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Date: 04/05/2022

Event: Managed Long-Term Services and Supports Meeting

Testing.
>> Testing. .
>> DAVID JOHNSON: Mike, this is David. Should I get started with subcommittee attendance?
>> MICHAEL GRIER: David, let's go ahead and get started. At 10:00 so let's go ahead and get started .
>> DAVID JOHNSON: Good morning everyone, this is David Johnson. I'll take subcommittee attendance here . Is Alan Crombie on this morning? Cindy Seeley?
>> I'm here good morning, thank you .
>> DAVID JOHNSON: Good morning. Neil Brady?
>> SPEAKER: Good morning David, good morning everyone I am here .
>> DAVID JOHNSON: Gail - -?
>> Good morning .
>> DAVID JOHNSON: Good morning. German Parodi ?
>> Good morning .
>> Good morning.
>> I see him in attendance, he might be muted .
>> DAVID JOHNSON: Juanita Gray ? Kyle closer. Lloyd . Good morning. Matthew Seeley? Michael Grier, her you were present.
>> MICHAEL GRIER: Here .
>> DAVID JOHNSON: Monica Vaccaro ? Patricia - -?
>> SPEAKER: Good morning everyone .
>> DAVID JOHNSON: Good morning. Richard dwellings is absent, Sherry Welch? Lastly Tanya - - . Okay, Mike, that concludes attendance.
>> MICHAEL GRIER: Thank you David. Some housekeeping tips to go over, please keep your language professional . This meeting is being conducted as a webinar with remote streaming. All webinar participants except the committee members and presenters will be in listen only mode during the webinar . While the committee members and presenters will be able to speak during the webinar, we ask that you use the mute feature when you are not speaking. This will help minimize background noise and improve the sound quality of the webinar. We asked the participants to please submit your questions and comments into the chat box located on the go to webinar pop-up window on the right-hand side of your computer screen. If you have a question or comment, type into the text box and press send. Hold all questions and comments to 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 . The meeting transcripts and meeting documents are posted on the listserv under the MLTSS meeting minutes. These documents are normally posted in a few days of receiving the transcripts . Captioning and audio recording , the captioner is documenting the discussion remotely so it is very important for people to state their name or to include their name in the chat box and speak slowly and clearly , otherwise the capture may not be able to capture the conversation. This meeting is also being audiorecorded .

The meeting is scheduled until 1:00 p.m. to comply with identical agreements , we will end promptly at that time. If you have questions or comments that were not heard, please send your questions and comments the resource account listed on the agenda. Public comments will be taken at the end of each presentation instead of during the presentation. It will be an additional period at the end the meeting for additional public comments to be entered into the chat box. The 2022 MLTSS meeting dates are available on the Department of human services website . That is the housekeeping point. Petitioner, we welcome you to our committee and I will turn it over to Jamie .
>> SPEAKER: Thank you so much.
>> MICHAEL GRIER: Paula, is she ready?
>> SPEAKER: I don't see Jamie on here right now .
>> SPEAKER: While you are looking for Jamie, this is Matt Seeley I just joined .
>> MICHAEL GRIER: Thanks Matt for letting us know.
>> SPEAKER: I don't see Jamie at this point so I will go to the first agenda item. The order I'm going to go on is AmeriHealth , pH W and UMPC .
>> MICHAEL GRIER: That sounds good, when Jamie comes on maybe we can take a pause because I know she had some items she wanted to go over so maybe we can do that. We will go ahead with the overview of the CHC MCO and AmeriHealth you are first up, thank you.
>> SPEAKER: Good morning, can you hear me? Okay thank you. I am the director of long-term service and supports clinical and home and community based services of AmeriHealth case staff. Today I presented using information on the complex care unit. If we could go to the next slide please. It appears we might be having some difficulty advancing the slides . If it's okay with the committee I think you were talking to the presentation to the technical difficulties .
>> MICHAEL GRIER: While you go ahead and do that . We will try in the background to get it fixed .
>> SPEAKER: Are complex care management units, we look to make sure that those what is meant with special needs get information and daycare care to meet - - collaborate with their primary MCO which may be a Medicare MCO for coordination and benefits for additional services to support that participant holistically in the community. We do offer provider education on the authorization process so we can help to avoid any delays with services or supplies ordered for the participant. Under the complex care unit guys is collaborate with the pharmacy team. If there is a medication need arising for the spent , you will also help to coordinate with the PCP to make sure that the pharmaceutical needs other parts of it are met . We also collaborate with behavioral health to coordinate the care for individuals with complex or special needs in the community. We have put in a fiber dispensed may benefit from our complex care management unit which is a specialized unit that helps participants to meet their needs in the community and manage their chronic conditions successfully . We do use a series of - - that system is able to help us identify participants who may be best suited for complex care management or outreach through our Compex care management unit. Whenever we are looking at that system or using data available to us, is proclaimed as we have as well as information we are receiving from assessments that are completed , information from the PCP , information on claims for pharmacy, hospitals, emergency room visits and also the social determinants of health surveys that helps you identify those that are at most risk for chronic conditions special needs to identify those individuals to enroll to our complex care management unit. The you also help with complex housing barriers through our Compex care management unit and we are able to work with our housing specialist on board at AmeriHealth and we are able to help with housing vouchers or identify housing arrangements help individuals exceed in the

