December 9, 2016
MLTSS SubMAAC
Honor's Suite 333 Market Street
Harrisburg, PA

>> PAM MAMARELLA: We're going to get started in a minute.
Good morning everyone we're going to get started.
Okay.
So let's start with introductions.
Why do I sound like I have a echo on my mic I sound really important don't I?
So Barbara why don't you start us off with the introductions
>> FEMALE SPEAKER: Good morning Barb Polzer liberty community connection.
>> PAM MAMARELLA: Hi James you are new, tell us who you are and why your here.
>> MALE SPEAKER: Sure I'm a newbie, James Fetzner I work with resources how many and community based care we also have shared housing services and we're in Erie and also in 7 or 8 other counties.
>> PAM MAMARELLA: How is the snow in eary.?
>> MALE SPEAKER: I made it out before they closed 79 in about an half an hour.
>> MALE SPEAKER: Good morning Blair Boroch united health.
>> MALE SPEAKER: Pete, Pennsylvania health care associate.
>> PAM MAMARELLA: Pam Marella with court land, Philadelphia.
>> JENNIFER BURNETT: Jen Burnett, office of long term living.
>> ALFRED: Fred Hess.
>> MALE SPEAKER: Steve Williamson.
>> MALE SPEAKER: Monica imtroductions.
[
>> PAM AUER: Pam Auer in for Theo braddy, CIL of Central Pennsylvania.
>> MALE SPEAKER: Ray push knock, there was show on the Turnpike.
[introductions]
>> MALE SPEAKER: Arse next ustayev.
>> PAM MAMARELLA: Can we hear from the people on the phone?
>> FEMALE SPEAKER: Tanya Tegl ow.
Ralph Ralph this is ralph, good morning everyone.
>> PAM MAMARELLA: Hello chairman Ralph.
>> JENNIFER BURNETT: Anyone else?
>> FEMALE SPEAKER: We should have Stewart westbury, and Brenda dare.
>> PAM MAMARELLA: Stuart are you on the phone, Brenda dare

are you with us?

>> ALFRED: How are you muted.?

>> FEMALE SPEAKER: May be on the wrong number.
I'll send them on the number.

>> PAM MAMARELLA: I'll go over the committee rules and Fred
has agreed to go through the evacuation procedure.
As always the language that we use as committee members
should be the utmost of professional and, colligulal, point of
order, collect your comments to the chair wait to be called on
keep your comment toss two minutes.
The meeting minutes are at a Listserv that are attached to
the agenda that you have in front of you, if you could please
turn off your cell phones, make sure that, when you leave you
clean up your area.
The public comments will be at the end.
Today we'll adjourn the meeting five minutes early, so we'll
be adjourning at 5 of 1.
We did get to meet our new member James again welcome.
And now I'm going to turn it over to Fred for evacuation
procedures

>> ALFRED: Run! No.

[laughter]

If event of emergency or evacuation proceed assembly area
left the zion church corner of fourth and market, if acquire
assistance to evacuate you have to go to the safe area right
outside the main doors of the honors suite, OLTL staff will be in
the safe area, and stay with you until you are told you may go
back or, you are evacuated.
Everyone, must exit the building.
Take all your stuff with you, and do not operate your phones.
Do not try to use the elevators they will be locked
down you can't use them, use stairwell, one and two, for one,
that's down the hallway by the water fountain, stairwell one is
on left.
For number 2, honors Suite through the side doors on the
right side of the room or the back doors for those exiting from
it the side doors, turn left, and stare well two is in front of
you.
For those exiting from the back exit doorists turn left and
then left again and stare well two is ahead.
Keep to the inside of the stare well and merge to outside
turn left and walk down dewberry to chestnut, turn left to the
corner of fourth, turn left at Blackberry, cross to the train
station, straight to the train station.

>> PAM MAMARELLA: Any questions about that?

[Laughter]

Okay.

Great.

We'll turn it over to Jen Burnett to give us an update on OLTL

>> **JENNIFER BURNETT:** Good morning everyone I wanted to -- I have a few things that I want to update everyone on and then we'll move into the today's agenda, we have some very good things on the agenda.

Ben Laudermilch from the department of human services is coming to give us an update where we are with the housing plan you recall he came here six months ago.

We'll also have will Marie gone doless and Paul Saucier and Howard Degenholtz to talk about our quality plan for office -- for the community HealthChoices as well as our evaluation.

So, we're going to hear how we intend to measure quality and then also about our long term evaluation we've got some updates on evaluations, some work has already gotten down, gathering baseline data.

And then we'll go into Mike hale from my staff will be giving some an explanation of how to do managed care over sight and monitoring and then we'll open it up for public comments around 12:30, hopefully.

I'll start out by saying our last meeting was the day before the election.

And since then we have had an election and I keep -- I get a lot of questions about how the election will effect both our plans to move forward on community HealthChoices and as well as just Medicaid and Medicaid long-term care, Medicaid long-term services and supports in general.

So the change in administration we don't believe it's going to effect the implementation of the community HealthChoices we have no intention here in Pennsylvania to changing our course and moving forward with community HealthChoices.

We are sort of in a wait and see pattern we're doing a lot of work internally to really look at what the impact would be if we were to -- if the Affordable Care Act were to be repealed.

And there's a lot funding available through the a towardable care act we have taken advantage of here in Pennsylvania.

Many other states have.

So we're working with our associates at the national governor's association as well as the national association of Medicaid directors to really, gauge the impacts for Pennsylvania in particular.

So that kind of analysis is going on.

But I guess all I can say we're in a wait and see pattern like everybody else.

It really is just -- we're going to wait and see what

happens.

From he had Fred Jen do you have a contingency plan in case they start giving up block grants are we going to be able to work with a block grant

>> JENNIFER BURNETT: We'll have to figure that out, yes.
We're -- that's all, what we'll be you know, looking at how that is going to operate.
It's going to take a long time for them to implant block grants I can say that for sure.
On the community HealthChoices the update on the community HealthChoices as you all know, we have been under a stay all four of the protests have been -- the DHS has given the response to the protests.
And the protesting entities have four protesting entities had 15 days to submit an appeal to Commonwealth Court.
And that date, 15th day for that would be December 13th.
But we continue to work towards a July 1 start date effective date for July 1 so we still have a lot of work to do.
Once that automatic stay that happens with the opportunity for the protesters to submit an appeal to the Commonwealth Court, we're in an automatic stay because of that until the 13th.
And that means we can't start our negotiations or start our readiness review or anything.
We are poised to begin ready this is review as soon as that -- all of that has been adjudicated.

>> ALFRED: Jen for some reason it if it goes on, up towards July, are we going to extend?
Burp buffer we're going to have to you know, consider an extension at that point yeah

>> ALFRED: That's what I was afraid of.

>> JENNIFER BURNETT: Yeah.
We will continue to work with the South Western part of the State as we have been.
Last week, we went to the southwest partnership for aging we were about 200 providers all different kinds of representatives there of South Western PA that was cranberry township, yeah.
It was, okay.
So we -- I'm really excited because there's a lot of knowledge and the people in South Western PA are really poised to help us get this right and help get the word out.
So do you have a question

>> MALE SPEAKER: If for some unfortunate reason you do end up having to push back how does that effect southeast?
Tread Fred yep

>> MALE SPEAKER: Southwest gets pushed back again?
How does that -- burp buffer we will likely move southeast

along with it, move it forward.

I wanted to give an update on the independent enrollment broker I've gotten a lot of questions about it.

I will tell you that we really have motor vehicled into a point where there, it is a pretty good steady state with them.

I am a little concerned only from a budget perspective that our aging waiver enrollments have increased by 75 percent in the last four months.

And that's a significant increase for us.

And in August of 2016, we had 495 enrollments.

And this is the first November that the independent enrollment, last month was the first month, IEB was facilitating enrollments in the aging waiver.

I wanted to give a little historical perspective and comparison to that August of 2016 -- from August to November of 2016.

In November of 2014, the enrollments for the aging waiver were administered by the area agencies on aging.

And we had 409 enrollments in November 2014.

Then, November of 2015, again, with the enrollments administered the area agencies on aging in that month, we had 492, enrollments it grew by a little less than 90 individuals.

In November of 2016 the enrollments are being administered by the independent enrollment broker and in November, of 2016, just last month, we had 867 enrollments into the aging waiver.

So the independent enrollment broker is definitely doing much higher volume than the area agencies on ages we have consistency how these enrollments are being processed we're measuring it U we were not able to do under the per view of the area agencies on aging.

So from August of 2016 to November of 2016 the enrollments went from 495 enrollments to 867 enrollments.

The n enrollment broker administered enrollments for November are really consistent with the area agency on aging administered enrollments, for the months of April, May and June.

2016, that -- that we also had significant amount of growth in those 3 months as well.

I have heard from area agencies on aging that in part that is due to the fact that they understood that the enrollment function was going to go over to the independent enrollment broker they really worked very hard and kind of processed their enrollments in knowing that it was going to be moved to the independent enrollment broker.

So they kind of I guess stepped up their game enrolling people in those 3 months at least that's what I've heard from area agencies on aging.

The customer service we've heard a lot of complaints over the
past six months at the independent enrollment broker has already
been improving and I'll just give you one of the measures of that
improvement which is the call abandonment rate that's when people
are calling and they hang up.

That's called the abandonment rate.

It's been reduce bid 79 percent, since August.

The call abandonment rate.

In August, the call abandonment rate was 6 percent and, in
November, the call abandonment rate was well within our standard,
what we require in the contract at 1.28 percent.

So we really made significant improvement 1.28 percent is a
really low call abandonment rate for a call center standard.

If you just look at a call center standards it is very low
abandonment rate.

We've been making a progress with the independent enrollment
broker.

We did have -- we posted the RFP we are reprocuring the
independent enrollment broker and we posted that for public
comment for 3 weeks.

It was posted in October and it closed on November 21st.

The total number of comments that we received in that
process is 1522 comments from 41 commenters, we are
analyzing all of those comments.

We had some good suggestions that we're going to be using and
making changes and adjustments in the contract.

Once again it's an unusual process to go through an RFP kind
of posting for public comment, but as a result we think that
we'll have a much better better procurement because of it.

>> **ALFRED:** You know I've got things -- you know I've got
points right?

About the IEB -- how many IEBs are going to be per region?

There needs to be I would think, one IEB per region if you
know, if there's more than that, we should split the regions up?

Is that what we're going to do with it?

>> **JENNIFER BURNETT:** Did you comment on the -- Fred tread
yes these are some of the comments?

>> **JENNIFER BURNETT:** Let me give you some of the areas that
we received the most comments on.

Program requirements was one of the things, what we're
requiring in the program.

The terms and conditions so the special terms and conditions
that were standard in DHS procurements actually Commonwealth wide
procurements.

Our service level objectives which are sort of our measures
of performance and penalties were also highly commented on and

interactions with community HealthChoices were also significant comments on that.

If you made that comment already we're considering it.

>> ALFRED: Okay.

Also the -- how come the IEBs do not fill out the PA600 anymore?

They used to they don't

>> JENNIFER BURNETT: They have never filled out the PA600 out.

>> ALFRED: They did it before when the IEB was the first step, it's right here.

>> JENNIFER BURNETT: Meeting was the first step they didn't fill it out per se.

It was -- it's really the, individual's responsibility they may help the person do that, they don't actually fill it out.

>> ALFRED: Okay.

If they're going to be certified options counselors to do this instead how do we apply to do that?

How would someone apply to do that

>> JENNIFER BURNETT: Linked to ADRCs have -- the access to the training that is necessary.?

So it would have to be through if you're ADRC you can apply.

I see Steve Horner in the room are we doing anymore training for the counseling?

>> AUDIENCE MEMBER: Yes 10 more trainings.

>> JENNIFER BURNETT: Ten more trainings Fred tread can you give me that information.

>> JENNIFER BURNETT: Can you send that information to Marilyn Yocum, where the trainings will be how to get the people registered for them, so far 800 trained --

>> AUDIENCE MEMBER: 600.

>> JENNIFER BURNETT: 600 trained choice counselors.

Tread Fred I have 3 others really quick.

.

How come the enrollments center operations has to be within 15 miles of Harrisburg just curious on that one is this

Why does it have to be within 15 miles

>> JENNIFER BURNETT: I don't know.

>> ALFRED: That's weird.

Okay.

The intake visit must be scheduled within 7 calendar days of the initial contact.

Whereas -- that would make it a lot easier tore people instead of what they're requesting now because if they can get it done within 7 days it will be a whole lot better for people, they're not getting it done in 7 days they don't have a 7 day

limit.

What kind of limit do they have right now?

>> JENNIFER BURNETT: I know for the PA600L which is the financial eligibility, the county assistance office has 45 days to fill it out.

So we have to consider kind all of the contingencies and the Fred tread putting people on load hold for a long time

>> JENNIFER BURNETT: Standard practice it takes a long time to get eligible for a long term eligibility.

A lot of documents are needed at the last meeting if you recall, we had Marcia Michaels come to talk to us about what is involved in the eligibility for a long-term care Medicaid and it is very -- much more complex than just regular Medicaid because we have we have the look back period and other contingencies

>> ALFRED: What is the look back period go?

>> JENNIFER BURNETT: Five years.

>> ALFRED: Five years.

Okay.

>> JENNIFER BURNETT: No.

Okay.

Because all of the comments we received, for the RFP we are not going to be able to have those processed and ready for issuing in December as we had planned.

We're moving the issuance of the procurement to January I wanted to also let folks now about some proposed waiver amendments that are in play right now.

So you can comment on them if you wish to.

In preparation for the community HealthChoices, we -- the department needed to submit a bunch of waiver amendments in order to make the transition happen.

So we currently have four amendments out for public comment.

Those amendments are for the aging waiver, the attendant care waiver, independence waiver and Obra waiver.

In all of the independence waiver the requested changes are in the main module section of the waiver application.

So here are the different things that we put into those waiver amendments tore your information we certainly welcome a comment on them while they're open for public comment right now.

We need to -- the State needs to request a waiver of statewideness in order to furnish the aging waiver attendant care and independent waiver services, to individuals who reside in non-managed care counties so those -- the 14 counties in southwest will under community HealthChoices the rest of the State will need to have a waiver of statewide newspaper for those waivers so they can continue -- there's continuity of care for individuals in those waivers.

