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EVENT: MLTSSS.

>> CAPTIONER: (on standby.)

>> FRED: Everybody, we are getting ready to start so have a seat.

Good morning, everyone. We have things to run through quick. I have the housekeeping rules. Please, remember professional language. We are not cussing in here. Direct comments to the chairman, which today will be me.

Wait until called on and keep comments to two minutes.

The meeting minutes are posted on listserv. Under the meeting minutes. The documents are posted within a few days of the meeting.

The captionist is documenting the discussion so please speak clearly and slowly. Turn your cell phones off on or about mute. Remember, when we leave, clean up all of your trash and throw it away. We are not animals, here.

Public comments will be heard at the end.

Evacuation procedures are as follows:

In the event of an emergency or evacuation we will proceed to the assess by area left of Zion church on the corner of Fourth and Market. If you require assistance, wait outside of the main doors of the honors suite. OLTL staff will be there to assist you. Wait until you are told you may go back or you are evacuated.

Everyone must exit building. Take your belongings with you and do not operate your cell phones.

Do not use elevators. They will be locked down anyway. You cannot.

Use stair one and two. For 1, exit this door, turn right and go down the hallway by water fountain. The staircase is on the left.

Exit 2, leave honor suite by the side doors or back doors. For those exiting side doors, turn left and stair 2 is directly in front of you for those exiting back door turn left and left again, and you will see stairs directly ahead.

Keep to the inside of the stairwell and merge to the outside. Turn left and walk down Dewberry alley. Turn left and turn left to Blackberry to train station.

If you can remember that, you have a better memory than me.

I am just going to actually run!

[LAUGHTER]

Is Jonathan and Joan --

>> PAT: Can you take attendance?

>> FRED: I'm sorry. Let's go ahead and start.

>> Good morning, Barb Polzer, Liberty Community Connections.

>> Jim Fetzner --

>> Blair Boroch, United Healthcare.

>> Good morning, Jack Kane.

>> Bill White, AARP.

>> Bob Theil, here for Pam.

>> Michael Hale, here for Jen Burnett.

>> Fred Hess, Disability Options Network.

>> Steve Williamson, Blair Senior Services.

>> Drew Nagele.

>> Ray Prushnok.

>> Jesse Wilderman, SCU healthcare.

>> Arsen Ustayev, from senior care.

>> MIKE: We will tell Jen everything went smoothly.

[LAUGHTER]

How about that weather?

It's about time!

[LAUGHTER]

Russ is here. We can start now.

>> PAT: We were waiting for Russ.

>> RUSS: Always hazed.

>> MIKE: Can folks on the phone hear me?

>> Yes.

>> Yes.

>> MIKE: Can we find out who is on the phone, please?

>> Tanya Teglo.

>> Brenda Dare.

>> Theo Braddy.

>> FRED: Right now, I would like to introduce, Jonathan Bowman and Joan Bradbury from the LIFE program.

>> JONATHAN: All right. Good morning.

All right. There we are.

All right. Thank you, everyone, for the opportunity to be here. My name is Jonathan Bowman. I am the program manager of the LIFE program with the office of long-term living.

>> Joan Bradbury representing the LIFE alliance, which is association for LIFE providers for the program.

>> JONATHAN: Today we will be talking to you about today's LIFE program. If we could go to the next slide.

Just real quick, I will go through the agenda. Brief history of the program, how it works, go through a couple facts about the program and then eligibility and services. We are, actually, going to see a

participant testimony, and then talk about how LIFE will work with Community HealthChoices.

Just a little bit about the history of the LIFE program in Pennsylvania. The program started in Pennsylvania in 1998. So we are coming up on 20 years. The program is called LIFE in Pennsylvania. It is based on the national PACE model, which is an all-inclusive model for elderly. We refer to it as LIFE program or living independence for elderly, because at the time of implementation, the PACE pharmaceutical program already existed.

So the Office of Long-Term Living provides long-term services and supports to qualified older Pennsylvanians and through a number of services. Today we are just going to focus on the LIFE program in this presentation.

The LIFE managed model of care is a managed care model for the frail elderly in Pennsylvania. The program integrates both Medicare and Medicaid funding through monthly capitation payments to providers. The program serves 95% dual eligible individuals and our LIFE providers receive capitated monthly payment from both Medicare and Medicaid for serving the participants.

It is a risk-based model. The money that the provider receives on a monthly basis is used to keep the participants in their home and served safely for as long as possible. The program does include nursing facility services, if an individual does progress to needing 24/7 care.

The LIFE program is also responsible for coordinating and managing all of the participant's personal and healthcare needs.

The program offers alternative to nursing care facilities services by fostering an environment where an individual can live safely in the community.

In addition, it does provide cost savings to both Medicare and Medicaid over what it would traditionally cost to meet the individual's needs in another long-term care setting.

In Medicaid individuals who are eligible for the LIFE program, can enroll for services through a LIFE program at no out-of-pocket expense.

Next slide.

So this slide shows some of the services that are offered through the LIFE model. The program is responsible for providing the following benefits:

Acute care services such as hospitalization, doctor's visits, long-term care services such as home and community-based services, personal assistance services, up to and including nursing facility services, pharmaceutical drug benefits.

It does include behavioral health services, social and community services and transportation. Transportation is the key aspect of the program. Individuals are picked up at their home and brought to an adult day health center where they receive many of their services and they are taken then from the center back to their home.

Again, the goal of the program is to enable older adults to live independently in their home for as long as possible.

So here is the -- this slide shows the eligibility for the program. In order to qualify for this program, you have to be age 55 and older. You have to be determined nursing facility clinically eligible. This is done by the AAA using level of care determination. You have to be determined financially eligible or able to private pay.

The financial eligibility is done by the local county assistance office.

You have to be able to reside calf in the community at the time of enrollment that determination is made by the LIFE program, and you have to live in an area that is served by a LIFE provider.

So the next slide shows the --

>> FRED: I have one quick question. Can you tell us what areas are not covered?

>> JONATHAN: Sure.

[LAUGHTER]

If you look behind you, there is a map of Pennsylvania. This map shows the areas that are currently served. The areas shaded in blue are those counties where LIFE services are available. The counties in red, or it says coral up there, are the areas where we are currently in the process of developing LIFE programs. The counties that are, I guess, shaded are areas that have been assigned to providers, but we are not currently developing those areas. We are looking to do that in the future.

The counties that are blank have no color, are areas that we are still trying to figure out, moving forward, how to get LIFE services to those areas.

By next calendar year, we are looking to have LIFE services available in 42 counties across the state, which is about 63%.

Nationally, we are one of the largest, if not the largest LIFE program across the nation. We serve 6,000 individuals in the program and we have the 19 providers offering services in about 40 centers across the state.

I am going to turn the next section of the presentation over to Joan. She will talk more about the specifics of the services offered.

>> POLYCOM: The conference has been muted.

>> JOAN: That's because I was going to talk.

>> That's right.

>> PAT: You should be good.

>> JOAN: Well, thank you so much, again, for giving us the opportunity to talk about and highlight the LIFE program, especially as we talk about Community HealthChoices and managed care models for long-term services and supports.

Jonathan and I will bring it back to that at the end of the presentation. As we continue to talk about that and those questions are percolating in your mind, we will hopefully answer those by the end of our presentation today.

I have it set to -- just click -- yep, thank you.

So say taking a look, Jonathan went through eligibility for the program. I want to step everybody through it to talk more.

Essentially, we have a senior who is living in the community. We always get chuckles when we talk about the eligibility of 55 or older for the LIFE program.

Being that most folks who are 55 would not consider themselves seniors, however, it is important to note given some of the changes of population of adults we see around mental health mental illness it is helping the program we have them at 55 you catch folks at the younger/older document phase and help start providing services as they age.

Folks eligible for the program clinical is age 55 or older. You would otherwise be eligible for services provided as Jonathan said in nursing facility setting you are what we call FCE facility clinically eligible. The individual must be able to reside safely in the

community.

In addition, again, we have folks in our program, the majority of which are Medicare and Medicaid eligible we call those dual eligible. We have a high percentage of those who are MA only. Very small percentage of population that pay privately for the program.

So you have those two combinations, those two equations and you would be eligible for the LIFE program.

So, essentially, we call the LIFE program, the best home and community-based service model. You have a participant who is living safely at home in the Community, more often than not independently with informal supports in terms of family members and caregivers that live with them.

The LIFE program allows you to live in the setting of your own home but be wrapped around with services in the community.

I want to go more in depth about some of the services that our providers offer.

If you take a look at this info-graphic, this comes from materials that we put together as the association. Really highlighting a lot of the services that Jonathan already mentioned, but the important thing is because it is a capitated rate, because this is essentially managed care model, home and community based, provider based, the provider has the flexibility to through their capitated payment, be able to provide the consumer with exactly what they need.

So it is completely person-centered.

So the individual living in the community may need therapies or rehab services with interactional programs. Our priors are licensed as adult day programs. Those centers have a healthcare component to them.

If I am living in the community and I want some socialization throughout the day, but I also need to see my doctor, and I probably should see my optometrist this week too. I really fell about a month ago and I probably need to continue with my personal therapy, I could go to the LIFE day program, a couple times a week, as often as I would like or as often as is needed for my care plan and receive all of those services in one location.

The important thing to keep in mind too, we always talk about socialization for seniors and the importance of that. The importance of services particularly to folks with early onset of Alzheimer's or dementia diagnosis.

It's important to keep in mind, especially we talk about this all of the time with the LIFE program if you are a senior now but somebody who spent your whole life at home independent, by yourself, reading a book and it is not your thing to sit with 50 other people during the day and socialize with others, then you don't have to do that.

So it's really about the fact that we make this person-centered. We are able to focus the services and needs around the individual. It's really about who they are and what they need and want.

In many cases, we have all different types of folks in terms of when they come to the center locations, how often, how infrequently. It really depends on their personal needs.

Other services that are provided both in the actual day program of the LIFE center are personal care services, bathing, grooming, laundry care. We have meal prep, warm meals during the day. Meals can be delivered at home to the individual.

All of these services can both be provided at the program during the day or wrap around at home to the individual at night.

It's important to keep in mind too that transportation, as Jonathan mentioned, is one of the biggest concerns we have with folks being isolated, especially as they age in the community, as well as being able to get to the actual services that they need.

