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Date: 01/04/2023

Event: Managed Long-Term Services and Supports Meeting

>> DAVID JOHNSON: Good morning, this is David Johnson, can you hear me?
>> Yes.
>> DAVID JOHNSON: Hey, good morning. I'm remote today as well. We will see if we can be heard in the main room.
>> MICHAEL GRIER: Can you hear me, David? This is Mike.
>> DAVID JOHNSON: Good morning.
>> MICHAEL GRIER: Good morning. Let's get started and we will ask the two new members to introduce themselves at the end of roll call.
>> DAVID JOHNSON: Sure. Good morning, this is David Johnson speaking. Happy new year. Welcome to this month's MLTSS committee meeting. I will take attendance. Mike Greer, you're present, yes?
>> MICHAEL GRIER: Yes, present.
>> DAVID JOHNSON: Allie, kromly? Anna warheight?
>> Good morning, I'm here.
>> MICHAEL GRIER: Good morning, Anna. Welcome. Cindy ceilly?
>> Cindy is here. Good morning.
>> MICHAEL GRIER: Good morning. Neil Brady. Gail Weidman.
>> Good morning.
>> MICHAEL GRIER: Good morning, Gail.
[Indiscernible]
>> Hashid is here. Good morning.
>> MICHAEL GRIER: Jay harner.
>> Present.
>> MICHAEL GRIER: Good morning.
Juanita gray.
Kyle gloazer.
Lura lions.
>> Good morning, I'm here.
>> MICHAEL GRIER: Hi, Laura. Good morning. Mike hurts?
>> Good morning.
Sorry I can't be right there.
>> MICHAEL GRIER: Good morning. Matt ceilly.
>> This is Matt, good morning.
>> MICHAEL GRIER: Good morning. Monica Vacaro.
>> I'm here, good morning.
>> MICHAEL GRIER: Good morning. Patricia.
>> Good morning, everybody. I'm here.
>> MICHAEL GRIER: Good morning. Sherry well.
>> I'm here. Good morning, everyone.

>> MICHAEL GRIER: Good morning.
And Tanya segro.
Are there any subcommittee members that are present that were unable to announce themselves?
>> Yes. Juanita gray.
>> MICHAEL GRIER: Good morning, Juanita.
>> Good morning.
>> MICHAEL GRIER: Anyone else?
>> Good morning, happy new year.
>> MICHAEL GRIER: I'm sorry. Did someone just announce themselves? I didn't catch a name.
>> Sorry. Allie kromly.
>> MICHAEL GRIER: Hello. Good morning. Michael, I yield to you for introductions here.
>> Thank you. As you may have noticed, a couple new members will be joining us. I thank all of you for your commitment to doing that.
And Anna, I wondered if you and Laura can introduce yourselves and tell us a little bit about where you are from and who you are and why you're interested. And we will go on with the agenda or go on with the meeting after that.
>> Good morning. My name is -- yeah, sorry, my name is Anna. I live in butler county. I started as director of regulatory affairs last October. Prior to that, my most recent position was a social services manager for CCRC out in western Pennsylvania. I have background, started my career doing activities in long-term care. Did an AIT program. I also got a law degree and masters in jairn tole ji from University of Nebraska. I did have advocacy work with AARP Nebraska and worked closely with care giver support network and housing issues, things like that.
To answer your question, why I'm in the field and passionate about it, I got my start with activities on memory support unit way back when out of college and got stung by the bug back then and it hasn't left me sense.
>> Thank you very much. We are excited to have you as part of our committee. Laura?
>> Yes. My name is Laura lions. I currently live in Erie county Pennsylvania. My background is a registered nurse. I have worked in long-term care for nursing homes prior and then I found this great program, life program, that I started working about 10 years ago. As the clinical manager. Then was their quality and Executive Director of the life program that currently has six programs throughout Pennsylvania.
My passion is seniors. I actually have multiple family members that are in the program as well. As a family member, I could not do it without the program. So that is my passion. So thank you.
>> Great, Laura, thank you very much for joining our group. I will be connecting with you guys, maybe through OLTL to get your e-mail addresses on that. I have a group e-mail that I can send out to everyone. I communicate with the subcommittee. So welcome. Thank you.
>> Thank you.
>> Let's go on to the housekeeping rules. Please keep your language professional. This meeting is being conducted in person at the Department of Education's building honor suite and a webinar --
[Indiscernible]
The meeting is schedule until 1 p.m. to comply with logistical arrangements we will end promptly at this time. All webinar participants, except for committee members, and presenters, will be in listen only mode during the webinar. While the committee members and presenters may be able to speak during the webinar to help minimize background noise, improve sound quality of the webinar, we ask that attendees do self-mute in using the mute button or mute feature on your

phone, computer or laptop when not speaking. Please hold all questions and comments until the end of each presentation. As your question may be answered during the presentation. Please keep your questions and comments concise, clear and to the point. We ask that participants please submit your questions and comments in the chat box located in the go to webinar pop-up window on the right-hand side of the computer screen.
To enter a question or comment, type into the text box under questions and press send. Audience members who have a question or comment should wait until the end of the presentation and to go approach one of the microphones located here if you are here. If not, to chime in. And we will recognize you. Please remember to make sure that you are saying your name so the captionist can capture the documentation of the dialogue.
To minimize background noise in the honor suite, we ask that committee members and presenters and audience members in the room please turn off your microphones when you are not speaking.
The captionist is documenting this discussion remotely, so it is very important that people speak directly into the microphone. State their name and speak slowly and clearly. Otherwise the captionist may not be able to capture the conversation.
This is also an aide for the captionist for who responds. It is important to include your name in the chat box.
Before using the microphone in the honor suite, press the button on the base to turn it on. You should see a red light indicating the microphone is on and ready for use. State your name into the microphone for the captionist and remember to speak slowly and clearly.
There is a trend with that. When you are done speaking, press the button at the base of the microphone to turn it off. The red light will turn off indicating the microphone is off. It is important to use the microphone around the room to assist the captionist in transcribing the meeting discussion accurately. Public comments will be taken at the end of each presentation instead of during the presentation. There will be an additional period at the end of the meeting for additional public comments to be entered into the chat box. If you have questions or comments, that weren't heard, please send your questions or comments to the resource account, and this is listed on your agenda. Transcripts and meeting documents are posted on the list serve under MLTSS meeting minutes. These are posted within a few days of receiving transcripts. The 2023 subcommittee meeting dates are available on the Department of human services website. David, ill turn it over to you.
>> DAVID JOHNSON: Hello, this is David Johnson. The following are evacuate procedures. In the event of an emergency or evacuation, proceed to the assembly area to the left of the Zion church on the corner of 4th and market. If you require assistance to evacuate, to go to the safe area right outside the main doors of the honor suite. OLTL staff will be in the area and stay with us until you are told you can go back into the honor suite where you were evacuated. Everyone must exit the building. Take your belongings with you. Don operate cell phones and do not use elevators as they will be locked down. Use stair 1, stair 2 to exit the building. For stair 1 exit honor suite from the main doors to the left near elevators, turn right and go down the hallway by the water fountain. Stair 1 is on the left. For stair 2, exit honor suite on the right side of the room or the back doors. For those exiting from the side doors, turn left and stair 2 is directly in front of you. For those exiting from the back door exits, turn left and left again and stair 2 is directly ahead. Keep to the inside of the stairwell and head outside. Turn left and walk down to the alley to chestnut street. Turn left to the corner of fourth street and turn left to blackberry street and cross 4th street to the train station. Back to you, Mike.
>> MICHAEL GRIER: Thank you, David.

