

>> TERESA OSBORNE: Good morning, everyone.

Good morning.

I see it's nice to know you're here -- talking that's why we're here to hear your voices my name is Teresa Osborne, the Secretary of the Pennsylvania Department of Aging and it is my pleasure to welcome you here. This is our fourth of six public sessions that we've had around the Commonwealth.

Last week we were in Erie, Allegheny County and then we were in Altoona yesterday, Scranton today and -- next week in Harrisburg and then in Philadelphia.

And it is just so nice to have folks come out and react and respond to the discussion documents and share with us your thoughts. And before we get into that portion of our time here together, this

morning, joining me here today typically for most of our sessions thus far, my colleagues, and state government secretary Ted Dallas the Secretary of the Department of Human Services he needed to travel yesterday and today to Philadelphia for other business he asked me to represent, all of us in particular him as well. His staff is with us I don't do that they will be reporting back to my colleague letting me know. Talk me up on this side!

[laughter]

>> SPEAKER: Secretary Dallas does send his regrets he could not be here, last week joining us was Secretary Karen Murphy, Secretary of Department of Health you may know Karen myself a native Scranton, Lackawanna County it's always exciting for me to be back home, I got to sleep in my own bed it's a treat these days and -- um, and my

colleagues stayed nearby hotels and said it was great they ate a nice dinner, it's always nice to show case Scranton on our visitors from the Commonwealth.

Secretary Murphy needed to travel to Washington she is not here with us today I'm the fortunate one who gets to be here today, to -- hear from all of you.

Joining me at the table is the deputy of the secretary office of long term living, Jennifer Burnett, next to her, is the Kevin Hancock, chief of staff for the OLTS under the department of human services an other staff, is here, with us as well. Including our time keeper, Heather Hallman is the executive assistant with Secretary Dallas she will talk about her particular role when we get into the time component of hearing folks speak. I can tell you 21 Fridays

ago, exactly, when my colleagues and I started this journey, with governor wolf he said many things to us, first and foremost he said we need to insure individuals who need to access home and community based services can do that.

And they can live, quality filled and productive lives in their homes where they desire to be, as independent as possible, with their family and friends and enjoy life in their communities. That's a pretty important priority, for our governor under his senior plan, which was pretty awesome, that the last Friday, February, five days before he was rolling out his first state budget he unroled a senior plan, that talked about a lot of things. One of which we're here to talk about today. I should not say one of which, they all support one another, to do, one thing.

That is to serve and protect

the most vulnerable among us,
regardless of age, under 60, over
60, individuals who need to access
home and community care eligible for
medical assistance, on Medicare
we'll talk more about that, when Jen
and Kevin do their portion of this
presentation, but that is critically
important.

So, with that, we developed a
discussion document. That is
released to you, here in this room,
as well as, thousands of people
across our Commonwealth.

Consumers, consumers
advocates, providers, um, you name
it, you name the stake holder group,
we desire to hear from you.

And today, is the beginning
of the conversations that occurred.

While, it started in
Allegheny county last week, we're
here in Lackawanna County today, to
hear from folks across the northeast
region, about what you liked in the

discussion, what you didn't like, what you fear about managed care perhaps.

What you think the challenges and pitfalls may be, what you think our Commonwealth needs to consider, as we develop a managed care program, managed care long term services program here in our Commonwealth.

This is our opportunity to learn from the mistakes in the past that we in the county or state government have made. Or, from other states that have walked these paths before, have done things well so we can benefit from them, this terms of mistakes or pitfalls or best practices we need to, I can't stress enough, hear from you.

And when we get these stenographer reports back, I can assure you that many of us will be counting the words in terms of how many -- how many times we talked

about engagement, stake holder processes, consumer choice, and ensuring that we, at the end of the day, do what we are called to do, that is to serve individuals who need to access home and community services, that's why we're here, I can't thank you enough that you took time out of your day in order to be here with us. I assure you that after today's session ends, as you walk out the door and you, think about what you heard, what you think as you processes evolve we need to continuously engage with us, this is not a one and done. This is a continuous dialogue. It needs to occur, so we can get this right in our Commonwealth and I can't stress that enough.

I also can't stress enough how many times I've heard, yeah, right we've heard that before. This is just a dog and pony show, not so much I'm not a dog nor am I a

pony,

[laughter]

They're cuter than I, however -- we, we know, we need to ensure we have a good program, and system in place build upon the fine infrastructure that we have, so we can serve older Pennsylvanians, who need to access home and community based services that's our goal, if I didn't believe in it, I would not have picked up my stakes to say yes to a government, that was kind enough to say -- come to Harrisburg and work with us.

I would not have done it.

So -- here we are.

With me, here today, my colleagues who are elsewhere, with us in spirit as we hear from all of you.

So with that I will turn this session, now over to Jen Burnett, who will walk us through the beginning of the program

>> JEN BURNETT: Thank you, Secretary Osborne, as she said I'm Jennifer Burnett, deputy secretary for the office of long term living, I it you willly recognize a lot of faces out in the crowd here, this is my second time as deputy secretary for long term living in the State. I was also here, from 2008 until 2010, as deputy secretary, and then I took a -- a -- leave from -- wasn't technically a leave but I I did take a leave if state government went to work for the CMS in the Federal government I made a lot of connections and also learned a lot how CMS works and I think it has really help medicine in terms of understanding the kinds of things we can do in state government, um, with our Federal partners and, figuring out how to do that in more effective ways.

As, Teresa said we're here today to hear from you, primarily,

but before we do that, we want to spend a little bit of time, level setting.

One of the things we have heard, in the last few weeks, about how fast this is going, is that people don't really understand -- they don't understand managed care, they don't understand how this might impact them. And, they -- because they don't understand how managed care works they are concerned that they will not be able to participate fully in these kinds events or that their comments to us, will not be relevant, just because they don't understand how managed care works.

I would argue that it doesn't really matter whether you -- at this point, and we're going to go through some slides to help you, um, understand the difference between managed care and fee for service.

But I would argue that it's more important for us to hear, what

is working in our system that we need to preserve. What is not working -- how can we make improvements and, what kind of things really matter to the people who use our services, to the providers that, deliver our services, and, to the -- um, to the governmental officials and other officials who help us -- help us to actually manage the whole system currently. So what is working and what is not working is what we're looking for.

The objective of today's forum is to share information about the current thinking as secretary Osborne said this is a discussion document it is our current thinking and best thinking.

We did spend some time over the last would months, kind of putting this document together in order to -- in order to have a starting point for our discussions

with all of you and with the Pennsylvania public.

More importantly, than sharing our information is getting your feedback and getting your ideas about what will work and what will not work.

So it really is, we heard a number of times, consistent theme as we're out and about talking about this is, that it's very, the discussion document is very vague there's not a lot of specifics in there.

And we don't really know what we're reacting to.

We did that, purposefully, because we really were looking for just a framework in order for you to illicit your ideas about what how we should change the system.

Going to the next slide -- I just want to do a quick comparison how fee for service works versus how managed care works. In fee for

service, the payments, the health care provider receives an individual payment on each medical service, so we're paying for a medical service delivery.

There's standardized payments for all providers on a medical service or -- social service that's delivered. And that's the way our current long term services and support system works fee for service system. In managed care there's a -- negotiation that happens between the provider and the managed care organization. And the actual fee is paid, payment is made may vary between providers.

In fee for service, there is no gate keeper.

There's no one place where all of the services behavioral health physical health acute care -- as well as long term services and supports are provided. It's a kind of a disjointed system that's not

really talking to each other. In managed care the MCO serves as a primary gate keeper really has access to all benefits available, under the managed care. Benefit package in fee for service there's a standardized benefit package, this may be prior authorization, requirements but -- um, also there are benefit limit exceptions in certain fee for service payments.

But in managed care there's defined set of covered services that may vary by insurance company. There may be the prior authorization requirements and the benefit limit exceptions. So those two things are similar.

And in the provider network, in fee for service, any provider is willing to accept the defined payment and is qualified it can, can provide services. And managed care, there is selective contracting with providers, so there's really an

expectation that the providers are driving towards quality outcomes and, it is much more outcome driven than just paying for the service.

That is something we're very interested in.

When we have been out, last week as Secretary Osborne said we were in Pittsburgh and Erie, I can tell you when Secretary Dallas talks about it, he talks about the improving the quality of our care and improving the quality of our service delivery.

Some -- some ofest people who have spoken at these sessions have talked about you're trying it reduce costs you're trying to cap costs. That's not even in the conversation when the secretary talks about it he seriously talks about improving the quality of care delivered in the support system. Managed care going to the next slide -- there is, a formulary in the pharmaceutical

list. It's rationalized or tiered, also utilization review and management, manages in-patient admission, length of stay those kinds of things. Capitated payment per member per month and fee paid. There's an improved area in which the managed care organization operates.

Next slide -- the managed care, historically states structured the Medicaid programs at just saying historically states have structured only a few started out of the gate with a managed care system, Arizona and a few others.