community . We also help participants access care through the primary care physician or specialists. We help to provide information about equipment and supplies available to participants. We also help to submit and receive transfer forms for participants transferring from one community health choices care management organization to another . Also through our complex care management unit, we support our nursing facility and eligible population who may reach out and express a need to receive long-term care services and supports in order to best meet those individuals needs we will also assist those individuals in a referral to the individual enrollment broker to have their needs assessed for appropriateness for support. Our complex caregiver works closely with the office of long-term living for the identified individuals for community health choices you may have special and complex needs that may impact their care planning and would require special intervention within the community. We did also want to go through a success story with this group . We do have experience dealing with a 35-year-old male, he is a past medical history of kidney disease, ocular disease, vascular disease - - complex care management in identifying outpatient dialysis center . The individual are concerned with behavioral health needs and having difficulty securing services through an outpatient dialysis center and was actually receiving his outpatient dialysis in the emergency room three times a week and that was not the most effective treatment plan for him. Our Compex care management unit and our complex care unit did reach out to multiple dialysis centers, we also reached out and completed and assisted in organizing a number of behavioral health assessments to assess dispensed safety . Whenever we completed those assessments and talk to an individual and his treatment team, we found that he was at low risk for behaviors or any outburst or harm to staffers with the risk . So we took the results of those assessments and made further outreach to outpatient dialysis centers. We were able to successfully get him enrolled in an outpatient center as well successfully get him enrolled with a kidney disease advocacy group . Now he has been with the outpatient dialysis, he is not utilized the emergency room for any visit since January 20 anyone. The coordination of care that a complex care management unit is able to provide identifies those with increased needs and is able to put services in place to best advocate and support for those participants with increased needs working in collaboration with specialists, pharmacies , other managed-care organizations and service coordination units in order to meet the participant where they are in the community ensuring that they have the right services in the right place at the right time. With that I can turn it over to see if we are ready for the next MCO .
>> MICHAEL GRIER: Hang on just a minute . Thank you very much for the presentation . Should we go to Jamie now? You will go ahead and have Jamie speak a little bit and come back to the presentations, thank you very much . It is very difficult to do it when the slides are not going through so I appreciate your flexibility with us, thank you. Good morning Jamie .
>> SPEAKER: Good morning, I am hoping everybody can hear me.
>> MICHAEL GRIER: We can.
>> SPEAKER: Perfect. A couple of announcements from the office of long-term living. The first thing I wanted to share with everybody was I've got lots of questions about when the MLTSS will return to an in person meeting and obviously we are subcommittee of the medical assistance advisory committee . In talking to our leadership and obviously - - medical assistance advisory committee is doing , the plan is that when the medical assistance advisory committee goes back in person that all the subcommittees of the medical assistance advisory committee meeting would go back in person subsequent . For example, if the max goes to an in person meeting in May and they usually meet in late May, all the subcommittees meeting after that was close to in

person meetings. That is our plan at this point in time. I believe I have the medical assistance advisory committee that they do plan on doing their first in person meeting for the May meeting dates. That would mean we are planning for the MLTSS meeting and I think the - - meeting to be in person is in early June following a late May : in person meeting . The next thing I wanted to share with everybody is , we had talked about in past meetings the agency's choice proposal office of long-term living is working on first request for proposal and second providing an agency with choice option in our community health choices and are over waiver program starting January 1, 2023. We did issue an RFI request for information that we plan on releasing . I know there was a request at this meeting obviously to go over the responses and have a more in-depth conversation with stakeholders about agency with choice first of all we are still shifting to the responses we got and because the agency with choice model would cover both the community health choices and overall waiver programs , we are going to put it on the agenda for the long-term service and support subcommittee at the Mac meeting. That meeting will be held on April 12 . Agency and choice will be an agenda item for that meeting . The office of long-term living plans to highlight the different issues we received in the RFI and have a stakeholder discussion agency with choice at that meeting. I know there was something else , all the other thing . Is that my mind just a minute. The office of long-term living met with the cochair Michael and David earlier prior to this meeting and they made a really good suggestion that we are going to implement not this meeting but the subsequent meeting. One of the things they highlighted is there are different issues that are raised at this meeting and the office of long-term living follows up with that participant or stakeholder that raised the issue but often the committee members or others to participate in this meeting aren't privy to the office of long-term living follow-up . We agreed it would be a great idea to set aside a portion of this meeting to talk about and make sure everybody is clear on our follow-up from the previous meeting just to close the loop on some of the issues that were raised with the office of long-term living to follow-up. That will be an agenda item for our next meeting in May but I wanted to let everyone know that was at the suggestion of the chairs and the office of long-term living think that is a good idea to everybody is looped into our follow-up. Michael and David, those are my three announcements .
>> MICHAEL GRIER: Can be asked a couple questions on your announcements?
>> JAMIE BUCHNAUER: Absolutely .
>> MICHAEL GRIER: Thanks. Regarding the agency with choice , we noticed there is a two week turnaround time for the questions . I have heard from a lot of the folks that we represent, the participants of the program Holly had the opportunity to put input into that . Is there a reason it wasn't 30 days or 60 days or something like that to gather more data from your participant? To find out about the agency with choice ? We're wondering from a standpoint of two weeks is a short period of time to gather responses . If you wanted additional input into development , it just seemed like it would've been better if it was a little bit longer.
>> JAMIE BUCHNAUER: Thank you for that Michael. Yes, we did have a short turnaround time but we continue to expect any comments we are getting after the deadline . We will have a public conversation on the agency with choice proposal . The other thing I would say that we did receive 29 public comments which was a pretty good response rate . Some of them likely, some of them shorter but if anyone has additional public comments they would like to provide , we are continuing to respect it. There's nothing to say if we did it after that that deadline and I'm forgetting with the deadline was, we would not consider it or accept it.
>> MICHAEL GRIER: Was put out on the 11th and due on the 25th so there was only a two week window to do that. In addition, as you are looking at the responses in the

