November 7, 2016
EVENT: MLTSS SubMAAC

>> RALPH: Good morning, everyone. Welcome. Thank you for coming today. If I may, I would like to take roll call starting with Barb.
>> Barb Polzer liberty community connections.
>> Tanya Teglo.
>> Blare united healthcare.
>> Bill White AARP.
>> Bob Thiel.
>> Jenn Burnett OLTL.
>> Fred Hess disability options network.
>> Ray push knack health plan.
>> Jesse willed man SCU healthcare.
>> Pam your for Theo Braddy CIL of central PA.
>> RALPH: People on the phone?
>> Steve Williamson.
>> Arsen Ustayev.
>> Estelle Hyde AARP.
>> FRED: Nirvel else?
>> Raferl: Is Terry Brennan on?
>> TERRY: Yes, I am here. Good morning.
>> JEN: Is Pam on?
[NO RESPONSE]
>> RALPH: No, bon Bob is here.
>> JEN: Okay.
>> Brenda Dare.
>> RALPH: Anyone else?
With that being said, I would like to ask the committee members and members in the audience to please be courteous and professional in your language as best you can, I will have a point of order, if I believe the comments are getting off base, off target and those who are speaking, would you please try to limit your comments to 2 minutes. This meeting, as well as every other meeting going forward and in the past is listed on the state's listserv. I hope you get a chance to review those minutes. We have a captionist who is captioning this meeting as we speak.
Please turn off your cell phones and clean off your area where you are at before you leave, please.
Public comments, we will take them at 12:45 today or sooner, if we have more time.
Now I must read to you the emergency evacuation procedures.
In the event of an emergency or an evacuation, we will proceed to the assembly area.
To the left Zion church on the corner of 4th and market. If you require assistance to evacuate you must go to a safe area, located outside of the main doors of the honor suite.
OLTL staff will be in the safe area and stay with you until you are told to go back into the honors suite or you are evacuated.
Everyone must exit the building. Please take your belongings with you. Do not operate your cell phone and try to stay -- skip that one.
Do not use the elevators. Use stair 1 and stair 2 to exit the building.

Stair 1 is located at the exits honor suit through main doors on the left side near the elevator. Turn right and go down at hallway by the water fountain. Do not stop at the water fountain, keep ongoing.
Stair 1 is on the left. For stair 2, exit honors suite through side doors on the right side of the room or the back doors for those exiting from the side doors turn left and stair 2 is directly in front of you.
For those exiting from the back doors, turn left, turn left again. Stair 2 is directly ahead of you. Keep to the inside of the stairwell and merge outside.
Turn left walk down to Dewwberry Alley to chest nut street, turn left to corner of 4th, left to black berry Street, cross fourth and meet at train station. Thank you.
With that being said, turn it over to deputy secretary Jenn Burnett for OLTL updates. Thank you.
>> **JEN:** Thanks, Ralph.
Good morning, everyone.
>> **Awed Yens:** Good morning.
I will start out about asking Kevin Hancock to do a Community HealthChoices update for us.
>> **KEVIN:** Good morning, everyone. Thank you, Jenn. I just have a quick update procurement-related activity.
The microphones are very loud today.
As many of you know, our procurement state is still? Place. What that means is we are still not engaging in any type of procurement-related activities with selected offers until we have resolution -- submitted to procurement and just to give a little bit of background we have had 10 debriefs scheduled with Community HealthChoices when we selected the offers on August 30th. The last 10 were the week of October. We had 4 active protests we were working through. There were 64 were withdrawn. We are hoping the decisions will be finalized at the end of November. While all of that activity is taking place, we will continue to be in stay and not be engaging in any type of communication regarding the selected offers and we are also holding to the blackout period as well talking about specifics of the mechanics of the procurement.
With that, I will look and see if there are any questions.
It's basically the same as last month.
>> **FRED:** You said it's going to be done by the end of this month. So we should be getting started next month or it may go longer?
>> **KEVIN:** The way the process will work at the end of the month we will have the decision made and there will be a 15-day additional period where offers would have the opportunity to be able to submit a claim to Commonwealth court.
We are expecting at this point that we would wait out that 15 days just to make sure that it's not a decision made by any of protesting entities to submit a claim to Commonwealth court.
So my breast estimate at this point would be that at the end of the month will be earliest possible dates most likely second week of debts would be the date we resume activities assuming these are not taken to Commonwealth court.
>> **FRED:** We can't do it in December, but in January, I would like to bring it up to everyone now I would like to get a representative from each of the MCOs is that we have signed on, once they are signed on up here to have us ask them some questions, if we can get that on; that's one -- the reason I am trying to figure it out is what the time line is to figure out when we can get them up here and grill them.
>> **KEVIN:** We would have to think about how to make it work. We can certainly make it happen. We would probably have them present tend of the table at the same time.

>> **FRED:** I have a lot of questions as well as everybody else in here.
>> **KEVIN:** We will figure out the objectives.
>> **PAM:** Are you allowed to say who the four protesting are?
>> **KEVIN:** I am we released it publicly.
Unitedded, Guise inninger, Molina and gateway.
Any other questions for me?
Okay. Thank you very much.
>> **RALPH:** Thank you, Kevin.
>> **JEN:** Thank you, Kevin.
I have a few things I want to update folks on, things that are going on in the Office of Long-Term Living.
First, I wanted to just mention the independent enrollment broker procurement that is out for public comment.
On Friday the 28th of October, the draft solicitation was posted to the OLTL website and it asks for public comment on the choice counseling that the IEB will be doing.
What we want to do in this procurement draft is put out for public comment so that we can get more feedback on what we are asking within the context of this contract.
I wanted to -- the comments are due by Monday November 21st. If you want to go find it, you need to look under the DHS homepage, which is WWW.dhs.pa.gov. There is a tab for partners. If you pull down that tab and click on Office of Long-Term Living, it will take you over to the IEB procurement that's on that page.
We urge folks to go ahead and take a look at that.
I also wanted to give an update. In April, we transitioned from the Area Agencies on Aging doing enrollment into the aging waiver to the existing independent enrollment broker which is maximus.
We have been doing a lot of tracking of data since then. I wanted to just give folks an update on where we are with the independent -- existing independent enrollment broker.
One of the things that we track is the average speed to answer the phone. In August that was 84 seconds. September it went down to 75.
Now, for the month of October, the average speed to answer is at 38, which is within the contract.
The -- another statistic that we track are the monthly enrollments. In August we had a fall in the enrollments when the independent rolement broker took over after 60 days. If you look at the July numbers, they are low. Since then, they have been steadily improving.
In August we had 495 enrollments. September we had 538 enrollments. October we have 730 enrollments, which is an increase of 87% from August to October.
We have really gotten back on track. I will say this is the highest number for October for 3 years for the month of October.
The other one -- another statistic that we track is the abandoned call rate which has dropped 57% since August at the call center.
It was 6% in August. It went up to 6.7% in September and it's down at 2.5% in October.
So the independent enrollment broker and switched to -- shall has really gotten back on track.
I wanted to just point out, though, in the procurement that is out for public comment, we are asking -- we actually have it in three lots. The offers can submit proposals for one, all or any combination of the three lots.

The lots coincide with roll-out of Community HealthChoices. One agreement will go to southwest , one lot in southeast and remainder of the Commonwealth is the third lot.
Again, those comments are due back by November 21st.
From Kevin's update, you heard that we are still in a stay for Community HealthChoices. I wanted to talk a little bit about our communications, though. We have been putting together communications to providers. They have not been sent out yet, but they -- because of the -- of the protests we received we put off notifying or engaging in communication with providers, but we are planning on sending a draft -- or a blast email to all providers in the coming weeks.
A question was asked last time when we were here at the last meeting which is adult protective services out of money?
I reached out to my colleagues who administer the adult protective services in the office of administration. There are no existing budget constraints for APS. There is none anticipated at this time. I can bring the APS team here if you have further questions, but at this point they are not out of money.
The last thing I wanted to talk about is, I would like to give an update on service coordinator trainings we are doing.
We released three on-line modules. Anybody can look at them. They are a prerequisite to the service coordinators coming to the trainings to in-person trainings.
We have held three in-person trainings so far. One in Harrisburg and two in King of Prussia near Philadelphia.
An extra session was scheduled in Harrisburg based on the demand. The three remaining sessions are Monroeville, Meadville and additional Harrisburg.
Position was provided for service coordinators. We have had very positive feedback on the training.
I don't know if anybody here has attended them but we have been getting good reviews in our evaluation.
With that, I would like to -- turn it over to Chris burn a reasonable doubt.
>> Brenda dare has a question.
>> BRENDA: Hi, Jen. Because I work closely with several agencies that have certified options counselors on staff, we were told that counselors may take over -- [inaudible] -- through the process. We have not heard an update on the status of that question since that first announcement was made. Can you give me any feedback there?
>> JEN: Kevin, do you know what she is saying.
>> JEN: Brenda, can you ask that again or maybe reword we didn't catch it.
>> Bren damplet. We were told as an agency that employers at TRCL we were told that assist -- people going through enrollment broker process in filling out their PA-600-Ls but they have not come through the system yet I was wondering if you can give update.
>> JEN: You are talking about person-centered counseling people trained throughout the state.
>> Brenda. Specifically we were told that our people who were PCC trained, were going to be assisting in the enrollment process.
>> JEN: I will ask Kevin to update us on that.
>> KEVIN: Hi, Brenda S.
We have been talking with the Department of Aging -- Pennsylvania Department of Aging about the use of the person-centered counseling roles through supports activities associated with the enrollment process. I think at this point because of capacity, the earliest that we would begin the process would be December at this point.

>> **BRENDA:** It is still planned that that process will move forward?
>> **KEVIN:** At this point, we are still working out the details. It's still definitely planned to be able to engage the person-centered counselor in the process smoi. Things are still being worked out.
>> **BRENDA:** Thank you very much.
>> **JEN:** I asked Chris Barnard to give update on home and community-based services loan fund.
>> **CHRIS:** Good morning. Hi, home and community-based loan program is a loan program for providers to help them function within the managed care environment for long-term services and supports.
The loan program was originated in 2010, but it went -- Governor Wolf wants to revitalize it. It's a joint effort between OLTL and PDFA.
We are wait willing to see if it is vetted for authorization.
Right now the memorandum of understanding between DHS and PDFA is still under review. We have the application and guidelines are written. They just have to be finalized. We cannot do that until the MOU is approved; that's basically where the program is sitting now.
>> **JEN:** Pennsylvania development fund administration which is in the department of community and economic development. PDFA and OLTL are partnering to make these programs available to home and community-based providers.
>> **CHRIS:** Any questions?
>> **PAM:** Who qualifies for it? I couldn't hear you very well?
>> **CHRIS:** It's for providers. It's structured for providers so that they could work within the managed care environment.
It's for providers. I'm sorry.
>> **PAM:** To do home and community-based services to do?
>> **CHRIS:** It's open to how create of the provider wants to be with their pro poses ail. My vision is that if they need computer support or if they need ways to upgrade licenses, software, any kind of support to work with the managed care organizations; that's what program is looking A. it's not strictly stuck to that. It really is up to the provider to creatively design the product they want to do.
The projects can be stacked, if it's part of a larger project. There is, because of the rule, home and community-based settings rule from CMS, the entire project is going to have to comply with that rule rule, which becomes more complicated in the review process. Does that answer your question?
>> **PAM:** I guess. I just have to find more information on it.
>> **CHRIS:** There is a letter from the Governor, I think it was February 24th. If you Google Governor Wolf HCBS loan program, it details the entire program.
>> **FRED:** Okay. So with this, somebody gets the loan. It's eventually supposed to help them to and able to train their consumers, right, on how to make a proper choice or -- on the MCO or is it just for AT upgrades or --
>> **CHRIS:** It's not really structured to, you know, say, it's not like you can only buy certain product or you can only apply for certain product. It's not structured that way because the provider has to be -- explain what the project they are envisioning.
If the project fits within the definition of working within a managed care environment, it can be for, you know, for training materials, for other items.