They started with managed care. Most other states have built a fee for service system like Pennsylvania.

For Pennsylvania, that makes us -- we do have a strong localized network of agencies and providers that are familiar with the delivering home and community based services that no, what the resources

are W within their community. And this is another consistent theme that we keep hearing over and over that, that local communities know best how to take care of people.

And, we want to tap into that rich understanding of our populations.

I will say that people does have two Managed Long-Term services and supports programs. You may have heard of the life program, which is Pennsylvania's program of all inclusive care for the elderly, we have a very burst life program we have over -- 5,000 people being served in the life program. That is a managed capitated Medicare/Medicaid payment system. We also have the autism capitated program which serves people who have autism, diagnosed with autism and capitated environment, we have experience in this area, they're very discreet, programs and

populations.

We desire a better coordination of services this really -- and payment reform, and, that is also driving other states to manage the long term services and supports, the desire for payment reform, not necessarily cost reduction but, payment reform like paying for performance and actually getting better outcomes, in the services that we provide.

22 states currently have Managed Long-Term services and supports. Some form of it, Pennsylvania is one of them I just mentioned the two discreet programs.

But I will tell you, having just come from the centers for Medicare and Medicaid services where I worked for four years there are at least a dozen states that are asking and have come to the Federal government and said, we want to do Managed Long-Term services and

supports and are at some level with negotiation with CMS to move towards that. This is real a a movement we're seeing in many other states and Pennsylvania -- is there as well.

The next bullet talks about that, since the 1990s, many states have moved the Medicaid population to physical health and behave I can't rememberral Hal edge services we have a robust managed care program in Pennsylvania. That -- the physical health has been around for a couple of decades now, we have a lot of experience with that.

And so, in recent years, states have been more -- moving towards moving the long term services and supports population. Recognizing that this is a growing -- very fast growing demographic and, also, the physical constraints that occur, in the situation you're not really managing your system very

well.

Going to the next slide,
here's our current system.

We have a physical health, in long term services who need long term services and supports they receive their services in a fee for service system, multiple health care providers with limited coordination, there's no coordination between Medicare and Medicaid and I think that is a fundamental issue that we want to tackle here in Pennsylvania.

We have many people who are duly eligible and, whose services are being provided by two completely separate payment mechanisms Medicare and Medicaid. And in places where you coordinate those -- those two payment mechanisms, you see better health outcomes and better population and health outcomes. We're very interested in that coordination of Medicare and Medicaid.

That's also, no single entity responsible for these significant changes from acute care, when someone is discharged, it does -- there's no single point where that is really being managed except for programs that the Department of Aging has begun to look at, in terms of, some of the AAAs doing that kind of work, care coordination as people are discharged from the acute care, but, really is only being done in pilot fashion, at this point. But we're very interested, that care coordination point at discharge or chain or transition of setting or service delivery mode is really, really critical to the person's outcomes and it can often mean the difference between, um, a rehospitalization, and quick rehospitalizations as a matter of fact when you don't do a good job on that care transition.

In behavioral health we have

managed care and in the Medicaid system there's limited coordination between our behavioral health system and physical health and long term services and supports. So, when we're hearing about the behavioral health for the long term services supports population very often people are falling through the cracks not getting good behavioral health supports.

Going to the long term services and supports system, again that's fee for service.

If you go into the nursing home it's payment, through the nursing home.

It's a per Diem payment to the nursing home and home and community based services, it's a -- um, an event, driven payment, when you -- when a person receives services, they -- the provider gets paid for it.

The long term services and

supports are coordinated by a service coordinator, there is still limited coordination between the service coordinator, who is responsible for the long term services and supports and home and community based services for example, and -- physical and behavioral health so, very often those 3 systems are not talking to each other.

And, the person who needs -- as secretary Osborne mentioned we're here because we care about and serve very vulnerable Pennsylvanians, those groups are falling through the cracks not getting optimal care.

Also, I just want to say this one last thing, we currently still have, even though you've heard a lot talk about rebalancing and balancing and -- many follows the person and the kind of programs that the Federal government has offered to states Pennsylvania still has an

institutional bias we still spend more of our funding in nursing facilities and other institutions, than we do in home and community based services.

As the governor told the cabinet on the first day, that they were here to convene in Harrisburg, not here in Scranton -- I'm sure you would have liked that --

[laughter]

In Harrisburg, really, home -- serving people in the community is where, where his -- that is his vision. He really wants to see us do that better and so, with that, he has charged us, with moving towards a Managed Long-Term services and supports delivery system and we're going to ask Kevin to come up and talk about the program goals and then, to -- because the program goals, which I was eluding to and the exact alluded to throughout really are critical I think it's

really important for you to understand what we're driving towards is better health and the safety of our vulnerable citizens.

>> KEVIN HANCOCK: Thanks Jen as you see up here, these are the -- these program goals were outlined in the discussion document and, they're sort of under writing the current thinking of Managed Long-Term services and supports in Pennsylvania.

First is promoting health safety well welcome of the target population. It goes to the details of the target population we're trying to build a system, a -- Managed Long-Term services and support system, that takes health safety and well being of the target population and their preferences in that environment into consideration.

We're also looking for opportunities to strengthen health

care and long term services and supports.

As Jen had mentioned, we have great components to our existing system. The fee for service system but they don't, talk to each other that well. We're looking for opportunities to be able to strengthen the integration and -- to have what works and, what could be built upon in the system and better balance and better, integrated throughout the experience for the participants.

Next enhancing opportunities for community based services.

Also as Jen mentioned, current system at least from a cost perspective has an institutional bias we're looking for interests to continue the work, to allow people to continue to receive services and the setting of their choice and to stay in their homes as much as possible if that is their

preference. A lot of the orientation for program design will be looking for building upon the infrastructure for home and community based services and for serving the participants themselves.

Next incorporating person centered service plan design.

Going into more detail in a few more minutes. What this means is generally to look for opportunities to assess an individual's needs, and also to collect the information about their preferences and to build their program their service structure around those needs and preferences to really take into consideration, the individual person, rather than, population or diagnosis related characteristic its.

So really focusing on the individual person.

Next, advancing program innovation, which means looking

for opportunities, not only from a technical perspective or from a systems perspective or from a technical supports perspective even from a policy perspective looking for ways to advance what it means to provide long term services and supports in Pennsylvania.

And looking for the best ways possible to achieve these goals and these outcomes.

And this also includes the financing of the program.

Looking for ways to encourage our provider, providers and also, our participants to participate in what we can do to advance these programs.

Last but certainly not least, ensuring efficiency and transparency and accountability and effectiveness of the programs making sure we're achieving the goals at the same time, making sure that the process we used to achieve those goals, is

very apparent and very participatory with the participants and with providers and also, with the managed care organizations involved in the program.

So talking about the target population, this is our current thinking of the target population. Includes the dual eligible population individuals who are considered to be nursing facility clinically eligible and are non-Medicaid recipients of the act 150 program, dual eligibles are eligible for -- Medicare and for the Pennsylvania Medicaid program.

And, these people, currently are receiving their services they may be receiving their long term services and supports, in home and community based waivers or in nursing facility or even in the life program.

But at this point, their physical and behavioral health

services are supported by our fee for service program and they may not be receiving long term services and supports at all.

But, the -- issue with the population, they're facing is that, their service system is, um, for lack of a better term disjointed there's not a lot of communication between the different payor systems we're looking to build this this program around them to provide better integration and, better service coordination across their payment system.

Next, for people who are not eligible not currently eligible for Medicare but are currently eligible for Medicaid, and maybe receiving services in a nursing facilities or in home and community based waiver programs but are, identified as being nursing facility clinically eligible. These people will also be participating in the MLTSS

program.

These people 18 and older, currently eligible for the Medicaid program and are identified as requiring some sort of long term services and support needs. They will be -- they will -- their current services will be coordinated in the managed care environment.

And, last the act 150 program, we have a program that has been in existence for decades, that supports people, through state funded dollars, that, that provides home and community based services, but is not, funded by the Medicaid program, since these -- there's a lot of parallels with people receiving services many this program, and in, our attendant care waiver some of our home and community based services we want to give them the opportunity to be part of this and have their services coordinated through a managed care

environment as well. So that's the population in our current thinking.

And going through, what we hope to be able to -- the individual program components, going through, we'll go through each of the individual program componenttion themselves.

We have, 9 different program component that is are part of the current thinking all of which were described in detail in the discussion document.

And, I had already mentioned person centered service planning we had this first because we really want this to be up front, have it be recognized to be included in the Managed Long-Term services and supports. As mentioned person centered service planning, includes, as mentioned service planning, service coordination, and self-direction wherever possible. So this will be taken into

consideration, needs and preferences of these individuals and we'll develop a plan that is holistic and we'll integrate physical health, behavioral health and services and long term services and supports. Second in this, is -- continued continuing option and building on the option for consumer direction for personal assistant services.