development of this, are you going to look to have potentially rather than a sole-source vendor, multiple sources? So people can have choice ? It seems like when it is sole-source , I understand the choices, I get that. It just seems like it is not enough consumer choice that would be available in the way that it is written in the RFI anyways.
>> JAMIE BUCHNAUER: I would clarify, is not a sole-source, sole-source something else entirely but I will clarify that. It would be an RFP process. A request for bid or agreement. Other entities have the opportunity to bid . Usually within a by one party that could do a work . The other thing I would say is we have gotten lots of comments so we're continuing to go through those comments and make any changes to the RFP that we think are warranted to those comments. What you mentioned Michael was on the comments we got and we are looking at our options .
>> MICHAEL GRIER: That is absolutely okay for us to distribute. How will the placement snow they could provide input into this? By word-of-mouth for the MCO's going to do any mass distribution ? I don't know how the process works .
>> We will send out a list that lets a number on the agenda and we can mentioned that they would rather submit obviously written comments , we are still accepting those . We got 30+ comments that we did have people that were able to make , likely to submit comments and we continue to consider them.
>> SPEAKER: It seems like you are ignoring the end date for the comment. The damning comments will be taken up o the May MLTSS meeting?
>> JAMIE BUCHNAUER: We always take comments Matt, is not to say he didn't meet the deadline we reject the comments. We don't do that with anything, we continue to take input in whatever shape or form individuals want to provide it to us.
>> SPEAKER: Why couldn't there be same at our meeting in May about this?
>> JAMIE BUCHNAUER: Who wanted to have that sooner than later and is going to be a change to participants and waivers. He wanted to have a discussion as that made more sense. It's not just community health choices change .
>> SPEAKER: I get that, but that does not seem like having input at the next meeting with her at at all, it would only help .
>> JAMIE BUCHNAUER: Thanks Matt, we can definitely take that back. I will add there is in the Czech Republic comment , she reminded of a dimension anytime you make a potential change to our labor program there is a public comment period that is required so obviously individuals would have the chance to comment on agency with choice as it was added to those that we brought in community health choices waivers. Discussions will continue.
>> SPEAKER: This is Jake and Mike and I come in?
>> JAMIE BUCHNAUER: Sure .
>> SPEAKER: You said 29 public comments . Other number that he said, that the very small amount to say we receive 29 public comments. I received no paperwork or anything regarding this change . I don't understand what the need is to rush this throughout this time . We are already facing - - changing with tempest and they're having a multitude of times to postpone their date back to July 1. My experience is that I can't even get them to answer the phones or get my direct care working correctly so I can receive services on July 1 . If anybody remembers Christian financial nine years ago and the service of that was how that was pushed through and people like myself , I had to borrow money from family and friends for three or four months to pay my direct care workers until Christian financial workers was straightened out and they were able to be paid. I don't see why this is being rushed through the a couple of weeks. There are already programs that are set up and have not heard one good reason why or heard anybody say that they want this. I feel we continue to hide and not answer questions. We continue to say we will listen to this and that, nothing changes. Here's another thing

that we are being told , I'm a panelist here but also a person that use the services. I am being told here you go, we have two weeks for public comment but have never heard any information about , I live in central Pennsylvania. Not one piece of mail , I have AmeriHealth. I'm grateful for the service I received, you are telling me that changes are coming that have no idea when they're going to happen. Why is this being pushed through ? You are saying January 1, 2023, that's less than eight months. Why is there a rush to make this happen?
>> JAMIE BUCHNAUER: Let me start by saying that this is an option. If a participant does not want, first of all if a participant is an agency model of personal assistant service and does not want to pursue a participant directed option , this would not change their services at all. If a participant does to write their own services , they would have another model to choose from. They'll have to choose this model, is another option that would be available to them. If they choose that they don't want to make a change, nothing changes for them. Honestly, nothing went out to participants yet because nothing is changing for them yet . We will be adding the option January . Obviously were not doing any mass communication to precipitants because there's nothing to choose yet . I think that is changing yet. There's nothing to make a choice. Obviously, we do not want to communicate to early because people get anxious about the change and there's no real change by adding this option.
>> SPEAKER: Was the rush right now? There's a new governor coming in the something has to be done before he leaves office? Why way to this time with the lack of workers and lack of pay , with 8% bonus thank you for that but we are still grossly underpaid and neglected when it comes to benefits, holiday pay and all of that . Try and push this throughout this time with the tempest changeover and all that's going on, why? What is the benefit of doing that right now at the present time? Again, to say we are going to get two weeks for public comments later on , does not appear timeframe to anybody. Just putting it out us, I've not heard one good reason why needs to be done by January 1, 2023. I believe it that .
>> JAMIE BUCHNAUER: You hit the nail on the head on why there's an increased reason to do that now. You are that he or she issued the direct care workers and being able to provide them additional benefits if they choose , this administration is really committed to supporting the direct care workforce and making sure that those direct care workers have the pay and benefits they need to earn a livable and sustainable wage. Giving people's option, people can choose to do nothing and nothing will change in their services. By providing this additional option people that want to choose to direct their own services their workers have access to benefits. Take time off, healthcare or other pay benefits they don't need. As an additional option, it further supports a participant directed workforce and give people another option.
>> SPEAKER: I've been hearing about the benefits and pay for years . Everybody knows my stance on this, I've been doing this since January 1998 hearing the same thing over and over again. It just seems like everything is trying to be funneled into a certain way and there is no input and not a lot of looking down the road. Matthew this year and now and the ramifications could affect the people at between the services. Thank you for your time .
>> JAMIE BUCHNAUER: I appreciate your questions as it helps honestly, it helps explain the reason for the change in the fact that this is not a mandatory change , individuals are going with an agency model and the agency is hiring their friends or family members and they want to continue that model of service. There will be no change for those individuals or their workers. This does provide an additional choice for those who choose it. They don't have to .
>> SPEAKER: I want to note that, thank you for your time.

