

MEDICAID LONG-TERM SERVICE AND SUPPORT
PUBLIC FORUM

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*Captions provided by
Christy Azzarello, CART Provider*

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>>SECRETARY OSBORNE: Good afternoon everyone. I knew there were people in the room, I could see you and feel you. Just to know that you're awake, hopefully won't go into a lunchtime coma. My name is Teresa Osborne. I am the Secretary of the Pennsylvania Department of

Aging. I am here with two of my colleagues. Those that did take the time to join us at this beautiful Blair County Convention Center. Ted Dallas needed to go to Philadelphia today, he extends his regrets and he will be thinking of us at this particular public session and reminded me to represent him well. If I don't you can all e-mail him and tell him if I did or did not represent him well. My other colleague that has been joining us in Erie and Pittsburgh, she was able to be with us in Pittsburgh, that is Karen Murphy.

I am grateful to be here with you today.

Joining me today is Jen Burnett. She is the deputy Secretary of the department of long term living. And Kevin Hancock at the Department of Human Services.

And we welcome you and thank you for taking the time out of your day today to be here with us for these very important -- I can't stress enough, the importance of the stakeholder engagement process as we as a Commonwealth look at the opportunity we have before us to implement a managed long-term services supports and program in the Commonwealth of

Pennsylvania.

I can remember back 21 Fridays ago when I and my colleagues started with Governor Wolf and his administration as he took over the Governorship of the Commonwealth of Pennsylvania and at that time the Governor talked to us who worked most closely in human services in particular aging services and health and other entities that needed to be engaged in this conversation too. Touched along the way of long-term services and supports such as transportation and military and Veterans affairs and the list goes on and on. What our duty is to serve and for our particular services and the Governor's plan was to serve the most vulnerable and make sure folks over the age and 60 and under the age of 60 with disabilities aid in some way shape and form through home and community services. Folks who want to defer nursing home placement. How do we serve them best and expand those opportunities and rebalance our system. Rebalancing the system are words you have heard. Those who have been in the field for years, you have heard those words for years.

This is our opportunity in the Commonwealth with the best thinkers around the table to engage with all of you in terms of what long term services and supports is going to look like in the Commonwealth of Pennsylvania. We cannot do that without you. Those who represent and those who advocate with and for. And if you are a consumer of services we need to hear from consumers as well. With that introduction. I thank you for your time. For those who will provide comment today verbally and those who will submit electronically and those that call us up. The conversation continues today. It started for us weeks ago. This is an ongoing dialogue. This is our opportunity to do it right in the Commonwealth of Pennsylvania and we need to hear from you how we're going to do this. I look forward to our time together here today. I'll turn it over to Jen Burnett. And Heather will give us the details.

>>JEN BURNETT: Good afternoon everyone. I drove from Harrisburg this morning around 10 o'clock and got here around noon, I was

impressed to see this facility. I've never been here before. But one of the things I want to share with you that I love about this job is we can get out and talk and coming here to Altoona is one of those opportunities. I am reminded -- I see a familiar face in the audience. Linda Livingood who is on the advisory committee and she also serves as community representative on long-term care and these are advisory committees, people that come into Harrisburg and help us get our services right and put the pressure on us to really make changes where we need to make changes. So it's very nice, I now know what your ride is when you come into Harrisburg.

The objectives of today's meeting, we are in a process of rolling out long-term services and supports. Elaine is my slide advancer.

The Governor announced back in March with Teresa Osborne, the Governor's senior plan which included rolling out managed long-term services and supports for this population. And since that time, a lot of work has been happening at the Department of Human Services starting with an engagement with the University

of Pittsburgh where they gave us advice and background information and research on managed long term services and supports. But the result of that work was on June 1st we made an announcement and we issued a discussion document. The discussion document is just that. This is our third public meeting where people are coming to talk to us about the discussion document. Pretty consistent feedback is there's not a lot of detail in the discussion document and we agree with that. It was purposely left without a lot of detail because we were inviting the public to give us their ideas about what we could do.

We are in the process of rolling out this discussion document by going around and doing these kinds of public meetings across the state. The purpose of today's meeting is to share information about our current thinking and again, second main thing is to gather participants. All of you. We invited you all to come in and provide us with your comments. When we went to Erie last week, we had 16 people invited and I think there was 7 that signed up to participate and give public

comment and we ended up with more like 75 people in the room and closer to 20 people commenting. So we had a lot of good feedback there.

We want to promote health and safety and make improvements to our system. We want to strengthen healthcare for people who need long term services and support systems. One of the most important ones is we want to enhance community based services and to that end, Teresa talked about rebalancing. We want to rebalance. Our current system we are not balanced. We spend more money in facilities than home community based services so we really want to push the envelope on providing better home and community based services.

We also want to incorporate the use of person-centered planning. This is actually -- person centered planning is something that's a hallmark of CMS's. Which was issued last year and we really want to build on person-centered planning so everything revolves around the person and their needs. Enhance innovation. There's opportunity in our systems. We want to use technology smarter. We want to use more

technology. And we want to make changes in the system that really do promote a build out towards quality and outcomes rather than paying for each service which is what happens with the fee for service model.