That is in section 4 of the main module.
Since OBRA will continue to be operated statewide, the waiver
of statewideness is not necessary.
We need to describe the process, that will be utilized to
transition individuals to community HealthChoices that has to go
into our waiver.
The waivers that they're transitioning from has
to have that language in.
And also, we need to have -- describe the process that will
be utilized to transition COMMCARE participanttion across the
State into the independence waivers for non-CHC counties and to
individuals, there's a very small number of them but 18
individuals aged 18 through 20 in the attendant care and
independence waivers who are not eligible to community
HealthChoices due to their age we need to transition them into
the OBRA waiver.
That is in attachment one of the main module of the waiver
application.
And in the independence waiver only we need to address dental
Habilitation and structured day Habilitation
so the participants can be seamlessly transitioned in the
independence waiver in the noncommunity HealthChoices zones.
All of those actions are described in those waiver amendments
and we're looking for public comment on them.
The day Hab and Res Hab appendix C of C1 and C3 of the waiver
application.
So they are currently posted for public comment and notice
was published this the Pennsylvania bullet continue on Saturday,
November setth.
Notification was also, sent to all of the OLTL Listservs so
all of our stakeholders got the notice so if you're on our
Listserv you probably already know about this.
And it provides information on how to supply public comment.
This 30 day public comment period runs through December,
Wednesday December 21st so you still have about two weeks little
less than two weeks to go ahead in there and give us comments on
them.
The other thing we did for ease of viewing I suppose is we
posted it on our web site on our OLTL web site it's easy to find
on the general OLTL web site.
You can submit comments via email, through the resource
account RA-waiverstandard@pa.gov all the information to
submitting comments is laid out with the posting we put
out.
We also got comments we already received a number of comments
because we held two webinars on the changes.

One was held on November 30th and the other was held on December 6th.
So we went through all of those changes with folks.
The last thing I see Ben Laudermilch has arrived the last thing I don't want to hold up his time I wanted to talk about is -- at the direct care worker policy clarification that was posted by released by the departments of health, the Department of State and the Department of Human Services on November 23rd it's regarding the provision of non-skilled home care services and activities.
So what the purpose of this policy clarification is to provide individuals with disabilities greater chance of remaining in their homes and community, when they were able to receive non-skilled assistance with long-term services and supports from director care workers.
So we -- the types of services that are included are -- it's actually the languages are included but not limited to assistance with bowl and bladder reteens, assistance with medication, ostomy care, clean and intermittent Court and jury therization, and wound care by direct care workers are all non-skilled home care services.
I don't know, Marilyn did you send the -- that bulletin out to this group?
On --
>> AUDIENCE MEMBER: I don't think so I think it went out to the Listserv.
>> JENNIFER BURNETT: We can send it out to you if you have not seen the policy clarification.
The decision to make this policy change was really the interpretation of the professional nursing law.
And let me just find the place here, direct care workers may perform the non-skilled services with acts of competency and training we have to still put together we're working with the Department of Health and state on that.
Provided they do not represent or hold themselves out as being licensed nurses, licensed registered nurses or registered nurses, or use in connection with their names any designation, tending to imply they're licensed to practice nursing.
So really what this is, is an exemption from the professional Thursdaying law.
And the language in the professional nursing law says it does not prohibit and this is the quote -- home care by the sick by friends, domestic servants nurse mates and companions or household ate aids of any time, as long as such persons do not represent or hold themselves out to be licensed nurses that language is what was kind of looked at to be able to do this.

Likewise the practical nurse law does not prohibit home care
of the sick by friends, domestic servants nurse mates and
companions and household aids of any type as long as such persons
do not represent or hold themselves out to be practical nurses.
So we have gone ahead and issued that policy.
However we do need to put together the training requirements
tore direct care workers to have in order to perform some of
those activities and the Department of Health needs to work with
it's surveyors in order to implement that I just wanted to make
folks in the room aware of that change.
>> **FRED HESS:** We don't have definitions what they can and
cannot do quite yet.
>> **JENNIFER BURNETT:** The Department of Health has --
actually implemented because we need to do a policy clarification
with them.
In order to, sort of put out to the field what this means.
>> **FRED HESS:** Is that just for consumer model or agency
model?
>> **JENNIFER BURNETT:** Home care model.
>> **FRED HESS:** Both models.
>> **JENNIFER BURNETT:** Yes.
>> **PAM MAMARELLA:** Before you go further I wanted to mention
that Brenda dare, Jennifer Howell and Es.
It ella and Ralph had a question.
>> **JENNIFER BURNETT:** Welcome everyone.
Ralph do you have a question?
>> **RALPH TRAINER:** Do you have any updaton the SFMSRP.?
>> **JENNIFER BURNETT:** I'll ask Kevin to come up -- he is more
involved than I am, hold on.
I know there's work getting done on it.
>> **MALE SPEAKER:** Good morning everybody, with the FMS RFP
we're exciting a contract execution, with the contract vendor
that will take place, will cover the calendar year that's
with our legal departments right now.
We're expecting the RFP for FMS4 of the new vendor to be
released in January as will with as the RFP for the independent
enrollment broker they're with the local department receiving
final review we think that the relevant information will be
available within the next couple of weeks.
Did that answer your question Ralph?
Did that answer your question.
>> **RALPH TRAINER:** Yes, thank you.
>> **MALE SPEAKER:** Before we hear from Ben can I digress for a
second.
I know you said folks have until the 13th to final a formal
protest are we aware if there's any tilers

>> JENNIFER BURNETT: 36 the vendors have profiled?

>> AUDIENCE MEMBER: Just real quick --

>> JENNIFER BURNETT: James Fetzner was asking a question.

>> MALE SPEAKER: Direct care worker clarification it's important to though that, previous guidance and policy under the Department of Health, not only made the distinction based upon the types of activities but on the types of disabilities and so specifically as it related to a consumer who is considered, capable of directing your own care, based upon a particular disability, I think it's really important with this policy clarification which I think is great by the way that regardless of the disability those services are not considered skilled services.

>> JENNIFER BURNETT: Thank you for that information I think that's what we need to work out with the Department of Health is looking at any guidance they have out there, that might not complement this new guidance.

So thank you.

>> JENNIFER BURNETT: That's all I had.

>> PAM MAMARELLA: Okay.

So welcome Ben Laudermilch.

>> BEN: Should I come up here.?

>> JENNIFER BURNETT: Come up here so you can look at the audience.

Rochelle Laudenslager thank you for having me here today I came here days after we announced the housing strategy back in early June.

So, it had been days -- we had some ideas how it would be implemented but, the exciting part is talk to you what we've achieved and what we see on the horizon, how many folks have heard my schpeil, housing strategy going through soup to nuts going through what we hope to accomplish.

So, fair number of people.

I won't go in too heavy detail I want to encourage you to go to the web site.

DHS.pa.gov/citizens/housing I lobbied for the housing topic to be the hop topic if it is you have to go down and drill into it I will give you a link in a couple of minutes.

So as a quick refresher secretary daily loss formed the office of social programs or reformed the office of social programs and one of our initiatives is the housing strategy five year statewide housing strategy, talked a little bit about the business case I think I did that back in June for why we're doing it it was released in 2016, May, set the table there's 3 core populations we focus in the housing strategy, folks rent burdened, low income individuals and extremely low income individuals rent

burdened.

Folks that are homeless.

And I think, primarily, primary concern for us today are folks who are living in institutional like setting that could be living in the community with the correct supports.

So those are 93 core populations acrosses the boundaries of many other state department core constituents we hope on to work with the State departments and locations to achieve a positive result if you advance to the next I won't go through the graphics so much, this is one of the things I think speaks to many folks.

So, conservatively we believe we have over 53,000 people, and some form of state centered institution not including incarceration.

A very conservative estimate, is that cost us about $62,000 a year to keep those folks in the State centers.

Some of the numbers I have seen, anecdotally are 300,000-dollar range.

To serve people in the community, in places like new court land is a good example and other places, to insert people in housing with the correct supports we estimate that cost to be slashed in half, $30,000 annually again I think even that number is conservative in the opposite direction I've seen numbers that suggest W it's maybe, 10-15,000, depending upon the supports the individual needs.

We want to ensure the high quality care, and serve people in the community to the current that we're able, one of the things that Jen and I often talk about is the fact that we have dual eligibles coming our way, the system over the next 10-15 years, may be flooded with individuals who need some level of care.

So, it's a great time for us to rebalance we think we're unbalanced we think we have a lot of people in nursing homes for instance, who could be living in the community if only they had the housing.

One of the things I talked about is the Federal reserve bank of Philadelphia study some years ago, the numbers have probably increased now, unfortunately.

That seem to indicate we have a deficit 272,000 affordable units in the State of Pennsylvania.

The horrible thing about that, deficit is that all population groups whether homeless rent burdened, folks generation ago would have suit first time home buyer mortgage, they're not doing that.

Look Ted study the other day, that showed that banks are a roving people at higher higher credit level they're existing the realm of 50 percent area immediate I can't be consumer more often

serving someone with 80-100 percent, thin below that, is
competing against our core constituents for housing.
So the market is really tightening in the rental arena.
There's definitely the economic argument if we can move just
500 of those 53,000 individuals into the community, we could save
the Commonwealth 15.$7 million.
And of course, the trick there is not just to save the money
but then to operationalize those dollars build more housing
we have a feedback loop.
That's really the business argument why we need a statewide
housing strategy, I of a lot of friends these days because
everybody agrees it's crazy the amount of support the idea of
housing is social determinant of help.
There's other social determinants if you don't have safe
decent affordable housing to a certain extent accessible housing
you cannot dot other things in life that's been proven the
housing first model is a proven evidence based practice its get
people in the housing help them find jobs an services help them
find other things they need to succeed in living.
So, that's our thought process there.
If you advance the next slide, I just want to -- I'm duty
bound to go through our 6 ideas of, solutions, to get there.
We want to remove the barriers there are a lot of barriers
and ones I didn't even realize.
So I will talk to you about an initiative very concrete
initiative in a minute I won't dive too deep we can't solve this
at the state level.
It's something that we'll have to solve with our local
providers and local housers there are a number of different
barriers, one of the things we're looking at right now is an
initiative in New York City eviction pretension through dollars
has increased from 4 million to over 60 million, there's some
recognition, by keeping people in their housing, you can actually
achieve a different kind of result New York finally gets it we're
looking at it one of the thing I did, I ran some numbers just
across the State let's talk about Philadelphia.
house someone in Philadelphia,
that's a fair market rate $6,000, to serve them a shelter is
roughly the same place price but in Philadelphia that's almost
certainly higher in Philadelphia.
You're seeing exponential numbers when you're you looking at
prisons, hospitals, detoxes in-patient is $26,000, many time more
expensive a month, what you would see P if someone were in the
correct supportive housing we need to connect people with the
housing opportunities.
For ten years, we have created something called the

20 percent units for folks who are not familiar with those, those are units affordable the 20 percent area median income there's a nice part of that, which is about half of those are meant to be accessible have mobile features built in, in PHFA Pennsylvania housing finance agencies portfolio of projects 30 percent are housing people who don't need the features yet I continue to hear, and my partners continue to hear that we have a need for those features so there are people who are nurse in nursing homes could take advantage of those features and live in the community, there are people living in those units who don't need the features right now we need to connect the people for housing we tried for ten years we need something that is a product of approach.
We need to expand the affordable housing dollars this is a no brainer 270,000 units we need to constant what we're doing, in 2012 the number was 200,000.
So the numbers is growing exponentially, each year.
So we need to grow that supply a of affordable housing we can't build our way of the housing crisis because the fact of the matter is in the entire history of the loan income tax credit program, Pennsylvania has built 135,000 units since the late 80s that's half of our deficit.
We can't build our way out of it.
We need to partner with local agencies I made that point earlier
>> **FRED HESS:** I was going it make that session I was going it make that session I got a recommendation that OLTL should establish a work group including consumers housing advocates the PA housing finance agency the CHCMCOs, to develop that kind of exact partnership, okay and provide in the CHC enrollees with affordable house using.
>> **MALE SPEAKER:** We had asked tore feedback OLTL and the six program offices for stakeholders we'll revisit that issue I think you did recommend some consumer voice.
>> **JENNIFER BURNETT:** We did.
>> **MALE SPEAKER:** That's a active partner we'll talk about that in a moment, maybe you and I can talk.
>> **FRED HESS:** Yeah. Absolutely.
>> **MALE STUDENT:** Great idea that is one of our strategies that I'll get into in a minute we're forming two groups I'll talk about one of them.
The bigger group is a group of stakeholders including consumers, who can help us move this forward.
Because again it's not going to happen because small office, in the Department of Human Services wants it to happen.
We need to pool resources we had a moment I described to a

lot of folks when we launched the strategy where 3 of the leaders
of different state departments really realized they had a home
mod program there was no coordination.
Low hanging fruit that's something we can fix by working with
other departments closely aging OVR, DHS, PHFA has a home mod,
local home mods.
>> **JENNIFER BURNETT:** DCD has a --
>> **MALE SPEAKER:** Right there we count six home mod programs
including local initiatives.
And we need to utilize data, and report back to you on the
progress, so I'm committed to coming back to you letting you know
how this is proceeding I don't have a whole lot in the way of
outcomes at this you don't want in time we have a lot of stuff on
the horizon that is very exciting let me go through the
strategies really quickly I'll talk about the 2 first, strategies
so I won't mention them, 3-4 assess new and existing programs to
determine future needs and measure outcomes that's what we're
doing here today as well as promote teamwork and communication
both and state legal government to promote housing opportunities
for all populations I only have an half an hour, I'm more than
happy if you want to contact me talk about those strategies let
me talk about the first two strategies if you advance to the next
slide to expand access to create new affordable integrated
supportive housing opportunities someone mentioned I think Jeff
Eismen has asked me numerous times, to include arc he is I
believe in that we'll look to make that change.
The first goal is a I very concrete goal it's about the 811
program, partner with the PHFA to implement the U.S. HUD
program, section 811 project rental assistance that's a Federal
subsidiary the reason it is so incredibly important it's been
riddled with problems we had the funding since 2012 and it real
we only got off the ground in April of 2016
But it's a micro version of what we've experienced over the
last decade in trying to connect people with housing.
So really that is the department of human services PHFA
linkage we've been great partners for ten years we've not made
the connections.
811 program is a great partnership we're plugging
units into existing projects that has it's challenges we can only
house them in the units when they are available.
Some of the challenges PHFA has really prioritized larger
multifamily projects one bedroom for people over the age 62 but 2
and 3 and 4 bedrooms for people ages 18-61.
This is a program for people between the ages of 18-61.
And there aren't the units available and the last qualified
allocation plan the guidelines tore the low income housing tax

