>> KEVIN: If you wanted to see the most up to date version, the DGS web site has, the draft agreement published with all of the addendums which are the corrections made.
Pam I do want to make a point of clarification about consumer participation, I think, we're very open to consumer participation in some form in this process.
But, it has to be, the participation of the consumer is going to be conflict free which means that, if the consumers had a any kind of relationship employment relationship with a provider that any way they had worked to the managed care organization they're not going to be able to participate, that's an inherent conflict of interest.
When we have consumer participation that will be -- if you have recommendations, please, keep that in mind that's going to be receipt helpful.
>> FRED HESS: Kevin see how I work for a Center of Independent Living which has, absolutely, nothing to do with MCOs

or anything else, right?
But, we do have a sister corporation, that you know, of Dawn's services which does do attendant care would that cancel me out?
>> KEVIN: It would have to be evaluated.
We would have to make sure that there was enough of a fire wall in place to represent objectivity it's pretty important in this process.
To be, fair to other participating MCOs if the sister organization you're describing is contracting with one of the MCO s not the other, for example, we would have to make sure that, that the person who is involved in that process, was not in any way showing favor Tim to any other managed care organizations just like everything else we do, it has to be, conflict, no apparent conflicts of interest, have to be
>> FRED HESS: Short answer no.
[laughter]
>> KEVIN: Short answer maybe.
>> SPEAKER: Consumers receiving services they're just receiving maybe attendant care but they, would be really good expert.
>> KEVIN: Consumers receiving services would be an expert actually.
But they, obviously, the same provision applies.
So -- okay
>> SPEAKER: Conflict free.
>> KEVIN: Having participants, involved in this process in some way, if they're receiving services, in the home and community based waivers or in a nursing facility, or, some sort of role with dual eligible we would gain value from that input we'll make sure that, there's some role we'll be borrowing from experience from other states to make sure this happens getting back to Randy's earlier point if he could, give us a sense as to how you think that role should be framed out we're very open to that.
>> PAM MAMARELLA: Any other comments or questions for Randy?
In the room or, Pat on the phone?
Okay.
We just bought back a lot of time.
Thank you very much Randy.

>> RANDY NOLEN: Thank you.
>> PAM MAMARELLA: Next on our agenda is employee services update.
Employment services update, with Ed Butler.
>> ED BUTLER: Good morning, always a pleasure to be back to talk about passionate subject of mine and yours employment.
So I'm here to give you a quick overview of everything that has happened with the employment in the office of long term living.
You're aware, we presently have two employment service definitions namely provocational services and supported employment.
With the renewal of our waivers, we'll be expanding to five new employment service definitions, these employment service definitions will continue under community HealthChoices.
The new employment service definitions are, job finding, job coaching employment skills development, career assessment, and benefits counseling.
These new service definitions were submitted to CMS in June, not yet approved and projected to be in place by January 2017.
Now I would like to move onto talk a little bit about the data that we're collecting in the office of long term living.
Because, when we talk about employment we need to have a measurement.
So right now, we're using the SIS system we're also using HIXUS we're working with service coordination entities to complete those areas of HIXUS that pertain to employment and goal or volunteerism that may indeed lead to competitive integrated employment.
In addition to that we're using question pro which has a two phased if a Facet, one in which we can survey, use to survey various entities an the other, Facet of is to use it as a monitoring tool.
So presently we have now developed, four employment questions , toe be included in the monitoring tool to look at employment within the office of long term living.
And in addition to that down the road, as we're looking towards the future because we know, where the office of long term living is, and how we're doing right now with employment, which is not very good, but I'm very optimistic now that we have