We are going to start the meeting off with follow-ups from our December 72022 meeting. And for those that are new to the committee, these are questions that weren't answered in the last meeting. That is why we are doing follow-ups. This is something that we initiated last year, I think, at around this time. And we found it to be a very good portion in dialogue within our meeting.
So we will go ahead and start the follow-ups now. And related to the November follow-up response, subcommittee member Matt ceilly requested a copy of the answer to the November follow-up question, number 6, about fir consecutive missed services resulting in MCO's outreach. There was a statement she would send a copy.
>> The answer to follow-up question number 6, Matt ceilly, via e-mail on 12/8/22.
>> MICHAEL GRIER: Thank you, Paula. Related to the cost impact to the state subcommittee member, Lloyd birds, asked, is the life program closed tomorrow and all of the individuals served in CHC-MCOs, does that cost to the state go up or down? Jonathan was asked to follow-up. However, Jamie, deputy secretary of OLTL, mentioned a life program is an all-inclusive model. OLTL would have to take into account the behavioral health services. It is hard to say that OLTL would not know which plan the individual would choose. There are many factors to take into account.
>> Jonathan responded that he would discuss the data request with the independent enrollment broker.
>> MICHAEL GRIER: You will hear that within the next three questions. So we will just say that we will have some additional follow-up on that question and the next three. Related to the life enroll subcommittee member Lloyd asked if OLTL has an estimate of percent anl of individuals enrolled in the life program receiving services.
Jonathan is also looking into that. We will discuss it. Related to data for life for CHC and for life audience member Janice minor asked, through the chat, if OLTL has data on the numbers of people who have switched from life to CHC and CHC to life over the last 2 years. We will also get that for you, Janice.
Related to reasons for switching from life to CHC and HCH to life, Matt ceilly asked, what are the reasons why individuals would switch from one to the other. P Jonathan reported that individuals disenrolling from life do not always provide a reason for that answer. Randy Nolan stated that for a transition from CHC to life, he will have to check with IED and OLTL should be able to provide the top three reasons. Like I said, we are still getting clarification on those last three or last four questions.
Three questions, four questions. To continue. Related to cell phones, audience member Shawna asked for an update on Jamie Buchenauer working to get offices together for a meeting. Randy Nolan said would he get back to that.
>> Jamie stated that OLTL is meeting internally in January to discuss an update of schedule meeting with other DHS program offices until after the internal meetings occur.
>> MICHAEL GRIER: Thank you. Subcommittee member asked if it would be possible to get data surrounding the length of time of a transfer request from life to actual transfer date consider CHC.
Can we get that from the IAD. There were asked for specific questions.
>> Randy responded for federal regulations surrounding of voluntary disenrollment from the life program, individuals may choose it disenroll without cause at any time. Effectivecate of voluntary disenrollment is always the first day of the month following the individual notifying a life provider of their disenrollment request. Because of the federal guidelines and rules transition timeframe to any other program, including CHC, should never be more than 30 days.

These guidelines can be found at 42cfr460.162.
OLTL is discussing with IEB date surrounding a length of time from request to life to actual transfer date and into CHC is available.
>> MICHAEL GRIER: Related to notification of the extension for IEB for 2023 to 2024, audience member Jeff Idman asked if the home health care provision of EVB going into effect 2023 is there anything that providers and consumers should expect to see? Randy Nolan said he would check. And we will go on with the extension.
>> Randy responded that a sent on 12/15/22, the effort for the home health care services, EBD certification. Janice added that OLTL issued a bulletin on EBB requirements for home health care services and the delivery and managed care delivery systems on August 10, 2022 bulletin number 05-22-09.
>> MICHAEL GRIER: Related to centers for Medicare and Medicaid services compliance with EDD Elizabeth said that she could take that to the steering committee to look at and look into how other states have made cell phones use work with EDD and the remaining compliance with CMS mandates. Elizabeth stated she would send a response of what she finds out from the meeting call and has been scheduled to find out what other states are doing.
>> Elizabeth will provide a response at the February meeting.
>> MICHAEL GRIER: Related to the enforcement of EBT monetary collection audience member Shawna asked if the community felt choices managed care organizations MCO's could suspend the enforcement of collection of money from providers because there may be a situation where consumers don't have a physical landline or have voiceover internet phone service. All through CHC and MCOs were asked to provide a response.
>> First responding they have not received money for noncompliance with EBD. PHW responded that at this time PHW is not enforcing monetary collections pursuant to their policy compliance enforcement would include the following. Noncompliance with requirements, providers who fail to comply with the requirements of the health and wellness program are subject to denial and nonpayment of claims. Failure to comply with all requirements may result in sanctions which include but are not limited to find suspensions and possible termination in accordance with their contract rule agreement.
Noncompliance with EBD training requirements may restrict the provider from receiving a prior authorization for EBD service if they're not, if they have not completed EBD setup and training. To claim payment authorizations might be subject to suspension as a result of noncompliance no direct activities are currently in place. Fines would likely be executed as a result of highly circumstances. Responding that established policies procedures and CHC waiver guidelines when attempting to recover overpayments from providers. The cures act says there must be verification of service delivery. If the consumer does not have a physical landline or a voice, the provider can request a fixed object device. All must be permanently affixed to the primary service location. For providers using the free exchange system, vox can be requested by the health plan network team and CHC providers at UPMC.edu. If a provider is not following guidelines, UPMC CHC may seek recovery of overpayment. If the overpayment causes significant hardship UPMC will work with the providers to establish a payment plan.
>> MICHAEL GRIER: Thank you, Paula. Related to UPMC contracting with mega agencies, there is a question submitted through the chat from Helix home health asking if there is any reason why UPMC only contracted with mega agencies and why they refuse to contract with small home care agencies. Randy Nolan stated that UPMC should reach out directly to Helix home care in response.
>> UPMC responded they have a diverse network including both small and large providers.

UPMC has been in touch with Helix home health inviting them for follow-up meetings as needed.
>> MICHAEL GRIER: Related to UPMC's accreditation audience member Janice minor asked through the chat about UPMC's accreditation from past home health -- home care providers if that would be accreditation by community health accreditation partners of the joint commission or some other accreditation. UPMC was asked to respond.
>> UPMC responded saying they would accept any accreditation for health care providers. Chat accreditation partner is most recognized. Feel free to contact UPMC, CHC providers at UPMC.edu with specific questions.
>> MICHAEL GRIER: Related to the motion for agency with choice subcommittee member Perodi made a motion for the subcommittee to oppose OLTL's application for CMS to amend the state's waiver to allow agency with choice model to proceed unless it includes at least three vendors per region to preserve consumer choice and control.
The subcommittee voted that OLTL should not proceed with the agency of choice unless it allows three vendors to serve consumer control and direction.
And we did have a vote on that and it did pass. I have contacted, this is Mike, I have contacted our chair and their agenda development will be at the next meeting. That is all of the follow-up that we have from last meeting. Once again, thank you all OLTL for putting this together.
I know it takes time.
But I think is well worth it. Hopefully we can get follow-up on the ones from the first page for next time.
I would like to turn it over to Jamie from OLTL. Jamie?
>> JAMIE BUCHENAUER: Yeah, happy new year, everybody. Welcome back for those of you who took time off during the holidays. I know yesterday was a little rough for those of us in long-term living. After an extended holiday break. I wish everyone a happy and healthy 2023.
All right. So we will give our OLTL update for January.
Startingoff our agenda, go to the next slide, an update on our payments. A quick update on the ARPA payment plan. Members are very interested in that. Also a quick update on acts 24 and some ARPA reporting we are asking providers to do. And a quick update on the process. I know a generated a lot of questions. We don't have a lot of updates but I will share with what we are telling others when they ask. Update on act 54 payments. You may recall that act 54 included arpa funding for long-term care providers. Nursing care homes. Assisted living. Home care providers.
Past providers in our participant directed populations, life providers, adult day. I know that if all residents on our --
[Inaudible]
I'm getting some feedback.
>> MICHAEL GRIER: I'm sorry. We are getting feedback. Can we make sure everyone is muted.
>> JAMIE BUCHENAUER: We are good now. So all of that is on the website of office of long-term living. We provided the website all of the providers and their payment amounts they should be expecting from act 54. Those ARPA funds. Most payments for providers wept out in early November and we did announce that. So remaining payments that we need to go out were actually for our direct care worker population.
So working with together closely with CHC-MCOs and those payments went out on December 13, 2022. That is good news for director population and they are able to receive ARPA payments right before the holidays.