credit program, PHFA, rye or it advertised the 811, we're
getting traction, 16 new projects coming online we want to get
the project rolling and demonstrate to HUD we want to get it done.
Well over 40 counties participating we have 118 of the 200
units that we were slate today do in the 2012 funding 118 committed we only have 7 units today,
filled.
That's because the units are committed but they're still
filled with the original tenant or the day they were committed.
So, that is really the demonstration the talk of it, the
small version what we hope to achieve in the larger level across
the State and, what is nice about it, we're working out the kinks
we understand we're not talking to each other at the local level
we have out liers Philadelphia does a good job talking to each
other there are people at the table that shouldn't be in the
rural area, people just simply are not talking to each other and
so we're facilitating some of those relationships so look for
more on the 811 program great success I calculate 3100 percent
improvement since 2016 it doesn't mean a lot it's only 6 people
[laughter]
If you advance to the next slide we hope to maximize housing
opportunities for extremely low income that's about the
20 percent units connecting people to units that are affordable
to them.
So we're going through a mapping process of understanding
what the problem is.
We've had a really great tool, are people familiar with PA
housing search pcoh you can use it yourself find a unit yourself
I used it when I was looking for a rental for a family member
it's a really great tool unmoderated what ends up happening is
people use it, and housing authorities have used to great benefit,
but the problem is, people who understand how computers work
they get there first, they find the units first people with
out any sort of disability get there first.
The population might have bought a home ten years ago they
get their there.
So we're looking at a moderated system where you would,
prescreen someone a service provider with prescreen someone and
menu of different options would pop up the person doesn't have to
go through building to building and applying waiting on a waiting
list that's the end game with the goal number 2, to maximize that
opportunity, we know we have the units we can't always connect
the people to them.
The IT enhancement that I talked about is goal number we have
a limited edition launch, exclusively for the 811 program it's
working great.
So it just launched at the end of the October we have well

over 50 people on the waiting list.
That will populate you should see as Philadelphia and algain
I come online you see thousands of people on the waiting list
just a little bit more than a month's time people have started
entering the data that's only for that small program.
Expanding the funding.
So let's talk about that for a moment.
One of the bright spots in otherwise dismal and over
subscribed housing arena is the fair funding the Pennsylvania
housing affordability reinvest enhancement funding source.
That was just announced by PHFA, 12.$67 million that's
not a lot for the State but it's very flexible funding.
Politics are due, January 13th, we're looking
into innovative projects we're hoping through that process to
gather some best practices around housing.
The other thing that we hope to do is to create efficiencies
with the existing funding so we'll go through a process right
now, through the department to identify, we think we spent a
couple hundred million dollars on housing this the department
sometimes there's a belief we don't do housing as the department
we do.
We're looking at whether or not some of that funding can be
moved around and, used in a more effective manner the other
thing we have a lot of hope I won't speak too much is the implementation of the community HealthChoices
through the that process and the idea that individuals should be
transitioned due to cost containment into higher levels of care
into housing we hope they will be an investmenten on the managed
care organizations and their partner those generate more housing
opportunities so that is going to be a huge next step if you
advance to the next slide I talked about the other side of the
coin here that's about creating that bricks and morter housing we
need expand access to housing related
supports and services we think that we can do through the managed
care environment as well.
So, some of that will happen organically, some of it has to
happen through a contractual agreement one of the things we're
doing right now today we're calling together a small group of
stakeholders to understand how housing and Medicaid work
looking at housing services definitions to make a change across
the department so we can build Medicaid for housing supports and
services.
>> **FRED HESS:** Hey Ben, have you -- do you remember the
recommendation I gave about using the houses on tax rolls?
Getting them refurbished have you given that consideration
>> **MALE SPEAKER:** Certainly something on my list of

considerations I'm not sure if we had any movement on that.

>> FRED HESS: Okay.

>> FEMALE SPEAKER: This is Jennifer howell I don't have access to the computer, may I ask a question is this?

>> MALE SPEAKER: Sure.

>> FEMALE SPEAKER: Okay.

One of the things that I'm concerned about is the missed population which I was apart of tore many years.
I certainly don't want to take any housing away from people in a nursing facilities or people who are homeless.
But the population that you are missing are people that are working, that they're on waiver services they're not able to -- they just miss the housing -- the cut off on for the low income.
And I made $400 too much for low income housing.
And you just missed that and with the governor's push to get people with disabilities to include the employment for dis*E people with disabilities my guess if you would
interviewer a lot of people with disabilities you would find one reason they're not seeking employment is they don't want to lose their housing.
Now, I was very fortunate in the fact that, when I was working I found a landlord that was willing to work with me and then when my house health got worse he was very funding.
And willing to work you know he lowered the rent he made it so I could stay there, because I was he liked having me as a tentant.
But a lot of people are not going forward.
Like it's hard when you have a disability you're in pain it's hard to like ride the public access buses every day and you know and I mean I would give anything to return to work I really would.
But people who don't have, who have not had that experience they're scared of losing their housing.
So there has to be a way that we can reach those people as well and tell them that getting this, will not cost them their housing.

>> MALE SPEAKER: I could not agree with you that more that argument resinates with our friends in the legislature.
One of the issues with Federal sources of fund requesting you're not allowed to provide a shallow subsidiary, whether you're talking about someone's benefit -TS or someone who is making minimum wage as soon as they start creeping up and making more and more money folks fall off the cliff sometimes it's the you know, 18-20 percent area median income you don't get back to where you were with the benefits until you're making 40 or $50,000 a year that's not really necessarily an option for everybody.

So there's no shallow subsidiary and we're actually working with the governor on a new initiative called home housing and health to implement some strategies around these issues so although, I would argue that I don't think we missed one of the 3 core populations we're working on is folks that are rent burdened and one ever the reasons folks would be rent burdened is because of this issue that you've described where they missed out on benefits if they make too much money something we're taking a look on, I on do want to focus on the economic benefit of the approach to the housing strategy we're talking about, in the hopes that if we generate more housing it will help all populations.

So I fully recognize there's no way I can hit on every single topic here today, transportation is another big one.

Folks re-entering the opiod pressure putting pressures on the housing market I regret I'm able to get to every single topic I made some notes I appreciate you bringing it up.

I made notes based upon your comment.

>> **FEMALE SPEAKER:** Thank you.

>> **MALE SPEAKER:** So in the CHC environment we're hoping that we can bill Medicaid for housing supports services if you advance to the next slide, we're hope to go do that across, I'm going to jump down to I can always people want to talk about the criminal justice system I can talk about that.

But if you go to goal number 3 the maximize Medicaid funding through housing related supports and services, we really vetted a process across walk in our own department, with all of the program offices involved with Medicaid and we have a draft services definition we're bringing it out to small group of stakeholders to poke holes in it, to tell us what is wrong with it and then it will likely be implemented in different ways with different departments.

I would think OLTL it's going going to be strongly implemented through the managed care ODP, office of departmentallal programs not managed care it will be waiver.

Or it could be a waiver.

And then it will be different with OMPAP and OMSAS look for that in the near future it should reduce challenges, to keeping people in housing.

The challenge of that I can't answer today is what the change and Federal administration means to Medicaid.

I wanted to mention that.

>> **FRED HESS:** If I could find the button here.

Are you guys working with the CHCs and MCOs and everything to get them to subsidize housing in away, to -- if they were to help get in subsidizing housing that will get people out, that will be to your -- I heard you say you're doing that to what extent

>> MALE SPEAKER: Extent is very limited we continue to be on in the blackout period.

>> JENNIFER BURNETT: Because of the stay.

>> MALE SPEAKER: So there is incredible interest and managed care organizations are reaching out to us and the partners consultants are reaching out to us on the basic conceptual side.?
Some really, innovative things that I don't think we thought of in the department about ways to generate housing and support people on housing.
Drawing from things we've done in the history of the State but also, some new innovative strategies that worked in other states so I'm very, that's one area that I'm really jazzed about I am bummed I can't talk too much about it at this point I look forward to coming back and --

>> FEMALE SPEAKER: This is Brenda dairy I have a question here.?
As a -- I'm excited to hear that you have all these plans to engage the MCOs in supportive housing I want to make sure at the other end of the that, as people move through the continuum and eligibility for services may change due due to employment, health changes due to family composition changes or whatever is there any plan to ensure a change in eligibilities for services won't necessarily even I loose my unit?

>> MALE SPEAKER: There is a complexity with the subsidiary.?
So the nice thing about the low North Carolina tax credit units once the person gets into the unit they a apply the threshold application is over, they can stay in the unit despite what their income is.
But the complexity is around the subsidiary let's say someone brings a housing voice voucher subsidiary at the table they can make at some point too much for the subsidiary that's the bad news, the good news, these units are built to be affordable you do see the difference between unsubsidized unit and low income tax credit portfolio and a subsidiary, to see that difference to be lesser in the market than in idea I was talking to someone in the Philadelphia, some of those units that folks are staying in, cost a $1,000 a month on the regular market they would be $2,600 a who.
So, you know I think that there's certainly still the issue where some of these eligible changes they make too much money they could run into trouble, if they're in one of those IRS low income tax credit units the pain will be a little less we have talked about it, with he though people jump off a cliff where funding is concerned, and they're not able to make it up through income earned income.
So that's a major --

>> FEMALE SPEAKER: Other thing that concerns me if you're partnering with the MCOs to provide support for people in housing I want to make sure that, those units aren't going to be tied to a particular MCO if I decide to change my health care MCO I don't have to move.
Services linked housing is something we've been through, we're trying to get away from that I want to make sure we don't build more of that into the system

>> MALE STUDENT: Some of the issues we face are where managed care organizations would like to do that and aren't able to do that because of fair housing and choice in services requirements.
So I don't want to speak for the Pennsylvania housing finance agency but I think, if they were here today they would back me up in saying that, housing can't be that directly tied.
We can market -- we can market to disability populations in a very general way but we certainly can't turn people a way, who are otherwise eligible for units.

>> FEMALE SPEAKER: Can I make a comment.?
Regarding goal number 2, on your slide --

>> MALE SPEAKER: Yeah.

>> FEMALE SPEAKER: I'm really glad to see the focus this the criminal question.

>> FEMALE SPEAKER: I have a question.

>> PAM MAMARELLA: We have a question if you can hold we'll get back to you.

>> FEMALE SPEAKER: I see it's for people with meantal or substance disorders I want to bring up the fact that metaanalysis of the research is showing 60 percent of individuals, incarcerated have a history of a brain injury prior to incarceration in our work in Pennsylvania, with guys who are released into the community we're finding a lot of them are ending up in community corrections settings in halfway houses because they don't have an approved housing plan so I'm just, hoping that group can be considered, for this goal.
As well?

>> MALE SPEAKER: So the housing strategy is a first run first attempt getting it right, there are a number of things that the accessible housing in our mission statement for instance that should have been included this is another example why limit ourselves when I toured Waymart a month or so ago it was clear these issues were not exclusively around behavioral health disabilities we definitely had issues around physical disabilities organic brain disorders, there are a number of different issues we'll look at as we do the next year of housing strategies and do some strategic planning we're doing

strategic planning this month, with the each of the program
offices so thank you for bringing that up.

Tax tax

>> **PAM MAMARELLA:** Tanya has a question?

>> **FEMALE SPEAKER:** Any way to make the income guidelines for
all of this more accessible to people?

Is there a way to make the formulas easier to break down to
be understood on a common basis because, right now, when you go
into like when you go to like the HUD housing web site for
example, there's like different income brackets no one tells you
there's no real information on what qualifies as what.

I think that would be a lot easier if people can know like
ahead of time like let's say, they're in the process of getting a
job or waiting to hear back from an employer about like, a
potential job.

It would be a lot easier for someone with a disability to
know what they were getting themselves into ahead of time instead
of having to wait until, they have already started the employment
process to be able to work with an agency like HUD on how the
rent was going to change.

>> **MALE SPEAKER:** That's a very good point.

>> **FEMALE SPEAKER:** I think we need to get the information
more accessible and more readily available to be out there.

>> **MALE SPEAKER:** I'm going to admit that I ran a housing
authority for 4 years worked at the housing authority five years
prior to that, ran homeless programs many years before that.
Where we were calculating I still don't understand how it all
works

[laughter]

So unless you're an expert, sitting doing this day in and day
out -- you don't understand how it works.

So I worry about trying to improve that.

I hope that we can speak to HUD and other -- the tax
credit requirements are equally strange and hard to follow from
time to time.

I think, one of the things that we can do is create this IT
enhancement, that makes it a little less of an inigma for
the consumers and the person supporting the consumer.

One of the problems is I can tell you that, coming from the
housing industry, your world frightens and confuses me, Medicaid
is very, very confusing.

And I didn't -- I've done some pretty low income tax credit
fields we don't necessarily speak the same languages this IT
enhancement has come with some rave reviews you enter the
person's information, get it all and it gives you a quick
snapshot, so one page of information you have a general idea what

the person's eligible for you go along through the process and
apply.
The idea would be you would have the host of different option
ons so through IT enhancements this is akin to some of that
assistive technology that we're seeing, that are allowing people
to live on their own.
I was speaking to shun who suggested that iPad is changed
their lives.
It's so -- critically important that we use these technologies
to improve people's lives I think this is another example
because I don't see the Federal government getting more simple
>> **JENNIFER BURNETT:** No.
[laughter]
>> **MALE SPEAKER:** On the income requirements if we have a
good translating system that's the answer I think.
Did I answer that question.
>> **FEMALE SPEAKER:** The other suggestion that I have, I know
this would take probably a lot of work I don't know if it's even
possible, but is there any way that the -- like, income guidelines
can be more succinct with each other?
That way you know if you hit like this threshold here, okay.
Instead of it being like different income guidelines for
absolutely every service there is, is there any way to get it, so
it's like a more like understandable formula is this because the
problem is, okay.
From what I have seen just trying to look into this in recent
weeks is okay.
There's a different income threshold for like care services
there's a different income threshold for housing, there's
a different one for like food stamps and still a different one
for like SSI.
It just gets really confusing there has to be a way to make
that easier.
>> **MALE SPEAKER:** I think we can start with some of the
department programs that we have partners at the department of
community and economic development who run homeless programs and
of course the Department of Human Services runs homeless programs
one focuses on particular area median income the other one focuses
on the percentage of poverty it's really weird to see how they interwave, depending upon the your
family size, we can streamline the things we can control at the
local level and talk to our Federal partners.
>> **JENNIFER BURNETT:** Tanya the challenge really is, I mean,
even in the programs between HUD and HHS health and human
services we even consider our age cut offs are
different.