released the employment bulletin that we're going to be moving in the right direction.
So, we are so committed to this employment first that we have engaged employment, in almost everything that we're going to be doing.
So, down the road, when we start looking at needs assessment, we're looking at, potentially putting, employment type questions, in that needs assessment.
We're looking at putting in a monitoring tools participant monitoring tools and other quality type monitoring tools, now, again, I want to reiterate this is in the future this is not, going to happen, immediately.
I told you in the past, build it will come, we will build this and, this will all come to fruition.
And in addition, to this, this will also be included with CHC and the MCO data.
So they -- we have that included in there, so they will be begin to also capture data.
To give you way little bit of an idea of, what we've done to date, some of this you've heard before.
But, with service coordination entities, we have used question pro asked them to gauge where they were with the employment.
As I told you in the past, we found that, not many of them, were very much engaged in employment, because, the feedback was we need to tend to basic needs.
So in addition, to that I reached out to five service coordination entities and had an interpersonal communication some dialogue with them on a one-to-one basis and basically, it reaffirmed, what the survey had told us.
And they basically, said you know, Ed, we're basically so busy addressing basic needs we have not even scratched the service of employment.
So one good thing is, since I've last been here, we have looked at the data of service coordination entities that have been providing, prevocational and supported employment and we saw an increase in those service coordination entities providing those services.
And indeed, billing for those services.
So to let you have a little brief overview of our goals

within the office of long term living, we're looking at our data to reassess it and improve the collection of our data.
We need a good system to be able to measure the quality of our initiative namely employment.
And employment first in the competitive open labor market.
We have reached out to stakeholders had one stake holder meeting in May so far, we received some valuable feedback and, some good input, which we indoctrinated in some of the things we've put out.
As I referred earlier, we released our employment bulletin in conjunction with the anniversary of the ADA, quite fitting I might add, and -- to that end we have two webinars scheduled for our service coordination entities immediately in August, one on August 9th and the other one on August 23rd.
In addition to that, we are continuing to develop and implement, service coordination resources and training.
Because we cannot have an expectation of our service coordinators if we don't give them the necessary tools that they need to carry out the task.
As far as budget, we're looking at some joint funding and, looking at some memorandums of understanding.
With other state agencies and departments to promote employment, since employment first, is going statewide.
And as I said previously we're still awaiting the CMS approval of our service definition.
We're Fostering very strongly, some interagency collaboration and some business out reach and within the office of OLTL to keep us on task, we have developed a long term and short term strategic plan with some time lines.
We have looked at the national average and our goal for services namely jobs, our goal is ranging between 14 and 16 percent on a national average.
So, that's the ideal marker for us to start.
I'm confident that we're going to exceed beyond that, if we work long and hard and consistently at it.
And, the thought that I want to leave you with is -- every OLTL participant every talent, every opportunity and every competitive integrated job.
That's what we're all about, and that's what the employment initiative in OLTL is all about.

Thank you and at this point I'll be happy to address any questions anyone might have.
>> SPEAKER: Hello Mr. Butler.
I talked to you on the phone in one of your conferences a little while ago.
Really my question still remains the same.
What is going to be done, in the office of long term living and in the State of Pennsylvania to ensure that if, people go to work and they get jobs, what's going to be done to ensure that there's services, remaining intact that they need to live.
Is that the income limit going to be going to be raised when I spoke with my service coordinator about an opportunity aides come up with -- I'll just say it, PPL2, to receive a stipend for something I'm working on with them.
He told me on the phone, that the income limits, was objection a little bit over $2,000 a month.
Husband husband 1,090.
>> SPEAKER: It's less than that.
>> FRED HESS: 1090.
>> SPEAKER: If it's less less than that, what I was told, how in the heck is men supposed to maintain a solid employment, opportunity, that is not part-time, that is a career, but, they don't make maybe more than, 40,000, a year let's say.
How are they supposed to live on that, work that job and still maintain the services, they need to live.
That's the glitch with this whole initiative.
And unless that income level is raised to something a lot more manageable areaable for a person to live you're not going to sigh, the numbers you want to see of people getting involved in the program because that's the crux of it.
You know, I mean, I've been, I've been to college I have a masters degree I'm a published author for crying out loud, but yet, I still can't maintain the type of life I want to live, because, if I do, the resources will all be stripped away.
>> SPEAKER: Don't even look at the out-of-pocket cost being a disabled person, it's huge just because we can't do certain stuff.
That's nothing to do with the service plan.
>> SPEAKER: Yeah. In order for you to see this influx of participation, you want to see in your program I whole heartedly