We also want to assure efficiency and transparency.

My slides are mixed up.

The current system. The current system we have a fee for service physical health provision of physical health. We also have a managed care behavioral health system in Pennsylvania and for long term services and supports we have fee for service. Currently they're not combined and connected. So for example, if somebody who is getting a home and community based waiver goes into the hospital because of an acute episode they may end up in a nursing home because the hospital is not connected with the waiver program. Unless they push the envelope and get information on what services are available for that individual they may end up in a nursing facility and they may end up there for a long time. In cases when people go into a nursing home family members

start spending down, they divest their assets and sell their house and the person ends up in a nursing facility longer term.

So at least under what we proposed in the discussion document we want to bring all this together under one accountability structure which is the managed care.

The time line, which is another chart. So this is our current time line for what we want to do. We issued the discussion document on June 1st and during the month of June we are out on the road, we got public meetings like this all other the state. We got three more to go. And then we have, by July 15th that's when we'll be asking to submit questions on the discussion document. I will say all comments are due on July 15th. That does not end our engagement with stakeholders. We will continue through the life of the project and then beyond even once we implement the project to engage stakeholders. That is a commitment that Secretary Dallas and Secretary Osborne have made that we want to continue to engage and hear from people on how things are going.

We will release an RFP at the end of

October 2015 so between when we get all the public input and the end of October. We will be engaging stakeholders to the extent we can under the procurement rules but we do want to keep hearing from people.

Hopefully by middle of spring 2016 we will have finished our procurement and contract with organizations for the ramp up period which is the readiness review process we have to go through. It is our intention to go to the southwest but we have not defined that. That's one comment we would like from people is to tell us what is the southwest. We are looking at potentially the ten county choice areas but if that doesn't work we want to hear from you.

So our first roll out will be in southwest. We want to begin enrollment on January 1st of 2017 for the southwest. We're going to be learning as we implement in that first year in the southwest for the southeast. We're going to go to Philadelphia and five county area is what our thinking is currently. But we would welcome feedback on that as well for roll out in 2018. January 2018 enrollment begins in the southeast and for the rest of the state we will

begin enrollment in January 2019. So that's our timeframes. We have set up internal work groups that really cross across work groups and the Department of Aging. Helping us make sure we have a good quality plan. There's a committee looking at evaluation and we finished looking at eligibility and enrollment. CMS need to work with them to get authority to do what we want to do. I should say that our discussion document really doesn't articulate we're looking at the duals population. We're going to talk more about the dual population.

>>KEVIN HANCOCK: I'm going to use the microphone because my voice does not project.

To the MLTSS populations. Thanks everybody. Just a personal note, I grew up in this area. I'm from Johnstown and I worked in Altoona. I'm looking for the particular concerns and questions you have in this model.

Target populations for MLTSS we're focusing on all dual eligibles over the age of 21.

Those dual eligibles will be Medicare Part A, Part B and Part D and eligible for Medicare benefits. Large component of this program is what we call the dual eligibles, people jointly

eligible for Medicare and Medicaid. And individuals physically disabled over the age of 18 who are considered to be nursing facility clinically eligible and also eligible for the Medicare program and those people might be receiving services in home and community based waivers or also services in a nursing facility or even potentially in the Life Program if they so choose. And the last population is non-Medicaid recipients receiving home and community based services. Represents approximately 450 thousand people and most of those people are part of the dual eligible.

So when we talk about the program components, this is a framework of the program. It gives a lot of room and opportunity for suggestions on what the individual program design could be as we move to achieve the objectives of each of these components.

Include these nine. Person-centered service planning. Access to qualified providers. Incentives. Preventive services. Quality and outcomes based focus. Services and support coordination. Emphasis on home

community based services. Participant education and enrollment support. And participant protections. We'll touch on each one of these and answer questions you may have as well.

The first is person-centered service planning. Focus on the assessed needs and individual preferences and making sure their service components are designed around those needs and preferences for those individuals. And also look for opportunities for self direction where ever we can. It's a major interest and component of the concept.

Second is continued person centered service planning. For self-direction in this program as we go forward.

Service and supports coordination. This includes the coordination of all of the services as best as we can. With Medicaid state planned services that we call them the Medicaid physical health care or acute services. Services they're receiving in the physical health environment. Often covered under the health choices program and mandatory managed care.

Also Medicare and community based waiver services. Medicare A B and D services. So coordination is meant to be integrated program, coordinates their physical health, behavioral health, and long term services and supports all into one package as we possibly can through an integrated model.

We're going to ensure consumers have integrated supports and services including Medicare services. We can't make Medicare a mandatory part of the program because of federal rules prohibit that from taking place but we're going to look for every opportunity to integrate the Medicare with Medicaid to achieve the holistic service design.

Next area of focus will be access to qualified providers. We have an interest to make sure that people no matter where they live have access. And part of the qualified provider would be credentialing and making sure that the right types of providers are needed for people to meet their needs in a given area. And that's regardless of where they live. Whether it be urban or rural setting.

