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MLTSS Meeting Wednesday, June 7, 2017 10:00-1:00 p.m.

>> CAPTIONER: (on standby.)

>> PAM: Good morning. We are going to get started, please? So let's officially call to order and start with introductions. Barbara, if you could start us off.

>> Barb Polzer, Liberty.

>> Jim Fetzner, Comfort Care.

>> Kiziann Powell, United Healthcare on behalf of Blair Boroch.

>> Carrie Bach here for Tanya Teglo, PCOA.

>> Bill White, AARP.

>> Pam Mammarella.

>> Jen Burnett, Office of Long-Term Living.

>> Fred Hess, Disability Options Network.

>> Estella Hyde, PCOA and AARP.

>> Ray Prushnok.

>> Theo Braddy, CIL-Central PA.

>> Arsen Ustayev, SarahCare.

>> PAM: Thank you. I will do roll call on the call. Do we have Brenda Dare on the phone?

[NO RESPONSE]

>> JEN: Brenda, are you on the phone?

>> PAM: Ralph, are you here?

>> JEN: This isn't connected.

>> PAM: Pat, we think the phone is disconnected. This microphone is dead. We were not able to get the projector on before. Bear with us for one moment.

>> Tanya said she cannot hear on the phone.

>> PAM: We will give it a minute.

>> PAT: Is the phone muted? I muted it when I set it up.

>> JEN: I unmuted it here.

>> She says they hear now.

>> PAM: Welcome, people on the phone.

>> FRED: Try again.

>> PAM: Brenda Dare, are you here?

>> [NO RESPONSE]

Ralph Trainer?

[NO RESPONSE]

>> JEN: Are people on mute?

>> PAT: Ralph shouldn't be.

>> PAM: Tanya, can you ask if people are trying to talk and we cannot hear them? Thank you.

>> FRED: Report, Tanya! Report!

[LAUGHTER]

>> PAT: Try Ralph now.

>> PAM: Ralph, can you hear us?

[NO RESPONSE]

>> I hear him. I can hear him through my phone.

>> JEN: You can hear him? It's not connected to this.

>> PAM: Now we will get started. We will take roll on the telephone by people weighing in via web or on the audio line that someone can hear from the Office of Long-Term Living.

And -- Jack. Welcome. Jack just joined us.

Fred, I will do the housekeeping rules if you do the evacuation procedures.

>> FRED: Okay. Emergency evacuation procedures: In the event of emergency or evacuation, we will proceed to the assembly area and turn to the left of Zion church on the corner of 4th and Market.

If you need assistance to evacuate, go to safe area located right outside of the main doors. OLTL staff will be in the area and stay with you until you are told to go back in or they get you out.

Everyone must exit the building. Take all of your belongings with you. If the place is on fire, you will lose it, if you need it. Don't use elevators. We will use stair 1 and 2 to exit.

Stair 1: Exit Honor Suite, left side of the elevator, go down hallway and stair 1 is on the left.

Stair 2: Exit Honor Suite doors, right side of the room or back door. For those exiting side doors, turn left and stair 2 will be right in front of you. Those exiting the back turn left and left and stair 2 is directly ahead.

Keep to the inside of the stairwell, merge to the outside. Turn left and walk down Dewberry alley to Chestnut Street. Turn left to 4th Street. Cross 4th Street to train station, which we will be taking.

[LAUGHTER]

>> PAM: Thank you, Fred.

I will go over the housekeeping and committee rules. Pat, if you can tell us how to hear from and communicate through the phone for the meeting; that would be good.

As always, we want to maintain the utmost professional language and interacting with one another. As point of order, speak to the Chair.

Try to deep your communications to 2 minutes. Everything is posted on the listserv on your agenda item so they are usually posted a few days after. If you don't see something that you saw in this meeting, please alert the Office of Long-Term Living.

Our captionist is here with us. Welcome. Hello.

Turn your cell phones off. Clean up after yourself. The public comments will wait until the end. We will endeavor to make sure we have time in order to include the public comments.

Ralph already went over the evacuation procedures.

>> FRED: I did? Ralph did?

>> PAM: Excuse me, Fred. I miss Ralph. I haven't seen him in a while.

[LAUGHTER]

>> PAT: Try asking Ralph.

>> PAM: Ralph?

[NO RESPONSE]

>> JEN: Ralph, can you hear us?

[NO RESPONSE]

>> PAT: Try Steve.

>> PAM: Steve, can you hear us?

>> He can hear you.

>> JEN: We just cannot hear them.

>> PAT: If they can type in any comments.

>> PAM: Type in comments or questions and they will relay them to me, and I will make sure that they are included in our discussion.

So Jen, I will turn it over to you.

>> JEN: Sure.

Good morning, everyone. I am, actually, going to have to leave for an hour. I will give my updates later in the meeting.

We have rearranged our agenda -- not having that microphone work is not helpful.

We have rearranged our agenda to accommodate my leaving and coming back. What I want to start out with is introducing Peggy Morningstar, our

chief financial officer at Office of Long-Term Living.

We will have a presentation on how we are setting the rates in managed long-term services and supports in long-term services. Peggy will introduce our speakers on that. I will remove myself.

>> PEGGY: Thanks!

Good morning, everyone. I know it's a little rainy out there today, but we will try to keep the topic as interesting as we can!

For rate-setting purposes, we use Mercer Governmental Human Services Consulting. With us today we have Katie and Tom, who will give us a presentation. It is a very high-level presentation on the rate-setting process as we move forward.

We have already set the rates for calendar year 2018 for the southwest and southeast. Then we will also work together with Mercer to continue forward to set the rates for calendar year 2019, which includes southwest/southeast and rest of the state for Phase III.

>> TOM: Thank you, Peggy, for that introduction!

Thank you, all of you, for making time for us today and thank you to OLTL for the invitation.

So today we will talk a little bit about the capitation rate-setting process, what that means to CHC.

We will talk about the -- how the rates fit into the program from a financial perspective. The rate development process and then we will also talk a little bit about some key milestones from 2017 and looking ahead into 2018.

It's kind of a dry topic, but if you have any questions, feel free to ask them as we go along. I think that’s usually better than waiting until the end.

First we will talk about the financial overview.

We have what are called the capitation payments. They are calculated to be paid out one payment for each member, each month. So there will be a series of payments made each month. MCO will be paid one capitation payment for every member.

If they have 1,000 members, they would get 1,000 capitation payments for that month.

We will talk in more detail in subsequent slides about how the rate

is actually calculated. The rate is going to be averaged across all members so the rate is not specific to any given person. The rates will vary for certain demographic characteristics and other characteristics.

For example, the rate can vary about age. It can vary about the region of the state in which the individual lives.

It varies depending on Medicare status dual eligible or not dual eligible.

The most significant thing it varies on is whether an individual is eligible for nursing facility services or waiver services or not.

Each of those characteristics I just went through is a big driver in how much we are projecting that individuals will cost from that group. The rate will be averaged across each of those groups.

The rates that we calculate are done well in advance. Right now we have rates established for 2018. In a few months we will start the process of setting the rates for the 2019 period so they are developed well in advance and once they are established, they are fixed for that period pending a couple modifications that are built into the contract, depending on how things play out.

We don't go back and revise the rates for, you know, depending on how things actually play out. They are set in advance and then the MCOs are at risk.

These rates that will be paid out to MCOs are intended to be used to pay claims to providers and then also to cover the overhead that the MCOs have, the administrative expenses.

Are there questions on the rates and how they fit into CHC before we move on to the rate development process?

[NO RESPONSE]

>> PAM: I will speak loudly since I don't have a mike.

I am safe to assume that cost of living of the southeast versus the southwest is taken into consideration when the rates are set?

>> TOM: That's right. The rates vary by region. As we will talk about, the rates are based on historical experience, which will reflect the differences between costs in the southeast compared to the southwest and then going forward in CHC, the costs in the other parts of the state.

>> PAM: Thank you.

>> JACK: Pam, I have a question.

I know you will get to this in more detail in talking about rate setting, given that you said how the rates are fixed well in advance and they are fixed. How does that account for inflation? How does that account for provider experience in needing to retain and recruit qualified staff?

In that regard, the salaries that have to be paid, how does that all fit into your dynamic?

>> TOM: We will talk a little bit about the inflation. We will talk in a couple slides about how we get from the base data period, which is in the past into the future. How we adjust for those changes that take place over time.

There are also some adjustments that go into the rates based on expectations and historical precedent around contracting between the MCOs and the providers; so that is also taken into account.

Beyond that, we are using actual claims experience, that are reflective of how much the program costs historically.

>> JACK: And how do you account for quality of care?

>> TOM: The focus of the rates is going to be on what the services have cost historically and then we will project out what we expect them to cost going forward.

The terms of quality is left to the contract language and MCOs. It's outside of the scope of the rate development process.

>> JACK: Okay. Let me push you a little bit on that. How can that be outside of the scope of the rate development process when the payments to the MCOs have to take into payments MCOs make to providers certainly have to take that into account.

In the first instance, don't capitation rates have to take that into account with respect to the MCOs?

In other words, don't the capitation rates have to have that taken into account so that in turn the MCOs take that in account when they set their payment rates for their network?

>> TOM: Yeah. There is an assumption in actuarial rate setting that the historical costs will be indicative of future costs. There will be adjustments applied, but the assumption is made that if costs were at a certain level in the paste, you know, we will make some adjustments, but it would be a similar cost going forward. How the quality is managed by

the MCO is, you know, left to the -- the terms of the contract and business decision between MCO and the providers.

>> JACK: So there is the basic assumption that the prior rates were adequate to assure quality of care and access to care; is that correct?

>> TOM: Yes. There can be adjustments for different things, which we will talk about in a little bit of detail in future slide. Overall assumption is that cost will be similar.

>> JACK: I just want to say for purposes of adequacy of provider payments, the standard that applies, in my view, both to the Commonwealth and then to the MCO, is that provider rates have to be consistent with efficiency, economy, quality of care and sufficient to assure access to service; that's the standard.

So all of those elements need to be taken into account and I am just eager to hear how you go about doing all of that. It's obviously a complex process. Quality is a key ingredient of the rate setting process and I'm not sure I agree on reliance on past experience is sufficient to assure quality of care and access to care.

>> PAM: Thank you, Jack.

>> JEN: Jack, I want to point out that we have those standard requirements in Medicaid today. Those are already taken into consideration for the rate setting process we went into before. Moving forward that is what they are basing it on. We are required to do that today.

>> JACK: I know. Obviously from time to time there is dispute as to the adequacy of fee-for-service payment rates; that's why I am asking in terms of putting together the managed care rates, what goes into those, what are the assumptions that go into that?

>> PAM: We have another question on the phone and then get to your question.

This is Dr. Keating, proxy for Drew Nagele today. What is the allowable rate for an MCO to take for their overhead?

Secondly, will there be rates developed for different diagnostic categories such as, anorexia, brain injury concussion?

>> TOM: Rates do not vary according to diagnostic code. The rates need to be based on characteristics identifiable in advance. Logistically the MCOs need to be paid the capitation payments. Having them based on what actually happens would create an issue over the timing.

They would not be based on diagnosis code but based on the historical mix of diagnoses that we have seen.

>> PAM: The overhead. What is the allowable rate for MCO to take for their overhead?

>> TOM: With regards to overhead, we do have a model, proprietary model, that Mercer owns that is used to develop projected administrative costs for MCOs; that was built into the rate development process. Beyond that, CMS does have a limit of 15% for overhead, which is significantly higher than what we built into the rate.

There are extensive rules around capitation development that we need to adhere to. The more significant recent one was CMS Medicaid managed care final rule which came out in May.