So transportation services are covered by the LIFE program as well. What that also means is, if I am going to the day program at some point during the week, but I need help getting up in the morning and getting showered, dressed, ready, fast, taking meds. Somebody can help get you ready in the morning, transportation from program will pick you up, take you to the day center, you could have your meals, all of your programming, all of your services there throughout the day and you wind up being taken back home at night.

I want to spend time talking about different ways LIFE providers provide housing needs. One thing as we continue to talk about the importance of home and community-based services without the home.

How do we address the need with our specific LIFE participants?

Given this issue of housing -- many LIFE providers community partnerships. In one of the ways they do that is through affordable housing needs.

So either our providers might be engaged through their actual organization in providing housing be it they are connected like Portland

others who found ways to partner with local housing providers try to figure out ways to keep folks in the community but give them that ability to live there as well as assist with the nursing home transition program.

A year ago we had a consumer that was -- talked about having been on the waiver previously she wound up in a nursing home at one time and wanted to transition back into the community and through the nursing home transition program she was able to do that because our LIFE provider had worked with the local and had a partnership with one of the nursing home transition providers. They were able to work together to transition her into a safe home in the community but then also she was eligible to enroll in the LIFE program and immediately wrap her with services in the community.

We have other providers working on community partnerships in many ways there are partnerships colocated with public housing buildings or HUD high rises.

We have others that provide services to housing communities in the local area so that could be transportation services, that could be going into any of it those local housing units preventive services we are building that relationship with individuals and one day they may become eligible for the LIFE program and they are supporting them in the community and building that partnership.

And then, again, other partnerships in terms of public housing authority HUD arrangements nursing home transition program.

We wanted to take a minute in preparation for Community HealthChoices. Some of providers in the southwest which is first as we all know implementation phase of Community HealthChoices.

Some of our providers in that area have gotten together and working on a lot of their marketing efforts.

Manage we are able to talk about LIFE about one included participant currently served in LIFE programs.

We wanted to share portion of the video with you today to hear a participant testimony about LIFE.

(Video)

>> We want to talk to you now because you are the participant. So you have been able to benefit from all of this wonderful stuff. Tell us what this has done for you to be able to go to the daycare.

>> It has been wonderful. I was in a very bad depression. I got involved in it. It brought my life back. It helped my family. I am in a private home. It's individual homes -- LIFE has been so good. They have so many programs. Sometimes you can't do all of the programs in the time you are there.

>> What is your favorite?

>> I like chorus. I don't have a good voice.

They play games, exercises and we have religious programs and crafts. Oh, all kind of things to keep you busy every day. There is always something going on.

>> That has helped you emotionally physically everything.

>> I would recommend it to anybody if in need of help.

>> I could have stayed with my family but then I was disrupting their life. I just felt that it was more important -- they are all satisfied.

>> Great to see the benefit of what you are able to do.

Mark and Martha, thank you so much; that does it for the show today.

If would you like to know more about the LIFE programs of central Pennsylvania, go to lifeprogramspa.com.

>> JOAN: It's really wonderful to hear from a participant. One of the things I find myself talking about a lot when we talk publicly about the program and share information provide education is that truly if the LIFE program is working the participant has no idea how to describe it.

Being able to have Martha talking about personally what the experience has been for her and her family is kind of the best type of testimony we can get from folks. Otherwise, it's the provider completely managing all of the care and services. You don't have family members having to make phone calls individually to different physicians and set up transportation and figure out ways that they can get off work to be there with mom at her appointment. All of that happens by the provider and their ability to coordinate those services seamlessly.

It's wonderful to be able to hear from a current participant who has experienced -- had such a great experience with the program and as well as for her family.

We want to transition a little bit to be able to make the connection with all of you about the LIFE program and Community HealthChoices.

>> JONATHAN: I just wanted to wrap up here and talk about moving forward, how the LIFE program is going to work and the future of the program.

So the LIFE program, as Community HealthChoices rolls out, will continue to be an option for individuals who are eligible for the program in areas where the program is offered for individuals who are clinically eligible and age 55 and older.

Any transition information that Community HealthChoices individuals would receive could be made available that the LIFE may be an option for them as well.

The independent enrollment broker will be supporting LIFE enrollment. An individual contacted the independent enrollment broker, they can receive education on the LIFE program enrollment options for the program if it's an option for them where they reside.

Any future outreach and education efforts are also going to discuss the LIFE program and just want to keep making individuals aware that the LIFE program will continue to be an option here a loaning side of Community HealthChoices.

So next slide.

Here is just some information if you would like more information on the program you can search the department's website key word LIFE. PaALPA has a site coming soon.

>> JOAN: Our new website would be coming soon with a zip code search. Because it's not statewide it's important that often folks have the question of whether it's available in their area. Coming soon you just type in zip code and you will be able to reach out to someone directly.

>> JONATHAN: The national PACE association have informative website CMS centers for Medicare services, which is federally regulated, they have a lot of information on their website.

Just contact information for myself or Jim.

Any questions?

>> FRED: Yes. I have three quick.

How much is self-pay or does it vary?

>> JONATHAN: The self-pay is based on the Medicaid rate for individuals. It can vary but it's based on the Medicaid rate.

>> FRED: Okay. Now you're partnered with several people. Are you partnered with CILs or are you partnered with other types of community organizations such as CILs? Centers for Independent Living.

>> JONATHAN: We are the oversight agency for the providers across the state, there are 19 of them. The individual LIFE providers can set up their network and work with whomever they like. I don't know specifically if any do currently. In the future, there is opportunity for partnering with CILs. The federal government recently proposed moving toward -- they released PACE individual Act who may allow individuals under 55 do be served in a similar program.

>> FRED: Excellent.

>> JONATHAN: Pennsylvania is interested and has commented on the PACE innovation Act.

>> I have a question.

>> FRED: Is there anything in your program that is mandatory for participants for anybody? Absolutely mandatory?

>> JONATHAN: As far as mandatory service, the service package is identified through an inter-disciplinary approach. So the LIFE program has a team of professionals that will meet and they can meet with a participant and family member to develop a service plan for that individual and determine what the individual needs.

As I mentioned before, acute care benefits, long-term care benefits, pharmacy, behavioral health, transportation, they are all included in the program. They are all included in the rates that are paid to the providers. If any of those services are needed and identified by the inter disciplinary team they would be mandatory services.

There are appeal rights and everything that we can get involved if there is, like, a service denial or if anyone wants additional services, the state does get involved.

>> FRED: One second, Drew. We had a question on the phone?

>> PAT: Brenda also has a question.

>> THEO: Are you accepting any additional LIFE providers in the

network, if so, how would you go about doing that?

>> JONATHAN: Can you be a little more specific about -- what do you mean by the network?

>> THEO: Are you increasing your providers in the LIFE network.

>> JONATHAN: Moving forward we would be open to that as we move into additional counties. We have had a lot of interest from our current LIFE providers we currently have 19 LIFE providers we have had interest from those same 19 providers in expanding into the other counties of the state.

We would certainly be open to hearing from any other outside organizations if they would, you know, want to establish a program in Pennsylvania.

>> THEO: Okay. So that person would call the 772-1145?

>> JONATHAN: Yes, they could, yeah.

>> THEO: Thank you.

>> FRED: Brenda, you had a question?

>> BRENDA: Yes. Early in the slides you mentioned one of the criteria to be eligible for LIFE is a person be able to reside calf in the community. Can you tell me what criteria is used to make the determination and what appeal rights there are if not deemed safe?

>> JONATHAN: Sure. Those criteria are outlined in each provider's program enrollment agreement. They do differ between each of the providers. The -- basically, what the LIFE provider wants to do is, make sure when an individual enrolls in their program that nursing home or nursing facility placement not eminent.

They are going into the home to assess the individual and make sure that they can serve them safely in the community.

If anybody is denied enrollment into the program for something such as, you know, deemed not safe to serve in the community, those denials come right to the department and we see those denials and get involved if we need to.

>> JOAN: Brenda, the only thing I would add to that is our providers, also, through your networks and local services help to provide modest home modifications. If there are simple needs the individual has within their current home, it certainly behooves the provider to work together to try to support those needs to keep them

safely there, exactly because of the point that you mentioned, that folks need to be able to remain living in the community safely.

So it's important that the provider continue to help them be safe.

>> BRENDA: Exactly. The testimony you presented is wonderful. Somebody with outside family support a lot of the seniors we work with don't have that. I was wondering how often people are found unsafe because they don't have family that lives with them or a caregiver that is with them full-time.

>> JOAN: One of the benefits of the program is truly the LIFE program are constantly with or touching that individual. Either in seeing them and bringing them to the day program or providing those care services at home.

So really they are acting as if they were those in-home supports and those family members.

>> BRENDA: Okay. Thank you.

>> JOAN: Absolutely.

>> DREW: The program really.

>> TANYA: I have a couple questions. Is it okay if I ask them?

>> FRED: Yeah, go ahead.

>> TANYA: One of the concerns that jumped into my mind as we convert over to Community HealthChoices is that the LIFE program only works with specific providers right now. Correct? Like they have to be designated providers through the LIFE program, I have that right. Correct?

When we switch over to CHC, assuming that number of providers is going to be further limited, how are you guys at LIFE planning on handling that challenge?

>> JOAN: Tanya, one of the things I think you may be touching on is about network adequacy and a lot of the concerns that have been raised at this SubMAAC previously about having an adequate number as well as type of providers to support members move forward with Community HealthChoices making sure that the managed care organizations have adequate provider networks.

It's a little different when we talk about the LIFE program. Our LIFE providers will not change or reduce with Community HealthChoices.

In fact, moving forward, the state is working with us to focus on the LIFE program being available to more individuals across the state by opening up more territories for the program to be provided; however --

>> TANYA: How are you guys making that happen? How did you set it up so that you actually can provide more services under CHC than what you are currently?

>> JOAN: Essentially, there is a procurement process that our providers go through with the Commonwealth when they are interested in a new territory of the state. Recently, there were a couple counties that were awarded to our existing LIFE providers to begin offering LIFE program services and open them up in new counties it is ongoing in the state. As the state and our organization together have been working together to identify those areas across the Commonwealth where there are significant populations of eligible individuals for the program, making sure that the program is an available option to folks living in that area.