It's supposed to be working within the managed care environment to help providers in the environment, transitioning.
>> **FRED:** What benefit does it have for the consumers? How does this affect the consumers?
>> **CHRIS:** It's not a consumer loan. It affects the consumer if you have more providers come on board. If the MCO has more choice of providers and if providers can work with the MC Os. If they have to have certain criteria to work in managed care -- like if MCO sets up certain criteria, licensing, software, hardware criteria, a new provider can choose to take a loaning for materials like that -- it gives consumers more choice of providers.
>> **FRED:** That's what I was looking to know and boiling it down to.
When we get around to it and get a chance, I have stuff I would like to talk about with RFP for IEP whenever we get a chance let me know. Any. >> Chris. Yes, sir?
>> **Rich:** How much more money.
>> **CHRIS:** There is $4.3 million in an account that PDFA manages and that's to be used for the loan program and Then as it -- payments come in, the account should keep rolling as long as the program goes to sustain itself.
>> **RICHARD:** Will they set terms and conditions for qualifying for the loan?
>> **CHRIS:** The MOU is agreement between DHS and PDFA on the loan program itself.
There will be a guideline and an application; that will set forth what needs submitted for the loan, the criteria for the loan.
>> **RICHARD:** The MOU will be published?
>> **JEN:** No, the MOU is just going to outline what DHS does and what DCED does, the different responsibilities.
DHS or Office of Long-Term Living will review the application from a programmatic standpoint. The DCED folks at PE dpp FA will look at viability of the financing of the company.
>> **RICHARD:** I was wondering. It seems to be a public record and you would share it with the committee and anyone who would want to look at it.
In terms of the MOU and setting up the program, that to me, people might be interested in looking at that.
With respect to the announcement about qualifying and filling in the application, how do you propose to put out that information?
>> **CHRIS:** That will go out in the Pennsylvania bulletin.
>> **RICHARD:** As a notice?
>> **CHRIS:** Jess.
>> **JEN:** We will also probably do a press release.
>> **RALPH:** Any more questions?
>>: When are you looking at when we can apply for this loan?
>> **CHRIS:** It depends on when the MOU gets agreed to; that's where we are at right now. Once that gets taken care of, it should be shortly afterwards.
>> Okay.
>> **JEN:** It's ready to go. We are waiting for our legal office to --
>> **FRED:** A week? A month? A year?
>> **JEN:** Possibly a month.
>> **CHRIS:** Possibly a month. I could not give you a firm.
>> **FRED:** That helps. As long as we know it's a day, month, year; that narrows it down.
>> **RALPH:** You will get a Christmas present from the state.
>> **FRED:** Goody!

Latch laugh.
>> **RALPH:** Anybody else?
>> **CHRIS:** Thank you have.
>> **RALPH:** Thank you.
>> **Jenn:** Did you want to ask a question about the IEB?
>> **FRED:** Yes. Inyesed time limits 60-90 days.
There is a lot of concern about the slowness of IEB.
Maximus -- there's 80% of the applicantants to maximus -- to people over 60 were not even returned. Okay?
There is so many issues in here. I have got the testimony from Pennsylvania housing and older adult committee, the Senate aging and youth committee and only about 20% of the referrals are being done. What happened to the other 80% of the consumers that got referred?
We have lost 80% of them somewhere that are not getting the services that they need. This means more than 4,500 referrals have not been reconciled to this point.
It means 4,500 seniors entitled services are not getting them and have no idea when they will get them.
The time limits are ridiculous on this.
When we get the new IEP, are we going to have 1 in each area or are we going to have 2 or 3?
We can't just have one maximus itself is not doing it. They are not -- they are falling down.
Seventy-four individuals were referred to maximus for enrollment. Okay for the six-month period from April to August. Of those, 13, which is 17.6% have actually enenrolled. 9 refused to continue in the process because they needed the help that they cannot get in a timely fashion. It wasn't available because the enrollment process took too long.
Four consumers had to enter a nursing home and five died waiting why is there such a problem with this? How many will we have?
>> **RALPH:** Let her answer some of these questions.
>> **JEN:** First, I want to say because we require anybody applying for services to go through the Medicaid eligibility process, the financial eligibility process, 50% of those people -- 50% of the people are ineligible for; that accounts for a significant amount of people is there.
I will turn it over to Kevin who has been much more engaged in the date-to-day work of the IEB.
>> **KEVIN:** Fred, I wasn't sure which kind you were talking about. Do you mind if I answer about the data?
>> **FRED:** Sure.
>> **KEVIN:** You mentioned the people not getting to referral process, the way it is working. It is a true data point.
The way it is working independent enrollment broker receives referral, somebody calls them or submits referral via email.
Of all of those referrals coming through, they do roughly 7,000 referrals a month, we are finding that 80% of people are not going -- actually making it through to the application process which is a serious concern.
We cannot -- there are steps in the process that can improve that. The reality is the complexity of the process and complexity of the forms what is really presenting the challenge.
We don't really attribute that.
There were service issues with independent enrollment broker long call times, delays in processing and so forth that Jenn had talked about earlier; that's certainly improved. What you

are talking about is something that is actually happening at the beginning of the process when they are introducing themselves to services.
What we find in the 80% as Jenn said in a lot of cases they look through the process and recognizing that they may not themselves be financially eligible. They may choose not to continue. In many cases they may just need help. They need -- they may need guidance or steps to get through this complex financial eligibility process.
What we are talking about at this point is two steps. First was -- Brenda mentioned it earlier -- we are looking at using existing infrastructure with aging and disability resource centers to be able to intervene on behalf of participants and provide some of the guidance/support; that's one option that we have been looking at.
The other option is to change the flow of work with the independent enrollment broker, so that instead of having I in-home visit at a point we know they are ready to fill out application or the application is already completed we will move it to the beginning of the process so that the applicants, when ready to fill out the 600-L will have somebody there to answer their questions. We recognize there is a failure in this process is really at the beginning because people don't know what to do. It's a real challenge.
One thing I have to say about this process is that this is always been a challenge we can't blame this problem on independent enrollment broker we need to blame it on the needed complexity of the process and just recognizing people need help. The CILs have been providing the help, AAAs have been providing this help for a long time. It's a very complex process. We are looking for ways to intervene and for ways to give people the information they need to understand whether or not these programs are right for them so we are not wasting their time as well. Sometimes we are -- we have these requirements that we want people to go through financial eligibility and Medicaid because we want to be -- want them to be able to access services as quickly as possible. If there is no way they will be eligible for these programs. It's not fair to them to have to go through the process.
Having conversations with different stakeholders to figure out how to better manage all of the points in the up-front process to make it work better for people but it's a complex process. We recognize it is a problem. We are taking steps to be able to make it better for people. We have received a lot of great ideas and a lot of feedback from a lot of stakeholders like the CILs, et cetera to help make the process better we appreciate it very much.
>> **FRED:** Under previous enrollment system 6-800 people per month that is total 2,400 to 3,200 people enrolled over 4 months as expressed OLTL staff member at long-term care subcommittee meeting.
Maximus enrolled about 400 people total in the first 4 months it held enrollment contract; that's 100 people per month. Why did it switch? If we were doing that good before, why did it drop so bad can't we just go back to previous one.
>> **KEVIN:** I provide the a lot of clarification on this data. This is data I will be willing to go on record saying that.
During the time period between February 2016 through June 2016 we saw aging waiver enrollments increase 94%. It's absolutely not a true statement that people were not being enrolled in the aging waiver from April through August. The only month that really saw a significant dip was July April, May and June. The reason why that is we were still processing enrollments originating AAAs. They were asked why they had such a drastic increase from the prior year during those months' time periods. It was told to me that they were cleaning out their own outstanding enrollments that they needed to process to get caught up for that transition process. It

is absolutely not a true statement that we have only enrolled 400 people between April and July. We enrolled thousands of people between April and July.
The point of origin was actually the Area Agencies on Aging.
To be clear and put it in context, we are back -- October hit 730 enrollments. We are back to the levels that drastically-increased levels of enrollment with aging waiver that we were seeing earlier this year. Now we are at a point where we have to start talking about what's happening that is seeing all of the increases? It's a great thing that people are getting into the program, but our enrollments for aging waiver are way up for 2016 compared to 2015, even with the month of July that really taverned.
So just to be very clear, aging waiver enrollments are up for this year and they are trending high. We are paying attention to that from budgetary perspective. To be very clear independent enrollment broker wasn't in the position to be able to process a lot of enrollments because of the length of times it takes to be able to process enrollments.
Just to be clear, that 400 number is misleading number.
>> **FRED:** I am just repeating the testimony.
>> **JEN:** Fred, I want to tell you no we cannot go back to the way it was. We will move forward with having an independent rollment do the enrollment.
We have been disallowed Medicaid match on this process for several years now CMS told us we needed to change it August or September of last year.
We are -- what we want to do is get it back to being Medicaid function. CMS believed that the Area Agencies on Aging there was a conflict of interest between them enrolling an individual and serving the individual in the same program.
>> **FRED:** Right. I remember the split.
>> **JEN:** We were required to do that.
>> **FRED:** Right. Okay.
Approximately 40% of documents sent from our agency to maximus are reportedly never received. Who is covering the ich EP and why aren't they effective at --
>> **KEVIN:** We have seen really -- really serious problems with the service levels with independent enrollment broker during roll-out. There is no question there were balls dropped. Jenn gave statistics that it has since improved we believe it has we seen it improve as well.
We are really refocused -- the issues we are hearing from independent enrollment broker we hear specific issues of cases that have problems, but the issues we are seeing now are more about making sure people are getting service quickly enough is the focus we are pushing heavily right now.
We believe that steps have taken place through aggressive monitoring of the independent enrollment broker and through holding them accountable that has seen increasing we know there is a lot of room for improvement.
You pointed out that one of the biggest challenges is at the beginning of the process. The other challenge is at the end of the process, making sure that people -- after they are determined to be eligible, to be moved very quickly through the actual service planning process.
Those are the two points we know need a lot to have focus at this point. The first might be outside of the independent enrollment broker. In the back end is the independent enrollment broker and it's been addressed through staffing. We have seen improvement.
Just to be clear, across the actual array of services, independent enrollment broker has been providing it has improfferred. At least from our perspective.