The purpose of the rule is to ensure a fair process representing the need of different stakeholders. The idea being that it doesn't serve anyone's interests in the long run to have rates that are too high or too low. If rates are too high, it would mean more money in the system at the same time it uses up a larger portion of the state budget; that money has to come from tax payers originally.

At the same time, if rates are too low, it can impair MCO's ability to pay providers and their financial stability, which is also in the best interest of the public to have financially stable MCOs.

Beyond the Medicaid Medicare financial rule, there is an actuarial standard of practice managed care rate setting that lays out the different steps. So the final rule also lays out the steps of rate setting. So it prescribes what the process should be, you know, all of the key steps and it also talks about what sort of documentation needs to be submitted to CMS to gain their approval for the rate-setting process.

It's all a fairly standardized process.

Meeting those terms, the goal is to have rates that are considered actuarially sound. What it means is that they provide for all reasonable, appropriate and attainable expenses that the MCO is going to incur fulfilling the contract.

The rates need to be appropriate for coverage they need to match what is eligible and the benefit package or covered services.

They are going to be, you know, lining up with the population and the services covered.

Finally, the rates have to be certified by credentialed actuary in

good standing with American Academy of actuaries; that's where Mercer comes in.

Are there questions on the regulatory basis?

[NO RESPONSE]

The overview of the rate development process. We will talk about each of these in more detail. The initial step, which I alluded to earlier is that we will use base data that reflects the historical fee-for-service experience.

We will apply a series of adjustments and then add on a non-benefit load that is intended to cover the MCO's administrative expenses and certain other expenses like taxes.

>> PAM: We wait for questions from the public until the end.

>> VERONICA: Is there a say in rate?

>> TOM: Fee-for-service payment rates will be adjusted, which we will talk about in a little more detail in a moment here.

Then the actual terms of what the providers are paid by the MCOs is negotiation or business decision between provider and MCOs.

>> JACK: So if I hear correctly, the capitation rate assumes that the historical fee-for-service rates are adequate rates; is that correct?

>> TOM: Yes. We make adjustments to the historical rates. Those are the starting point.

>> JACK: Okay. You will talk about the adjustments?

>> TOM: We will.

>> PAM: Barbara?

>> BARB: How do you address if there is no historical data for services such as the employment services that have been added into the waiver the pest eradication, and things like that?

>> TOM: It's a good question. We will talk about that with the adjustments. I will defer that question for a couple slides.

Okay.

So the rate-setting process begins with the data. We rely heavily on the data so the old saying "garbage in/garbage out" really applies here.

We need good data.

We receive data from OLTL and review it for reasonability and do other checks on it. The data is going to show what services were delivered and who received them, how many services were delivered. How much was paid for those services. So it has all of these details that we will use during the rate-setting process.

Beyond that, we also receive eligibility data from OLTL so that we can see who was eligible during the time period. How many people were eligible from those different groups that I mentioned before. The age ban, due eligibles, non-dual eligibles and so on; so that we are able to properly scale the claims experience that we see to understand what the average is per person.

We clean up the data so that it fits the CHC population. Like I mentioned before, it needs to match who exactly is going to be eligible. Further we will limit it so that it matches the CHC benefit package, if there are any other extraneous pieces of data that are provided at the same time.

We will include all historical expenditures and then make some -- including ones that are outside the fee-for-service system.

We will also adjust for costs that are incurred but not in our data.

For example, if an individual goes and receives a service, the provider is not going to be paid instantaneously. There will be a leg there while the claim is adjudicated. So we adjust for any of those claims that are believed to be outstanding, the amount of money that was connected to that; that wouldn't be reflected in our data.

So there are, you know, like I said, a few adjustments that are applied.

>> PAM: May I ask a question? I'm sorry if I misunderstood this.

Did you just say that if it looks as though a provider has charged the MCO too much it would go to adjudication?

>> TOM: No.

What I am saying is, if an individual has a service -- this is in fee-for-service prior to CHC implementation because that's our data from the past -- if an individual receives a service there is a certain amount of processing time. Maybe adjudication is a bad word in this case. The processing time that it takes before the claim gets back to DHS and then the payment goes out and provider receives payment for that service.

There is a little bit of a leg there that is the processing time. So when we get data, there is going to be some services that happened but the payment hasn't actually been made yet. There is no record of the payment yet. So that's what I am talking about that we will adjust for.

>> KATIE: Tanya has a question: If the amount of money given is based on population, how can you assure quality assurance to areas smaller population using MCOs versus other areas in the state? Could this cause MCOs to only want to work with areas that have higher populations and are there safeguards against this?

>> TOM: It's a good question. This is where the -- our review of the eligibility data comes in so that we are able to, as I mentioned, properly scale the claims for the eligibility base. We will look at how many people are eligible, how many people did it take to generate that volume of claims and then we will scale it appropriately so that we are back to a per-person basis.

As someone asked before, there are differences by region. The southeast has a higher cost of living so, naturally, that will be a little higher than other parts of the state.

>> Katie: We are going to try to get my mike live again and take a minute to disconnect and connect.

Thank up.

Back to you, Tom. Thank you.

>> FRED: And now, back to you!!

[LAUGHTER]

>> TOM: All right. Are there other questions before we move on to talk about adjustments?

>> JIM: How often will the capitation rates be reset based on new historical claims data? Some states it's monthly, annually per the contract how is that being done?

>> PAM: Before that answers I have been asked by the people on the webinar for us to speak up louder and perhaps if you could repeat the question you were asked before you answer it that would be really.

>> TOM: I can repeat the question.

So the question was around how often is the -- are the capitation rates restated based on actual claims experience?

Per the final rule issued by CMS, capitation rates are for 12-month periods. The capitation rates will be re-evaluated on an annual basis.

We will move ahead to the adjustment slide. Katie is going to go through that.

>> Katie: All right.

So regarding the adjustments, we have a series of adjustments that we apply to the historical data that Tom just talked about. Those adjustments are made for different things that could happen between that historical time period and the future time period that we are setting the capitation rates for, which in this case was calendar year 2018.

Examples of things that could happen are: A change to the benefit package. This is related to the question I think, Barb, that you brought up. Today there are five different OLTL waivers. They each have slightly different benefit package. Under the CHC program, there will be one uniform CHC waiver and it will have the same set of benefits for everybody that is in that waiver.

So that would mean some people have access to new benefits that they didn't have access to before, and wouldn't show up in our historical claims data.

Through CHC there is also a brand new service, pest eradication, that wasn't offered historically and it wouldn't be in our historical claims data.

This was one of the key adjustments that we had to apply to the historical data. The way that we did that is, we looked at a lot of the historical data for the services and the five different waivers. We looked at which benefits are offered under each of the five waivers so we could do a gap analysis to say, These individuals in waivers A, B and C did not have access to the employment services before, but they will going forward.

We need to project what the cost is of those services going forward.

In that case we looked at some of the waivers that do offer employment services. Today they are slightly different but we could leverage some of the data that was historically provided there.

We did some modeling processes. We had a lot of discussions with the department to talk about going forward. These individuals that didn't have access to these services, how many units of service do we think that they will utilize going forward?

What would the cost of those services be? So we projected that through a pretty detailed analysis, got all of the feedback from OLTL and built it in as rate adjustment above and beyond the historical dollars that were in the base data that Tom talked about.

Do you have -- I don't know if you have a follow-up question based on that explanation?

>> BARB: What if your projections are wrong and the rates are only adjusted annually?

>> KATIE: We talked about OLTL, that this is a projection. There are three different risk mitigation mechanisms in place that are basically there to -- we won't talk about those in detail today -- they are there to protect the MCOs if something very significant happens differently than how we projected it to occur. There are some provisions there around the risks.

OLTL and Mercer will be watching as the programs start to come into play. What does that look like so in future years' time, once we have data, then we can use that to make the adjustment, instead of a modeling process.

>> BARB: Just the concern over the fact that pest eradication is something we don't even know about at this point. It is very, very widespread.

>> KATIE: Yep. Again, we did have discussions with OLTL about a projected number of users for that new service; looked at potential costs associated with that service; and did a projection there.

As you mentioned, yes, it is a projection and we understand that there is risk associated with that. Some of that service I would say in particular is very low-cost compared to the rest of the services so we don't think the risk is incredibly high but, yes, it is there.

>> BARB: Thank you.

>> JIM: This is Jim Fetzner.

>> PAM: Jim can you speak up.

>> JIM: Could you speak at all about any adjustments or incentives in the capitation rates for different goals of the program, like rebalancing or different things and how it was included in the rate capitation?

>> KATIE: Sure.

In terms will of rebalancing, we had discussions with OLTL about this. They felt very strongly for year 1 of a brand new program they wanted it to be successful. They wanted to not require that the MCOs have to rebalance in year 1.

In terms of, you know, achieving potential cost savings through moving individuals to maybe a more cost effective level of care.

There actually was no assumption made around -- like a downward adjustment for assumed savings or rebalancing.

>> PAM: Should we expect to see that in year 2 or further down the line?

>> KATIE: I think that still hasn't been decided, but it definitely would be incorporated at a future year of rate-setting process. I am not sure which year, though.

>> KATIE: Okay?

>> PAM: Uh-huh.

>> KATIE: Then the next slide also talks about adjustments. You know, in addition to making that adjustment for this change in benefit package, we also make adjustments for cost and utilization increases that can happen over time.

So this would be things like price increases due to inflation or direct care workers, you know, over the years are getting raises, perhaps; that's like inflation type of adjustment.

We also have utilization changes. An individual might start getting more units of a certain service over time or more people might use a certain service over time. Like the employment services, if that's a goal of the department, we might see the usage of those services increase in the future. So we look at a lot of the different factors in the historical data in terms of those prices and utilization have been growing historically or changing historically.

We also think about, going forward, how that could be different or similar. We made upward adjustments around trend -- we call that "trend" -- the cost in utilization changes projected between historical and calendar year 2018 time period.

>> ARSEN: Hi. My name is Arsen.

What happens if Philadelphia implements $15 as minimum wage?

>> KATIE: Good question.

I would talk about that as something like a program change. If there is a new law that says, you know, minimum wage is changing, and if it's a very significant increase that is significantly above and beyond what we would have considered through this "trend" unit cost increase; that would be something we would talk with the Department about.

Depending when it happens it would merit an analysis to see if it's a significant impact. If it is deemed "significant" we may have to make an judgment to rates at that time.

>> ARSEN: Thank you.

>> KATIE: Sure.

>> PAM: Jack?

>> JACK: Do you make the trends publicly available for the public to see in terms of what trends you took into in adjusting the database.

>> KATIE: I don't believe it is --

>> PAM: If we could repeat the question about that again?

>> KATIE: Sure.

Yep. The question was: Do we make the trends assumed in the rate development process publically available?

I was saying that I do not believe. Right now they are not publicly available. I don't believe OLTL intends to make them publicly available.

>> JACK: A follow-up question. To follow-up on the question about city, for example, raising its minimum wage to $15 an hour.

Separate and apart from a city doing that, what is it you look at or what did you look at to take into account obviously an economy that is rising and employment numbers are under -- well under 5%. So providers, in turn, are having issues, as I said before, recruiting and retaining direct care workers.

Can you elaborate somewhat on what you took into account in setting the rates for '18 to adjust the rates so that in MCOs, when they set payment rates for providers, that challenge was taken into account?

>> KATIE: I will let Tom talk about that.

>> TOM: So the question is around what consideration is given to how costs increase over time.

>> JACK: Yeah.

>> TOM: The trend as Katie mentioned does include inflation. To the extent it matches inflation or is in line with inflation then it would be built in as part of the trend development. The trend development also considers changes to utilization, which refers to the number of services being delivered to individuals in total; so that includes both increases in the number of people receiving services and average number of services per person that are being delivered.

As those change over time it is considered part of change development.