So HUD has program that's start at age 62, we have programs
that start at 60.
Social security is 65 and plus.
So some of this is actually in Federal law, these guidelines
the income limits and age limits.
But I just also wanted to mention Ben said something that I
often say is that, housers and people who are in health and
human services speak very different language we have all
different acronyms I mean I've -- I'm sort of a hybrid so I've
had to learn like what a CHODO is, what a PJ is -- and so -- a
former colleague of mine Lacie Yaffe use today work at the
Pennsylvania housing finance agency, had this is when the
Department of Human Services was called the Public Welfare housers
speak housish, and people in health and human services
speak wealthish.
>> **MALE SPEAKER:** That's true the next slide has the link to
-- we can share this with the group the link to the housing
strategy, if you have not already taken a look at it the videos
are embedded, 2.5 minutes and the strategy itself, is 20 pages
there's also some infographics the hope is in the coming months
too much a more interactive web site.
Again because of the way Pennsylvania is organized I can see
that having some information on here, but what we are really
talking about is greater coordination of the local level it's a
county controlled system a lot of ways.
So we'll be looking at at the county partners they are doing work I visit a lot of counties across
the Pennsylvania,
we're very impressed look at this web site to too launch you into
the local jurisdiction in the near feature you if you advance to
the next slide, my contact information H Jonathan McVey's
information I don't know if you know Jonathan, he has history at
the department he is a policy expert, he understands a lot of
things about the department.
Had never done housing I understand a lot of things about
housing.
Never done Department of Human Services, so -- it's been a
great partnership up there, either of us welcome phone calls
recommendations at any point in time I have that tax roll issue,
but you probably need to talk about that some more.
So, again we will welcome your feedback it's part of our
housing strategies to take feedback.
And, provide you with the feedback.
So we would like to have that dialogue.
I don't know if there are any questions
>> **PAM AUER:** Someone had asked me to ask what is he a rent,
what do you mean by a define rent burdened.

>> MALE SPEAKER: Okay.

So one of the slides that I did not include today talks about the it fact someone is earning the minimum wage they would pay the fair market rent for Pennsylvania.

So $739 minimum wage is 7.25 let's say they're on SSI, they may have 2 percent of their income left at the end of the month.

To spend on other incidentals they will spend almost all of their funding on housing.

46.5 percent Pennsylvanians are rent burdened they spend more than 30 percent of their income on housing.

That's rent burden.

So we have a lot of Pennsylvanians who spend more and that hurts you know, if you need an economic argument, I found this to be really relevant because I want to do the right thing, right.

We all want to do the right thing.

Economic argument is, if folks are sending more of their money on housing they're not spending money on goods and services and things that they need, to live.

They can't support themselves.

So if we don't address this issue, we have to address it one way or the other, we talked about minimum wage and how that is impacted folks the fact that -- the assistance has not kept up with inflation the housing rates creep up in price, these are all, really, applying pressure to Pennsylvanians across the board.

>> PAM AUER: Thank you.

>> PAM MAMARELLA: Okay.

Do we have any other questions?

>> RALPH TRAINER: Yes.

The department of agriculture has been involved in this also, they have programs that help people with disabilities.

With rural housing as well

>> MALE SPEAKER: Yeah. I'm not familiar with some of the work although, someone brought up AG the fact that we have some housing pressure from migrant workers so, I was in an event where someone brought that up I was not aware sounds like J. N is aware of some of the programs?

>> JENNIFER BURNETT: They have rural housing program.

>> MALE SPEAKER: I know USDA has.

>> JENNIFER BURNETT: Yeah right.

>> PAM MAMARELLA: We've been asked to repeat questions because the people on the phone are having a hard time of the people who ask questions on the phone.

So we have to be a little bit louder.

>> JENNIFER BURNETT: I was just saying, yeah USDA has rural housing program that provides rent subsidies for rural housing.

>> MALE SPEAKER: I will check on the PA department of AG

that was brought up in another session I'll be sure to bring that
up, that is brought in context of the migrant workers and the
pressures on housing.
So, again, what is happening is all of these different
special populations and constituent groups are competing with
each other for finite resources it's something to take a look at.
I'll look at the Wednesday department of Ag services to
support persons with disabilities.
Thank you for bringing that up, Ralph.
>> **RALPH TRAINER:** Thank you.
>> **PAM MAMARELLA:** Do we have any other questions, before we
thank Ben for coming back and updating us?
>> **FRED HESS:** I'm actually good Pam.
[laughter]
>> **PAM MAMARELLA:** This is kind of funny I looked at you Fred?
>> **FRED HESS:** No it's not it's horrible.
>> **PAM MAMARELLA:** Thank you so much, do you have any other
--
>> **FEMALE SPEAKER:** Pam, I'm sorry.
This is Jen I have a question may I ask it is this
>> **PAM MAMARELLA:** Yes.
>> **FEMALE SPEAKER:** Okay.
I know that I called the department with the interest in
getting all this together about housing I really appreciate -- I
appreciate the staff in bringing all this together I appreciate
you've spoken on this, I can see that he is really serious.
One of the things however I'm concerned about in order for
people with disabilities to get this any housing a lot of us need
home mods I know for a fact that there are thousands right now,
of home mods this is really more for secretary Rurnett there are thousands of home mod requests
are sitting at the state right now waiting for approvals.
And they're past their limits -- pending limits people
are just waiting and waiting and waiting for home mods.
So --
>> **JENNIFER BURNETT:** I'll look into it Jennifer this is the
first I'm looking over at my staff to see if anyone knows
anything about this.
We'll go back to the office and see what we can find out, I
have not heard anything like that.
We have home mods approved every day.
We're doing home mod approvals every day.
I'll look into it.
>> **FEMALE SPEAKER:** I'm personally waiting for my home mod
and, it's been well passed -- I've talked to providers and it's
happening around the State.
>> **JENNIFER BURNETT:** Jennifer when did you apply to have a

home mod done?

>> **FEMALE SPEAKER:** A two months ago.

>> **JENNIFER BURNETT:** Okay we'll look into it.

>> **MALE SPEAKER:** Also part of the housing strategy to take a closer look at the home mod program and it was not just about, improving thing but making sure that the funding is appropriate and then we're spending the dollars in the right way.

>> **PAM MAMARELLA:** Any other questions?
On the phone or from the committee?
Thank you very much Ben we're looking forward to having you back

>> **MALE SPEAKER:** Thank you invite me any time.

>> **JENNIFER BURNETT:** Thanks Ben.

>> **PAM MAMARELLA:** Next on the agenda is an update on medical assistance quality strategy plan and the CHC evaluation plan we're going to hear from Wilmarie Gonzalez, Paul Sauci. R and Howard Degenholtz.

>> **WILMARIE GONZALES:** Sitting among two roses.
For those who don't know me my name is -- okay.
Can you hear me now?
Okay.
For those who don't know me my name is will Marie gone daily less I work at the office of long term living with me today is Paul Sauceir and house a reasonable doubt Degenholtz from health policy management at the University of Pittsburgh.
So we will try our best to continue our dialogue we have been here I think all 3 of us have presented to the committee in maybe once twice already, so today we want to continue to dialogue more importantly everyone has been very, very interested in learning more about how we're designing and building our framework for the quality some of the thing we have done just for point of reference there have been, some third Thursday webinars we've already presented to stakeholders with regards to the quality strategy and some of the components that make up quality.
We talked a lot about readiness review, monitoring, pre and post and obviously our evaluation.
So we know that, everyone is very much interested in what we're doing, and the quality.
So next slide -- today what we're going to do is, you know, we recognize that there are many pieces ensuring we have a good quality program, for community HealthChoices.
It is a animal, it is huge.
It is huge to say the least.
Store those very passionate about quality and performance measures you know that it is a lot of information and so our

attempt in trying to make it as easy as possible so it's comprehensible and better to understand is what we've been trying to do for the past couple of months today we'll talk about the quality strategy we're building upon what we've already talked about.

We will mention, that we are part of the over all DHS quality strategy plan that we hope on will be published in the Pennsylvania bulletin in the next couple of weeks and obviously we're going to make sure that we provide an update on the community HealthChoices evaluation plan that has -- has had activities for quite some time.

Next slide -- this is a diagram and really it is really setting the stage with again what we already talked about and in some of our presentations with regards some key components of the community HealthChoices quality.

And these are areas that we have already talked about so when you look at those -- 11 key components that we have identified as part of CHC quality and you have already heard presentations with regards to readiness review, Randy Nolen has come here and presented to the committee he has doing a third Thursday webinar.

I have talked a little bit more about the external quality review.

We have done presentations on that.

We have also talked already about the this happened evaluation.

And we'll later on in the presentation we'll provide you with a more detail.

Today we'll really going to concentrate on two areas that is monitoring compliance and performance measure.

The reason we're doing this today is obviously Mike Hale is today he is going to present on the monitoring compliance.

But we want to make sure that we are having, we're talking through exactly what we want to do with community HealthChoices I think that's really important.

When you look at all these key components it again, like I said it's huge under each of these components there's a number of key indicators that we are recommending for consideration.

Next slide so I like to invite Paul Saucier to talk more about those comments that we've already talked about

>> PAUL SAUCIER: Thank you will Marie.

Nice to be here again.

So we're going to take you through each of the 11 components briefly.

And later next year when the quality strategy is out in draft form you'll be able to all of these within the strategy.

Readiness review quality begins before any member is

enrolled, before the plan is able to enroll any member.
As will Marie noted Randy Nolen's team is preparing with
the readiness review and you've heard a lot about it I
won't spend a lot of time here, but the idea is, that every MCO
gets a thorough looking over before single member is enrolled and
that consists of at least a couple of things, looking at documents
and other artifacts that demonstrate that spoils,
procedures et cetera are in place.
But also, doing observations on site to make sure that things
are there and that systems are operating and so on.
So really critical area and as soon as the program is no
longer under the State, this can get there are way.
It will happen simultaneously with negotiations.
The next area, monitoring and compliance just touch on very
briefly because Mike Hale will do an in-depth presentation in a
few minutes.
This is the notion that once the plans are in place the
department doesn't just kind of wash their hands and say it's all
yours now.
The department's critical role is to monitor that on a
continuous basis.
And there will be a dedicated teams in place, to hon tore the
MCOs and make sure that they're complying with all aspects of the
contract.
Next area network standards.
This will be, one of the key areas that is addressed, both in
readiness and review and in monitoring.
How many of each type of, first of all, what types of
providers are needed in this program LTSS being an obvious area
how many do we need and how far away can they be from people and
reasonably serve them and even if they're there in place which
you can look at, by looking at whether certain number of provider
agreements are in place so on, do those providers actually have
capacity to take more members?
So is the ability there to take more folks and so, um, they
will be standards in place for the different types of providers
at readiness, we are looking to see if a sufficient number of
contracts have been signed with those providers and then, as part
of monitoring is there actually enough capacity to serve
the need.
Grievance and appeals another critical part of quality.
This is -- will be sort of a new component tore the people
involved in managed care.
There are processes that the MCOs must have in place to
hear complaints and concerns from their members and to act on
them.

And if their members are not satisfied with the initial
response the ability to appeal that and then ultimately for
issues where there's still not satisfaction to go to a fair
hearing process with the State so, this process is a key
protection and on an individual level.
But also in the aggregate when you look at all of the
activity around grievances and appeals the monitoring of this
will tell the State what kinds of issues keep coming up, which
ones are systemic and how are they being addressed and how long
is it taking to address them.
And critical incidents is something you probably are familiar
with, because it's a concept from the waiver programs in LTSS.
It will continue to be in place monitoring reporting and
critical incidents in addition to grievances and appeals,
critical incidents are serious things that occur to members you
know including death, abuse, neglect, so on.
So there's a reporting system for this in place today that
providers will continue to follow but in addition, MCOs will use
the State's enterprise incident management system to also report
critical incidents so that the State can have an ongoing realtime
indication of what the critical incidents are out there
and how they're being followed up on.
And so with that I'll turn it back to wilmarie.
>> **WILMARIE GONZALES:** Thank you Paul.
So I want to talk a little bit about performance measures
obviously this area is very critical.
Important to note on ther P form answer measures we have a
-- several work groups internally looking at a lot of this this
stuff we've done a lot of research we've had conversations with
other states and we have what we did is try to group some of the
things that we know for a fact, other states are, have within
their program and adopting it for Pennsylvania.
We recognize that there are national measures out there, that
we have to do under a managed care system as well as state
specific measures.
The next slide we'll give you a little bit more detail in
what that looks like.
That's something that has come up in a lot of our stake
holderring engagement that's been you know how do you make sure OLTL
that you're looking at a lot of some really critical areas that
are impacting consumers starting day one.
And so that's what we refer to as program launch phase.
If you go to the next one, we sort of identified 3 large, 3
areas and organized performance measures based upon again what we have researched and
identified.
The goal here is to focus ensuring consumers are receiving

services and providers are getting paid.
So performance measures, that we are considering under
community health choice program on the national these are the
easy ones HEDUS adult COR, adult nursing cap types these are all
measures that are consistent with what other states are doing.
And MCOs are familiar with it, our goal and we will continue
to do that, is not only to educate stakeholders in
Pennsylvania, because this is new for us, but really making sure
that we understand what other measures that fall within each sub
category.
Really important is understate measures you have grievances
and appeals and things like area that's concern us in long-term
services support community based services service coordination,
which is really big and, I wanted to just give you sort of an
example of some of the State measures we're considering when you
look at complaints and grievances things that we think are
important would be you know the number and types of complaints by
MCO.
We want to make sure we are receiving that data, we're
actually evaluating an analyzing those.
We want to make sure we know how many appeals and complaints
and grievances are they being resolved in a timely basis and how
many are there.
We want to make sure that timely issuance of denial and
changes of notices are done again in the timely basis so again,
our goal will be --
>> **FEMALE SPEAKER:** Excuse me, this is Jennifer Howell on the
phone I can't hear anything.
>> **WILMARIE GONZALES:** I'm sorry.
Do you want me -- can you hear me now?
Oh, man.
>> **FEMALE SPEAKER:** Just barely.
>> **WILMARIE GONZALES:** Is that better.?
>> **JENNIFER BURNETT:** Come up front sit right in front of
this thing we'll have them move.
>> **JENNIFER BURNETT:** We're making an adjustment in the room.
>> **WILMARIE GONZALES:** Can you hear me now?
>> **FEMALE SPEAKER:** Yes thank you.
>> **WILMARIE GONZALES:** No, no that's okay.
Thank you for letting us know.
Okay.
So loud now I feel like I want to sing
[laughter]
>> **AUDIENCE MEMBER:** We'll listen.
>> **WILMARIE GONZALES:** Thanks Pam.
As I was saying, when I talking about performance measures we

talked about identifying some of the categories for each of these
for each of the categories we identify in the 3 areas where
we're going to need a lot of stake holder engagement and input is
going to be on the State measures our plan is to include
performance measures as part of the quality plan as I mentioned
earlier, there will be a draft quality plan published on
Pennsylvania bulletin we hope as soon as that is published we'll
send an email obviously on the Listserv let the committee
members know that is there.
But there is a specific appendix within the quality plan and
it lists not only the 3 areas that you're seeing on the screen
but we're also going -- we also have identified identified
specific performance measures so the State area because when you
think of on the nationallal and the national hear you think of HEDUS
measure and adult CORE measure when you look at the performance
measures under that, that's a lot of medical stuff.
We're moving individuals in the waiver program into a
managed care system.
We want to make sure we're identifying things that are
impacting community health choice participants in the community.
So LTSS while there are no national LTSS measures that are
available they are working on it.
There's a number of advocates I believe there's some
organizations here in Pennsylvania who are part of that national
dialogue in identifying some LTSS measures but we have, we're in
a very good position right now with adopting some of the measures
that some of the other states who have a managed care already in
their states we have identified some of those things I think that
will work for Pennsylvania.
So again we've already compiled some of those
measures and our goal will be to share that with stakeholders and
so that we can get, reactions and we can get some feedback from
all of you.
So the next -- within that, the State measures obviously one
of the two key areas to that we want to make sure is identifying
you know how do we make sure we're capturing performance
measures in housing and employment you know that's also part of
our focus areas as well.
We have talked a little bit before on surveys, that is going
to be a part of our requirements making sure that the MCOs, have
surveys.
Recently CMS published a HCBS satisfies CAHPS survey it's
been approved by the consortium we're going to be
requiring MCOs to implement.
so -- we will again provide you with more details on
that.