So we are still working and there was a slight delay for personal care homes and assisted living residences. Long-term living generating each of the payments, we are working on that and actually started that up in earnest in December. So those payments are rolling out to personal care homes and living residences. We will continue to do that. It will take us another couple of months to get all of those payments out.
Just a reminder for the providers who received payment for act 54. You will need to report on the use of those payments. They had to be used for COVID related expenses. We are working on the reporting system. It will look much like the reporting system that was rolled out for the act 24 payments and the strengthening workforce payments. I know there is a lot of payments and a lot of reporting systems but the bottom line here is that act 54, you will have to report a system is not out yet. So just keep your documentation and make sure you're tracking how you use act 54 funds.
One thing I don't have on the slight here and I just thought I would mention it because it is late-breaking, so act 54 also required a couple of things in record to nursing payments. You may recall that nursing facilities add significant increase as a result of act 54. Those increases work to support nursing facility increase staffing requirements that the Department of Health was working on regulations for. Those regulations are in place and obviously nursing facilities now have increased staffing requirements that will take effect as of July 1 of 2023. To support those increase staffing requirements obviously funding was provided in the budget to increase nursing facility rates as of January 1 of 2023. So fee for service rates were calculated and are posted on the website, taking effect January 1 of 2023. Those are the nursing facility rates. The CHC-MCOs were required to follow that fee for service fee schedule and they have a new minimum payment schedule. The fee for service rated an add-on payment there previously access to care payment or nursing facility assessment payments. They are now going out as plain payments so CHC-MCOs have to follow the minimum payment schedule and the rates for each nursing facility are out on the DHS website as well under the long-term nursing facility provider website underrates.
So if anyone is interested in that information, I don't have a slide on it, I should have, but didn't. Didn't think about it in time.
But I want to mention that as well. If there is any nursing facilities that didn't get that information, and are interested in their new payment rates as of January 1, 2023.
So ARPA community base service funding plan, you may recall that one of the points of our funding plan included a home and community base improvement funding. Applications, we started taking them, actually I can't remember. I think early July. July 1 of 2022. And the deadline was December 31 of 2022. So this is app update on the screen and slide of where we are on those applications as of mid December. We don't have updated numbers as the application period just closed on December 31. We could see the number of submission and approval of payment and then obviously the number of rejections and the pending applications that we are still considering. Just a note here that total dollar amount allocated and pledged and sent out to providers was around almost 29 million. You may recall that we had 38 million available through ARPA funds for home and community quality improvement funding. So obviously we may have funds left over. It remains to be seen how many applications between December and the very end of December.
So just an fyi on that. The strengthening workforce payments which is part of the ARPA rescue plan that 10% increase this we got we sent out funding for providers to strengthen their workforce. And then the act 24 of 2021 payments that went out to nursing facilities personal care homes and assisted living residences in very early went out, it went out in September of

2021. I have to remember my timeframe. We did release information to all providers who received those payments that it was time to report on how they use the payments and with act 24, 21 payments and strengthening the payment and that was due November 30, 2022. Many were having trouble getting into the system to report and we backed up the first reporting period and the first reports are due February 28 of 2023. So just a note, if you have not seen that list of announcements, reports that were due as of November 30, are now due February 28. I'm hoping I got those dates right.

I'm looking at my OLTL counterparts. They are not correcting me so I think I got right. Finally, moving on to our CHC agreement and procurement. Just fyi, for all stakeholders that are CHC-MCOs and office of long-term living, completing the 2023 rate and agreement negotiation process. All rates have been set as of December 16. Hopefully well under way and in reviewing their, completing their review process, although we know we got approval on our 2022 agreement in mid July last year. So hopefully it is not as delayed a process for CMS this year. We are starting agreements through our formal signature process here in the common real j that I believe comptroller and delivery process and they are working on that as well. One 2023 agreement, we will post to this OLTL website, I know we get a lot of questions about that and if they have a copy prior to but we do post it on the OLTL website once we get approval.

But just so you know, that amendments to the 2023 agreement do take effect as of January 1 of 2023. So an fyi on that.

And then, the last slide that I have is really on the reprocurement process. We have been talking to stakeholder and I will caution a little bit on this one. So the office of long-term living does plan on issuing an rfi in early 2023 to get feedback from stakeholders on the new CHC procurement. I would caution that OLTL is planning to issue that rfi but obviously all of you know we are undergoing a transition in the governor's office with our state leadership and obviously we will have a transition and a new leadership team in the Department of human services as well. And if we just want to make sure that before we accepted out any rfi that they are on board and in agreement. That will obviously we will wait until we get approval for the new leadership team in DHS. So we are planning on doing it but please note we want approval of leadership before we do that.

Also just an fyi, 2023 agreement will become the statement of work for the new procurement and that it is something that we will be asking stakeholders to comment on. If and when it does go out which is an fyi on that. Implementation is targeted for the new, obviously, rfi and we have to issue an rfa and then obviously, we review the responses and go through the procurement process but we are targeting implementation for January 1 of 2025. We know that that is coming fast and furious, so that's our targeted date. Because of everything that short of being in flux right new we don't have timelines to share but those are the rough timelines that we will be working towards when we are able to, I would say, nail down actual dates for many of these items.

So just an fyi on that process as well.

A few other things to mention very, very briefly. So at the last MLTSS meeting we asked stakeholders for feedback on appendix k. Appendix k flexibilities are in place and roughly in place for six months after the end of the public health emergency. And we discussed at the last MLTSS meeting and in the subcommittee meeting, how the office of long-term living is really looking as a kind of possibility early. Our target date for ending is April 1 of 2023. And we one of the ones that main flexibility pushing up to end appendix k flexibilities is to get back at in-person and seeing individuals. And so we did not get any push back about ending those appendix k flexibilities so we are working in the office of long-term living on the notice that would let all

stakeholders and interested parties know that we intend to end the appendix x flexibility in 2023. And to issue that formal notice and formal indication in late January. So please be on the look outfor that.
We two know there was a federal piece of legislation passed by the Federal Government right before the holidays or maybe mid holidays. And we understand that it had implications for the end of the health emergency and decoupling of eligibility for the end of the health emergency. We are awaiting guidance on all of those changes that were made by that federal piece of legislation and as soon as we have guidance from CMS we will put that out to stakeholders. I want it recognize we are looking at this and awaiting federal guidance. So with that, I don't have any other updates and I don't know where we are on time if you want to take questions now or I can hold them.
>> MICHAEL GRIER: Any questions from the audience or committee members for Jamie? Committee members?
Audience?
>> And with the presentation that Jamie just gave --
>> JAMIE BUCHENAUER: I will be here for the whole meeting. If something comes up during public comment.
>> MICHAEL GRIER: Great. Thank you very much, Jamie.
>> My name is Monica. I have a question. Sorry, I'm ringing in a little bit late. The question is about appendix k and whether the virtual assessment will end or --
[Inaudible]
>> JAMIE BUCHENAUER: So appendix k flexibility gives service coordinators the ability to do the assessment telephonically if that is the choice of the participant because they do not want individuals in their home. That flexibility will end with the expiration of appendix k. So the assessment would have to be done in a person's home. And the person would not have the choice of doing it telephonically. I'm not sure what the CRT means.
>> Cognitive therapy.
>> JAMIE BUCHENAUER: Oh, sorry. I was thinking of the assessment. So yes. It would end the ability for that rehab service telephonically.
Or virtually. You would have to provide it in-person.
>> MICHAEL GRIER: Any other questions for Jamie?
If there are any other questions you can ask ahead of the agenda and that's okay. I need all the help can I get. Next is behavioral health care. I see John McFarland, UPMC coordinator is up first.
>> JOHN MCFARLAND: Good morning.
>> MICHAEL GRIER: Good morning, John.
>> JOHN MCFARLAND: My name is John McFarland. I have been asked to discuss how we do behavioral health coordination in a brief view and generally across the three Community Health Choices coordinations. Ourself, UPMC as well as Keystone and behavioral health and wellness. So with that in mind, basic question of how do the CHCs identify behavioral health meet within our line of work.
It is usually done during our routine assessment for service coordinators for those who have home and community services as well as nursing facilities and scheduled participant outreach and routinely scheduled for participants being called with other matters or calling to ask various questions. And from a care give to provide earn there are other people involved within participants and expressing behavioral health concern to us.
And in contact from other managed care organizations and.

And confidentiality.
Going into our assessments, our service coordinators and leaving after incidents and so on, and when they are asking questions about fiscal health and functionality, and ability to take care of yourself, and we also ask questions about behavioral health. And perhaps when you are expecting and depression, anxiety, psychosis, hallucinations, hearing voices, also other things like irritability, cognition. Questions about the thought process. Substance use. And things that people perhaps don't necessarily associate but other professionals do. Memory, sleep, isolation. And all of this can impact behavioral health if they are together with other factors.
Some will be connected to behavioral health services. Imagine primary care physician, services, anything to add to for the system.
Our case is referred internally in CHC behavioral health designated staff.
We do manage long-term service and support. And but the behavioral health goes primary for 95% of participants through Medicare when it is for in-patient and out-patient services and Medicaid as secondary. We do have 5% of participants coming in with various waivers and may not have Medicare but again a smaller crowd. And others have a private insurance. And so for example, that is psychiatric hospitalizations. And outpatient going to mental health clinic to see a therapist or psychiatrist. And Medicaid does cover those services and with different names or terms and specialized services and ancillary services and so these would be for example, peer support, targeted, behavioral health, case management, mobile mental health treatment. Psychiatric rehab.
And community treatment. And where available and crisis services among other examples and new programs that might be developed.
Next slide, please.
And this leads to a combination where participants behavioral health can be covered by dozens of combinations of one of each. And Medicare plan that for most would be fee for service or they might be enrolled with 1 of the 10 eligible special needs plans offed in time of CHC enrollment. I do have all of the names which you can see for life at high mark home care and health partners plus and United Healthcare, health care Keystone, well care, bravo, humanna as well as others covers by Medicare advantage plan as well.
This would be combined and on the Medicaid side. Everyone in one county assigned to the same Medicaid regardless which is behavioral health or CCBH, beacon, Magella in or perform care or CBH. So internally to coordinate between ourselves and the other managed care, service coordinators were the onees who first learned about concern from participants and will engage with behavioral health and who have designated context as behavioral health and MCOs. Keeping in mind, if you ever tried to look at yourself for therapist or psychiatrist or sometimes you can navigate the website, and other times they can take 10 to 30 hours of a work week and navigate through various contacts and our staff simplifies that by designating contacts and knowing who to talk to and to cut through all of that. And they have researched organization provider and having that information as updated as possible or know where to go. And also monitoring daily in-patient electronic exchanges we have with Medicaid and MCOs where we meet by mutual agreement and exchange notifications and in-patient hospitals between members and participants.
We have meetings and coordinate properly and as well as other weekly or ad hoc or biweekly or clinical cases that require higher need, higher concern as per again mutual agreement.
Next slide, please.
So yes we do have routinely schedule meetings and this describes also partly partnership meetings where all five and three CHC organizations directly host a meeting with providers and