We also consider how is the mix of services changing so our, you know, certain higher cost services replacing lower cost services or vice versa and how does that influence the change in cost over time?

Furthermore, we do look at the contracting situation that is likely to emerge between the MCOs and providers and how have the fee-for-service rates been -- or the fee-for-service payment rates been historically. So there is some consideration for that specific issue.

>> JACK: Talking about inflation adjustment, so what is the inflation adjustment you look to apply in your trend analysis?

>> TOM: We look pretty closely at the CPI medical rate but furthermore, we look at what have cost increases been, you know, historically in the fee-for-service experience for this set of services.

>> JACK: So to the extent the fee-for-service system has not been adjusted to account for inflation, that would be problematic in terms of your database, wouldn't it?

In other words, the fees are old and have not been changed in several years to account for inflation that problem is reflected in your database.

>> TOM: That's right. That's why we do look at the contracting situation between the providers and MCOs understanding that the fee-for-service payment rates sometimes are held flat.

We do see adjustments for the most part historically in our data.

We do see increases in cost that, you know, can sometimes be attributed to other factors rather than free schedule changes but, you know, we will combine what we see historically with an understanding of how things may look in the future.

>> JACK: Pam, just one more question.

You mentioned CPIW. Wouldn't the Medicare home health market basket index be an index that should be taken into account?

>> TOM: The CPI is going to be used more when we look at the medical services. The waiver services and nursing facility would be looking more heavily at the fee-for-service experience from the actual Pennsylvania experience for the last several years.

>> PAM: Thank you, Jack. Arsen, do you still have a question?

>> ARSEN: I just wanted to point out that currently, attendant care waiver, they do not have access to adult daycare services. Once that gets combined into one waiver, now you have a whole bunch of people that are also able to access those services. I just want to make sure you had accounted for that because these people might be utilizing these services and they were not able to before.

>> KATIE: Yep. And that was part of the prior side when we looked at all of the five waivers individually. What do they have access to today, and then going forward, what new services and what they have access to.

Then we modeled additional utilization costs associated with that. So, yes, we considered that.

>> PAM: Thank you, Arsen. Fred, do you still have a question?

>> FRED: Yes.

Taking into account right now the federal budget and cuts coming through, how are you guys going to cover that? Have you thought about that?

>> KATIE: You can certainly add more, but what I would respond to on that one we set our rates separate from what is happening in terms of what budget is available for states or federal government.

We need to set our rates to make sure that we think they are appropriate for the costs that the MCOs will incur.

Budgeting in terms of having funds available to pay for that is completely separate outside of our process.

>> FRED: The reason I asked is if we are very short on money because of this federal cut. How are you going -- are you going to cut down on the rate on the MC Os or -- to pay them a little less to try to cover more?

>> KATIE: You know, we give the rates that we have developed to the

department. It is up to them to determine how they will fund those. I guess -- I don't think I can answer that question in terms of what they would need to do if they have cuts coming.

>> PAM: We can defer that to Jen, Fred, when she comes back.

>> FRED: Yeah.

>> PAM: We have a question from Dan Keating.

What is base year of historical data that was used in this model?

>> KATIE: We used calendar year 2014 and calendar year 2015. A little bit of 2016.

>> JACK: You but those costs forward using inflation index?

>> KATIE: Yep. We brought those costs forward basically about three years from calendar year '15 to calendar year '18.

>> JACK: Using inflation adjustment based on CPIW?

>> KATIE: And other factors.

>> JACK: I understand it's the department that makes the decision in the end regarding capitation rates, but do I understand you develop a range of rates? From an actuarial perspective, there can be a range of rates that are considered actuarially sound. It's a zone. Within -- it's a range and within the range you can have the top of the range and the bottom of the range and can the Commonwealth chooses where they want to put the rates; is that correct?

>> KATIE: Yes, that's correct.

>> JACK: Okay.

>> PAM: Barbara?

>> BARB: How are eligibility issues factored into historical data? Meaning --

>> KATIE: Can you talk more specifically about what you mean?

>> BARB: A lot of people can lose eligibility for one reason or another and your claims are denied and you have to have eligibility restored. Once it's restored, you bill and get paid. Does that get factored into historical data in any way?

>> KATIE: Yes. The historical data we are receiving would only be

showing claims, expenses during the times at which people are eligible. So if there was a month where a person lost eligibility and their claims were not covered by Medicaid, that wouldn't show up in our historical data.

>> TOM: Just to add to that, if an individual's eligibility status changes or whatever is retro actively changed, then if it happens before the data is generated by OLTL and provided to us, then we would have that in our data and we would be aware of that retroactive status change.

Obviously, we have to cut the data off at some point so there is potential for some changes that happen even after that run-out period. There is a pretty significant leg for most of that data before we actually get it.

So there is time for the vast majority of those changes to occur and be reflected in our data.

To the degree that there are some still that might occur, it's not usually going to be significant for the program as a whole.

Obviously, significant for that individual but when we are talking about total cost of the entire program it's not going to really move the needle, so to speak.

>> BARB: Okay. Thank you.

>> KATIE: So moving on, the next adjustment we make is for -- I think Tom mentioned this earlier -- the non-benefit expense, which is a term we use to refer to the overhead or administration load that the MCO has, as well as their ability to provide care management and service coordination costs to participants.

So we have a Mercer model that looks at, what are all of the types of administrative costs a mood he will would have to run the CHC program?

For example, they have staff that they need to pay wages to. They have a CEO. They have a human resources department. They have a member services department. So we look at all of those different components that they need to have and we price out each one of those. They have a it building rent and maintenance and computer staff.

We look at all of those things and associate a cost with that.

Then we also look at what it would cost the MCO to provide care management and service coordination costs. They have to employ service coordinators. We build up similarly a cost for that item. Then we combine -- those form non-benefit expense load. We also would include in

this component any taxes and fees that are required for the MCOs to pay.

>> PAM: We have a question from Brenda Dare of: Is data included for folks who are in appeal status? Did you factor that in in your adjustments, people in appeals?

>> TOM: I think that goes back to the -- a couple questions ago, that we are going to use data for whoever was eligible at the time the data was pulled.

To the extent that any appeals have been resolved, prior to the data being pulled, they would be reflected. If it's not resolved or still outstanding, then it's not going to be reflected because, as I said before, the data has to be pulled at some point and so there has to be a cut-off of, you know, what it accounts for.

>> PAM: Thank you.

Do we have any other questions from the committee?

>> THEO: Yes.

Did you share any data costs with the MCOs about the costs associated with service coordination being done internally versus subcontracting that service out?

>> KATIE: We build up the service coordination expenses based on what we project that the MCOs would need to pay service coordinators in terms of a wage. We did not make an adjustment that differentiates if they are providing the service directly or contracting out with service coordination entities.

>> PAM: Okay. I have another question. Brenda expressed -- this happens for folks who work and need to appeal to keep services when their income changes. So she was concerned about appeals being included, which we understand that they are upon us receiving the financial information once the appeal is resolved.

Okay.

So do we have -- do we have any other comments from Katie or Tom? Any other questions from the committee in the room or on the phone?

>> KATIE: I just have a couple more slides.

>> PAM: Okay. There are a couple more slides.

>> KATIE: I think the next slide summarizes once we put the pieces together that we just talked about, that develops this overall capitation

payment rate that we project will cover the MCO's service and non-benefit expenses.

As Tom already talked about, these rates get paid from the department to the MCOs, once per month for each personnel I believe and enrolled with the MCO.

>> PAM: Arsen?

>> ARSEN: If they switch in the middle of the month, what happens to the payment to the MCO?

>> THEO: Good question.

>> KATIE: There are rules around that in terms of how the system, you know, identifies a person moving and what day of the month that happens. I don't know the details; so that would be something that maybe Kevin might know. We can talk to OLTL about it and follow up.

>> Maybe Jill knows.

>> JILL: Hi. There are dating rules put together. They are mirrored off of what occurs in the Health Choices program today.

If somebody switches prior to, like the 12th or 14th of the month, their start date isn't until the beginning of the following month and after that, it would go to the beginning of the second month.

So all of that is being finalized for us on the CHC side, and we will have finite guidelines for how it occurs.

>> KATIE: The monthly capitation rate then gets prorated?

>> JILL: Yes. It is all programmed into the system. Once all of that is put into the system, it happens automatically based on those enrollment dates for the MCOs.

>> PAM: Can you state your full name.

>> Jill Vovakes.

>> ARSEN: It will be OLTL telling MCOs how many people they have and what they will pay or opposite and what the payments should be to them?

>> TOM: The question is, Is it OLTL saying how many people are enrolled or the MCOs saying who is enrolled?

>> ARSEN: [NODDED HEAD]

>> TOM: It's OLTL.

>> PAM: Arsen, did you get the answer you needed?

>> ARSEN: Yes. Definitely. Thank you.

>> KATIE: I think we are running a little short on time. We just wanted to highlight a few key milestones. I think we have talked about a lot of this so far.

So everyone is on the same page, we did start this process back in 2016. Where we started pulling the claims data? It is a complicated process that takes quite a long time. We started in October of 2016, worked on the rates through March of 2017 and then OLTL, Mercer held rates meeting. The MCOs were given opportunity to ask questions. We had dialogue back aesthetic forth. Eventually, the plan is that once OLTL and MCOs agree to the rates, they will then be certified to the federal government through our actuarial certification letter, which is a required step in the process.

We are targeting right now late June early July to be submitted to the federal government.

To make sure we are all clear the rates we set and talked about today are for southwest for the January 1/December 31, 2018 time period and also for the southeast zone for six-month July 1st to December 31st, 2018 time period, since that zone does not have managed care implementation until July.

>> PAM: I have a question about that. When we started this process with the Office of Long-Term Living, we were informed that they were going to learn from what happened in a launch in the southwest and it would inform, in some way, how they could adjust for the launch in the southeast.

Does that include the experience both MCOs and the people receiving the services from the MCO have? And if it looks like there needs to be a rate adjustment, will we be able to see that once it moves to the southeast or what it is today with no adjustment factor for real historical data as we start to launch this program?

>> KATIE: I think OLTL plans to learn, in terms of membership enrollment and lessons learned there from southwest to apply to the southeast.

In terms of the rates, they would not be changed based on what happens in the first 6 months, they would not be changed for southeast.

>> BILL: Bill White from AARP.

Somewhere in my history I used to be in charge of DPW rate-setting for hospital and entire fee service, which was impossible to do but, there I was.

I want to comment that it is an entirely different payment system and change is difficult. What I heard today was a very sophisticated, professional way to set rates, that takes in as many factors as you can. It's not a perfect system, but it's a better system than what I worked on and Jack who is much more knowledgeable than me, we were talking about something as simple as an inflation factor.

About I worked at DPW setting hospital rates, we never considered inflation. So what you now hear is a system that says, We are going to try to do something fair. We will consider wages. We will consider location. We will consider as many things as we can.

My constituents, which are senior Pennsylvanians, when they go to the doctor for a doctor's visit, at least somebody is looking on a capitation basis to say, costs have gone up. We will set the rates appropriate.

What the folks are trying to do is just set rates. The real action goes back to the managed care organizations that have to actually provide services.

So I was at least impressed by the new system and I think it was a better system than I worked on. Thank you.

>> PAM: Thank you, Bill.

>> TOM: Thank you, we appreciate that.

>> PAM: But Jack has a question.

>> JACK: First a comment. Thank you for coming and providing a good overview of what is a very complex process. I also want to make sure I understood what you said.

In evaluating the cost database, you looked at '15/'16 fees, 16/17 and 17/18 into calendar year '18. Is that using -- I think you alluded to CPIW?

>> TOM: So the question is, We adjust for the passage of time. We have base data that is from calendar years '14 and '15 and some from calendar year '16.