>> JAMIE BUCHNAUER: Absolutely.
>> SPEAKER: This is German Parodi, one more question for so many questions, cannot wait but at the end he mentioned AWC care workers would have benefits when not connected going to be a great difference ? It's not who was negotiating the benefits, it's in wages and other benefits. At an average consumer body doing this .
>> JAMIE BUCHNAUER: You bring up a good question, the Department of human services working to develop a rate for this model or service model so we don't know what that rate is now. It is currently under development.
>> SPEAKER: Does this include participants ?
>> JAMIE BUCHNAUER: No, the actuary that works on her ratesetting, that does not include participants when did you are ratesetting. I'm getting a note that her acting secretary is on the line. I want to be respectful of her time. I will be available but I will cut over to Meg right now . Acting secretary Meg Snead?
>> MEG SNEAD: Good morning, can you hear me okay? I apologize for being a couple of minutes late and I won't take up too much time, happy to have a conversation after I go through what our priorities are . It's been a year, I cannot believe it's been a year since I've been in this position. Since several of you probably heard me give some version of this presentation previously , we continue to be focused on the three priorities that came into the secretary position. The first of which is around housing. The apartment the department is administering the emergency Federalists program on behalf of united states treasury, we are working closely with our partners at the county level really administering this on the ground. We have somewhere north of $1.4 billion available for emergency rental support in Pennsylvania we are focused on a year into that program of continuing to spend down and reallocate those dollars from communities that have not been able to spend them to communities that can recognizing that we want every one of those dollars to stay in Pennsylvania and the use exactly for what they were intended which is an emergency one-time basis. We have engaged a consulting firm to come in and assist us with technical support with additional capacity for the counties as they continue to work to spend down and eventually offload that program when the funds run out. We are continue to get all hands on deck approach to emergency rental assistance and also looking more broadly at housing supports as it relates to DHS and doing our due diligence to ensure that we are maximizing our role as a department in providing housing supports and services to people in every possible place that we can. That's the first update. Secondly, I announced when I came into this office that we were taking advantage of an American rescue plan at previously if a woman was covered in Medicaid because of her pregnancy the coverage ended 60 days following the birth of the baby . Under this program or extension we will be sending the link to that postpartum coverage from 60 days to one year following the birth of the baby . As we continue to be in a public health emergency, obviously nobody is being disenrolled from Medicaid and that includes individuals were covered because of the pregnancy , but that benefit went into effect on April 1 and when the public health emergency does come to an end , we anticipate about 10,000 women per year being able to benefit from that postpartum extension period . We have horrendous maternal health outcomes in the United States. While I recognize is one smaller step in a much larger puzzle, relative to attaching health insurance to these folks , it is a very important one. We are the only country that is a higher rate of maternal mortality than we did 25 years ago and it continues to grow. So a real opportunity for us to try and reverse some of those devastating trends . Finally, and this has been happening very much in real time, I have talked a lot about quality in our licensing process. The bread-and-butter of the agency is regulatory and license focus. We license thousands of providers across the Commonwealth of all different

kinds. I was asked the question, are we going to do an inspection of the facility, are we looking at how far away from the door the fire extinguisher is ? Or are we looking at how the residents and staff are interacting with each other? I was surprised to find those are weighted pretty equally on expection checklist . Past Randy be wrapped at the last of our licensing visits but Andrew Barnes who is DHS executive Deputy and I have been making the rounds with each of the program offices and shadowing them on inspections to understand for ourselves what goes into an inspection. It has been eye-opening across the board , everything from mulch issues to issues to plugging and unplugging lights . We really looking to take what we have learned and apply it to our own regulatory process. This is not intended to create additional regulatory burdens or barriers for people but really to apply practical lessons. Generally when we have stood up regulations, is typically in response to something. Let's use personal care homes as an example. If 30 years ago they were personal point care homes operating , we designed regulations to lack of a better way to describe it , weed out bad actors and keep the good ones . We never adjust those regulations to be not so punitive in terms of trying to get rid of the bad actors and instead focus on how we can empower providers and the consumers that they serve wherever they may be to be providing the best quality of care. I don't know what the silver bullet is there but we are definitely doing our due diligence to take what we have learned and apply it to our regulations . I've to this previously, we are time-limited in this administration and I'm certainly under no impression that then the next seven months we will be able to solve all of DHS regulatory challenges. It's a good opportunity to start, there's not a lot of silver linings to a pandemic , but one is that it shined a very bright light on where we all knew there were holes in the safety net and now it's incumbent on us to fix those . That's what we are intending to do. None if that is meant to overshadow the incredible work that is being done across the agency . DHS is the largest of the state agencies, we have 16,000 employees and serve 3 million Pennsylvanians on any given year . It's an incredible opportunity to be at the helm of his agency doing the work that makes me take , but it is the folks here that do the work every day that is really important. Anything we could do to be better partners to all of you , please let us know. We have got a lot of momentum going into the final months of this administration and we really want to make sure we are able to shore up all the incredible work we've done over the last seven years and the Pennsylvania and his agency in a better place than we found it. Thanks for letting me join you all today.
>> MICHAEL GRIER: Any questions from committee members? I guess you covered it so fantastic that we will have questions.
>> MEG SNEAD: Please feel free, have an open door. There are questions you want to follow up on my will make myself available.
>> MICHAEL GRIER: The key to being a successful subcommittee is flexibility and we will have some today. Let's go back to the overview of the CHC MCO complex care units. Were we on PSW with that?
>> SPEAKER: Good morning, can you hear me okay?
>> MICHAEL GRIER: Yes we can.
>> SPEAKER: Are you going to pull up my deck .
>> MICHAEL GRIER: I will ask you if you need that .
>> SPEAKER: Let me see if I can share my screen .
>> MICHAEL GRIER: Can go ahead and introduce yourself and tell us what you're going to be talking about how we can see if we can get Steve and I have it pull up on my screen so I'm good to go. Hello everyone, I'm Heather Clark, the director of the complex to unit at PA health and wellness . During this brief time I will talk about high-level overview of our complex care unit that we conduct. Also going to go through one of