home community based providers and other guests in which address topics of behavioral health and innovations and any topics that for example when we just have last month we discuss substance abuse and how to access substance use treatment. We have been trying to educate more nursing facility staff and community based service providers and be eligible to navigate the world. And presentations for management and other topics and also hearing from providers as to their concerns and how we can best assist them. We do trainings. A year ago did a round of trainings for nursing facilities. And we also do other joint meetings with providers and agencies as the opportunity arises.

Now some key points around behavioral health services are voluntary. Saved for the very few exceptions of an involuntary psychiatric commitment to the hospital which happens far less than is commonly believed an outpatient services of any kind and services are voluntary. Providers have a right to refuse a referral for reasons. There are network agreements with parameters around that. And some may not have any availability for various reasons. Staffing has been an issue everywhere of course in 2022.

And neurology, there is a fine line between what falls in the behavioral health treatment per se and what might be referred to more to urology or services more in the realm of dementia or brain injury. Support might be something other than behavioral health. Jer an tole ji and other specialty designed services pch the managed care organization is based on the consent and for substance abuse and it requires separate very explicit consent.

And behavioral health is normal. We did a lot of stigma around it. It has always been discussed. And at least prepandemic 25% of U.S. adults so 1 in 4 have had behavioral health issue in a lifetime or currently estimated and citizens and roughly 30% are currently experiencing in the world of behavioral health. Next slide, please. We do get askeds at various meetings regarding residential settings.

There is often the rather troubling question as to can we just place this person in a behavioral health setting. CHC is a model by design and participants to reside? The community by choice and safely and trying to make sure that that can happen as much as possible.

And behavioral residential settings are not available in every county and managed by that counties administration and a setting does not meet within a living criteria. And by federal guidelines, a participant may not receive their home community based services. And most settings do not meet the criteria, unfortunately. These settings are also, for the most part, not to handle acute and functional needs here. The main focus of being able to help. So the treatment setting, in-patient settings and acute care and so on that can be funded by the behavioral health care organization are not meant to be permanent. They are places where they stabilize under acute symptoms and not to moderate or mild communities. And to extended care unit, programs such as prior transition, substance abuse rehab, substance abuse half way house. Again, following a treatment plan, improving symptoms, and safe transition to the community, a person will do so.

Other community settings, county funded, have a long wait list. Intended to have someone who h have moderate to mild symptoms integrate into the community with some support and going from most restrictive long-term structured residences, and having a few beds, few openings, community residential settings such as group homes and some counties might offer behavioral health housing apartments but that is minimal support and depending on how the county sets it up with housing with housing case checking on a person and connected otherwise to service and supports.

And that wraps up my presentation. I will turn it over to the next presentation.

>> MICHAEL GRIER: Thank you. Are you open to take some questions?

>> JOHN MCFARLAND: Of course.
>> MICHAEL GRIER: Committee members. Any questions ?
>> Thank you for your presentation. Well done. You mentioned peer support services early on but nowhere else in your presentation did you note how they are marketed within a skilled nursing setting or with families. In general I would like to hear how you market behavioral health referrals and services to individuals living in nursing homes. We know there is 50% chance that an individual in a skilled nursing setting will suffer from major depressive disorder. Understandable.
And how is that marketed and how are family members made aware so that they might be able and willing to work with loved ones in getting services they need to prevent the exacerbation of mental illness and of course debilitating effects to have on their physical condition as well.
>> JOHN MCFARLAND: Since we are not peer support services, we are not directly involved with marketing. Marketing comes from providers. We do encourage in making nursing facilities aware and have joint meetings to make them aware of that. When there is peer support service in a county showing willingness to work with a nursing facility, we will work with the managed care organization to get flyers, get information, get referrals, any materials that we can and internally through service coordinator as well as through our contacts in nursing facilities.
Is often a matter of getting to the key staff at a nursing facility and make sure that a person is aware of that. And it is a service that within the constraints of us not managing directly and over all as much as we can and after peer support being available and working in the nursing facility for that county.
>> There is a catch 22. If you are assessing the need for these services, wouldn't there, by almost necessity, be a point of which you need to take responsibility for kind of making sure that people are aware of them and know how to seek them. There is a need but it may be known by the family member or occasion the consumer himself, that there is a need. So how do we deal with that bifurcation that it can occur and should occur when it comes to treating --
[Inaudible]
>> Our coordinators do identify that participants and trite to make the recommendation. And make a suggestion. Ultimately the information is passed down to the facility in this case or service coordinator is working in the community with the participant we also have service coordinator discuss that service with participant and make them aware. When you are available.
>> Do your service coordinators work with targeted managers like behavioral health and service coordinators in the county are in place for that particular person?
>> If we have release of that information to coordinate with the target case manager, as well with the need and identified.
>> Thank you.
>> Hi, there. This is Heather Clark from PHW. Just wanted to add to John's comment. This is a great example of instances where we, as CHC-MCO may take this case to the BHMCO for discussion and case conference and many times the BHMCOs will make recommendations to us, at times we may be clearly see everything this participant could be eligible for. Or could benefit from. So BHMCOs could match us up with providers and possibly peer supports that match the participants needs.
>> Is that usually through the targeted case manager that that happens?
>> The coordination and between the CHC and MCO and the presentation --
[Inaudible]
Then reach out to the appropriate agency that is then involved with the participant that has identified needs. For example, if we are discussing a case, the agency is usually, we have

participant that we have become aware with functional needs and addressing that part of it and behavioral health need that is emerging. And a person has an increase in depression, needs support, needs help in accessing perhaps a clubhouse like we have and MCO will identify they have a case manager.
One way the service coordinator may reach out directly to target case manager after confidentiality allows or managed organization themselves and reach out to their contact that that agency as well or most often we do look differently at times our outreach efforts.
>> Thank you. Jeff?
>> Yeah, this is Jeff. The list you present for behavioral health, is that more of a sampling. There are ones in community mental health, I didn't see schizophrenia, bipolar, split personality disorder, I didn't see those covered under behavioral health.
>> I did not. I did not describe manual diagnosis. If someone has major depressive disorder with psychotic symptoms, our service coordinators wur not a trained therapist, would be assessing symptoms of depression. How sad are you? How often? Are you having hallucinations? That's how we are identifying and figuring out if it is bipolar, anxiety, triggering what someone may have compulsive disorder, PTSD and so forth. Ultimately we want the person to contact with whatever service they are eligible for in that county. Most services will have a definition of what counts as significant psychiatric illness.
[Inaudible]
What other supports can we get if that is not helping improve them, what else can we do to help?
>> And just to comment on what you are talking about mebt Al health programs, we tend not to use group home or group -- or.
[Inaudible]
Tends to be --
[Inaudible]
Rehabilitation as you mentioned, lodges or those typesettings. Also supporting housing and among other things.
You do have a number of settings in the community and some other community based than others. Thank you.
Other questions from committee members for John? Or from the audience?
>> John, it is my understanding through general presentation covers all of the MCOs. Kind of a -- if there is a distinct difference, I'm sure we will find out as we move forward.
>> Yes. Within a 10-minute presentation, people who know me know I will talk your ear off. And in asking what we do at CHC level. How to identify, how to process and how to help the participant and how else to follow up. Ultimately there is concern that the person able to help, and needs are not ignored. They are connected to treatment. And they improve.
>> MICHAEL GRIER: Thank you. Paula, anything in the chat for John?
>> Quite a few.
But I will ask, are we going to maybe ask the questions after Duncan's presentation also? We may get some answers.
>> Oh, yeah, yeah. Why don't we do that. Are you still going to be here John?
>> JOHN MCFARLAND: Yes.
>> MICHAEL GRIER: Okay. Thank you very much. We will move on in our agenda to the work flow process. Duncan Bruce from Community Care Behavioral Health of Pittsburgh.
>> DUNCAN BRUCE: Thank you. We will discuss how we work closely with the CHC program. Before, I want to mention I do work with community care behavior hall health. However this is a

reflection of what all do. This is a general presentation of what we all follow or do. And MCOs have options. Community behavioral health, and Magellan and all on the phone today. Secondly, I know this meeting has a firly wide and diverse audience so I want to take the beginning of the presentation and identify differences between Community Health Choices through those folks who are not as familiar.