We adjust for changes to get us into the future period of calendar year '18 and those changes include things like inflation, service mix

changes. Utilization changes and the percentage of people who are receiving services.

So we look at all of those factors. It's not limited to just CPI, for example.

>> JACK: So the rates -- is it fair to say the rates would rise?

>> TOM: Yes.

>> JACK: Okay. Thank you.

>> Katie: So the last item we wanted to cover was just to give you a preview that as one of the questions asked earlier was, will you do this? How often? We said annually.

We will follow a very similar process down the road when we need to set rates for the calendar year 2019 time period. We will pull more recent data. New data as base data. Then we will basically redo our process starting this fall through March of 2018, to look at all of the adjustments, look at the non-benefit expenses, and then follow a similar process: Develop rates, talk about them with the Department, and then present to MCOs collecting feedback and questions. Will.

>> PAM: If I can interject. I guess we will start -- end a little about where we started with the idea of quality. Now we will have experience were first year ace rate adequate to deliver on the promise everybody wants to make sure the Office of Long-Term Living, the MCOs, the people around this table.

Is quality taken into consideration as you go to the second year in some way?

>> KATIE: So we would, you know, see it when we are setting the rates and when they need to be finished if there is any data available at that time. If we are finishing the rates in March of 2018, the program will only have been implemented about 3 months.

So it's not likely that there will be a lot of great data available yet at that time, but we will, you know, see what is available, assess at that time if there is anything that we can look to.

I don't know that the Department is also planning to monitor quality indicators. We are certainly in discussion with the Department about different things they are seeing.

If it is it was we can utilize when making certain assumptions or adjustments, we certainly would. Yep.

>> PAM: Thank you.

>> KATIE: In addition to the southwest and southeast, we would also be setting rates for Lee Hi-capitol northeast and northwest as well since it will be statewide managed carat that time period.

>> PAM: Jack.

>> JACK: Just talking about quality. Would you, for example, take into account or be looking to take into account provider staff turnover/vacancy problems? That, surely, is a sign that providers are having a problem recruiting and retraining direct care service staff.

Again, going back do our discussion earlier, in a rising economy, individuals will look to see where the best benefit package may be. The jobs that we are talking about are not easy jobs in any sense of the word.

In order to fairly pay those jobs, there has got to be fair reimbursement rates.

I do hope that among the other elements that you look at, turnover of staff, vacancy rates that providers experience are things that Mercer and MCOs will need to take into account.

>> KATIE: Yep.

We, definitely, are aware of the issues with direct care workers being able to retain them, hire them. The wage levels that need to be paid to be competitive.

So, you know, as Tom said, when we develop our trends, we have these different factors in mind. We feel that the overall rate is sufficient to allow the MCOs to run, you know, a high-quality program that has access.

It's up to them, then, to determine, you know, what do they want to do to address some of these issues with providers in terms of, you know, retention and further education programs and stuff like that.

>> Richard: Will there be provider network or various entities within the MCO that will address these issues? Is that accounted for within the analysis?

>> KATIE: Could you repeat your question?

>> RICHARD: Just to continue with the question of quality. How will that be assessed with the MCOs or will there be a Department or someone monitoring this?

>> KATIE: There is an individual in the Department that is in charge

of that outside of the realm of what we do with the capitation rates, though.

>> Hi, this is Randy Nolan. I am with OLTL. Yes, quality is a big part of what we are doing. We have quality plans in place. We will be working very closely with the MCOs on a number of quality indicators. We will be doing launch indicators as the program comes up January 1st. The first 3 months we will do extensive quality checks. Part of that will be looking at quality network on a continuous basis to make sure that there is adequate number of providers out there, adequate number of qualified providers out there.

We will be working with the MCOs and requiring a lot of data and a lot of work around quality issues with them.

>> RICHARD: Thank you.

>> WILMARIE: Hi. This is Wilmarie Gonzalez. I want to add to what Randy said. Our plan is, as many of you know, the quality plan has already been released. Next Tuesday is the deadline for feedback from stakeholders regarding the quality plan.

Within the quality plan, we have proposed a list of performance measures. It does include rebalancing. It does talk a little bit about the CMS waiver assurances that we have already listed in our CAC application. It also includes workforce measures, retention and recruitment.

We have already had extensive discussions with MCOs. They have provided feedback. We hope to share that feedback with the MLTSS membership here at a later date.

>> PAM: Thank you, Wilmarie. Thank you, Randy.

>> BILL: Bill White from AARP. Once again, what you hear the quality issue is mainly on the managed care organizations by the staff managing the quality issues at that level. The rate setting is kind of above that. The real action, my understanding, at the managed care level, which is where the important oversight has to take place.

Thank you.

>> CARRIE: I am sitting in for Tanya Teglo today. My question is, I understand these are the rates that have been set for the MCOs. Also, my understanding is that the agreement says that for the continuity period, that rates for providers must be at the level that they currently are and cannot drop below that.

Has there been a calculation made for a bottom rate for providers that also takes into account inflation and all of the other things that you have discussed? Will that be done if it hasn't, and will it be made public?

>> TOM: Any rate floors that are required are part of our rate development process so we do look at that.

>> CARRIE: Is that something that will be made that portion of it public? I realize the whole process is an agreement between the MCOs and the department, but the part that would the rate floors for providers, is that something that we will be able to see?

>> TOM: I can't speak broadly on that topic. In the context of the rate setting process and the assumptions that we made, those are not public. It's not public information.

>> CARRIE: Okay. Thank you.

>> Veronica Comfort from PCOA. Are there any specific adjustments for residents in nursing homes?

>> TOM: Can you provide more context around what you are thinking?

>> VERONICA: If there is a resident in a nursing home, what would be the rate? Does MCO provide the care for or -- the provider of the nursing home. Is MCO paying the nursing home and are the rates adjusted because they are living in a nursing home?

>> TOM: So the rates that are paid to the MCOs is based on whether they -- the rates do not vary when in a nursing facility. We take all of the historical experience for people in nursing facilities and build that into the rate process. So those costs are accounted for but the amount that the MCO is paid does not change if someone is in a nursing facility. Okay?

>> VERONICA: [NODDED HEAD]

>> PAM: We have time for one or two more questions. Jack?

>> JACK: Not so much a question but a comment with respect to data that may or may not be publicly available. That raises questions for another day, but obviously, Mercer could say that their model for developing the administrative portion of the capitation fee, I would assume that you would look to say that that's proprietary and you may not, otherwise, voluntarily release it, but whether and the extent to which other information -- again, including that model might be available, actually are legal questions. I understand your position that you don't

believe the -- that information we have been talking about is publically available, but I think I have to say for the record, that that's not necessarily so. Thank you.

>> PAM: Thank you, Jack.

We have a question from Ralph Trainer.

Will rates for Act 150 be the same as they were before?

>> It is --

>> KATIE: It wasn't part of this rate development process.

>> PEGGY: Act 150 is not part of Community HealthChoices, and is not on the discussion today. So to repeat the question, they want to know if the rates for Act 150 will change. Currently, the rates are the rates for Act 150. It is not something we are here to discuss today.

>> PAM: Thank you. There is time for one more question if anybody has one. If not, then all that is left is to thank Katie and Tom very much for fielding all of our in-depth questions.

Your information was very helpful to us today.

I'm sure there may be other questions the committee or public has. Will you be here until the end if there are any public questions?

>> PEGGY: We can be.

>> PAM: That would be great.

Again, always go to your listserv if there are things you think about after the meeting you want answered send it to the listserv so that we can continue to ask the questions that we need to ensure that the launch of MLTSS is as good as it possibly can be.

Thank you very much!

>> KATIE: Thank you.

>> TOM: Thank you.

>> PAM: Next on the agenda is a discussion about the ABLE program; that's from Charles Geld. Is Charles here? Hi, Charles.

>> CHARLES: How are you?

>> PAM: Very good. Welcome!

If you can get the flash drive in. Why not begin and we will see if we can get that up and running for you.

Why not get started and that will catch up to you.

>> Charles: I want to thank everyone for having me my name is Charles Geld. I am a Pennsylvania program representative within the Treasury Department I promote two programs Pennsylvania 529 college savings program and Pennsylvania ABLE program. I am here to give a brief overview on the PA ABLE program.

State treasurer Joe Torsella is pleased the program is now open for enrollment. We at Treasury want to Mick sure that everyone eligible to have an ABLE account know about this extraordinary new low-cost vehicle allowing people with disabilities to save for qualified disability expenses.

When I say qualified disability expenses there will be a slide.

The great thing about that is, it's very broadly defined. There are a lot of expenses it can be used for. There are none mentioned that it can't be used for; so that is great.

The Achieving a Better Life Experience Act or ABLE. What is ABLE? ABLE stands for a Achieving a Better Life Experience. It is a savings program designed for individuals with disabilities. It allows them to plan for financially secure future, save to pay for disability-related expenses, have assets without losing federal and state means-tested benefit, which we will cover in a few slides from now, receive significant and federal state tax advantages and be more financially independent by controlling the account; that's a very important point because when I am speaking to different advocates or groups about having an ABLE account, the great thing that they always say is, Now the individual with a disability has the control of their money in their own account; that's one of the most important aspects.

We have six investment options and interest-bearing checking account. You are able to put a percentage of money in the interest-bearing checking account where you can mix and match investment options. You can have control of some money at all times but then save some in some sort of investment portfolio.

Interest-bearing checking account is something that many, many advocates and families are very happy we have and also a debit card that can be used for purchases is also something. The most important thing in this for special needs trust is that the individual with the disability the control of their own money to pay for different disability-related expenses, which is very, very important.

So some background on ABLE: Federal and state authorized -- create and maintain PA ABLE. The law itself provides framework and details are provided by regulations from the IRS, proposed regulations have been issued and PA ABLE has been designated to comply with those.

Federal agencies SSA or Social Security Administration have issued guidance on how ABLE accounts will affect federal benefits other federal agencies have not leaving a number of unanswered questions.

We know a lot about what is going on with ABLE. When we reach out to different agencies and they have not yet gotten back to us, it is still pending or we are waiting for a response. There is some detailed questions that people ask that we try to get back to them on, of course, we have a website and info page that people can ask questions. Sometimes the response back may, unfortunately be, "We are still waiting to hear ourselves."

We get back to everyone with specific questions.

>> PAM: Do you want to wait until questions until the end because there is a question for committee member.

>> Charles: That is up to you based on time and whatever your thought is, depending on who I am speaking to or how much time I have some groups like to wait until the end.

I tend to like to answer during but I have also seen that extended.

Whatever you feel is appropriate.

>> PAM: Let's take the question. We have to be mindful of time because we did go over on the last session.

>> FRED: This is from Tanya Teglo. Ask him whether or not federal organizations such as HUD are being made away of how the ABLE accounts are supposed to work and are these other programs that are affected by income ready to help assist those who may wish to sign up to are ABLE accounts? Has there been clear communication between offices so each will know how they will have to work in conjunction with each other?

>> CHARLES: Yeah. Great question, Tanya!

I would think this started from a federal level. This is me as a field representative talking. Of course, there are plenty of people above me within the Bureau that have dealt with the baby steps leading up to the implementation of it to know who has been contacted from a federal level.

I would think from IRS, SSA that HUD was also probably in that conversation. I am going to show an info@PAABLE.gov where that question

could be asked. I can get a definite answer but an answer now I would think federal and state agencies are trying to get ahold of all of The Arcs and they are getting ahold of us. We are trying to do PR related to it. I think the federal agencies are talking.

The clear communication part, I would think as much clarity that could be given at certain times that still have if-y or unanswered questions, I am not sure how clear the inner governmental relations would be from a state to federal aspect of it, but we at Treasury are trying to communicate the best we could to everyone in advocacy groups involved I could say.