our success stories. The purpose of our unit is to ensure that participants with complex care needs with traumatic brain injury, mental interdependence that my attention to their needs and support in a timely manner. Our unit is located and managed to our care management , CCU unit does have registered nurses , licensed clinical social workers , licensed practical nurses and their chief medical officer . Next slide please. We do receive referrals from the CCU unit for a variety of methods. The participant can dash family can refer or the caregiver PCP office , utilization management , some of is provided specialists , home care agencies can refer members to the CCU unit. Most commonly, most of our referrals are received through facilities or service coordination. Next slide please. Our model for the CCU unit is participant centered . Looking at all the providers involved in the participants care and all public services that are available to that precipitant . In this graph and picture you can see the participant in the center , we will put the PCP, BH MCO indicated, providers available for Medicare services , waiver services and community organizations. We like to take a holistic approach to assessment of our participants that are in our complex care unit. We take a look at what formal and informal supports they have . Most importantly, we take into consideration the participant's choice and what services they would like to have and what they would like their care plan to look like . We assisted living environment and situation . We take into consideration cultural and spirituality needs . We assess behavioral health and physical health needs in relation to what available benefit are and looking at benefits available through the CHC and if they are eligible , we assess the benefit that they may have their Medicare either through welfare or Medicare through another MCO and we look at any community resources that are available to support the participant. Next slide please. Some examples of tangible activities , we do spend time scheduling appointments and transportation identifies specialty providers for participants to review medications , linked to community resources and facilitate DME. One of the most common activities that we do on the unit is facilitate complex discharges were all these other activities fall under that activity . We do create care plans and all the participants in the CCU unit. Those integrated care plans are aligned with the person centered service plans and many service coordinators to ensure that the service care plans are aligned . We do create specialty assessment when warranted . Next slide please. Other examples are CCU coordination , we do have discharge planning meetings , frequent meetings. We do have care meetings and we also have weekly complex care alert rounds with the medical director were CCU staff training and more difficult cases for medical director insights . Sometimes we do schedule care review and we coordinate with multiple providers. Next slide please . The next few minutes, I wanted to go over the CCU actions - - story. Sally Joe was recently discharged from long-term acute inpatient hospital stay . She was placed on a ventilator and needed gastrointestinal feeding tube placement. Sally chose a paraplegic participant and so was her husband who was her caregiver . Both participants are clinically complex - - readmission. The CCU learned of the case and confident urgent care complex with a multidisc Larry team and the plan was with ongoing interventions. Sally Joe made it very clear to the CCU team that she did not want to go to a state nursing facility and was very adamant that she wanted to go home with her husband. Next slide please. Some of the intervention that we crew completed to help Sally Joe reach her goal was we collaborated with the service coordination and privatization to do that trigger event assessment. We arrange for respiratory therapist to ensure that ventilator was set up correctly . The assessment, we are able to authorize 37 hours of personal assistance per week bringing the total hours to 84 hours. We provide education on maintenance, oxygen needs, positioning and wound care . We completed urgent skilled nursing assessment for the clinical needs . Through this we were able to authorize home healthcare for three hours a day

three days a week . By working at the service coordinator , we coordinated the delivery of DME including - -. We ensure that this DME was at the residence discharged and we also coordinated the delivery of oxygen to the participants home . A PCP telehealth appointment was scheduled three days post discharge and the CCU team was able to arrange for transportation . This was a little complex with the oxygen requirements. Next slide please. Just a picture of where Sally Joe is today, Sally Joe is able to understand and participate in her own respiratory care which allows her what she desires. She is able to demonstrate knowledge and understanding of when to call for urgent and emergent health and collaboration - - creating resources to understand the importance of diet and supplement to support her skin integrity and overall clinical status. She did maintain the telehealth PCP appointment and had scheduled wound care and is prepared for in person for the wound care physician and it will be transported on a stretcher with oxygen. Most importantly she has the necessary equipment to remain as independent as possible for as long as she can stay in the community . Again, this was what Sally Joe and her husband wanted to accomplish . - - Was able to help Sally Joe accomplish her goals and she remains engaged in service coordination and the additional follow-up and monitoring. I believe that the end of my presentation . I'm happy to answer questions at the end or now,
>> MICHAEL GRIER: I'll ask the committee if they have any questions now, thank you for the presentation. Members, do you have any questions for PSW?
>> LLOYD WERTZ: This is Lloyd, first question is what are the qualifications of an individual who is making the assessment for the need for behavioral health services and complex care for those events?
>> That would be a licensed clinical social worker .
>> LLOYD WERTZ: Very good, good choice. The other thing I have is under what circumstances is it determined that a peer review is called for?
>> SPEAKER: The dispense circumstances if the prospectus in the hospital and they may have recommendations for the attending physician to consider. Those would be instances where - - would be scheduled .
>> LLOYD WERTZ: Thank you .
>> SPEAKER: Can ask a dumb question? This CCU, this is a team, not a place right?
>> SPEAKER: That is correct .
>> SPEAKER: That these participant another go anywhere, they are calling for the team .
>> SPEAKER: That is correct , it's a program however participants in this program , most of them have service coordination so in the event that the CCU team identifies a need for any face-to-face intervention , we can ask the assigned service coordinator to make a home visit and do face-to-face assessment and intervention.
>> SPEAKER: What do you mean by intervention?
>> SPEAKER: Intervention can mean providing education, it could be assessing the home environment , it can be conducting face-to-face assessment . Most of the time, in-home interventions are just placing eyes on the participant and ensuring that the home environment is safe and conducting any specialty assessments that may need face-to-face touch .
>> SPEAKER: If imprisonment does not want their home life to be intervened?
>> SPEAKER: We could definitely do it telephonically Stephen okay, thank you .
>> SPEAKER: Share . Our service coordinators were not just show up at the member's house , we would definitely give them a call if they were open to it. If not we would definitely respect your choice .
>> SPEAKER: It made it sound like it's in voluntary you and oh no, it is definitely not involuntary.