We want to make sure that, the consumer direction, as an option is continued to be preserved many the Managed Long-Term services and supports. We have heard this pretty frequency and, in the other public session that's is something that, the participants want to see maintained and we're going to do everything possible to make sure that not only are we maintaining it in the new model but we're also building upon it, to find ways to improve it and to expand to other service components.

Moving on.

Service and supports
coordination.

This is the major advantage of managed care option. It provides an opportunity to be able to integrate the Medicare services, Medicare service system, the Medicaid physical health system, the Medicaid behavioral health service system and long term services and supports.

Building a system that the managed care entities and their partners are working with a participants to coordinate the care and ensure the services are seamless in a way that they're provided for participants, and the participants have a lot of, input in the way that all of these services are coordinated together.

Next, we have access to qualified providers.

Access to qualified providers

considers, credentially, it considers access and the availability of service providers and given region, Pennsylvania is a big state.

And we have different levels of development for long term service and supports and provider development in general.

This, in this, model, in managed care model, there's an opportunity to be able to -- to -- build out networks for long term services and supports and, to provide degree of parity across the State regardless where you live you'll have the opportunity to have access to the -- to the same types of services, or to have -- to -- have some degree of access, regardless of -- of the setting in which you receive those services.

So, that's going to be a continued large focus of the MLTSS. In addition, emphasis on home and

community based services as Jen mentioned, our current services system in Pennsylvania for long term services and supports E has an institutional bias especially in the way that the services are paid for.

And with this emphasis, or the continued emphasis on home and community based services we'll continue to focus on building out programs where people are receiving services in the setting of their choice. And -- as the second mentioned, secretary of human services mentioned frequently and, in his talking points, that the surveys of preference for people receiving services 95% of people still wish to receive, their services and that includes long term services and supports many in their homes.

This MLTSS program will continue to build on that preference and to ensure that people will be

able to continue to receive,
services in their home for as long
as -- they wish.

As is reasonable.

Next, we're going to
emphasize performance based payments
incentives allowing for the managed
care entities and also the service
providers to look for opportunities
to enhance the quality, and,
efficiency and over all participant
satisfaction for the programs and
the services people are receiving.

And, also to look for
innovative ways to be able to just
in general, improve the participant
experience. So when we talk about
performance based payment incentives
we're looking for opportunities to
be able to build ways to, to enhance
quality of the program, to look for
ways the providers can, can with as
much, creativity, flexible as
possible, generally improve the way
the services are being delivered.

Participant education and supports.

Currently we have for home and community based waivers and for the physical health program, there is, independent enrollments, with this -- with this component we're looking for opportunities across the board, to make sure that, participants, have as much enrollment support as they need.

To be able to know all the information they would need to have, to make the best choices possible for themselves and the services they receive. In addition to that we want to make sure as part of the enrollment support we want to make sure that they have as much education as possible for the entire service system, includes physical and behavioral services, we want to make sure people are informed as much as possible to make the choices best suiting their needs and their

wants.

For other components, preventative services -- the Medicare program right now is growing and emphasis for preventive services we want to build on that, that service augmentation and build it into the holistic program, consider preventive services and physical and behavioral programs and long term services and supports to ensure that people have opportunities for wellness checks and for the opportunity to keep them, as healthy as possible to be able to maintain as much control over their lives, as possible.

And in addition, we're going to continue to build on the strong participant protections that currently exist and to look for opportunities to integrate those participant protections to make sure that the best approach, to the health and welfare of participants

is maintained in the system we want to make sure that, what we have that exists for participant protections is maintained we want to look for opportunities to increase and integrate those participant protections to cross the service system and last but not certainly least, is, is -- the, quality and outcomes based focus for Managed Long-Term services and supports, with quality, what we are looking for is an opportunity to build out an evidence based and comprehensive approach to understanding how well these programs are supporting participants in needs and wants I'm going to -- I keep saying that over and over but I'm trying to make sure it's emphasized and looking for opportunities to be able to use data and assessment, make sure that the participants' experience and their own view of their experience is, is part of how we can, we can move

forward, with improving the services, from top to bottom, make sure that, that -- we are baselining, how services are being provided to participants and then, building out ways that, that the participants themselves, providers and the networks are recognizing the services can be improved.

And, then, ultimately, using data, using quality measures and looking for standard approaches to be able to evaluate the program really is moving forward, and advancing and meeting all of these goals we have already discussed.

Quality is, is a major component that, of this program, it's a major challenge as well. But we're looking forward to that challenge and we're looking forward to -- to -- seeing in a holistic way that the program in the end is really meeting what the participants

are asking for.

With -- next slide.

I'm going to turn it back to Jen, she is going to talk about the plan for the program and then, we'll move into the questions and, answer portion of the presentation.

So thank you.

>> JEN BURNETT: Thank you Kevin.

We have laid out a time line for to take a look at I'm going to quickly go through it, because we're really looking forward to hearing from you folks in the audience and, not only those of you who have prepared statements, we invite those of you who have been stimulated by what we just said, have questions about what we just said to please get up and talk with us.

And -- Heather will manage that. Heather Hallman.

So we released a discussion

document on June 1st. That was released along with the press release. And it was, it was also, publicized the following Friday with a public notice in the Pennsylvania bulletin.

We have our June and July comment period on the discussion document itself.

With the deadline of submission for comments of July 15th.

We are then going to be releasing our RFA which will be released in late October, of 2015, but between July 15th and October 2015, we're not going to stop with stake holder engagement, we're not going to close our door we want to get feedback what we're thinking once we analyze all of the feedback that we've gotten, through the process, as well as the input that we're getting on our mailing and email and tell phone opportunity

for people to give comment. So we're getting a lot of comment, aside from this, this process, um on what we should be thinking about in terms of the discussion documents. So it's not like, we're going to close it off and go into our you know close our doors up in Harrisburg and write this, we really do want to engage stakeholders. One of the things I asked when I was in Erie is, if you have thoughts on how to best engage and keep in touch with the stakeholders over this time period, and beyond, one recommendation was that we use electronic means such as webinars and conference calls those kinds of things so people would not have to travel into Harrisburg.

And, I invite you to also comment on that, we really do want to have a continued involvement of stakeholders as, both as we roll this out and then in a onward

process throughout the life of ow
ever long we do Managed Long-Term
services and supports. We do have
3 phases -- ramp up period, RFA will
be released in October, with several
months for the managed care
organizations to respond to it.

And-, you do our ramp up
period writing the reviews through
December 2016. With our phase one,
and enrollment date of June 1, 2017,
and our current thinking is, that
our first enrollment phase would
include the southwest part of the
state. We were in Pittsburgh last
week and, talking to them we had a
standing room only room, so that is
an indicator that they know they're
first in line. So -- following
that, we're going to be doing the
same thing in phase two ramp up
period through July of -- until
December 2017.

And I also want to say that,
in phase 1 not only do we plan to

enroll people come in January 1, 2017 we want to be able to gather data, and see how that first roll out goes and really learn from the first phase to make improvements as we design and take on the second phase, the second phase will be beginning January 2018. And southeast part of the State we're currently thinking of -- five county region, but -- would welcome ideas if that region makes sense, or are there other regions that are rational, the last phase is 2019 the remainder of the State. That's our current thinking on our time line.

We do welcome any feedback that you have on the time line.

I think, I really think that, part of what we want to do is really kind of, learn as we go and, continue to improve the program, through good use of data next week. We have some questions that we have, I think I'll just leave those up on

the slide rather than going through them they may stimulate some thinking for you and -- some thoughts that you might have. In terms of your ideas about how some of these questions might go we would like to hear from you and the folks that have come here to provide their comments. Leather.Heather

>> HEATHER HALLMAN: I have the mean part to tell you when you can't talk I get to tell you when you get to talk we ask everyone come forward to the microphone so everybody can hear.

We ask you to stick to five minutes, who we have scheduled to speak, um, if everybody sticks to the five minutes we'll actually have some additional time to allow others to come up ask questions, provide feedback so -- um, we didn't bring the huge hook to pull you off the microphone we left that in Harrisburg.

Have your five minutes I'm going to get up and slowly move forward if you don't, um, stop talking, Virginia, is going to tackle you --

[laughter]

She is very scary and she does bite. So --

[laughter]

I am warning you this is up to you guys how you want to handle it.

So -- we first are going to have Joanne Karasac, if I misspronounce it's not my faulty blame those that wrote the list how that about. Follow we'll we'll Keith Williams, Joanne, please come forward. Thank you.

>> AUDIENCE MEMBER: Thank you. Thank you Secretary Osborne and secretary Dallas for the opportunity to provide comments on the state's plan to implement a Managed Long-Term services and

supports model, for home and community based services for older Pennsylvanians and individuals with physical disabilities, my name is Joanne Karasac, you didn't butcher it too badly. I've been employed by the manner area area of aging for 32 years, last 16 years supervising the aging waiver. I'm also a consumer and a caregiver with the 94 year old mother-in-law, 86 year old father and 67 year old spouse over the past 38 years, I have seen the role and scope of services of the area agency on aging grow and change many times as philosophies change, demographics changed and the administration change.