agree it should be there, but until those obstacles are met and lifted somehow, you're not going to see it.
And it's a shame.
>> SPEAKER: Wouldn't mod help keep your health insurance and waiver if you're eligible for MAWD you work with -- isn't that the answer?
>> SPEAKER: I didn't hear that.
>> SPEAKER: I can speak to that.
A little bit --
>> SPEAKER: I missed the question.
I'm sorry.
>> PAM MAMARELLA: Pam do you want to repeat that question on the microphone and probably direct it, if you direct towards me so that we can keep it, moving forward.
>> SPEAKER: Sorry I'm just saying that would be MAWD be the answer because with MAWD if you qualify for that while you're working, you should still be able to keep your long-term services supports if you are still getting Medicaid isn't that correct?
>> PAM MAMARELLA: Tanya, do you want to respond?
>> SPEAKER: Can I please?
>> PAM MAMARELLA: Yes.
>> SPEAKER: I have a friend of mine Lona in Philadelphia, who works's psychologist, she is disabled but, the only way she is living, and able to keep her job even with MAWD is because she is living with her parents at home still and they're doing the majority of her care, they're driving her back and forth to work. They're doing, like a lot of the basic needs, living stuff because if she, were to go out on her own with the limited income, that she, that she gets, because of MAWD, she would never be able to make it.
>> PAM MAMARELLA: Thank you.
I think we have a question or a comment on the phone Pat?
>> SPEAKER: Brenda?
>> PAM MAMARELLA: We're going to put the Mic down, go ahead Brenda.
>> SPEAKER: Okay.
And I know, you're going to hear me say this loud and long. Perhaps Tanya is MAWD is the answer I don't believe it's the answer if it's implemented correctly -- county assistance worker railroads not properly trained to apply the formulary but the --

the large answer to this question is because MAWD was so strict in this year's budget it can't be a solution unless money is put back into it.
But the larger issue to the question is, Act 150, has to be opened wide, to allow for people to transition onto Act 150. When their income exceeds the waiver and -- I would argue that there also needs to be a transition period put in place as far as I know, it doesn't currently exist to allow people to, remain on their current or on community HealthChoices, for the same period of time as a trial work period and then, transition onto Act 150 once they have proven they are disabled.
>> JENNIFER BURNETT: Thank you Brenda.
Those are all good ideas.
And Tanya, the issue that you're talking about is one that we want to tackle:it's not, there's no solution today.
But it's one that we're very much aware of and, part of, I don't know if you saw the bulletin, but part -- the bulletin does talk about, why don't you talk a little bit what it talks about
>> ED BUTLER: Part of the bulletin talks about resources some of those resources are very familiar to all of us.
Namely the office of vocational rehabilitation.
The mawd program and certified work force incentive counselors and ticket to work.
So we're starting those as the initial building blocks of resources that are available.
To start helping people, who are interested in segwaying into competitive interest greatlied employment
>> JENNIFER BURNETT: Brenda what you just talked about, goes a little further that's something we had not really considered but I think is a good idea, which is the transition to Act 150 and how do people transition from waiver to Act 150 effectively and smoother.?
Those are pieces we appreciate that feedback but we'll have to, tackle Ed mentioned that he, had a stake holder meeting I guess did was half a day meeting sometime in May.
We brought together a lot of, employment experts people who are really interested in the employment of people with di disabilits to the table they had a lot of good ideas but Brenda maybe you want to I think Tanya did you attend that by phone.