All right. So the behavioral health choices program is part of an integrated human services of Pennsylvania. Three pieces to it. Physical health choices program. When we talk about behavioral health, there is a term covering mental health. Then developmental disabilities. One of the differences for behavioral health programs, operating under the direction of the county, that means that each county gets to pick or decide which MCO they would like to work with and manage the Medicaid behavioral health benefit.

And the way this manifestes it self from being different is this. They have a choice of three different CHC.

Behavioral health is different. The behavioral MCO you work with is dictated by the county in which you live. And the next slide to show what covers what area. And one of the other things I wanted to mention is that you know many folks that are covered by Medicaid andMedicare being one of them know that as John mentioned earlier, roughly 95% of individuals who are enrolled in CHC program are dual eligible for Medicare and Medicaid. Medicare has a behavioral health benefit and the dynamic between Medicare and Medicaid is that Medicaid is the payer of last resort. And so someone has to use Medicare behavioral first and Medicaid secondary. It is important when we look at behavioral health coverage through Medicaid and how it works within the CHC program.

So this is a map I referenced earlier showing you which behavioral health MCO covered which county. For example if someone lives in Allegheny county, their plan would be behavioral health. If you cross the border to butler you have beacon options. So the MCO depends on the county in which you live.

And this is the same information. Showing county which we cover. Next slide. Here is a list of all of the state in-plan benefits. All behavioral health MCO's must cover. On left all of the mental health services. On the right, substance abuse treatment services. Again, many of these will look familiar.

Also many are covered by Medicare as well. I just showed this state in-plan benefits. In addition all behavioral MCOs can provide additional services yopped those on the state plan called in lieu of services or supplemental services and they vary greatly from county to county. And in fact they are varied and diverse and it is really difficult and confusing to list them all. I want to point out that that is not the end of the story. There are lots of supplemental benefits. John has one or two listed on his slide deck as well.

It is important that if anyone wants to know about any of this, contact any of the behavioral MCOs and we can figure out if any of the supplemental services may be benefit somebody.

If you can move to the next slide. Touching on four areas where the rubber meets the road. And in collaboration with a lot of the folks we work with. And so the first area I wanted to mention with customer service and all MCOs operate customer service department that operates 24-hours a di, and 365 days a year, and providing benefit information. And eligibility. And we can evaluate measures so that level of need. And if there is a situation where it is escalated to staff getting involved. We can do that too. Again customer service can answer just in the general member provider questions.

If we move on to care management and all MCOs have care management team. And they collect and review clinical information. And in short coordination and continuity of care. They

work on promoting full member of family participation and treatment. And they participate in interagency team meetings. If you go to the next slide. In addition to a sort of regular care management team we all have carriesing management team which is a specialized care management team. They often work with high risk members that are folks that have a complex presentation and often can be individuals that have complex behavioral health, physical health needs and social determinant health needs and so someone who has a sort of a condition or high risk management team and they utilize their strategy and working with folks over extended period of time and can be years in some cases.

And there is linkage to specialized services instead of monitoring outcomes. And last thing to touch on and regarding collaboration and is position and psychological services all behavioral MCOs have teams of doctors and psychiatrists and evaluate treatment for innocent quality. And they render medical necessity determinations. And attend meetings on complex cases. And they help promote recovery and treatment. And they do functions too. Like often providor meetings and training. Those four areas, care management, customer service, high risk care management and psychological services and only departments that all of the behavioral health and MCOs and that have often where a lot of the collaboration and treatment takes place within those departments.

How do I get started? Just to mention that all behavioral health MCOs have staff that can work with you and answer your questions. We can all help you find providers and make sure that members receive the right type of service.

And all of the behavioral health have providers lines and at the end of the presentation I do have some contact information and some do including the member and provider lines in those slides.

And to aproasm to someone and also if someone and treatment to list all of customer service and having websites to help locate providers for example a lot of people who have access traditional treatment and look out for the website and schedule your appointment with sort of no quest and we all have e-mails that are available on our website to communicate.

And you can ask the service coordinator for help and lastly anyone can ask behavioral health or MCO coordinators for help too and so how you go about accessing behavioral health. And for the next slide.

And since the program started in 2018, and all of the behavioral health MCO have been having regular meetings and review cases and you know on a regular basis. We have our number of areas where we exchange and share data to help with coordination collaborations that John mentioned earlier and we all have daily in-patient admission exchange going on and again I listed a few other areas where we share information but hopefully helps us to coordinate effectively. For exam sharing follow-up reports. Admission reports. Et cetera, et cetera. We do a no wrong approach to working with each other. I want it mention that all of the behavioral MCOs have staff and in working with CHC and our care management staff are familiar with the resources and providers in the area in which they live. And again we have our advisors or doctors psychiatrists that consist with case reviews and pour those in for cases. You can get the next slide.

And so I'm just going to quickly run through because I know I'm using my time up here. And a couple of areas with specific liqueured nate collaborate with CHC. All of the CHC and behavioral MCOs have a coordinator who is a professional located in Pennsylvania. One of the slides here in a minute will show you who all of those folks are so if you need to contact information you can have them.

Already mentioned all of the BH MCOs and regularly scheduled meetings and regularly monthly

or biweekly. And to the next slide.
And regulating interagency team meetings to coordinate and collaborate on the cases. And so I did want to point out that the meetings include behavioral health and we often have other providers and stakeholders and a request for an interagency team meeting can come from really anywhere.
And lastly, just to mention again, utilizing local care management staff, and again that are familiar with the community, and local programs and resources.
Go to the next slide.
And so, next couple of slides here are contact information.
So this is the flier created a few years back and we shared this extensively with all of the nursing facilities and providers and variety of folks. And sort of one-page flyer that lists coordinators and BHMCOs, our e-mails, phone numbers. And anyone with, not sure where to start, you couldn't go wrong by contacting any of us here to kick start helping out a behavioral health need. So this slide, cut and pasted that. And that the other side of the flyer which shows chu behavioral health areas. And the rest of the slides are really just the contact information for all five MCOs. So probably don't need to just sort of linger on those too much. If you want to move to the next one quickly. And beacon's contact information, you just click through them and see we have contact information for all of those.
So that's all I have. I thought I would take a quick second there to answer Lloyd's question. Asking about how we have peer support to nursing facilities. Great question. Something we are continuing to work on. I wanted to add a couple things to what John mentioned.
I know that as a program, and came along in different phases, all of the BH MCO's contacting nursing facilities and offered to do individual trainings. And so I know from, speaking for community care but we met with a large number of nursing facilities, at lot of those willing to meet with us and behavioral health 101 and what benefits those.
And a couple providers come in and peer support and present some of the other Medicaid behavioral benefits not covered by Medicare. So people have a potential option. And then I know a couple of my colleagues on the phone too but I know there is specific initiatives to work directly with nursing facilities as well.
And a great question. How do we make people aware of these services. And I think there is more work to be done but we have done some stuff to get the word out about it.
Thank you, Duncan. I have talked about it a number of times but is there contacting internal ombudsman at skilled nursing facilities so they are aware at nursing offerings and social workers at if silts in order to move this process along and there is an individual in place or who simply does not recognize his or her need which can happen routinely whether elderly individually or disabled individual or not. And also to contact their families for that same purpose.
>> They are typically more, we haven't gone through the ombudsman and typically reaching out to the nursing facilities we often contact the director of social work or director of nursing instead of starting points to get the foot in the door.
But a point well taken. And maybe connecting with the ombudsman and sort of yield better results.
>> Thank you.
>> If I could. This is Lauren keen from Magellan. Also aging offices with help desk with ombudsman we have direct contact with om budsman to engage nursing providers but also when there's been a hard time connecting we also use the aging office which is also a great resource for helping pro vote health services available.

