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Date: 01/05/2022

Event: Managed Long-Term Supports and Services Meeting

StreamBox

>> Good morning.
>> Good morning.
>> Happy new year, everyone.
>> I can hear.
>> I can hear.
>> Hi. Good morning, Jamie. This is pat. Matt and David are both on and it looks like most of the committee members are on.
>> JAMIE BUCHENAUER: All right. Sounds good. I was just looking through. Yeah. Whenever the members are ready to get started, it looks like it is 10:00.
>> DAVID JOHNSON: You can take attendance. Is Ali Kronley on the call? Okay. So --
>> I'm sorry. I was going to say I don't see Ali.
>> DAVID JOHNSON: Great. Thank you. Is Cindy Celi present?
>> Yes. Cindy Celi is here. Thank you.
>> DAVID JOHNSON: Okay. Thank you. Neil Brady?
>> I don't see Neil.
>> DAVID JOHNSON: Okay. Gail Weidman? German Parodi? Hershie Zinman?
>> Good morning.
>> DAVID JOHNSON: Good morning. Jay Harner.
>> Yes. Hold on one second. I have to -- okay. It looks like -- it looks like Jay may be self muted.
>> Present. Good morning.
>> DAVID JOHNSON: I'm sorry. Was that Jay speaking?
>> Yeah. Sorry. This is Jay Harner.
>> DAVID JOHNSON: Good morning, Jay. Thank you. Is Juanita Gray present? Okay. Kyle Glozier? Is Lloyd Wertz present?
>> I am here. Thank you.
>> Excuse me, Mike. You may want to self mute when you're not talking. We're hearing a lot of background noise. Thank you.
>> DAVID JOHNSON: Thank you. Is Matthew Seeley present? Mark Gusek? Mike Grier?
>> MICHAEL GRIER: I'm here.
>> DAVID JOHNSON: Good morning, Mike. Monica Vaccaro?

>> Hi. This is Monica.
>> DAVID JOHNSON: Good morning, Monica. Richard Wellins is not attending. Sarah Glasheen? Okay. Sherry Welsh?
>> Good morning. Yes, I'm here.
>> DAVID JOHNSON: Hi. Good morning, Sherry. And Tanya Teglo? Okay. That is the committee list.
>> MICHAEL GRIER: Thank you, David. Is there enough folks for aquarium, for the meeting?
>> One, two, three, four, five, six, seven, eight. You have nine.
>> MICHAEL GRIER: Nine.
>> Is that enough for a quorum. I see Gail is now on. A couple people jumped on.
>> This is Michael. I'm sitting in for Ali Kronley from SCIU.
>> DAVID JOHNSON: Great. Thank you, Michael.
>> Let me see if anybody else is on. And I think Sarah has joined as well.
>> MICHAEL GRIER: How many do we need to proceed? That is the question that I'm asking. Maybe we should go to Jamie.
>> Quorum is a majority.
>> You have 11 out of 19. So I think you have enough.
>> MICHAEL GRIER: Okay. All right. Thank you, Pat. I'll just move right into the housekeeping. Can we -- should we do that right now?
>> Yes.
>> MICHAEL GRIER: Some of the housekeeping or committee rules is please keep your language professional. This meeting is being conducted as a webinar with remote streaming. All webinar participants, except committee members and presenters, will be in listen-only mode during the webinar. While committee members and presenters will be able to speak during the webinar, we ask that you use the mute button or feature on your phone when not speaking. This will help to minimize background noise and improve the sound quality of the webinar. We ask participants to please submit your questions and comments into the chat box located at the go to webinar pop-up window on the right-hand side of your computer screen. To enter a question or a comment, type into the text box under questions and press send. Please hold all questions and comments until the end of each presentation as your questions may be answered during the presentation. Please keep your questions and comments concise, clear and to the point. Meeting minutes, transcripts and meeting documents are posted on the list serve under MLTSS meeting minutes. These documents are normally posted within a few days of receiving the transcripts. The captionist -- the captionist is documenting the discussion remotely. So please -- so it is very important for people to state their name and include -- and state their name or include their name in the chat box and speak slowly and clearly otherwise the captionist may not be able to capture the conversation. This meeting is also being audio recorded. The meeting is scheduled until 1:00 p.m. To comply with logistical agreements we will end promptly at that time. If you have questions or comments that weren't heard,

please send your questions or comments to the resource account on your agenda. 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. The 2022 MLTSS sub mac meeting dates are available on the department of human services website. Merry Christmas and happy new year to all of you. Thank you for joining us today.
>> JAMIE BUCHENAUER: Mike, I don't know if you want me to take over here. If we move to the OLTL updates. All right. I'm not hearing otherwise.
>> MICHAEL GRIER: I'm muting and unmuting to keep the disruption down. Yeah. We will just move to your presentation, Jamie. Thank you.
>> JAMIE BUCHENAUER: Sure. Great. Welcome, everybody. Happy new year. I'm happy to be with you in 2022. Wow. I can't believe I'm saying 2022. The next year always seems so far away and it comes so quickly. So many thanks to Mike grier and David Johnson our new committee chair and cochair. Also welcome to the new members of the MLTSS sub committee. Jermayn I'm hoping you have a list of the new sub committee members and we can recognize those new members of our MLTSS sub committee. At the last meeting we recognized those who were transitioning off the committee. Probably still joining us by phone and we're glad to have them. But for our new sub committee members, do you have a minute to just kind of recognize those new members? I know you said you're going to send me the names. Do you have that list?
>> Jermayn: Yes. Give me just a minute. The committee members appointed at the beginning of January 1st, 2022, we have Jay Harner, Kyle Glozier, and we have Sherry Welsh. The rest of our members are continuing with us.
>> JAMIE BUCHENAUER: Thanks, jermayn and welcome again to our new MLTSS sub committee members. With that I will get to the OLTL updates that we have for the new year. Most of our updates honestly are focused around -- if you go to the next slide, the -- our plans for the American rescue plan act. That is what that ARPA acronym stands for. So I will spend most of my time talking about those updates. Then I want to give you some really, really quick updates on the Community Health Choice waivers, our financial management services transition, nursing home transition. Just to give you an update about this. I wanted to state publicly we're taking input. And then ask the committee members and others some -- you know, I want you to think about what your plans and what the committee wants to focus on for 2022. So we can talk a little bit about that at the end of the meeting. So getting into our office of long-term living ARPA updates. And I apologize for going into the background. But for those who this is a new subject, I want to quickly cover that background so it is not confusing to those who -- this is a very new topic. For those who have heard me talk about it a number of times, stay tuned. I'll keep it brief. The American rescue plan act was passed in March of 2020. It provided a 10% point increase to the federal medical assistance percentage. What we call FMAP for certain Medicaid expenditures for home and community based services. From April 1st of 20 -- yeah, from

April 1st of 2021. I'm sorry it was in March of 2021. I'm getting my dates confused. I'm bad with dates. So I should just think about it. ARPA was passed in March of 2021. So we are earning additional FMAP between April 1st, 2021 and March 31st of 2022 on our home and community based services. So we're earning all of this additional FMAP. What ARPA said is that you can use it to supplement your home and community based services. You can't use it to sub plant any existing state funding. Your state funding that is already paying for these home and community based services has to remain constant. But you can use this additional FMAP to improve, enhance, or -- improve, enhance or expand home and community-based services in your programs. So CMS wanted all states to submit a plan on how they intended to use all of this enhanced state funding for home and community based services. Pennsylvania put together a plan. It was the department of human services. And please understand, it is not just the office of long-term living that has and provides home and community based services and gets this additional FMAP. It is many offices across the department. It is the office of developmental programs, the office of mental health and substance abuse services, the office of medical assistance programs, and obviously the office of long-term living services. So OLTL put our plan together along with all of the other offices and submitted this to CMS. And then it sat for some period of time. Finally on December 1st of 2021, CMS conditionally approved our plan to spend this enhanced FMAP. So what we're providing you today is our overview, with more detail. We provided in the past but now we are providing additional detail on our American rescue plan act to spend that enhanced FMAP for the committee. So if you go to the next slide. The biggest piece of the office of long-term living plan is -- I think you may have skipped a slide. Oh, maybe not. Okay. So -- so our biggest piece of the -- uh-oh. So I'll just talk about it. So the biggest piece of our office of long-term living enhanced FMAP is actually being paid -- spent on enhanced payment rates in our Community Health Choices and our overall waivers. And those enhanced payment rates are starting January 1st of 2022. The enhanced payment rates are increasing the personal assistance service rates by 8%. Like I said in Community Health Choices and OBRA that is by 8%. This is going to apply to both the agency and participant-directed models of personal assistant services. It is our intent, the office of long-term living intent and the department of human services intent to sustain this increase after these ARPA funds have been exhausted. So many have asked obviously most of personal assistance services is paid for in managed care. How will that rate increase be passed on to agencies through managed care? And so just for everybody's information, for the Community Health Choices program in 2022, the agreement specifies that our CHS and have to pay the minimum OBRA schedule rates which do reflect that 8% rate increase. They can pay more and they can also enter meaning they, the provider and CMC can enter into value based payment arranges but cannot pay less than those fee-for-service rates. Please understand that obviously that rate increase will take effect January 1st of 2022. And the CHCMCOs are prepared to pay at least those OBRA schedule fee rates for personal assistance services. So just so everybody understands, you know, we

understand in the Community Health Choices program that providers may have negotiated a higher rate than the -- than the medical assistance fee schedule for OBRA. So those providers may be seeing less than 8%. In some cases I hear that providers were paid less than the overrates and they may be getting more than that 8% increase. But please understand the 8% OBRA waiver rates are I want to say the actual bottom level. I mean providers need to be paid at least those rates.

So moving along and I'll talk about this slide now, Pat. Sorry about that. I think -- I think maybe we have a mix-up in the office of long-term living. It's okay. I can talk about all of these things. The next slide actually reflects some additional information. And probably very pertinent to some providers now as they're working on our strengthening the workforce payments. So for everybody's information, another piece of our ARPA plan in the office of long-term living was sending out strengthening the workforce payments. We heard from providers by and large that they were having trouble recruiting and retaining staff and that they needed infusions of cash in order to I want to say support the workforce that they had, retain the workforce, recruit new workers, and obviously pay for PPE expenses. So hearing that, we set aside some funds for strengthening the workforce payments. The total available funding for those one-time payments for personal assistance services, residential and and providers was $49.5 million. Out of that total amount, 44 million was allocated to PAS and community integration and 2.5 million was allocated to residential habitual services. We have a one-time payment that is functioning in the same way to our adult daily living providers or adult day service providers. And they will share in $13 million. So as of December 21st, many of you may have seen the list serve notice that went out by the office of long-term living. We did release information letting providers know that these payments were coming. A letter went out on the list serve. And actually individual letters went to providers explaining the strengthening the workforce payments and the adult daily living provider payments. And that providers had to complete an attestation that they were going to spend the funds as we had requested they spend the funds. So they had to be spent on providers providing bonuses to their workers, retention payments, bonuses to incoming workers. They had to use it on provider benefits, innocentives for vaccination, providing PPE. And the list was actually in that list serve notice and obviously in those letters as well. Providers that complete that attestation by January 7th of 2022 will receive their payment in February of 2022. Now, please understand that January 7th is not a deadline. It is not a hard deadline that says listen you have to provide your attestation by January 7th or you will not get paid. It is just if you get it to us, if you get the attestation to us after January 7th, you will be paid sometime later than February of 2022. So the later we get your attestation, the later providers will receive their payment. So we were trying to set a deadline so we could quickly turn around those first payments for providers that got us their attestations quickly. And you can see on the slide that the attestation form can go by snail mail. And that information was included in the list serve in the letter or you can return it to the web address that is on the form. Just so you know that

we -- we did post all of this information on our office of long-term living website. There are actually the payments are listed by providers in different spreadsheets. So I would encourage anybody who has questions to please check that website first. We are getting questions about payment amounts. And so it is really helpful if you check that website first and review that information before sending us some questions. What we are seeing, please understand that providers qualified for payments if they were open and active as of November 1st of 2021. We did not want to close -- or we did not want to pay closed providers. And I think that is causing some issues for providers. You know, it's -- we use the records that we have in our system, meaning promise to the best of our ability. Sometimes the records in our system maybe providers don't keep them as -- as up to date as they should because most of the payments are being made out of managed care. But I would remind you because the department of human services, the office of long-term living relies upon the provider records that we have in promise, it is our -- it is our database of record. It is very important for providers to keep their information up to date. And this is only one of the reasons why it is so important to keep that information up to date. So please recognize that.