>> MICHAEL GRIER: Angular questions from the committee members? Thank you for your presentation, it was excellent.
>> SPEAKER: Thank you for your time .
>> MICHAEL GRIER: We will go on to UMPC.
>> SPEAKER: Good morning everyone, I am the senior director of strategic initiatives and clinical programs here at UMPC CHC which includes our complex case unit . Excuse the sneezes and snuffles that I will probably have throughout this , I will try to be brief. If we can go to the next slide please. At UMPC we leverage all of our additional teams that I'm supporting service coordinators since the inception of CHC. Our CCU is tapping senior service coordinators to focus on complex cases that are hard to place, individuals that are aging out of the only periodic screening program transitioning to a new phase of adulthood . Really working on helping to make sure that services are in place during this transition so there is no service gaps are gaps in care, we are ensuring that the assessment is appropriate to get them the best services in place . We also work with supporting service coordinated with the complex care needs for individuals with traumatic brain injuries or ventilator dependent. We have a dashboard to help those tracker individuals who were on for the leaders so when we have things in the winter like objectives storms and the ability for power to go out , we make phone calls to make sure everybody's pet for an emergency in those cases and help work through those for we also work with the policeman to transition from other long-term programs like the act of 150 options, wife, ODP waivers or directly from other programs. We also work with the dispense were transitioning to CHC from incarceration or some kind of legal status and may need some help transitioning into medication program to make sure they are assessed appropriately. One keynote for our CCU at UMPC is that is activated internally. We don't manage our cases long-term, we assist the service coordinators were long-term on those cases so ensure that report is built and we have some experts able to help with those more difficult items that are hard to know about and have good resources. If you have a complex case that needs additional assistance the new service coordinators want to be your first go to. Next slide please. For new participants, we assist with establishing a transition care to appropriate providers . This is really big with our individuals. Our CCU will make sure that we are ensuring those initial assessments. We make sure that temporary services in place while CHC assessment is completed. We assist service coordinated with finding appropriate providers for the participant and referrals to any new providers that may be necessary . In the case of - - individuals they often transition from a pediatrician sobbing to make sure that their conditioning to other providers for primary care as well as specialists. We do that like the continuity of care service form for up to 30 days while we get out and do our assessment. We work with the one hand off for ongoing service coordination and remain available for any time the individual needs extra assistance. Next slide please. With our skins who are established , we are practically working to identify outreach to them to assist with the service coordinator to help information, support . He may not have the best places to go to help there. Our staff are well-versed in those areas and help support our staff to make sure our prisons have everything they need . They really focus on our person centered approach, we provide service recommendations that include all of those potentially complex needs for medical conditions , there are behavioral conditions which collaborate , we collaborate with the Medicare plans if there is one so we really make sure you're giving a holistic wraparound care for participants. We are short and sweet today so that is our last slide if anybody had questions.
>> MICHAEL GRIER: Any questions from the committee members?
>> LLOYD WERTZ: I was wondering if there is a similar qualification for folks doing behavioral health assessments through UMPC as well?

>> SPEAKER: Because we are not behavioral health manage we are not doing specific assessments and working very closely with MCO to make sure that our needs are met. Our separated social workers, nurses or have an extensive history and service coordination so we are able to within a file any red flags were help may be needed so we can start to pull in those additional providers in managed-care organizations as we can.
>> LLOYD WERTZ: Thank you.
>> SPEAKER: Absolutely .
>> MICHAEL GRIER: Any other questions for UMPC? Very good. Thank you very much for the presentation . I was wondering Jamie, are you still on the line? I had a question coming via text and I was wondering if I could ask you that .
>> JAMIE BUCHNAUER: I'm sorry, I am here I was double muted . Can you hear me now?
>> MICHAEL GRIER: That's a significant issue being double muted, yes I can hear you fine . Let me find it . It is pertaining to the federal money follows person and funds will hundred 10 million at the Biden Harris demonstration are releasing to the states. You tell us number one how much is PA getting? Number two, is any kind of plan for the utilization of that ?
>> JAMIE BUCHNAUER: We just saw the announcement in Pennsylvania that HHS is providing 110 million so honestly what we are particularly interested in was the announcement that CMS said they were increasing the reimbursement rate for subtle mental services and expanding the definition of subtle mental services to include additional services that can support individual transition from an institution to the community including short-term housing and food assistance. So great question. We have a lot of questions as well on this announcement. I saw at least information that we got that CMS is going to issue additional guidance for states and the person program about what the announcement meant and how we can use the money. I think all that is to say more information to come . As soon as we know we can share the information with our stakeholders as well .
>> MICHAEL GRIER: Any idea how much it was?
>> JAMIE BUCHNAUER: For Pennsylvania specifically I do not have an idea that. Whenever the announcement that was put out, he said hundred 10 million for MSP but they also allocated a certain amount of those funding for new states meaning states to join the person program if they were not already participating in some portion of those funds to expand the subtle mental services. We are already in money follows the person states so our interest is really around the expansion of the subtle mental services and how much of the funding can Pennsylvania get to use for short-term housing . Honestly, that is one of our biggest interests .
>> MICHAEL GRIER: Exactly. Are there any questions from the committee members in reference to money follows the person funding? Well, we are way ahead of schedule and I cannot imagine that the doctors are on .
>> SPEAKER: We do have a few questions in the chat .
>> MICHAEL GRIER: Let's go through them, thank you .
>> SPEAKER: The first one is asking is the CCU episodic model or service were present for participants?
>> SPEAKER: Good morning, this is Misty again, the referrals to the CCU are episodic in nature and their generally open for approximately 30 days, however they can remain open longer to meet the needs of the participant as needed.
>> SPEAKER: PSW, anything to say to that?
>> SPEAKER: Our process is very similar, our cases stay open for 30 to 60 days depending on the complexity . However, we have no steadfast close date. As long as