And each and every time, the 59 area agencies on aging and the Commonwealth, adapt as required as the State moves towards the model history shows that the AAAs have the ability, the desire and the

experience, to change and adapt as needed, to continue to have a role in the new system.

Across the Commonwealth, the people at the local area agency on aging have literally thousands of years of experience.

That experience should be utilized in designing MLTSS will look like and be part of the service delivery model when implemented, what we do best, is take the policies and regulations, and make them work at the local level for the consumer questions serve. The names of have changed over the years, case worker care managed service coordination, whatever you want to call it, we do it best at the ground level.

The MLTSS model needs to include that face-to-face contact with the consumer, if you call my father or mother-in-law, they will tell you, what they tell you will be

far different from what is happening, my father will tell you he ate he could go to his home there's no dishes in the sink, my mother-in-law will not tell you her feet are swollen she cannot walk she doesn't want to bother you. Years ago I had a case of a mother and a daughter, two of my most memorable consumer they were alert, oriented and educated and artic cue late they would tell you what you wanted to hear.

But over the phone, you would not see the five foot hole wall of stuff with only a tiny path through it, that stuff included their bodily waste, packaged in bottles and cans because the bathroom didn't work no one could get to it and they had devised incredible system of survival, but you had to be at ground level to see what was really happening and MLTSS must get people on the ground, and hopefully that

will include the agencies that have been doing it for years, the consumer and the caregiver needs to be part of this planning process and they need to be part of the ongoing process for monitoring the model.

The time frame for implementing MLTSS is ambitious the time between the release of the position paper engine 1 and the release of the RFP in October, provides very little time for public comment and input on the final product.

MLTSS is going to be mandatory enrollment for adults requiring long term services if MLTSS is going to be a complete model of managed care with a capitated rate including not only many he had call services but Medicare services there needs to be time to educate consumer and representatives what it means. People were outraged at the Affordable Care Act with the

perception was they would have to give up control of their medical services.

What doctors they could see and what hospitals they could go to and what treatments they would receive.

We all heard the misinformation about the dreaded death panels.

We do not want people to refuse home and community based services, that could help them remain in their homes safely and with dignity because they face the loss of their medical care. The need for consumer choice and conflict reservice delivery has been the focus of home and community based services for the last few years.

There may be only one or two MLTSS vendors to choose from in a region, people may have to choose a vendor that does not include the

consumer's current health care providers. In many cases helping people understand the process, and make educated choices, will require one-to-one contact.

The area agency on aging, are in a position to assist that process.

Currently all willing providers who meet the standards for waiver service were enrolled by the department of human services, consumers can choose from the extensive list of providers for personal assistive service, durable medical equipment and et cetera providers of PAS include large franchised based agencies as well as smaller local companies.

Is the MLTSS vendor going to be required -- excuse me.

To be required to contract with any willing qualified provider? Or will they be able to elicit providers to two or three per

service? What is the definition of a qualified provider?

We have 34 providers at PAS in Monroe County, how many of these companies will remain providers under MLTSS, in our region. Small locally owned companies are the life blood of the service delivery in our county. Are they going to be able to compete with the larger franchises in the process, at least 30% of consumers utilize the consumer model of PAS will this remain a choice for consumers? The ability of MLTSS vendors to provide -- agency consumer models of PAS in the seamless transition of service when the current provider model to managed care model is going to be paramount importance, to make sure the consumer railroads not affected by the changes thank you for the opportunity to provide input we look forward to the opportunity to continue to provide services to

consumers in home and community based care and to provide Commonwealths it next stage of development of the Managed Long-Term service supports model.

>> HEATHER HALLMAN: Thank you.

And also if someone wants to provide a written copy we'll have this available, it's also great to get a written copy or email it also to the email address that would be great. Keith Williams is next, followed by Kristen Hamilton.

>> AUDIENCE MEMBER: Thank you.

Good morning.

And I had the pleasure to meet Heather and other staff members at a hearing in Marywood University back in the spring. She is right about that hook.

[laughter]

We have seen it, I don't see it around, but -- I'm sure you have it when you need it. Secretary Osborne welcome back home, good to see you. Jen it's been awhile. We have known each other working with the independent living council.

And -- other Harrisburg initiatives, over the years. And thank you, as well from Kevin, it's great to hear your comments when you presented earlier, because that's really, the crux of some of my thoughts particularly about, combination of consumer control and a situation, that affects me personally and that's the Act 150.

My name is Keith Williams thank you for allowing me the opportunity to speak today.

I'm a consumer Act 150 consumers I'm also the advocacy and out reach coordinator for the Center of Independent Living in Scranton.

I've been on the Act 150 program since early 1987 I had to chuckle myself when you talked before, when you said Act 150 has been around for decades, yeah don't remind me, decades, not the about the program, it's great, from aging perspective. I'm not getting any younger. It is a great program, obviously, many other people have a across the State, as well.

Some of my concerns,, um, with that, I think, kind of -- transcend from Act 150, into some of the waiver programs.

Medicaid waiver programs funded in Pennsylvania.

And that is, um, we're happy to see the consumer control is going to be a strong element and as you said it might be even looked at to be enhanced. But we do have some concerns. I have some concerns as do other people with disabilities on the consumer model and reading

through some of the, PowerPoints that were provided earlier and today's summary. We'll talk about consumer managed services and self directed services, but right now I think, there's a series of questions that many people with disabilities have about the future of the program, not so much criticism or negative comment. But basically, the fact that there's some, um, unknowns. The one -- the department of human services and talking about self-direction of services, are you referring to the current consumer employer model as we know it?

As we know it historically throughout Pennsylvania.

Or, are we talking about some degree of control? In other words, how much control, on a nuts and bolts level, will someone have with a disability, have with the delivery of their services? Will the plans

use existing fiscal management services to provide payroll? The payroll piece of it? Or, perform these tasks internally within the HS itself.

Rather than going into a -- physical management services provider. On every day level and operational level, who is going to get -- I mean by who, which organization is going to conduct the background checks, perspective attendants, consumer enrollment information and perform any of the payroll activities with all of those associated activities.

Right now, that's -- one giant question mark.

In terms of who that organization will be.

Many attendants I can use myself, some of mine, who have been with me for a number of years I know other consumers in the same situations many attendants are not

in the health related field. They might have an attendant job and met the income, because they know the person, they may work for 1-2 people, in addition to non-health care related work and supplement their income. This leads to questions. What qualifications, if any, will DHS impose on attendants?

Will there be some stricter guidelines that existing attendants, perspective attendants would have to meet before they work for consumers. Or, will a truly be the consumer's choice who works for him or her. What will be the legal status of the consumer employers.

How will they be considered?

Um, will it still be the consumer employer employee relationship? Finally, will consumers still retain the ability to schedule the days, hours and times, that their attendants will work? I understand this is, these

questions are a series of finer points as you work out the program. I understand we're just talking about the framework today.

But these particular points, are the issues that can, um, mean the difference between institutionalization and, independence.

For a person with a disability.

So I applaud your efforts so far.

Um, and an advocate, again more basically as Act 150 consumer, I would urge you to strengthen the consumer control in all aspects of the program. If possible. Again, thank you for the opportunity.

>> HEATHER HALLMAN: Thank you. Okay.

So next we will have Kristen Hamilton followed by Mia Bartoletti.

>> AUDIENCE MEMBER: Good morning, thank you for the opportunity to offer comments my name is Kristen Hamilton I'm currently the deputy director at the area agency on aging for the counties of Bradford, Sullivan and Susquehanna and Tioga counties, normally our executive director, would be here today offering these comments what I'm going to share with you, she prepared, she is at a board meeting today.

With our agency board. Our agency, is located in Northeastern Pennsylvania and, services covers 3600 square miles in Pennsylvania. So we're very rural.

So some of these comments come from the perspective of trying to be, that local resource, for the individuals, both in our towns and out in the mountains of Pennsylvania.

Our local agency, served as a

central point of contact and local resource for older individuals persons with disabilities and caregivers and their families we provide array of home and community based services aimed at hoping older persons remain living independently in their own homes and communities.

We have have developed very strong collaborative partnerships through the local medical facilities, long-term care facilities and human service agencies and other critical local community agencies.

Due to the partnerships that we have established, we are able to work with a variety of organizations and agencies, at the local level, to address the unique needs of our consumers.

It's a true collaboration process and our networking together, allows for creativity, resource efficiency, and timely provision of

services.

Which is critical to our consumers.

One thing that we would like you to consider, is the time line for your implementation. As the Commonwealth aggressively pursues MLTSS we offer caution, and implementing a managed care system, that does not adequately, educate and inform, consumers and caregivers and the impact that it will have their on lives it is critical, consumers family members and caregivers are given the opportunity to fully understand, what is being proposed and that caregivers are given the opportunity also to be able to express and to understand the whole process.