Then the -- then the next update that we had for everybody on our American rescue plan act updates, we are working on a grant program that will provide funds to providers to strengthen and improve home and community-based services. And so this was part of our plan that was submitted and approved to CMS. And so we are working on our statement of work for our grant program as we speak. We were looking for the grant program to provide funding to providers to address social determinants of health for our home and community based services populations. Purchase remote support technology for home and community based providers, develop and provide training on infection control practices, or purchase and implement new software or technology for electronic health records, quality or risk management functions, or possibly enable providers to contract with the health organization so they could connect to a local or regionally based health organization allowing them to exchange their medical records in real time to ensure they have the most up to date information on the populations that they serve. We've been having conversations additionally with providers on different needs of their workers. And so I don't want to say this is an -- this is the list. I think we're still working on modifications. But what I want to stress to this group is that we are obviously working on this grant program to strengthen and improve home and community-based services. So we are obviously looking forward to issuing this in the very near future. Our priority in the office of long-term living was obviously making sure that we had those rate increases in place and ready to go for January 1st of 2022. And then distributing the strengthening the workforce funding. Obviously we will be working very near into the future on our home and community based service grant program. Like I said to strengthen and improve home and community-based services. So definitely more to come on that piece.

Then finally some other initiatives that were in the office of long-term living home and

community-based ARPA plan. So we've talked about this in the past. And we included funding in the 2022 Community Health Choices rates for the CHC-MCOs to work with the new financial management services vendor to procure a curriculum training for our population. So the CHC-MCO and the financial services vendor will be working to put that in place in the very near future. And we've been working with interested stakeholders on that piece. So hopefully, you know, we're hoping by mid-year we have that training piece in place. And that our participant-directed workers can start to avail themselves of training that is available to them. The other piece that we are working on internally within the office of long-term living is creating a registry of direct care workers and participants that are looking for direct care workers. And so when I have talked about this in the past, I think many have expressed some concern that you know was this going to be a mandatory registry. I assure you it is not a mandatory registry. Really the idea of this was that participants who are looking for workers can register and workers who are looking for participants can both register and they can be matched and exchange and communicate without exchanging any identifying information until one or both parties felt comfortable doing so. Some other states already have this in place. And I was at the advancing states conference some weeks ago. And actually states talked about it with advancing states that they have created registries to allow workers and participants to do this. And so we're looking at examples that other states are already doing and using to provide this -- this actual function to the participant-directed population as well as others. So very exciting things coming on the horizon. And hopefully we will have more information to share as we work on meaning the office of long-term living works on this registry piece. And then the final piece of our office of long-term living ARPA plan was creating incentives for our Community Health Choices MCOs for nursing home transition and meeting some quality benchmarks. And so the office of long-term living is in the process of setting the benchmarks for 2022 that the CHC-MCOs must meet. And it is part of the 2022 agreement. These are really pay for performance arrangements. So if the CHC-MCOs hit those pay for performance benchmarks then they can receive payments in 2023 for quality and meeting those benchmarks.

So that is the extent of the ARPA home and community based services plan that I had to share with the group. So I know I have provided some of that information in the past. Hopefully some was additional information for the group. Especially related to the rate increases and the strengthening the workforce payments. So moving along for the CHC waiver updates. This really is an FYI. I know -- I think it was two meetings ago Patty Clark spoke to the MLTSS and provided updates on the 2022 CHC waiver amendment. And so we're just letting you know here that we're submitting our waiver changes I want to say in two phases or with two amendments. And Pat, I think you can go to the next slide. There you go. So the first one which we submitted and we actually received CMS approval was the explanation that Patty provided at the meetings on the service definition changes and the performance measure changes to the CHC amendment for 2022. That information was

presented. It is now online at our website. There's a comparison of what has been changed for 2022. As well as some additional information for those who are interested. So like I said, CMS did approve that first change. CMS recommended that we hold the financial management services changes until I want to say and submit them now so they are effective April 1st of 2022. They didn't want us to submit those financial management services changes to -- for those to take effect on January 1st of 2022 when they really wouldn't be effective until April 1st, 2022. So CMS wanted us to submit our amendments I want to say in a two-step process. So we did obviously -- we did do our public notice including those financial management services changes. We got public comments on them. So we will now submit those changes to CMS. If we haven't already, they will go sometime this week. And then upon CMS approval those changes will be effective April 1st of 2022. So just wanted everybody to know about that two-step process that is happening. Patty, when she presented presented an overview of all of the changes. About you they all didn't go in for January 1st. Some of them, the financial management services were held until April 1st. So that's an update on the CHC waiver updates. Like I said, all of those changes are available on our website. If you're interested. I didn't want to rehash that information. But that information is all available on our website if you have questions. I'm happy to take them. And you can visit that information there.
>> Hi, Jamie. Lloyd Wertz here. Could you briefly describe the performance improvement measures for which financial incentive will be provided for the MCOs. I'm not looking for detail, but is there a general sense of where those are? Am I the only one that is not hearing anything.
>> I was going to check. Jamie, it looks like you're talking, Jamie but we're not hearing you. It seems like, Lloyd, that Jamie is having some audio issues.
>> Lloyd Wertz: That happens a lot with me.
[Laughter]
>> Sellers: I know we have -- Jamie, I don't know if you want to try logging out and coming back in? I know -- I don't know, Randy -- and I can also -- I see Jill is on. I can make Jill an analyst while we're trying to get Jamie's audio fixed. Lloyd, could you maybe repeat your question for Jill and Randy?
>> Lloyd Wertz: Certainly. Good morning, Jill and Randy.
>> Good morning.
>> Lloyd Wertz: Jamie referenced the submission -- the intention to offer performance payments. Pay for performance to the MCOs for certain measures in their performance. And I just wondered if we could briefly hear about what those are, even if it is just kind of the realm in which they exist. Is it you got more people out of a nursing home, you connected more people with behavioral health services. I would love to hear that. I wonder if there are general areas in which the performance measures might be characterized.
>> Jill: Yeah. So there are some specific performance measures. And Lloyd, I'm looking up to give you a little more detail. I know that a lot of the performance measures are focused

on, you know, improving quality. But also looking at nursing home transition. So let me pull that information up and then I can give a better detailed response.
>> Lloyd Wertz. Thank you. Also I had a general question. The funds that are being distribute to providers seem to be going directly from the OLTL relative to the ARPA funds, go directly from the OLTL to the providers, not routing through the MCOs. I was wondering if there was a reason for that. It seems to be a break in practice. But I don't know if there was thinking about that.
>> Jill: I received a message from Abby. If you can unmute Abby Coleman, she has the measures right in front of her.
>> Okay. Hold on one second.
>> Jill: Thanks, Abby.
>> Sellers: Abby, you should be able to unmute yourself.
>> Abi: Hi. Good morning. Can you hear me.
>> Sellers: Yes.
>> So we are looking at seven paid for performance in the office of long-term living. Four of those measures will be based on the MLTSS measures that I think I have presented to this group previously. The first one is looking at comprehensive assessment and update which is whether the MCO did their assessments in a timely manner and met certain components within the assessment. The next measure is looking at comprehensive care plan update. And, again, did the MCO put the care plan into place in a timely manner and meet certain criteria. The third measure is looking at reassessment and care plan update after an in-patient discharge. So, you know, again did they do the reassessment, get the care plan in place in a timely manner after there was an in-patient discharge. And then also did the MCO share the care plan with the participants primary care provider? So the MLTSS measures, we are also looking at nursing home transitions in terms of how many nursing home transitions the MCO performed during the year. As well as we are looking at the HP overall satisfaction with the health care plans, specifically looking at the aligned population because in the office of long-term living, the MCOs do submit two versions of the cap HP plan. So we would be looking at the participants who are in an align [Indiscernible] with the MCO. And then the final measure is from the HSBS cap survey. And I actually -- I know I said I have all of them in front of me. But I believe that one changed. I believe it is satisfaction with your person center -- the person centered service plan. I can get the exact loss measure to you guys. I know -- sorry. I said I had them all in front of me. I thought I could say them off of the top of my head. I lied. I will get the measures. But that is the general gist of the measures.
>> Lloyd Wertz: That is great, Abby. Thank you very much. Will there be kind of a per unit incentive or is it an overall, you know, here is what each of the individual MCOs will get? How are you going to dole out those incentives.
>> Abby: What we are looking at, there will be a benchmark for each of the measures. And then for all of them except for the nursing home transition, there will be incremental

improvements as well. That's what we're looking at right now.
>> Lloyd Wertz: Thank you.
>> MICHAEL GRIER: Is there any other questions from the committee members? Let me ask, is Jamie back on yet?
>> Sellers: She is back on but I don't think we can still hear her. Jamie, I'm going to -- I'll send you the dial-in number, Jamie. Maybe you want to dial in by phone. Do any other committee members have any questions? We have about four minutes. If not, I do have some from the audience. Okay. And maybe -- maybe Jill or -- I don't know if Jen is on. Try to get the information to Jamie. Yeah. Jen hail is here. I'm going to also unmute her. The first question is from Janelle gleson, can the ARPA workforce payments to community based providers be used to cover prior qualifying expenses or are the providers restricted to using this funding for new future workforce initiative?
>> Jill Jill. Is Jen on?
>> Sellers: Jen should be on.
>> Jen: I am. This is Jen hale with the office of long-term living. Pat, I think I caught the question. Can you just repeat it?
>> Sure. Can the ARPA workforce payments be used to cover prior qualifying expenses or are the providers restricted to using this funding for new future workforce initiatives.
>> Jen: I think we're looking for providers to be spending money on new workforce initiatives. In the letter and the information provided on the DHS website, it does outline some of those initiatives such as sign on bonuses, retention payments, COVID -- COVID vaccine incentives. And there's a few others. But I think we're looking for new initiatives to really benefit workers. And strengthen the workforce.
>> Sellers: Okay. Great. Do those funds need to be used by a certain date? Would they need to be used by March of 2024?
>> Jen: They do. Pat, sorry. This is Jen again. They do need to be used by March of 2024.
>> Sellers: Okay. Great. The next question is -- we answered that one. So Pam was asking, does that mean that providers need to give the 8% directly to the direct care workforce? So this is the 8% rate increase.
>> Jen: So for the 8% rate increase. This is Jen again. For the 8% rate increase, yes, we are encouraging providers to raise direct care worker rates that 8%.
>> Okay. And I think Lloyd had a question that we may have missed. He was asking -- he said that it sounded like DHS or OLTL was making the payments directly to the providers and not through the managed care plans. I think is the 8% rate increase, that is going through managed care. But the workforce development is going from OLTL to the providers. Is that correct?
>> Jen: That is correct, Pat.
>> Okay.
>> JAMIE BUCHENAUER: Pat, this is Jamie. Can you hear me now?
>> Now I can hear you.