>> I would add too, I forgot to mention that we work with a couple of nursing trade associations with the Pennsylvania home care association and also to try and communicate with nursing facilities to make them aware of the different Medicaid behavioral benefits as well. So again just another avenue we find.
>> I know you mentioned it too, that you know, as you reference, we have been, every year continued rounds of outreaching to the nursing facilities in the area and to offer our supports, again educational behavioral health services and to promote peer services and I know a couple of counties we have been successful in connecting particular facilities with one particular peer provider for that direct referral and building of relationship between the two organizations. So we have been working on that and had some success and in one county because of a connection and in general in promoting in the community we also have a program at Magellan where we are outreaching to members in the community and initially to assess for social determinant of health needs and supporting those needs but have identified a member has possibility interest in obtaining behavioral health supports and connecting to Magellan's that we have on staff and initial connections and discussing opportunities and referrals for community based specialist or some other type of service.
>> You can tell me if this makes sense or not, but is there a determination about how will you gauge that there is sufficient uptake in penetration in behavioral nurse services and across the board for CHC to satisfy at least a reasonable advocate which I try to be on occasion, questions about are we doing the best we can to lift awareness about these services and use of services within the CHC population as a whole.
And in terms of mentioning that the Ben tracing rate which is the commonly used metric and what percentage of individuals access the behavioral health and I know that again can I only speak for community care and the population of the whole and compare to CHC population and relatively close. So for example, for 2021 for community care, the overall penetration rate is a little over 21%. And 19.5 for CHC population. So relatively close. Not that, you know, perfect, maybe want it to be closer.
But it is not a massive discrepancy. That is a good method to look at whether we think the CHC population as whole are getting you know an adequate amount of behavioral treatment. In the interest of transparency and honestly so that is for the population as a whole, I know that when you pull it out, when we look at the whole population, it is fairly close.
I don't know if that is helpful or not, Lloyd.
>> Well, it is something. People in the CHC, enrolling from CHC, may have a higher need for BH services, especially those in skilled nursing services. Are there comparisons with other states where BH services are provided to the populations and is that same Ben tracing holed in the other states as we see here or is there a noted difference?
>> If I can address that from the CHC angle, you're focusing on the claims and measure in behavioral health treatment accessed via the amount of claims or services at a given facility. And it is large amount and through straight Medicare and other times and nursing facility and already have a bundle and rate on the outside causes and therefore is not differentated. So we try it compare claims across states to try to measure active services and very complete picture of what we prefer is having service coordinators assess behavioral health and via the questions and information we get from nursing facility staff.
And therefore try to connect the person to treatment.
[Inaudible]
[Inaudible]
Gn[Inaudible]

>> Test test test.
>> Our audio cut out. We need to look at what is going on.
>> We can hear you now.
>> Okay.
>> Okay.
>> Paula, you said there were questions in the chat?
>> Yes.
>> Okay, thank you.
>> Yes.
>> Okay, first question. To Ann. What is the overlap of behavioral health providers for Medicare, Medicaid and MCO providers? Is it hard it find behavioral health providers that are MA providers?
>> Do you want me to repeat it?
>> No. It was directed to me. Sure. It is varied by county. Some counties will have several providers and Medicare and Medicaid and coming to mind for example and other counties that have several providers over all and large choice and with the agency and they are enrolled for example.
I'm not sure if that answers the question.
>> Go ahead with the next question, P Paula.
>> How do service providers work with nursing home residents to identify and address behavioral health needs? Some are just going to be general behavioral health needs questions.
>> Yes. Our routine assessment.
There is one I'm not quite grasping here. Facility providers we expect to capture that within the minimal data set and evaluate that as per regulations.
And our service coordinators will be assessing routinely and based on the data submitted by nursing facility and asking them questions that I have described before generally this vary by CHC which is why I did not go into the detail of lessons and in our cases of questions or so which is CHC and that question can be, are you feeling sad, lonely, nervous. General language of questions. BHQ9 depression questions for example.
>> Again, general question. If participants are suffering, from PTSD, anxiety, major depression disorder, how do they reach out for resources or how can the care giver reach out and get the resources if the participant isn't getting enough services under CHC model?
>> As Duncan pointed out, they can call in. And if it is confidential and participants may not want us to discuss those details with caregivers we can listen and we can give general references and again, the person, say they have UPMC and perform care, they could contact either one of us to express or contact and express that and we would coordinate. So any agencies involved with the care and match care organization level can listen in and can give counties and give specifics out on participants confidential record to be protected.
We can give general fed back and general information.
Sn.
>> DUNCAN BRUCE: This is Duncan from community care. They can reach direct care management if needed.
But again, my suggestion is that they have place to begin.
>> And a question in what in-patient not hospital behavioral health services are available in PA? People with disabilities to have support. Want me to read it again?
>> Yes, great question. Off the top of my head, I don't know.
Which one specifically would sort of meet that need.

I will probably have to get back to you on that one.
>> The question itself, if you have Medicare, your in-patient services have to be hospital. It wouldn't be nonhospital. A partial program might be a middle ground. And we are talking about level three nonhospital. So rehab person would be eligible for that via Medicaid. Since that is not a Medicare coverage service. And that would be an example.
But typically again, in-patient Medicare. So it would be, being in-patient nonhospital, and what do we get in the community? partial program intensive program? And what services can we bring? Which ones can accommodate persons with disabilities and varies quite a bit by county and what might be a network provider and also which disabilities with are talking about.
And are we talking about someone with vision difficulties, vision impairments, behavioral health treatment, and different conversations than say someone who is having mobility issues and what is more accessible for that particular person and provider.
>> Okay. I think we are ready to move to the next. Many.
>> MICHAEL GRIER: Are there any other questions from the general audience for Duncan or John, for the process and some of questions about referrals and the process for behavioral health and CHC?
>> The only other question I would address would be towards OLTL. And at the top levels of your policy component, are you satisfied with the way behavioral health services are being determined and assessed as being needed and provided for the client base since this is going to have a direct impact on the cost of the services provided within the CHC system.
>> MICHAEL GRIER: Jamie, could you want to take that one?
>> JAMIE BUCHENAUER: Yeah, hi, this is Jamie Buchenauer. If I caught your question, you are asking if the office in long-term living is satisfied. We are working closely, obviously we have individuals in our office of long-term living that meet with CHC-MCO as well as the MCOs, I believe monthly or quarterly, to talk about how the process works and any program improvements. We brought everybody together today to give you the overview which we have provide he in the past to groups. This group understands the process of how it works and collaboration that exists between all of the parties to ensure it is an individual obviously in a nursing facility or home based community services behavioral health services or is referred in some way and they are willing to receive services that there is coordination to ensure they are getting services that they need.
>> Thank you.
>> MICHAEL GRIER: Any other questions regarding CHC and behavioral health?
Thank you, guys. I appreciate the presentations and thoroughness of it. We are going to move on to some behavioral health referral success stories and some innovations. Kellie is here from OMHSAS. And Marjorie is here from OLTL to give us updates.
>> I'm not the speaker, it will continue to be CHC and MCO and behavioral health organization to discuss success stories of the collaboration taking place.
>> MICHAEL GRIER: Okay, great.
Do we have someone?
Why don't we come back -- oh.
[[Indiscernible]
>> MICHAEL GRIER: Is it Jennifer who is talking?
Okay, I know that --
[Indiscernible]
>> I think Heather is on the line.
>> MICHAEL GRIER: Heather?

>> Yes. Hi there, this is Heather Clark. I wanted to give you a story that we worked on. I chose this story to share that really highlights how addressing behavioral health can have a significant impact on overall health outcomes. This participant is a 53 who suffers from diabetes, hypertension, asthma, sleep apnea, morbid obesity and depression. Through assessment it was uncovered that the participant was not using nis glue comter, not taking insulin, and he was a full-time care giver for his mother who has late stage dementia and chronic conditions herself. Interdisciplinary care team met to develop a care plan to address the behavioral health and physical health concerns really taking that whole person approach that interventions that the BHMCO and PHW conducted was the first step was consult to secure behavioral health provider that was able to address this participant's depression.
We also made appointments with weight loss program. Addressed diabetes, hypertension and asthma. Requested a blood pressure cuff. Blood sugar log book. And referral submitted to independent enrollment broker for the participants mother. We have some great outcomes of this story. And the participant does attend behavioral health treatment for depression and report improved mood and energy. With that improved mood and energy, this participant is attending appointments. Regularring using c pap and blood pressure cuff. Regularly using glue comter insulin and he actually logs his blood sugars in the log book and takes those to appointments with him. LTSS was approved for the mother which gives that participant respite and more time for self care. And participant reports a 20-pound weight loss in five months. So with lifting of some of the depressive symptoms, this participant now has the energy and motivation to take care of his physical health concerns and I just wanted to end on a quote that this participant indicated that he cannot wait to talk to his care manager to tell her all of the programs he is making. So he is super excited and proud of all of the achievements he has made.
>> Okay, I will do this differently. I want us to take time to talk about the success. That's what we work for in collaborative aragements. Any questions for PA health and wellness on this story? From any community members?
>> Great story and thanks for sharing.
>> Welcome.
>> I wanted to ask, how much was the target case manager for the behavioral health side involved for this?
>> You mean the BHMCO manager or case manager or service care manager? There were different members of the care team that assisted with different interventions. So it was really a collaborative approach.
>> Okay so they were involved, gave input and had a role in this positive outcome?
>> That is correct.
>> This person lives independently?
>> This person lives in the community with HBS care services and is the care giver for his mother who lives with him and suffers from late stage dementia.
>> That's excellent.
Excellent.
All of the partners came together. Any other questions?
Great story. Powerful.
Great, thank you. Back to AmeriHealth.
>> Great. Can you hear me?
>> Yes we can. Sorry for the snafu with the sound.
>> No, no, no, I apologize too. My name is Jennifer. I'm manager of behavioral health and collaborative services representing AmeriHealth care talking about Keystone First. This is our