The other area, as well, that we want to make sure that is
included, will be the provider survey and, Howard will talk more
about that, how the provider survey how this has come up in our
quality strategy I think that's really important.
Next slide.
I will not talk too much on the EQR the external quality
review organization.
But we have talked in-depth about the role of the EQR what
they do, it's been on the webinars we thought it would be
important as part of our framework for quality that you note
there are four major protocols within the EQR that's CMS
requirements it gives you a sort of sample of things that CMS
going to be looking for under each of those major protocols.
Next slide -- the last two areas that are more for the future
is obviously performance improvement projects or PIPS as they're
referred to is something that we are going to be apart of on the
ongoing monitoring analysis of data, and again that is for future
when we start receiving and collecting the data, but on the
longer term.
And OLTL will establish annual performance improvement areas,
in partnership with the MCOs.
This will allow us to -- identify and address some critical
areas that we think is are important, and one of the
requirements will be for MCOs they have to establish some
performance improvement plan.
And some of this will involve the EQR, the EQR
will be required to help us validate some of those PIPs some of
the projects.
So that's going to come.
The next slide is value based payment and this is again a
future.
It is something that, we don't, we do not have right
now.
I wanted to share with you a couple of things.
Earlier this year, in April, Pennsylvania was one of 9 states
who participated in the planning inthough vision accelerator
program, it was a strategic track planning track it was for six
months.
And all of the program offices were represented within DHS.
Our participation in the track had helped us do a couple of
thing.
It gave us access to national and state and other states with
existing LTSS systems, so that, Pennsylvania can look and review.
It gave us an opportunity to hear from other states who are
in the early stages of the designing and implementing LTSS.
And it allowed us the opportunity to help us design what our

quality strategies should look like for community HealthChoices.
And I think that's important and you'll be able to see that
when you, when we do publish the plan that we hope that is
comprehensive and it's, hopefully it will be easier to read and
understand because there are a lot of components.
The last thing we thought that collectively as a group in
Pennsylvania, we thought that our participation on the planning
track met our expectations and when I say this is, it gave us an
opportunity to not only learn from other states and hear from
experts but it help haded us to sort of recommend to CMS can you
make sure that we as an organization, as a group
collectively have an opportunity to share resources.
And lessons learned and continue the conversation that's
something that, has come up out of our participation in this
particular planning tract.
With that, I would like to invite Howard now to talk a little
bit about the independent program
evaluation.
>> HOWARD DEGENHOLTZ: I have to look at the slides to
remember what I put up there.
I've been here -- perfect.
So, I've presented before on the broad overview of the
evaluation plan and some components of it and, I'm going to take
a couple of minute those give a brief update on some of our
activities, the first the over all goal for everybody in the room
is aware is, to serve as an independent evaluation of the near
term and long term impacts of the change to community
HealthChoices.
And we're doing that through 3 main activities, one is
interviews with stakeholders.
Two is analysis of already existing or program generated data,
so claims and, administrative files.
The third is a prospective interview study.
So let me tell you a little bit where we are in terms of our
activities, towards those 3 main over all components of the study.
First was we developed our evaluation plan.
That was reviewed with OLTL worked evaluation work group,
also components were shared here and then it was published for
publish comment, we received over 200 comments on the evaluation
plan.
And we reviewed all of those comments, discussed them
analyzed them and have published a revised and updated
evaluation plan.
I want to share with you, just as an example of some of the
comments and the changes that we have made and you can see the
updated plan, along with there's also a memo that summaries the

major changes so you can see the -- so you can track how we have been responsive to public comments received through that process and also through this committee.

One important thing that we've done and Wilmarie mentioned a moment ago we've decided to add a statewide survey of LTSS providers to the over all evaluation plan.

This had not been in our original evaluation plan because, we felt in the original plan we had a lot of input from the providers, but the point was raised that, there are quite a lot of areas where providers perceptions of their interactions with the managed care organizations, would be very important information to collect.

So we've decided to add a component, basically be an annual statewide survey of providers, our plan is to conduct that online through platform called qualtrix, a online web-based survey tool. And it you'll be hearing more about that in the coming year.

That's one, that's one major change that we made.

Another comment that came up was that, was to address participants perceptions of their housing environment and community environment.

Sort of the near environment to where people are living.

So this is really important it's something that we had in mind but it was very, we're very grateful for the feedback on that part of the evaluation plan and what we've done in this area is we've made sure to include a number of sections in interviews with consumers that address not just a home modifications which came up earlier in this meeting but also, consumers perceptions of their home and neighborhood environment and in terms of safety and accessibility.

As well as, when our interviewers go out to people's homes in their communities, they will also jot down objective notes about what is the -- what kind of street are people living on what are some of the -- are there any safety or quality concern was on the streets where people are living?

And this really goes to accessibility being able to leave your home when you want to and so on.

So these were two very important topics that came up that we're addressing in length.

The next issue that I want to brief you on is, focus groups.

We have started conducting a series of focus groups with program participants and the purpose of these focus groups during the preprogram period where we are now, is to really help us inform the design of our survey instruments when we start actually conducting statewide interviews with consumers.

This has been very, very helpful for us to talk to people who

are dually eligible who were not currently NFC, or enrolled in the waiver program, people age 21 to 59 in a waiver program, people 60 and older in a waiver program.

We're also talking to caregivers for some of these people in the ladder two categories as well.

And, one interesting thing that came up which we had not anticipated that I can share with you and it's a change that we have added to our data collection plan which is, a number of people reported that trust in the medical care system is a very important issue and this has to do with race diversity and perceptions of bias and discrimination.

So we think that this is an important outcome that is modifiable by managed care and, we're going to look into capturing data on that issue.

Finally we've started two more points I'll try to keep going quick we have started interviewing stake holders in the southwest region to to talk to them about the initial preparation for community HealthChoices and as people who have read the evaluation plan in a lot of detail, will know we have a large number of different categories of stakeholders we'll be talking to.

We're still very -- it's still very early so providers are starting to learn about CHC but there's still a lot of other programs that are not -- have not been determined or put out into the public yet.

And so we are starting to talk to providers we'll be continuing to do that over the coming months that's an ongoing activity that will take place over the next 3-4, 5 years throughout the life of this roll out and then finally we've been analyzing data from existing OLTL programs to establish a baseline for the evaluation.

And those data include basically claims, data from the waiver programs to analyze factors for example the number of providers in each of the waiver programs, identifying in-home services, the volume and market share of those providers, as an indicator of network adequacy and a number of other outcomes that we'll be tracking over time.

As that data is analyzed and reports are finalized they will be made public.

Thank you.

>> WILMARIE GONZALES: Okay.

Thank you Howard.

As you can see you know, I wanted to make sure to remind everyone that the evaluation plan is a fluid document.

It is something that we are going to be continuing to look and review.

Our goal will be to do a couple of thing.
Make sure that both the committee as well as our stakeholders
are informed of the status of the evaluation plan and the
activities.
I'm sure that many of you are interested in hearing you know,
what kinds of data and information we're actually getting from
the focus groups in more detail, we are more than willing to come
back and continue to provide you with those updates.
Two last things I just want to make sure, I do and that is
the DHS quality strategy plan will be posted soon.
We will communicate that to everyone.
Both via the Listserv.
I also wanted to make sure that we also share with you that
other subcommittees are interested in it as well what we're doing
with community HealthChoices we're also going to continue our
conversation with the MACC, LTS subcommittee next week they will
be hearing for those who are going to be at the meeting you'll be
hearing the same thing just me this time I want to thank Paul for
being here and helping us as well both Paul and Howard, helping
us with our quality plan and, if no one has any other questions
thank you very much.
>> FEMALE SPEAKER: Yes, I have a question.
I'm sitting in for Drew Negle from brain injury association
my question is about the specific measures I see reference the CAHPS
survey we were reviewing it I want to make sure we're looking at
the current survey there are multiple surveys when you go to
their site.
>> WILMARIE GONZALES: 3 of the surveys we are recommending
-- as part of the performance measures the longing home --
>> PAM MAMARELLA: Wilmarie can you repeat the question
before we answer because people can't hear on it the phone?
>> WILMARIE GONZALES: Monica sitting in in for drew Negel
asked the question about you know, can I be more specific on what
CAHPS survey am I referring to.
Am I referring to.
So I wanted to make sure a clarify that in what we're
recommending on the performance measures 3 different CAPHS that
is the nursing home long term stay questionnaire.
The HCBS CAPHS survey and the health plan adult Medicaid
survey.
And I believe that the latest version is 5.0.
Yeah. And I wanted to make sure that within our performance
measures we're not only have Iing those 3 areas that we talked
about national measures state measures and program launch, we're
also going to be providing links to each of those subsections so
that you'll be able to really look at them, because one sub

category can have 30 performance measures.

>> FEMALE SPEAKER: Wilmarie you can imagine the concern is the ability of these survey instruments to yield valid data, with persons with cognitive impairment and how they would be conducted would they be over the phone, by someone over the phone, with knowledge with the that population it's a variety of questions.

>> PAUL SAUCIER: That's a great concern one of the new CAHPS satisfies HCBS it was effort tested significantly with people of cognitive disabilities and found to be valid.

There are two recommended ways to administer it, in person and other phone but not mail.

So I think, how the -- they will be administered is yet to be determined it will definitely either be phone or mail.

>> WILMARIE GONZALES: Monica if you've not had an opportunity to see the survey we can certainly share that ahead of time with you.

>> FEMALE STUDENT: We've seen the one home and community base services are you going to be using that one.

>> WILMARIE GONZALES: The one got release aid month or two ago.

>> FEMALE SPEAKER: I'm seeing it on the web site.

102 questions.

It does ask questions, how frequently are people on time when they come to your home I think, I'm surprised that -- that is been found that people provide reliable and valid response he's to a question, when time monitoring is a cognitive process and impaired with brain injury I'm surprised that data has validity, so you know, if you can provide the reference on the study I would love to it

>> JENNIFER BURNETT: Monica we can also put you in touch with the people who did all the interrelatability testing it's been tested in the process of being interested since 2010.

>> FEMALE SPEAKER: That will be help actual.

>> JENNIFER BURNETT: We can give those folks to actually you can dive deeper in what they did to validate it.

>> FEMALE SPEAKER: Great.

It appears this survey is specifically for help in the home like, refers to personal assistants or homemakers.

So I'm wondering if there's something similar for surveying folks who get their services out sides of the home, say, day treatment or something like that is agency based not home based.

>> PAM MAMARELLA: Thank you Monica.

Jessie you have a question

>> MALE SPEAKER: So, I'm wondering what the, if there are going to be metrics around the work force?

Because I don't think the work force is sort of ancillary to
the outcomes that we're trying to achieve in terms of quality and
cost.

With CHC and so you hear a lot of about
stake hold we ares and providers and the work force
in particular, are there going to be measures or Hetricks that, I
know, as part of the RFP and the process that innovation and work
force and developing the work force and providing the work force
with the training and support they need to be successful, making
sure there are enough workers to provide people care and support
in the only opposed to other kinds of settings we're facing a
care gap here in Pennsylvania like we are nationally in terms of
the numbers of workers who are available to provide services in
the home versus the number of people who want services in the
home.

So I don't know if that's sort of built into what you're
thinking about but measuring the outcomes of the work force, to
me at least is not an ancillary issue in terms of when we're
going to expand home and community based services and achieve
quality and lower costs

>> HOWARD DEGENHOLTZ: Well I would just like to make one
comment.

>> WILMARIE GONZALES: You just want to sit close to me.

>> HOWARD DEGENHOLTZ: That's right.

It's a great issue we have not addressed it
through the measures if you have suggestions for the work place
measures we would love to take a look at them, certainly if a
capacity perspective we can count people that's easy.

But how you kind of measure the quality of the work force if
you would I agree that's a really good issue and, if you can give
us a some leads we'll definitely look at them.

>> HOWARD DEGENHOLTZ: I can address this this is one of the
-- part of the Rationale for having a statewide employer survey
so we can ask about changes in staffing and, training
expectations.

>> WILMARIE GONZALES: Okay.
Thank you.