>> JAMIE BUCHENAUER: Sorry. I have no idea where I ended where you can't hear me.
>> I think Lloyd was asking you the question and it was around the performance measures for the MCOs. And then Abby answered that question. And then Jen answered a few questions around the workforce development payments. And we are I guess probably at the point where Mike and David that we need to transition. But I will make -- I will make -- mention one item. I did post in the chat the link to the OLTL web page where it has the information about the different ARPA payments that Jamie was covering. As well as the fee schedules that are effective January 1st, '22 for OBRA.
>> MICHAEL GRIER: Did -- thanks Pat. Is there anything about employment -- employment funds potentially in the ARPA payments? For employment, for people with disabilities?
>> JAMIE BUCHENAUER: So not specifically, Mike. But what I will say is that, you know, I think -- I think you heard me talk -- so I'm not sure where I cut off about the home and community-based services grant program. Really, like I said, it is a work in progress. And we're looking for providers to really kind of think outside of the box about the way that they can improve and strengthen home and community based services. So if there is a proposal that you're thinking about and it involves employment, I think we would like to see it.
>> MICHAEL GRIER: Okay. Thank you. Yeah. I think if there isn't anything else in the questions, Pat, I think we should -- if Marjorie is ready, I think we should move on in the agenda.
>> We do have additional questions, but normally what we try to do is transition those to the additional public comment period to try to stay on the timeline.
>> MICHAEL GRIER: Okay. That sounds great.
>> Okay. Marjorie?
>> MARJORIE FAISH: Good morning, everybody. Today I want to talk to people about how D-SNP relate to CHC-MCO. Next slide, please. So today we're going to cover D-SNP basics, Medicare basics, some Medicare coordination highlight that's are from the CHC agreement and some Medicaid coordination highlights that are in the 2021MIPPA contract. I do want to point out that the -- I apologize. I want to point out that the 2021MIPPA contract has been extended for '22. I apologize. Next slide. So this slide shows Medicare options for people who are dual eligible. To be a dual eligible, it means that you qualify and are eligible for both Medicaid and Medicare. For Medicaid these individuals are in the Community Health Choices program and in a CHC-MCO. For Medicare coverage they have three options. The first is they can enroll in a CHC companion dual eligible special needs plan or referred to as a D-SNP is run by the same organization or the parent entity that runs the CHC-MCO. These members can also enroll for Medicare in a noncompanion D-SNP or any other kind of Medicare advantage plan. And the Medicare advantage plan is simply what we think of as MCO on the Medicaid side. And the third option is that these individuals can enroll in original Medicare. Original Medicare is also referred to as fee-for-service. Next slide, please.

So I want to talk about a little bit will D-SNP basics as we talked about specifically it stands for special needs plans. The only individual that's can enroll in a D-SNP must be eligible for both Medicare and Medicaid. D-SNP must have a contract in place with the state Medicaid agency in order to operate in that state. The federal government has identified the eight minimum contract elements. And this was identified in the Medicare improvements for patients and providers act, otherwise known as MIPPA of 2008. One thing that I want to point out is that the state Medicaid agency and Pennsylvania is the department of human services. Some examples of what is included in the minimum elements put forth by CMS are categories of dual eligible beneficiaries that D-SNP can enroll and the service area covered by the D-SNP. And service areas are broken down by counties. Next slide, please.
In addition to the state MIPPA contract, all D-SNPs must have a model of Kara proved by the national committee for quality assurance referred to as NCQA. The model describes how the plan will assess beneficiary needs, develop individualized care plans, establish and utilize integrated care teams, and coordinate care, including during care transitions. It there are currently ten D-SNPs operating in Pennsylvania. As we mentioned previously, DHS requires the CHCMCOs to operate a companion D-SNP aligned with the CHC-MCO. In Pennsylvania there are three companion D-SNPs. The other D-SNPs are referred to as not aligned -- I apologize. They're not aligned with the CHC-MCO and they're referred to as unaligned or noncompanion D-SNPs. Next slide, please.
So I want to talk to you a little bit about the Medicare coordination highlights that we find in the CHC agreement. DHS requires all CHC-MCOs to assist members with questions about care coordination. This care coordination involves behavioral health MCOs otherwise known as BHMCOs. It can involve Medicare coverage. It can involve care coordination with the companion D-SNP and also unaligned D-SNPs. The CHC-MCOs also must put information this their newsletters about their own companion D-SNPs. It must include services covered by the D-SNP, the benefits of enhanced services by enrolling into a companion D-SNP and how to enroll in a companion D-SNP. CHC-MCOs must ensure smooth transitions. This involves working with multiple pairs including Medicare pay for service, Medicare advantage including companion or unaligned D-SNP and bh MCOs. Next slide, please.
So I want to talk a little bit about the Medicaid coordination highlight that's are in the MIPPA contract. Remember, the MIPPA contract is for D-SNPs and this coverage is Medicare coverage. So DHS has made significant efforts to ensure care coordination between D snaps, the CHC-MCOs and the BH MCOs to improve health outcomes for CHC participants. Under the PAMIPPA contract, D-SNPs must assist members with filing grievances and appeals with Medicaid. This is a federal requirement. Must coordinate with the CHC and behavioral health MCOs. Next slide, please.
D-SNPs must provide 48-hour notification to the extent possible. Certain events to the CHC-MCO service coordination staff. This includes hospital and skilled nursing facility admissions and discharges, ER visits, and significant medication changes. Additionally D-

SNPs must cover a member for six months if they lose Medicaid eligibility. This is to provide them the opportunity to regain it. And D-SNPs must conduct education about maintaining Medicaid eligibility and assist members in applying for Medicaid redeterminations. Next slide, please.
So what is the end goal here? It is to improve care coordination to offer better health outcomes for CHC participants. As this graphic shows, there are a lot of players involved and a lot of requirements. There are federal requirements, there are DHS requirements, the difference players involved include the D-SNP, the CHCMCO and the behavioral health MCO and it also includes service coordinators and providers.
Next slide, please.
This slide gives resources for information on this topic. For more information on the MIPPA contract, there's a link to the CHC-MIPPA documents. Questions specific to the MIPPA contract itself may be sent to the MIPPA mailbox at RA-PWPAMIPPA@pa.gov. Thank you and that concludes my presentation. And I think we're going to move into hearing from the CHC-MCOs.
>> Yes. Thanks, Marjorie. So we are going to transition. And this time we will be starting with Pennsylvania Health and Wellness. And Heather Clark and Jodi cichetti. Yes. Thank you.
>> Yes, thank you.
>> Heather Clark: Good afternoon, everybody. Thank you for allowing me the time today to review how PA health and wellness manages transitions of care. Both behavioral health and physical health transitions. Next slide, please.
In all instances PWH discharge planning begins the day that we are notified of an admission. We will schedule a case conference for any cases that we consider complex. A case may be considered complex for a number of reasons. The most common reason we consider a case complex is because we need assistance in securing a SNP placement. This is seen a lot specifically with psych admissions where the previous SNP will no longer allow the participant to return due to those behaviors. Another reason we may consider a discharge complex is due to the lack of willing or available provider. Other reasons include ventilator dependence and other complex conditions which require special care. And so in those instances we would conduct case conference. Folks that may be invited to those case conferences can include the participant, if they are willing and able. Their family or caregiver. The facility. The social worker and/or discharge planning representative. The other CHC or D snap MCO as well as the BHMCO if behavioral health is indicated. And then PHW representatives based on their involvement in the member's case, particularly the service coordinator. And any member of our integrated care services specialty teams which I talk about on the next slide. You can move to the next slide, please.
This slide really talks about some of the specialty programs that PHW does have that may be involved in the case and invited to the case conference for discharge planning. Or these could be potential programs that the participant can be referred to post discharge. I'm not

going to go over this slide as you see there is a lot of information jammed into it. But just to highlight, we do have a behavioral health case management program for members, participants that have been identified as having any unmet behavioral health needs. They may need connection to providers, they may need coordination. We have a clinical management program that has registered nurses on staff to assist the participants with securing any physical health services that they may need. They work very closely with our service coordination team. We have the special needs unit which really works very closely with facilities and our service coordination team to ensure organized and timely response to the need for support for those complex and hard to place participants. The special needs unit and the transitions of care team are always -- most likely invited to those case conferences. Our transitions of care team really work with the participants and/or facility and providers to coordinate that care, mitigate and remove any barriers and coordinate the plan to prevent any unplanned readmission. And then lastly we have our program that is really for participants who are at risk for an onoid misuse disorder or have a current diagnosis of opioid misuse. Next slide, please.

Our next step in the continuum of managing a transition of care is to determine if behavioral health services are warranted. If it is determined that behavioral health services are warranted, we would inquire with BHMCO or CHC participants or their Medicare primary MCO as the primary care for behavioral health if they have a D-SNP MCO or if there are behavioral health -- behavioral health services currently in place. If there are services currently in place, we would work with that existing provider to schedule post-discharge appointments for that participant f there are not services in place, we would look for an in-network provider. Hopefully with a specialty that meets the participant's needs and schedule post discharge appointment with that provider. We really look to have those behavioral health appointments in place prior to the participant's actual discharge. And then just a note, a side note, considerations for potential behavioral health services as a result of a physical health transition of care. So participant with a newly identified chronic health condition, participants who may experience lifestyle changes as a result of their physical health condition, possible permanent disability and mobility limitations, also could pose -- could also be potential reasons for referral for behavioral health services post physical health transitions of care. And then on the flip side, for participants who have a discharge from a psychiatric in-patient stay, these participants who are not currently connected to behavioral health services who will need behavioral health services post discharge are really those members who have a new diagnosis, symptoms not previously experienced, treatment not compliant and need for support groups. Next slide, please.

Next on the continuum we will coordinate benefits with the other CHC or D-SNP MCO. Routine coordination occurs on any in-patient or SNP admission and discharge and ED visit. Also with any high priority health concerns such as cardiac or orthopedic, which may require procedure or oncologic diagnosis that may require chemotherapy. Next slide, please. So this slide goes over the post-discharge process. So for any psychiatric discharge

or behavioral health care manager outreaches to the participant two days post-discharge for discharge assessment and coordination of any appointments or services they may need. The service coordinator will follow up with the participant within 14 days post-discharge for reassessment. On any admission or discharge behavioral health or physical health. The service coordinator will update the person-centered service plan as indicated. We will also update the other CHC-MCO or D-SNP MCO by sharing any discharge planning documents and any significant medication changes. And then lastly, the service coordinator and behavioral health CM will follow up as indicated. That follow-up really is determined on what the participant's discharge needs are. So it may be assistance or reminder calls on appointments, securing needed services. Whatever that discharge plan looks like in the post-discharge [Indiscernible] of the follow-up. And I believe that's our presentation. So thanks again.
>> Great. Thanks, Heather. And right on schedule. Mike Smith with UPMC is up next and you have about ten minutes.
>> Mike Smith: Can you hear me okay?
>> Yes. Thank you.
>> Mike Smith: Perfect. Next slide, please. So we wanted to really lay out a journey for participants based on the assignment that OLTL gave us around the participant's journey of somebody who might have suffered a heart attack in our program and how we might engage and coordinate their care more broadly. So this is a story of Larry. Specifically our request from OLTL was can you share how you would arrange care for a participant after being discharged from the hospital after a heart attack. Specifically the role of CHC and the MCOs play and please consider that the person may have behavioral health needs or chronic conditions that would be factors to consider. So we developed our presentation today to really walk through Larry's story and provide a picture of how this might unfold in a real scenario in the community.
So today's discussion is based on -- and Larry is a composite of our participant. He is a 60-year-old gentleman who was prior to his heart attack was working remotely and he basically suffered an injury prior -- three years prior in an auto accident and was already a participant in our program as an HCBS participant. He has an adaptive vehicle, uses a wheelchair and enjoys spending time with his friends and being outdoors. He has an apartment that is located -- that we located after his accident. That was mainly accessible. It was obtained with the help of our housing support team in conjunction with the service coordinator at the time of his participation in the program. A vehicle and minor home modification is needed to make the house fully accessible were supported by the service coordinator in conjunction with our home modification team. His mother and sister providing some basic PAS, personal assistance services to him. And help him prepare for his day, the beginning and end of his day. And Larry in addition to those -- his activities, he -- we helped him with our employment concierge program that we talked about in previous discussions along with the service coordinator to engage the office of vocational