referral success story. This participant to give background, an 85-year-old female. Her primary diagnosis is Parkinson's, diabetes and hypeo lipedema. She lives with her son, daughter and granddaughter. The behavioral health MCO, in this case, Magellan, reported to us that she had hospitalization recently for neuro cognitive disorder. So from there, Magellan made us aware that they felt she would qualify for LTS sjts services and she had not yet been connected with them. So we made a referral to our case management outreach team and they worked with both her and her son in this process we found out that they were not aware of services in fact the mother or participant had moved from another country only a few years before to receive better access to health care. So this was kind of the new thing and our internal case management team helped usher and with we have a process and we were able to get services within six weeks and we expedited service coordination team being involved as early as possible. They assisted along with Magellan and our behavioral health team to provide that progression of Parkinson's disease. We had home deliver id meals for her to have something quick to eat during the day when her daughter in law and son were at work. Some services, including adult day care once or twice a week. She continues psych services for medication management and the family leveraged respite resources for care giver burnout and stress to make sure they are managed as well. So the family reported to AmeriHealth after a few months that they felt that Mrs. O was more emotionally stable with her disease process. They felt more supported. And less stress prior to hospitalization. We are happy about the coordination that happened here. Thank you.
>> Thank you very much.
Any questions for AmeriHealth on Mrs. O's story?
>> Next story, please.
>> We kept our story to a coordination that happens in complicated cases. Someone that may sound more ordinary quet is a success story and illustrates what happens most of the time. Health choices participant who was requesting a nursing facility in west moreland county. The facility on their own attempting to connect him to a provider that was not in network with his managed care organization and not having any success and not having the process come through completely. And the service coordinator of UPMC becameware of this case and discussing it with a nursing facility and participant and there was a need. And the service coordinator discussed with the coordination team and the team contacted participant's care organization, health options. And found a service to meet the needs. Although for the county we did find a telehealth provider that the nursing association was able to accommodate. There were immediate openings and were able to assist with appointments and the participant was able to see the provider.
Any other questions?
>> MICHAEL GRIER: Thank you, John. Any questions for John on coordination story in reference to UPMC?
Thank you. Very good. It is always good to hear success stories.
They are why you guys do the work. And why us, as committee members, need to see there is another progress and success, so thank you.
We will move to the next part of our agenda which is additional public comments. And we are actually a little bit ahead on time.
>> Kellie from OMHSAS, I'm wondering if the teams in existent in our countryies to monitor the provision of medical assistance services, have they been requested for directed to assess the consumer satisfaction for individuals in the CHC program who are receiving MA funded services in their various settings whether home or skilled nursing centers.

>> Good afternoon, Lloyd. I, at this point, do not know. As you know, this consumer family satisfaction team, they are three state required questions that have been the standard state required questions for years on this consumer team. However, they determine the primary contractors determine the level of care they are reviewing and sometimes it may be just you know, certain levels of care each year are the high provider, high volume providers and they are the ones that determine who seek out for services to give their to surveys. We can follow up with that and see if anyone looked at stuff. As you know, the last several years since CHC, members are residing in nursing facility is, you weren't gaining access to individuals. Unless there was other ways to do surveys, I don't know if they did. Obviously even during COVID, they were not doing face-to-face surveys during that time. Just slowly but surely starting to get back out and doing the face-to-face as opposed to mail-in surveys.
>> And this would be an avenue to use or dedicate a little bit of time to try and figure out if services offered, is there awareness and are they satisfied with the results of those services. Thanks.
>> Yeah, again, that would have to be determined, we have to get the list, because a lot of these individuals, 95% of Medicare primary. So they are probably getting their services paid, for the most part, through Medicare. Through there are services of peer support et cetera that are strictly Medicaid. So those are services we may be aible to look at.
>> Thank you.
>> MICHAEL GRIER: Paula, anything in the chat?
>> I do.
Some of these go back to EBD questions.
So one of the questions is, will LLTL allow consumer participation in the cell phone EBD discussion?
>> So I think we had the discussion here and I think we got feedback from those that is the last meeting on the EBB cell phones positions and what consumers and some are thinking. The other opportunity is I know the EBB, there is an EBB group that meets CHS wide and one of the things we talk about and are going to talk about when O OLTL meets about it is if she needs to go to a broader group across DHS. I know obviously there are stakeholder meetings just on the EBB topic that obviously could be used to gain feedback on the topic.
>> Next question for MCOs. Asking, how do you conduct assessments when the consumer is not able to be reached by phone?
>> MICHAEL GRIER: Let's start with PA health and wellness.
>> Hi there.
If we can not reach the participant by phone, depending on the incident, we may have the service coordinator go do a wellness check to make sure things are okay.
And use that avenue.
We try to call the participant's providers, you know, to find an alternative number, if that's the case, to see if there is another phone number we can reach them on.
We do have, we tap into again, service coordinators a lot to try to reach the participant through our experience we learned that the participants don't always answer calls from some of the representatives at the plan. Some of the behavioral health care managers because the number is unknown.
But most of the time they know through service coordinator phone number and they will take their service coordinators phone call. So we leveraged that resource a lot.
>> In addition to that we send outletters. And in the last couple of months we sent out notices about 59 days before the assessment is due. We give the participant a heads-up that their

assessment is due and we will be contacting you to complete it. That's particularly in the cases of it wouldn't go out to all participants but in the cases of individuals who may not have been assessed more than one time last year. If they had any change in conditions or trigger events that would be the case so much because then that resets it.
But notices by mail. Service coordinationout reach. In some cases, they use drop-in but also working with past provider if we are having a lot of difficulty and engaging with that participant.
>> Thank you.
>> AmeriHealth?
>> Hi, this is Jess from AmeriHealth. We do the same as the two previous MCOs. We send out letters. Reach out to people on their contact list.
>> MICHAEL GRIER: Thank you.
>> Hello this is UPMC community choices. We do a similar approach where 60 days prior to a person's assessment that's due, we initiate the outreach. We have calls and do pop-in visits. If they can't make contact we do letters and collateral contact as they identify within the plan and attempt to get a hold of someone.
>> Thank you.
>> Just a follow up. We have a question that came in. You send letters and give follow-up. And you do on-site visits. Do you also send e-mail?
>> If we have that as a listed preferred contact for participants we can send secure e-mails. We do not have e-mail contacted. They would have to identify that for us to initiate that.
>> You need that also from PA health and wellness.
>> Is that the same?
>> Yes. Same.
>> Thank you.
>> MICHAEL GRIER: And AmeriHealth and PA health and wellness, affirm that they do the same in reference to if it is a secure e-mail?
Thank you.
>> This is a behavioral health question. What percentage of residents are receiving behavioral health servicees from behavioral health MCOs. It doesn't make sense. Let me read it again. What percentage of residents are receiving behavioral health services from MA behavioral health for MCOs -- p.
[Inaudible]
>> I will try and, the question is sort of confusing.
But I want to go in and I will answer the question and then go back to something that the office of long-term living is for. One of the things we are working on and honestly have been working on for some time and try to collect the Medicare claims data for all of our CHC participants. This gives us a better window into looking at actually, what percentage of our CHC participants are actually receiving Medicare funded, behavioral health services and obviously we have that Medicaid behavioral service health data. A pint that John made earlier in the meeting, some of our participants may be receiving behavioral health services that are actually funded bay nursing facility and they are not making claims to Medicare or Medicaid. It also doesn't cover other private insurance. I know that is a pretty small population. So with that said, it is hard to answer that question right now as we don't have the data. We are working to get it. Even when we do get it, we won't have a complete picture. We will have a much better picture than having no data.
But it is much more incomplete data picture than we have now.
But that is where we are with it. So I will circle back to one of the questions that was asked, is