the participant has some of those intense medical condition and needs, we will keep the case open and continue to work to case until all of the unmet needs are met.
>> SPEAKER: CBO, and anything to add ?
>> SPEAKER: This is David from UMPC, either step away for a second. Our CCU is episodic , the team works with individuals when attributed been identified or the service according to need some assistance with the complex case here are service coronation team worked on an ongoing basis but can also reach out to the CCU if additional assistance is needed at any time .
>> SPEAKER: The next question is asking how personal Casey providers are involved in care planning initially and ongoing for changes .
>> SPEAKER: Good morning, is Misty again. We have the ability for providers to interact with our complex care management unit and are complex care management team with staff, RN and licensed social workers if additional assistance in managing the chronic condition is needed , education can be provided to personal since providers . As far as their participation with ongoing care planning , they care planning happens with the participant and the person centered planning team. If the person elect to have the provider as a part of that person centered planning team, and of course they would be included.
>> SPEAKER: Canada analyst on PSW address this? Not sure, anyone from UMPC?
>> SPEAKER: Be the same thing as AmeriHealth, we stay focused on our person centered planning team in which the participant is always the center of that. If they want to providers involved we absolutely have them there. As far as having peer to peer are complex case discussions, that is always available for providers to have with our service coronation staff, our complex care unit staff, our medical directors are always open to having those. It's not just RCC but dispense but anybody who may be having some kind of complex case that would be able to tap into those benefits but again, it's very person centered so we are not going to have some at the table that the participant is not going to want there.
>> SPEAKER: We as well as our colleagues have a similar process. All they care is person centered. We do extend the CCU benefits to any participant that may be at a lower level through our clinical care management program, however we offer those benefits across the board .
>> SPEAKER: What is the staffing makeup of AmeriHealth CCU ?
>> SPEAKER: Hi, it's Misty again, our CCU is comprised of registered nurses and licensed social workers.
>> SPEAKER: Another question , thank you for the presentations on the CCU , also the work and feels described are under the scope of what - - CCU stepped in when they cannot handle the amount of coronation assistance by participant? Is there anything the CCU can do that TSC is not required to do under the CDC agreement or waiver ?
>> Is Heather from PA health and wellness, I can talk to that . The CCU unit works very closely with service coordinators . Some of the things that the CCU can do is put in some of that legwork in making those calls to providers and facilities taking or I should say sharing some of the work with the service coordinator . If the team approached the CCU service coordinator . The service coordinator can going to the home and be with a member in person, that is one thing that the CCU is unable to do that typically the CCU cases do have a case conference in which the service coordinator and through that case conference, they discussed the case and decide who was on the first really to do specific interventions . That way we can expand the resources and if needed outreaches to get them done in a faster rate than having the service coordinator have to bear all of the administrative stuff involved in CCU cases. Just note, these participants that are referred to the CCU , these are highly complex participants with complex needs

so having a registered nurse or LCSW provided the additional clinical touch and insight for these participants is definitely of the value .
>> SPEAKER: The difference between CCU and service coordinators does.
>> SPEAKER: I would agree with Pennsylvania health and wellness in the explanation I just reinforced the special needs unit is a support to the service coordinators that can assist with the more complex cases and also helps to lend that critical lens to the case in order to holistically meet the participant's needs .
>> SPEAKER: Much like my peers said that is absolutely where service courtiers are doing so the CCU staff are not different in that however, part of what we have chosen to focus on is making sure that individuals coming into CAC have someone there first day they can start to begin some of these complex items while also getting the service coordinator in the region assigned an assessment set up making sure we are providing immediate attention to these complex cases as they come into our plan so there are no gaps in care when that happens.
>> SPEAKER: Those are all the questions AC related to CCU .
>> MICHAEL GRIER: We will get to those in a minute Jeremy. I wanted to ask that the CAC MCO's with the service coordinator and more than likely an intensive case manager on the behavioral health side trying to manage these folks in the complex care , which one from switch one? In other words, is it written down anywhere that we should move forward with this in behavioral health issues as opposed to those under the service coronation issues? I was wondering if anyone is said to speak about that because I can see very clearly where there could be some confusion on who's going to do what that . If you guys can respond to that .
>> SPEAKER: It's Misty with AmeriHealth, I want to rephrase her comment so we can answer the question. Your concern that with the amount of people that are working to coordinate care with the participant, it is difficult to tell who is taking the lead on which part, is that an accurate refreezing of your question?
>> SPEAKER: Yes. Particularly if you have a service coordinator in intensive case manager. But primarily to the same coordinating care so I was wondering about that .
>> SPEAKER: Sure. The service coordinators are used to working as part of a team . They work well together not only internally but when we bring in external partners such as the behavioral health MCO to work on a complex case, each case is unique and discussed on a frequent basis. So that a plan going forward and possibility for next steps is best outlined but is also at the direction of the precipitant and the way they want to move forward with the next steps as well .
>> SPEAKER: This is Marissa with UMPC . I completely agree. For the CCU coordinator , our CCU service coordinator at UMPC is an extra resource with the service coordinator is always good to be the primary individual with our plan on that case. They will all be working in tandem with any other case managers whether it be a complex case manager with Medicare, whether it be behavioral health case manager, whether it be someone from an OPP program they are transitioning to any work that is a team. This CAC service coordinator is going to be primary with the CCU person assisting always working together with the rest of the individual steam .
>> SPEAKER: Hi there, Heather from PA health and wellness. Similar to the others CCU's operating , release a partnership with service coordination and support service coordination . As earlier indicated we do have a lot of case conferences and are complex cases and everybody walks away from the meeting knowing who was responsible for which plan of action and who is best suited to do that. An example clear our behavioral health concerns , the service coordinator would talk and decide who would be best to address those issues . We are always closing the loop and making sure that the service coordinator is up to date on any interventions and that if there are