>> PAM: Thank you.

>> CHARLES: Uh-huh.

So what is presented here is what the Treasury Department knows but it is subject to change when IRS regulations and agencies are issued. We have no word on when that might be; that may also help with that question too.

So with the PA ABLE overview, before we can talk about the features and benefits of ABLE, we need to go over what the federal law provides, because Pennsylvania incorporates the federal.

There are two major federal benefits: First federal law expressly says assets in ABLE account qualified withdrawals account are not qualified in means tested benefits with limitation for SSI. We will go over that for a housing issue, of course.

This is extremely important because with ABLE how much individuals with disabilities can save and still receive government benefits was very limited. For example, SSI limit is $2,000.

The second major federal benefit is tax treatment. While contributions are made with after-tax dollars, any earnings or growth while in the account are not taxed which is called tax-deferred just like with college savings program money in there may grow federally and state tax-exemptions stay with ABLE account.

This is different from interest-bearing checking or savings account on which you need to pay taxes each year.

When you use the account for qualified disability expenses, which we will talk about later, you don't owe any taxes on earnings, which is called tax-free or exemption same with 529 plans.

The ABLE mirrors 529 plans traditionally there may be issues where it

does not or may not but it was look willed at to mirror qualified higher education expenses versus qualified disability expenses. It mirrors that with growing federally and state tax deferred and being tax-free.

The difference between taxed and untaxed earnings can be thousands of dollars over a lifetime. It means they can be used for disability expenses instead of paying taxes.

Because of tax benefits is used qualified expenses it is important to deep documentation in case you are audited.

They are not looking at it could be random sample, audit by IRS.

Obviously, with anything you do with your career or life, it's always good with a mortgage, rent, life insurance, buying a vehicle, renting something to obviously keep supporting documentation and receipts. The same importance is where the ABLE account too.

Benefits specific to PA ABLE account in addition to the federal benefits, the tax benefits, Pennsylvania law has several PA-specific benefits. They are only available in Pennsylvania if they used the PA ABLE program rather than other states.

We bring that up because in the beginning, before the implementation of Pennsylvania's the Treasury Department had a specific date set. We belong to a certain consortium. Instead of PA doing their own as many people may know, whenever you try to purchase or buy something, sometimes it's always better for lower costs to be in a group, whether it's buying T-shirts for an advocacy group or baseball uniforms, I want to buy more than less.

The same thing with ABLE there was a consortium of many states and it took longer to get what PA wanted. The beginning date was prolonged a little bit, but that was to help lower costs. The fight ended up going our way because it's free to enroll and minimum contribution when you put money in in the initial contribution would just be $25, which that went back and forth in the negotiations.

Because of it being a little bit longer, it may have somewhat angered people. We understood that but we wanted to make the implementation of PA's, PA-specific for different rules and regs. Different states implemented it quicker, we will say, but we fought for certain things for a legal standpoint to be able to PA-specific.

If somebody didn't want to wait, the point of this is, if somebody didn't want to wait and went to another state and opened an ABLE account that's fine you can roll over the ABLE account from another state into PA's; that's why we are mentioning that.

Similar to federal law state law excludes funds in ABLE account to be counted certain needs-based benefits.

Benefits related to health, including medical assistance disability or student financial aid.

State law mirrors federal law and tax benefits. There is no state income tax on earnings while funds are in the account or when the withdraw is used for qualified disability expenses.

One last and significant benefit is PA Department of Human Services may not seek repayment of medical assistance from the ABLE account. The federal law allows the state to seek repayment of medical assistance for all benefits provided while person with disabilities had an account from earliest age and all benefits.

PA law provides department -- once the assets from the account are in the estate, however, they may be subject to repayment under normal medical assistance rules.

In much more limited circumstances and amounts.

The deceased must be 55 years or older and repayment may be sought for services after that age and second repayment may be sought for nursing facility services, home and community-based services and related hospital and prescription drug services.

Repayment is postponed if there is a surviving spouse, child under 21 or child of any age who is blind or disabled.

We talked about ABLE being for individuals with disabilities but not all individuals with disabilities are qualified to have an ABLE account.

The federal law imposes two requirements: We will start with the second requirement because that's the easiest.

The onset of the disability must be before the individual's 26th birthday. If an individual is in a car accident and suggestion stained significant brain damage say at age 25 they can open an account but not if the accident occurred at 27.

>> FRED: What is the status of raising the age limit? I thought it was going up.

>> CHARLES: Great question. There is pending legislation now to make it 46, I believe. I will say, unfortunately, when this was being hashed out from a federal standpoint, the age was negotiated. To be able to sort of push this through or to be able to have this go through, negotiations had to happen as you would say with anything that you are

doing or promoting or trying to pass from a legislative standpoint.

I believe the difference in having age 26-46 was -- it's so significant I have it right it's -- 20 billion to 2 billion. The difference -- if it was that higher age it was going to be that much more.

There has been a tremendous amount of advocacy groups and people just fighting and fighting and fighting, which is obviously warranted, to be able to have this go through.

There are a few other legislative things going on too. Where is it at? I am not sure currently where that may be, but I know that it's been introduced; so that's good.

There may have been a hiccup last legislative session because I believe they tried to -- so there are three pending legislation issues. I believe they tried to bunch all three into one and I think that may have stalled it slightly.

One of the ones was making the age be 46 instead of 26. The other was, if you are able to deduct what you put in off your state income tax.

So, again, that mirrors 529 college savings programs.

Aunt, uncle, neighbor, guardian, mom and dad, a friend of mine that has a disability, I could put money into their account to help them but I also can't deduct it off of my state income tax currently.

If I have a younger child lives next to me I am invited to birthday maybe instead of giving same gift that they have, I can give money into a 529 college savings program and take a state tax deduction; that is also being looked at right now.

To mirror more what 529 is. I know there are two currently that I will say are pending. Currently right now I don't know the bill number. I am not sure where they are at.

The good news you can maybe say or maybe argue is that they have been introduced. I would think that if they were bunched and there was an issue hopefully they will not -- not to bunch them and maybe pass -- I don't want to say what is more important because it's all of equal importance but maybe, again, to get things through, they may have to see about where to promote it within the legislative session or in what committee.

Person can be any age when account is opened. The age restriction only applies to the onset of the disability.

Returning to the first requirement, there must be qualifying

disability so what is that? If an individual is entitled to SSI or SSDI, they have a qualifying disability they don't need to be receiving benefits just entitled to.

There may be reasons that a person is entitled to benefits but not receiving them. What about individuals who have a disability that would qualify them for either of these benefits but they don't have enough work history for SSDI and they -- there is a little bit more money in an account for them not to be able to qualify, say, for SSI. So they don't have a certain amount of money to qualify them for SSI.

For these individuals, there is another option and that is self-certification. With self-certification, I am looking to see here the specific notes. Actually, self-certification would be where you go to a doctor that is SSA certified or qualified. They would be able to sign off saying that it was a qualified disability.

>> FRED: Oh, okay. I got you.

>> CHARLES: I have been to some events where people said I have too much money in account and didn't qualify for SSI or a doctor said they definitely could get an ABLE account the doctor just needs to certify it. How do we go through doing that?

So, you know, different advocacy groups, IU, school districts, at least are guiding them or at least letting people know about maybe certain doctors to check into whether it's a former Dr. a child had to go to for a diagnosis or past doctor's visits to show supporting documentation and be able to self-certify that disability.

It so those first two -- if SSI and SSDI isn't the indicator to be able to have it, and it is of that age that we talked about prior to the onset being 26, the self-certification is the other -- you can say, rule or reg to be able to open an ABLE account.

We have talked about who can have an ABLE account. Now we are just going to cover, actually, opening an ABLE account. They don't necessarily have to be the same person. If the person with the disability is 18 or older has a legal capacity to contract, the federal law requires them to open the account for themselves.

After it's open, they may designate others to have some degree of control over the account with them, which is called an authorized agent.

They must be the one to open it. If the person with the disability is under 18 or lacks legal capacity to contract somebody can open the account for them, even though the person with the disability remains the account owner, that person, the authorized is fiduciary and admins for the

account owner and cannot benefit personally.

Federal limitations parent, guardian or person with power of attorney, as mentioned when you cover PA-only benefits in Pennsylvania authorized individual retains control. Once they become adult, they can request and be granted control once 21, unless there is a court order saying otherwise.

So the next slide --

>> JACK: I have a question.

>> CHARLES: Yes?

>> JACK: So a minor with an intellectual disability and the parent opens the account and the minor then becomes 21, in order for the parent to maintain control, they have to be appointed guardian or have a guardian appointed, is that what you are saying?

>> CHARLES: I am not sure it would be a guardian. I think --

>> JACK: You have court order.

>> CHARLES: I'm sorry is that what you meant?

>> JACK: Guardian is appointed with court order as opposed with power of attorney which doesn't need a court order.

I am just curious in terms of -- oftentimes, for someone with an intellectual disability, parents will not necessarily seek guardianship, formal guardianship nor will they when the child becomes 21 will they look to have a guardian appointed.

As I am reading what you have on the slide, someone with an intellectual disability, the account was opened, once they turn 21, according to that, they can request and be granted access to the account absent a guardian being appointed.

>> CHARLES: Correct.

>> JACK: I understand that.

>> PAM: We have a question from Theo.

>> THEO: I may have missed it or you didn't get to it.

Is it income restrictive?

>> CHARLES: No.

>> THEO: So anyone with a disability that could be entitled for SSI Social Security, who is working and has a certain amount of income could still open an ABLE account is what you are saying?

>> CHARLES: Correct.

If they are getting SSI, I believe the great thing about this is, you know, the extra money over the $2,000 could be put into an ABLE account. It wouldn't impact SSI. With SSDI, you are also able to have it. The important thing too -- I didn't mention it yet but will now with Theo's question. The important thing to remember, if say grandpa Joe or uncle Jim or somebody wants to gift money or guardian or anyone wants to gift money to the individual with a disability, you wouldn't give it to them for them to buy groceries.

So again my dad would see me next week and give me money to buy coffee because I live for coffee because I travel so much.

Giving me money for coffee makes a lot of sense for me. So in that case, it would hurt me because it would impact my SSI. So I would tell my dad -- I am bringing myself into this because it's easy to compare coffee whenever I talk about anything, I would tell my dad to just put it in my ABLE account then it wouldn't harm anything with SSI.

Anyone that could gift money -- if my family wants to give me money to buy groceries, I would say, put it in my ABLE account and it would not negatively impact me.

Depending how much money I would make, if I had SSDI or SSI, I can have that ABLE account. Considering self-certification or having a qualified disability, of course.

>> PAM: We have a question from Brenda Dare from the phone.

She would like to know what education is being provided to county assistance offices so they know it's not a countable asset.

>> CHARLES: I know within the bureau, we did some out calls. I know in the beginning of ABLE being established, recognized implemented, there was a lot of out calls and many things done. Many Arcs, centers for independent living, were doing a lot of outreach with counties.

In some counties we reached out to it may have gone to another department within and they got the brochures.

When people wanted to know about ABLE before it was official, we had something on our website where people called in where they could get updates regarding where things are pending or launched or there will be an

event.

Forms like this, I know that she cannot see this but it's called "a materials order form".

Many organizations sent in a certain county assistance agency, contact name, address, they requested 30 brochures and checked the box, requesting ABLE webinar, ABLE presentation, information for a newsletter, website, portal, social media outlet or host information table at an event.

When a county group was going to meet with different counselors or field reps. that deal with certain families or clients, and it's going to be just next week and they can't have us out because their agenda is already filled, they would ask for brochures and maybe their event in July we would go and personally give a presentation or if one month we couldn't, we will see about doing a webinar at 6:00 at night. They could definitely call the 1-800 number. Email us at info@PAABLE.gov. They could say I would like brochures.