The planning process, needs to have a mechanism for gathering consumer input, and the program design and ongoing operations.

Education, will allow

consumers the opportunity to understand and make informed choices about their health care delivery systems.

We strongly encourage the Commonwealth, to allow more time, for consumer input and to establish an advisory committee, to include consumers, caregivers and other major constituency groups.

Another key area that we urge you to keep in mind, as you move forward is the role that AAAs have served through the last 40 years and will continue to serve.

We ask that you look at the current support systems, that are in place, the AAA network, for the past 40 years has been a resource, in the coordinated service delivery system of aging services, we understand, the need to reduce fragmentation and expand options, for long-term care services.

And the person centered

manner. However, AAAs have demonstrated a long history of the providing quality in-home consumer driven services we have established a roots system, in local communities and are familiar with the challenges, resources and services, that are available, for that local coordination, again keeping in mind, person centered.

Each county, has a unique challenges and the AAAs have always remained flexible in their approach to meeting the needs of older consumers and individuals with special needs.

Another key area, that we ask you to look at is assessment.

We ask that the Commonwealth take into consideration, the expertise of the AAAs and the performance of standardized, consumer assessments for individuals 60 years of age and older and those, under the age of 60 with a

disability.

Aging network, requires assessors to be confidential, prior to performing assessments. The credentialing certification, process requires participation, and in a series of educational webinars and testing. Assessors must meet all of the criteria and complete the curriculum, to receive certification.

This, we believe, helps ensure consistency, and knowledge of medical terminology and conditions, then need to take that forward and work with the individual on those face-to-face visits and take a holistic approach and assessing the person's medical, physical, social emotional and cognitive supports.

We appreciate your consideration with these key issue and thank you for your time today.

>> HEATHER HALLMAN: Thank

you.

Next we have Mia Bartolietti,
followed by Robin Delocci.

>> AUDIENCE MEMBER: Mia is
not here.

>> HEATHER HALLMAN: We
have Robin -- they gave me the job
because they gave me the hardest
names this is not fair.

[laughter]

So after Robin we'll have
Tracey Hunt.

>> AUDIENCE MEMBER: Good
morning -- Tracey Hunt that's great
name.

[laughter]

>> AUDIENCE MEMBER: I'm
not going to read everything I
have.

So -- good morning.

And -- thank you, as my
physical low speakers have said this
a very important opportunity for us

to to engage and be apart of this process I whats very pleased with the beginning how, kind of explained it because for me it's been difficult to wrap my head around it I can see going forward we're going to need to relevant I feel comfortable with this as we talk with our consumers.

I'm Robin Delocci, the Italian version

[laughter]

Director of Pike County area an aging I'm a registered dietician, I'll speak to that in a little bit.

I had a couple of bullet points to go over, and, again, to reiterate the face-to-face -- which is so important for our consumers, whatever the changes are coming at them, in the mail, AAA was always the phone call that was made for explanation. Many times, it wasn't our change, but, our service coordinators or care managers, were

the ones left explaining and reassuring the consumers. AAAs have long been the agency that people call for help. We are the trusted and responsive ones.

Our care managers are service coordinators are familiar with the culture, geography of the counties, all potential communication barriers.

Plus they know the health care providers and all other resources necessary, to provide, the informal and formal supports to have the consumer to remain in their home. By breaking down the barriers the care planning process allows the consumer be the focal point and their suffer in the coordinator, is immensely important for positive outcomes please keep this facet, front and center, as this planning process, moves forward.

Their needs are changing not

one size fits all by any means.

And they should be respected and supported.

Our programs have managed change, change, change and more change in our long-term care system.

Not easy for them, even more difficult for someone in their twilight years who just wants to be safe at home.

No wrong door was mentioned as a concern.

Or the ARDCs, is a perfect example we manage to form a regional approach here in the northeast, even before we were asked to, with spirit of collaboration and cooperation, um, we work towards the linking get the word in --

[laughter]

-- with the consumer with the service provider of their choice. And we work together to form an over sight committee for programs funding and needs

assessments with people of disabilities and who are aging.

Also, mentioned was the aggressive start you were with the schedule we still need policy says and oversight for the transition I think that's been a -- ongoing concern. The conflict three was mentioned over, older Americans act, provision includes contents of the conflict litigation, eliminating interagency bias an eliminating consumer bias we must do our part to help. As a AAA we believe, we have been good stewards of the state funding and the lottery funded services by nature, are limited. Informal supports are key in providing the consumer Medes this the rural areas including pharmacies and with free medication and who are deliver and provider longer hours and families commuting from New York and New Jersey, a lot of our eastern counties have a multiple households

with community and family members.

They want to be a part of their family's care plan and they do want to assist in the transporting and things like that. So -- we are a little bit unique in that area.

We provide the most up to date relevant information helpful services and health promoting programs that our senior centers across the State, prime time health program, engages seniors to move, learn and stay healthy.

We're positioned to continue to gather seniors in a positive comfortable atmosphere to engage them and not only nutrition my personal favorite but information to benefit their long-term care planning at every step including avoidance, scams, exploitation and legal services all for free.

I might add.

I want to right now, talk about special message from one of

our PDA waiver consumers, Joanne was unable to make it here today she was willing, to we're given her a nice lunch

[laughter]

She is 65 years old, she -- this is from her writing.

I am a 65 year old individual, diagnosed with MS I have no use with my lower extremities I use a power chair to get around, MS a neurological progressive disease and it causes me to need a lot of care.

Thanks to the PDA waiver program with the assistance of area agencies on aging I get the carry need I have a home health aid for 7 hours a day, 7 days a week.

Reaching out to the -- the AAA to find out, about the PDA waiver program was the best thing I could have done for myself.

I was referred five years ago.

I was approved to have a wheelchair elevator lift installed at the house, true life changer before the elevator I could not leave my house for years.

I have a bi-level home, and my room is on the top floor.

Only way I could leave was by calling an ambulance having the EMTs carry me out.

Now, that I have the elevator I can leave my home and get to all my doctors's appointments I'm able to go to shopping and out to continue are and socialize at the senior center I was even able to be on my very first cruise recently my life is so full and complete now, just a month ago I was approved to have my entire bathroom renovated so it can be handicap accessible this will be another life changer, I will finally be able to get into the shower again, for years I have only been able to get bed baths.

Area agencies on aging also assist with the assess accessing all available state programs most recently the agricultural farm market voucher help me to eat healthy thank to the PDA waiver and the office on aging assist us on maintaining the program my life has changed greatly my quality of life has improved my life has more manageable, I have been given physical emotional and financial support, that has relieved many of the hurdles that come along with the disease of MS.

Okay. And thank you again for the opportunity to share this information.

>> HEATHER HALLMAN: Thank you you were getting close Virginia was like on her.

[laughter]

Yeah.

I saw you.

So, next we have Tracey Hunt and, followed by Patty Fretz.

>> AUDIENCE MEMBER: Good morning I've been changing as we've been going on, so bear with me. My name is Tracey Hunt, I'm employed by allied services in-home services for over 22 years, in-home services is one of the continuums of care that is provided by allied services integrated health care system, are not for profit health system includes, skilled nursing center, two rehab hospitals and outpatient rehab facilities home health hospice, behavioral health services and developmental services to name a few. In-home services provides direct care services for all, the home and community based services, currently operated by the department of human services.

These direct care personal care services, play an important

role to help keep seniors and physical disabilities in their home we've been providing the services throughout the northeastern and central part of the state for 30 years I appreciate the opportunity to provide comments to the Commonwealth's plan, to implement Managed Long-Term care services and supports I would like to focus on a few key items that I feel will be most critical to successful implementation.

The first one is enrollment in eligibility our current system is fragmented and complicated for many individuals to apply for the services paperwork need completion is cumbersome and many individuals do not have any formal or informal supports to assist with the process. This is troubling because these individuals, need these services now and not 4-6 months later.

You are aware that placement

into an institution is not -- we need to change the institutional bias and revisit the idea of eligibility for HCVS there's a recommendation made by the former long-term care commission to streamline and standardize eligibility across all settings I'm hoping this is a consideration as we move forward, with the implementation of the MLTSS.

Second item I have is -- consumer choice and consumer control.

This is something that Pennsylvania has prided it self on, for many years, with HCBS the consumers have the ability to switch care provider and agencies, they also manage the services they receive in their home. For many receiving these services, it will be able change in culture and process they will need to be educated on, if they're not in control any longer.

The manage the care model

focuses on reducing hospitalization and preventive care as a performance goal, performance goals, with MLTSS needs to be measured how the provider helps the consumer maintain their health status and stay as home as long as possible I believe.

Many of these being served by the waivers cannot access the preventive health care. We provide the service to the frailest and sickest members. Their only goal is to remain at home as long as possible.