>> MALE SPEAKER: Sorry just -- that's good having employer
survey, it is not sufficient I would argue in terms of getting
actually down to the direct care work force and, so when you are
saying employer survey it's one thing to survey the employer and
another thing to survey the people doing the services every day
and in terms of people going into people's homes and providing
that support and then I also, just remind you there's a large
group of independent provider workers who don't, who are employed
by the people that they support and don't have an employer so

just thinking about ways either through the employers and other
independently to get down to the direct care work force and to
measure their outcomes so to speak, seems to be the way of doing
it.
>> **WILMARIE GONZALES:** Jesse we'll follow-up with you thank
you.
Other questions?
Okay.
Any other questions?
>> **WILMARIE GONZALES:** Ralph, hello Ralph.
>> **RALPH TRAINER:** Good afternoon, morning I'm not there in
important, one of the things you spoke about was the grievances
and appeals process.
I would encourage you and the State to assure that consumers
be apart of that.
I think that will be very helpful for consumers to know
with CHC coming about they have another avenue of assurance or
consumers being part of that process going forward.
Thank you
>> **WILMARIE GONZALES:** Okay.
Yep.
Okay.
Thank you.
Thank you.
Good recommendation.
>> **PAM MAMARELLA:** Do we have any other questions?
From the committee in person or on the phone is this
>> **FEMALE SPEAKER:** This is Jennifer Howell on the phone.?
And I have a question and it's more of a comment sort of
following up on what Ralph was saying if I may ask it.
I don't mean to criticize the department for all the work
that's gone into I do applaud the program the openness to
listen to us.
I was just really nervous as -- I hate the words consumer it
seems like consumer sources and don't reality I give back I call
myself a participant as a participant all the unknowns with
community heal choices and evaluations ourselves and the whole
process as if we're being told it's going to be decided then
we'll let you know.
I think that consumers need or participants need to actively
involved decision-making process because we're after all living
it and I do applaud the administration because you've guys had
been involved more than any other administration that I know of.
But I still don't think we're involved enough.
And in making important decisions such as the grievances and
the appeals it's kind of like we'll make the decision and then,

we'll tell you what it is.
And it is just makes me really nervous because we're living
it out and for those of us who know how to navigate the system
I'm not as worried as for those people who really don't.
And, who don't have plans and don't know to call you know, if
they have problems they can call, organizations like Pennsylvania
health law or disabilities rights network or one of the centers
for independent living.
I just think there needs to be more participate input in
important decisions with grievances and appeals.
>> **WILMARIE GONZALES:** Thank you duly noted I appreciate that.
>> **PAM MAMARELLA:** Thank you Jennifer.
Do we have any other questions or comments we're not up for
public comment yet.
So, questions or comments from the committee?
Thank you thank you very much Wilmarie Paul and Howard for
your presentation.
We look forward to seeing you again.
Jen is queuing me Mike hale is next, with the MCO monitoring
update.
>> **FRED HESS:** Oh, no not Mike.
>> **MIKE HALE:** Good morning, everyone can you hear me on the
phone okay?
>> **RALPH TRAINER:** Yes.
>> **MIKE HALE:** High Ralph, how are you doing? Ralph Ralph
sorry I'm not there to grill you.
>> **MIKE HALE:** I'm not here, for those don't know Georgia Goodman,
we have the kind of relationship that dancing monkeys may appear
me at any given time if that happens please let me know.
[laughter]
I'm just joking
>> **PAM MAMARELLA:** That's too bad I was looking forward it.
>> **FEMALE SPEAKER:** Can still arrange it.?
Mail mail okay just checking so I'm going to talk about
monitoring the rams going forward.
An important aspect, like -- the group that was just here,
and the wellness group monitoring is going to be really
a vital part of making sure that we're successful implementing
the CHC going forward.
There's going to be 3 primary phases of monitoring.
And as has been mentioned a couple of times already the first
one is readiness review.
Randy Nolen has done extensive discussion about readiness
review I'll talk about that, I'll give you an update as far as
readiness review and bring everybody remind everybody what that
is all about.

The second part second most really important part, is going
to be launch and you've probably heard it, talked about here a
few times early implementation but we're going to be calling it
launch I think it's more appropriate.

The third one is steady state, that is afterrest program has
gone into effect the long term review and ongoing review of the
program, making sure it's performing correctly is doing
everything we -- living up to our expectation.

Each of these phases -- or each of these phases of monitoring,
are going to be part of each of the phases of implementation.

So, the first implementation the southwest and then the
southeast and then, for the rest of the Commonwealth, these each
of these phases will take part take place for each one of those.

So the first one I want to talk about is, readiness review.
Readiness review is primarily, how we're going to measure
the selected MCOs, managed care organizations prior to them,
prior to CHC going live in that, in each of the phases readiness
review criteria and benchmarks set by the department we'll use,
reviews and as well as on site visits as part the readiness
review process.

The primary process itself, some of the items have been based
upon a lot of the experiences of the HealthChoices program which
has been successful in their readiness review process has been
successful.

And we're going to modify a lot of the not a lot but as much
as we can, HealthChoices for our use although we'll be use
requesting a separate tool for CHC as opposed to the
HealthChoices tool.

We thought it was better for us to have a tool that was
specific to MLTSS opposed to the physical health side.

>> FRED HESS: Can you clarify on site reviews who is that
with?

Providers consumers?

Or --

>> MIKE HALE: Managed care organizations.

>> FRED HESS: MC Os.

>> MIKE HALE: That's correct.

Part of the readiness review is gathering a lot of the
information I'll get into what we're going to be looking at, in
just a second.

Some of it will be asking for information, to be submitted to
us, for review here some of it will be -- going on site and
viewing, a lot of the things that, that the -- will required
of the MCous, thanks for clarifying it.

The readiness review will be made up teams each team is
assigned to a Harrisburged care organization the team is going to

be maded 3-4 department staff.
For readiness review so depends how many, managed care
organizations are selected, how many staff will be involved from
the TKEFPLT each team will have subject matter experts we'll be
bringing subject matter experts throughout the Department of
Human Services and as well as other departments within the
Commonwealth as needed.
Readiness review will review all of the LTSS components but
physical health will be, reviewed in conjunction with the
HealthChoices program because the physical health side of things,
we don't want to duplicate we want to be able to utilize some of
the information, that they're gathering through their readiness
review process as everybody knows the HealthChoices program is
going through their most recent selection of ongoing managed care
organizations as well.
So, depending upon the selected MCOs and depending upon the
schedule the new schedule for HealthChoices, how much of what
we're going to be able to do together or to utilize from
HealthChoices is going to be kind of dependent upon that.
As of right now, any way.
So the MCOs under readiness review will have to demonstrate
compliance with implementation of specified policies and
procedures.
There's a list hopefully behind me not dancing monkeys,
there's a list behind me of administrative functions, and
enrollment related functions this is a pretty good list of what
the initial readiness review is going -- there's subsets to
every one of these but, this is pretty good list of what the
readiness review teams are going to be looking at and, it's
important to remember too, that, the results are going to be
compiled prior to implementation of CHC.
We currently will is a schedule I wasn't here for early on,
any updates I don't know if you guys got an update that the
schedule has changed as of right now we're looking at a go, no go
date that is currently set for April 30th of 2017 and as
you know, we have an implementation date for CHC of July 1,
2017.
Currently so -- we're hoping to have go no go for each of the
individual MCOs by April 30th.
And once that occurs we'll be able to say whether or not they
can go forward and we can have them start you know actually doing
business.
So again that's April 30th is the go, no go.
As I said these are the areas that they're going to have to
be looking at results of readiness review are going to be
provided to the other phases of monitoring, when we get into the

launch I'll tell you a little bit more about launch but all of
the things from readiness review are going to be pushed
forward into the launch phase as well as a steady state phase so
we know, where the MCOs stand and where they began where they are,
in each of the phases currently.
Contract monitoring functions is an ongoing over sight of the
MCOs.
Once, readiness review has been completed for each stage.
Any issues that are identified, in the readiness review will
be addressed and resolved prior to the go live date, prior to
giving that MCO a go no go.
Or at least they're going to have to show they're ability to
perform with corrective action plan in place.
It will depend, Randy Nolen has a better handle this temple
preclude someone from starting there will be corrective action
plans put in place, hopefully they can work through the
corrective action and still be a -- allowed to be a go opposed to
a no go.
The early implementation of the launch and external quality
review, organizations also get information from the readiness
review teams.
But then we're going to maximize those resources to ensure
the successful readiness review and ongoing phase 2 and 3 of CHC
that is, if all of the current MCOs in the first phase are
actually involved in second and third phases geographically or
whether they're part of the second and third phases.
So one of the other things that MCOs will have to demonstrate
is the coordination with the behavioral health and make sure
there's a understanding in the time between CHC MCOs as
well as the behavioral health MC Os in the community,
enrollment broker there's a relationship with the IEB and,
understanding of the functions there.
As well as the physical management services currently,
everybody knows that, FMS is currently with PPL and they are also
going to be extended through 2017 so there will have to be a
relationship developed with the FMS provider whether it's PPL or
whoever it is in the future and again I want to stress that go no
go date is currently set for April 30th, 2017.
So let's talk a little bit about launch.
And again you may have heard it, early implementation or
implementation, but launch is, going to be, something that once
we really start this, there's two areas hopefully you've heard
this before.
And I'm certain you'll hear it going forward but, there's two
things we're going to be primarily focus on, is making sure that
participants are being served and served correctly based upon the

service plans.
Also going to make sure that providers are getting paid
correctly and on time.
Those will be two primary goals in that order by the way.
But the two primary goals of the launch monitoring and the
steady state monitoring.
The first to tell you a little bit about how it's going to
work we'll have the team of leadership OLTL meeting directly
during launch you may have heard this as a SWAT team, I like as a
more
nonviolent vent team, leadership, by Kevin Hancock, it will be
composed of the deputy secretary, bureau directors MCO contract
managers and then others as needed we'll bring in, subject matter
expert he is as needed.
But the primary reason, we want to have this group is to --
we'll do this daily.
We'll have daily meetings going on for the
group.
One of the primary thing is to have a rapid decision-making
process to address the critical issue that's come up as quickly
as possible.
That because we have this composition of members to this team
we'll be able to assign the Bureau directors and staff available
to us we'll be able a to to address the less hour generality
matters to the staff we'll be able to key in on those things that
we know are primary and very important be able to make rapid
decisions from a total office standpoint because all of the
Bureau directors will be involved make sure that those things get
corrected as quickly as possible.
These meetings will be held daily we'll taper them off as we
need to.
Weekly we're intending it is our intention to have open phone
calls with stakeholders to let everybody know how we are proceeding
how the -- what the results of those daily meetings have been.
And making sure we get input and let people know and be open
as possible as what we see as problems, what barriers we may be
running into.
Maybe ask for a assistance from stakeholders as well.
To give us input over how to overcome some thing.
>> **PAM MAMARELLA:** There's a question from Brenda on the
phone, after she asked the question if you could repeat it.
>> **MIKE HALE:** I'll repeat it, the best as I can.
>> **FEMALE SPEAKER:** Hi Mike.
You're going to have a readiness review tool that is unique
to MLTSS I'm glad to hear about it, is the committee going to
take a look at the tool, I don't know if it's implemented in the

readiness process, I know there are complications I would like
to take a look at the tools so we know what it is, is -- expected
of the MCOs to be ready, so we're able to tell you whether or not
we're seeing it on the ground, whether those things actual
>> **JENNIFER BURNETT:** Brenda the readiness review
tool is mirrors almost exactly all of the components of the draft
agreement that was posted that we got lots and lots of input on
so if you want to take a look at it and get a sneak preview what
it is, it's just we've taken all those different
components from the draft agreement that's what we're going to be
evaluating, in the readiness review.
>> **MIKE HALE:** So that answers your question Brenda?
>> **FEMALE SPEAKER:** Yes.
>> **MIKE HALE:** Okay.
Brenda said yes.
So again one of the purposes of launch monitoring sharing the
continuity of providers and consumers during transition.
We want to make sure like I said we're doing this on a daily
basis.
But the Bureau of contract and provider management will be
responsible for monitoring MCOs through all the stages.
The MCO monitoring teams are going to be established with
each team as being assigned to a specific MCO, we'll -- that's
currently how it's being done in HealthChoices and it seems to
work very well.
You have a -- a team lead for each one then you have a, few
people underneath there, then you have, monitors
underneath them so it is a team that can be made up, depending
upon the size of the MCO you can have a team of anywhere from 8
to maybe 12 people in various specialties looking various
items.
These teams will hopefully be assigned we're in the current
process of finding out whether or not we can hire so -- and in
developing our team goals and that kind of thing so we're in the
process of developing the launch monitoring teams.
Something else from -- during the MCOs specific monitoring
based upon the readiness review also in the agreements.
The launch monitoring teams will be looking at a lot of the
information that is, that's been gathered from readiness review
whether it's issues or problems or whether or not they have to
look atmosphere various corrective action plans if there's any
corrective action plan in place.
And again, corrective action plan doesn't necessarily, mean
that someone will be restricted from starting we will follow
along with that, if we need to, have someone stop being you know,
provide it, because they're not meeting the corrective action

plan we'll have to deal with that as the time, when that time comes but, these teams will be working on that.

As I said before, electrical be desk and on site monitoring reviews of the key systems during implementation.

From readiness review we'll be evaluating a lot of the reports from the MCOs determining compliance the and corrective actions and those things will be brought forward to the management team as well on a daily basis to make sure that when we see these things we can address them as quickly as possible any issues, then we'll evaluate lessons learned from launch and, apply those to the later phases as well.

One of the things that the in launch what we're going to be doing, we have specific indicators that we're going to be looking at, in particular.

And, I think, there's five of them I don't know if there's five or six I wrote this I don't remember.

But there are certain indicators that we're going to be looking at in depth to make sure the program is going correctly.

So the first indicator is, making sure that participants are enrolled and receive LTSS services without interpretation.

As I said before, we want to make sure the participants are parked and providers are getting paid and being paid correctly.

This is going to include daily review of participant enrollment and disenrollment numbers when we transfer these people to various MCOs we'll be following whether or not people are being enrolled in the MCOs how they're being enrolled how quickly, we want to make sure that any disenrollments that we're made aware of and why, and whether there's appeals on those and, how those are going.

So we'll be looking at those numbers very, very closely.

To make sure as people are enrolled in these various MCOs it is done correctly and services are continuing based upon their service plan.

Participants who are receiving HCBS services we want to know how many in the past week.

We'll be looking at the procedure code level to make sure that, all of the services within their service plan are in fact being utilized.

We're going to also be looking at participants who are receiving nursing facility services in the past week.

Making sure that again, that everything is on their plans are being done.

We'll be working with Department of Health in a lot of areas when it comes to the nursing facilities.