The key right now is to make sure that the program is available to folks in every county within the southwest Community HealthChoices implementation; that's really what we are focusing on now to make sure that the one and a half counties since half of Somerset is currently served.

It would be the remainder of Somerset and Bedford county are the last counties that the LIFE program will be in by the time it is Community HealthChoices is implemented.

>> TANYA: When that happens will you be able statewide?

>> JOAN: Moving forward that would allow LIFE program to be an option for southwest region for CHC implementation.

The next section is to be prepared for southeast implementation.

Awards were recently made for Montgomery County and Chester County will be out for bid in the near future.

Once those two counties have been awarded LIFE programs are up and run the entire southeast will have the LIFE program at the same time we have community health choices implementation.

>> TANYA: Are there any concerns or challenges that you guys have with this MCO transition? How could we as a subcommittee help you address those challenges for the betterment of the program.

>> JOAN: That's a wonderful question, Tanya! Thank you. That's

great! I appreciate that!

I think Pam, one of our co-chairs is one of our LIFE providers, having her participation on the SubMAAC has been helpful.

The most important thing is really sharing the education and awareness about the program.

One of the most difficult things about LIFE is figuring out a way to talk about it so that people understand how it works and that they can share the information with friends, families, caregivers and the community.

From my perspective, on behalf of the association, I think the number 1 thing is, remembering to continue to talk about the LIFE program every time we talk about Community HealthChoices. It will continue to remain an option for folks who are eligible and it will be able to be that option for folks in those implementation zones.

I really appreciate that question, Tanya. It's important that we continue to talk about it as we talk about Community HealthChoices and develop CHC.

>> TANYA: One last question. How do financial constraints inhibit you from being able to service other populations of people you might know need the services in the State of Pennsylvania that cannot get them?

How close are you to being able to service the state population in full? What could be done to help eliminate that problem?

>> JONATHAN: So the program is financially vie annual for the state when we set our rates we look at what it would otherwise cost to serve a person in another long-term care setting.

This program is cost effective for us.

Moving forward in offering services throughout the state, this isn't an overnight opening where we can offer services in Center County next month or six months from now.

We go through a process where we identify interested providers and then we, essentially, do as Joe mentioned, a competitive bid where we ask for applications to come in and get a group of experts within a department to review the applications and select an applicant to then go ahead and offer life services in the county.

They have to go through -- they have to offer an adult health center facility so they have to go through that process of identifying

property and building.

Really, this is an 18-month possibly 24-month time line before services become available to any given area, which is why we are looking at that now. We want to identify areas where we have interest for LIFE programs to expand across the state and hopefully have them available in the future.

We do have -- we have had expressed interest for many of the remaining counties. It is promising and it would be our goal to have services available statewide.

>> FRED: Is that all Tanya?

>> TANYA: Yes. Thank you.

>> DREW: Thanks. The program really sounds great and a great idea for keeping people in their homes in the community.

If I could meet the eligibility requirements, I would sign up with you now before I left it sounds so good, especially the choir!!

How does the program deal with some of the more common diseases found in aging such as cancer or -- my own mother-in-law for example who is 89 would have been a great candidate for the program. She has Parkinson's disease with dementia. I could see her being served by this program, but then, as the disease has progressed over the last year or so, you know, it's the disease process that made her unstable in walking and then she had a series of falls one of the falls she sustained a brain injury and was never able to come back after that.

How would your program deal with that? You can't keep serving that person. Right?

>> JONATHAN: So that's an excellent question. This program is an all-inclusive program. Any services that an individual needs would be covered by this program. The LIFE program if they don't have oncologist keep providing services to those individuals.

Whatever services the individual needs to keep them served safely, they will do.

In some instances, I think the program is at around 7% right now who receive 24/7 care in a nursing facility. Each of our LIFE providers need nursing facility network if an individual needs 24/7 care in institutional care setting they will contract or somewhere associated with nursing facility.

For the majority, 93% of individuals they are able to serve them

safely in the community. They will contract with specialists, with providers take them to whatever services they need to deal with any conditions that individuals have. A lot of our centers are having memory impaired units where they can take individuals to maybe a less-crowded area of the building for a more calming effect to get all of the hustle and bustle to get them away and into a relaxed environment.

They can deal with any diseases or conditions that may develop as they age.

>> DREW: Just one follow-up. What if a person needed kidney transplant or heart transplant?

>> JONATHAN: I believe we just have done one. Yeah. One of our providers has just successfully done a kidney transplant.

>> DREW: When a high-cost provider is needed, what does it do to your overall program viability financially?

>> JONATHAN: That is kind of the whole concept of the capitation model. I mentioned before, this is a risk-based model. The provider has an incentive to identify services that are needed for certain populations.

If there is any cost savings that they can set aside from the rates that were paid to an individual that needs less services, they can kind of risk pull or pull the Medicare Medicaid together for instances where there is a much higher cost individual they can tap into the funding to pay for those services.

>> JOAN: One thing I wanted to add, Drew, first and foremost I am sorry to hear about your mother-in-law, also that in a lot of the services Jonathan discussed, the interdisciplinary team of the social worker, the physician, the specialists, the care coordination the transportation driver, all of those folks meet on a daily basis within each of our programs, so they constantly all know about the changing needs of their participants.

So there is never a case where you don't know what is going on with your mother-in-law, don't know she has fallen or if someone wound up overnight had to have an emergency acute care need that the team is constantly in communication about those things, literally, on a daily basis to be able to change the needs to be able to continue to keep them safe.

>> DREW: I am sold on the program. I have friends who are therapists and work in the program. I think what they do is just

terrific. I just don't understand the financial viability of the model if you start caring for someone when they are 55 and, you know, my mother-in-law is still living. She could live for another 10 years. She could live -- she is getting good care now.

For 35 years through Catastrophic illness and nursing home costs, I mean, I guess the program has been around for a while. So I am interested in, you know, as you care longer for sicker people, what that does to the viability of the program? I can connect you. The program has been in existence in Pennsylvania since 1998 and has done nothing but continue to grow. Certainly our providers have found ways to make it work and we continue to serve more and more folks year after year.

>> ARSEN: Do you have to stay there until you disenroll yourself?

>> JONATHAN: Great question.

You don't have to remain in the program. It's a voluntary option. Enrollment is on the first of the month and every month you have the option to disenroll from the program into another service option.

There are select instances where provider can disenroll you from the program, it's called involuntary disenrollment that is kind of few and far between. Every one of those that happens, the state gets involved in and we look at the case and it has to go through an impartial third party -- it's kind of a long process to justify the disenrollment just an example of where that would happen is, like service plan non-compliance where the visit needs some type of service or therapy or medication to keep them served safely and they are non-compliant and it's putting the provider at risk.

>> JOAN: I will add to that. Top two things that we see are family members move to a different place and that would be a cause for -- the individual decides to leave the program and they want to stay close to their family and they are relocating. Another thing, death. People die and given how long the program has been in existence we have seen a large increase of the folks that have been in the program for almost 20 years.

>> ARSEN: So then, in essence, a provider cannot just discharge someone because the costs are becoming too high to provide care for them. Correct?

>> FRED: We need to wrap it up. If anyone has other questions for Jon or Joan, get ahold of them. You can get their contact information behind me.

Susan, are you ready?

>> SUSAN: Good morning. Thank you for inviting me to talk about the CAHPS home and community-based services survey. I am Susan Raetzman. Truven developed the survey as well as the measures you will be hearing more about.

As you've previously discussed, consumer surveys are a key component of the quality strategy. Such surveys are best used in conjunction with other methods to generate a full assessment of product quality.

The HCBS survey elicits direct feedback on outcomes and quality of life as a result of receiving Medicaid HCBS services and supports.

What distinguishes this survey from other surveys is that it was designed to be completed by broad range programs. This includes individuals who are frail elderly, people with physical disabilities, people with intellectual or developmental availability, individuals with brain injury as well as individuals with a serious mental illness.

The survey was designed to be as accessible as possible to all of those people, including beneficiaries with cognitive and intellectual challenges.

I will highlight some of those features that make it accessible as we go along.

Next slide?

Most of us are familiar with satisfaction questions. An important difference between satisfaction questions and experience of care questions is experience of care focuses on aspects of the care delivery process and aspects of the provider's behavior. It helps tell the "why" about whether something is going good or bad.

It produces information to be acted on to improve quality.

Focusing on this is important because of the most recent HCBS rule requiring programs to move towards person centeredness, which was built into the survey development process.

I will talk to you more about that as we go along.

Next slide, please.

The entire development and testing process, which began in 2010 was funded by CMS under two different projects, the most recent being the Tuft grant. It is rigorous and beneficiary involved. This diagram

outlines the three major phases. It began with informative research stage to identify at the time key domains and concepts that the survey should deal with.

This stage included both one-on-one interviews as well as focus groups with individuals in the programs to learn what was most important to them when they receive home and community-based services.

In Phase II, survey development continued with multiple iteration of cognitive testing in both English and Spanish. It was field tested and pilot tested.

Phase III the data from the pilot and field receives tests were analyzed to determine which items worked, which ones didn't and the survey was finalized.

It received the CAHPS trade park last summer. CMS and team submitted to national quality forum they were endorsed.

The survey and measures are now being provided by CMS as a voluntary tool.

In all phases of the development process, there was a technical expert panel that provided guidance. It was made up of beneficiaries, program staff, survey methodologists, representatives from advocacy organizations as well as national associations such as Medicaid directors, state directors of developmental disability services, state united for aging and disabilities, state mental health program directors, as well as the state head injury administrators.

This slide shows the states where the survey was field tested and pilot tested. There were over 3200 individuals who took the survey in 10 states and 26 programs, using both fee-for-service as well as managed long-term services and supports.

So geographically it is east New Hampshire, Georgia, Maryland west side is Arizona, Colorado, kind of circling down through the middle, Minnesota, Kentucky and then Tennessee and Louisiana were either -- well, they were pilot states.

Next slide, please.

This slide shows that among those pilot states and field test states there were beneficiaries from up to 4 HCBS programs in each of the states.

The columns are the different programs.

There were a couple states that actually had four different

programs being tested. All of them are represented. So I guess that's the main point of that slide.