>> SPEAKER: Yes.
Yes, I did.
>> JENNIFER BURNETT: Tanya attended that by phone Brenda were you part of that?
>> SPEAKER: No, I was not I would be interest -- if there's going to be a future meeting I would be glad to participate.
>> JENNIFER BURNETT: Okay.
We'll make sure Ed has your contact information.
If anyone else is interested in this issue, and wants to participate, in Ed's process ed is going through in terms of engaging stakeholders, you can, let either talk to Ed after the meeting or send a request to the resource account.
>> PAM MAMARELLA: Pam?
>> SPEAKER: Is this for aging waiver as well or is it going into that?
>> ED BUTLER: It's not for the aging waiver although, we're not discouraging people in the aging waiver
interested in employment and, independently we've been having some conversations with Rocco Clonney regarding the implementation waiver program,.
>> SPEAKER: Going to be more barriers over 635 they won't qualified for MAWD they won't have an Act 150 program, it's going to be a lot harder I do know some people over 65 who want to work, even a little bit.?
>> PAM MAMARELLA: Thank you Pam.
Do we have anyone else with a question?
Or a comment for Ed?
>> JENNIFER BURNETT: I would just say that, what Ed is doing now, is laying the ground work as we move into community HealthChoices.
If you recall, in community HealthChoices we ask the plans, to submit their ideas for inknow vision around employment and, some more to come on that as we move into managed care.
But Ed will be sort of our expert to work with managed care organizations to help them as they develop their any kind of employment program that they want to have.
>> PAM MAMARELLA: Yes.
>> SPEAKER: If I can add one other comment this is Brenda Dare I'll be very brief people need to be aware that -- it's implemented in Pennsylvania they could potentially be a source to

shelter, some of the income without, rendering people ineligible
for community HealthChoices or other supports they need
and, we need to be educating the people that we interact with on
a day-to-day basis that program is due to roll out,
hopefully in January 2017.
>> JENNIFER BURNETT: Did you just talk about the able
program?
>> SPEAKER: Yes.
>> JENNIFER BURNETT: We can have someone come and talk about
able if you -- the able account possibility if you're interested
in that we can do that, but, we're working very hard, with
our partners in the office of developmental programs, and, the
department, the treasury department on implementing AB,able program
we're
working with the CMS
and the Federal government and IRS to get some clarity on the ABLE
act the actual law and Pennsylvania's law around this.
And, so any ways we are getting ready to issue some guidance,
but we're working closely with the Department of Treasury, on the
ABLE act we can have someone come and talk about that, if you're
interested in it.
I want to say, that, Brenda you mentioned the county
assistance offices and their understanding their knowledge,
they're -- you know, what they know, and certainly service
coordination entities, what they know, what they know about this,
this is going to take some time, but the county assistance
offices are, one of part of the office of income maintenance my
colleague Lordes Padia, the deputy secretary for the office of
income maintenance, she and I and Nancy Thaller deputy secretary
for the office of developmental programs, report on a -- every
five weeks to the secretary on some of the data that was just
mentioned, that Ed just talked about through something
called people stat, we, it is employing people in the DHS
system, getting finding employment getting people employed.
Including people coming off of the TANIFF temporary native
families these are all things that we're reporting to the
governor's office, this is very important, secretary is really
important, as we heard there are barriers to it, those
are barriers that, we'll need to address and Ed is sort of our,
team member to help us, keep that -- keep those things moving.