Critical incidents in the past week -- you've heard some talk
from Wilmarie and her group about critical incidents a
little earlier.
We want to make sure that we track critical incidents as they
go.
It's going to be -- that grievances and appeals we really
want to focus on especially in the first 90 days to hear what is
happening and hear some of the problems that may be existing from
a participant standpoint, in the transition into the managed care
organizations.
So participants being enrolled and receiving LTSS without is
a primary okayedor.
The second indicator is receiving service coordination and
functioning properly.
One of the things we're going to be looking at, in total LTSS
participants assigned to a specific coordination entity.
Making sure the numbers appear viable that, that they're
hatching up with how many should be transferred, making sure that
the numbers of service coordinators are -- they can actually
handle case loads.
We're going to be looking at, LTSS participants who had a
change in change in service coordinators we want to see if
service coordinatation entities are losing participants as well
as gaining participants we want to make sure that, if there's a
big change in service coordinators in any specific area or
agency, it may be because there's a problem with that service
coordination agency and we will be looking more in-depth at that
he.
We want to look at LTSS participants who received inperson
contact electric the service coordinator in the past week.
We'll be looking to see what kind of contacts have been made,
why they were made, how often they were made.
And primarily the nature I know the nature of them, something
related to a problem with LTSS services, and the service
coordinator is getting stuck or has to help a lot, from the
specific agency what those problems are, so on a daily basis we
can get those numbers we can see those numbers and, start working
towards change.
We want to look at number of participants who received a
phone contact, service coordinator in the past week.
Those who have received a comprehensive needs assessment
from the service coordinator in the past week we want to look at
the experience of service coordinators, this is one of the
things that the University of Pittsburgh Howard's group is going
to be looking at we'll be looking at a lot of those various areas.
And using some of the reports from the University of

Pittsburgh around service coordination as well.
And the experience of participants with their service
coordinators we want to hear from the participants I think
Howard well be able to give us some of those indicators as well
through some of the surveys that he is going to be doing, with
the communication he is going to be doing with the
participants of the program.
All of those are going to be coming back to the team for us
to review on a regular basis to try and stave off any problems
occurring.
The third indicator that we're going to be really focusing in
it on is, that the providers are continuing to deliver services
and they're paid promptly.
Now I know that, primary goal is making sure participants are
getting services things are going well for participants that's
going to be a primary the primary goal of ours however,
without good providers making sure good providers are comfortable
in this system as well, the system is going to break down.
So we want to make sure that, we're reviewing total claims
received for HCBS for the past week by provider type making sure
we're getting billed for those services, and paying for those
services that are actually being delivered.
We want to make sure, we're looking at the total claims, that
were receiving for nursing facilities in the past week, so we're
not overlooking that population making sure that we're transition
of the nursing facilities to managed care is going smoothly as
well, making sure they're being taken care of.
Totally HCBS and nursing facilities claims paid pending and
rejected by unique provider type and reason we want to, we're
going to be looking at why there may be rejections what the
problems have been with billing we'll look at all phases of
billing making sure that -- if it's a specific service, specific
reasoning behind why there's rejections or why there's problems
in billing that we actually get to it as quickly as possible as
opposed to some of the times that we receive some of these
complaints now, some of these problems dragon and there's no real
reason for it.
Other than the fact that we don't get to it quick enough.
Well we're hoping we're going to get to it quicker and we
have billing issues sometimes, it takes awhile to correct them
but we always try to correct them as fast as we can, we're going
to be able to approach it quicker because of the daily meetings
we'll be having with the proper people in the teams are going to
be able to have firsthand experience with the dealing with some
of the situations.
I'm losing my voice.

I have a two year old who will be 3 in a week, I -- I want to say that I don't yell at him.
Obviously my voice is going -- so get in the car this morning was a hard thing to do.
So --
>> PAM MAMARELLA: Mike before you go further I want to inform the committee that Cassie has been on the phone the whole time was muted at some point and then I want to make sure the Cassie is doesn't have a question I'm not clear on that.
>> MIKE HALE: Cassie do you have a question?
>> JENNIFER BURNETT: Are you polluted.?
>> PAM MAMARELLA: Did we loose her again.?
>> AUDIENCE MEMBER: She was trying to come off mute perhaps.
>> MIKE HALE: If she comes back if she has a question let me know.
>> PAM MAMARELLA: Thank you.
>> MIKE HALE: So the fourth indicators that we're going to be looking at very extensively is making sure networks are robust and, making sure that we have enough providers in our network.
That is -- we are going to be working really closely with the Department of Health they're going to be helping us with making sure that we have network adequacy.
LTSS providers with MCO contracts making sure they have capacity and providers we'll be reviewing those contracts, between the MCOs and those provider agencies.
We're going to be, working with provider agencies, to make sure they have an understanding of how to tie in with the MCO organizations.
But we, we want to make sure that there's a good marriage between the MCOs and the provider networks out there.
Making sure that, that -- um, there's a clear understanding of both parts because this is relatively new for a lot of the MCOs we want to neighboring sure they're comfortable of the providing agencies they're accepting as well.
Network contracting experience, we want to -- hear from the network from the provider agencies on a regular basis we'll be asking for information on a regular basis from them.
To see what problems have occurred to make sure there's good communication between the MCOs and the contracting agencies and the provider agencies.
Complaints and grievances related to provider access, in the past week, weekly we'll be looking at data and information.
On complaints and grievances related to provider access and making sure that providers have their answers to their questions and think problems, with them getting on board.

And enrolled, making sure that they -- we're quickly getting
people into the system as quick as possible the network adequacy
is going to be important.
We'll be looking at trends for complaints and grievances
related to provider access trends for the first 90 days after the
first 90 days we'll be doing extensive research in trending to
try to alleviate any problems coming we see coming up.
I always loose track where I am.
So communication, communication is going to be the last
indicator fifth indicator we'll be looking at.
Stakeholders have the information, making sure you have the
information they need, as I said earlier, we want to make
sure that we're having weekly calls with stake holder groups make
sure we're addressing the issues that stakeholders may be raising.
That relate to communication or lack of communication someone
mentioned earlier that, this is really an open group that
hasn't happened in a long time I have to agree with that.
I think that we as a department especially those at OLTL
making sure we have are sharing as much information as possible
that our stakeholders are really involved in, understanding how
this is, working.
Because we want it to be a successful program.
Participant provider line calls related to communication
or lack of communication, we'll be looking at all the hot lines
we have set up we're going to be setting up to see what kind of
trending we have there, what kind of communication barriers or
problems being identified.
Through those phone calls.
And then, we want to see what our perceptions of
communications among the stakeholders we want to make sure that
we are actually doing what we are doing what we said we're going
to do making sure that, what the perceptions are out there as far
as how we're communicating how the programs are actually That has to do with the launch.
So some of the other areas of interest we're going to be
looking at IEB call volumes an the nature of the calls with
the IEB how they relate back to CHC we'll be looking at call
center themes.
Like I said earlier we're going to be looking at trending and
whether there's any specific theme that seems to be coming up
more than most.
And addressing those as quickly as possible.
We're going to be look at CHC web site statistics.
Seeing how much, how many users we're getting where
they're going, once they're navigating through our web site,
whether they can navigate through the web site.
Making sure that we put as much information out there as

possible it's being looked at.

And then again I can't stress this enough we're going to be asking for stake holder feedback throughout the entire process of launch and early implementation, launch is what we're calling it.

So we want to make sure that we keep those lines of communication open.

So let me get down to, because it's been so successful, there's been no glitches things went even better than we expected even better than we expected we get to a place called steady state.

Steady state is the ongoing monitoring of the successful program making sure that, there's ongoing over sight of how things are being put into place and, continue to be.

Steady state is going to occur after statewide implementation.

So when you hear about the early implementation of the launch period, that's actually going to be through all 3 phases, all 3 areas of the CHC development.

Once we have statewide implementation, it's going to be continuous monitoring and program improvement I think that's the important part of steady state the program improvement a lot of times programs are implemented and, they stay the same forever you never see any of the information that is being gathered being used for anything positive.

We're hoping that what we're going to be able to do with CHC because we'll have the opportunity to do it, is to utilize feedback and the information we're gathering to really work on program improvement.

Because, this program to be made anywhere, when you have things like this going on.

The role of, the role of steady state is going to monitor the MCO compliance, with remote and on site.

Of the MCOs and determine corrective actions if necessary.

The Bureau of contracting provider management right now is going to be responsible for monitoring most issues.

Yes

>> **FRED HESS:** What would corrective actions be?

Would they be, I don't get it, what would be the corrective actions be showing them what they're going to do is there anything punitive?

Anything?

>> **MIKE HALE:** The question is what constitutes corrective action.

>> **FRED HESS:** Right.

>> **MIKE HALE:** It can be almost anything.

It can be whether -- they're losing their network if they don't have enough providers to do a lot of the services, for

example, okay.

Corrective action for that might be that they have to show us, within certain amount of time that they built their inest work back up.

They're working with the Department of Health and working with the Department of Human Services, to make sure that they are doing everything they can, in the area to make sure that, they have good providers, competent providers that they're providing the training they're supposed to you know all the things that all the things they would need to do to be a decent managed care organization.

The things we saw at the beginning of the -- for readiness review it if any of those things fall down.

Corrective action this those areas.

If it gets to a point where corrective action is not working then there's a further discussion, whether or not they're going to be able to continue as a managed care organization.

>> **FRED HESS:** Okay.

>> **MIKE HALE:** Pam?

>> **PAM AUER:** Just wanted to follow-up --

>> **FEMALE SPEAKER:** This is Cassie --

>> **PAM MAMARELLA:** Let's hold and let Cassie before we loose her again.

>> **FEMALE SPEAKER:** I was having trouble I'm doing it on my iPhone.

So -- um I just wanted to I have concerns about nursing homes making referrals for transitioning who is monitoring that?

And how is that being monitored that's one question.

I also have concerns about only two MCOs I mean, especially in light of, when I talk to other states and all MCOs drop out.

So what are you doing to make sure that another MCO could be replaced quickly or have you added MCOs I know you're under some kind of process.

>> **MIKE HALE:** Jen can you address the two MCO issue first?

>> **JENNIFER BURNETT:** Yeah.

Cassie asked a question about whose monitoring nursing homes making referrals to transition.

Transitioning.

Currently the office of long term living monitors that and we also manage it because we some changes to the nursing home transition program.

We'll be working with the managed care organizations to make sure that referrals are getting made particularly so that we're in compliance with the requirement that nursing homes make referrals for people who fill out section Q of the MDS in a positive way that they are interested in transitioning interested

this moving out.

We, at the state level have to be looking at that, today
we're doing the monitoring of it.

But, there's -- there will be conversations with the MCOs at
some point for that.

And in terms of the number of MCOs we actually have 3MCOs
selected but we're in a state right now,

there are some protests appeals filed with the Commonwealth Court
and, we have to wait to see how those get adjudicated before we
can say we have 3 plans or potentially we can have more, it
depends upon the outcomes of the appeals in the Court.

>> **PAM MAMARELLA:** Pam?

>> **PAM AUER:** I wanted to follow-up with Fred's question
about the corrective action plans I'm just -- I'm concerned
hearing that if you do the readiness reviews and some -- one of
the organizationses has a corrective action plan they might still
be able to start being a provider that makes me nervous a lot of
us remember still Christian financial and there were a lot of
people involved with that training they put that out even along
the way they were trying to fix it, at the state level until it
could not be fixed I'm just, I'm concerned you know, there's
great I appreciate all the systems you have set up, Mike, to
monitor and follow through, but if you're starting at the beginning
with letting someone who has a corrective action plan roll out,
it makes me very concerned.

>> **MIKE HALE:** I don't think I guess I wasn't clear enough.

>> **JENNIFER BURNETT:** Can you repeat the question.?

>> **MIKE HALE:** I'm sorry the question was, for those who are
on the phone, the comment was there's a concern about allowing an
MCO to begin who may be under the corrective action plan.

I think that I mean I wasn't quite clear enough.

We're not going to allow an MCO to begin if they failed in
a lot of areas that are of significant observation.

If it's a matter of not having internal training for example,
having that curriculum totally done but we seal them working
towards that and may be dates in training down the road opposed
to the initial, if there's, if there's things that aren't going
to impede them actually delivering services correctly, if there's
things that are not going to impede them from being able to
communicate correctly with the department, for billing purposes
that sort of thing, it's going to depend upon what the area is,
that they're in the corrective action on we'll not allow an HCO
to begin if we think that, again, there's two primary goals we're
looking at is, delivery of services, continuing the way they're supposed to, and proper billing
we're not going
to let them allow to continue, if those things do not occur.

This list is small compared to what readiness review is
going to be looking at, if you look at that, if it's any of these
things, and we don't feel that they can function correctly going
forward we aren't going to allow them to start.
So the go no go again you have to look at the go no go date
of April, the sooner we can get in and do readiness review
the better the MCO is going to know where they stand as far as
some of these items they have to correct.
Corrective action plans will be given out as soon as these
things are seen, it's not going to be a last end of April 30th is
not when he we're going to be dealing with some of these
corrective actions Pam.
So, you have to understand that, that -- it's a process.
It's no different than the -- for example, the current
process we have providers under corrective action, it depends
upon the severity of the corrective action there's levels of
that, too, things you'll have to do, if you feel that they can't
continue.
So, don't, please don't be alarmed when I say, we're going to
allow people to start under constructive action there's going to
be levels of that and it's going to depend upon what the area is.
Okay.
>> **PAM AUER:** Okay.
I appreciate that.
Um, at the last -- one of the last meetings
>> **FEMALE SPEAKER:** Tanya --
>> **PAM MAMARELLA:** Hold on Pam has a follow-up question.
>> **PAM AUER:** We talked about, when we talked about readiness reviewed I had asked about
consumers being part of the team, they said no, that can't,
happen, we were told we're going to be able to review the tool.
>> **JENNIFER BURNETT:** No, the tool is, exactly just go to the
draft agreement you already have access to what is in the tool
it's all of the components of the -- and the standard that's are
listed out in the draft agreement.
So just, take a look at the draft agreement and that will
give you what it is that we're going to be measuring in the tool
>> **MIKE HALE:** For those on the phone the question was, what
is going to be in the tool can they see the tool?
The answer was, it is everything that is in the draft
agreement, that's currently, or the agreement that is online, I
can vouch for the fact all those areas that are in that agreement,
are what the topics are on the monitoring tool for readiness
review.
Okay.
So if you look at that, you'll see exactly the areas and
then, actually, the agreement when you look at it Pam,

if you look at all those areas it will really get more in-depth
what the tool is going to tell you you'll actually see what we're
-- what it is that, has to happen, within each of those areas so,
it may actually be more information to look at that, opposed to
the tool.

>> PAM AUER: Okay.

>> MIKE HALE: Okay? I don't think -- I think at some point
in time if people want to see a form, we can put that up here too.

>> JENNIFER BURNETT: It's an excel spreadsheet.

>> MIKE HALE: It's going to be.

>> AUDIENCE MEMBER: Very long meeting.