Anything like that. There is no limit. You know, if we cannot get out there because things will be in certain areas, we try to make everything work when it comes to these forms. I could email this form and a PDF of the brochure if anyone that is asking questions or that is here may want it.

We are doing things like that whether they ask us or we do a random outreach call list. We are trying hard to reach all of them.

>> PAM: Thank you, Charles.

>> CHARLES: Uh-huh.

This slide could appear to be confusing, but we are not trying to do that.

We are just showing the six options: Aggressive, moderate, growth. Different portfolios in the investment breakdown just like people's retirement or anything like that with investments. A certain possessage of stocks and bonds are what makes it aggressive, moderate or, you know, anything conservative or things like that.

This is broke even down on what the percentages are. The riskier the investment and more money you are investing a little more of what that will be.

This just shows we have seven options one is interest bearing checking account which has a debit card, which people I said really,

really like.

Then we have six individual-type portfolios that have stocks and bonds with different comfort levels, of course. This slide just shows that.

The checking account option and cost, I won't go into too much detail about that. The bank is called fifth third bank. It needs a slight definition because depending -- have many people herd of Fifth Third Bank.

>> FRED: It's mostly in the south and not up here.

>> CHARLES: It's mostly from Ohio they branch for brick and mortar facilities.

The first thing to say is with consortium and administrative -- our vendor for the program came up in negotiations of the bank. It wasn't a PA treasury Department negotiations. It's just Fifth Thirds Bank that's what it is.

If you go to Fifth Third's website you could put in a zip code. There will be ATMs at random placed that you are able to withdraw the moneys from. I think in the Philly area or in the southeast area I believe Wawa is a certified ATM. I was giving a presentation in northeast PA last night to the Center for Independent Living in the Scranton area. As I said this same slide -- I said oh, I don't want to go to the website I want to make a slide available but it would -- I fool around about coffee but this is a serious fact.

Where will I stay at the beach in I go to Google maps I put Dunkin Donut location it will go aerial view if it's too far to go for a coffee I don't care if it's ocean front. I have to be able to get coffee. Hotel coffee will never cut it! That's how I stay at the beach.

Same thing with this Frith Third Bank, with dots saying with where it is.

The lady said there is one at ACME. It's easy to do, but I just don't like saying, go to the website and check it out yourself because that's real good customer service in my opinion. I know the lady did it within 10 seconds and found it. I would like to eventually have a slide for everyone that maybe has northeast and southeast, different parts of the state that will at least have a snapshot of maybe where. Maybe not so much the address because somebody within our bureau said this slide will be crazy with how many dots will be there.

I feel like having a slide to guide you rather than no slide. We were working on something like that. The lady mentioned it was easy to

find.

>> PAM: I will alert you; you have five minutes.

>> CHARLES: Very good. Thank you.

Of course, Fifth Third has ATM, checking, electronic is a little bit cheaper. You can see from the slide up there zero-dollar overdraft or return payment fees. Some people call the bank to get the answer some call PA ABLE service Pam in-house treasury deposit that deal with 529 and ABLE they get the individual disability set up to be able to guide them in a certain way according to cost, rules and regulations, of Fifth Third.

Sometimes I debate why it is so far into the presentation because it's so important. This is what you can use the money for. Those are the qualified disability expenses. They are defined as basic living expenses. I will say from the beginning infancy stages of this to now, the one non-qualified withdrawal that you can argue or possibly say is gambling. You can't use it for gambling.

Then I also had people at different groups counter and say, you see up there education and wellness. So some people questioned if I bring my nephew to the casino and I -- you know, socialization that is a good argument. If you put $50 bucks down and lose $50 it's educational to know that -- [LAUGHTER]

Also, if you win money it's an addition problem.

There was an argument for and it doesn't say it can't be. It's been said from the beginning that that probably is something that is a little more gray than clear. There was argument, definitely for it.

You can see funeral and burial to make sure that moneys left in ABLE can be used for unfortunate situations legal fees and health.

The question is what can't it be used for, in all seriousness. It's not defined very well; that's good.

I would think as the years and quarters pass and there is significant uses for this, that they will come out with non-qualified, if it tends to be a continuing issue as with anything, with college savings or some things that it can't be used for and with this, possibly, there may be. They like it to be very broad now to have people, to be able to use it for basic living expenses like it's intended to be. I think it's important take-away from that slide.

Qualified or non-qualified. Obviously the qualified expenses are what I showed on the last slide. Non-qualified, if you take it out the

earnings will be taxed federally and state plus an additional 10% federal penalty. Keeping documentation is key, whether qualified or non-qualified in case there is an audit.

Qualified housing expenses. I jumped ahead there. Housing expenses for SSI purposes, the difference housing expenses are listed mortgage, property taxes, rent, heating, fuel, different things like that; that was just recently added to be brought up for SSI purposes. Just to be a bit more direct towards some expenses.

Interaction with SSI. With ABLE the amount in the account is not counted as resource up to $100,000 amounts above that are counted that means SSI recipient that has $102,000 in resources 100,000 in ABLE or 2,000 in other or 102,000 total. SSI you can save up to 102,000 whereas prior to ABLE it was only 2,000; so that's the good news with this.

Very briefly with housing. I keep saying with limitations for SSI. With housing, qualified but can impact SSI benefits. Under the rules of SSA if individual receive money to help in any way with monthly housing costs it would result for moneys being reduced as much as 1/3 since ASSA looks at SSI only on the first of the month if the withdrawal is made same month as housing expense is made there is no impact.

Taking out the same month is withdrawn is what the key is.

If it's used after, it could negatively affect SSI for that next month; so that's where the "with limitations" would be if it goes into the next month it could negatively impact SSI -- sorry to rush a little at the end. I wanted to give more detail now that we have implemented. I would like to thank everyone --

>> PAM: We have a question from Brenda. She would like to know for people with disabilities who work, how often would they be able to roll money over into ABLE?

>> CHARLES: How often? I don't know a limit of how often. I know systematically give from different areas. The silly example of coffee money. Loved ones and guardians can give money to ABLE. Money from work. They don't have the $2,000 limit because of SSI. So they could put it systematically in monthly. They could put it in at-will. There is nothing that limits them on when they have to do that because they work.

>> PAM: Thank you very much. Thank you for your presentation.

>> PAT: She clarified by before --

>> PAM: She wanted to know from her 401K.

>> CHARLES: So just like with college savings, you can roll over a 529 into a PA-529. 529 to 529 is tax-free event within 60 days, of course.

Is it may not be able to be tax-free roll-over but taking money from 401K early whatever the rules and regs for tax consequences would obviously go into play for that.

Having money from working, being gifted or anything like that, you can put that money in, just like if you have a savings bond and take it out. It may not be a tax-free roll-over into 529 you can do that but rules and regs from taking money out early would be in effect. When you have that money, I think you could put it into an ABLE account because you have that money to put in.

It wouldn't negatively affect SSI if you put it in your account because of you getting SSDI, I would think.

That may be a good -- I think maybe the last slide -- after questions. I will see if -- if we go to the exact last slide right there. Anyone that has a question or maybe a little bit more detail about the guardian question or maybe anything like that, info@PAABLE.gov comes to Is. We shoot answers back out. If we don't know because of it not being clarified we will let you know; that's where questions could be sent. It's a great email address to be able to get us; that's our website which is done, in my opinion very well. The 1-800 number, there are treasury department employees that deal with ABLE.

>> PAM: Thank you. That will be posted. You will be able to get to Charles. Will that go to you directly Charles?

>> CHARLES: Oh, yes.

>> PAM: That will go directly to him. The Chair wants to recognize that Jen Burnett is back in the room. Jen as you can see we are behind on our agenda. There is a lot of energy around the methods used to set rates. I am going to turn it over to you for your update. Do you want to come to the front?

>> JEN: Should we do a five-minute update on functional eligibility do you think you could fit it into five minutes?

>> MIKE: I can do anything you want, Jen.

>> JEN: It will only take 5 minutes. He doesn't have much.

>> MIKE: Jen just said I don't have much. Thanks, Jen.

>> JEN: You know I am kidding.

>> MIKE: Just an update on the testing. As everybody knows April 26th we had training for the assessors functional eligibility determination tool which is the tool we are working on to replace the current level of care determination tool.

April 26th we had testing for the assessors. After that and during that meeting and after that meeting, we had discussed protocol for how the testing was going to go with the University of Pittsburgh and Steve Albert, Dr. Steve Albert, who is heading this up for Pitt. He and the assessors had a good discussion and good communication between the end of that training and testing, which started on the 15th of May.

Currently, the testing is under way. We have approximately 30 assessments, FED assessments that have been done and submitted for review by Dr. Albert's group and concurrent level of care determinations because they are doing a comparison between the two.

We want to have 200 of those completed by the end of June. Dr. Albert is confident given the progress that the assessors are making because there is more that haven't been submitted to him yet but they are being completed regularly.

He is confident that we should have those 200 done by the end of June.

Currently --

>> PAM: Mike, you are being asked to speak up louder.

>> MIKE: Really? Wow!

>> JEN: Come over here you need to sit near here that's what the problem is.

>> FRED: They can't hear you on the phone.

>> JEN: Yeah.

Sorry about that on the phone. He is moving over near you. Front and center.

>> FRED: Loud but not that loud!

>> MIKE: I am not sure if you want me to start over, that gives me another 5 minutes Jen said, No.

The assessors are doing a fine job. we hope to have 200 tested FEDs by the end of June.

Currently, I don't think I ever mentioned to this group where the testing is being done at, but currently we have 10 AAAs representing 14 Counties that the testing is being done in Perry, Warren, Forest, Erie, Union, Snyder, Montgomery, Blair, Philadelphia, Fulton and Wayne County those AAAs are participating and have graciously given us a staff person to work on the FEDs for the month.

At the end of this month we will be compiling the results and putting together a report. I will have Dr. Albert come to this group and give an update at that time as far as what the results were, where we are at with it and what the next steps will be after that; so that's my five minutes, Jen.

>> JEN: Very good. Thank you.

Any questions?

>> MIKE: Any questions?

[NO RESPONSE]

>> Did you say the report will be done at the end of this month?

>> MIKE: Could you repeat the question please?

>> JEN: He wondered if the report would be done at the end of this month? Mike confirmed it would be done at the end of this month.

All right. I am going to start out with some updates where the Office of Long-Term Living. Then open it up for questions. Fred has already informed me he has three.

[LAUGHTER]

>> FRED: Not me!!

[LAUGHTER]

>> JEN: I will start out with a question and comment Tanya made. Tanya, I understand you are on the phone. She sent in a question about Services My Way in my managed care environment.

One of my concerns is since MCOs are managing all facets including attendant care what consumer have to do services my way and what they will be responsible for in the future.

That was one of the questions.

Tanya, Community HealthChoices will not change self-directed model

including services my way. We will continue to have fiscal management service and continue in the role that they are currently in.

The next question she asked is: If someone is in control of their whole budget and the types of services they receive, does this mean the scope of choice will be widened to include all types of services and all providers and will the consumer dictate that in terms of costs? Meaning, will said consumer not have to determine wages of workers but types of treatments me receive? How will this work in terms of medical equipment and how soon will we know style which MCO chooses to run it.

Again, Services My Way will not change or Community HealthChoices. You will continue to do everything you do in the current fee-for-services my way so none of those things will change.

How would MCOs go about correcting lapsed orders in terms of medical equipment and services delivered? Again, this will continue to be handled via FMS as it is today and we are not changing that. That will continue to happen as you do it today.

In terms of the regular consumer model I am also curious to know will training of workers be required by managed care organizations?