rehabilitation and help him train for a position that he was working remotely. In addition to that, Larry is also participating in a dual special needs plan that CMC provides through UPMC for life. And they are helping manage his medical needs around DME, specialty medical management, around catheter care, making sure that he is getting his eye and dental care, wound avoidance support and inhaler use. It is really a team effort there to make sure that Larry's circumstances were addressed well. Next slide, please. Unfortunately Larry had a heart condition and suffered a heart attack. And Larry's hospitalization, we were notified through admissions discharge notification. This notification comes to us through the health information exchange that UPMC subscribes to and receives information about the participant when they enter the hospital, have an ED use, those types of things. Emergency department use. This notification was received and not only by the service coordination team but also by our UPMC for life care manager who knew about it and the admission almost immediately and started to work on the transition of care record. The admissions also triggered a critical incident response because hospitalization is an unplanned hospitalization is a critical incident. And the SC, the service coordinator ultimately understanding the participant was with UPMC for life in our care manager there was relying on them to work with the facility and participant in terms of planning for that eventual discharge home. That information is available to our care manager and service coordinator because we share an electronic health record where we maintain those records in terms of serving and coordinating care for the participant. They also were notified, the service coordinator was notified of the discharge from not only the task that was provided by the -- by the care manager, there was also a notification to them through the admissions discharge and transfer notification. So they were aware of that discharge and they followed up within 14 days of the trigger event to do their assessment. So just -- just as an aside, I want to make sure that I noted that notifications can come to UPMC through many mechanisms, not just discharge -- admissions discharge, transfer notifications but also through participant and provider contact and other means of contact where we might find out participant has entered a hospital. Not all hospitals, just to be clear, participate in the health information exchange. In this state we're getting more and more enrolled all the time. I think the last number that I saw were 75% of all hospitals were engaged. And that number was going up at the time. So really good news in terms of expediting contact for us. But it is not -- it is not actually available in every part of the state at this point. So the critical incident team and quality team, I wanted to spend a little bit of time here because you heard at admission, Larry's admission, we were notified by the critical incident team that Larry was in the hospital. And this is really critical because we want to -- UPMC wants to make sure that we're really doing a great job at coordinating not only his care between the members of the team but also making sure that we're accurately and consistently and efficiently monitoring and managing critical incidents. And so our -- that internal critical incident team really helps us maintain our time frames for follow-up, maintains, you know, report -- [Indiscernible] pulls together interdisciplinary teams to work

on critical incident that's are affecting participants in the community. And also just helping us maintain our record-keeping with OLTL. So they're really critical. The other thing that I wanted to note is that this scenario is really targeted around a dual special needs participant who is with UPMC. So if they were not with UPMC, the scenario for that participant might be slightly different than what I have said to this point. And where it would be different is if the participant is in the traditional fee-for-service Medicare program, they may not have a -- they would not have a UPMC special needs care manager. They would potentially have -- they would have a service coordinator. And that service coordinator would then be responsible for engaging in the hospital discharge planning more actively because they don't have that secondary support. We also have another scenario where we would have an aligned -- so say if it was Aetna or another one of the D-SNPs that will present later in today's call, those folks would be notified through telephonic outreach and a referral form that was developed where we exchange information as well as data exchanges that we do with these other special needs plans in order to create that coordination of care. So they're a little bit slightly different. The nice thing is when you're working with UPMC for life and a service coordinator from UPMC, we're sort of in the same systems and collaboration is a little bit more real time and [Indiscernible]. And so now I'm going to step to, you know, Larry is basically returning home from skilled services. Skilled services from the hospital. And you will see those points on the left hand side there. He is basically returning home with physical and behavioral --
>> Mike, I'm sorry to interrupt up. Can you wrap it up in two minutes.
>> Mike Smith: Yes. Sure. As well as other services that are available through Medicare. Next slide, please. So the trigger event basically -- what happened here is in discussions during the trigger assessment and care planning process, we learned that there was significant heart damage and that potentially Larry was not going to be -- was going to be debilitating and he may not fully recover as expected and he may not be able to work in the future. And we noticed through our behavioral health portion of our assessment that Larry was not himself. And he was depressed over the -- or upset over his heart attack, his post-heart attack abilities and loss of abilities. And so we engaged and provided additional supports. But we also made referrals to behavioral health MCO. Behavioral health MCO task we follow up with significantly, not only for services but also for behavioral health referrals to make sure that Larry was involved in his own care and if we have any questions we use motivational training to help engage Larry, listening and restating his concerns so that we can get him the support that he needed through the behavioral health services. Thank you. I'll just hold -- I'll just stop there, Pat, and we can get to any questions, I guess, as we wrap up.
>> Okay. Thank you very much, Mike. And then we will turn to Jen Rogers for ameri health Caritas.
>> Are you able to hear me.
>> Yes. Thank you.

>> I'm here today to present on our process for care coordination between the Community Health Choices managed care organizations and dual eligible special needs plan. Next slide, please. So as Mike stated, we were assigned a scenario. Amerihealth. We will be speaking about a participant and their return home from a skilled nursing facility after a broken hip. We will be talking about our role as the CHCMCO. The role of the BHMCO. We will be taking into consideration the participant's newly identified health needs based on their lifestyle changes, mobility limitations and the possibility of a permanent disability as well as other behavioral health factors. There is a lot of background noise. I don't think it is me.
>> Oh, yes. Chris compliment, could you please self mute.
>> Jenn: Thank you so much. So the service coordinator's responsibilities are outlined here. So we would start with conducting a trigger event comprehensive needs assessment. We would want the service coordinator to facilitate a person-centered service planning meeting. That meeting would include anybody of the participant's choosing. Those responsible for discharge planning at the nursing facility and potentially others from the D-SNP plan. But we will get to that in a second. Really what we're trying to achieve here, who does what? What does the care manager at the D-SNP do. What are the services of the service coordinator. And also we want everyone to pay close attention for the potential for behavioral health needs due to the newly acquired condition in this scenario the broken hip. The service of the service coordinator to update, revise goals, looking at giving the participant choice of new providers for newly -- new services that will need to be put into place by the community. And connecting participants with community based resources as appropriate. Coordinate the care and service delivery preand post-discharge of the nursing facility. Going shoulder shoulder with the participant, leaving the nursing facility, returning home and hopefully setting the participant up for success in the home for sustained community living. Next slide, please.
So during that comprehensive needs assessment, it includes the administration of the patient health questionnaire. We refer to this as the PHQ-9 which is a set of questions really to see if the participant has any unmet behavioral health needs. So the service coordinator is responsible for exploring with the participant any behavioral health concerns they may have. And, again, to take into consideration the lifestyle changes brought on by what could potentially be a permanent disability with a broken or fractured hip. We're asking, is the participant currently connected to the behavioral health services. If the answer to the question is yes, then the service coordinator would assist the participant with setting up an appointment if there is not one already established. Next slide, please. If the answer to that question is no, then it is on the service coordinator to ask the participant if they want to be connected with behavioral health services. We want to be mindful of getting consent from our membership to take action on our behalf. So if the participant does not want to be connected to behavioral health services which is their choice, the service coordinator will be setting up an alert on their calendar to check back with the participant to continue to have that discussion with them to see if action is needed to take

next steps to connect the participant with any BH services. Next slide, please.
So if the participant does not want to be connected with behavioral health services, the -- I'm sorry. Does want to be connected with behavioral health services, the service coordinator will refer the participant to our plan behavioral health coordinator. So the role of the behavioral health coordinator is to contact the appropriate BH managed care organization and the participant's D-SNP if they're enrolled in one. So we know this because of our network and having continuous engagement with the BH-MCOs which are established by counties in Pennsylvania. If the desired behavioral health service is covered by the D-SNP, the coordinator needs to know that and coordinate the service with the established D-SNP. And the D-SNP case manager. If the desired behavioral health service is not covered by the D-SNP then the behavioral health coordinator will work with the identified behavioral health care organization to seek out providers and work with the participants to connect them to those providers and the BH services that are needed. Next slide, please. All right. There we go. Our short and sweet. Hopefully we're within time, Pat. And I'll turn it back to you for any questions.
>> Great. Thanks very much, Jen. And OLTL wants to hold all of the questions to the end. So with that, we will transition right over to the special needs plans to D-SNPs. And I think first up is the group Aetna, United Health Care and UPMC. And I think for Aetna, we have Shoshana and Chris compliment. For United Health Care, we have kia melon and Joyce wail. And for UPMC we have Tara olrich.
>> Good morning. This is Tara.
>> Yes. And you will have about ten minutes, Tara. Okay. Thank you.
>> Tara: Great. Thank you. Good morning. I'm the senior director of medical management at UPMC health plan. As was previously mentioned I have joining me today to present kia, the director at United Health Care and Shoshana who is a senior director at Aetna. We will be talking about care coordination for CHC participants specifically as it relates to an in-patient mental health day and the role of CHC and behavioral health MCOs. Next slide, please.
So on this slide we're providing a high level overview of holistic care management approach. Improving continuity of care through monitoring and supporting a transition during and after is crucial for not only a physical health admission but also that behavioral health one as well. We all know when a participant changes care settings there is always the potential or risk for fragmented care. So that is why it is so important for us to be notifying the CHCMCOs of any in-patient event upon admission and discharge that was previously displayed and conveyed during the presentations just before this. We also notify and collaborate closely with the behavioral health MCOs and the facility where the participant is at to arrange for a lesser level of care when stabilized. This collaboration can be bi-directional though. Meaning either entity can initiate the coordination efforts. And through that coordination and in collaboration, we're able to identify who should be part of that inner disciplinary care team for the participant which helps us in individual IPP

meetings to address member needs, available benefits and any other additional concerns for that participant. Ultimately we're hoping to get a comprehensive assessment completed, especially with the potential of a new diagnosis that may be there. Developing and/or updating a person centered care plan to meet the participant's identified needs. And leveraging expertise and capabilities of community based organizations to ensure the best health outcome possible. So that is kind of like a high-level overview. I'm going to hand it off to Kia from United Health Care that will talk more in depth what occurs after we're able to engage with that participant and CHC behavioral MCOs. So next slide.
>> Kia: Hello. Good morning, everyone. So with care coordination, we like to break it up into two phases of care coordination for our members when they have an in-patient behavioral health stay. So during that in-patient stay, care coordination starts immediately upon admission. Really working with the facility, the discharge planner, the facility utilization reviewer and members if it is appropriate to contact them at that time. To really coordinate care to make sure that they have a safe discharge home. And a safe discharge that will help keep them stable post-discharge as well. And then we have the second phase which is that care coordination and making sure that people have services in place when they are discharged from the in-patient stay. Whether that is a step-down unit, whether that is the group home setting or which ever setting is most appropriate for them.
So in the middle of all of this really what comes front and center is the member. We put the member first, their needs first. And really we spend a large amount of time trying to make sure that we identify their personal goals and connect -- connect them to additional services they may need in order to remain as healthy as possible. So this could include access to healthy foods, financial assistance, access to safe and stable housing. We coordinate with the PCPs and specialists, family supports with the behavioral health MCOs, their providers, pharmacy. The CHCMCO and service care coordinators, community resources, as well as their caregivers. You know, if we have approval from the member to collaborate on their behavioral health needs. But also to wraparound and make sure that their medical needs are also addressed as well. Because the two go hand in hand. So once we engage them in that transition of care program, our -- the behavioral health care manager utilizes internal resources such as social work, pharmacy and nurse case managers to explore and address those special determinants of health and medical health needs. And then also as I mentioned the additional needs are identified. And then the care is coordinated through the behavioral health MCOs and CHCs as needed. Individualized member centered care plan is developed. And with the member consent as I said we reach out to their other support structures. In addition, the behavioral -- the D-SNP behavioral health team ensures that they have access to behavioral health follow-up within up and 30 days of discharge from in-patient care. So the outreach occurs at intervals agreed upon by the behavioral health care manager and the manager post-engagement. And the member's progress is measured by utilizing conditions specific health assessments. One thing that I wanted to stress is care collaboration is bi-directional with behavioral health MCO,