The next provider network standards MCNs need to understand how this the direct care services is -- to maintain the independence in the community and avoid unnecessary cost of institutionalization.

The current HDBC should be able allow to provide in the network current provider in the network are licensed by the different health agencies have been monitored by the quality management efficiency team

does, I am sure that you are providing services in compliance with the waiver standards and regulations by the health and human services agency.

Let me give you an exam, what happens daily for most of us direct care provider was receive an individual to provide services to.

Let's say -- the consumer is 30 hours a week of care, something happens with the direct care worker at my agency and I work closely with the service coordination entities to help secure another provider for that day of coverage.

There are many consumers who have more than one agency helping in their home on a daily basis and it's working.

Ultimately our goal is to provide care to the individuals and keep them home.

The direct care worker is a life line to the person they care

for. We need to ensure had a that
the consumers, we need to ensure
consumers do not lose access to the
providers during this transition.

The direct care workers provide the
most interest in the service daily
that being said any eligible
provider, should be able to
participate in the met work, if they
meet the State's criteria and the
performance goals. Rates and
reimbursement this will be say
significant challenge for providers,
currently providers only deal with
the department of human services to
coordinate payment for services
rendered MLTSS will require
providers to contract with MCOs and
each contract comes with its own
process we're asking the
administration to consider setting a
rate pay equal to the current
reimbursements that the providers
receive from the waiver programs if
that rate is set, administration

needs to look at the current operate
it's too low, needs to be increase
bid 10%, increasing rate is not as
costly as it would be to provide
services institutional settings,
direct care, providers are faced
with raising health care costs for
her employees and costs associated
with training direct care workers to
meet all the competencies and
standards set forth by the
departments.

In transition to -- MLTSS
this processing will be very
challenging, we need open
communication, to ensure consumers
are informed, advisory councils are
wonderful public hearings are
wonderful however some of the people
we provide these services to, do not
have access to that e from personal
experience many don't have phones.
I am concerned for those
individuals, who will be helping
them with the transition, how

complicated it will be for then?

Many individuals don't know how the office service is funded or any of the steps needed to get them they know my worker comes to take care of me every day, baths, grooms Medes me, talks to me and does anything I cannot do for myself that's our reality.

Many of us here today have been providing these services for almost 30 years, have the territory and the people and the community. We need to make sure that our recommendations are considered, throughout the process, and for example, rural Pennsylvania is greatly differenten from the urban areas many things in the rural areas are very difficult to access to.

Hospitals transportation, even physicians grocery stores -- post offices -- implementation in these regions will be significantly different and need to be cared

through the plan. Many changes made through the department impacted the lives of consumer questions service, transitions went smoothly others were not as easy for consumer or providers we're willing to work with you to ensure this transition is implemented successful in closing I would like to thank you for the opportunity, two provide comments on the future of the MLTSS will be implemented in the Commonwealth we look forward to working with all parties to shape and create the new system of long-term care

[laughter]

>> HEATHER HALLMAN: I don't think you took a breath the entire time.

>> AUDIENCE MEMBER: Easy name and speed talker.

>> HEATHER HALLMAN: All right. Patty, followed by Dawn Napora.

>> SPEAKER: I'm patty.

>> SPEAKER: Joanne had represented our agency.

>> HEATHER HALLMAN: Okay great thank you. So Dawn is next.

Followed by Michael Moran.

>> AUDIENCE MEMBER: Good morning. I'm here in place of Jacqueline Sturgis who doesn't have a voice. I'm her voice these are her words I'm going to read what she wrote.

First thank you for the opportunity to make comments, on how Managed Long-Term services and supports should be designed and implemented in Pennsylvania.

The opportunity to given put, when such a shift stands to have a impact on our most frail and elderly population is greatly appreciated, we want to stress how important it is, for the input and collaboration to continue throughout the process.

There was very little time,

between the release of the discussion document, and the public comment hearings. While we're grateful for the opportunity, it is our hope that as the plan starts to take shape, that the discussions and opportunities for comment continue to be available.

It will be important for consumers to have input into the planning process, and on an ongoing basis.

Area agencies on aging, as well as consumers, and their family members, need strong representation, on an advisory committee for this new system.

Much has changed in the aging system over the last 3 years, as well as those serving the under 65 population. It is our hope we'll be able to work together to make these up coming changes as unnoticeable to the consumers as we serve as possible. While we

realize this will mean hard work and collaboration, that is nothing new to us and certainly what we're willing to do, to best serve our consumers.

We understand that something is ultimately needs to change, in order to develop this system, let us be careful in those areas where our consumers, many of them are frail and somewhat less interested in details, are apt to be affected. In order for the changes to be seamless for those we serve having it written into the plan that the area agency on aging, continue to conduct the assessment, and provide options counseling for all consumers served, who are potentially eligible for services, through any of the OLTL home and community based service waivers and continue to provide service coordination, for over 60 age consumers served through the aging waiver will serve our

consumers best. We'll work with you on building fire walls to eliminate any potential conflicts of interest.

Our consumers and their families, know the area agency on aging and trust the area agency on aging we know them.

We have built relationships with them. And have worked to keep them in their homes and communities effectively.

It makes sense to take advantage of the strong relationship we have, and improve on that.

One area where we cannot expand is the data that is collected. We have the rapport and the bond with consumers in the past it did not look at the measurement outcome that's is easily remedied we can incorporate a few key health care effectiveness data end and information measures into the assessment and planning process and

those measures would depend upon the individual consumer and what their needs ailments are, they would be person centered.

Area agencies on aging work well together, throughout the network across the State.

And our northeast region Wayne Pike and Monroe County work together, as the regional link -- everyone's link for those who are aging and/or have disabilities and we are resources for consumers and providers.

We collaborate together, to meet the needs of the community in our rural region.

We can continue to evolve together, within the new system.

Another consideration, starting good health education, much earlier than when a consumer finds themselves in the aging waiver.

While this process will take time, involving health education and

learning opportunities throughout the life span, having targeted education at an earlier age, will lead to healthier less frail adulthood and developing independent conscience adults to manage their needs for a longer time. Having education and outreach at senior centers measuring what consumers learn and measuring the impact on their own going health there are also ways we can show our impact on those who are served, not only through the aging waiver, but before they're on the aging waiver.

Configuring the system so that prime time health programs are included as part of the service plan will allow for already in place evidence based programs to be used, and they can also be expanded.

The area agencies on aging have been a great resource for Pennsylvanians we look forward to working with you, to identify, how

this resource can work for our citizens and as we explore the changing health care system.

Thank you for your time and consideration.

>> HEATHER HALLMAN: Thank you.

>> AUDIENCE MEMBER: Didn't even have to stand up?

>> HEATHER HALLMAN: You are afraid of Virginia next we have Michael Moran followed by Carmella Pyneatizson.

>> AUDIENCE MEMBER: Good morning and, thank you for the opportunity to appear in front of you today, to comment on the Commonwealth's long term services and supports discussion document.

My name is Michael Moran -- close.

[laughter]

>> HEATHER HALLMAN: Okay.

I blame the people in the back.

>> AUDIENCE MEMBER: Okay

I'm administrator with Abington Manor and Genesis health care facility member of the Pennsylvania health care association and the center for assistive living management, statewide advocacy organization for the Commonwealth's elderly and disabled residents in and their care providers. Our vision at Genesis health care to set the standard in nursing and rehabilitation care, to clinical excellence and responsiveness to the unique needs of every patient we care for. We strive to be the recognized leader in our clinical quality and customer satisfaction in every market we serve as a member of PHCA, we support the administration's commitment to long-term care system that's person centered, coordinated and focused

on preventative services, and participant outcomes.

However, we have serious concerns regarding the approach outlined in the discussion document. In short, we feel the reach is too broad and it moves too fast and the desired outcomes are too uncertain. Own the issue of oversight and quality we have two main themes we want the department to be sure to address. First is around the delegation of functions we believe it's critical, that the State retain responsibility for management and guidance and continue strong aggressive oversight of the quality and care outcomes.

It is critical that the State dedicate adequate resources, to assure that vulnerable, populations receive optimal services and supports.

There's a lot of -- of the department is responsible for

implementing and monitoring at this time.

Medicaid expansion of 800,000 people is a huge lift, that deserves the full attention of the department, to ensure that all Pennsylvanians, receive the services, for which they are eligible.

Taking on, another large scale policy, and program change, threatens the success of both the expansion and any new program.

This is the especially critical in feeling with such diverse program and policy needs as well as populations.

The second is that the State must establish quality and outcomes measures that are true indicators of the quality of care, that the consumer railroads receiving under the long term management and supports and long term health care outcomes. At Genesis, we expect

nothing like the highest level of quality we care for residents who seek around the clock skilled care needs. These quality and outcome measures should be standardized across the entire Managed Long-Term services, and supports program.

We want to be very clear here.

Reduced use of nursing homes is not a valid indicator or a health outcome.