>> PAM MAMARELLA: We have a question or a comment from Jessie and Pam I see your hand coming up Jessie.
>> SPEAKER: This is just a small point, I had to step out for a second, so apologize if it's been raised already.?
But, just thinking about the all these managed care organizations are going to be, ramping up their operation so to speak in Pennsylvania and, I don't know as part of the engagement around their procurement, negotiations, whether there's a, an ability to put measure on them to hire people with disabilities to help staff their operations and run their operations if that can be part of the -- you know providing families sustaining real jobs, for people with disability, as part of their mission of ramping up in Pennsylvania.
>> JENNIFER BURNETT: Thank you Jessie.
>> SPEAKER: My question Jennifer when you talk with the people from OMI, income maintenance, are you discussing the issue of, the Medicare deductions not being a deduction to allow you to get on Medicaid?
Because I'm struggling with one case right now, really -- a lot.
>> JENNIFER BURNETT: We're aware of that problem.
>> SPEAKER: Getting working onto get resolved.
>> JENNIFER BURNETT: I don't know how far along it is, it's in the woods I'm not sure but I can check on the status of it.
I know, I know it's being discussed.
>> PAM MAMARELLA: Any okay other questions or comments?
Ed thank you very much.
But but thank you.
>> PAM MAMARELLA: So we are officially now away ahead of schedule for the first time.
>> FRED HESS: Second time.
>> PAM MAMARELLA: I missed that, before we open it up for public comment is there any other complements or questions, that anyone on the committee has, for Jennifer?
>> SPEAKER: Pam again it was a question I was going to send in, but -- I'm just, wondering about the managed cares met with, I believe yourself or, someone from OLTL or, department of human services, but, I was, told that there wasn't any representation consumer representation, at the table that was a parent, I thought it was a recommendation of the group, I might have missed

it I was very surprised is there any representation I thought that, the one individual, he is not here today the one consumer, who Richard like most conflict free, was he part of that? Because I thought that was the one that you guys were going to look at.
>> FRED HESS: Yeah.
>> JENNIFER BURNETT: Are you talking about the oral presentations by the managed care organizations?
>> SPEAKER: Yes push.
>> JENNIFER BURNETT: Buffer no, we cannot do that that's built into our procurement law, it's blackout, the State staff are what allowed, who are allowed to be in those presentations. So it's just, we can't even entertain that, we've pushed the envelope on our push the limits on the procurement processes big time and, that was, definite knitly something not going date of birth allowed
>> SPEAKER: Is that CMS, the person seems?
>> JENNIFER BURNETT: P Pennsylvan ia's procurement law.
Okay.
>> PAM MAMARELLA: Thank you.
So at this point let's open it up to the public do we have any public comment or questions?
If you want to -- start to make your way to the microphone. Gentleman in the blue shirt and, I'm going to ask again that we, keep our comments, or questions, to or the comments really to two minutes from the public also.
>> SPEAKER: Yes my nape is mark Saltis I'm with MSI medical supplies.
I'm also a board member of the Pennsylvania association of medical suppliers.
Recently, we became aware that, Hanneman university hospital has been dropped from the united health care community plan and, what that is going to create is a situation where, certain managed cares will, have -- be contracting with the hospital and other providers will not be contracted with the other managed care plans.
So, patients some of these patients are going to have to pick between their hospital and other providers I just wonder if you were aware of this and whether it was something that was, brought

to your attention before they decided this.
And, what the impact will be on the readiness and the network adequacy of that.
>> JENNIFER BURNETT: I'll let Blair -- before you respond to that, you are talking about HealthChoices not community HealthChoices?
Because we don't even have contracts yet with any of the --
>> SPEAKER: Correct.
It's --
>> JENNIFER BURNETT: Talking about HealthChoices.
>> SPEAKER: Yes they are one of the 14 plans.
>> JENNIFER BURNETT: Right.
But we have not, we haven't -- it is not under the hospices of long term living.
And the question, if you want to talk to a state person it would be for Lisa Allen deputy secretary for medical assistance programs.
I would recommend too, if we don't get you know you don't get your answer here you go to the MACC meeting medical assistance advisory meeting ask there.
Or ask Lisa directly.
>> SPEAKER: Thank you.
>> JENNIFER BURNETT: Go a lead.
>> SPEAKER: I would just add, so, you know the focus of the contract termination, has been on the coordination care for our united health care members that are already with you know, getting -- receiving services from Hanneeman or the hospital or physicians.
All of the MCOs don't contract with all of the hospitals.
And so, we had attempted contract negotiations with them and, to the question, DHS aware, certainly we coordinate very closely with office of medical assistance programs to make sure coordination of care is handled properly if a contract falls through like that.
If there's any specific questions, that you would like to talk about, how that works, things like that I will be happy to talk to you further about that
>> SPEAKER: Okay.
Thank you
>> PAM MAMARELLA: Thank you.