Emphasis on home and community based

services. We are going to try to continue to focus on our balancing efforts in long term services and supports areas in terms of costs. We are still heavily oriented toward extended facility based care. We are looking for opportunities to balance that care so people have the services they need in the setting where they choose. And that's continuation of existing efforts. It's in the managed care model as well.

Next, performance based payment incentives. This will provide opportunities for achieving program goals which include quality and also access. And also looking for opportunities to be able to emphasize ways that we can use the payment model in managed care to encourage the best results for the recipients.

Participant education and enrollment supports. We're looking for every opportunity to make sure that participants in this program know what's available to them and what choices they have to be able to develop that person-centered service design. A component of the program for services, is also an opportunity to be able to educate them what

type of choices they'll have with their service plan as they will be able to access it across the board. Education on what the program actually is. How we're planning to achieve that, we're looking for suggestions. We're looking for opportunity to have an entity that provides that to recipients.

Next there's a heavy focus on preventive services. Medicare right now is expanding its focus on preventive services. We want to expand preventive services across the continuum which includes Medicare and Medicaid. Looking for opportunity to provide wellness services that will keep people as healthy as possible and to potentially keep people in their homes and independent as possible as well.

Next involves participant protections. We have existing participant protections in our programs and we're looking forward to enhancing and expanding those protections in this new service model.

And last but certainly not least would be focusing heavily on outcomes and building a quality based focus for all the programs across the board. Looking forward to opportunities to

look at the goals that we had set up when we decided to go forward with this program as Jen had gone through and making sure that the program is meeting those goals and objectives and ultimately improving the participant experience for the program over all. To make sure that the people who are receiving the services are having the best possible experience that they can and also making sure that they are receiving the type of services that truly meet their needs based on who the person is as an individual. And the best way to do that is through really data driven analysis. Looking for opportunities to expand our information technology structure and quality data collection to demonstrate through evidence that we're achieving our goals. So those are the program components at this point.

And Jen already gone through the time line. So the next step in this process is to actually hear from you. Heather Hallman who is our master of ceremonies is going to introduce people that already signed up and also to step us through individual components. And we're looking forward to your ideas for how we can

make this the best possible change to an integrative care.

>>HEATHER HALLMAN: Thank you. I get to be the mean one to keep you all on time. But we actually only have seven people so far registered to speak. So we do have plenty of time. Hopefully at the end if anyone then decides they would like to speak we'll open that up to you. We do ask that you stay to about 5 minutes so we do have time for everybody. So I will be timing you. If you go over 5 minutes I'm going to stand up and kind of walk over. If you go way over 5 minutes I'm going to give Elaine a sign and she will tackle you to the ground. She's scary just to tell you that now. She is very tall. Line backer kind of, it will be good. Don't worry.

So I will let you know, first we're going to have Gina Graciano. Did I pronounce that close? And next is Kathleen Gillespie. I'll give you a heads that you're next. So thanks.

>>AUDIENCE MEMBER: Good afternoon Secretary Osborne, Secretary Burnett, Kevin Hancock. My name is Gina Graciano and I'm with the senior Life Program. There are currently 19 living

independently for the Life Programs throughout the Commonwealth. We provide acute to over 5 thousand frail older adults in 34 centers operating in 34 counties in the state of Pennsylvania. Right now one of three dual eligible seniors have access. As a provider of Life Program we serve 1300 Pennsylvania seniors with vast majority dual eligible. In 2006 first opened, we operate in 11 counties including Blair county. As the Commonwealth's first and only managed care for eligible seniors, we support and look forward to participating the state's efforts to design and implement a Medicaid long-term services and supports program. Life is the first in the country to offer fully integrated payment model. To serve dual eligible elderly qualified for nursing home placement but want to live in the community with person-centered.

Life organizations are able to help over 90 percent of nursing home eligible to remain living in the community. It isn't just about cost savings -- excuse me -- life is funded through fixed capitated. Life Program assumes full financial, including unlimited nursing

home care. Assume the risk that is less than 60 percent of Medicare cost and saved the state. It isn't just about cost savings, it has better outcomes including quality of life and high customer satisfaction. Consumer choice. Where they prefer to live which is in their homes. In 32 states Life has proved with risk based capitated payments can be beneficial. Several states implementing concepts to serve the same population. I'm here today representing senior life. PA Life Programs association and offer policy and recommendations with the goal of assisting the state's MLTSS efforts to lower costs and improve care for dual eligible citizens. I'm here to ask you consider these three goals when creating the MLTSS. The first being understand there's important distinction between life and plan based healthcare options. Life is maintained as distinct enrollment option for the frailest alongside large scaled healthcare.

Can choose it as enrollment option. Our recommendation is the state use third party to ensure conflicts of interest to be served by life and other managed care. You should be a

provider or counsel those eligible to receive those. Same organization cannot do both.

Three, using universal eligibility tool to remove subjectivity. Our recommendation the state adopt universal, allow expedited clear long term and assure individuals immediate access to care at a greater speed.

Four, establish Medicare payments that support consumer choice. Our recommendation is the state uses distinct for non-certified and duals for MLTSS health plans, establishes an opportunity for individuals to make service changes in their health status.

Five, regional approach to phase implementation. Rolling out managed care by geographic locations has lower success. And consideration of the vulnerability. Consider phased approach. Allows time to identify and implement challenges and allow for course correction.