>> JENNIFER BURNETT: Yes.
As Pat Brady said it would be a very long meeting if you
wanted to go through the tool it might be two meetings

>> MIKE HALE: Okay.

>> PAM MAMARELLA: We have a question from Tanya.

>> FEMALE SPEAKER: Yes, my question has to do with the over
all function of the services my way under the MCOs because
typically with services my way you have the capability of being
able to purchase goods or services that might not be covered
under Medicaid insurance as they currently stand.
But how is that going to work if the MCO is basically in
control of everything.
You understand what I'm saying?
There would not be a difference between your insurance
provider and your service coordination then, so how -- I guess,
the question is, is like how would the determination be made
what would be -- I'm sorry, what would be covered under your
typical insurance plan versus what could be covered under
services my way.

>> JENNIFER BURNETT: Tanya this is Jen services my way is
not changing it's still going to be managed as it is today.
Through the FMS provider.
And we won't be making any changes to services my way at all.
And I would say, that one of the advantages of moving to a
managed care system from fee for services there's a lot more
flexible in what managed care organizations can do I think you'll
see things that are beyond I know you'll see things that are
beyond what are currently available through fee tore service in
managed care.

>> FEMALE STUDENT: Okay.
Do you understand what my question is though?

>> JENNIFER BURNETT: Yes, I answered it.
The services my way is not changing at all.

>> FEMALE SPEAKER: Okay.
Thanks.

>> JENNIFER BURNETT: Yep.
>> MIKE HALE: Okay.
So now I totally lost where I am.
The other thing that the other thing with steady state is
that we're going to have encountered data, we'll
be able to utilize at this point by the time we'll have the
informations, have functions and function unitation report, EQR
will be up and running we'll have external quality review from a
neutral party given this information, corrective action plans
like I said Pam we'll be able to the extent of those, whether
there's areas that we need to really treat more importantly than
others.
If there's things we need to change through the program.
And all these things like I said, hopefully with the
communication that we're planning, we'll be able to do that with
stake holder input too we wanted to -- I'm not, I'm being totally
serious we'll have these, try to have these weekly phone calls
with stakeholders making sure that everybody knows what is going
on and where we're at trend wise.
We're going to be able to look at the HEDUS measures, health
care data information set, for MCO records and reports we'll be
able to see such things as hospital admissions and readmissions
and nursing facilities readmissionations using cancer screenings
there's a lot of health areas we'll be able to focus in on, we've
never been able to, with the with the limitations we've had,
within some of the HCBS programs.
So I think, that some of the other things the CMS the adult
care measures developed by CHS and the national quality
forum, being able to look at, controlling high blood
pressure, blood pressure screenings breast cancer screens
ambulatory health services these are just examples out of 30 on
the data systems set we'll be able to look at, we'll be look at,
we're going to be looking at.
So, the minimum data set the MDS information for nursing
facilities.
Things such as short and long term admissions paid days of
admissions, Hawaii risk patients and pressure ulcer issue.
That's a few.
We talked about the CAHPS tool earlier it will allow us to
get participant experiences with services and delivery of
services for a change opposed to just knowing how many like, some
of you had said earlier today, just how many numbers are out
there.
You know, opposed to, yeah we have this many people, this is
how many of these services we give, but we'll be able to look at
participant outcomes as well for a change I think that's

something that we have not really been able to do in a long time.
So I think our steady state, we're going to be able to
evaluate lessons learned from readiness are he view and launch
we'll learn how to apply those in later phases, ongoing nature.
We're going to be able to evaluate consumer provider contacts
complaints in areas needing corrective action not on the MCO part
but internally within the Department of Human Services adds well
making sure we're correcting things we have corrective actions
internally that we can do to change things and turn things around
make things little more positive in the experiencing a lot more
positive.
We're going to be able to see make sure that, the MC on Os
are adhering to the contract standards that the MCOs -- are
meeting CMSs and the department's assurances.
PAR that's it in a nutshell
>> **PAM MAMARELLA:** Ralph has a question.
>> **MIKE HALE:** Of course Ralph has a question.
>> **RALPH TRAINER:** The subject matter experts you talk about
I certainly hope that you prosecute use the look at the consumer
that's are there to utilize some of the committee members, and
others throughout the State Mike that I think are really some
experts.
Experts in that group you're talking about.
>> **MIKE HALE:** I look to my right --
[Laughter]
And Fred is always willing to help.
I think Ralph, when I say stakeholders I'm sorry Fred I think
when I say stakeholders Ralph I mean, this group in particular
but, usual stakeholders in a lot of the stake holder questions go
to.
And yet, as you well know, um, is comprised of a lot of
participants in the program and a lot of individuals who are, avid advocates hopefully it will
include, a lot of the people in the room as well as people I know
are on the phone as well as people that I know are in the
community, that who have always been a vocal and vital part of
developing programs with the department.
>> **RALPH TRAINER:** Great thank you very much.
>> **MIKE HALE:** Great you.
>> **RALPH TRAINER:** Have a good holiday?
>> **MIKE HALE:** You too, sir.
>> **PAM MAMARELLA:** Does the committee have anymore questions
before we thank French?
>> **AUDIENCE MEMBER:** Brand a does.
>> **PAM MAMARELLA:** Phone then to Monica and back to Pam,
okay.
>> **FEMALE SPEAKER:** Okay.

My question is, that once you get to the steady state, can
you talk about who is going to be responsible for what?
It wasn't clear on your slides what, where OLT fits into the
steady state monitoring
>> **MIKE HALE:** We'll have monitoring teams assigned to each
of the MC ons, each one will have it's own team, to work with.
That team will be comprised of however many people it takes
and however mem we're able to hire at the time.
But, they will go through monitor them, based on all of the
information all we have the areas that we have -- I've discussed
here.
Each team, each MCO that will have a specific contact person
within the department it will be the department, it will be a
team of individuals, per MCO.
And, that's how we intend to do it at right now.
>> **FEMALE STUDENT:** I just wanted to state it clearly it is
on the slides the Bureau is going to take over a bit of that, I
want clarification.
Thank you.
>> **MIKE HALE:** As of right now.
That's where those teams will be reporting to or -- out of.
Yeah.
Hail
>> **FEMALE SPEAKER:** Okay.
>> **PAM MAMARELLA:** Monica.
>> **FEMALE STUDENT:** My question is not about MCO monitoring
about a earlier stage in the process hope you could provide an
update on the, functional eligibility determination and the
entity going to be administering that and I think, request came
previously as whether or not this group, would have an
opportunity to see the agreement with that activity.
>> **MIKE HALE:** Do you want to address that?
>> **JENNIFER BURNETT:** Function al eligibility
determination we did complete a procurement, to build the
software for it, we're getting -- it's still in negotiations to
figure out who is going to be actually completing the tool.
>> **FEMALE SPEAKER:** Hasn't been -- nothing has been
determined.
>> **JENNIFER BURNETT:** It hasn't been determined, hasn't been
finalized in.
>> **FEMALE SPEAKER:** In other RFPs or RFQs the group has
been able to see those.
And I don't think, I don't know that we've seen that
particular one, is that will we have a chance to look at it.
>> **MIKE HALE:** RFQ is on the DGS web site.
>> **FEMALE SPEAKER:** Okay I will find it thank you.

Far
>> MIKE HALE: Okay.
As far as yeah.
RTQ is on there.
>> FEMALE SPEAKER: Okay.
>> PAM MAMARELLA: Pam?
>> PAM AUER: I was going to beat a dead horse I'll leave it
alone for now.
With the stake holder communication what is the State going
to do, what are you planning to do make sure there's cognitive
accessibility in all of the documents do you have someone working
on that, or all the communication that's one question and then
the other someone asked me to ask, was, about the making sure,
how how the -- making sure attendants are getting paid in the
beginning of process.
Is when you were talking about making sure providers get paid.
>> MIKE HALE: I'll address that part first.
One of the things I said when it came to readiness review was
that making sure the MCOs are having that
communication ready to go with the FMS provider, those
participant directed workers need to be paid and paid on
time, that's one of the things we want to make sure as well.
That has to do with making sure services are being provided.
Okay.
So one of the things within readiness review that we're
going to make sure is, that the MCOs and the FHS provider whoever
it may be, does have that relationship, to make sure that those
payments and that that information is ongoing.
Okay.
So, I don't want -- that's one of the primary things they
don't have that again, you can have corrective action plan to
make sure that's in place, that's one of the things if it's
not in place the MCO is not going to be ready to go, okay?
So -- those are kind of things we're looking at.
The individual contracts between the MCOs and the FHS
provider are going to be vital as will the information, sharing
between the IEB and the MCOs there are certain things behavioral
health aspect of this is very important.
As far as the cognitive addition
>> JENNIFER BURNETT: Wait can I add one thing to that.
Hail hail sure Far
>> MIKE HALE: Sure.
>> JENNIFER BURNETT: That's for the consumer directed model
Mike was talking about, in addition to that, we certainly have a
lot of people that are using agency model service delivery and
when we talk about the providers getting paid

and timely is a measure we're going to be looking at, that's
another thing we'll test in readiness review whether they're
nursing home providers home health providers, whatever the type
of provider there's an ability for them to build MCOs and for MCOs
to make the payments to them.
>> MIKE HALE: Okay?
The other -- I'm sorry the other one was cognitive additions.
Can you elaborate on -- ask me the question again however it
was said to me.
>> PAM AUER: Um, readability levels, making sure that it's
level of people who have different learning abilities, are able
to or -- be able to process it, white space, larger point with
lots of white space.
There's a whole -- a lot of information on the web about it,
but just making sure because if you really want the consumers to
understand it you have to make sure that it's something that they
can get
>> MIKE HALE: Sure.
I'll repeat the question for people on the phone.
The question was, from Pam auer was making sure that, all
the information that we're, putting out there, the communication
all those things, are done so that, readability in
the Commission is acceptable, from the stake holder groups
standpoint.
The various stake holder groups standpoint Georgia go ahead
>> FEMALE SPEAKER: Thanks Mike Georgia Goodman I've been
working with the press and communications office and the folks on
the third floor over in the secretary's office on our
communication efforts for CHC and, though you have not seen them
I know the necessary question is when, we're still committed to a
pretty robust stake holder engagement process which includes,
sharing all of those documents, with this entire group
so if at that time you're not satisfied with the readability of
which we're committed to the best of our ability, getting things
down to a fifth grade reading level with some of the key
terms relating to long-term services and supports and waiver
services, Medicaid, it really is a complex process as everyone
here is aware.
So we do have some challenges and getting thing down to a
fifth grade reading level we have done some research on cognitive
accessibility on the web if you have a specific link or a
standard that you guys use, through the CIL of central PA that
will be great.
If you want to send it to me I'll be happy to you my card we
can work through that.
As well.

>> PAM AUER: Okay.

>> FRED HESS: Are there any other questions from the committee members?

>> FEMALE SPEAKER: This is Jennifer Howell may I ask a question or two.?

>> MIKE HALE: Yes, Jennifer.

>> FEMALE SPEAKER: My question is is, going back to the MCOs corrective action plans if an MCO is given a corrective action plan will the committee be made aware of it or have a copy of it, to see what they were corrected on?

>> MIKE HALE: The answer to that question is yes. I think that in order for us to be as transparent as possible in the process, when I said we'll have stake holder communication stake holder calls I meant that I think that, any of the information that we have where the MCOs are are, we their performance levels are, the trending we're seeing all of those things are going to be part of the discussions making sure the stakeholders now we're we're doing and proceeding with CHC that would I think, would be included in that, yes.

>> JENNIFER BURNETT: Yeah I also just want make sure people understand that corrective action plans, can be applied instead I state monitoring they can be we can use them during the launch and we can use them, during not -- not during readiness review it's not something that is associated with readiness review it's used throughout the our cycle. As it is today. With providers.

>> MIKE HALE: Right.

>> FEMALE SPEAKER: Follow-up, follow-up question -- and I have I don't know of anything related to the validity it, correct me if I'm wrong, people with a physical disability currently works with the Department of Health human services I'm going through the process of trying to hire people, is there because, all of this, with CHC especially, effect people with disabilities as well as many others and, the fact that the governor has request on the employment of people with disabilities is there a place to look for people with disabilities two hire in those areas , because the leaders in the experts and, people within the disabilities I would say, would be your greatest experts.

>> JENNIFER BURNETT: Jennifer this is -- this is Jen Burnett I'll answer we need to wrap up the meeting is just about over here. OLTL and the Department of Human Services, we employee a number of people with disabilities. Not just in OLTL but in other parts of the Department of

Human Services, there are a number of people with physical disabilities, cognitive and sensory disabilities there are people with disabilities that are in
our, in the Department of Human Services.
As far as any kind of push we have, in order to move
further on the pendulum hiring people with disabilities that's
absolutely true we have civil service requirements we are a civil
service agency any applicant for any of our positions would have
to go through the civil service testing for each of the types of
positions and we've got a lot of different position types
primarily it's human service program specialist and the supervisors.
That's for the -- at least for the ongoing monitoring.
And that is the model that the office of medical assistance
programs is using in the over sight of the HealthChoices program,
it's worked very well for them.
But the governor has also authorized an employment first
committee that's part of the governor's cabinet for people with
disabilities and in order to address the states, the actual
Commonwealth, hiring more people with disabilities, the secretary
of the administration which is where our hiring and interface
with the Civil Service Commission, happens, is on that committee
and this is something that is very much known to them, that we
want to make be able to open the door for women with disabilities
to get employed in state government I will tell you that, at the
Federal government level, there is schedule A and, schedule A,
allows any person with a disability to bypass what is I guess
what you could call the Federal civil service process it's not
called civil service they do have, testing as well.
So people with disabilities, if they have a physical or any
kind of disability, they can bypass the requirements to go
through for example, USA jobs they don't have to do that they can
just go get on schedule A there's some forms that are filled out
to get on there.
That's not a model that the State has.
But it's a model we are looking at to see how that something
like that could be implemented here but we're nowhere near to
getting to that I would urge you advocate if you want to see
movement on that, with the secretary of administration.
Her name is Sharon Minnich you can look her up on the
governor's web site.
So thank you for that
>> FEMALE SPEAKER: Okay.
Thank you.
>> JENNIFER BURNETT: With that I think the meeting is is
over.
>> FRED HESS: I'm afraid we do not have time for questions
from the audience meeting adjourned.

>> JENNIFER BURNETT: If people in the audience have questions please send them into our -- we'll look at email questions and bring them forward here Marilyn where should they send those?

Send them to the RA account.

RA- -- on the agenda, at the bottom agenda

[meeting concluded at 1:00]