Next slide, please.

This table provides information on the Respondents in that test. Again, of the -- there were about 3200 total people who took the survey we used about 3,000 of the completed surveys because they met the requirements of what CAHPS complete survey.

This slide shows information about proxies.

The field test did not start out allowing proxies because it was consistent with the CAHPS rules.

Because of the challenges vendors were having in terms of getting participation -- particularly with individuals who had guardians, we relaxed the rules and included proxies or individuals that could help respondents complete the survey.

So the third column of this table shows that there were about 700 proxies, which accounted for almost 1/4 of the total surveys analyzed.

You can see if you look at the different rows, that there is a range and number of participants in each disability group who were included in the test.

Smallest was about 230 for individuals with a brain injury and closer to 1200 for individuals who are frail elderly.

Next slide please?

The focus of the survey is on the most common services and support providers across the Medicaid HCBS authorities and programs.

These are personal assistance, four in the case of programs serving individuals with serious mental illness, behavioral health staff cue individuals for activities that they want to participate in, home makers is another category of provider, case managers and medical transportation providers.

The survey questions asked for feedback about the specific types of providers and the services that they deliver. We will look at some of the questions in a minute. They actually refer to that type of provider and when possible specific individual.

So when we were developing the survey, we knew that there were very few uniform names across the country for programs and for providers as well.

For example, Pennsylvania uses the term service coordinator instead of case managers, as I understand it.

The survey was designed so that survey sponsors could incorporate terms that are specific to the program when they are talking about categories of staff and when the interviewer is conducting the interview, they can actually insert providers specific names that the individual says that they call the staff who help them.

The preferred terms can be used throughout the survey and on the screen, the areas that are bracketed, that is where the interviewer would know to read out the specific term because they would be using a software, interviewing software that would have inserted that term once it was introduced at the beginning of the interview.

Next slide, please.

The survey items provide information about specific domains of the HCBS experience. I don't know if you can see it on the slide so I will read it out quickly at the top.

Whether staff are reliable and helpful, staff listen and communicate well, whether case manager is helpful.

There is also a series of questions about choosing the services that matter to you. There is a category of questions about transportation to medical appointments.

Also unmet needs, person safety and planning activities, which is really about community involvement and integration.

These are also the topics of the 19 measures derived from the survey and endorsed by NQF.

Next slide please?

In total, the survey instrument actually has 81 separate questions, plus demographic questions and interviewer questions.

However, because not everyone answers every question the average time to take the survey is about 30 minutes.

It was designed to be administered by an interviewer either over the phone or in person. The pilot in the field test results supported both modes as appropriate ways to administer the survey, which is very important because offering both options does improve the overall response rates.

In order to make the survey as accessible as possible for

individuals with cognitive or intellectual disability an alternate response scale is offered, I will show you that in a couple slides.

And unlike the field test and pilot test, CMS is allowing proxy responsibilities for future uses of this survey.

In that case, a proxy would answer the questions in place of the beneficiary. If the beneficiary is not capable of responding and we have been advising people to consider when thinking about who a proxy might be, that it be someone familiar with the care that is delivered and in regular contact with the participant.

This is, ultimately, the survey sponsor's decision about how they want to structure that.

Next slide, please?

So as I said, not all Respondents will answer every question. It depends in part on what services they receive; that's based on some questions that are asked at the very beginning of the survey to identify the services that they receive and then it's possible for the survey to skip to those questions dealing with those services.

The survey also skips among questions based on how an individual responds to some initial questions.

So, for example, on this slide, you will see that there is a set of questions focused on whether the individual goes with or without bathing -- I'm sorry. Without help in bathing or getting dressed because there is not a personal assistant staff person to help them.

So the very first question, number 16, basically asks whether the person needs help with getting bathed or showered or dressed.

If the person says, No, they skip all of the rest of the questions and go on to an item about personal privacy.

If the beneficiary says, Yes, that they do need help with that activity, then the survey goes on to ask additional questions about unmet needs in that area.

Next slide, please.

I would like to provide for information about participation particularly alternate response.

So what we found out during the cognitive testing, as well as other parts of the survey development was a simplified response option made the survey more accessible to some individuals.

So as shown in the slide, the ideas that the interviewer would start with reading the standard CAHPS responses. These, oftentimes, are never, sometimes, usually or always.

If the Respondent has difficulty using that particular question in response format the interviewer can ask alternate version, in this case is mostly yes or mostly no?

If the interviewer finds that they have -- they do this with three questions in a row, then they just decide to use the alternate response throughout the rest of the survey.

The survey has a supplemental model related to employment services.

Although assistance not offered across all programs the expert panel encouraged inclusion of these items because they are so important for full community participation especially for working-aged individuals served by the program.

This slide shows an example of questions from that supplement about the beneficiary's experience about employment services.

Next slide please?

This slide just illustrates an option for how to present the results at a very high level. The types of results that you can get.

This is showing the global ratings for different -- the three different categories of staff that the survey focuses on the most. And the different colored bars -- or the different clusters of bars are for the different populations. Individuals with physical disabilities or frail elderly, brain injury and so on.

Next slide, please?

And here is another example. These are the composite scores, as well as some global ratings. Again they are ranked from highest to lowest but this is another way in which the results can be portrayed and then, you know, used to inform decisions.

Next slide, please?

So this slide is kind of a recap. As I said before, the survey is provided by CMS as a voluntary tool states and accountable entities such as managed care organizations have the option of using the survey for quality management.

Some of the features are: Person-centeredness in development as

well as how it is used.

The fact you can use survey for a broad range of individuals with disabilities; that means that different programs can be compared because they are using the same instrument.

In addition, the survey facilitates access to all HCBS recipients by phone mode and in-person mode, simple response option as well as the proxy response we talked about.

In alignment with CAHPS means it focuses on issues important to beneficiaries, the CAHPS ensures methods used to develop it are rigorous. Providers do recognize that trademark.

There is still flexibility to add state-specific questions or sponsor-specific questions to the survey.

It doesn't preclude adding to it.

And, for example, in Pennsylvania there is a participant satisfaction survey, which is an example of some questions that could be added.

Next slide slide please.

If are you interested in more information about this tool, there are a couple sources that you can go to either now or in the future.

First under the grant program that I mentioned, there are seven states that now that the survey is developed, they are demonstrating how to use it in their programs and how to use the information from it for a program quality management.

Their experiences, we do expect to be available to learn from in the future.

There is currently a web page at CMS under Medicaid.gov. It has the survey instruments, the core survey, the employment module in both English and Spanish there, as well as some technical assistance -- there is a link to a mailbox. If you go to that website and have questions about the survey, you can use that link and there will be staff that will respond to your questions.

The measures themselves are on the NQF website the number is 2967 if you want to go into it or I can give more information; that's it.

>> MIKE: Questions?

>> SUSAN: I am happy to take questions.

>> DREW: Thanks for your really good presentation. I think it answers a lot of questions that we have had about the tool. I'm particularly glad to hear you address the issue of proxy Respondents being allowed by CMS.

Also, the idea of a simplified response option and the notion that it can be -- the survey is designed to be done in person or on the phone.

These were not clear to us before. Okay?

You did also say that it would be OLTL's decision, I think, as to whether to allow those options; is that correct?

>> SUSAN: It is the survey sponsor's call. CMS is saying that it's an option.

>> DREW: Right. So I think that now that we know those accessibility options are available for the tool, for anybody who has cognitive impairment whether an adult with dementia, a person with acquired brain injury a person with interest elect wall disability, it really becomes a civil rights issue if you use a tool in a manner such that you are not allowing that person to give the information you are really seeking. It becomes imperative that these options be utilized.

>> SUSAN: You might be interested in actually one of the states they have actually already administered it with their programs. One of them was a physical disability group one was frail end elders and one was brain injured.

They actually give them the choice when the recruiters called the participant. They said would you like to have this done over the phone or would you like to do it in person?

Overwhelmingly, they are individuals chose over the phone. It was higher in the elderly and the disabled group. It was about 80% of the brain injury group that chose over the phone.

They have had very good response rates.

>> DREW: That, actually, now concerns me more because it gets at the root of cognitive impairment. If you understand cognitive impairment, you could ask the person and give them that choice and they might say, yes, I would prefer to do it over the phone.

Then, while doing it over the phone, they may or may not be able to remember all of those options that you are giving them for the choices and the person taking down the information wouldn't know that

the person is, actually, not able to consider all of that.

So the mechanism of just giving people a choice is insufficient to deal with the whole issue of cognitive impairment.

>> SUSAN: I hear you.

I know some of the grantees -- well, I think all of the grantees have tried very hard to select vendors that have experience working with the populations. I know it's another mechanism that they have used to try to make sure that they are administering the survey in a way that gets the best input; so that's another option that -- or another way of going forward that might be useful.

>> DREW: I think we have to take this information back to OLTL and really work with it in making those decisions, because there are a lot of decisions here to be made.

>> SUSAN: Yeah.

>> DREW: Thank you.

>> FRED: Thank you, Drew.

>> MIKE: Any other questions for Susan?

>> TANYA: Yes, I have one. Is it okay if I ask it?

>> MIKE: Yes, please.

>> TANYA: My question would be, is this going to replace what service coordinators currently use for surveys when they do monitoring visits?

They have current questionnaires. Is this something that they do -- is this the tool that they use in the future?

My other follow-up question to that was, sort of what was said about the civil rights issue, I guess.

How can we be assured that, like, the state is going to -- or whoever is going to use it will keep all of the very personal questions and information that are available through the survey confidential? Are there, like, protections set up for that?

>> SUSAN: Do you want me to answer my understanding? Wilmarie will correct me if I'm wrong.

>> SUSAN: My understanding is that it doesn't take the place of

monitoring visits.

>> MIKE: That's correct.

>> SUSAN: Those would continue as they do now. This is Wilmarie Gonzalez. I think you are referring to the tool service coordinators are using when visiting consumers; that's another source of way of us to hear directly from participants and this would be another option for them as well.

>> TANYA: Okay. Will we be required to do both?

>> WILMARIE: I think it would be helpful.

One of the things we want to be sure at OLTL that we hear feedback from participants who are receiving services. So you have a couple different ways of telling us that. You have a way to have a conversation with your service coordinator and answer some of the questions that they provide through the PRT tool, the participant review tool.