We are requiring pre-service orientation and not training in the new FMS procurement. Main curriculum topics include understanding independent living principles, recognizing and reporting fraud abuse and neglect, workers rights, operational procedures and paperwork including but not limited to who the employer time sheet requirements, he pay schedules and overtime requirements.

We have a big problem in this area where many of the consumer employed believing FMS employees them they believe they are employee of the FMS.

This new orientation we will be requiring really goes over the fundamentals of what the self-directed model is, so attendants when they go before a hearing, for example, there is a lot of turnover with attendants. There is also a lot of workers comp. claims. In worker comp. claims we have an issue whereby the judge ends up believing the FMS is the employer and not the consumer. We are trying to fix that by providing the pre-service orientation.

How will worker wages be determined? We are not changing this. Again, this is determined between the employer and the employee.

Will there be a scale of wages like to there currently is under PPL or will MCO simply dictate wage like was previously done before PPL took over and as much as coordinating agencies had control of payroll.

Under CMS rules we have to provide max billable rate; that's what we provide as a parameter for FMS to operate under.

It is a requirement that means that the employer sets a rate that has to take into account the consideration of all ancillary costs such as employment, unemployment comp., taxes, other fees related to being an employer.

So that max billable rate is not the rate. It is just the max billable rate. So whatever the participant or employer, which is the person receiving attendant care, the employer sets their rate but it also has to be able -- we the FMS has to be able to pay all of those other things as well.

The next thing I wanted to talk about, we had some questions about this is, the consolidation or unification of state government and that's four departments being unified into one new department in health and human services. Those departments are Department of Aging, the Department of Human Services, the Department of Drug and Alcohol Programs and Department of Health.

He does announce about two weeks ago that he intended to nominate the current Pennsylvania insurance commissioner, Teresa Miller, to serve as inaugural secretary of health and human services. He had -- there was a quote about her qualifications in press release that went out. We don't expect that to affect Community HealthChoices; that's the question that was asked us. We don't expect it to have any effect on Community HealthChoices. CHC is top priority of the Governor. Secretary -- future Secretary Miller is a proponent of managed care. She has been asking me to give her a briefing on where we are with Community HealthChoices. It's being scheduled.

I don't think that that is going to change the direction we are moving with Community HealthChoices.

Another thing that I was asked to talk about here is that -- we have started inviting the managed care organizations to come -- the CHC MCOs to come to the meetings.

I want to give you a heads up if you are going to them after the meeting and asking a lot of questions and they are not able to answer the questions right now, there is a reason for that; that is that we are still in negotiations around what their agreement is and what we are expecting them to do in the program.

We got that agreement to the MCOs in the last couple of weeks. They are pouring through it right now. Some of the questions that they are getting asked really are things that should be directed to the Department

not to the MCOs at this point. If you have questions, come to us rather than directly to the MCOs at this point.

We are asking the MCOs if they do get questions from providers they don't know the answers to we are asking them to submit them to us as opposed to try to answer them whether they don't know all of the answers at this point.

We also have our RA box where you can always ask questions.

Provider communications. Can we put that up on the -- oh, here. We do have it. Okay.

Two communications will be sent out, I believe today. Actually three today but two that I am going to talk about here.

We have a series of meet and greets with providers in the southwestern part of the state at the end of July a flyer is going to be out. Can we show that flyer.

>> It did go out.

>> JEN: And it went out.

This flyer has the dates and the locations of the three meetings. One in cranberry, one in Pittsburgh and one in Altoona.

We are going to be replicating this series of meet and greets in the southeast as well.

The afternoon break out groups, we are working on right now for the providers are nursing facility providers, home and community-based providers, Area Agencies on Aging and service coordinators, physical health providers which we have not done a lot of communication with but we need to so we will be working with the hospital association and with Pennsylvania Medical Society.

We have had meetings with them. They said just let us know when we can help you. We will be working with them to set up the breakout on the physical health side.

And then last is behavioral health we are working on physical health break out and partnering with office of mental health and substance abuse services on the behavioral health breakout.

So that is the flyer that went out.

The next flyer is a participant communication, which we would like feedback from. We are planning to send this flyer out to participants in

the southwest in early July. I believe the date is July 7th.

We would like to have your feedback on these participant notices sent to our resource account, which Marilyn is -- do we have it up there? Yeah, it's up there. The resource account that you are to send it in to.

So the purpose of this flyer is just to give them a heads up. It's not a notice. It's nothing. It is to begin educating people.

There are some participants out there that really know a lot about this and are paying a lot of attention. There are others that know nothing about it. So we really want to start making sure that we are putting information into their hands.

To the extent that you, as a employer, especially if you are in the southwestern part of of the state, you can make sure that -- including direct care workers, I think it is really important. I think as participants get these messages, it's a flyer. They will have questions.

They will turn to who they are used to turning to. They may turn to their attendant or Center for Independent Living or Area Agency on Aging. They might call 211. All of those places where people get information, we are trying to educate to make sure they understand what is happening.

You will have that -- Marilyn will send it out to the members. Okay. Great.

I wanted.

>> PAM: Before you move forward I will take you back for a second there is a question that came in I didn't ask from Brenda. She wanted to know if the Services My Way education and training was online or in person? She said that the pre-service training, is it in-person or online.

>> JEN: Pre-service orientation is what if is called.

We, actually, convened a group of participants to help us test the pre-service orientation. There was a whole process that we went through. I can tell her more about that, if she is interested.

The DHS quality plan, I wanted to put this out there that there is a -- it's posted on the DHS website. It's also -- there was a notice published on May 13th in the Pennsylvania bulletin about the quality plan. It's a very broad quality plan that is required for managed care and so DHS has a lot of managed care being operated by different offices. Each of those offices have a component in this DHS quality plan so it's a very broad-based quality plan getting to your questions, Jack, about quality

earlier.

They are looking for public comments. The public comment period ends next Tuesday. So please go on the DHS website and find that. I don't know, do you have a sense of where it is -- is it easily accessible from DHS? You go on homepage and is there a live link from there?

>> WILMARIE: CHC website.

>> JEN: It's also on OMAP website on -- what other websites? Top DPs website. All of the program offices that are included in the quality plan have posted it on their websites.

We also have been involving our performance measures for Community HealthChoices we recently received feedback from managed care organizations. We submitted those performance measures and will be scheduling a quality-focused meeting with the MCOs in the very near future sometime later this month.

We have this afternoon a CAP stakeholder meeting; that's the CAP stool client assessment provider survey. The one on home and community-based services.

We are meeting this afternoon with the State of Connecticut. They tested all through the testing of the CAP's tool now they implemented it. We will bring them here actually to this room from 1:30 to 3. You are welcome to attend that if you want to.

I wanted to talk a little bit about committee membership yesterday or the day before I sent out several letters to people who have missed a number of meetings because we have requirements under the medical assistance advisory committee bylaws.

I am required to send out a letter to let people know that they have been not coming to meetings. The thing if you don't show up to the meeting the meeting isn't as rich. Also, if you don't show up to the meeting and don't tell us it is an unexcused absence; that's how this works. If you are participating by phone, make sure we know.

If you receive one of those letters, let us know if we have got it wrong. This is our record of what attendances look like. We are looking to hear from you. There are instructions on how to do that on the letter.

>> FRED: I didn't get a letter.

>> JEN: It just went out yesterday, Fred.

In July, I will be announcing if we are accepting new nominations; that will happen next month. Those members who are recommended to

continue for another year, they will be emailed in June.

So if you don't want it to continue being a member, you kind of don't find this useful anymore, please let us know so we can open the position up to the membership for nomination.

Just a quick update on Community HealthChoices today, the agreement -- our agreement, which is still in draft because it's out with the managed care organizations, but it was finalized and finally reviewed by legal, our legal counsel did a very thorough review of it. It's now out with managed care organizations for their review and they will be submitting questions to us. We are getting very close to having a final agreement and our final rates.

Again, just in terms of outreach and the work we are doing on outreach, we will be doing significant outreach in the coming months in the southwest. We are planning 20 events throughout the southwest all over the place to really help spread the word.

We are going to be going to lots of different venues. We will be going to Area Agencies on Aging. We will be going to Centers for Independent Living. We will be going -- we will be using existing meeting rooms in the community that people know about.

We also hope to get to a senior center or two. We hope to get to nursing facility so we are really going to be out there letting people know about Community HealthChoices.

We will also be doing training on providers in the middle of the summer. This is a real nuts and bolts what it means for you as a provider; we will be doing that sometime in southwestern part of the state in the middle of the summer. I am looking to -- we are thinking August, maybe. I am looking over at my team.

Look for that.

I will open it up for questions. We have a half hour left?

>> CASSIE: I heard Secretary Dallas indicated continuity period would be extended. Rumor has it that has either eight months, two years can you confirm.

>> JEN: No, it's not. No, it's not extended.

>> CARRIE: Okay. Thank you.

>> PAM: Isn't it funny how a rumor can gets started a Senator all of a sudden eight months turns into two years?

>> JIM: Hi, Jen. When they were going through the rates they mentioned that the capitation rates were going to be the main source of revenue for the MCOs. I am curious if there are other sources of revenue for the MCOs that are existing in the contracts? Will there be incentive payments or anything like that?

>> JEN: Not yet. In the future we would like to have some value-based payments in it. At this point, we are just standing it up. We won't have any other payments that -- I am looking to Peggy. She is shaking her head, No. Did you want to say something, Peggy?

>> PEGGY: It's the main revenue from Pennsylvania to those MCOs. The MCOs may have other revenue sources.

Like Jen mentioned, we are in negotiations. It was mentioned we have risk mechanisms in place. We cannot speak to them at this point; so that could be some adjustments to and from MCOs from the Department.

Again, we cannot discuss them at this time.

>> Jim. Okay. Thank you.

>> JEN: Okay. Thank you.

Any other questions?

>> RALPH: Yep. I got my three.

>> JEN: Theo and then Fred who has three.

>> THEO: That flyer, is that first correspondence going out to participants or does anything else go out to people in the southwest?

>> JEN: Nothing has gone directly from us to the southwest.

Your feedback will be invaluable to make sure that we are communicating it in a way that people can understand as best as we they can in this Don fusing time.

Fred?

>> FRED: I have several questions some from cannia and some from Pam Auer.

>> JEN: Okay.

>> FRED: Tanya has concerns about medical assistance for workers with disability.

The fact that the state just slashed the budget by $10 million, how is that going to bode well for employment first initiative? Second was that she is hearing about service coordinators being confused about their role in the future of CHC. Has it been made clear to them what the MCOs have stated regarding coordination and will we as a subcommittee be able to evaluate the tools that determine level of care and how the MCOs will determine what the standards are or will that be something that is left to readiness review?

>> JEN: That was a lot in there, Tanya.

>> FRED: Do you want to read it?

>> JEN: Yeah.

Starting with the medical assistance for workers with disabilities. I am not aware -- I was into the aware of the cut. My understanding was if it was cut by $10 million in part is due to the Medicaid expansion that people have become eligible for Medicaid through Medicaid expansion, at least that is what our budget office told me win time about medical assistance for workers with disabilities. I will look into that and somebody can MAWD could come talk to this committee since it is of interest to you, Tanya.

Service coordinators being confused. We are doing as much as we can to educate service coordinators we are doing a lot of work, for example, last week I was in the southeastern part of the state. There were about 175 individuals there. Many of them were service coordinators and we did a -- an update where we are with Community HealthChoices.

Something I didn't mention that I encouraged the people at that meeting to do and I encourage everybody to get on our listserv. If you are not on our listserv you are not getting the regular provider communications that we are sending out every two to three weeks.

Get on our listserv and encourage your employees to get on the listserv and colleagues to get on because that is how we send out information.