We need to hear cases brought to us to address on individual basis or continue to look at all of the numbers in aggregate to make sure there is no slipage. It is a government entity monitoring the contract we have to make sure that they continuously get better. We have seen improvement at this point. We need to continuously -- every single concern that was raised about the service levels and independent enrollment broker was fair and valid. We believe corrections have been addressed but there is always a lot of loom for improvement.
>> **FRED:** Okay.
How many enrollment brokers are we planning to have through this IEP? One still or are we going to have three? Are they going to be in regions?
>> **KEVIN:** Jenn mentioned 3 potential lots which means there could be three by region.
The first region is the southwest, which is concurrent with Community HealthChoices southwest; second is southeast which is concurrent with Community HealthChoices southeast; third lot is I capital north and northeast the rest of the state. We can have three brokers, three geographic potentially one stateswide that wins all of them a lot of variations on how that can work out, but --
>> **FRED:** I would make a suggestion here if you do take three that you have all three of them throughout the entire state that way it will speed up the process you won't have to hire as many people --
>> **KEVIN:** We are getting -- my recommendation is for you to submit it as a written comment and tell us why you think it would work better. It is something we are -- obviously the reason we are putting it out for public comment is to receive comments like that.
>> **FRED:** If you have three of them all three of them throughout the state, it would be much improvement, save a lot of time, save a lot of money and get people enrolled faster.
>> **KEVIN:** Not pushing back, when you submit your public comments, one of the tellingcal challenges we want to address is how would people -- which independent -- if we didn't have one independent enrollment broker per region and had three how would people know who to call. You don't have to answer the question now if you could answer the question when you submit public comments that would be particularly helpful.
>> **FRED:** Sure.
>> **RALPH:** Thank you, Fred.
>> **PAM:** I have a question.
>> **JENNIFER:** This is Jennifer Howell on the phone. I don't have access to a computer now. Could I ask a question.
Isms, Jen. I don't have access to a computer right now. I am just on I phene phone could I ask a question to follow up on your comments as well as Kevin?
>> **RALPH:** Yes.
>> **JEN:** Yes.
>> **JENNIFER:** My question and one of my concerns with independent enrollment broker right now is from what I understand from hearing -- I apologize with my healthy haven't been as involved as I would like to be. I hope that changes. I am working on it.
From what I understand, through what I read on the hearings, Maximus is getting paid per application going in so they don't get paid when the process is completed. They only get -- they get a set amount of money per every application that is submitted.
Even though -- even if people don't follow through, there is, you know, no penalty or no -- to Maximus.

I understand the office of long-term living is allowed to withhold the money but there is no -- I would recommend in Community HealthChoices, that -- as well as in the new -- independent enrollment blocker -- the department could withhold money until services are improved.
Another thing I would like to comment on is, the training that Maximus is receiving in working with the elderly population because I myself know that there is a difference.
Most -- not all -- this is a stereotype and I do apologize. A lot of elderly people, their disabilities come on them later in life. They are used to doing things their whole life by themselves.
So I am using my grandmother as an example. When she was first -- she had Parkinson's, which now turned into Alzheimer's. When she was first interviewed by the AAA for services, they seventy a male out to talk to her. She said I can dress myself I can do everything myself.
Her son was standing beside her, my uncle. He wasn't familiar with the process. He doesn't want to contradict his mother.
So I called a supervisor friend of mine at AAA and had the evaluation redone and they were very accommodating in allowing me to talk about my grandmother's needs to see where they could help her and they were very respectful in the way that they asked their questions.
I am wondering, is Maximus getting any training like that?
>>: Ralph: Jennifer, if I can, you got three questions going on.
>> KEVIN: I think I got them. Hi, Jennifer, nice to hear from you.
The first -- you made a couple sessions, one of which was to have a payment or management process that is associated with the completion of enrollments and also the holding independent enrollment accountable.
It would be helpful for us to see how you would want that to work medically.
If you would be willing to submit public comment and send it to me directly; that would be great.
If you want to submit public comment on how you would think that that would work better, that would be probably the most helpful.
We have beefed up significantly the service level requirements for independent enrollment broker where you see gaps; that would be particularly helpful.
Regarding your training, what you describing in my opinion falls under broad umbrella of cultural competent training which will be covered with all of our contractors and vendors. We will be making sure that how that is approached and how our contractors are required to meet the cultural competency is very clear.
We think that in that regard, there is a lot of room for improvement with independent enrollment brokers as well as with all of services. Some AAAs are great leaching this particular population and we would want to communicate with AAAs to make sure we are incorporating their suggested approach to reach this population; thank you for the comments.
I would love to hear more for you on what you think would be able to work.
>> JENNIFER: Thank you, Kevin.
>> RALPH: Thank you, Jennifer. Please, submit them, if you will, to us like you usually do. I am glad you are participating in this meeting. Thank you. We miss you.
>> JENNIFER: Thank you, I miss being there.
>> RALPH: Kevin, thank you. I will ask now for Kathleen McGrath to present on the ABLE program. After that, we will have Mike Hale speak about the MCO monitoring. Thank you.
>> KATHLEEN: Do you have a clicker for the slide?
Good morning, I am Kathleen McGrath with the Pennsylvania treasury department. For the last oh, 18 or so years I have been running the caller savings program.

As of April, treasury was charged with implementing the ABLE Act. I'm pretty sure you have heard of it. Who has heard of the ABLE Act? (Show of hands.)
Great. I am here to give you detailed information about the Act and how it works, tell you a little bit about where Pennsylvania is in terms of implementation and introduce some of our implementing staff.
We have -- excuse me I keep turning my head.
We have several of our field staff with us today. Kelley Davis. Kelley, would you stand. Chally and Dave Dominick is head of outreach effort.
We have other staff as well that could not be here this morning.
We are able to go out into the state and make presentations and talk to folks. Somewhat like what we are doing here today.
With that brief introduction, let me get started.
The first slide we talk about the act itself, which was passed in December of 2014 by the federal government. It does not create ABLE programs, but what it does do is authorize the states do that.
Our legislature passed the law unanimously, which is a wonderful statement about the support from the General Assembly for this program.
This is the bill -- several bills were introduced. This is the bill that gives the department the most flexibility in adjusting the plan as needed, as federal law changes. As we all know, federal law will change. It already has changed, actually.
It -- so many disability organizations were behind this bill.
So what is ABLE?
Well, in essence it's a savings program for individuals with disability. That's not saying enough about T. it's sort of a very big deal because it allows individuals who have disabilities, many of whom use federal and/or state supported benefits to have greater assets than they have been able to have up until now and still receive their benefits.
In addition to that, there are great tax benefits. We are going to go through all of that. One of the really important things about the program is that the individual with disabilities, him or herself, if they are able -- if they are an adult and have the capacity to control their own finances -- the account is theirs and they control the account.
It's not like a trust.
Who do we are and will use these funds? Anybody who has a disability and is eligible to open an account.
We think that it will serve adults who have the capacity to manage their own finances and they can save for day-to-day expenses, mid-term expenses and long-term expenses for housing, to buy a house in the future.
We also think that parents of minor children or those who are not able to manage their own finances can access these accounts. They would open it for the benefit of their child and they might be using it for day-to-day expenses or they may be saving for long-term when they are no longer around to provide the support they have been providing for a while.
Let's talk a little bit about eligibility? Who can have one of these accounts? There are two basic requirements. The first is you have to have a qualifying disability. We will talk about what that means.
The second is, your disability has to have started before age 26. This is somewhat of a disappointment to some of those in the disability community who have been working on the

legislation for so, so long. It was a last-minute comprise to bring cost it to be able to be passed. There are empts to increase it but now we are living with an onset of 26.
That does not mean that only people under 26 can open an account. You can be 50, 80 now and open an account, as long as your disability started before your 26th birthday. It's just the onset that is important, not the age that you are right now.
The other thing -- that's the easiest of the qualifiers to take about.
The other qualifier is that -- having a qualified disability.
So if a person is eligible for either supplemental security income or Social Security Disability insurance, then they are automatically -- their age of onset is before 26 they are eligible.
Everybody know difference between SSI and SSDI? Any need to go over it?
SSI is for people who are low income and don't have much in the way of assets.
SSDI is for people who have had a work history that makes them eligible. For example if they worked more into their later years they would be getting Social Security retirement.
So we know there are individuals who have severe disabilities but don't qualify for SSDI because they don't have a work history or don't dwf for SSI because they have too great assets or income.
This third group is eye group that can self-certify. What this means is that they are able to say that they have a physical or mental impairment that results in severe functional limitations that is expected to or has lasted for 12 months or result in death.
It's, essentially, the same level of severity that you would need for SSI or SSDI, but you can't qualify because of other reasons for those benefits.
What these folks need to do is obtain a written diagnosis from a physician that SSA recognizes, Social Security Administration, that is related to their disability.
They don't need to submit that written diagnosis. We are going to just have themself-certify that they meet all of the criteria and that they have the written diagnosis.
If an agency were to ask for proof of it, they would have to turn it over. So it's important that they keep it.
So how will the Social Security Administration know about this? Well -- excuse me a minute -- anything -- as you all probably know -- anything that affects SSI eligibility needs to be self-reported, but in addition the ABLE law requires the state who run ABLE programs to submit monthly reports to the Social Security Administration on each and every individual account. Those reports will include the balance on the account and any withdrawals that are made in the account.
So the SSI will be getting a list of people who said they are eligible. Okay?
Let's turn a minute then to the federal benefits. We mention these a little bit in the introductory remarks, but the most important one is that the assets held in an ABLE account are not to be counted for any federal means-tested benefits. The Act does not list them it just says "any" with the limited exception of SSI.
We will go into detail about SSI requirements in a few minutes.
In terms of the tax advantages, the money that is put into the account contributed to the account is after-tax dollars.
Once it's in the account, the earnings don't get taxed as long as they are in the account and when they are pulled out of the account, they don't get too muched as long as they are used for qualified disability expenses.
Now, who is going to be checking this? Mhhhh, no one.
This is much like any tax it is all self-reporting. So when the individual needs income tax they have to look at the tax year how much they withdrew from their ABLE account and what they

have in qualified expenses. As long as what they withdrew is same as or less than all of their expenses, they will not owe any taxes.
The really important things for people who are using ABLE accounts is to keep documentation of their expenses.
There are also bankruptcy protections. Basically, what they do is say, somebody who contributed, as long as parent or grandparent that contributed to an individual's account that money depending on how long it's been in the account and how much is in the account won't be subject to being pulled back if there is a bankruptcy declared by parent or grandparent.
We talked about the interaction with SSI very briefly now we will go into detail about that.
The ABLE Act limits the total dollar amount that can be protected in an ABLE account without impacting SSI benefits; that total amount is $100,000. After $100,000 anything additional in that account is counted as an asset.
Now, what happens when they go over $100,00 that would be wonderful if we have that problem. Right? If they go over 100,000 their SSI is suspended, not terminated. If they fall below 100,000 they don't have to reapply.
In addition, their medical assistance is not impacted. If the reason you are not eligible to get your SSI anymore is because of your ABLE account, you still continue to get your medical assistance, which we know is very, very important to people.
There is one other tricky thing regarding SSI -- excuse me. Housing expenses are qualified expenses. People can use it but not be taxed.
The law says, but if you use it for housing and are an SSI recipient it can impact on SSI benefits. So on the one hand you can use it and not be taxed but if you are an SSI recipient you could suffer penalties in terms of how much you get per month for your housing.
But the SSA, Social Security Administration, has told us -- it sounds weird but they told us and pit it in writing -- as long as you use, withdraw from your ABLE account for housing the same month that you took it out, then it won't impact you because they are looking at the account only on the 1st of each month.
If my rent is due December 1st and I take a withdraw from my ABLE account on November 17th for rent I am okay. But if I take it out November 30th and pay rent December 1st, then it can count against me. It is a very important thing for people who have the accounts to understand.
The other tricky thing is the -- first of the month rule also applies to non-qualified withdraws. As long as you take the money out and use it in the same month, even if you use it for -- my favorite example is a trip to Las Vegas, it will not impact your SSI.
Now, it impacts your taxes because you use it for non-qualified purpose but it does not impact your SSI.
It's really, really important for people who are on SSI to realize the timing situation.
The other thing that's really important for people with SSI is that anybody can contribute to an ABLE account; however, it's really important to contribute directly to the ABLE account and not through the individual him or herself.
I have a nephew for CP for his birthday I give him $100. I give it to him and say, put this in your ABLE account, it's considered income to him and it impacts on his SSI.
If I take that same $100 and give it directly into his account, it is not impacting his SSI. I can give him a birthday card, I put $100 in your ABLE account; that's fine. I cannot give him a check in the card for $100 and say, you should put this in your ABLE account.
I know there are a couple crazy things that people scratch their head about but these are the rules and we need to play by them.