You also have a way, we are hoping you also have a way with this tool, if this is a tool we adopt, to also share with us your experience of the services you are receiving.

You also have the hotline number you can always pick up and call if you want to share any concern you have with the service you are receiving.

It is another way for us to hear directly from participants, feedback directly from them.

Did that help?

>> TANYA: Okay. Yes.

>> SUSAN: You had a second question about the information that is collected and how it would be protected.

>> TANYA: Yes.

>> SUSAN: Usually, there are agreements ahead of time about who will see the data and the responses and typically, the surveyors are only -- well, there is an understanding of who gets the data; that would really be up to the sponsor.

>> WILMARIE: Absolutely. The information we collect from the vendor who helps us implement the tool in Pennsylvania, it's one of the things we make sure they adhere to that the information is confidential

and protected.

>> TANYA: Okay.

Why I ask that kind of question was because before when we transitioned from different programs and different financial providers and different things in the past the way the information is presented and you had to sign your time cards and task -- depending who the provider was less than dignified for the consumer. I want to ensure that dignity and privacy and protection are always thought of when these surveys are done.

>> WILMARIE: Thank you very much; that's a very good concern.

>> FRED: Any other questions?

[NO RESPONSE]

>> TANYA: You are welcome.

>> FRED: Thank you very much. Let's move on with the OLTL update with Jennifer Burnett.

>> JEN: Good morning, everyone. I want to start out with an update on Community HealthChoices. I also have a few other things that I would like to talk about.

On March -- we were given the green light to move forward on Community HealthChoices approximately two weeks ago.

What that resulted in is, our being able to reach out and communicate with managed care organizations. We held a an all-day implementation meeting with three selected offers managed care organizations which are UPMC, Pennsylvania health and well necessary and -- Fred and others have asked that we invite the managed care organizations to this meeting in the future and I have gone ahead and done that.

I would like to introduce you to representatives from each of the managed care organizations. They are here with us today. We are -- I don't have a lot of time to ask questions today, but what I am looking for is for you to submit questions to me through the research account mailbox over the course of the next couple weeks so that we can share them with the MCOs and they can come prepared for the next meeting in a more -- I think it is more effective use of their time and our time.

With that, I will ask Patty right from Ameri -- to say a few things about their program and their vision of providing Community HealthChoices. Thank you, Patty for being here.

>> PATTY: My name is Patty Wright. I am happy to be here.

I am Ameir health -- I am administrator for CHC contract.

I have vast experience in LTSS. My background is a social worker. I also have members of my team here Kathy Gordan is an RN she joined our team.

>> KATHY: I am a registered nurse LTSS for five and a half years.

I implemented several programs in multiple states. I am looking forward to working with Pennsylvania and with the participants.

>> PATTY: Chris has joined our team as part of our team.

>> CHRIS: Good morning, I just recently joined. I have been in Medicaid managed care since 2008. I have been working together with LTSS program since 2011. In various states Delaware and New Jersey is the latest I had just recently worked over in New Jersey in their LTSS and Medicaid programs.

I do look forward to moving forward.

I am glad we got the green light and are good to go.

>> PATTY: Tiffany just joined our team.

>> TIFFANY: I am LCSW I worked in many states beginning in 2012 and helped implement in New Jersey and most recently was working with participants in the State of Virginia. I am really excited about this opportunity and moving forward.

>> FRED: What is LCSW.

>> TIFFANY: Licensed clinical social worker.

>> PATTY: I am a social worker working in managed care for a long time. I have been working with the LTSS population in multiple states since 2010.

In addition to the team here we have a whole team back at home on the phone with AmeriHealth. We are really excited about this.

We want to reiterate our commitment to both participants as well as provider partnerships.

>> JEN: Thank you, Patty, and your team.

Next I will introduce our member, Ray Prushnok.

>> RAY: I echo the sentiment we are all grade to be moving forward I will ask Jacqueline Smith to come up. First, I will say a couple words.

I worked with aging and long-term living programs about six years ago where I began focusing on our DSNP where I learned more about the response of Medicare and seeing many of the gaps firsthand.

We are really excited for the opportunities of integration and many of these things are low-hanging fruit that require better communication and technology.

It also really looking for strong provider partnerships, continuing a lot of the work that we have done on the PCP and hospital side with value-based and quality-based shared savings types of programs and taking those types of innovations into the LTSS space.

Our RFP and approach is about community collaboration and looking forward to working with the organizations we have been in contact with and getting to know many more of you.

Request me is Jacqueline Smith, who I would like to introduce to the group.

>> JACQUELINE: Good morning, I am new to UPMC, been here a couple months. I have been working in the LTSS space since 1987 with the Star Plus program in Texas; have implemented 15 of these types of programs around the country. I am an RN.

>> JEN: Thank you.

>> RALPH: Thank you very much.

>> JEN: Last but not least is Pennsylvania health and wellness I Welcome Joshua -- to join us at the table.

>> Joshua: Good morning I am Joshua Sloop. I appreciate the opportunity to be here.

I have been with LTSS since 1999 and been part of the implementation across 7 states a few things about Pennsylvania health and wellness we are locally based here in Camp Hill. We are backed by our corporate parent organizations -- which has about 30,000 employees. We serve over 11 million people across 28 states.

A little bit about our philosophy and how we approach things. Two things: Members get services and providers get paid.

That's not something that is original to us. We actually borrowed that from the State of Tennessee. A few of us on the team were part of the launch there in 2010. The State had a very simple but extremely effective approach. Everything that was part of the build, the launch and the maturity of the policeman was measured against are members getting what they need? Are the providers who serve them getting paid?

We plan to implement that. There is a lot of work to be done. Plenty of opportunities to be distracted. So we want to make sure that in all of that work those two things are accomplished.

As far as experience for Pennsylvania health and wellness, we operate in 17 states, specifically for LTSS serving over a little over 200,000 bear currently the largest provider of programs of this type.

Finally, when it comes to community engagement stakeholder engagement, we recognize that the program will not be successful unless we listen to the people that are receiving services, the people that care for those people receiving services and the providers.

While we have significant experience and we have done this in other markets, this is new to Pennsylvania, we do not have all of the answers.

So we firmly believe and we will look to be held accountable to be listeners, to take and apply that information and that's not a once and done. It's not just during go live or the build phase it's throughout the program to that we can continue to evolve.

>> JEN: Thank you very much, Joshua.

As I mentioned, we would like to get questions in before our next meeting and have a time to have much more of a dialogue with the three selected offers.

You have it on your agenda at the bottom where we have the resource account RA-MLTSS@pa.gov put in the subject line MCO.

I hope we get questions in advance so that we can really work with our -- with the MCOs and get them -- give them an opportunity to hear the questions and really think strategically.

As you heard from each of them, there is a whole team back at the ranch, so to speak. They may not have all of the answers, but if they are able to engage with the whole team with questions in advance, I think they will have a much better, Morrow bust answers for you.

I did mention that on March 30th we hosted all of the MCOs, who brought five of their staff representatives to the meeting. We had about 15 people.

In addition to that we had a bunch of Office of Long-Term Living staff there.

We spent time discussing our communications process and what kind of communications are coming down the road. We talked about the rates and the agreement negotiations and what we are going to do in that space.

We also had our actuary come and do a two-hour presentation on how the rates are set and what goes into the rate-setting process.

We did a brief presentation on readiness review. It was high-level. Tomorrow we are hosting them again to really dive deep on what we will do about readiness review and introducing them to the readiness review team to start having that relationship and working together.

We discussed our waiver, the Community HealthChoices waiver application and the submission of that waiver with the time frames for submitting the waiver application.

I will say that we are looking to submit the waiver application. We are really hoping very strongly by the end of April it gets submitted to CMS. We and CMS having numbers of questions and we will go through the process we go through with every waiver.

And we also talked about data and IT requirements. There is a whole team at DHS that is working very, very hard to make sure all of our systems are ready for Community HealthChoices and that includes, as Joshua talked about, providers getting paid, we want the MCOs to get paid; so that includes things like N10 testing for payment through promise it includes engagement through client information system which is the eligibility system that the county assistance offices use and many other systems that we have at the state.

We need to make sure that those managed care organizations will be able to speak to those systems and that there is interoperability for them.

So our data and IT folks are in the process of scheduling a meeting. I believe it is next week.

Randy, I am looking to you. Do you know the date?

>> RANDY: I don't know the date either.

>> JEN: I think it's either next week or the following week to begin the conversation, get them in touch with the right people in DHS that can help.

It's primarily people who can work in our bureau of data and claims management, who will handle just like they handle for health choices they will handle all of the claims management for CHC; those staff will be engaged, as well as the people in our bureau of information systems. There is a whole team of people.

One of the things the bureau of information systems has to do and it is just for your information, they have to apply to CMS using an advanced planning document process and that APD is what gives us the opportunity to work on and build systems at a 90:10 match rate. It's important we engage with them to leverage those resources.

Other topics, we had a whole presentation on the ongoing availability of LIFE. We want our managed care organizations to be very familiar with your LIFE program. We will continue to engage them so that LIFE continues to be something that they know about, that there's communication between them.

We also spent time discussing our the draft agreement which is the original draft agreement issued back in March of 2016, as an RFP.

We have had to make changes to that. We spent time going through some of the changes that were made as a result of the managed care final rule.

We knew that the managed care organizations are paying a lot of attention to the managed care final rule, but we wanted them to see what kind of changes we were making as a result of that.

So, again, I just want to encourage you to submit your questions to us.

The other thing that I would like you -- -- I'm sorry. The RA-MLTSS box is related to this committee.

The email box for sending in questions is RA-PWCHC@pa.gov.

I apologize for that. We will make sure we post it on the website as well.

I wanted to talk briefly about the functional eligibility tool, which is something that we have been working on for over a year.

We recently held -- this is a new tool to get at functional eligibility, what is currently called the level of care determination or the LCD for nursing facility level of care. It is the functional determination to get long-term services and supports, whether it is in nursing facility or home and community-based services.

We have been working with a team of people to reimagine what that tool could look like. Have been meeting over the course of the last year a number of times with various stakeholders that are interested in making sure that we get the tool right, that included a number of AAA and staff who had good input on what this will look like.