Medicaid MCO and the D-SNP MCOs. We refer frequently collaborate with them. At the same time we do get referrals directly from the behavioral health MCOs to the D-SNP plans to help with coordination of care and from the Medicaid MCOs. So really trying to stream line and collaborate to put that member at the forefront of this. So what we will do is I will transition it over to Shoshana at Aetna. She will tell you a little bit, walk you through a member's story. And this is one example of what all of the health plans do. You know, Aetna will explain their member story. But I think it is representative of the quality care collaboration that all of the health plans do the D-SNP plans. Thank you.
>> Next slide.
>> Shoshana: Good morning. My name is Shoshana. The senior clinical management for our Aetna Medicare program that includes the D-SNP membership. For the sake of time I'm not going to read word for word this entire story but I want to call out a few things. This is a real life member example. This is a member that one of our skilled clinicians worked with post hospital stay. She is a 70-year-old female referred to us after her in-patient mental health hospitalization both in February and May. She was having some psychotic symptoms. Diagnosed with bipolar disorder. Her first admission in February she was voluntarily hospitalized due to a suicide attempt. At the time of the second she had psychotic and religious symptoms. After discharge and actually before she was discharged we completed outreach to make sure that the discharge planning was effective and would meet Christine's needs once back in the community. The clinician outreached her. Within two business days of receiving that notification. We also utilized the Coleman model of transition for all hospital discharge programs. So we have a heavy emphasis on education, making sure that the member understands their diagnosis, their medications, what to look out for in terms of red flags when they need to call their doctor and things like that. We completed a pretty comprehensive behavioral health assessment that is designed to tease out what is going on with the member right then and there. And what type of resources they may need to remain successful in the community. One thick that I wanted to call out we mentioned in the previous slide that we use paired assessments to measure the member's progress through the program. We do that for a couple of reasons. One, it helps inform our clinical approach to how we work with folks. And it gives the member a strong sense of the progress that they're making. They can see how far they have come in a short amount of time. So during this program our clinician administers the health survey and by the end of the program the score had increased to the point where we saw about a 57% improvement in the member's perceived quality of life. She was able to see that as a result of following through, making sure she was with adherent with treatment and discharge plan, she was actually able to improve the overall quality of life. We utilized the depression screen as well. Her initial score was a 5. Her final score was a 2 which is a pretty massive decrease in depression symptoms. So, again, it gives the member a really positive sense of the progress that they have made and it helps us show and demonstrate the effectiveness of our program.

In terms of long-term successes, Christine was able to understand her diagnosis, how her medication helps her to effectively treat and remain stable. She had a very significant decrease in her behavioral health symptoms as we have already discussed. And she is just much more aware of when she needs to seek out help. Speaking with the care manager who worked with this member, she also felt more comfortable asking for that help when she needed it. And that's -- that concludes our story. This, again was a real life example of a Pennsylvania member that we worked with.
>> Great. Thank you very much.
>> Thank you.
>> So now we will transition to the next group which includes for amerihealth, Nancy Becker. For Cigna, Kim and Mary sho. And I apologize if I mispronounce any names. And then for [Indiscernible]
>> Good afternoon. Can you just forward up two slides, please. Okay. So thank you for the introduction. And the three plans amerihealth Caritas, Cigna and HPP were to share about a hospital discharge post heart attack. For the sake of time, if we can move to the next slide. All right. So we wanted to give a high-level overview of what a D-SNP model of care is. Since Marjorie did a fantastic job providing the D-SNP overview, we're just going to touch on a couple things here. There are two sometimes of D-SNP plans, full dual and partial dual. Medicaid and Medicare coverage. And partial duals qualify for Medicaid and get expenses for Medicare premiums and cost sharing. And presented today Cigna is a full dull: There are three types of SNPs that limit membership. Chronic care, dual eligible and institutional special needs plans. And on the call today Cigna who is presenting with us is a chronic care and they have a chronic care diabetes program and ameri health Caritas, are dual and neither of us have an institutional -- have an I-SNP program. As Marjorie stated, the Medicare advantage plans must abide by requirements in addition to the individualized plan approved model of care. The model of care is designed to meet the specific health care needs of dual eligible beneficiaries for providing and coordinating services. This coordination between the D snap and the Medicaid CHC plans is critical so improving outcomes and ensuring the members are receiving the care that they need to keep them healthy, independent and in their homes. And what is really important between Medicare and Medicaid is the CHC offering of the waiver services and the benefits that exceed what Medicare offers. But there is also vice versa that there are offerings that the Medicare plans provide that are supplemental benefits that Medicaid may not. So we really need to be coordinating back and forth between the CHCs and the D snaps. With that, next up will be Nancy Becker from amerihealth who will talk about how we coordinate with the CHCs. Thank you.
>> Thanks, geri. Hi. It is Nancy Becker. The director for population health for the Pennsylvania Medicare plan at ameri health Caritas. What I will be talking about today are the roles and responsibilities of D-SNP plans. And this primarily focuses on those situations in which a member has had a transition from one facility to another or to home. So

admission and discharge information is shared on a daily basis from the D-SNP to the CHC plans. And collaboration and coordination of services with CHC is typically based on a health risk assessment which is actually performed based on the model of care as geri mentioned and we do it annually and -- sorry. Initially and annually and we also do another assessment for each and every transition of care. So when we're notified that a member is admitted or discharged and again we use HI reporting as well to get that information, the D-SNP works with the discharging facility to coordinate the planning needs for that member. And update anything, revise anything that might have already been in place prior to admission. And then we encourage the discharge planner to connect with the CHC service coordinator if there is one established at that point of admission. The transition of care is a reassessment for changes in the condition obviously and the discharge planning needs that may have been altered as a result of the admission. We assist with making the follow-up appointments, obtaining medications, doing medication reconciliations. And again determining what home care needs are required to make the discharge transition more seamless. And if they have -- if the member is already receiving the LTSS waiver services but needs to be re-evaluated we will connect them with the service coordinator. If they're not in place, we will -- we will work that connection as well. With either an aligned or unaligned CHC service coordinator. Next slide.

So there we go. Post discharge pharmacy referrals are also completed. Any -- all of these transition of care members will go through an ICP. So the pharmacist will make any recommendations based on that med rec that comes through post discharge. Any changes will be shared with the CHC plans and service coordinators. Same with behavioral health referrals. The care manager will determine the behavioral health need after the transition. And again someone mentioned earlier about the PHQ9. I believe it was Jen. We do a PHQ9 to determine the needs and refer as needed to the CHC service coordinator for collaboration, support. We in the D-SNP will arrange for outpatient if needed for behavioral health care and consult with the BHMCO if intensive care is required for the member. And in case rounds which is the interdisciplinary care team which I referenced earlier is handled for each -- happens for each member with the transition. And any -- and will also include a CHC service coordinator if the member has one already and can add to that discussion and also for information sharing. And on an ongoing basis there is telephonic information exchange that goes on between the D-SNP care manager and the CHC service coordinators. So if something comes about, even long after the transition discharge, we will connect with the service coordinator if that is what the need is or we will handle it as the D-SNP. So there is an ongoing telephonic information exchange between the plans.

And that's it for me. And I'll hand it over to Kim and Mary for our member scenario.

>> Mary: I'm one of the managers at Cigna for the special needs plan. We created this fictional character John Doe. A 67-year-old male who was admitted to mercy hospital on 12/21 for chest pain with a confirmed nonSTEMI. Hypertension, hyperlipidemia and diabetes. Hospital course was unremarkable. He was discharged on 12/23 to home. The

post discharge course did include a fall. The customer also happens to live alone. Next slide, please. Part of the initial part of communication starts with the ADT that we send out to the MCOs. Our UM care manager also works with the facility social worker and care manager to ensure that the hospital discharge is a safe and appropriate discharge. At the time, the case is then handed off to our medical case management team. Our D-SNP case manager then initiates the verification of the dual status and the MCO partnership so we can start that collaboration. And the preferred method of communication. And right now everybody's preferred method is e-mail via a secure e-mail coordination. Our D snap case manager will outreach the customer. We facilitate health risk assessment and our post discharge assessment. All in the attempt to identify needs barriers gaps in care. At that time we also review medication. We provide education on any current issue or any area that the customer requires education on. And then of course we make the appropriate referral to pharmacy and/or PH. I'll let Kim take the next slide, please.
>> Kim: Thank you. This is Kim. Mary's counter part with Cigna for the D-SNP plans. The case manager is going to outreach to the customer and he or she will learn that the customer did have a fall. And that he could benefit from additional aid hours. So the CM will reach out to the service coordinator with the MCO to assist with that process, the assessment of getting more hours. Case manager also assesses and learns that the members dealing with feelings of sadness and loss of interest in favorite activities after the hospitalization fall and she will collaborate outreach to the member and support. Going to reconcile the medications and work with the pharmacy team to make sure that all of those post-discharge ms have been reconciled with the PCP. Next slide, please.
And the CM is also going to ensure that all follow-up appointments are made and arrange transportation to the appointments through the plan vendor. Case manager also is going to assist with any COVID vaccination appointments, transportation and education as needed. And then from there, the CM and behavioral health team are going to develop that individualized care plan and accepted that over to the MC and request that patient centered care plan in return. Okay. I think we made it.
[Laughter]
>> Thank you.
>> Great.
>> Thank you. Right on time. Okay. And then the last group will consist of Gateway, which has sesly Cleveland. And then Geisinger who has Hoffman and Diana Jackson. And Humana who has Kelly Burke and Kendra. And then Pennsylvania Health and Wellness who has Michelle. I apologize if I mispronounced any names. And you have about ten minutes.
>> Okay. You guys can hear me?
>> Yes. Thank you.
>> Okay. Good morning. Good morning. My name is Kelly Burke. I am an associate director for Humana SNP care management program. Today I'm representing the group as she mentioned that includes Gateway, Geisinger and PHW. And I will be joined later in the

presentation by Kendra denning one of our behavioral health specialists and managers here at Humana. As everyone has mentioned in their presentations today, SNP plans provide coverage for the vulnerable populations juggling multiple chronic conditions and barriers for self care including social determinants of health and other barriers to access of care. So SNPs provide that personalized guidance and resources to help those members get the right care. And information based on their specific conditions or needs. Next slide, please.