How much can be contribute ?d federal law defines how much can be contributed $14,000 but it can go up depending on inflation. The most that can be put into an account is $14,000 from all o sources.
If grandma puts in $14,000 mom and dad cannot put in $14,000. It doesn't matter who it comes from. It just matters the amount.
The other limitation on contributions is that the account balance cannot be more than, in Pennsylvania, $511 ,758 to be precise this seems like a strange number, I know.
Let me tell you why it's a strange number, the federal law says, the maximum you can have in the account at any one time is the same maximum account for college saving. It is to set the limit. Pennsylvania set the amount by looking at five years of undergraduate school at the University of Pennsylvania plus two years of graduate school at Warden.
So I am proud to say that this is the highest amount in the nation.
So -- thank you so much!
So how much or how will contributions be accepted? Contributions will be accepted in almost any means. Can't bring us cash and knock on the door and say, Here is cash.
We expect people to go online, checks, we and payroll deductions or automatic withdrawals from checking or savings accounts.
Before I go into Pennsylvania ABLE details, I should go over what the qualified expenses are. There are a list of 11.
I will not read them to you but just know that the IRS has said that they are going to broadly interpret this in their proposed regulations. They say it includes basic living expenses. They do not define basic living expenses but they say it includes it.
In hearings that they had on the proposed regs they were scratching their heeds to figure out what was not a qualified expense.
Now, I should say, what may be a qualified expense for one individual may not be for another, depending on a particular disability and their functional limitations.
The example given in proposed regs is that some disabilities may be aided by an iPhone, others may not.
In one situation -- I should say a smart phone -- a smart phone may be an acceptable qualified expense.
The one thing that people think may not be included is entertainment and, of course, gambling, my favorite example is, take $5,000 out of your account to go to Vegas and blow it all on gambling. Not a qualified withdrawal but you will have to pay taxes on the earnings but not the contribution portion.
If you are SSI recipient and lost it all on one month your SSI is okay so not to worry about that.
Turning now to Pennsylvania's policeman. Again, this is all what we and. We are still in negotiations with potential vendor so all of the details are not ironed out but I feel confident enough to this with you at this time.
We are aiming for December launch. We know that's right around the corner. We are working very hard and still anticipate that we will launch sometime in December. Probably not the beginning, but probably before the end of the month.
Why is this important? It's important because you can only put $14,000 in in one year. If people miss this year and it goes into January, they will have missed the opportunity to put in $14,000 this year.
We anticipate that enrollment will be done at first only online. This is to meet the deadline. They say to get the papers up and on their system will be a longer process. We are hoping within just

several months of launch. From the get-go it will only be online. We want to keep the program very, very affordable. So we anticipate that the amount you will need to put in when you contribute will be around $25. You don't need $250 to open an account, just 25.
Again, we talked about eligibility. We are not going to require people to submit anything but they will have to fill out an enrollment form online that says, are they SSI eligible? Are they SSD eligible? Are they self-certifying? Do they have written diagnosis if they are self-certifying from their doctor?
Make sure they don't have any other account, ABLE account, there can only be one for each person.
A few things like that they have to self-certify under penalty of purgary.
On audit, the IRS may. If federal or state agency asks to see documentation, they would need to have it.
So then the next question is, who can actually make this application? Make this enrollment? Well, the statute says the beneficiary, the individual with disabilities is the account owner, but we know that account owners can be children or individuals who don't have the capacity to contract.
So what about those folks? What the proposed regulations, the federal regulations say is that it can be a parent, a guardian or a person who has a power of attorney; that's the limitation. Pennsylvania law went farther and said, in addition to those, it can be a person who is a trustee, an SSI representative payee, a designee of parent or guardian.
Pennsylvania has said, you are tooary strictive you should also allow these other folks, but we won't know the answer to that until the regs are final.
I think the interesting thing about Pennsylvania law is that the person who opens the account for a child or someone who doesn't have legal capacity to contract remains that person's authorized signatory even when that individual turns 18, in the case of the minor.
This is trough verse imral I know once the person is 18 it is thought they should have control of the account.
In thinking about this when the law was passed, there was concern that parents, grandparents, others may not be able to contribute to the account if the child got full control at age 18.
I know I have three kids, all who are adults, none of them have any disabilities, but I would not have given them any amount of money as in $250 ,000 when they were 18. Maybe 25.
So this is very unique to Pennsylvania law and again, as I said, it's somewhat controversial. We believe that it is important so that people feel confident in giving money to the individual with disabilities.
We do have another provision in Pennsylvania law that is complimentary to this. Pennsylvania treasury department has the authority to involuntarily terminate an account if it's in the best interest of the beneficiary.
So you say, well, when would that happen? Well, if you have a child -- an adult child say who is 40 now, has no intellectual disabilities and mom and dad are saying, we don't think you are quite ready or mature enough, that individual can petition Is to involuntarily terminate mom or dad's significant authority and make him be the account owner. There is a hearing so there is due process in terms of that.
So what kind of vehicles will people be able to use? We anticipate having an interest-bearing checking account, like a normal checking account with a debit card.
In addition, we have f anticipate having 4-7 different mutual fund-like options that will be going from very aggressive -- all in stocks -- to very conservative -- all in bonds -- people can pick the

miasm that is right for them in terms of how much rising they are willing to take with their funds and in terms of how long they are planning to save it for. If they are planning to save for 40 or 50 years it's probably good now to be more in stocks. If they are planning ton using it daily for basic expenses, probably I object-bearing checking account is their best bet.
They will be able to switch options from conservative to aggressive or checking but they can only do that twice a year.
Every new contribution they put in, they can put in whichever the options they choose.
So how about the cost of this program? Well, we are working with 13 -- well, 12 -- other states to create the program. The reason we are doing that is to pull all of the populations together, serve a greater population and that will keep the costs of the program much lower than if we tried to do it on our own.
It's a little complicated trying to get 13 states to agree on something, bit we are working it out, and we think that in the end we will have one of the lowest-costing programs in the nation.
We anticipate an annual account maintenance fee. We are hoping it to be around $40 table out quarterly from the account. You would be able to see whatever it ends up being when you look at it was taken out.
For interest-bearing account, the banking git, there will be normal banking charges, AT 34*7 charges and that sort of thing.
for the mutual fund product there will be an asset-based fee which is basically a couple pennys that are taken out from earnings. You don't see it as something subtracted from the fund it's just like any other mutual fund which will be impacted by the funds you do, the returns will be subtracting those expenses in terms of the cost.
We talked about some of the Pennsylvania benefits, but let me sort of give you a lineup of all of the Pennsylvania-unique benefits.
First, ooze there are no federal income taxes on the growth, as long as it's in the account or when you take it out, as long as you use it for qualified expenses, that same applies to Pennsylvania income tax.
Also, there is no state inheritance tax, which could be as much as 15% on the total assets in the account. Our state law exempts these accounts from being counted in the estate.
The law also says that the amount an individual has in an ABLE account does not count against them for any state means-tested benefits that are disability related, medical assistance related, other health related or student financial aid.
These accounts are also protected from creditors in Pennsylvania. So if the individual is in a car accident that is their fault and they don't have insurance to cover it, the person who they injured can't go against their ABLE account.
We talked about the fiduciary being in control and the treasury to be able to close an account.
The other somewhat controversial point is, what happens when the person who is beneficiary of the account dies?
So there is an issue as to whether or not the account can be transferred to a sibling who also has a disability. You can transfer to a sibling during the lifetime of the individual, but whether you can do it upon the death is a question that the IRS has not yet answered. We hope that they will answer that in the regulations when they come out as final.
But the ABLE account can be used even after death to pay outstanding qualifying expenses. If there were medical expenses that have not been paid, they can be paid out of the account. It can also be used to cover burial and fiewn expenses. What happens after they have been paid is that it becomes the estate of the beneficiary. When it moves to the estate of the beneficiary did is

subject to ordinary income tax but not 10% additional tax which is the normal situation when you take it out for a non-qualified purpose.
It's important to realize that you need -- that you should pay the expenses, any qualified expenses out of the account, before it is transferred to the estate. As long as it is coming out of the account, there is no taxes due. Once it comes out of the account and is transferred to the estate, then taxes are due on the earnings portion.
So now the question has arisen about repayment of medical assistance. Pennsylvania -- the federal law says that any state can file a claim against an ABLE account for the medical assistance paid during the lifetime of the individual while that individual had an ABLE account. It is permissive, not mandatory.
So when Pennsylvania passed it's law, Pennsylvania said, Mmmmm, we don't want to do that "repayment".
So Pennsylvania law says, No state agency can file a claim for repayment against the account or the proceeds of the account. We were the envy of every other state ABLE program. They were, like, Wo! That's great. Can we do that too?
The Department of Human Services said they were a little worried about this in terms of whether it comported with federal law.
They went to the centers for Medicare and Medicaid services and asked the question. What they were told is that, Yes, you don't have to file against the account; that's permissive in the federal law; however, you do have to follow the normal estate recovery rules for Medicaid; that is a Medicaid law, federal law, it's in the state plan. So the account can be subject to it once the proceeds of the account are transferred to the estate.
Now, there is some limitation on that repayment. First of all, the deceased has to be 55 or older. If the person dies before age 55 there is no repayment.
It's -- the normal federal law is that even if they are over 55, if they are survived by a spouse or a child under 21 or a child over 21 who has a disability, there is no repayment.
The Department of Human Services is getting back to us whether that applies here or not. Those limitations.
The other ones they haven't given me final answer on.
What can be repaid is only expenses that were.
>> **Georgia:** Excuse me if you are on the phone can you mute the phone so we don't hear you.
>> **KATHLEEN:** What can be subject to repayment is only the value of the medical assistance that was paid after you turned 55 in these three categories, nursing facility services, home and community and related hospital prescription and drug services, which I understand are the big basic ones.
So let me stop there I am under my half hour which is a big deal for me because I can go on forever about this.
Let me ask if there are any questions that I can answer? Yes?
>> **PAM:** So an individual with a disability, they have their disability before the age of 26 working full-time could do this as well?
>> **KATHLEEN:** Yes, as long as they have a qualifying disability.
>> **Richard:** Hi, I thought it was clear and informative presentation. I also have no doubt if you will be managing it, it will be well-managed and fairly managed.
>> **KATHLEEN:** Thank you, Jack.
>> **JACK:** When do you think the federal regs will come out?