As Life provider in southwestern Pennsylvania we agree with this approach and starting in southwestern Pennsylvania will provide the state the opportunity to study the market.

And lastly recognize the importance of promoting quality and accountability. For consumers, family and state policymakers to monitor managed care based on outcomes and quality data. To support informed consumer choice by allowing for accurate value. This will allow for greater transparency among providers.

Thank you for your time and attention. Managed long term care in the state of Pennsylvania we look forward to working with you, building managed care in the state provided by Life. This is what we live and breathe and we're happy to join you alongside. Thank you.

>>HEATHER HALLMAN: Kathleen Gillespie. And following, Minta Livengood.

>>AUDIENCE MEMBER: Good afternoon. Secretary Osborne, Burnett and Hancock. My name is Kathy Gillespie and I'm the chief executive officer at the Clearfield County Area Agency on Aging. Nonprofit. Providing advocacy, protection, care management service coordination. Options, counseling and information services. We provide 550 hot meals to seniors daily. Also

known as senior centers in our area. We offer insurance plan education and assistance and other areas based on the needs of the consumers at the time. The services and supports provided are varied and dependent on the needs of those in local communities. Some offer home modification services and transportation. Health coaching and medication management services. Thank you for the opportunity to share comments and thoughts with you on the implementation and design on long term services and supports for older adults and individuals with physical disabilities in Pennsylvania. I appreciate your time, patience and the Governor's willingness to engage the stakeholders.

The implementation of long term services and support change the way in which our most vulnerable population will access services in order to live in their homes and communities with the best practical quality of life. We have an opportunity to implement any positive changes in the provision of services and supports but we must remain cognizant of risks as well and work diligently to mitigate those

risks. For the past 40 years the area agency on aging have successfully provided services to allow individuals to remain in their homes under the capitated. Care plan and costs are a significant part of our every day tasks in order to serve more and serve better in our program areas.

The network is accustomed to managing costs and providing services based on realistically based needs. While funding has always fallen short, our network has responded proactively by incorporating informal supports including friends and neighbors and groups and churches. Collaboration in our local communities. This is the essence of service coordination. We have evolved into the experts in assessing the needs of the elderly in our respective areas including medical, physical, psycho social, environmental, spiritual and recreational needs. We continue to assess our service provision effectiveness based on the ever growing needs and expectations of our consumers and the silver Tsunami which we are aware. We develop and operationalize our plan to make sure our elders receive the quality care they

so deserve at the right time and right place and right amount we are obligated to provide.

We must be cautious and understand that establishing a high quality program is a complex program that requires initial investments of time and resources to ensure that the new arrangement for providing these services will be effective and viable over the long term. A time line from public discussion to implementation is extremely aggressive. I encourage the administration to reconsider the time line as outlined in the discussion document. Specific outreach is necessary to reach all individuals who are eligible for and or transitioned into the new program. Including potential impact on providers, guardians and representatives. For current consumers this will likely create stress. Outreach to these individuals should be coordinated to those individuals. Such as areas on aging, aging and disability resources, centers for independent living, assistance programs and county assistance offices. Implementation of long term services and supports will require on going and consistent

education, option counseling and support for those consumers and family impacted. Input in program design and ongoing operations is necessary for a strong foundation in this new model. Advisory committees should be established where at least 51 percent of the members are representatives of consumers and caregivers. Consumers should continue to have a choice in how their services are delivered. Available options must include a consumer directed model as well as full service agency model or a combination of the two.

The documented goals of managed long term services and supports include person-centered program design. Services and supports will be based on the needs of the individual. Those needs will be assessed using a standardized tool. The process to be person-centered, self-directed and include transitions to ensure quality outcomes. Agencies on aging provide navigation to seniors to help transition across the entire continuum from acute care to discharge. Allow individuals to age in place has been the mission of the aging network. I see I'm running out of time. So I thank you

very much for your time.

>>HEATHER HALLMAN: If you want to give us a copy that would be great. If anybody wants to provide a copy of their testimony we will have the closed captioning to help with that but we want to make sure we accurately portray the things you say. If you e-mail it to the e-mail address we will make sure we accurately portray what you have to say. First is Minta Livengood.

>>AUDIENCE MEMBER: My name is Minta Livengood and I am a senior citizen on Medicare and Medicaid who lives in Indiana county. Also I head the Indiana County Welfare Rights Organization. I am here to tell you about my concerns with regards to this personal and to ask some questions. I am concerned that the proposal mandates all dual eligible the vast majority of whom do not get long term healthcare go into Medicare managed plan under Medicare laws, beneficiaries have always had the freedom to choose whether or not to get their coverage through the managed care plan and many dual eligibles in the area choose to stay in Medicare. That must be honored.

This program should be mandatory and it is not -- it is as good as the state says it is, people will want to opt in to have their care managed in this way.