>> SPEAKER: Wanted to follow-up on the discussion about employment.
>> PAM MAMARELLA: Introduce yourself.
>> SPEAKER: David gates health law projects I was involved in Ed Butler's group on employment.
So -- certainly an issue near and dear to our hearts.
First of all, I think that, there really needs to be a lot better training, both the county assistance offices and, of individuals on waivers, about mawd there's a lot of confusion.
And I know I've represented consumers one of whom is actually on this committee, whose county assistance worker didn't understand that being on MAWD meant he could continue to stay on waiver.
And there are some income disregards that people don't know.
And it's a technical thing so I think we need a lot more, training on how that works.
Secondly on Act 150, I would like to point out, that neither this administration or the previous have supported increasing Act 150, that's unfortunate, I think it needs to be increased.
The problem has been there's only state funding.
There's no Federal match for Act 150.
And it also becomes more logistically problematic, when moving to community HealthChoices, because, as I understand the proposal, those folks if they, transferred to Act 150 would then be taken out of the community HealthChoices, because it doesn't cover Act 150.
So, that could be problematic there in terms of, their providers.
So, I think, that it's really, really -- we need to get serious looking at what we call spend down to waiver, those individuals, whose income is above, the waiver income limit which by the way is $2,199.
If it's over that limit if they would be able to -- pay what is basically a monthly deductible towards their care, which would enable them, to then become keep on community HealthChoices and keep their waiver services.
So I think that's really, consistent with the governor's declaration of employment first and I would hope that really, office of income maintenance, seriously considers that.
Thanks.

>> PAM MAMARELLA: Thank you David.
>> SPEAKER: Allen Holdsworth again, I've got 3 questions I'm going to be talking a lot, in the next few moments about MAXIMUS.
We're doing some research into them as a company.
Because you know it's a global company, so they work in Australia, Canada UK and as well as the U.S. base.
One of the questions I've been asked to ask behalf of that is, will you be us anotherring the LEMAR system to you know, within the program that you're asking MAXIMUS to do, is that what the system is called LEMA?
>> JENNIFER BURNETT: I don't know anything about that.
>> SPEAKER: Computer system which basically, helps ask the questions as to whether people qualify for attendant care services employment or whatever.?
It's a system that they use.
MAXIMUS uses this all the time.
So I was wondering whether you had any discussions with them about that.
>> JENNIFER BURNETT: No we didn't as Kevin mentioned I mentioned earlier we're going to put the procurement out, the -- RFP, request for proposals out for public comment for 3 week he's would recommend, that you, give us a recommendation on, yay or nay to this system.
>> SPEAKER: Definitely a nay, the second question is this -- the second question.
>> JENNIFER BURNETT: Very clear.
>> SPEAKER: More than -- I left my paper at home, the ones I can member from making notes.
The other question is asked tore you there's a thing called the thresholds, you understand what the threshold is.
So this is like how you know, if you're a disabled person you go through the questions, if you answer the questions in a certain way you meet a threshold you get your services.
What has been happening with MAXIMUS and other company in other countries is that whoever is employing MAXIMUS that IE the States, will then be able to have a meeting with MAXIMUS, if targets are not being being met which target they could be profit targets or MAXIMUS or some other targets putting, you know, putting people off services by the State.
And, in all examples I've been able to find, there's been no