>> **KATHLEEN:** Hopefully by the end of the year. They told us we can go ahead and go forward and then if what we did was contradictory too what they come united with they will give us a long period of time to make any corrections that we need to make.
Part of me wants us to get up and running first so that they see how well we are running --
>> Jack. The changes will be prospective presumably.
>> **KATHLEEN:** Yes.
>> **JACK:** One final point this is rather complex for people: Will treasury be putting online a presentation on bullet points like this so that the public can better understand the requirements under the law?
>> **KATHLEEN:** Well, actually, that gets me to my ask of you.
We are doing a couple things. We are putting up a website. We are working on that now. We hope it's, you know, not too long from I know that the website will be available.
The other thing that we are doing, is creating a training module, several training modules that people can go through that has a lot of this information in it. We are working with the office of administration to make that available to all of the state agencies so that people who are in DHS or special ed. division of the Department of Education, veterans affairs, aging, anybody will be able to go in on the OA system and take this training module.
We are also hoping to make that training available private sector organizations, those who advocate and serve individuals with disabilities. Even the smallest organization that has two or three staff people can take advantage of this.
That is coming, we hope, early December. We are working on that now.
The other thing we are doing is, we really want to get the word about this program out to as many people as we possibly can. So that every person who is possibly eligible knows about it and can make a decision as to whether it is helpful for them.
So we are asking individuals like yourself to take the word back about these to those that they serve.
We have and will be putting it -- I understand this PowerPoint will be on our website. We also will have a brochure that we have developed called "coming soon ABLE".
Question can make that available in whatever quantities needed or they can print it out themselves.
We have a sample. Our field staff has some. I don't know if they have enough for everybody.
We also have a materials request for.
>> **JEN:** Kathleen, we can send these out by email if you get it to Marilyn, electronically.
>> **KATHLEEN:** Thank you.
>> **KATHLEEN:** If you pit out a newsletter, do you want webinar for your staff we can do that we can do this presentation as a webinar.
If you are hosting an event that you think it would be important for us to make a presentation at or just have an information table at, we can do that with our two, three, maybe four field staff. We can cover the entire state.
So we are really gearing up to make this very well-known. We want it to serve the needs of the people that it was designed to serve.
We have been listening to people in terms of what they are looking for from this program.
We are treasury, we know the investment we know the college saving model. We were not very knowledgeable about disability and disability expenses and those sorts of things. We have reached out to the community to ask about, you know, what best will serve their needs.
So we welcome any input.

In the PowerPoint I have my contact information as well as there is info@paable.gov.
If you go to you're website you can get further information. As the for example is being launched we will tell people, hey, it is coming on December X, whatever the date is.
We does you to sign up on there. We also ask you to tell people who might be eligible to sign up and that way they will know as soon as the date for enrollment is available.
>> **RALPH:** Kathleen, what about individuals who qualify under a disability but they are over 67, for example?
>> **KATHLEEN:** Age 56?
>> **RALPH:** Yes.
>> **KATHLEEN:** As long as their disability started before age 26; that's fine.
If the disability started at age 30, that's not fine.
It really goes just to, you know, when was the disability apparent?
Anything else?
[NO RESPONSE]
Thank you very much for your attention. I really appreciate your interest in this. We appreciate any support you can give and any help you can give to us in making sure the word about the program goes out.
If you have any questions or concerns, just email me. One of my persons on the ABLE persons team will get back to you. I promise.
>> **RALPH:** My staff at abilities in motion has been looking for this for years we are so happy it has come along and the benefits it will provide to people with disabilities not being peoplized for having money to do certain things in their life. I want to thank you for that.
>> **KATHLEEN:** Thank you.
I can tell you, for everybody at treasury it is a labor of love. We are excited to be doing this and really think it's a wonderful thing that government is finally doing.
>> **Zachary:** I have a question. I wanted to ask, is there verbage or information on the link or program as far as you know employment how does that work?
>> **KATHLEEN:** I'm sorry? In terms of funding?
>> **Zachary:** The person with a disability being able to have gainful employment --
>> **KATHLEEN:** I am not sure I fully understand question.
People can make contributions into the ABLE account. They can access that account for any reasons that they would want. I am not sure --
>> **Zachary:** You am send that out to us; is that correct?
>> **RALPH:** We will, Zach.
>> **PAM:** Just a quick one. I want to make sure that all of the documentation that you put out for this is not only cognitively accessible but also accessible to individuals who are blind, no PowerPoint, have Word documents that they are able to access them as well. Not only the stuff you give out but on the website as well.
>> **KATHLEEN:** We are working on that. We are not there yet. We have to meet with some ear organizations to do the braille and working to make sure that the website is compliant with all of those requirements.
>> **PAM:** You have somebody you are working with that I know the ADA.
>> **KATHLEEN:** We do if you want to volunteer.
>> **PAM:** I will ask I friend of mine she is ifnted in it.
>> **KATHLEEN:** Great.
>> **RALPH:** Thank you very much.

>> **JEN:** I want to ask Marsha Mikos to do a presentation LTC. She will simplify it and make it so that people like me can understand it.
>> **MARCIA:** Hi, everybody, I am Marcia to talk to you about eligibility for long-term care and home and community-based services.
I would like to talk to you about basics of process, fair consideration, spousal requirement and common reasons why applications are reject ped the first time someone applies and how we can rectify the situation to make them eligible.
Before I start I would like to -- when I state long-term care services throughout the presentation I mean facility and waiver I will differentiate if there is a need to.
First, I would like to talk about eligibility dry tearia. The CO needs to define four areas. Function eligibility do they meet nursing facility level of care. We get this from PA17868, H clp B sch eligibility form or functional eligibility for services.
Then non-financial eligibility such things as citizenship, identity, enumb ration and residency.
Then we get into the big two: Financial: Income and resources.
When looking at income we verify income of the individual applying for benefits is at or below 300% benefit rate 2,199/month when I say it's for the individual applying if married couple it's only individual applying and comparing it to the limit.
If income is at or below, they are eligible. If income exceeds 2199 a month and they are applying for long-term care facility services they will probably still be okay. The reason for that is because we have medical need only or long-term care M&O option semi-annual.
The income exceeds 2199/month we will look at 6 months deduct 6 months of medical expenses. The medical expenses include nursing home private pay rate. On average in Pennsylvania that's over $9 ,000 per month. Meeft people will be eligible we will take that and deduct it from semi annual income and compare to semi annual income limit of 2,500.
We do not have this offense for waiver. I will go into detail at the end of the presentation about what you you have to do if you have income exceeding 2199.
Resources is 2,000 about standard 6,000 disregard for people at or below 2199 a month.
If income exceeds that and they are applying for long-term care facilities services the limit is only $2400.
The long-term care application process begins when long-term care facility, independent enrollment broker or nirch applies for benefits for the individual. Request for benefits includes a completed PA600L application for benefits on paper, via come pass or electronic application web site we also need MA-51 medical evaluation form completed by the physician; a functional ettlibility determination form and MA103 admission and discharge transmittal form. They are the three we need for long-term care facility services.
MA-51 is very important to CO because it verifies whether they are short or long-term meaning are they expected to return to the community within 6 months of admission.
If they are and they provide verification of shelter and facility expenses while in nursing home we can give deduction from cost of care called home maintenance deduction I will talk more about that in a few slides.
For waiver services in addition to the completed application, we need the PA-1768. As I said before, that verifies clinical eligibility it also verifies the date they were assessed as functionally eligible and which behavior they are applying for.
Before I leave this slide I just want to stress, if your current medical assistance recipient you don't have to complete a whole new application. We will send you a couple pages of the application, photocopied with certain questions highlighted. These will long-term care specific

questions, such as do you have intent to return to your property? Did you give away any assets within the past five years? Things like that.
We do need that information back but you don't need to fill out a whole new application.
Once we receive the information, the application, the functional elogyibility formtz pending verification list to all involved parties.
What we have to do is request a snapshot of income and resources as of the requested effective date; that's why we get specific and ask for bank statements, financial account statements as of that specific effective date. We also ask for gross income nesks, life insurance cash surrender values titles to vehicles deeds to property and bank accounts.
Any accounts closed within the past five years, we will be looking at a paper trail. We want to see what accounts closed, the date it was closed and closing balance. We want to see where the money was deposited or spent.
The CO has 30 to 45 days to process the application. Once they do, they will send a notice of eligibility or ineligibility to all involved parties; that will include the date eligibility begins, cost of care for individuals who apply for long-term care facility services, the reason they are not eligible if they are not eligible and fair hearing paperwork.
Now, for a cost of care, this is the amount of income that the individual must pay every month towards their care in long-term care facility. We have a cost of care for long-term care facility services but not for waiver services.
Once the CO determines whether the individual is eligible, they go on to a second step for long-term care facility services determine how much cost of care will be every month.
We have common deductions we look for: Personal needs allowance everyone gets usually $45, court-ordered guardian fees. If someone has guardian and court ordered we need to see the paperwork, maximum of $100. We have home maintenance deduction I touched on already. Currently it is $750.0 which probably goes up within 6 months from admission if considered short-term by physician.
We have spousal allow nans and also we can deduct medical insurance premiums will they get deducted by the nursing home.
The next major topic I would like to discuss is fair consideration. When the CO is reviewing for eligibility they must verify whether or not assets were transferred for less than fair market value during look-back period. This is considered fair consideration.
If they transferred assets less than market value inability is going to be established. It's important to note that they are still eligible for fee-for-service they are just not eligible for long-term care facility room and board or waiver services.
Look-back period is usually five years; that's when we have are to look at fair consideration and five years from application date.
We are going to determine the length of the penalty period in days. Basically, we look at every month that has asset transfers totally fair consideration and wasn't received we add them up divide by average daily private pay rate which for 2016 and determine the number of days they are not eligible for payment of long-term care facility or waiver services.
Ineligibility period for long-term care is determined, as I said, using average daily private pay rate. For applicants it is requested effective date.
For recipients it starts the first day of calendar plo after 15-day advance notice expires.
For example, Mr. Jay is open waiver services on July 10th we determine he tranced $5,000 didn't receive Nair market value we process a notice it will say that he is not eligible for payment of waiver services from August 1 fort through August 167th. It starts August 1st because it it ended