If you do not decide to be mandated enrollment into managed care, there should be no lock in period. And instead, people should be able to change plans at any time if their needs are not being met. I am concerned that the state is rushing into the majority upheaval into how hundreds of thousands of elderly people and adults with disabilities are accessing their healthcare and their long term care. The proposal gives very few details about exactly how this major change would work. And that it makes it hard to give meaningful feedback. The long term care commission recommends that the state proceeds with a demolition project and I agree. Managed care plans have no experience with providing long term care services. Like home and vehicle modifications. Personal care services and nonmedical transportation. Home making services and community transition services. The state should proceed cautiously and test

how the plan performs on a small scale before imposing this across the state. I am concerned that under this proposal, under Medicaid will no longer be carved out but will be fully integrated into one plan. That means that people like me who use behavior health services will no longer be able to access some services that are critically currently available as supplemental services under the health choice behavior health plan. Such as psychiatric rehabilitation services. These services are critical to many people in managing serious mental health issues in working towards recovery.

Several drug and alcohol treatment, detox and non-hospital services. It is critical that the drugs and alcohol treatment services remain available under the new model. Finally, I have some questions I would like the panel to answer.

Will the long term managed care plan provide behavior health services directly? Or will they subcontract these services to another entity? Will the county mental health and drug and alcohol offices continue to play a key role

in these services? Will the supplemental services I just mentioned be required to be covered by the managed long term care plans? The proposal does not mention the Life Program. At all. Will those in that program be able to remain and will others be able to join in the future? The paper does not address at all how the proposal would work for nonduals that is how this would work for those who are currently receiving Act 150 services. And those who are only on Medicaid and needing long term care. Could you speak more about this?

>>KEVIN HANCOCK: Sorry, I have to use the microphone. One comment that I wanted to make on one of your statements, you mentioned about Medicare enrollment to be mandatory. Just to be clear, at this point, Medicare would -- we're looking to integrate with Medicare but Medicare is optional enrollment for the program so that's not something that would be part of the program. Our current thinking would be mandatory for the Medicare portion. We're not talking about Medicaid.

And I wanted to make sure I'm answering your questions correctly. You asked whether or

not the long term services and supports plan. To be honest, that decision has not been made and we would like to hear how you would like to see that working in the program. What do you think would make the most sense based on what's working in the current service system and how we're looking to improve the current service system to have a better integration with long term supports and physical health. So to answer your question, I'm putting it back to you. I think -- what do you think? You're probably going to hear that statement made again. You asked whether the county mental health that currently exist will play a key role in this managed long term services and supports system. I think we can say with certainty they will play a key role but what that role is, is open to discussion. So we would like to hear from them and also from recipients on how they would like to see the system maintained and most especially how they would like to see the system improved that will be integrated and make more sense across the board for recipients. You asked about supplemental services. I think it's safe to

say that the program is not meant to be cutting any services. But we probably need to hear more from you on how the supplemental services would be integrated with long term services and supports and how you would like to see the service design be seam less. And you asked how the Life Program is going to be part of managed long term services and supports. We can say with certainty at this point the Life Program will continue to exist. The current thinking -- it's also based on sort of regulatory frame work from our federal partners -- will have life as an enrollment option. That's the current thinking. We would like to hear feedback from the life providers. Life providers since they have been performing this. But at this point the Life Program we're planning to have the Life Program continue and grow as an enrollment option with long term services and supports. Did that answer your questions?

>>AUDIENCE MEMBER: Yes. Thank you.

>>HEATHER HALLMAN: Thank you.

>>JEN BURNETT: I wanted to reinforce these kinds of questions are the kinds of questions

we want to be hearing from everyone. We want you to ask questions that you're confused about. The discussion document we did mention, it is very vague. And it's vague on purpose because it's your feedback that we're looking for. I want to reinforce Minta what you said, the question about the drug and alcohol and county mental health retardation entities, we have heard a lot about how important Pennsylvania local services are and there's a lot of already existing, really high quality local services out there in our communities. And we do not plan on destroying that. We want to tap into it. If anything we want to help it get better at coordinating across between behavior health, physical health, and long term services and supports. So I want to thank everybody for your comments.

>>HEATHER HALLMAN: Thank you, and I didn't time Kevin but if I had, I could have had Elaine tackle him.

So next we have Nicole Fideli-Turiano and then we will next have Steve Williamson.

>>AUDIENCE MEMBER: Thank you. My name is Nicole Fideli-Turiano. I serve as the policy

director (indiscernible). And I'm a member of the Pennsylvania home care association which represents more than 700 home healthcare and hospice. UPMC affiliates serving this region and other agencies more than one million Pennsylvanians each year. Home nursing agency worked with MCO's and health choice MCO's. We're an aging home waiver. Just like other home health agencies across the state. With respect to time I will share three areas I think are most critical to a successful long term program. These dovetail the Pennsylvania long term care commission which my colleagues Dr. Charles. These four recommendations included care coordination, service delivery, quality and sustainability.

First, I believe we need to fix the enrollment and eligibility process. Home is where most people want to be yet under our current system eligibility for funding home care can take 3 to 6 months depending on where you live. If the goal is to coordinate care this particular piece of the puzzle must be addressed sooner rather than later. I was pleased to see in the discussion document

increased emphasis on home community based services and financial incentives for MCO's to use community based providers.