It is a policy goal.

The same with ER visits or the proportion of consumers, transitioning to home and community based care.

Rather than the department should work with experts in the field to develop a comprehensive quality strategy that's transparent and appropriately tailored to address the needs of Managed Long-Term services and support populations, it is our understanding

that the hedus measures which are a tool used by more than 90 percent of the American's health plan to measure performance on important dimensions and care and services does not address mapping Managed Long-Term services and support measures.

Once developed these measures would be over seen and monitored by the department, through their external quality review organizations.

It is important to note, that many of the review organizations, are also, inexperienced in long term services and support arrangements, and will experience the learning curve that places additional treasure on resources it is essential that any performance measure will include metrics designed to assess the access of long term services and supports to improve the quality of care and

consumer outcomes.

Real quality measures should include the following indicators including -- consumer health status, change in daily activity function over time, incidence of injuries, or secondary health conditions such as burns falls, skin ulcers or involuntary weight loss, preventable serious adverse events, avoidable hospitalization, ER visits, and nursing facility stays.

Risk adjusted for the unique needs of the consumer being served.

Avoidable hospitalization, of a middle aged man like me, is far different, than avoidable hospitalization, or younger person, living with a disability, or a frail elder, in need of around-the-clock care. Other so called quality measures such as community placement and consumer satisfaction ratings are important are not as critical as the outcome measures I've mentioned

previously.

It is in the best interest of consumers outcomes and quality measures, be weighted more heavily than process measures.

We're not supportive of Managed Long-Term services, and support efforts that focus on the reduced utilization, spending over resident outcomes and quality.

Managed Long-Term services and supports is relatively new, the body of evidence is effective and still being built there's not enough understanding with the expertise, of other state programs to draw conclusions with any certainty. The project of the depth and breath of proposed by the Commonwealth, discussion document deserves enough time and effort to assure collaboration amongst quality medications for program plans.

Development and meaningful stake holder engagements including

those individuals, whose health care will depend upon the decisions made during the process.

Thank you.

>> HEATHER HALLMAN: Thank you.

All right. I boxed Mike's name. Carmella Pyneatizson there's a P on my paper all right. We have Cheri Santori next.

>> AUDIENCE MEMBER: Good morning my name is Carmella. I work for allied services waiver coordination, which a service coordination agency, serving elderly disabled participants over the age of 18, or enrolled in home and community based services, my past work experiences include the behavioral case management, for children and partial hospitalization settings and a skilled nursing case manager and discharge planner as part of

interdisciplinary team. Allied services waiver coordinate, provides care in 25 counties in the northeast PA we assess and oversee the care plan for a wide variety of physical and behavioral finances we strive to promote the involvement of informal support as well with as non-waiver supports, to maintain the highest level, of health and welfare.

My staff and I appreciate, the opportunity to assist the Commonwealth's implementation, of Managed Long-Term living services and supports.

I am encouraged that open dialogue will continue through the process, and as there will be significant changes for the participants with he serve.

This dialogue, will aid in the MCO's education for specific waiver requirements as well as the unique needs of the HCTB

participants I would suggest that the HMOs provide for participant councils in each region of service for the best person centered system, developing successful long term system we want to focus on quality care and positive participant experience in order to maintain services that reduce health care.

I will focus on two inefficiencies in the present long term living system, that have caused disenchantment from many individuals seeking to remain in the community. The first inefficiency is the intake and enrollment process. Engagement and timely also of intake and enrollment are necessary to maintain community living.

Communication and education, are critical at this time.

The new enrollment process should include a central contact to assist the participant and their

families with available care options and many participants contact our service prior to involvement with questions concerning their status of the application, in years past, enrolling agencies followed the applicant closely from intake to enrollment.

Often times the new participant comes to the service coordination entity, uncertain about the care plan process, and choices between agency and participant directed models. On two recent occasions we received enrollment, enrolled participants under the age of 21, who were never, referred to the EPSDT program.

And in the above mentioned situations, available -- additional delays to care and supports occurred, and these delays have potential for more costly nursing home placement.

The second insufficiency is

the current -- excuse me
inefficiency is the current
participant directed model of care.

With previous CSMS consumer
models the start of the model was
timely, currently there's no case
management system to assist in the
many facets inherited, implementing
and maintaining a home employer
status.

Many participants, it's less
time consuming and better supported.

Often the FCs are tasked we
intervention to help participants
complete the process, and to help,
prevent health and safety issues.

Service coordination, has
seen the utilization of units with
no stopgap measure, preventing
participants from receiving their
weekly authorized hours in the past
few years we've been directed to
increase service plan units, without
adequate documentation from
participants, regarding these

utilization over utilized periods to aid in case management SMC contractors should adhere to service authorization forms, and follow the person centered service plan.

Adding time sheets would also ensure the MCOs that service is flowing as authorized in the individual's service plan.

One aspect that encourage the new system, is to allow, access to case managers that is a one-to-one experience.

In our agency we have reduced case loads, to better adjust changing needs. We have organized case loads to keep service coordination travel limited to localized geographic areas these changes allow for greater efficiency and more importantly for individualized attention to help the welfare of our participants personalized approach is paramount for a person centered program and

the service plan.

Readily involved physicians, nurses and therapists and other health care professionals to promote positive outcomes, to truly reach a desired health care savings participants needs to be invested in the care and accepting of the education and proactive approaches, proposed in this new system.

Transition to manage long term living services, will require, participants caregiver trust, for continued continuity of care the system should maintain, current service plans for certain periods of time after initial enrollment to the MCO allowing for education and new assessment, and care delivery systems.

We encourage atmospheres that will maintain PA jobs, when seeking MCO contracts and providers, I respectfully suggest that the system contract language should state that

managed care maintain participation of any provider who into meets the State's credentialed material and the MCO's performance goal, there are numerous providers who have met standards for high quality and participant satisfaction.

To maintain the health and safety of the diverse population, we need more than adequate supplies of providers to allow for consumer choice, and to varied geographic changes in Pennsylvania. Finally, the new system, should require the MCOs to maintain the independent living facility, a person centered plans with participant direction as possible, timely advocacy and appeals, clearly defines processes for recording and intervention, on fraud and critical incidents, standardization of the enrollment and eligibility, standardization of the documentation, and payroll and billing systems and, centralized

approach for participant directed
model of care.

Thank you.

>> HEATHER HALLMAN: Thank
you.

Already next we have Cheri
Santori followed by Stephen Cozzo.

>> AUDIENCE MEMBER: Good
morning. My name is longer in
Italian.

[laughter]

>> AUDIENCE MEMBER: Good
morning, everyone my name is Cheri
Santori. I'm the agency --
director at the area agency on
aging in Carbon County.

I thank you for the
opportunity to be here today.

Pennsylvania's pursuing a
major shift in the delivery of
long-term care services which will
fundment tally change how seniors
and persons with physical

disabilities, access and receive their services.

While opportunities exist, and implement many positive changes there's also, significant risk to the beneficiaries managed care, is used to reduce, needed services and limit access to the community providers.

However, if implemented and operated in a man or which places needs of seniors and persons with disabilities first the managed care delivery system has potential, to expand, at -- access to an array of services which consumers want, in locations in which they want to receive them.

I would actually like to share some personal experiences, that I've had with and without managed care on a personal level in two different ways.

The first one is -- we began the administrators position in

September 2006, October 14 was a day that would change my life forever my husband had a seizure and, was misdiagnosed and eventually in December had major brain junk I for terminal brain cancer when I inquired about home health-care services I was told my husband was not eligible the social worker did nothing to explain to the services that were available to him why he wasn't eligible for home health care, had it not been for my employment as a AAA director I would not know to where to turn for a person under 50, in June, deteriorated to the point he needed nursing home placement according to them, because I knew about nursing home transition, I was able to try and access services, but I could not totally avoid, the placement in the facility.

It took 3 months have my husband return home only for a month

later for him to pass away.

That is 3 months of my life and his, that we could have shared together.

Behavioral health side when my son entered kindergarten he had behavioral problems although he had already had provider 50 services paid for by Medicaid, in the home, and he had a psychologist recommending services, he had to wait five weeks and be out of school, until the psychiatrist, could recommend a partial hospitalization.

A few years later, he had a relapse in the fall of 2013, the first instance was prior to managed care. In the behavioral health for children.

He had a relapse in the fall of 2013, was hospitalized and subsequently, again, recommended for partial hospitalization. My son returned home, while school was

closed. Had medical recommendation, that he -- partial hospitalization was medically necessary, yet he still had to wait four weeks to get back into a school system.

Working with the elderly, and, over 60 population, we -- I heard other people discuss today, about when the elderly people get applications in the mail they get mailings they call and turn to the area agencies on aging.

One really important example of that is -- the CAO reapplications that needs to be done every year many of them get it in the mail and toss to the side. No matter how much of you explain to them, that this is what is the payment for the aid in their home, all they're worried about is that aid coming to give them a bath.