in July it gives provider to know they will not get payments and family members to know we need to figure out how to deal with it.
If asset transfer penalty period is established, there are different ways the individual can handle this. They can appeal the decision, they can apply for undue hardship waiver and do both we get asked the different between the two.
In context to have asset transfer appeal is done when you don't agree that assets were transferred for less than fair market value or you don't agree with monetary amount determined.
Undue hardship however is denial of payment of long-term care would deprive individual medical care, endangering the person's health or life or deprive individual of food, shelter or other basic necessities of life.
The appeal process is the same as it would be for none-asset transfer issue complete fair hearing paperwork, send to CEO, they forward it to bureau of appeals and setting up pre-hearing conference if issue cannot be rectified during pre-hearing conference it will go to hearing, the administrative law judge takes testimony from both sides and has 90 days from appeal date to make a decision.
For the undue hardship application process, the undue hardship is one page, just front side of one page. It's sent out with asset transfer notices. It has to be completed and sent back to the CEO within 30 days of the date on the notice like the appeal paperwork would be.
With it you send supporting documentation.
Supporting documentation is very individualized. It's on a case-by-case basis a couple examples would be assets were transferred four years ago and individual was in good health. If a doctor sines a statement saying, Mr. So-and-so had no expectation of needing waiver services at this time that's a good supporting documentation that there was no expectation of poor health or needing these services.
Another example would be if you sold res or non-resident property for less than fair market value a signed statement from licensed realtor stating this is the best offer we could get the property was in very bad shape or property values are very low in the area; that would be an example of supporting documentation.
You would send it in within 30 days of the date of the notice to the CO. The CO forwards it to us at the bureau of policy. We make a departmental decision. Send the decision back to the CO sends out the decision whether the undue hardship waiver is approved, partially approved or denied on an appealable notice.
If you don't like the decision, you can appeal it as well.
If the personality period is determined, you can appeal that. You can also apply for undue hardship waiver. If you don't like or agree with that decision, you can appeal the undue hardship decision. You have a lot of different options there.
I would like to get into spousal immove I shallment provisions were put into effect in 1989. They are allow married individual who applies for long-term care services to protect minimum level of income and resources for the spouse and community.
When I refer to community spouse I mean a spouse of individual applying or receiving either long-term care facility or waiver benefits we call that person the community spouse.
When married individual applies for long-term care services we have to determine the couple's countable resources as the date of entry into LTC facility at least 30 consecutive days or the date one spouse assessed as being functionally eligible for HCBS.
We need a snapshot of resources as of either the admission date or assessment date.

Once we get the resource assessment form back and all of the verification of countable resources we add it up and divide the amount in half.
Usually half of the total countable resources is protected share that the community spouse keeches free and clear we don't touch it.
However, there are a few -- there are standards we have minimum protected share and maximum set forth by government every year we have to follow those.
Currently minimum is $23,844.
Maximum is $119,220.
He and his wife owe total countable resources protected share is $42,000 half is between minimum and maximum.
If they only had $40,000 total resources half is 20,000 we need to bump up to the minimum.
In addition to that, the institutionalized spouse gets to keep either $8,000 or $2400 depending on gross income.
The spouse sal maintenance allowance is another part of spoisal immove I shallment it is only 2KER78D for individuals applying for long-term care facility services it's a deduction from the cost of care that we can give so that the institutionalized spouse some income gets transferred to the community spouse to help pay their bills in the community; that's less money going to nursing home every month in the cost of care.
So we are going to ask for verification of the community spouse's gross income and shelter and utility expenses. We try to do this to help; that's why we ask for this.
Now, common reasons for long-term care rejections. In my 14 or so years I have seen three reasons for them to be rejected the first time they apply:
First is failure to provide documentation. We know it's a very tough process. It's usually a child or someone else involved in getting all of this information, dealing with the parent who has to go into a nursing home, poor health, they are stressed about that.
I have been on the other side with a grandparent. I know it's hard. Unfortunately the CEOs have to follow guidelines and time lines.
So if you are rejected for failure to provide you have couple different options you can appeal within 30 days of the date oven the notice or you can ask -- call up CEO and ask for reconsideration. I would like the application to be reconsidered.
Now, the thing with reconsideration that you have to provide all of the missing documentation within 60 days of that application date. If we hold it for 45 days you only have 15 days to get us all of the information.
I hate to say this because we hate appeals in this situation I would suggest you appeal because that's going to give you more time. Either way, you get to -- you don't have to complete a any application if you can get us the information in correct time frames we save the original request effective date. Appealing gives you a lot more time.
The second and third reasons are excess resources and i income.
I will talk about each now.
There are multiple options for reducing resources. Depending on how the resources are reduced will determine when the individual's resource eligible.
If you reduce resources by purchasing irrevocable burial reserve or spending the resources on medical expenses such as hospital or doctor bills, then we are essentially going to pretend the resources never existed and go back to the original requested effective date.

If you reduce them on non-medical expenses buying car or paying off a mortgage; that's okay but you are not resource eligible until the day after the resources are reduced to within the limits; that's really important here.
I will give you an example. Let's say Mr. C. considering payment of long-term care facility services effective May 10th he is over resources.
On July 11th he pays off his mortgage. Now he is eligible for payment of long-term care facility services to begin July 12th.
Remember, his resource limits is either $8,000 or $2400 he has to use the little bit of money to pay the long-term care facility for services inkirred May 10th through July 11th.
It's very, very important to consider how the best way is for you to reduce resources. No matter how you do it, you have to provide a paper trail. We need to verify fair consideration was received; otherwise, we will determine a penalty period. When I say paper trail, we want to see copies of bills paid, the date they were paid and the account balance showing these withdrawals were made.
>> **PAM:** Does that spend-down allow for people on the waiver as well? Are you able to, like your income is just over $2,199 and can you get burial plan and pay the $40 out of your income and that lowers your income.
>> **MARCIA:** Income spend-down is different. We just talked about reducerring sources your income limits, under $2199 but you had -- you could create burial reserve or pay off a medical bill; that's the resource portion.
Now we will get into the income portion.
For income spend-doing we don't have long-term care facility option for waiver services. We can't use nursing home private pay rate as a medical bill. We don't spend down to $2199 a month we have to spend down straight medical assistance categories with very low income resource limits.
It is hard to live in the community off straight medical assistance limits. We don't have the $6,000 disregard with straight medical assistance categories that we do with waiver. We don't use 3000% of the federal benefit trait (350300).
You have to decide if you can afford this. There are two ways to spend down. Straight MA none money payment and -- you have to provide verification of CEO of medical expenses incurred or paid in that month. We get it and then you are eligible from the day after those expenses were incurred through the end of the calendar month. You have to keep doing this every month. The date could change every month and when you are eligible.
So it's kind of a pain for the person applying, CO and providers.
We have -- you have to provide more medical expenses because you have to provide six months' worth of spending down six mods' worth of income and we will authorize you for six months.
You will get a copy of the PowerPoint and then slide 16 through 19 have examples for single and married individual with both options.
I will go to slide 20 just to show you the differences between NMP and MNO.
Duration means when I said about monthly versus semi annual.
We determine you eligible for partial portion of the month or for six months at a time, depending on how much medical expenses you provide to us.
Income and resources count? When we say very deeming for NMP it 3450E7BZ if I are married we will look at income and resources of both spouses and look at two-person income and resources.
NMP two-person is 1,1333.30 and resource is 300.

If you are married, this may be better option no matter what your community spouse earns we are only looking at spouse applying and for their income and resources applying to semi annual limit and $2400 resource limit. It depends.
Basically, if you are over income and rejected for waiver services, you can call the CO and say, I am interested in spenddoing there are very few people that can afford to do this unless someone is helping them with bills.
The CO doesn't always ask about this. Once you talk to them about it, they can talk you through it or they will call us. You also have my contact information and can call me if you have any questions as well.
The last slide, I just want to talk to you about medical assistance for workers with disabilities very quick quickly.
For someone who is applying for waiver services with income exceeding 2199 a month, if you are working and fit the MAWD eligibility requirements this is a great program.
You have to meet the age requirements of at least age 16 through 64 you have to be employed and getting paid there is no hourly work requirements. I seen a person walk their neighbor's dog once a day and they are meeting the work requirements.
You have to be disabled according to Social Security or medical review team. If you are function anally eligible for waiver you should neat the requirements; that's not a problem usually.
You need income employee 250% FPIG ($2,475 for one person) (if you have income exceeding that and are working ask us to look at MAWD we have a lot of earned income deductions we have for MAWD not for waiver. It is a great program. Do not let that stop you.
We look at community spouse's income and resources we have the two-person income limit of 33,338 the household is 10,000 or less and willing to pay monthly premium of 5% of net monthly income it's after we take all of the earned income deductions.
So, again, CEOs don't always think about MAWD. Please, if you are working, and you are just not meeting the waiver requirements because of your income, talk too the CO. Remind them of this great option.
All I have, the last slide I have is my contact information and helpful links.
Anyone can contact me if they have any questions, once they read over the PowerPoint when they get it. Any questions now?
>> I know of one county where they insist on having five years of bank statements. I know of another county where they insist on six months of bank statements and five years of tax returns. I haven't been able to get a clear statement as to exactly what it is folks are supposed to provide.
>> MARCIA: We have a policy clarification out there they are to provide monthly statements for two years, two months for each additional -- the three additional January/June something like two months of bank statements for those years; five years of tax returns if filed.
However I say this I have the policy of clarification that says that but it's individualized basis. We don't need to ask for that much or if we are finding more information we are looking and seeing asset transfers we can ask for more that's the gist.
If you want to give me names of counties I can talk to them.
>> Sure Montgomery says five years of bank statements and then it was -- it is a hub. I think it was -- I am trying to think now. It's the hub that handles Cumberland but it's not Cumberland County. You know for LTC they are hub counties. They had five years of tax returns but six months of bank statements.
>> MARCIA: We heard Montgomery many times is this still happen willing?
>> I heard a couple months ago.

>> MARCIA: It was addressed since them I will let operations know so they can keep a watch for it.
>> Thank you.
>> PAM: Is there anything that can be done for an individual who is 25 to $40 off/over on income? Their income is being counted before their Medicare premiums? Is there anything that can be done? They are $40 over. If their Medicare premium was not counted, then they would be eligible.
If they lose their waiver for $40 a month, they will go into a nursing facility. I have three people that I know are dealing with this. One individual is going to go from 92 hours a week to a nursing home.
Is there anything that he can do with any of the stuff you are talking about?
>> MARCIA: We have nothing in Pennsylvania currently that allows us to do that. There are some federal rules that could potentially allow us to spend down to $2199 a month but that's something for the Office of Long-Term Living to address.
>> PAM: Okay. Can I email you to find out what those federal things to bring them down or?
>> JEN: What was the question? I'm sorry.
>> MARCIA: She is asking about federal regulations is there any way we can spend down the 2199 a month for [inaudible]
>> JEN: I have talked to the office of income maintenance Lord he is Pidea the deputy secretary about this.
Because it has ramifications downstream she is not -- we are not considering it right now.
>> RALPH: We have an audience question. Please use the mic.
>> Hi. Do you know why for long-term care MA applications they will only be reconsidered within 60 days of application as opposed to within 60 days of denial because it's within 60 of denial for other categories.
>> MARCIA: It's ridiculous. Secretary Dallas would like to get it changed. It would make things easier and make sense.
>> Great. Thanks.
>> FRED: Please turn off your microphone.
>> I am Pam Walls from community services thank you.
>> JACK: Marcia, very well-done. It is a very complicated process and you did a very nice job explaining it to us.
You also pointed out some significant policy issues which will be taken up at a different time and different place. Thank you. Very well-done.
>> MARCIA: Thank you.
>> Raferl: Thank you very much.
>> Jenn.
>> DREW: This is Drew. Could I ask a question?
>> RALPH: We will have Bob Kafka. Who is on the phone speaking?
>> JEN: It was descry.
>> Drew Nagele. I had a question earlier on the call but I dialed in on the wrong number so I wasn't heard.
Could I ask it before we go on to Bob? It has to do with clinical eligibility determination?
>> RALPH: You want to ask the question of Bob Kafka?
>> DREW: No, it doesn't have to do with Bob. It has to do with previous discussions that we had on the call about eligibility.