Community based will become the de facto for entitlement to make this entitlement tangible, streamline and standardize the eligibility determinations across all settings. So institutional care is not always the first stop.

Second, we need to educate MCO's about the value of home care. We were pleased to read this tenet was included released June 1st. A state support system must train MCO's on community based resources and supports. The value of care home based services can provide. Look for opportunity to vendors to communicate outside negotiations. For one consumer the value of home community based services can be reflected in just a few visits a week from a home care attendant to monitor their health status to prevent hospitalization. It may be a physical therapist to avoid thousands in rehab.

How about the value of home community based services to the unpaid caregiver. In Pennsylvania alone we recognize family members

provide the backbone for an average of up to four years for much of the care that is received by our aging folks. According to AARP providers are entitled to 20 billion in uncompensated care in 2012. More person-centered. Hence this provider type must be considered differently in measuring adequacy.

Finally the negotiation of contracts in setting. Currently, only interact to coordinate payment with the new arrangement require to contract with several MCO's and process but get more open and transparent process should be required when amending the provider rate. Provider advocates call for a baseline payment equal to Medicare reimbursement so they will not see a loss in revenue. Here in Pennsylvania RMA rates are already significantly below what they need to be to cover costs. When the Commonwealth considers parameters for the MCO provider contracts the current rates are not an acceptable starting point. Respectfully in addition to annual inflation update on the MCO contract and 10 percent increase of personal

assistance rate it is requested that that occur so we can provide competitive wages and cover the cost of care and keep families together at home rather than forcing consumers into a high cost setting. Costs that are unsustainable in Pennsylvania. Thank you for your time.

>>AUDIENCE MEMBER: Thank you. You were like 5 seconds over, that was impressive.

Next is Steve Williamson followed by Veil Griffith.

>>AUDIENCE MEMBER: My name is Steve Williamson. I'm president of Blair Senior Services AAA in Blair county. As we move to Medicare managed care and long term living supports and services program. Pennsylvania's pursuing a major shift to older adults with disabilities. There's opportunity for positive change there's significant risk for participants with managed care. Limited access to providers. Operate in a manner that places the interest of older adults and persons with disabilities in the fore front then the managed care has potential to expand services while at the same time producing desired outcomes. Based on our review of the discussion document

I would like to submit the following five comments for your consideration.

First, local service provision. Working with consumers to identify their needs and coordination of services is best done locally. Knowledge of local community and resources and existing working relationships will positively impact. I don't believe this is the most effective model, for Pennsylvania most at risk residents. Face to face interaction with consumers and their families remains the best methods of achieving desired outcomes.

The aging network has been an integral part of long term delivery system in Pennsylvania. We have over 40 years experience in this arena. Take advantage of the infrastructure put in place by using opportunities to build on this service delivery system. The aging network works. The aging network solidly established in 67 counties and has years of experience working with older residents to perform functions such as assessment, care management, information assistance and consumer advocacy. Extensive working relationship with the hands on service providers in community based

services. Implementing delivery system that's more comprehensive and integrative.

Three, preserving the role of other providers. Significant investments in Life Program who works under managed care project. These programs work. Again, we urge you to take advantage of the existing infrastructure by building on these service systems.

Four, system coordination and integration of care will be one of the keys to integrating a successful system. We should strive to leave the pendulum in the middle and not swing from one extreme to the other. A narrow view will result in fragmentation. Long term investments in the existing systems. And the common sense approach. Provide holistic approach while addressing conflict of interest issues.

The proposed move to managed care break down silos and address over regulation or regulation based on exception in favor of providing service in an environment that's more conducive to common sense approaches.

Five assure adequate time for planning and input. There's adequate time for consumers to be informed. The discussion document provides

for three years. Input as things progress public venues are only available June 1st to July 15th. Additionally add ongoing advisory mechanism as a means for stakeholders, particularly consumers and families to provide input related. Pennsylvania has the opportunity to present a system that aligned with consumers' needs and prevent disruption and access to care, ongoing monitoring and protection of the state's most vulnerable residents and control costs, we're encouraged by the discussion document and the open approach. We welcome the opportunity to be part of that process. Thank you.

>>HEATHER HALLMAN: Next we have Veil Griffith. She's our last scheduled speaker so if anyone else would like to consider speaking after that, just let me know or I will ask for volunteers afterwards. Maybe if any of our panelists have questions we can open that up too.

>>AUDIENCE MEMBER: Thank you Secretary Osborne, Deputy Secretary Burnett, Kevin Hancock for the opportunity to present. My name is Veil Griffith, I'm the administrator of

the Cambria County Center Agency on Aging. While the goals of containing costs and improving health costs. Research is mixed as to whether managed healthcare organizations for long term services and supports can achieve this goal. Currently only a minority states are using this to coordinate long term services and supports. One of the challenges is effective capitation rates for a population that is much sicker and uses a greater volume of services than the typical Medicaid advantage care enrollee. The American healthcare association recommends that states ensure rates reflect the needs of the beneficiaries with updates based on each managed care organization's experience. Another key finding in a report by the American healthcare association is that studies on the impact of MLTSS on costs are inconclusive. May have difficulty achieving Medicaid savings.