stake holder involvement when those thresholds have been moves.
Basically it's changing it up a little bit change a little
bit in the computer certainly that person was qualified is now no longer qualified.
And they're doing that, you know, without any stake
holder involvement in Canada and Australia and in fact just been
a documentary in Australia from ABC about what they have been
doing there and how they have been found out they have also had,
disabilities discrimination cases settled out of court,
whether they refuse to employee a disabled person, illegally.
So there's a lot of stuff we want to bring up about that, I
will send some stuff in.
I've been sharing with some of the members of the committee
you can have a look at it and hopefully, in that 3 week period
you can make sure not only MAXIMUS, amount to anything, doesn't
involve stake holder involvement, especially when it's about the
assessment tool being moved around so we can meet --
>> JENNIFER BURNETT: . Miranda plus --
>> SPEAKER: Sometimes fraudulently as well, come back and
pay the States back, and working for them, they have been falsify
ing claims.
>> SPEAKER: He investigating them, global level.
>> JENNIFER BURNETT: MAXIMUS does not conduct that
eligibility determination, our county assistance offices, conduct
the eligibility determination for financial eligibility.
And our area agencies on aging, conduct the clinical
eligibility for the functional need that you're talking about.
Then our service coordination entities, do the service plan
or care plan with the consumers for the person centered
planning process, MAXIMUS is an objective independent, the way
we're using MAXIMUS, they don't have a tool, that would, yay or nay
someone -- they're using what we, the inputs that we give them
through the level of care determination, through the financial
eligibility determination, and for physician service.
They use, all ever those, processes being we require.
So, in our use of MAXIMUS, does not include, that kind of,
threshold, conversation, they don't -- they don't have anything
to do with thresholds they just take the input that we give them,
and -- it's very clear.
It's it's very clear what they do.

The only threshold that we have changed for MAXIMUS in the current contract that we have with them, which is the independent enrollment broker is, the expectation, that they conduct, they do the full enrollment, the full enrollment get someone from the time time they, you know, come on board, to the time they're enrollinged was, reduced from 90 days, they were given 90 days that was per -- through a lawsuit to 60 days they're now required to make a determination within 60 days.
So, I think it would be really helpful to have your input when we do put the RFP out for the new procurement that we're going to be doing.
But in the meantime we're doing some, fixes with MAXIMUS.
>> SPEAKER: Okay.
All right.
One last observation -- but, on the financial thing I saw, I know, I know it's top end stuff it's like -- maybe I'm wrong.
Almost half of your budget is going on putting people into nursing homes or long-term care.
Half the budget.
Right.
So -- you know, I think that, what I would like to see in the financial break down I'm sure we would all would, would help us to see how that money is starting to decrease, and talk about it, per head, how much is it costing, how much is it costing in the community those are the figures that we need to be seeing, we need to be seeing them change and, we need to have targets for those things.
So, that you need to say next year, that figure for nursing homes you'll be going down, this is going to be going up.
But that's what we need to be satisfying that helps me, Cassie says follow the money
>> JENNIFER BURNETT: One of my main goals with community HealthChoices to serve more people in the community thank you for that.
>> FRED HESS: Also the governor's goal.
>> SPEAKER: Hello everybody.
Lefter Ben net, with supports coordination I'm going to be quick.
[lestter
[the problems we're seeing with the -- MAXIMUS, I hope the

office of long term living stays involved when the managed care organizations come this.
I think it's great that I'm able to run to the office of long term living and say I'm having problems.
I'm getting stuff done.
I'm having problems with providers.
I love the fact that I can run to the office of long term living and I get support.
So, Mr. Randy talked about and I see he is gone, he talked about some SWAT team.
I want to know more about that SWAT team hopefully that SWAT team will be part of watching over like, this whole community HealthChoices thing.
And making sure, maybe, they can be the people we can be running to, to say like this is what is going on.
Whether we're a provider, or whether we're an MCO whether we're a stake holder I mean, we're all stakeholders we're basically consumers too I just basically want the office of long term living not to back away and have managed care, just report directly to them, but, be able to still be available to all people involved.
That's it.
Thank you.
>> JENNIFER BURNETT: Thank you good recommendation.
>> SPEAKER: Thank you.
>> PAM MAMARELLA: Thank you.
Is there anyone -- is there anyone else who would like to make a comment or have a question?
No one on the phone?
So, with that said then, meeting is adjourned.
Thank you very much everyonement
[meeting adjourned 12:15]