>> **RALPH:** What is your question?
>> **DREW:** It has to do with clinical eligibility determination process. Jennifer kind of got at it in her question about how the various contractors are trained and Kevin answered that there are certain competencies required and my question is are those competencies for specific populations, such as those with dementia or those with brain injury?
Could we actually see some of the language in the contract with aging well OLTL has to assure that these competencies are met?
>> **RALPH:** We can certainly look at these. Kevin is not here right now.
>> **JEN:** Drew, I will take it back to Office of Long-Term Living and make a decision as to whether or not we would provide that language. Thank you.
>> **DREW:** Thank you, Jen. It's more than providing the language. We would like to make sure that the proper training is going to be provided to those doing clinical eligibility determinations.
>> **JEN:** We would require them to be trained; that's already a requirement.
>> **DREW:** What we want to know is what the specifications of that training are going to be.
>> **JEN:** I think we can get that for you.
>> **DREW:** Okay. Thank you.
>> **RALPH:** Thank you, Drew.
Now we will have Mr. Bob Kafka join us, please, by phone. The floor is yours.
>> **BOB:** Request you hear me? I am here.
>> **JEN:** We can hear you well, Bob.
>> **BOB:** Okay.
>> **RALPH:** Tell us about Texas' managed care.
>> **BOB:** " am Bob Kafka an advocate here in Austin, Texas for good or for bad, Texas stayedwide for managed care for acute and long-term services and supports.
It started as a pilot down in Houston, Texas, originally when it was proposed. It was going to include all populations and so at the time, the disability community, you know, was willing to give it a chance at the very last minute the developmental disability community opted out and so the pilot was just aging and physical disability. We are now in the process of integrating the developmental disability population into [inaudible] is the name of our managed care company -- I mean program.
Throughout the development of star plus we had a committee probably similar to the one you are all on called independence advisory committee which was created in response to the Supreme Court Olmstead decision.
The whole advocacy was based on this to be a functional system where individuals would be able to have choice.
On the acute side there is access to specialists but also the concern about consumer-directed programs, as well as relocation.
What Texas has done as combined quite a few different funding sources. We are under 1115 waiver. It originally was a 1915 (b ?mplet c).
I am not technical expert Jennifer -- well they felt they may have more flexibility with 1115 waiver.
Some of the main things we got initially is in the contract this the MCOs sign, they have to offer consumer directed as first delivery option to the individual so that the individual would have that. Now, in all honesty, we are not totally comfortable about how a lot of the MCOs deliver that, but it is requirement. We monitor it. If the numbers don't sort of match up we ask for clarification. There has been quite a bit of consumer input with f to the contract MCOs sign.

Very different than a lot of the public programs, managed care is able to do it off the contract. It's kind of important that we have input at the contract development so that we can get, you know, the questions that we want into the program.
The other money that we hooked up with that was the money following the person, MFP money. Those funds have been used to contract with the independent living centers to do relocation services.
The funding in terms of moving people out of nursing homes into the community has been quite successful, actually.
Like I said, most of our census we have one AAA that has a contract but all through the state the contract is done with the DIL. They work cooperatively with the MCOs in their region.
We have 5 major MCOs. I don't know if they use the same name, but the ones that we have here are AmeriGroup, Senatorine, Molia, health spring are the major ones that are currently contracted in different regions throughout the state.
Every region has at least two MCOs for the individual to choose from and in our larger Medicaid area which is down in the valley and west Texas there are three MCOs.
We have gotten where you can, actually, switch an MCO, you know, with just the 30 days administrator requirement.
They tried to, you know, report that back. If you are not happy with the MCO -- you know, they negotiate rates that our ILs, home care agencies and also with our nursing homes.
It's kind of important that we have input into all those areas.
The thing also that we have hooked up with is Texas last June began community-first choice option; that has -- it's going to be used to sort of be the bridge to integrating the developmental disability community into star plus program.
I can tell you, it's sort of kicking and screaming of the developmental disability community, but we have made the case that, you know, people with dementia, people with brain injury post post age 22. It does take time because the systems are different. It does need to be transition open time to educate, get the provider base and some of the things that drive us crazy, computing, billing, provider coding and things like that.
It is part of the difficulty in breaking down of the silos so we are in that process.
In Texas, because we are one of the lowest Medicaid reimbursement, managed care is, actually, reduced our waiting list on the aging and physical disability side because everyone on SSI is entitled to the community services, if they are eligible, functionally eligible.
So that is really a wiped out quite a bit of the waiting list aging and physical disability.
We also have another program that provides basic attendant services to people between the SSI and 300% of SSI so they -- it's a Medicaid-funded program but it's the people that don't have Medicaid card. The vast majority of those people are on Medicare or older but it has younger people with disabilities.
We have not experienced what a lot of advocates worry about in terms of loss of consumer control and putting people in nursing homes.
We have found over time that the incentives are a win/win for both consumers and for the MCOs because, again, if, you know, we believe what we always say that nursing homes are more expensive than community, then you would think it would be logical that a for-profit MCO would want to move people into the community.
Now, I know there are a lot of different pressures political and otherwise, but in essence, what we have sort of advocates for and been oak successful that, you know, they work with the relocation people to make sure that if they go in they are only in or for a short while and they

also, basically, are hooked up with the relocation people to get them, you know, out in terms of that.
The other thing that -- we keep tracking this -- a lot of the "specialists" on the acute side you hear stories that, you know, they are not in the network.
Now, our MCOs at every meeting we have, you know, say that it's called single-use agreement where they can actually contract urologist, especially therapist and whatever the specialist might be. They don't have to be on the large network that they can be on the network. How well it's working? We just keep tracking it.
Single use contract is the thing when we bring up the issue about specialists not being in the network, that that option is on the table in terms of that.
We have quarterly meetings with our Medicaid office where the statistics on star plus, how many people are on the various different programs; that's been really from an advocacy standpoint, you know, as much sunlight in terms of numbers, in terms of how many people are getting consumer-directivelies, the reason why they are not doing that, how many people are in nursing homes.
We are trying to track, you know, those numbers.
Again, you can't advocate if you don't know what the numbers are.
Assuming your committee would do that sunshine transparency and try to keep general fer honest, I suppose -- [LAUGHTER]
>> **FRED:** Good luck, Bob!!
[LAUGHTER]
>> **BOB:** I've known Jennifer for a lot of years so --
The issue is that, you know, we have cooperative as well as a healthy tension in terms of the whole program. We meet in at least parts of Texas meet with the MCOs.
The big he shall issue here is we have such a low Medicaid rate for our workers that there is a crisis sis.
We have been working with the MCOs to try to find, as well as moneys and also other ways to sort of attract workers because we are having more and more people that cannot find an attendant.
Consumer direction is great, but if you can't find an attendant, you will either keep a bad attendant or some bad things.
Again, the MCOs --
>> **JEN:** Are you back.
>> **Bob:** I must have said something bad about Jennifer.
[LAUGHTER]
Again, the MCOs, in terms of it's in their self-interest for people not to get the -- for health not to deteriorate. To keep turnover rate low is also in their interest, not only in concerns for individuals' health but also their bottom line; that's what we tried to do and tried to see where the intersection is.
Again, managed care is, you know, seen as being brought into, you know, just slash and burn programs.
Even though that may be the goal of some in legislature, what we have found is that if we can find places where they intersect, we, you know, have been successful.
The community first choice option, we are one of the few states that get 6% enhanced match and it's somewhat important if eventually your goal is to have an integrated system for all populations because so much money is wasted on administrative agency money that, you know, really the silos have built on previous sort of assumptions in terms of the populations.

Again, it's from the individual and family member level, they want the service. Sometimes providers use us as a way to keep their population.
So CFC is sort of the way that we are trying to bridge that tension so that people who have the label of DD, you know, are receiving star plus services and they are finding they are not, you know, lying under a bridge or things like that.
Again, I am not going to say it's easy, the politics are extremely tense, but from our philosophical grounding about functional assistance -- because, again, if one does a functional assessment, cognitive disability, brain injury, Alzheimer, stroke why is it different than if you were born with a cognitive disability? If you think about it the assistance with financing and check writing are very, very similar in terms of that.
The medical stuff may be different, but, again, spinal injury is different than someone with polio or stroke.
Again, we are talking about long-term services and supports in the community. The commonality is much more than is commonly thought.
You know, saying that, it's a political hot potato.
I really think that, you know, it should be a long-range goal to have integrated system because imagined care is said to work with people who are aging and physical disabilities why not people with developmental.
If they don't think it works for that population, why then are they inflicting it on the aging and physical disability?
It's usually not couched in that way.
So I went go on and on about that, but the thing that we have, you know, really pushed is transparency, getting numbers, freak meetings with both MCOs and the agency to sort of, you know, make sure that some of the principles -- now, I am no expert. I was listening to the previous speaker in terms of a lot of the technicalities. Even though I am a policy law it's way over my expertise.
What we are trying to assure is that the principles that we fought for in all long-term services and sport programs don't get lost in the managed care.
Then, the other thing that we have found to be extremely important is the role of what we call service coordinators, someone spoke about case manager.
You know, again, we don't think that is funded enough here. It's key especially to people who need more complex combination of needs.
A good service coordinate naturor, ideally it would be good to be contracted to a community organization but even if it isn't, the service coordinator and the requirements of what they do, I think they really warrant a lot of attention by your group because one of the things that we have found that people with, you know, complex and significant disabilities do need a range of services and so that needs to be coordinated and service coordinator is the place that we think it should be done.
Good requirements of how many visits. It's not appropriate just to call up once a month on the phone for some individuals but it might work for others.
So the role of the service coordinator is another thing that we are constantly doing.
Just recently, the new rule on network advocacy. Network advocacy has mostly been on the acute side but we have been promoting and hopefully we will be getting it in advocacy in terms of having enough attendants for people to choose from so that it puts it on the requirement and we can see month in the report, if, in fact, the MCO or the home care agency or the IL is providing enough attendants so that people have a choice to do that.