Another quote, evidence suggests that integrating Medicare and Medicaid benefits may not reduce costs. Medicaid spending may actually increase.

Research indicates that MLTSS programs

reduce the use of institutional care and access to less costly home and community based services and models which emphasize movements or patients to home and community based services normally do yield long term savings. Older adults and individuals with disabilities in most cases prefer to be in their homes, not institutionalized.

Additional research is needed regarding care coordination models including identifying which are the most effective and how much they cost.

Staging several pilot projects including large and rural areas prior to large scale will certainly help in developing strategies that will improve outcomes.

Improvement in quality are also not guaranteed because MCO's are required to deliver all beneficiaries. Managed care financing models can inadvertently encourage MCO's to provide inadequate or less care to maximize profits which would negatively effect health outcomes.

Another finding by the American healthcare associations, is MLTSS programs have shown

mixed results regarding health outcomes. A robust MLTSS program requires strong participation by medical specialists. Their analysis reported early and significant investment in administrative infrastructure is one of the keys to a cost effective program. Most likely due to the need of MCO's especially quality incentives. Can serve as a key component of administrative MCO delivery of supports and services. Stretch across the Commonwealth with experienced caring professionals already meeting the needs of older adults. Include health professionals such as licensed, registered nurses. We have consulting relationships and contracts with area physicians in addition to serves as gatekeepers trained ombudsman advocate for quality care. Protect the frail and elderly and disabled from mistreatment. Staff are knowledgeable about available supports and experts at coordinating services. I recommend integrating the area agency. With enhanced monitoring infrastructure to strengthen health outcomes for older individuals and disabilities.

Managed long term services and supports for older adults. Capitation rates will be a key component to assuring adequate network of qualified providers rather than allowing any provider to enter the system. Achieving the goals of cost containments and improved health outcomes require enhanced monitoring capacity which the area of agency are staffed and poised to deliver. Thank you.

>>HEATHER HALLMAN: Thank you. So we have time if anybody else is interested in speaking, please let us know. Yes? Thank you. If you could state your name when you start that would be great.

>>AUDIENCE MEMBER: My name is Ethan. Clearfield Area Agency on Aging. I'm excited about the opportunities that managed long term services and supports offers. I'm a licensed behavior specialist so I have experience in long term managed care. It's a concept that offers a unique benefit. Finding out if we're actually doing our job. In our current system that's hard to do. It's hard to track. Trying to find definite numbers of our successes can be difficult. I think that as an agency we're

very good at what we do. I think we're good at coordinating services and good at educating consumers and I think we're very good at impacting our communities. We tie a lot of people together. As been mentioned by my other AAA colleagues, we know our communities. For the most part I can tell you just about everybody we work with. I experienced them in some way or another. I think that personal touch is important going forward. So I would like to advocate for the AAA's to coordinate care. I understand that it will take a different form. But I think it's important to keep that coordination. So thank you.

>>HEATHER HALLMAN: Thank you. Anybody else? Free reign. I'll give you 7 minutes, just kidding. All right. Yes we have one more. Please remember to state your name when you start. Thank you.

>>AUDIENCE MEMBER: Hello my name is Tammy, (indiscernible) cerebral palsy and serve the under 60 population. I also look forward to the opportunity that managed care brings to the table. As I can see many changes will happen. But we lived in the last three years we've had

huge changes to the service coordination entities that are currently in place. I also agree that we need to have more outcomes based, however I will tell you as an under 60 we struggle over the last year in our changes in trying to work in conjunction with physicians and behavioral health agencies to provide a holistic opportunity for our consumers. Our consumers also, they do utilize all of these services and I believe with our coordinators that having all of this integrated together gives us a better opportunity to serve the consumers. We have been tracking our outcomes for the last two years. So that we have a better understanding of -- and part of this was forced on us -- which is a good thing. Hospitalizations, ER visits. Any abuse or neglect. We have been tracking all of that information and we have been implementing preventive measures to prevent them from going to the hospital or having ER visits so we can find are there better ways to do that in the home. Do we need to have more contact with physicians or skilled nursing agencies and we have been trying to push forward with having

those contacts so I also see opportunities in integrating all these services together. I also believe the time line is a bit aggressive. Only because I've seen other programs and that have been referred to as trying to put the plane together as it's being flown in the air. While they have great potential, it's years in the making to get them where they need to be. And better planning may have been the way to do that quicker. But I wanted to at least say for the under 60 population, there are many opportunities with this being done in the right manner and planned the right way and service coordinations as well. I agree with the local. We know our communities and as social workers we know what's available in the community. We look for the resources available. We're serving 47 counties so the rural and urban offer more challenges. Rural being the services just aren't available to find. But we do our best and utilize what's available. So we look forward to also being part of the discussion.

>>AUDIENCE MEMBER: Thank you. Anybody else? I think Elaine -- oh Minta would like more?

Because if you go over six minutes -- I'll have Elaine jump she really wants to do it

>>AUDIENCE MEMBER: In the process of looking at all of your reviewing things, I'm thinking about the medical transportation program. How would that work if you're Medicare and Medicaid and are you going to be able to still provide medical transportation through the M and G P program versus just aging. There are ones out there that don't qualify for aging transportation. So it just happened to pop into my mind. So, thank you.