Awesome. Thank you. Sorry. I'm just -- my computer is lagging. So I wanted to make sure it was the correct slide. Our question that we were charged with answering surrounded a member who is being discharged from a home from a SNP after a broken hip. Set that stage forker stoury. With I wanted to walk you through a member's personal perspective. Here we see Rachel our 73-year-old member managing CHF, diabetes and moderate depression. She will also be managing that broken hip upon her return home. So upon notification of her impending transition home, we will outreach Rachel and conduct a health risk assessment to identify what specific health management needs Rachel might have. And upon completing that assessment, Rachel would be strike that identified into an LOI appropriate for those concerns and barriers. Based on those concerns and barriers we would work with Rachel to develop a plan of care that would address a multitude of areas including what we felt was imperative from her discharge information, what was identified in our clinical assessment actually on the -- you know, part of that conversation with Rachel, and then also what Rachel herself identified as being important to her to address at the moment. And as we know, sometimes those three things aren't always the same. So making sure that we take into consideration all of those aspects. After this, we would identify the inner disciplinary care member that's would assist Rachel with her care plan needs and engage these members in an internal system or ICT interdisciplinary care team. This could be extended to a physical meeting engage of these members kind of as that need dictates. Sometimes it does and sometimes it doesn't. Once all of these things have been completed and based on Rachel's LOI, we would determine a cadence that best aligns with care management success and Rachel's care plan. Depending on Rachel's needs. It is important to call out that many of these things are really kind of happening simultaneously and or concurrently. It is not always, you know, boom, boom, boom, one after another. Sometimes we have to go back and reassess and reevaluate that care plan. And additionally if there is another acute event or an issue surrounding a transition, we would make additional outreach based on that to engage and assist. These might include an impending admin which would allow us the opportunity to discuss preadmission plan with Rachel. Maybe a post discharge screening related to that in-patient stay. And assisting with the ever important but often difficult to navigate for our members is that post-transition doctor's appointments. We can move to the next slide, please.

Awesome. Thank you. And so we've kind of taken -- so we have walked through what the typical movement through the internal processes might look like for Rachel. It is important

to point out if we identified Rachel needing other services such as waiver support, we could refer for assessment of qualification for Medicaid service availability. And our highly skilled clinicians are really educated on these potential benefits and have been empowered to utilize their clinical judgment to engage services where appropriate. The recently implemented referral worksheet has really been a perfect addition to our ever increasing collaboration tools. And the coordination of benefits for Rachel is really an integral part of how we work to mitigate that risk for her and our other members. So that bottom box calls out the collaboration through our interdisciplinary care team which is utilized internally and externally as I mentioned. And if we move to the next slide, I will highlight a couple potential specific interventions for success for members like Rachel. Thank you. And so, you know, that coordination of benefits is something that we take very seriously and our clinicians have that ability to do. That's why we included it as the first bullet point there. It truly is a differentiated for our snp members. I mentioned the expertise and part of that is the utilization of the DSBP and leveraging that tool. So we have access to dieticians and pharmacists internally to Henry deuce the access barriers to their specific catalog of clinical knowledge as well. Sometimes not immediately recognized as an intervention for success is the regionalization of care management teams. For Humana what that looks like is this intervention is one where our clinicians can become subject matter experts in their member's care and potential interventions as well as really digging in to build those relationships to increase the likelihood of success. It is not just some random individual who is calling them, trying to, you know, set up these different things. This is somebody who Rachel has talked to before. It is somebody that she will talk to again. Somebody who knows her. Has built this relationship with her. Knows her needs. Who has had those conversations with her. And knows the potential resources that she could access. But let's turn our focus back to Rachel specifically. And if you recall, Rachel is also working to manage her depression. And this remains a large concern for once she returns and out of the direct eye of the different facilities that she has been in since this point. So we can move to the next slide. Please. And I'm going to turn it over to Kendra who is going to share some information regarding our behavioral health coordination that would be addressing this need for Rachel.

>> Thank you, Kelly. Just a pulse check, you can hear me okay?

>> We got you.

>> Beautiful. So as Kelly mentioned we are an internal ICP partner here at Humana with behavioral health coordination and consultation. So what happens is our SNP partners will complete their assessments and identified that Rachel did in fact have behavioral health concerns. And what they do is loop us in as an ICP participant. What we do for behavioral health consultation coordination is really just meeting the member where they are. We complete a thorough risk assessment and provide education. We work to resolve any access to care concerns. Obviously if risk is present, we will complete any kind of safety planning including contact with local emergency services if that is necessary. And our goal

is short term acute triage essentially. We will be focusing on educating sign symptoms short term resolutions until we can get a member face-to-face with a provider or telehealth provider. We are here to educate, help the member understand what is going on, identify what their concerns are. We complete intensive assessment to make sure that we're really understanding the full picture. And then we're always coordinating back with our ICT partners. We work to make sure that we're getting our members connected like I said face-to-face or telehealth as appropriate, especially during this pandemic. And then we are available during the hours of 8:00 to 6:00 eastern. We are educating on any kind of 24-hour crisis management. We work with our members as little or as often as needed to resolve the behavioral health concerns that they are experiencing. So we will call them sometimes multiple times a day, a couple times a week. It varies member to member to make sure that they're getting connected with the services this he need. We can move to the next slide.
>> I was going to say that actually brings us to the end of our particular slides. So I appreciate you sharing that information. Kendra. On our internal processes. And also wanted to call out too that, you know, for our BH coordination, we do have a whole array of clinicians but we also have the nonclinical support roles. Really a whole team to help assist the member with navigating and receiving that access to care. So that brings us to the end of our portion. And we welcome any questions later on regarding this or anything with Rachel. So thank you.
>> Okay. Great. Thank you, Kelly. So with that before we turn to questions, I did want to let David, Mike, jermayn and Ellen know that we did have Neil Brady and Juanita gray join us. And then I think Cindy. Cindy has the first question for committee members.
>> Cindy: Thank you so much. I appreciate the comprehensive presentation. I know there is a lot that goes into transition and care settings and the handoff communication. So I was curious if there was opportunities for a provider that has been chosen by the participant if they would have an opportunity to be invited to attend should something come up as a high risk category. I'm just thinking, you know, of my own personal experiences lately with some elder care relatives where they had a high risk for falls when transferring home from a care setting. And we needed to get the emergency response system in the home. And just thinking, you know, in those situations where you have these very high risk identified issues and participants have chosen a provider to address those, would there be opportunities for those providers to come to some type of meeting if there was a high risk conference meeting or something like that as the client was transitioning back home.
>> This is Kelly Burke from Humana. Is it okay if I take that question.
>> Sure.
>> Kelly: Awesome. I think I can probably speak for all of us when I say absolutely. That we would have that opportunity to engage anyone in those type of high risk situations. We are always open to arranging those type of meetings, bringing that collaboration from all of those individuals both internal and external. At this point we don't have any necessarily

regular -- regularly scheduled meetings at least for us. But really do those on a case by case basis. Depending on what those member's needs are. But absolutely.
>> Okay. Thanks, Kelly. Do any of the other D-SNPs or anyone have anything that they want to add to what Kelly provided?
>> Nancy: It is Nancy Becker from amerihealth. I would add that first as a requirement if the member does ask to have a provider join those round meetings, we are required to do that. Arrange for them to -- we will schedule with them accordingly and get them into that meeting so they can provide that input to the medical director and other disciplines in the organization.
>> Okay. Thanks, Nancy. All right. Do any other committee members have questions for the CHC-MCOs or any of the D-SNPs.
>> Yeah. This is Mike grier speaking. I was wondering in reference to the behavioral health, you talked about short term crisis resolution type of thing. What happens when the individual is needing long-term behavioral health support, maybe rehabilitation support, not from a physical need but from almost like a behavioral health rehabilitation?
>> Kendra: For Humana, I will speak on behalf of Humana. We will evaluate is available to the member. That could be the MCOs to identify a boots on the ground management program that will support the members long-term to make sure that their behavioral health needs rock addressed accordingly. That is part of our assessment. We don't necessarily never speak to the member again. Maybe we attempt to get them connected with outpatient. Maybe routine counseling. And they are working with their RCP -- SNP partners and let them know it is not effective. They will loop us back in and we will coordinate that care to make sure that they get connected with that appropriate level. It is a lot of evaluation and conversation and meeting the member where they are. But we will make sure that we get them connected with the appropriate supports.
>> MICHAEL GRIER: Thank you.
>> All right. Any other D-SNPs want to -- or CHC-MCOs want to add anything else.
>> This is Shoshana with Aetna. Part of our transition of care program is also an ongoing assessment of what a person's long-term behavioral health needs might be. We have a track that follows that program called our complex case management program that can last up to an additional six months and runs in coordination with the coordinated program as well. If we're not actively working with a member on a behavioral health care plan we also provide consultation services to the primary case managers just to make sure that the BH needs are kept in the forefront, that the needs are addressed and resources are provided and the like. We're also heavily involved in our ICT conferences as well.
>> Okay. Thanks, Shoshanna. Anyone else? Okay. Any other committee members have questions? No? Okay. So then I do have some questions from audience. So from Janice [Indiscernible] for the CHCMCOs. [Indiscernible] and I believe we will start with Mike for UPMC.
>> Sorry about that, Pat. I was looking for the mute button. Unmute button, I should say.

The ADT we receive a number of different feeds. So including the admissions discharge transfer when we're not aligned can come to us as secondary payor. We also get hospital pre-- which I didn't mention. I was trying to get all of the notifications we get in there. We get D-SNP node notification on admission as well for participant that's we share care with. That may be a little delayed. It is not as immediate. We also get information when there is prior authorization for services on occasions at hospitals. But usually as a secondary payor, we're not getting those types of requests immediately. So it really varies where we get the information from. And it is available though in other places when we don't get them through the ADT.
>> Okay. Jen, how about for amerihealth?
>> So Mike pretty much covered how it is for us too, Pat. ADT admissions discharge transfer lists. We also get notifications of behavioral health admissions for some of the care plans. But we get those feeds daily. We have teams of folks who are looking at those reports and disseminating that information out to the service coordinators so we can act upon the information and get to work addressing needs and coordination with the participants and other plan -- as we talked about other D-SNPs.
>> And Jen, can you remind me what does the acronym ADT stand for?
>> Admission discharge transfer.
>> Okay. Thank you. Jodi and Heather, anything to add from the PHW perspective? I guess not. Okay. So then the next question is from Pam hour. And participants are still experiencing barriers between Medicare and Medicaid to get their needs met. There is a battle between Medicaid and Medicare on who pays for durable medical equipment. Where does the coordination come into play for all CHC participants? Who is working on behalf of participants to get rid of these barriers? And why don't we -- because we have such a large number of individuals involved, I guess maybe we can first ask the very first group of the D-SNP plans if someone can perhaps speak for that group? And that would be Aetna United Health Care and UPMC. And maybe Mike since UPMC is in that first group maybe then you can also as part of that speak to how that coordination happens between on your side on the CHC side.
>> Mike: Pat, this is a question of who pays for what.
>> Right.
>> Mike Smith: And I think that is the gist of it for Pam. And Pam, when you're working with participants who work with UPMC, I always encourage you to encourage them to work with their service coordinator to Henry solve these kind of issues as well as our -- if it is somebody who is just well dual eligible individual. So if somebody has Medicare and Medicaid and not long-term services and supports. Again we have telephonic care managers who support those folks to Henry solve those. So, you know, really what we're doing in a lot of these cases is looking for a denial from the -- of the DME. And then we can move forward with taking care of the response to the need typically if it is a covered benefit within LTSS within the program. So I -- you know, the bigger problem here is the -- when we