So the new rules on network advocacy allows the state to do whatever -- to set their own standards.
The rules allow Pennsylvania to set up network advocacy on a whole bunch of longive term services and support.
What we have heard here and I'm sure you will hear, there's not a lot of community standards. There is a lot on the acute side, BP, diabetes they can oobtively say. Well, is there are no objective standards in terms of community -- long-term services and supports.
I think it's just a lack of creativity. I think you all could come up with things like, you know, choice of attendants, wage rates, where people are put into assists living and in their own home, nurse delegation, there is a whole range of community support that have allowed individuals with disabilities to have non-medical support systems as possible.
So with that, we are pushing on that too.
I think that's just general overview. Like I said, statewide it gives transition over time. Our big push is now integrating developmental disability population using CFC as the bridge, the thing that is currently going on we will start our legislative session? January. They probably will continue to be a political hot potato, but at least they are -- ADAPT is continuing to build a good functional system to individual and family member.
>> **RALPH:** You are fading on me, Bob.
Let me open it up, if I may, to questions for the members.
>> **Tanya:** I have a few if it's okay. I think they are short and can be answered relatively quickly. One is, how do you handle conflicts within the MCO system that is currently set up in Texas? What I mean by that is, are there ever conflicts between the insurance provider and service coordinator? If so, who is there to be the advocate on behalf of the consumer receiving services?
>> **BOB:** Well, if I think I heard the question correctly, it's conflict between MCO and service coordinator? Well, currently here in Texas, the service coordinator works for the MCO. There is an appeal process on all decisions that are made. It's not so much with MCO and service coordinator you can start there. You can do Medicaid appeal on decisions that you might agree with.
We encourage folks. They try to low-ball the number of hours people need. We are encouraging people to do an appeal if they think the hours are low.
One population that the committee -- subcommittee working on is people on ventilators are about 125 folks in Texas that are on ventilators in Medicaid nursing homes.
They are looking to see what the package of services that might be able to be put together to get those people out of the nursing home and into community waiver.
>> Tanya. My next question was: Currently there is a big push in the State of Pennsylvania to employment more involved into the new Community HealthChoices model that will be rolling out.
Is that going on in the State of Texas? If it is, how is that being handled?
>> **BOB:** If somebody could repeat if, I didn't get what it was?
>> **JEN:** Tanya made the statement that here in Pennsylvania we are doing a lot of work through our waiver we just added five employment services and we are getting ready to roll it out, but that's also going to be a requirement in Community HealthChoices. Our managed care agreements detail information about what the managed care organization will do in the area of innovating around employment for people with disabilities.
So her question was, is Texas doing anything similar to that?

>> **BOB:** Yeah. In fact, it is just starting to do employment first task force. Again, with the most recent CMS guidance on Olmstead and sheltered employment and day activity; so that is also spurring on the integration.
Again, it's in the integrating of the developmental disability area. What we have found is, many of our DD providers are also under the guise of day activity are also 14 (c) subminimum wage holders. Even though they are technically not using Medicaid money for sheltered employment, they are just coincidentally in the same location.
So we have been very, very much you know trying to have that overseen so that, you know, our DD providers are not, basically, homeless, skirting the prohibition to do sheltered employment with Medicaid money, but they sort of mix their day activities.
Again, it's just beginning. Part of that is -- has been the positive of the trying to integrate the developmental disability because the climate in Texas has been almost totally in the developmental disability waivers and all of the other in physical and aging waivers, employment in the past had not been included.
As we are going to be integrating, they are adding those services that can go into your plan of service when a setted to keep you in the community.
There's not been a long history. We don't have any statistics that I can get to you.
>> **RALPH:** Thank you.
>> **Tanya:** Thank you.
>>: Ralph: Any ear members with questions?
>> **FRED:** Hey, Bob, it's Fred Hess.
You answered these but I would like a little more clarification. The service coordination, are MCOs subbing it out at all or are they doing all of their own service coordination?
Two, the consumer hours, did they go up, down or remain pretty much even with everyone after transition time.
>> **Bosch:** The service coordination has been kept within the MCOs we have advocated for it to be separated. All of the relocation specialists using the MSP fund of getting and keeping people out of nursing homes is contracted out to the independent living centers.
P and one agency for aging. We wanted to see, you know, were people getting cut services. Under our previous fee for service our agency could give you a weekly average of what people were getting.
So now we are getting that same number. So far, it's been pretty much the same. There hasn't been a drastic cutting of services.
I will tell you, it's one of our big fears in Texas as med okayed -- the over time rule at the department of labor, we are really worried they will assess for people with significant disabilities will amazingly always stay less than 40 hours so that they don't have to pay the time and a half. Like I said, I don't know where Pennsylvania is on that, but in Texas, we have now in response to the DOL, that no attendant who are more than 39.5 hours for any one agency or individual. The good part is, you know, we don't have a lot of people getting a lot of hours.
The bad part is the exact same thing. So we are worried about the future that people with significant disabilities that need more than the 39.5 hours and would like to have, you know, one attendant that knows their body, that we are going to see that they are assessed --
When I talk about transparency and getting numbers, those are the kinds of things that we have requested as a committee, so that we can see, if in fact, we are seeing a marked decrease and so -- then we can ask the question why if there is any explanation.
>> Ralph. Thank you, Bob. Any other questions?

The gentleman there? Do you have a question for Bob?
>> Not really for Bob.
>> RALPH: Okay. Then we will wait.
Bob, thank you so much for joining us today and letting us know what is going on in Texas.
I know Fred, Pam and others.
>> BOB: It was funny. Pennsylvania is always like a state that we aspire to be like, you know, in terms of -- even though you have more waivers than anybody in the country.
>> RALPH: It's good to hear because I always hear Texas is the best. Glad to hear it. Glad to hear we rose above you in something. Thanks again, Bob, we talked to you.
>> FRED: You mean we are bigger than Texas?
>> BOB: You are the center of the universe. Maybe I will do my little non-partizan -- make sure if you haven't voted vote!!
That's it. That's my one pitch.
Thank you very much.
>> Ralph. Thank you, Bob.
>> BOB: Take care.
>> RALPH: Any public comment? Please identify yourself and have at it.
>> My name is Art Guld. I am from Lebanon and own my h home.
I dovered a gap in the waiver. I cannot do any own yard work and remove my own snow and whatnot. In June I went through a stroke.
Now I am unclear as to whether or not -- I haven't been able to do it all summer. I have had my PCA who is privately hired do this. Thank God.
Otherwise I would be getting fines. Any grass over 6 inches high is considered a weed you are fined by the city.
Snow must be removed from your sidewalk, public sidewalks within 24 hours of a snowstorm.
I called my service coordinator and I called OLTL and I called the office of the aging. Nobody knows where you can get any help.
My service coordinator keeps threatening me that if she catches me out there with a lawn mower or snow shafl she will take hours away from me. What am I supposed to do about this?
>> FRED: Jenn!?
>> JEN: Art maybe we should talk offline with service coordinator and see what we can do.
Virginia, is there any prohibition from the aid doing that in the independence waiver?
>> Virginia: I think we have allowed it in the past.
>> The problem with the aid, which is me, I am going to be 59 and with shoveling the snow for him the past two wenters, the first winter I developed bursitis.
It reached a point where, unfortunately, I couldn't get myself out of bed without help, I couldn't dress myself or anything. They gave me injections but that aggravates it removing the snow and so forth.
I don't want to lose my job. If he gets the fines he will lose his home.
>> ART: Jenn is my weekday PCA. I have a different agency that comes on the weekends. The weekenders have volunteered to do it for me, but they are told if they do do it, they will get fired.
>> JEN: As I said, this is really an individualized situation. Let's -- we can -- I can have one of my staff talk to you afterwards and get more details about it. We have to talk with the service coordinator.

>> **PAM:** Is it possible to get clarification on seasonal hours I get questions some people have it. Some people don't. Sp people are told yes. Some service coordinators say it's not available. Can we get clarification on what is available for everybody?
>> **JEN:** Yeah.
>> **PAM:** Thank you.
>> **FRED:** Any other questions?
>> Thank you. Hello, everybody.
Regarding supports coordination I think the eligibility had a lot to do with my questions about the IEB.
I am kind of confused on the whole approval process.
I have had phone duals from consumers after they -- I am assuming after hearing this presentation after they received a letter from the county assistance office saying they are financially eligible. They will say that they are financially eligible but yet they are under the belief that they are now eligible for the entire waiver so that they get information and it has to go back to maximus to say, okay they are financially eligible but we are not approved for the entire waiver.
I just got\ off the phone with someone last week.
Once everything is done they still have 45 days to get confirmation from the office of long-term living.
Is this true?
Help me understand, again, just the whole who process of being approved.
>> **JEN:** Clinical eligibility which the AAA conducts that.
Then the independent enrollment broker will come out and talk with them about what service coordinators are available and fill out the forth that Marcia was talking about, the 1768.
I am still confused, are they being told that they are financially eligible before they -- before maximus goes out?
>> **JEN:** I don't know.
>> That's what I think is happening. I am not sure.
>> **JEN:** If the county assistance office has determined them financially eligible they will get a notice from county assistance office, Marcia said all involved parties will get notification which includes the employment broke earn.
>> It makes the consumers they are eligible for the entire waiver. They are saying, where are my services now.
>> **JEN:** You can explain to them they have to go through a clinical eligibility determination by AAA; that should have been happening concurrently.
>> That's what I was going to get to. Thank you.
Who is telling them the steps in the program; that's end up being myself they see us on the commercial. You shouldn't have to have seen a service coordinating entity on the commercial to understand the steps in the process so that they are not so lost.
I thought I was confused but I understand it's confusing.
>> **JEN:** I unfortunately don't have any bureau director here that knows the ins and outs of this in detail. I cannot answer your question. I am pretty sure that one of the things they get when they get the packet from maximus is a flow chart or something that tells them what will happen and the steps that will be taken I will check on that.

>> Let's make sure maximus does that. I don't mind at the end of at the time day I can reach out to OLTLy they are at and help them understand, which gives them the calm. I feel if we could give them the calm prior, I could be doing other things; that's all.
That is pretty much it. I will send the email to Ms. Melissa about the questions I had.
Thank you.
>> RALPH: Mike, if we can get you on the me. Meeting.
>> Mike, no way!
>>: Ralph: That would be wonderful. I'm sorry we couldn't get to you today. There were just more important pome -- [LAUGHTER]
(People).
Any other questions?
>> Tanya: I'm sorry to bring this up late in the meeting but I didn't really get a chance. I wanted to ask someone at OLTL to please get in touch with somebody at OVR because there are major concerns with Edinboro community that there is going to be major changes in the way that OVR is funding physically disabled students to go to school.
There is rumor they only want to fund the first two years of students to get 24 hour PC care in the dorm, which is equivalent to, like, the care and services that we receive every day.
Why this becomes a concern and a problem is, okay, if the waivers don't kick in until they are 21, and students are usually in school up until that point if you are going to college and pursuance of a 4-year degree, where do they go to get the services that they need to be able to finish up?
>> JEN: We had David De Notaris the director of OVR at the meeting last time. I can ask him that question. I don't know anything about it.
>> Tanya: I didn't expect you individually would, but I was hoping you could get me or the university itself in touch with someone that could give them some answers.
>> JEN: I will put you in touch with David De Notaris after the meeting.
>> Tanya: Thank you very much.
>> PAM: I have more questions but will limit to one.
>> RALPH: Go.
>> PAM: My question is certified option counselors will that replace the idea of navigators? If not, what is happening with that?
>> JEN: Nothing right now. We are doing research on what is required in the final rule.
>> PAM: Certified option counselors those are to help people who need help with IEB and how?
>> JEN: Aging disability resources person-centered planning counselors are -- is what Kevin was just talking about we are in discussions with Department of Aging about what their role will be. He gave a good explanation. We haven't finalized anything.
>> PAM: Okay.
>> RALPH: They are being looked at.
With that being said, the meeting is adjourned. Thank you everyone.
(Meeting adjourned at 1:02)
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