We are planning to launch it in the fall of this year, the new tool. It will be new participant eligibility determination for functional ettle for long-term services and supports.

We did hold a well-attended stakeholder meeting in the last two weeks, I believe. It was attended by about 45 people. We had -- oh, here it was March 20th.

That meeting was a webinar presentation and then an ability for interested stakeholders to ask questions.

It really -- the goal of this new tool is to have a more consistent and less subjective process and provide a more valid gateway for people entering long-term services and supports in Medicaid funded services; that's really what the goal is of this.

Our next steps include a training on April 26th, which is -- we will be training assessors, 10 areas agencies on aging held up their hand and said we would like to participate in testing the tool. We will have a training for them and do testing and validation over the course of spring and summer months.

It will actually be testing the tool on participants entering into the program in those selected counties of the Area Agencies on Aging that have offered to participate.

What that means is, we are testing for the validity and the inter reliability and all of those types of things, but we have a tool based on already-existing, valid, tested questions for this tool it's called inter RAI for home care.

So what we anticipate is implementing this new functional eligibility determination tool after the testing is done and after we take a look at what we learned in the testing and made any adjustments to the tool. We will then begin, actually, using it hopefully before the end of the summer.

What counties are participating? I don't know the answer to that but I can get the answer to that for you.

I am looking over at Mike Hale.

>> MIKE: I don't know them all offhand: Philadelphia and Pittsburgh, Erie.

>> JEN: We will get you the full list of the counties that are participating.

>> RALPH: Okay. Thank you.

>> JEN: That is the functional eligibility tool update. We are looking forward to working with the MCOs as well, as we get into using the new FED tool.

I just came from a hearing in the House over at 140 in the main capitol on what is called the Department of Health and human services unification. The House actually did bring all of the secretaries, Secretary Osborne, Secretary Dallas from Department of Human Services Secretary Murphy from the Department of Health and acting-secretary Smith from the department of drug and alcohol programs; those are the four departments that are envisioned to be part of this unification.

So what we are doing is going through a public process with the legislature. There was a Senate hearing last week. This week was the House hearing.

What we have done internally in the four departments is working with the Governor's Office. They have set up a number of work groups to really talk through what does this mean operationally for these four departments?

So that Senate aging and youth committee but also other communities, intergovernmental committee of the Senate as well as the human services committee of the Senate.

It was a joint committee meeting of all of those different Senate committees that was held on March 29th.

On March 29th, they also had a second panel that they listened to, which was Secretary Minich of the office of administration, Secretary Albright from the office of budget, and Secretary [inaudible] from the governor's office of policy and planning.

All of those folks also had a chance to ask questions and be heard from.

The next thing I wanted to brief you on -- as I mentioned, the work groups are really working at a lower level really looking at what staff goes where, what bureaus will handle what and figuring out how the new department will operate.

I also wanted to mention two days ago, I was able to attend the ABLE implementation launch at the capitol. It was held at the rotunda.

Senator Casey who sponsored the ABLE legislation at federal level and Senator Baker who sponsored our state-specific legislation spoke on the implementation of ABLE.

It officially launched the ABLE savings -- Pennsylvania ABLE savings program official life launched on April 3rd two days ago.

The Treasury Secretary right now, the department of -- the Pennsylvania treasury department is now accepting ABLE account applications. I met with the staff at Treasury yesterday to talk about how to get the word out in the department of human services.

They reported that as of the first day they already had 45 applications processed.

So people are starting to pick up on this. I wanted to -- you will recall we had Kathleen McGrath come to the meeting about three or four months ago. She really talked about it as a concept because they hadn't ironed out a lot of details about how the savings program would work. They have done a lot of work with the Internal Revenue Service and there is a lot of reporting that has to get done to the Internal Revenue Service also a lot of reporting that has to be done to the Social Security Administration because they do not want any risk to SSI.

They have done a lot of work to make sure that that happens.

ABLE is a savings program designed for individuals with disabilities. They, actually, in the application, list out all of the disabilities. The treasury Secretary says any disability would be able to be applied for.

It's it really allows people to plan for financially secure future. It also allows them to save to pay for disability-related expenses and then it -- what is important from our perspective it gives them an opportunity to have assets without jeopardizing federal and state benefits. It allows individuals to be financially independent by controlling the account themselves.

I was at the rotunda a where a number of advocates who had participated in getting our Pennsylvania ABLE program launched. It

included somebody who has come and spoken to this group, which is Michael Anderson, who is a consumer of one of our waivers. He spoke about what this is going to do for him.

The money in the ABLE accounts can be used for education, housing, transportation, employment training, assistive technology and devices, personal support services, health, prevention and wellness, financial management and administrative services, legal fees, funeral and burial expenses.

There are all kinds of things that they can be used for.

The event that I went to on Tuesday really showcased the work that is being done by the Pennsylvania treasury department. They have dedicated whole heartedly to launching this.

It actually is a group of people who have been managing the savings account for college called the 529 program. It's that staff that has been doing this work. They have, actually, created a new division that is really about savings accounts not just college savings or ABLE savings.

They really are very willing to come out and talk.

If you or an organization wants to sponsor an event or anything, they have a place on their website to request speakers. They also have a ton of new information on their website including the full application.

We will be -- as I said, we will be scheduling them to come back and talk at a future meeting. I think I brought brochures here. Did you bring them?

>> GEORGIA: I did not bring them. Sorry.

>> JEN: We will make sure that they come to the next meeting.

Web address is PAABLE.gov if you want to look for information.

The update is RFP will be issued for new independent enrollment procurement.

There is a lot of work to do. We have made significant improvements in customer service at the call center. We know there is still work to do and we do work on a daily basis with the IEB.

We are working with them regularly to address customer service as well as smooth enrollment for people.

Our staff have been trained and the staff at Maximus who is our current IEB -- we received very few complaints in the last two months on the issue of delays since January.

I hope things are on track we are pursuing independent enrollment broker with a whole new statement of work that will allow us and it's required under mandatory managed care to have an independent enrollment broker but allow to engage with Community HealthChoices we instructed them we know that referrals are being made by call center staff to the linked to aging disability resources the Pennsylvania Link program.

We also provide information on denials by the IEB.

We continue to see record enrollment in the Aging Waiver it is continuing to grow very, very rapidly.

They have started leveling off from the peaks in December and January, but we continue to see those enrollments remain high.

And, again, that RFP -- I am hoping today -- [LAUGHTER] -- when it comes out there will be an announcement with it. It doesn't just go on DGS website but you will have information on how to look at it.

>> FRED: Jen how many will we have? Just one? Two or three?

>> JEN: We don't know. We don't know how many are going to apply. It's one independent enrollment broker we will secure statewide; that will continue to be a statewide process for consistency at application.

Another a recent meeting we were asked about adult protective services. We talked to colleagues at bureau service licensing where adult protective services is managed.

As you know, our regulatory process is very lengthy and we have a final regulation that is undergoing final stages of review internally in. Department of Human Services before moving on to the next steps in the process.

The adult protective services as you probably will recall was as a result of Act 70. It was -- it provides a system to address situations of abuse, neglect, abandonment and exploitation of adults over the age of 18.

We have child protective services which serves up to 18. There used to be a gap between 18 and 60 and over 60 with older adult protective services and it filled the gap.

There is a lot of -- there are new requirements for reporting,

including general reporting requirement for mandatory reporting -- any administrator or employee of a facility who has reasonable cause to suspect recipient is a victim of abuse, neglect and exploitation as well as mandatory reporters are required to make an immediate oral report to APS hotline.

When those mandatory reports come in, they are followed up within 48 hours with a written report to the agency that the local contracted provider protected services is mobilized.

I don't think I -- I do want to talk about -- a little bit more about waiver-specific transitions and advance -- in advance of Community HealthChoices implementation.

This does get a little bit confusing. We do have a --

>> GEORGIA: Don't call me an expert.

[LAUGHTER]

>> JEN: Come on over here I will ask Georgia to join me.

>> FRED: A very knowledgeable person. How is that?

>> JEN: We have a graphic we can share with you that shows the transitions and what they will look like.

We are also doing a lot of working on a lot of communication for them.

Did we -- are we putting up a slide with a presentation?

>> GEORGIA: I don't have them on the slide I have the draft documents. Do you want me to pull them up?

>> JEN: Yeah.

>> GEORGIA: Were you thinking of the flow chart?

>> JEN: Start with the flow chart. Never mind. We will get it to you. It's actually a little confusing but once you go through it it does make sense.

There are I want to start with the OBRA waiver. All people on the OBRA waiver will start with clinical level of care determination for nursing facility clinical eligibility.

We know that there are some people on OBRA that are not nursing facility clinically eligible they will remain on OBRA.

For those who are clinically eligible for nursing care facility will move over to community care health choices.

If they are IFC or clinically eligible for nursing facility care they will go into Community HealthChoices.

They will all need to receive a level of care determination. Pennsylvania association Area Agencies on Aging to make it happen. Individuals who are 21 and over -- not 18-20, they will not be in Community HealthChoices.

21 and older were determined FCE will go into Community HealthChoices as the zones are implemented.

Folks will be moving as the zones are implemented.

>> FRED: Eighteen to 21 will be on OBRA. Correct?

>> JEN: Eighteen to twenty, 21 and over will -- most immediately southwest will need to be reassess the.

We do have a chart that we have provided to the Area Agencies on Aging in the age western part of the state that has the breakdown by County of the 473 individuals that will get a reassessment.

They are received that. I actually am going to be meeting with a group of the Area Agencies on Aging who are affected by this. I don't know the date of that meeting but it is in the very near future.

I wanted Georgia to talk a little bit about the communications that we are in the process of finalizing in advance of making all of this happen.

These are changes and we need to notify people that they are going to receive a change.

I will ask my expert to talk about the communications.

[LAUGHTER]

>> GEORGIA: Thanks, Jen.

So if everyone is a little confused, you are not alone. It's okay. I have it all written down and it's still somewhat confusing.0 We are talking about individuals over the age of 21 that are currently receiving services through OBRA waiver and need reassessed.

Reaching individuals who will be impacted by those trans ingses we at the department have put together -- seven different letters

relating to the OBRA reassessment process.