get into something that is really a bigger ticket or larger item and we need to have -- make sure that the Medicare benefit is -- denial is appropriate. And really it then becomes sort of a discussion, a conversation between the D-SNPs, the Medicare advantage plans if they're available. That is somebody not at the table today. Working through those challenges. In terms of coordination of benefits. Certainly that is -- we work with sometimes in the DME space even providers are very knowledgeable in this space and we work closely with them to sort of loop in all of the parties necessary to try and get this resolved. So it is a broader issue. It is one that, you know, would also benefit from some probably legislative changes. But that is sort of my long answer to a difficult question. It is not always straightforward.
>> Yeah. I think -- so Pam was relaying part of the challenge is from the participant's perspective, it seems like on the Medicare side -- on the Medicaid side, they're wanting the Medicare denial. And then on the D-SNP side, it is something that they -- it just -- as you said, it takes so long to try to get through that process. And in the meantime you have the participant who is waiting for, you know, whatever the piece of DME might be. And I don't know if anyone has -- in your coordination discussion, any helpful hints of how to help someone navigate through that process.
>> Chris compliment: This is Chris compliment with Aetna and D-SNP. I think what is so critical here is the early identification of who is who. Right. So we work very hard to understand who our contacts are with the Medicaid MCOs. So that if something is not covered or is denied, we're in touch with them right away to try to see if they will cover it. And then there are times that something is not covered by anyone. We have to have our social workers get involved to try to find other resources. But that communication and collaboration early to establish those communication lines is so important. And we also have advocates who are specifically tasked with watching denials and appeals so that we can see very early on where a denial has occurred and we can get that process started right away to collaborate with Medicaid to see if it can be covered there.
>> Mike Smith: These are good additional points. I want to throw in that we have regular -- Pam, we have regular coordinated meetings with all of the D-SNPs to go over this type of thing. It is more challenging when you're a fee-for-service or a traditional red white blue card carrier and trying to get these denials processed.
>> This is Tara from UPMC. I want to add that's why it is crucial and important for that collaboration between the D-SNPs and the MCOs to be occurring. And I [Indiscernible] it is about early identification and getting on it as soon as possible so we can potentially look at, you know, what options are out there. Do we need to pull in a medical director for that particular request? And does it get transferred then? You know, it is denied and we're looking at the CHC to help out with facilitating that.
>> Okay.
>> Hello. This is Kia from United Health Care as well. I'm just, you know our plan also has [Indiscernible] which help navigate for all of our members. Decent members help navigate these systems. So if the member has an issue reaching out to our care navigator in their

one to one pair, they can help them navigate that system and we can escalate as appropriate and I concur with everyone else. Thank you.
>> Okay. The next question I have is from Joseph. He is wondering if the D-SNPs can identify your health coordinator contact. He is with one of the behavioral health managed care plans. And I think that is another linkage that needs to happen going back to -- I'm trying to remember if it was -- if Mike asked the question about the need for long-term -- longer term behavioral health support. But in addition to the CHC-MCOs you have the plans on the Medicaid side.
>> Hi there. This is Heather.
>> Yes.
>> Heather Clark from PHW. There is in circulation a behavioral healthysa on contact sheet that is currently in circulation that has the contact information for each liaison. We could leverage that document to have -- if there is a primary contact on the D-SNP MCO side that we can add that to the list so it is all inclusive.
>> That sounds like a great idea. Maybe I guess, you know, Marjorie, maybe that is something that you can help coordinate on the D-SNP side.
>> Yeah. I can take that on if you want to connect with me off line. We can collect that information and add it to the existing file that is currently in circulation.
>> MARJORIE FAISH: Yeah. Are you thinking about the -- like one of the documents that like Duncan Bruce or somebody like that put together for the CHC coordinating.
>> Yes. That is exactly the document that I'm referencing. It is a really nice document. It has each CHC and BH-MCO main point of contact. It also has a color-coded map by county of Pennsylvania that indicates which BMCO belongs to that county. I think that would really enhance that document to make sure that all bases are covered and there is a person from each MCO that someone can turn to if they run into any barriers.
>> Great. The next -- the next question is from Janice minor. Can the D-SNP speak to the challenge of finding behavioral health providers that are credentialed by both Medicare and Medicaid?
>> Chris compliment: This is Chris from Aetna. I'm not on the behavioral health side but I can tell you the biggest challenge for us is finding providers that are local and also bilingual. We have a lot of Spanish membership. And it is very, very hard to find Spanish-speaking providers. Or any providers really. Shoshana I'm sure will back me up on that.
>> Yeah. No. I definitely would back you up on that. And in terms of accessibility for behavioral health providers, it is incredibly difficult. One of the things that my team runs into the most is members -- provider who's are credentialed with the Medicare portion but not the Medicaid portion but planning to take our Medicare primary D-SNP members. It is a work in progress. To be honest speaking with other MCOs and the like, it is not an uncommon problem. It needs to be looked at across the board.
>> This is Amy. I concur with what was just said regarding the challenges with getting providers who accept both Medicare and Medicaid. I've been in the field for many, many

years now and this has been an issue since I have been in the field to be able -- for a variety of reasons. You know, reimbursement, you know, credentialing, challenges with Medicare. There are quite a few barriers that are put in place by organizations or overseeing governing bodies that are really difficult to work through.
>> Agreed. This is Nancy from amerihealth. We have the same issues across the board. Location. There just doesn't seem to be many BH providers that we can refer to. And, you know, a lot of folks who don't even -- aren't credentialed with one or both plans. We have an ongoing problem with it as well.
>> And I'll just third or fourth that. At Humana, we run into the same. I think it is the consensus across the board. Cannot find those providers that work with both.
>> That seems to be the resounding answer. And then just a follow-up question that is also from Janice for the D-SNPs. Do you all -- do you have your behavioral health services as part of your -- your plan or is it something that you're subcontracting out and using another vendor?
>> Geri: Hi. This is geri for HPP. We contract with the behavioral health vendor magelin. We contract that out. Others have it in house. I will let them speak to it.
>> Okay. Maybe we can go down alphabetically. For Aetna, they're in house. How about for amerihealth.
>> In house.
>> In house. Okay. Cigna.
>> They have their own behavioral health team. Inhouse.
>> Okay. How about Gateway?
>> In house as well.
>> Okay. Geisinger.
>> In house.
>> Okay. We talked about health partners plus. Humana.
>> In house.
>> Okay. Pennsylvania Health and Wellness?
>> In house.
>> Okay. United Health Care.
>> In house.
>> Okay. And UPMC.
>> In house.
>> Okay. Thank you. And then I think the next question that I have is how -- how are the D-SNPs assisting members when they have housing challenges? Such as homelessness.
>> Chris: This is Chris from Aetna. I can speak to that. We have social workers available to all of our members. They're located in the county where our members live. And they have not been in the field recently because of COVID. But they have all been going back into the field within the next few months. They are really the experts in knowing what the resources are. There's ways of researching and locating new resources. Certainly referring to housing.

Because it is a pretty significant need. But that's how we address it.
>> Thanks, Chris. Anyone else?
>> Hi. This is Joyce from united. And I would echo what Aetna has said. We have case managers. They have not been in the field of late because of the COVID. But they will be returning to the field. And those are folks who know the local and current resources in the geography. And they assist with the housing issues as well.
>> Okay. Anyone else?
>> Hi. This is Mary from Cigna. Our case managers reach out to the community resources and also use the fine health which formally is known as and Bertha. We work with our case managers to assist with needs.
>> Yeah. Same with ameri health. We use [Indiscernible] as well. And provide resources. I have a whole host of folks who have great resources. And we main the listings to help members find whatever they may need, including housing.
>> Yeah. And I will ditto that. This is HPP. We use [Indiscernible] and all of the community resources. Which is challenging to find housing.
>> A very, very challenging and I think a big part of it is the long, long wait for public housing. So that is kind of a systemic issue.
>> Hi. This is Chelsea with Gateway. We also have housing -- housing coordinators dedicated to helping our members finding housing. And, again, just echoing everyone. They are the experts in those specific areas and connecting our members to their needs.
>> Hey there. Heather from CHW. We also utelize Pam Bertha and we have care manager who's are available to help find housing as well as a housing specialist on staff who is dedicate today asitting with these housing issues.
>> Hi. Amy. We are also using a product in addition to having a robust community care management team that is out in homes and communities and we have a mix of community health workers. Those with the social work background that are able to build relationships with community resources and get them connected to what is available for housing which as others noted, there are extensive barriers in place there with waiting lists and lack of availability.
>> Okay. Great. Thank you. And then there was a suggestion from Lynn Cooper about -- based on all of your responses about the challenges with the availability of behavioral health providers, especially those that take Medicare and Medicaid. And, you know, maybe Mike and David, maybe this is something that the committee wants to take back to consider is forming some type of task force that would work on the issue of provider limitations. And Jamie, I don't know about your thoughts around this either. Since it really does cross over to the behavioral health manage care plans.
>> JAMIE BUCHENAUER: So pat, I think that is something that we can take back. We have a group that meets quarterly already to talk about behavioral health issues. Maybe we just need to widen the invite list.
>> MICHAEL GRIER: I agree.

>> Okay. So with that, I -- it is really the questions that I have related to the D-SNP coordination. So I guess do we want to transition to additional public comment and then circle back? I have some remaining questions from the OLTL update after any additional public comments.
>> MICHAEL GRIER: That sounds good, Pat.
>> Okay. All right. So do any of the audience members -- and, again, I have some remaining questions that we will ask. Are there any other public comments that anyone wants to make? And I guess while I'm waiting, I'll go ahead and start with some of the questions related to -- Jamie said the first one is from Dana shut. Where do we send questions if our units of service are incorrect on the spreadsheet calculating the additional payment? I did not receive a letter but we are on the spreadsheet.
>> JAMIE BUCHENAUER: So the best thing to advise them right now, there is a -- there was a e-mail address on the letters that you can send the attestation to. If you could send questions there, we can get them to the right point of contact. I don't know what the e-mail address is off the top of my head. I can get it and post it.
>> Yep. And I think -- I can probably provide additional information just because we had received a question in researching it. So what was used in [Indiscernible] data that was submitted through fee-for-service. So that would have been on the OBRA [Indiscernible] data came in from the CHCMCOs. And there might be slight discrepancies regarding calculations. So sometimes it may have been billed under -- if you have multiple service locations, they may have information -- the information may not always be coming through at the service level location or the encounter data. So meaning that data may combine all of your service locations if you see between multiple service locations. And then the data was pulled using the dates of service to pull the pay date detail. So you may see a couple of fluctuations because of the timing of some of those payments. And I think in general OLTL has -- had confidence on the accuracy of the calculations. So you could send, if you have very large vair apps and you're concerned about those, you could send those into the RA account that we can post. But I think, again, OLTL was -- pulled the data that they had available and had confidence in that data. And if you think you're being underpaid, you definitely may want to have those researched.
Okay. The next question came from Pam hour. So does that mean that providers need to give the 8% directly to the direct care workers when the rate increased?
>> JAMIE BUCHENAUER: Pat, it sounded like this question was asked before. And I'm hoping I'm giving the same answer. So the requirement is that the CHCMCOs pass along at least the OBRA waiver rates to the agencies. The agencies obviously set their rates with their workers independently. We are encouraging them to pass along as much of the rate increase as they can. We've been told by many agencies that obviously they need all of the increase to keep and retain their workers and they're going to use it all for rates. But we don't set those workers' wages and there was no way that we could require it in any kind of agreement. Obviously the one law that sets minimum wage, and we have been trying to