>>JEN BURNETT: Thank you. We recognize that medical transportation is a critical access issue and so we will be looking for feedback on what's working for medical transportation currently and what isn't working and how can we make improvements. We don't have the answer but we recognize it's essential for access.

>>HEATHER HALLMAN: Thanks. Yes? Fran. And if you would state your name also.

>>AUDIENCE MEMBER: My name is Fran, I work at the Pennsylvania project and I'm in our Pittsburgh office. Since you have time, one thing that having read the document and spoken

to lots of people what's not clear is how this system would work alongside the existing waiver enrollment system. So does that go away totally? It's totally unclear what the role of the enrollment broker would be. It sounds like in the document that everybody who is dual eligible who is already getting their Medicare services through a managed care if all of a sudden I'm that person and I think I need more help at home do I not go and say I think I need a waiver, do I get those services and pushing the plan. Like I'm pushing the plan to pay for physical therapy or dental appointment. There's no need for enrollment broker for people to push for that level of service. It wasn't clear from the document. And I know you are renegotiating that contract. Can you speak to whether or that will really exist any more with this system. It's not clear. Am I making any sense?

>>JEN BURNETT: Yes you are, it's unclear because we don't have the answer. I would give the micro phone to Kevin but he's not allowed to talk about it because he's involved in the procurement. There is open procurement out

there now. There is language in the RFP itself that will support managed long term services. We do know there will be some type of enrollment broker. And to speak to your question about waiver, that authority, we're not even sure of the CMS authority we're going to be using but we recognize home and community based services will continue to be provided to folks who need them who are participating in the managed care. Whether it's a 1915 C waiver which is the current authority we use to provide services in Pennsylvania for both aging and under 60, I don't have the answer to that. So there are a lot of other more authorities that CMS has available to states and we're investigating and looking into who those might be. Sounds like it started raining.

>>HEATHER HALLMAN: All right if that's rain we got some time if anybody wants to speak.

Anybody else? I don't know if you guys have anything you would like to say? Elaine is really upset she didn't get to tackle anybody.

>>SECRETARY OSBORNE: For those of you who have spoken, the two at the end who provided comment, we thank you. Again I started these

words a while ago in this session thanking you for your time, attendance and willingness to engage with us. I can't stress enough that this conversation needs to continue. As you leave here and talk among yourself with your peers, those whom you serve and work with in your community about what this would look like in our Commonwealth and in particular for your communities where you live and work and play in. It's important that the conversation continues. Don't think, oh I didn't stand up or I provided comment and I have something more to say. This conversation dialogue continues. If I, our stenographer I give so much credit to, I can't imagine doing that. It's incredible the way her fingers work. I am anxious to not only to hear what others say, as I sit in these sessions and I jotted down a couple notes for key items that I need to take away, I'm not as strong as I used to be, but when we read we have these take it and note so we can go back and read. A couple times I want to go back and see how many times consumer choice was mentioned and how many times local community involvement and provider

relationships was mentioned. We will be paying close attention to that. So again, we cannot stress enough how important it is that as you leave this session, if you have additional thoughts and concerns, and those in communities such as yours, now that those people have this all figured out -- the state already knows what they're doing -- what do they want to hear from us for. As you have heard, this is a work in progress. We can look at other states and we are. We can deal with it and connect with experts and we have. But what's important for us is what's going to work for Pennsylvania. 67 counties. Our infrastructure is unique. You go to one community in one county and the needs are different. I hail from the northeastern part of the Commonwealth in Scranton. The needs are different than they are here. We need to continuously hear from you. We are ever so grateful for your support and attention and your time and we encourage you to keep in connection with us. Heather is the executive assistant to Secretary Dallas. She will report back. That will be helpful. So thank you heather for joining us today. I

hoped I talked long enough that the next rainstorm passed. Again, I cannot stress enough we need to continuously hear from you. This is again, a work in progress and I will count my own words how many times I said those words. We have three more to go. It's not a finish line for us. It's not this is it and we're done listening. I cannot stress enough we need to continue hearing from you. Because at the end of the day, as Governor Wolf charged us in terms of his senior plan and his desire to ensure that seniors and individuals with needs of long term services and supports system, I sat with Governor Wolf, told me he was interested in serving in this capacity no one is more surprised than me. But he said several things to me in terms of his desire for individuals in our Commonwealth to live in their homes and communities and access care in their homes and communities. To be certain a nursing home will always be needed for someone but that doesn't mean it should be the first place. It should be an option. Those most vulnerable among us that need to be in an institution have choice and options. Obviously

tainted and bias, if I didn't believe as an advocate for my 25 years of service, I wouldn't be here. Neither would the Secretaries that came on board to make this happen.

Transportation was mentioned, drug and alcohol was mentioned. As former director of human services, I get the integration. But you do too. And that's why we need to continue to hear from you. So am I over my time.

>>HEATHER HALLMAN: I think so. But Elaine said she wasn't going to tackle you.

>>SECRETARY OSBORNE: I hope you all have safe travels, thank you so much for being here with us today and let the dialogue continue if you have additional thoughts please let us know.

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