We have decided to communicate in a somewhat strategic way beginning with provider service coordinators and KAAA it's scheduled to go out April 24th. It's in final review stages we want to share it with provider agencies and this group in advance of releasing that.

We will ask for a really quick turnaround, Fred. I am just warning you.

[LAUGHTER]

Following that letter which will include information how to register for a webinar which is scheduled to be held on May 4th. We will hold the webinar where most importantly AAAs and service coordinators can ask questions. This is a process for service coordinators that they are very familiar with. Service coordinators do regular waiver program transfers and AAAs obviously do regular level of care determinations.

Following that technical assistance webinar, we are scheduled to communicate with participants in need of reassessments on May 8th. I am qualifying those individuals as being in need of reassessments if they have not had a level of care done since November 19th of 2017 -- 2016. Sorry.

Which would be within the most recent year of the scheduled transition date when individuals would be transitioned to CHC.

Our efforts in doing this would give the AAAs eight weeks to complete the level of cares that need to be done. We are averaging about 20 level of care assessments per each county in the southwest zone with the exception of Allegheny and Westmoreland counties, which are higher because of population density if they need more time we can work with that.

What we are looking to do is have all of the assessments completed and have communications completed with all of the participants that could possibly being transitioning to CHC in advance of mid-August, which is when we begin communicating with all individuals transitioning to CHC it gives individuals currently receiving services through OBRA waiver, the same opportunity to make informed decisions about the MCO in which they think can best meet their needs.

Do you want me to go through all of them including ComCare?

>> JEN: No, I will do those.

Do you have the final ones that went out? We did a provider communication and communication on interface between behavioral health and CHC about a week and a half ago, I believe. It was on a Friday. I just wanted to show you those. Some will be familiar with them. This is the look that we are trying to achieve as we do this.

>> GEORGIA: They are all available on the website. I was going to show you all how to get there but the internet doesn't seem --

>> JEN: You don't have them on your laptop?

>> GEORGIA: I was just going to show --

>> JEN: The ComCare you heard it before, but I want to reiterate it, the ComCare waiver will become the Community HealthChoices waiver; therefore, the ComCare people who are in the ComCare waiver in zones 2-5, not in zone 1, will have to be transitioned to they have to leave the ComCare waiver.

What we will do is transition those folks into the independence waiver.

What we are doing right now with the independence waiver is -- independence and ComCare are almost identical with the exception of two services. What we are doing right now is amending the independence waiver is structured day rehabilitation and residential rehabilitation. Those will be added to the independence waiver effective October 1st, 2017.

Individuals residing in zones 2-5 in needing those services they will be transitioned from -- to independence once those services are effective.

We are looking mid-October to mid-November to transition those individuals in those zones.

So there is also communication that we are developing -- oh, there it is. That's the waiver transitions that we just went over it is a graphic for you to refer to to help you understand it. All of the communications will have this logo and look that we have adopted for Community HealthChoices.

We have a lot of communications that we are beginning to talk about.

This one is how Community HealthChoices and behavioral health will interface.

I know Patty Wright mentioned she has a background in behavioral

health. The fact that behavioral health is carved out of Community HealthChoices means we have to do a lot of work to engage them. We are working very, very closely -- I do want to take a moment to recognize the passing of my colleague Dennis Marion, deputy secretary for the office of mental health services who passed away suddenly last week.

I would ask this body for a few seconds to just take a moment of silence. I want to talk about some of Dennis' legacy in this space of coordinating between CHC and behavioral health.

If we could take a moment of silence, here.

Okay.

This is such sad news for us. He was truly a leader. His leadership really showed in how he mobilized his staff to engage with our staff. How he made sure that we were having meetings, holding meetings and coordinating between the two and developing processes so that it would not be confusing out in the field.

He was doing the same thing with health choices and health choices and behavioral health choices. Again, there is a carve-out and how those two communicate and coordinate with each other.

In my mind I have a commitment to continue his legacy of making those connections and working very hard both at state level here amongst our staff but then also at the local level to get started with -- at the local level between NCOs, CHC and MCO in behavioral health.

I believe there are two MCOs in southwestern zone because their zones are different than ours.

I am looking forward to it.

This was actually kind of a result of our work together putting this communication together.

Do you want to do the one that went out to providers?

>> GEORGIA: Sure.

>> JEN: These are up on the Community HealthChoices website; that's where we will post them under the tab for providers. This is a message, beginning message to providers. People who come to this meeting are very familiar with all of this stuff. This is probably very simplistic for you.

For many of our providers they haven't been paying attention to what is going on. So what we want to do is make sure that our providers

start really engaging and understanding what they need to do.

I think one of the things I wanted to point out on this the three MCOs are there. We were also given the email address for providers to reach out to are on this.

It is one thing we heard from. They asked me during third Thursday webinar, How do we know how to reach them appropriately?

We used the email addresses that the try MCOs gave us.

So with that, that is all we have for -- I do have one other question from Jeff Iseman to ask about the status of RFP for fiscal management services.

I will ask Mike Hale to give us a status because he is my expert on FMS.

>> MIKE: Is this will be easy.

We are dotting Is and crossing Ts.

Answered a couple questions today for procurement for finalization I hope to have the RFP out on the street, if not by the end of this week, by the end of next for sure.

I would like to invite Randy Noland to talk briefly about readiness review and what you have gone through.

He has a meeting planned for tomorrow. He can tell us a little bit about -- Drew, did you have a question?

>> DREW: I have a question about transitions? I think it was in January's meeting where we talked about the new service definitions for vocational services that went into effect on October 6th of 2016.

I believe the process that was described is at some point the department would direct service coordinators to back out the old services and replace them with the new services going forward.

It's now six months later and that process hasn't happened yet.

I believe the providers are ready to go forward with the new services, but I don't know. It's going to be a financial nightmare to figure this all out. What is happening with that?

>> JEN: That's a little in the weeds. I did don't know. Does any staff have an update on where we are with that? I will ask Jill to come up and give us an update. Thank you, Jill.

>> JILL: We were allowing time for claim adjustments and that kind of thing -- we are end dating those services and we are in the process of getting all of it updated for you.

I can give more detail back and it can be shared with the group.

>> JEN: Okay.

They were waiting for claims to catch up; that's what Jill just said. Now they are going to go through a process off end dating.

>> DREW: Can I ask what to expect about that timewise? I mean, what is going to happen?

>> JILL: It's happening now. We are actually working on it now.

>> JEN: Jill said it is happening now we are working on it now.

>> JILL: The codes will be updated. I would expect we have it all completed by the end of the month.

>> DREW: Service coordinators need education about this. They don't know -- if you ask them they have no idea.

>> JEN: We have done webinars. I guess we need another webinar for service coordinators. Go ahead, Barb.

>> BARB: I sat in on a webinar back in November. We were told the providers had until December 2nd to make a decision whether they wanted to continue with the new services. Then the service coordination agencies would be notified with a list of consumers and what needed to be done and we should expect that by the end of December.

We haven't gotten anything yet. We are kind of in limbo.

>> JEN: Okay. Thank you. We will go back and look into this. Drew?

>> DREW: Thank you.

>> JEN: Next is Randy Noland, who is leading the charge on readiness review, which is an extremely important activity that we will be undergoing in the next 6-9 months.

>> RANDY: Hi, everybody. My name is Randy Noland, I am overseeing readiness review as we move forward with CHC.

Basically, what we are doing right now is finalizing everything as far as the documents that will be used and putting the teams

together. We identified our staff who will be the leads for each plan. We have had some communications with the plans back and forth via email.

We are in the process of trying to set up computer systems, docushare things like that so MCOs can have access to the documents they need to submit and have access to the documents they do submit.

We have been working through that part of the process.

We have a readiness kick-off meeting tomorrow with the MCOs they are each bringing 10 staff to that meeting.

We will have our staff there. We will have a lot of our subject matter experts there from IT and certain areas, pharmacy will be there, to discuss and answer questions.

The staff will be there from the Department of Health who have the Respondent of overeying network advocacy they will be there also.

We will have the kick-off meeting tomorrow. We will put some things in place over the next couple weeks so that, hopefully, by the end of the month, the MCOs can start providing us documentation so that we can start actually doing the readiness review and policies and procedures and other things as we move forward.

As part of the process, especially on the provider network advocacy side of it, Department of Health is fairly comfortable doing it on the physical health side medical services side because they have been doing it for health choices over the years.

On the LTSS provider side, there is a lot of concerns about how do we determine what is an adequate network for those types of providers?

We have done a couple things to try to address that. One of them is, we are meeting both with DOH, ourselves, with Pennsylvania health law project and a number of consumers and participants to a sit us in determining the prior types and the standards we need to look at.

We have had two meetings already with that group we will get another meeting scheduled here within the next couple weeks as we try to walk through that process and trying to identify standards.

We have done research. We have done it as the department, Pennsylvania health law project has done research. There is not a lot of information out there from other states on standards surrounding MLTSS provider network adequacy.

Most of the states just say, they have to have choice. Some say

they have to have two. There is nothing out there that is going to be any guidance to us. We are having a lot of internal discussion about how to figure it out.

That is basically where we are at. We are building the internal team. We are moving a lot of staff within the office to work on readiness review at this point in time. We are establishing that at this point in time.

>> JEN: Thank you, Randy.

Fred asked -- first of all, does anyone have questions on readiness review and that process or network adequacy?

[NO RESPONSE]

No? All right. Great.

Fred asked that we put up the letters that are going to go out to consumers. We have a draft and need input we will get those out to you for feedback on those.

>> FRED: Good.

>> JEN: I think she is going to put it up.

>> GEORGIA: I am trying. Technology at the state is challenging.

>> FRED: Hopefully it's better than the phone system is.

>> GEORGIA: It seems to be thinking.

As I was talking about, there is not a date scheduled but we are talking about May 8th as a possible release.

As Jen said, we will share this with members of the subcommittee.

>> JEN: Can you come over here and talk?

>> GEORGIA: Sure.

As I stated, we don't have the date currently listed on this communication but we are aiming for May 8th to send this out, which, as I said, this would be the last communication to go out and it is scheduled to go out to participants as we will be communicating with provider service coordinators and AAAs so they are prepared to take questions, if by chance the participants have questions about the contents of the letter, they would at least be aware of the process that

is going on.