increase that. Unfortunately we have been unsuccessful to date.
>> Okay. Thank you. There was a question. Are strengthening the workforce payments to Commonwealth employers in the CHC self directed program? If so do they use the provider attestation form.
>> JAMIE BUCHENAUER: So yes the strengthening the workforce payments will be available to the participant directed direct care workers. And PPL is in the midst of receiving those funds and administering them to the workers. They are not required to submit an attestation. Obviously because it is going directly to the work.
>> And then Pam hour had a suggestion. She would suggest OLTL talk with the consumer workforce council on their recommendations on a direct care worker registry. Jamie, can you provide some comment similar to what you did at LTSS last month on funding for disability employment for LTSS consumers dug their ARPA presentation, the office of developmental programs, 23 million being utilized greater disability employment opportunities for ODP consumers. Can you comment on what OLTL is doing here. Provider payments and/or other incentives to increase disability employment for consumers, CHC and OBER waivers applicable under the PH department of human services federal ARPA plan. Thanks.
>> JAMIE BUCHENAUER: So I think I answered this question. So our ARPA plan for the office of long-term living didn't include any employment initiatives specifically. However I think there is an opportunity like I said for providers offering employment services to apply for -- and we haven't released it yet. The home and community based improving and strengthening -- home and community based services grants. So we will take that back and we would love providers to think about how they can improve and strengthen employment services and how they would use grant funds to do so.
>> The next question is also from Pam and maybe Abby can answer this for you, Jamie. What are the benchmark numbers for nursing home transition?
>> Abby: Jamie, have we published what the benchmarks will be for pay for performance yet.
>> JAMIE BUCHENAUER: Abby, I didn't recall that we had. So last year the last calendar year I said that it was approximate hundred nursing -- 300 nursing homes per plan. We were working to establish the benchmarks for 2022.
>> Okay. Thank you. The next question is Roy Cooper was checking in to see about I think there have been previous requests around behavior health data. The number of members receiving behavioral health assessments. The number of referrals made and specific services provided by the CHC and behavioral health managed care plans. I don't know if anyone has an update on that.
>> JAMIE BUCHENAUER: So pat, I don't have an update on that. I'm not sure if anyone else in the office of long-term living does have an update on that. We can take that back as a -- as an item. You know, I will say that, you know, we've been working in the office of long-term living on I want to say accessing all of the data that we have. And so that does -- does

remain a challenge to us still.
>> Okay. The next question is from Malcolm Kerry. My question is, what are the CHC-MCOs process for getting -- providing assistance and benefits counseling providers involved? And maybe Malcolm could you maybe clarify -- I'm not sure I understand the question. I'm sorry. I should have sent it back to you before I read it. But I will go to your next question, if you can clarify that one for me. Malcolm was also asking and this would be for Mike, Jen and maybe Anna. How are the CHC-MCOs coordinating with the centers for independent living? And I guess Jen, I think we went to Mike first last time. So if you want to provide the first answer.
>> Jen: Sure, Pat. Can you hear me.
>> Yes.
>> Jen: Perfect. Coordinating with centers for independent living I think overarching -- we rely on this for independent living as a source of resources for our participants, especially our peer support and other skill development. It is department to independent living. I know we're making referrals and suggestions all the time to our CIL partners. Centers for independent living sites. The acronym. So they can take advantage of the wide array of services available through the CILs. If there are folks on the line from the CILs. I know Mike we're in -- for our service coordination teams as well to take advantage of the expertise that they have have to offer.
>> Okay. Ann?
>> Yeah. Hey, Pat. Happy new year to you. We work with our CILs very closely. Transition for individuals coming out of the nursing facilities is a key partnership that we have with our centers for independent living. They're also helping us going into 2022 with a really strong initiative towards educating and supporting individuals to get vaccinated and get their booster. So that is an area that we have recently worked with our centers for independent living to help us accomplish. And then we have a training contract with the Pennsylvania center for independent living which is shared across the entire state to educate over 500 service coordinators every year on the philosophy of independent living and then the values around transition out of nursing home facilities and principles around independence and choice. So that's really where we are at in addition to what Jen said. PHW works closely with our centers for independent living.
>> Okay. Mike, anything to add?
>> Mike Smith: Not too much. A little differentiation. We're at the same place looking at the training opportunities with the CILs. We work with our nursing home transition activities formally and then informally when there is, you know, transition activities that are related to the non-- you know, the broader CIL networks, centers for independent living network that we work with them as well on that. And peer support is a great opportunity and skill -- skills training is another one that always are really beneficial for participants. So just a little tweaks between the two. But we all work with them. And are familiar with them. And consider them to be a valuable community resource that we work together with.

>> Okay. Thanks. The next question is from Tom Nelson. And will support coordination organizations see any of the ARPA funding? And I guess -- go ahead, Jamie.
>> JAMIE BUCHENAUER: Oh, no. I was going to try and answer that question. And then if OLTL, other staff have any suggestions. So, you know, I guess my answer is I'm not sure. So if -- I mean potentially a -- potentially a service coordination entity could apply for a home and community based services grant. And so that would be up to them to apply for those funds to improve home and community based services and they potentially could get some ARPA dollars.
>> Okay. Any -- anyone want to add anything to that? Okay. The next question is from Amy loenstein. I understand the nursing home transition benchmark plans have been been established for 2022. Will the benchmarks be higher than they were in 2021?
>> JAMIE BUCHENAUER: So Amy, I think while I haven't seen the suggestions yet, we're working on them in the office of long-term living. I assume, yes, they will be higher.
>> Okay. Circling back to Malcolm's question. He did clarify that yes, the question for the CHC-MCOs and Anna, I think you would be up this time, is how are you assisting participants with applying for the Social Security benefits? What counseling are you providing which is actually a waiver service?
>> Anna: Yeah. That is a great question. We have been doing a lot of training with our service coordinators. And we actually have written in to -- because we outsource our service coordination through an agreement with 10 providers across the state. They have language within their agreement that this is a responsibility that they have and we're tracking the data to identify how many individuals that each service coordination agency did support in that initiative so that we can hit some KPIs or performance metrics that we have established for ensuring that individuals that need that assistance are given that help to access whatever waiver benefits including employment benefits that are available. But we have written certain targets around benefits counseling for 2022 to ensure that is getting done.
>> Okay. Mike, how about for UPMC?
>> Mike Smith: Yes. Sorry about that. Yes, we also have employment performance goals that we set as well. In terms of benefits counseling, specifically, our employment concierge which I was trying to allude to in our presentation today are really engaged as an additional support to our service coordination team to help connect those with difficulty with counseling are having concerns that the service coordinator is really complex. The service coordinator has that concierge service available to them through our program. This is our staff. Who will work with them around benefits counseling and make sure that they're connected with the public resources that are available out there as well. So not only do they have training on this and background and goals for employment with our program but we also have additional specialized staff that we have targeted to support us with engaging the benefits counseling piece of this too.
>> Okay. And Jen.

>> Jen: Not unlike the others who responded, I just want to clarify that if we're talking about Medicare enrollment or Medicare education, we do lean on the Pennsylvania apprise program or the Pennsylvania Medicare education decision insight program. So our coordinators whether internal or external use that as a resource in those discussions with participants. And the way I heard the question was specific to helping folks enroll in parts of Medicare. But to speak to benefits counseling, we have our service coordinators trained so they are confident in explaining the service to participants. And it is stated as a goal on a person centered service plan. We have targeted outreach specific to, hey, let's start with benefits counseling. See if you want to take part in having that service provided by one of our employment providers. And then we also explore if the participant is interested in taking that kind of first step in the employment benefits counseling then we move to the other services that are available under the waiver. So our goal is to not overwhelm folks but to have concentrated conversations when documented that they do have a goal of engaging in competitive and integrated employment.
>> Okay. Thanks. The next question that I have is from rose. I'm not clear on the answer about the ARPA grant application. Could the D-SNPs like Aetna apply for this and use it to pay providers to improve community home based services for our members? If so what would the grant application entail? Is there anyone specific to reach out to?
>> JAMIE BUCHENAUER: So I think at this time we didn't envision allowing the CHCMCOs or the D-SNPs plan or anyone who was not a home based community based provider to apply for those ARPA funds. That's not to say that a D-SNP couldn't work with some of the home and community based providers on maybe an idea that would be allowable for ARPA grant funds. But it would be the home and community based provider who was the applicant.
>> Okay. And then Malcolm Kerry sent a follow-up. That said, to whom would one speak to become a Social Security and all benefit counseling from our CIL in bucks county? And I don't know, Mike, Jen, Anna, if any of you.
>> Jen: Pat, can you repeat the question.
>> Yeah. That said -- and actually I'm not sure that I'm understanding exactly what you're asking, Malcolm. So how about if I try to unmute you so you can ask directly. You should be unmuted, Malcolm.
>> Yeah. My question is if one wanted to become a provider as a benefit counselor, ie, Social Security because it is a complex with benefits and stuff, who would one speak to become that provider, the MCOs and that kind of stuff.
>> So pat I think that is a great question. And I think I can speak on behalf of all of the plans. We of course welcome the opportunity to become a network. The first step, Malcolm, provider application with OLTL as a provider for benefits counseling and any other services that align with the CHC waiver offering. And then from there, it would go to a contacting -- you would be meeting with our provider network team to become involved as a provider. That is an overall kind of summary of the steps involved. If you're interested in providing benefits counseling for CHC participants.

>> Okay. So you start with the office of long-term living. And then proceed from there to you guys? It is not a direct to you all?
>> Jen: Yeah. Pat, if you can give Malcolm my e-mail, I can give him the steps. It is kind of hard over Zoom.
>> Yes. I will connect you by e-mail, Jen, with Malcolm. I think it can be confusing, Malcolm. But you do have to be enrolled as a Medicaid provider to be able to contract them with the MCOs. But Jen can lay all of that out for you.
>> Right. We did that with the service coordination prior to the MCO. So we do have that. I was just talking about now for benefit counseling. How is that [Indiscernible] thank you.
>> Yeah. It would be -- yep. Okay. Any other questions from the audience? That is everything that I have as of right now. I don't know if any committee members have any other questions?
>> MICHAEL GRIER: Pat, this is Mike. Jamie, are you going to kind of lay out to the board members like what you're envisioning as the priorities so we can [Indiscernible]?
>> JAMIE BUCHENAUER: Mike, perfect timing. I think I only caught like every other word that you were saying. But I was going to break in as long as we have two minutes left. It was my final slide that -- of our presentation for the office of long-term living today. So with the -- with Community Health Choices being implemented the office of long-term living is welcoming the sub committee to pick a few key area that's they want to focus on to make policy development and program recommendations for the MAC to consider. And so we talked about this. I think the MAC actually is working on doing this now. The medical assistance advisory committee. They're working on doing this now and they're asking all of the sub committees to do the same. And so at the next meeting, I think it is very early in February, I cannot remember the first date. I'm looking if it is on the agenda. The secretary is going to come. She plans on being and presenting at the MLTSS at 10:30 to talk about her priorities for the coming year. And so I think that will be a really good segue to -- for the committee then to talk about their priorities for the coming year. And what recommendations you would like to make to the MACC and to the office of long-term living. And so with that said, Mike, I think it is helpful. Obviously if the OLTL presents our priorities as well.
>> MICHAEL GRIER: Thank you, Jamie. I just want to comment to the committee members, you will be receiving an e-mail from David and I just to gather data from you guys. So know that something will be coming your way.
>> Okay. I don't have any other questions from the audience, Mike. And it doesn't sound like any committee members do. So do you want to adjourn?
>> MICHAEL GRIER: Yeah. I would say thank you, everyone, for their participation today. And I look forward to working with you this year. As of now, the meeting is adjourned. Thanks.
>> Thank you.