Many times, when we are doing, our monthly checks as

mandated, to see if the consumer is still eligible for services, we find out, that they were terminated by failure to complete the reapplication.

We immediately get on the phone, and terminate services through the providers, however, subsequently we also go to the home, and on non-billable time it is a financial application, help them one-to-one fill out this application.

Without the assistance of the feet on the ground Joanne, these people would go months, without services, until someone, could help them where they could get somewhere, to redo the application.

Thank you.

>> HEATHER HALLMAN: Okay.

Thank you.

Finally we have Steven Cozzo and then, following Steven, if

anyone else would like to get up and speak we'll have a few minutes for that, so -- start thinking about it.

All right.

>> AUDIENCE MEMBER: Good morning, and thank you for the opportunity to come and comment today my name is Steven Cozzo the director of public policy for Amerihealth, our national recognized managed care plans operate in the Commonwealth as part of the health choices program we also operate, dual special needs plans as well.

Amerihealth has long been a partner to the Commonwealth, serving the State's most vulnerable citizens and our mission is to help people get care and stay well and build healthy communities.

We have have over 30 years X, in Medicaid managed care, we expanded our capabilities in the

past years to include experiences, Medicaid Medicare plans, and other states, offering integrated physical, behavioral and MLTSS benefits, through the Medicare and Medicaid programs for part of the financial alignment demonstrations. Managed Long-Term supports and services system, affirms our mission and we want to express our support for the program proposed, Amerihealth commends the governor's proposal to benefit the older Pennsylvaniaian an individuals with disabilities by implementing a program, that will reduce barriers to care, rebalance long term services and supports, and reduce the fragmentation that currently exists in the long-term care system in Pennsylvania.

The proposed program, has the potential to improve the lives of over 450,000 Pennsylvanians and further promote the better outcomes

for the sick and vulnerable citizens we support, we would like to offer the following comments -- first, Amerihealth includes with the inclusion, dual eligibles and non-dual eligibles receiving MTSS, we receive the Commonwealth should maximize enrollment of these individuals and MLTSS programs across the State, in order to successfully rebalance care increase quality and reduce unnecessary costs.

Additionally, we feel including these populations, will also delay the need for LTSS, for at risk dual eligibles by keeping them healthier and independent for longer through early intervention and better care coordination.

Second, Amerihealth applauds the Commonwealth for emphasizing necessity for coordination between Medicare and Medicaid service hours, dual eligibles, who make up the

majority of consumers receiving long-term care supports and services. We support, and MLTSS program, that focuses on integrating care for individuals, across multiple programs and settings -- such as, physical health, behavioral health, pharmacy and long-term care services, such as nursing facilities and home and community based services.

While we recognize the challenges in aligning the programs integration is essential for the appropriate, coordination of care, and, emphasis on integration leads to improved health outcomes and long term cost savings.

Third, Amerihealth supports a regional approach to the proposed MLTSS program we recommend that the Commonwealth, align the proposed MLTSS zones with the existing health choices to zones to reduce confusion and fragmentation for beneficiaries

and enhance continuity of care for as many individuals may be transferring from the health choices program, to MLTSS program, as their needs and conditions change.

In conclusion, we thank the Wolf administration for allowing beneficiaries and advocates and providers and health plans to given put and feedback on the proposed MLTSS program.

We look forward to partnering with the Commonwealth, and all stakeholders, in the coming months to help develop and implement a MLTSS program ensuring Pennsylvania's most vulnerable citizens ensuring the right care the right time and the right setting.

>> SPEAKER: Thank you. We have about 15 minutes left, in our scheduled time for today's session, if anyone would like to get up and share anything, we would be happy to have you join us.

Any takers, great.

Could you share your name with us first.

>> AUDIENCE MEMBER: Sure.

Thank you. My name is Paul Bartalitti former CEO of Caregivers of America, I just want to spend a few minutes, off the cuff to talk about something that I -- the decision I made, just recently, I merged my company with a large company out of New York State.

That's in every part of New York and New Jersey and Florida.

And -- I did that because, really, because of managed care.

And, I did that, I started the decision-making process about 2012, two things happened, one was the managed -- I was in New York, at that time, even before I merged my company I saw managed care, in New York.

And I knew managed care was going to come to Pennsylvania.

And, um, the other thing that I was very concerned about was that, Obama care was going to happen, all these things have happened and -- I believe I made the right decision because I think those people that -- are going to survive in the managed care will have to have skill and now be I believe, I hope that -- my company, and merged company will be a major provider in managed care.

What I'm really concerned about with managed care is one bullet you saw up there, that says -- that, providers will go out and negotiate rates. When you go out and negotiate rates, what you're really doing is, you're putting the -- to get the business you really have to be aggressive in your rates.

So, to be aggressive in your rates, and lower rates, it puts a squeeze on -- the boots on the ground. Because -- everything trickles down in business, to cost.

And if you have cost like my costs, in this year because of Obama care we just started in 2015, went up 70%. So when you have, and only had one vendor that would be willing to put the care on praying health care we brought on 500 new employees they had no history of this.

So no one wanted to quote us.

What I'm trying to to say here is that, when you don't have standardization of rates, what you see, is a squeeze.

And, it is a squeeze of providers and then, the trickles down to the people that really are, the heart of managed care and provide care that's the caregivers.

So, in New York, what they have done, even though they have a capitaed law in Manhattan, in April of this year they raised their waiver rates by \$3 an hour for the disability waivers.

So, that is about 15%

increase around 22-\$23 an hour now.
Because they understood, there's a
lot of costs, associated with
providing care at the ground level.

So, I hope, that,
Pennsylvania will take a look at New
York's model and see that, um, they
understand there's a cost associated
and that they will raise our rates
or standardize the rates so that,
there is not a -- a more -- when
going to these managed care
organizations to cut rates, cut
rates and then, because when you
continue cutting rates you cut the
quality at the end of the day and
it's hard to find people, of 10
people we interview daily we may
hire one, I'm sure Tracey Hunt with
allied and echo my sentiments.

Those are my comments.

I appreciate what you do is
off the cuff. Thank you.

>> HEATHER HALLMAN: All

right, anyone else?

Okay. Any takers?

Anyone up here?

>> SPEAKER: You're limited to five minutes.

Heather has been waiting for an opportunity to tackle me the last couple of days I started these -- this session, with these words and I'll end this session, with similar words.

We can't thank you enough for your time and taking time out of your day to be here.

For sharing your thoughts with us, and many of which were filled with passion and, wise man once told me, if passion in the room could solve all of our problems we would have no problems left to solve.

And, that is palatable hear, those who spoke from your heart and from your experiences we thank you.

For those Paul and others who, spoke off the cuff, we're willing to do so, we're grateful for that as well and as we have stressed, we need to continue to hear from you.

You heard very onset of this opportunity, for us to be together this morning, you mo, what the framework is.

And now we need to put flush to the bone and meat to the bone so to say to make this possible in our Commonwealth. We have also, um, heard many, many times, as we traveled across the Commonwealth we heard, here today, I lost track of how many times it was said about an ambitious time line we appreciate your cautiousing us with regard to that and trust me after each session we debrief we comment on that I can share with you we're taking that to heart as we are, everything, that has been shared as we go back and we

work continuously, with stakeholders across the Commonwealth in order to ensure that we implement the best program possible. The governor when he shares with us, many of us expectations, it's -- it's to be bold and ambitious in all that we do. Not with just managed services and, managed an opportunity for Managed Long-Term services in the Commonwealth but across all cabinet officials and programs I can share that with, it Resonates with me and my colleagues Secretary Murphy and Dallas working with me closely on this imperfect, don't forget for one second we also know the transportation is apart of that, we also that military and veterans affairs and the department insurance, you name the department there's a trickle effect, ripple affect across all levels of the Commonwealth, when governor says to us, be bold and wishes everything is

on the table but the status quo we
take that to heart we cannot
continue to do the same thing and
expect different results we cannot
continue with the influx of folks
needing long term service and
supports in the Commonwealth, under
the age of 60, every under 60
consumer attendant care 150 services
today, becomes an over 60 consume
are tomorrow, 2.7 older
Pennsylvanians in the Commonwealth
of Pennsylvania today and a whole
unflux coming behind them it's
critically important that we do
this, we do it right we do it well,
we believe with the best thinkers
around the table, in a Commonwealth
level I'm biased, doesn't include
myself at all, we also rely on all
of you. Again, so as you leave
here today, you have additional
thoughts concerns comments, call us,
email us, write us, do -- tackle us
--

[laughter]

Do whatever you need to do, we are willing, ready, listening and responsible enough to do so I thank you behalf of my colleagues that are here with me today as well Secretary Dallas and Secretary Murphy for your time, safe travels enjoy the beautiful day I'm thrilled to be here in Scranton will eak out as much as I can, before heading back to Harrisburg thank you very much.

[applause]

[Session concluded]