What we have tried to do in these letters is make it as clear as possible and offer participants the relevant information been what they can expect in the upcoming months the fact they need to have an assessment done if they are determined to be NFC and are over the age of 21, of course, they will be transitioned to CHC.

>> FRED: I see it says just OBRA, just people in the OBRA it is going out to?

>> GEORGIA: Yeah.

>> FRED: What about all of the consumers explaining what CHC is, telling them you will have this choice. It is coming.

>> GEORGIA: I don't have it yet.

>> JEN: We have to do OBRA transition and needed to get it done first. It is sort of the next stage to do -- when do we ape that going out?

>> GEORGIA: That ties in nicely with this. As I said, all of these types of activities are scheduled to be completed by mid-August so all individuals who will be transitioned to CHC will receive same types of communications which is the type of letter that you are actually asking about.

There is still a bunch of decisions about what type of content needs to be included in that, some back and forth between us as program office and legal and those types of things.

>> FRED: Under the circumstances and the committee, do we have input on the letters? Will we be able to see them?

>> GEORGIA: They will absolutely be shared.

>> JEN: Like the OBRA, we will ask for your input on them.

I want to make note on the fact that Health Choices is also undergoing some change. We are coordinating with Health Choices with a regards to how we communicate we don't want Kuhn fusion.

There is a small number of people who will go into Community HealthChoices -- not necessarily a small number but a number of people who are on any of our under-60-waivers they are currently in Health Choices.

We do not want to confuse them by getting them Health Choices

communications and a Community HealthChoices communication. We are in conversation with OMAP to make sure we are line those communications and those people get very targeted communication and don't get several different communications and not know what to do.

We are doing a lot of work. Our consumer subcommittee of medical assistance advisory committee has done a lot of advice to us on this. Really does want to see us make sure that those individuals that are on those under 60 waivers.

People on aging waiver or are dual eligible are not in health choices so none of those individuals will need to receive the -- this distinction between health choices and Community HealthChoices.

I just wanted to make sure that you knew we are aware of that and starting to really think about what it looks like. I meet on a regular basis with OMAP to map out those communications.

>> FRED: You have a question, Pat?

>> PAT: Brenda does.

>> FRED: What is your question, Brenda?

>> BRENDA: In the paragraph that says as part of assessment a letter will need to be sent to your doctor, there is a sentence that says, you don't need to do anything. I would recommend maybe we add something there if it's not there already, about calling your doctor to say the form is coming and it needs to be done in a timely manner isn't a bad thing for the consumers I work with and for myself from my own personal experience, if I don't do that with my doctor's office it often gets filed away until my next visit to address the paperwork.

It is a good thing to encourage people to make the call if they feel comfortable doing so.

>> JEN: Thank you for the feedback.

Brenda, do you mind, we will be sending it out but would you mind putting it in writing and giving us recommendations you have on language, that would be great.

>> BRENDA: Do you want it to the resource account or you directly?

>> JEN: Where do comments go to this?

>> GEORGIA: It will be in the email.

>> JEN: We will have an email to send it back to when we send out the email this afternoon or tomorrow Marilyn will send out email follow-up with this letter in it as well as instructions on how to get feedback to us.

>> BILL: Be careful with the acronyms sometimes you spell it out and sometimes you don't.

The other thing I would encourage you to give it to a participant, somebody like my mother or somebody's grandmother and say, what do you think of this letter. I think you will be amazed of what you would hear.

>> JEN: What would be great is if any members of the committee who have access to consumers like Brenda, Fred I know you do, to show this letter to them and get their feedback that would be helpful.

>> BRENDA: I would be willing to do that.

What about for consumers who need this letter -- I can think of two right now that I work with -- who are not -- literal are there plans for people who are not able to read the forth or any other type of outreach?

>> JEN: You are talking about somebody who needs special accommodations for being able to read things?

>> BRENDA: Yes. Or who just doesn't read. Period. I have a couple people who get most of their mail their attendant reads to them but I think an attendant is probably going to have enough questions about this that it would be confusing in and of itself.

I wonder if there couldn't be a telephone campaign where those folks who identify that way can either call in and added to the letter and have it explained to them or there can be an outreach campaign to touch base with them by phone.

>> GEORGIA: That's a great question.

It's good feedback. I will try to -- I will look into whether or not we have the capacity and capability to do that.

I think we would be -- to some degree relying on service coordinators and providers to assist with that type of communication facilitation.

That's expressed in some of the -- in the letters to AAA's service coordinators and provider.

The participant would be hearing from AAA to discuss level of care assessment, and it would start to make sense.

>> JEN: Our challenge is we don't know who these people are. We don't know exactly know people with limited English proficiency here at the state level. We will rely on our networks to help us with that.

>> BRENDA: I will put references to that in my feedback to the letter in general.

>> JEN: If you can give feedback and how we can handle it, that would be great. Thanks.

>> FRED: Also, I just spoke to a couple of my co-workers and everything, she is visually impaired. It would be best to email that letter, then it could go through screen readers and everything like that for her to be able to read and deal with.

>> GEORGIA: Okay. That's good feedback. For participant letters we were planning to email addresses are difficult to keep track of and I am not sure we actually have access to those in the systems where we are pulling people's actual addresses out of.

>> JEN: Yeah, the client information system, which is the system that we are using to pull these names out of, does not have accurate email addresses. It's a challenge for us; however, what we could do is, again, relying on our network of providers, is to get electronically to you all. If you know people who receive things better through email, then you can simply forward it to them.

>> FRED: A good suggestion would be to get it out to things like the light house for the blind. What are some other good places what other places providers for people with vision impairments to get it out to their consumers. What would be some of the main agencies? BVS, the blind association.

>> JEN: We will contact our colleagues in blindness and visual services and get their provider lists.

>> FRED: I want to make sure everyone gets it again.

>> BILL: Just reminder that the elderly, many times, do not use email or go to websites we find it almost always. I want to emphasize that. Thank you.

>> JEN: Aside from the fact that our system doesn't have current, accurate email addresses, that's why we are sending it snail mail.

Barb, you look like you want to ask a question?

>> BARB: Brenda brought it up about physician certification. If you are working on a tight deadline, that's going to be your biggest challenge, getting that form back from the physician.

I don't know. Is there some way that you can put your logo on that letter? It might carry more weight.

>> JEN: Yes. Yes, we can.

If you wouldn't mind putting it in writing when you get this back, that would be great. Thank you.

>> FRED: This is Michelle's contact information.

>> JEN: Thank you, Michelle.

All right. I think we are through our agenda. Right at 2:30. We can take public comments. First, I will open it up to the committee and go for public comment. Anybody on the committee have any other questions on comments they want to raise?

[NO RESPONSE]

Public?

>> LESTER: Hello, Lester -- functional eligible tool will it be used in OBRA, reassessment for OBRA?

Okay. And then --

>> JEN: It's not ready.

>> LESTER: That's what I was thinking. I wanted to make sure.

With that letter, also, I am kind of concerned, when we are saying you don't have to do anything because most doctors that I have been in contact with, with that letter, they might not do anything, if the consumer hasn't been seen.

I don't want the consumer say, Well, they told me I don't have to do anything. Then the doctor says they do.

I am concerned about it.

>> JEN: Can you put it in writing?

>> LESTER: Yes, ma'am!

>> JEN: Okay. Thank you.

>> FRED: Anything else from anybody else?

>> LESTER: I want to get at the second part. Sorry.

With the OBRA portion, just to make sure in my transition, I am -- you are sending out the AAAs to do the level of care. Then you are asking the service coordinators to transfer them in the waiver; is that correct?

>> JEN: Yes.

>> LESTER: I need to make sure before I tell these people.

>> JEN: We will do a webinar training.

>> LESTER: They don't pay attention. I have to do it all myself.

>> JEN: That's your job.

[LAUGHTER]

>> David Gates. The three MCOs you have chosen for Community HealthChoices, all three are going to be operating the regular physical health choices plans as well in certain areas --

>> JEN: Right now we have a stay on health choices. We cannot even talk about it. I am just letting you know that.

>> DAVID: If you can just listen instead of talk.

[LAUGHTER]

When this comes about, and assuming that those three will also be running regular health choices, I think it will be important that the cards that people get will distinguish the Community HealthChoices from the regular health choices for those same plans.

It's going to be very confusing for people and for providers, since the scope of benefits is going to be quite different between the two programs.

>> JEN: That was a good recommendation it actually came from consumer SubMAAC as well from one of your colleagues you must talk to each other.

>> DAVID: I was asked to re reiterate that.

>> JEFF: This is Jeff Iseman, from PA-SILC, for those on the phone.

Relating to state budget there is a budget bill moving House Bill 218 that passed out of the House, do we know if there are changes in OLTL at this point in the programs?

>> JEN: I don't have the budget documents with me I do know there is a $25 million cult in long-term care.

>> JEFF: Okay.

>> JEN: There are cuts in pretty much all of our lines. Millions of dollars of cuts in all of our lines. Yes.

>> JEFF: Okay.

>> JEN: House budget bill that passed out of the House yesterday.

>> FRED: How will that affect CHC in the future?

>> JEN: Well, as you know, it's a bill so it has to go through a process. I cannot really answer that question. We don't anticipate we will continue working on CHC.

If you don't like the idea of all of those cuts, after this meeting go right down the street.

[LAUGHTER]

>> FRED: Go get 'em!

>> JEN: One thing it does do it continues the Governor's proposal of four departments in that bill.

>> JEFF: Next question on federal budget as most folks know we will run out April 28th, as far as continuing resolution is done. Do we know anything as far as any possible cuts anything for the budget from then until September 30th?

>> JEN: I don't really. I am not paying that close attention. Does anybody in the room know any more about that? Pat do you know anything?

>> PAT: What is the resolution?

>> JEN: Whether there is a continuing resolution when the -- if Congress doesn't move by April 28th.

>> PAT: Oh, the federal level?

>> JEN: Yeah.

>> PAT: No.

>> JEN: We don't. Sorry.

>> JEFF: All right.

>> JEN: All right. Any other questions or concerns?

[NO RESPONSE]

All right. Thank you very much. You have a half hour back in your day.

(Meeting concluded at 12:34 p.m.)