That meeting in the southeast parts of the state in Philadelphia there were probably 175 people participating. I am going to say less than 10 raised their hand when I asked, are you getting these communication -- provider communications?

That means people are not signed up for the listserv. It's really one of the best ways to find out about what is going on and to stay current.

We now have on our Community HealthChoices website, which is easily accessible off of the Department of Human Services website. You go to www.dhs.pa.gov for this website. There are hot topics, Community HealthChoices is one of them. Click on that and it will take you directly to our website.

There is a little video that is being played in the lobby downstairs. Change to Community HealthChoices high-level of what is happening. Right above the video is a new -- are you trying to go to the website?

>> PAT: Yeah. It's very slow!

>> JEN: There is a new subscription direct link to the listserv. The -- that's the easy way to get to it. We used to tell people to go to the DHS listserv list and there is about 30 listservs there. This goes directly to the Community HealthChoices and then you can have an opportunity. There is a description of the -- it tells you how to subscribe. You just plug in your name and email address. The last step is to confirm. They will send out an email to you asking you to confirm. You have to do that in order to get in.

Jill, did you have a comment?

>> JILL: I did.

I just wanted to add that these one-pagers that we are are doing to all of the providers are also, once they are distributed on the -- through the listserv, they are also posted out on the CHC website under "for providers".

Specifically to Tanya's question, we are currently drafting a provider one-pager specifically for service coordination; so that will be coming out soon.

>> JEN: Tanya, I will repeat that. Jill Vovakes, who is involved in the provider communications, just said all provider one-pagers, which is what we are calling these, are also posted. Once they are distributed, they are posted on our website so you can get them if you missed them we are really encouraging people to use these in their newsletters to get the word out, to share them with their employees and that's how we are trying to communicate as best we can.

To your point, Tanya, about service coordination confusion, we are drafting a one-pager that will go for -- that is called Community HealthChoices and service coordination. You will get that.

I am going back to your email, Tanya.

Will we as a subcommittee assess tools how MCOs will determine what standards are? That is what is in the agreement we have standards in the agreement but MCOs are not involved in determining level of care. They are going to -- the assessors through what Mike Hale was just talking about with functional eligibility determination will functional eligibility determination we have gone through a very robust public process to get input on the functional eligible determination. Right now it's in testing. If you would like us to bring the tool to you to show it to you once we have tested it -- I think Mike did say he will bring it here to the meeting after we are done with the -- see, that is so fussy!

>> FRED: I know!

>> JEN: After we are done testing it, he will do a presentation on it at that time.

So that's the end of those questions.

>> CARRIE: Tanya has one more. Thank you, Fred for asking those. Tanya pre-loaded me as well. She gave me one more to follow up with you, Jen. With the employment initiatives, apparently in the past she had asked if there were any formulas for individuals with disabilities to assist them in determining what they could accept as a salary without being removed from different programs that are currently available to them. She was wondering the status of those?

>> JEN: I don't know.

There is benefits counseling, which is what we recommend she get benefits counseling. We could have Butler speak on what we have done around that we did a lot of specialist training all over the state. We have been conducting training all over the state. We are very closely aligned with -- the problem with benefits counseling is we don't have enough providers in the state and they are overwhelmed. The benefits counseling training, there is only one place in the country that is certified by Social Security Administration to provide benefits counseling training; that is the University of Virginia Commonwealth University I have been working with the office of developmental program to get them to give us a proposal to bring them here and have them do training for providers who are interested in becoming certified by SSA benefits counselors; that's in the works.

We don't have anything Devon that. We are also giving feedback to the benefits counseling program at VCU at around expanding benefits counseling to include other ancillary programs like housing HUD housing and that kind of thing.

It's still a work in progress.

After Fred is done we will go to Estelle.

>> FRED: This is my turn then I will hand you Pam's question.

Right now with the federal cuts coming out I was told to ask you this part. With federal cuts the massive federal cuts coming up, does the state have any plans to offset that or to system be able to continue or what will we do on 90% of our federal funding is cut?

>> JEN: Yeah, that would be a big problem.

>> FRED: Yeah!

[LAUGHTER]

>> JEN: I do know a letter went from the Governor to the President about this just a little while ago. Earlier today.

If the Governor is sending letters, maybe other people should too. We don't have any -- we are just going to as we do all of the time make adjustments. There will be cuts if those things happen.

>> FRED: Oh, yeah! That's what I am afraid of.

This is a question from Pam Auer. Actually, Pam, we are going to finish the member questions before we go to the public questions.

>> ESTELLA: Hi. Yes. You talked about the educational programs that you are going to do in the southwest to kick this off.

Given population there and all of the people who may be involved in one way or another, either as consumers or as people doing these services, in different capacity, do you think 20 sessions enough? Do you have plans to do more? This is the first roll out. I am wondering if 20 sessions to cover all of these people in all of the -- I mean, you've got all of these different people that need to know because they will be involved as workers and con simmers. I am wondering if 20 will do that.

>> JEN: It's what we kind of came upon as pretty reasonable. There are 14 counties in the southwest it is more than 1 per county. We will assess that at the end and see whether or not it was sufficient.

We also have great partnership with the Jewish healthcare foundation. They have been doing a tremendous job of getting the job out.

>> FRED: I have been working on that too.

>> JEN: Fred and Brenda Dare, our members have been participating with the Jewish healthcare Foundation's effort. We will look to

community-based organizations to make sure that they are getting to and informing their constituents. If they are a good community-based organization they will inform them.

We are also partnering with anybody that is, you know, willing to help us get the word out. If we get invited to a meeting -- I have to say, I speak at probably 10 events a week about this. So we are really working very hard.

I will also tell you that I had a -- feedback on one of the provider communications that went out I believe on Friday. After that was sent out, I received feedback from one of the Community HealthChoices MCOs that they have been involved in MLTSS roll-outs in other states and this is, by and large, the best provider communication process that they have ever experienced.

We are really working very hard to make sure that we do. Estella, if you have any suggestions we are starting with 20 because that's what we have budget for. We will really rely on other ways of getting the word out.

>> Estella: Having past experience in these types of thing I think partnerships are critical in getting word out and many of these partnerships would be organizations that are not looking for financial reimbursement of any kind to do it.

I just think that that would be critical just as you are working with the Jewish center but there are so many others out there who do this type of thing or have a speaker that will do that for you. I think that maybe it might be very worthwhile to look into some of the partnerships and making sure if they are willing to do it they have a speaker to go out and give some of these talking.

>> JEN: Jewish Healthcare Foundation and United Way of southwestern Pennsylvania are in partnership with us in getting the word out to grassroots.

One of the things they suggested was make sure -- they have a robust 211 in Allegheny County; that all of the 211 workers are aware of what is going on.

When we it send that flyer out, it could end up that people are calling 211. I just got this. What is this? We are they thought of a lots of -- actually they and the committee that they have convened have come up with a lot of ways for us to get really to the grassroots and so I think you are right. Partnerships are key. Thank you, Estella. Any other members?

>> PAM: We have comments and questions from other members.

Dan Keating sitting in for Drew Nagele wanted to comment we need to advocate for saving Medicaid. No cuts. No caps!

I would like to march around the room on that one, but I don't think that would be appropriate right now.

[LAUGHTER]

We have a public comment. I will wait to ask the committee again, do we have any other questions for Jen Burnett before we turn it over to the public?

[NO RESPONSE]

Hearing none, I will start with the one I have in front of me and alert Jen and the committee I have to leave at 5 of today I will turn the meeting over to you and to Fred when I do.

The public comment is from Karen Brodsky are NFCE rights blended or home and community services and rates be separate from NFCE enrollees?

>> PEGGY: It is a blended rate.

>> Pam: I think we heard that earlier today about we talked about the methodology.

>> JEN: I will go with Pam Auer's question: We have previously urged Office of Long-Term Living to create an independent navigator to educate and assist people in accessing services through Community HealthChoices after choosing managed care organization. Advocator could person-centered plan, participate in direction options including Services My Way and choosing priors and it could provide assistance with appeals.

With Community HealthChoices about to start in southwestern PA in six months what are OLTL's plans regarding creation of such post-enrollment navigator function?

We actually have a meeting on this next week. It is called in the managed care final rule it's called a beneficiary support system. We will be going out with a procurement for that. It's just -- we are in very early stages of having conversations about it.

She has an IEB question: What is the time line for a barring contracts for new independent enrollment brokers? Does anybody remember? Did he say August?

>> I think the end of summer.

>> JEN: We are hoping sometime in August to have that contract awarded. It closed yesterday. The procurement closed yesterday.

We have an evaluation process we are moving into.

Okay. I guess we will open it up to the public. It looks like we have about five minutes. Any other questions?

Hi, Steve.

>> STEVE: How are you, Jen?

>> JEN: Good.

>> STEVE: I think at the stake holders meeting a couple weeks ago in Philadelphia, it was announced that the amendment for the waiver application for CHC was submitted to CMS; is that final copy available for public review and if not, were there any material differences from the draft application?

>> JEN: It was the Community HealthChoices BC concurrent 1915 (b)(c) waiver submitted to CMS.

Virginia, is that up on the website?

>> If you look behind you it's there.

>> JEN: Waiver application is on our website.

>> VIRGINIA: The actual application submitted to CMS the two applications are not posted on the website but the comments received and the response documents are posted.

They are at that link that -- right here.

If you look down at the bottom keep going, Pat.

>> JEN: Read it out loud.

>> VIRGINIA: Here is comments response documents for both of the applications.

>> STEVE: But the actual application is not available?

>> VIRGINIA: It's not been posted. It's my understanding that a decision was made that it would not be.

>> STEVE: Okay. Are there any material differences between the draft and the final application?

>> VIRGINIA: Well, we did consider all of the comments that we received. We received -- probably I think 45 pages of comments on the (c) application. You can see where we did make changes and accepted the comments that were received by the commenters.

>> JEN: It is with CMS right now. We have already received informal RAI, which is their way of asking us questions.

On the (b) waiver, we have already received those questions. We have a meeting where CMS next week to go over the questions that they asked.

It's in a negotiation process. It's not final yet. Once we have a final one, I don't see why we couldn't post it.

>> VIRGINIA: Once it's final it would be posted.

What Jen just references was part of the reason why the decision was made not to post what was submitted because it will continue to change based on this negotiation back and forth.

>> STEVE: Thanks.

>> JEN: Thank you.

David, you and then you. Hi, David.

>> DAVID: This is a question for the folks at Mercer. I am not sure I really understood this business about you developed costs for individuals based on region, age, whether they were going to be receiving LTSS, but what I didn't understand -- then you said, but the rates would be averaged. So what is actually paid per capita to the plan would be the same regardless of whether the individual is receiving LTSS in nursing home or is just a dual; is that correct? I am just not understanding that.

>> KATIE: Yeah. So basically, there are different what are called rate cells. There are a few different rates that we develop. For example, one rate cell might be for dual eligibles that are in a nursing facility or a waiver and that are over 60 years old just for example.

So we would take all of the people in the historical data that met that criteria, average all of their costs together and come up with one rate specific to that grouping of people. Then we would do a similar process for all of the other rate cells that have different age or dual status criteria.

>> DAVID: So there are different rates, depending on the particular characteristics of the enrollee; is that correct?

>> KATIE: Basically, I think we have about -- I can't remember if it's -- about 12 rate cells and 12 groupings of people type and different rates for each grouping.

>> DAVID: Okay. That makes sense. Thank you.

>> KATIE: Yep.

>> JEN: Actually, I have to get going because I have a meeting over in health and welfare. Do you want to send me a question?

>> LESTER: I am cool.

>> JEN: Thank you, everyone. See you next month.

>> RALPH: Our next meeting is Friday July 7th. A switch up from Wednesday. Be ready for that.

(Meeting concluded at 12:57 p.m.)