long-term living satisfied. I think, Lloyd, after we get data and have a better idea, we will be in a much better place also obviously to answer that question. We are definitely satisfied with the level of collaboration going on now with the data would give us a better idea of are the individuals receiving services and with he could point out percentages.
>> MICHAEL GRIER: Thank you. Kellie?
>> KELLIE MAINZER: I don't have anything to add. I was confused between use of residents and community base. So those would be two.
But towards home and community based services, they are always available for health choices except for individuals in the waiver previously before CHC. So the penetration rate as Duncan, over all, has always been between 20, 25% penetration rate of behavioral health choices for individuals. I know I can't answer for the nursing facility because again, a large portion of those individuals are coming from Medicare. We don't have access to that claim information to know and as well as for nursing facilities and they are required to also provide some behavioral health type services and those that have not severe or depression or anything like that obviously but having adjustments to be placed in the nursing facility. And some of that services might be provided and some do as pointed out contrast with providers that come in and provide basically everything from the therapy to the, you know, psychiatric consultation and either in billing to Medicare or part of the -- they are not contracted, even though I know the organizations have reached out, some have they brought into their networks and are working with them and so we don't have as far as Medicare data to be able to accurately know if people are getting services that they need.
>> And it might be light on when you compare Medicare data and I know that a community care we were able to take a small subset of the members and combine with Medicaid data and we did it for a couple of different counties and it is only meaningful when have you a descent volume to look at.
But when we did do that for Allegheny county for example, we compare Medicaid and Medicare data. This is off the top of my head, can I go back and look it up, but I think we were close to 35% rate of individuals get something type of behavioral health treatment. A lot of it was medication manage the, psychiatric treatment.
But a fairly descent rate when you look at data. And again, you know, what it looks like when you look at everything across the state. And you put that out there for a small sample and we are able to get information from you know, it did paint a picture that people were accessing behavioral health. And I was going to mention that earlier when Lloyd asked the question but I had trouble unmuting my phone. Just wanted to add that now.
>> Thank you, Duncan. And to be clear, it was just a snip of information that you had, correct, Duncan?
>> DUNCAN BRUCE: Yes, but I think 35% range. As I mentioned earlier. The Medicaid penetration rate in general is lower than that.
>> MICHAEL GRIER: Thank you.
>> Another question. A participant that is hospitalized may not be able to be discharged. Based on behavioral health history. What type of community living is available to them?
>> All of our community living arrangements from the community, CRRs even some of our -- you basically have to be somewhat independent and be able to take care of your needs.
And there is large physical home, there is not an option. Especially in nursing and physical home, there are not many options. Obviously if there is a placement to be found we can try to wrap behavioral health services around the individual in the community.
But as far as residential on the mental health side, there are not, few and far between. And as

far as nursing facility, we do not have a, you know, we do not have nursing facilities or personal care. Those are not health providers.
>> County specific?
>> Very county specific.
>> Do you know if they do anything that looks like out of county placements or any of those?
>> Again, if it is a nursing facility care, for lack after better word, the office of Medicare doesn't pay the nursing facility. So I don't know -- if they can find a nursing facility they will take a person out of county. They try to keep them in county if they can. Some counties do have personal care homes that they work with. To work with individuals to meet their health needs. But that is more county specific.
>> Great, thank you.
>> John from UPMC again. If a participant meets a level to be a nursing facility, that describes a certain care for fiscal health needs and functional needs that usually exceeds what these community settings are designed for. And having behavioral health need is a very wide vague term. If a nursing facility is unable to manage behavioral health issue, what is that behavioral health? Are we talking about aggression? Are we talking about depression and psychosis? We expect the nursing facility to be able to accommodate nonthreatening issues or behaviors of any sort to continue finding such a facility that can accommodate and how. What this involves, a person is stuck in in-patient setting. And their baseline moves on. It does involve a case by case very creative brainstorming across all agencies. And can the person live independently. Is there such a setting? Is there an apartment, relative, roommate to live with. And do they meet it mentally and physically. And mental health services as well. And back to the drawing table as far as nursing facility or some other setting that may not address those. Is there an issue with the referral that is misrepresenting the person's current condition? Often cases, describing such a scenario, a person in the hospital for a year and a half, and referrals have information from admission and go to excessive history and not focus on the current presentation at which point we encourage, please refer with current presentation. Please update diagnosis. Again, interviews. See what their concern is about. Ultimately the solution is very complex brainstorming and case by case and finding what is it about this case and about this person that may not be accepted by facilities and behavioral health quotation marks is not acceptable as an excuse.
>> MICHAEL GRIER: Thank you, John.
>> A question for Jamie. Question comes in from Amy. Mentioning nursing facilities providing behavioral health services. As part of a bundled rate. What whe would nursing facilities in PA have behavioral health services as part of the bundled work rate other than short term advantage nursing facility stay?
>> Yeah. Thanks, Amy, for that question. I think I spoke in John's language. I was referring to behavioral health services by the nursing facility and they are not making another claim to Medicare or Medicaid. They are providing behavioral health services with members of 24EUR staff whoever and obviously their staff look different and nursing facility by nursing facility. And we have heard this when we talked about a staff psychiatrist or psychologist and some have licensed clinical social workers on staff that will provide services to their population and they wouldn't do a separate, file a separate claim for services it would be part of obviously the payments they are receiving from Medicare mode Cade or whatever their payer sources are to provide that service to the population.
>> Next question active behavioral health. Are case workers trained on scheduling ASL interpreter?

>> They should be. If you are talking -- I don't know what case manager part is. We have targeted case managers in the community. And care managers at each of the behavioral managed care organizations. And yes, behavioral health care organizations are required and should know how to access for ASL or any other language line separate from ASL. Any type of interpretation type services. I will add as Medicaid provider, managers are responsible for the same thing of having, being able to access via language line, anything for ASL, you are supposed to have the contracts in place as well.
>> All right. I have to read through some of these. If they are questions or just comments.
>> Okay, next question from Janine Rogers. This is for Jamie. With the expanded basis of nurse practitioners serving patients, many consumers see the nurse practitioner and not the primary care physician. When will enrollment certification reflect this? Much of the delay in enrollment for CHC and other waivers in getting the PCP signature and the form to be completed correctly.
>> So we have not -- this was not included as part of the waiver amendment for 2023. Jen may want to weigh in on this. I know we did allow for services that do require authorization to be authorized by CRMP or PA but not the requirement for the physician certification.
>> Good afternoon, everyone. This is Jen hail. I don't have any other information to add. If that answer Janine's question. We did not adjust the requirement for physician certification for enrollment into the waiver. That r requirement still applies. And will still apply.
>> Let me scroll down through here again.
>> Okay, this is a behavioral health question.
Do you have requirements for frequency of contact the case workers would have with the consumers when their case -- do you have requirements for frequency of contacts the case workers would have with consumers on their case list?
>> Yeah.
>> Yeah, we are talking about behavior case organizations, no.
But they have to have contact with individuals on their caseload. Depending on high risk care managers, care managers, caseloads will be different based on their needs of the individuals they are working with. Care managers are there to help arrange and utilization review for services that require prior authorization. They are also participating with case management and discharge but no there is no amount of time that clinical care manager and behavioral managers have to have for the caseload.
>> The second part of this question many is asking if a safety consumer asks CHC service coordinator for behavioral health assistance, would the coordinator have a behavioral health coordinator that they can be directly connected to?
>> Hi, John from UPMC again. Arranged by CHC-MCO, and is there a health coordinator, yes, at UPMC.
We have a team dedicated to that. We have an internal referral process.
With you one person being point of contact and being the primary and from there we have several different people who can help with specialty.
>> Thank you, John. Is that the same for both AmeriHealth and health and wellness? They both have responded in the affirmative.
>> That is all I have in the chat.
>> MICHAEL GRIER: Great. Thank you, Paula.
Are there any questions from committee members? We add pretty significant discussion today about behavioral health and MCO's working together and the processes. Are there any other questions before these guys go?

From committee members or audience members?
>> I don't have a question. I just have something for committee members.
>> MICHAEL GRIER: Go ahead.
>> I think this is the first meeting of 2023 and just so the committee members know our staff will be reaching out to the committee to ask for some meeting topics as we progress into 2023. Our staff does a pretty good job of obviously monitoring the committee and bringing issues to the attention of not only the committee but obviously the audience members and other stakeholders on relative topics that are timely and any input with the committee members on agenda items as well. Just fyi, if there are things you want it hear about for upcoming meetings, we will be seeking your assistance.
>> MICHAEL GRIER: Thank you, Jamie. I have the e-mail distribution list ready to roll.
With the exception of the two new members. Are there questions of anyone here for MCOs?
Hearing none, I suggest that we adjourn the meeting a little bit early.
So thank you, guys. Our next meeting date is February 1.
And it will be right here in the honor suite.
If it is face-to-face. Or we will have a streaming option as well.
I would like it thank all of you for your participation and I look forward to seeing you next month.
Thank you, everyone.