any changes to the plan of care , that is incorporated into that person centered service plan for monitoring.
>> MICHAEL GRIER: Thank you. Let's go to the questions you submitted for Jamie . Stephen will there be virtual access for in-person meetings in case someone cannot attend in person .
>> SPEAKER: At this point most businesses Stephen on toric lenses for Jamie . Splitting that would be great. This a moral question for you because you can tell them how it is going to work .
>> SPEAKER: We will follow there. If they go back to person and may because we are meeting virtually but we would have our meeting in person for anyone who attended in person meetings in the past , we plan to handle things the same time in-person where you can come too but we would also have the webinar like we are doing today that people campus today virtually . Next question and hopefully Jamie has contacts with this, an option to pay more to BCW. Not sure if you want to add in the chat onto this about what option you meant .
>> JAMIE BUCHNAUER: So Jeremy, I think if I'm thinking about this correctly, Pam was referring to the agency with choice option for participants and their direct care workers and the question would be where they pay more ? That is something I do not know, we are still working on a rate for an agency with choice option and I am not sure if she is asking the question would be whether it be more overall for the purpose of the directed model of service for more than what we are now paying for the agency model of service? Or if she's actually asking about the direct care worker rate . That I cannot answer as the rate is set by the participant and will continue to be set by the participant with choice options . I'm not sure if the worker rate would be more than paid by an agency so the agency again is setting the worker rate and the precipitant directed model . Once we have the idea of what the proposed rate would be for the agency choice model. I probably cannot comment on whether the worker would make more in the precipitant directed model . I'm not sure exactly when the rate was set for the agency workers , we don't always know what that rate is and honestly for all participants , the participant puts the worker's rates . We can tell you whether the range was lower or higher but not exactly what the rate paid to the worker whether it's lower or higher. I hope that makes sense, I feel if you got confused in my own explanation and I'm sorry about that .
>> SPEAKER: Next question is from Terry Henning, is OLT are planning to do an agency dash since 2012 .
>> JAMIE BUCHNAUER: So Terry, since we have moved to a managed care model for most of our services that are provided , we have not plan to undergo that work for the overall waiver program . It is something that probably into the future , we may need to look at in the overall waiver program.
>> SPEAKER: Next couple of questions are about emergency housing . - - Is asking how much emergency housing money has been used and when the most of the money be used?
>> SPEAKER: I think asking about emergency rental assistance program that acting Secretary Sneed talked about, I know that there are reports available on the program, I don't know the answers to answer questions off the top of my head .
>> SPEAKER: A comment from Paulette about agency of choice. I want to have agencies to be chosen to be local . Those are the only questions I have related to what has been covered already .
>> MICHAEL GRIER: Thank you very much. Can you guys see if the physicians are here so we can get started a little bit early if we can?
>> DR. LARRY APPEL: This is Dr. Larry Appel, I am here .

>> MICHAEL GRIER: Hello, you will kick it off about the role the CHC MCO's own medical directors and we love a series of people speak and I will turn it over to you Dr. Larry Appel.
>> DR. LARRY APPEL: Thank you very much and thank you all very much for this morning. We wanted to take a few minutes this morning to introduce ourselves and to discuss a bit about the role of medical directors in the CHC program . My name is Dr. Larry Appel and has been my privilege and is my privilege to be the director of long-term living for the past 3.5 years. I am joined today by Dr. Crystal Clark, the chief medical officer for UMPC CHC, Dr. Susan McAllister the chief medical officer for - - CHC and Dr. Craig Butler, chief medical director for PSW. Doctor David Kelly, my colleague in the chief medical officer for - - and office of long-term living unfortunately could not be here today , he is cochairing international standards meeting . Next slide. So the role of the medical directors really comes from the goals of the CHC program that most of you are familiar with. Enhancing opportunities for community-based living, strengthening coordination of other types of healthcare including Medicare and Medicaid for people eligible, enhancing quality and accountability , advancing program in innovation and increasing efficiency and effectiveness. The medical directors , while we do focus on all of these goals in various aspects, a lot of the work that we do is especially pertinent to goal three and goal for around enhancing quality and accountability and also advancing program innovation. Hopefully that will become evident on the next couple of slides. Next slide please. As far as clinical support for high-quality CAC Princeton care , this slide shows that the OLT alchemical team and the CHC plans clinical teams as well . We work in tandem and we have the same goals . Perform clinical reviews and clinical reviews are largely individual participants and situations being reviewed relating to individuals. We monitor quality metrics and those are for more of the entire CAC population and clinical initiatives. We were together to implement and initiate clinical initiatives to improve care for the entire CAC . On the OLT outside there are medical directors not to Doctor Kelly and myself but we invoke the knowledge and consultation of other Department of human services medical directors , which there are several. Specifically we work with the Bureau of quality assurance and program analytics . I'm a part of that Bureau . We worked there are multiple levels both in terms of program analytics, quality insurance and the clinical review team . If several different aspects that we will go to vary briefly. First, we will talk with the clinical review team. That's on the next slide. The clinical review team's role is again individual review of individual assessments needs and how what the individual person's needs being met ? The critical review team ensures that assessments are timely and complete. We sample assessments for each of the plants on a monthly basis. We review the - - to determine if appropriate care levels are being decided . We reviewed the emergency medical assistance request on community-based services answers largely for noncitizens . We conduct clinical reviews on assessments and service plans for physical health, pharmacy and long-term services and support . Again, these are done on an individual basis . The next slide is an example of how the clinical reviews team interaction works. There was a 59-year-old with diabetes , spinal disease and bipolar disorder and the extent of the disease was not well understood and clear on the assessment . So the clinical review team, we notice this and discuss this . I had a conversation with the planned medical director and also with the office of mental health and substance abuse abuse services director , and we really defined a particular set of services that made the most since for this participant including sugar checks , blood sugar frequently and appropriate monitoring of blood sugars , monitoring with a primary care practitioner , ensuring that appropriate equipment and dietary counseling was implemented. The CHC planned medical director after this discussion had internal

discussions to ensure appropriate service planning and implementation and after a year , this participant is doing very well . That's how the clinical review team works. The next slide we'll talk about the medical director developing standards and monitoring quality standards for the CHC plans for multiple data inputs and standards are set. We have the help of effectiveness data information set which is national standards plans submit to the national organization . We monitor our plans one to the other and also the CHC plans compare nationally as well. We have quality monitoring and operation reports also. We also performance improvement for each of the plans . Currently it is our focus on care coordination and nursing facility transition . We review the prior operation review policies for each of the CHC plans really with an eye towards specifics of how that relates to all TSS energy services . We had the home and community-based services systems annual survey data that was recently presented and we have data from the Medicaid research center from the University of Pittsburgh in their reports as well. So an example on the next slide on how the medical review and measure review comes into play . There are - - measures showing that the federally care practitioners receiving the service plans was an area of concern . So after discussion and deeper dive with the OLTL clinical team and the CHC plan medical director to determine the particular issues involved with service plans being received by the PCP approaches to improving the sharing plan were implemented and the measures have improved related to sharing service plans and most importantly primary care practitioners now have service plans much more frequently than they did previously . Here is the data from and 2020 showing a substantial increase in statewide sharing of service plans with primary care practitioners. The next slide please. Again, another facet of the medical directors role is to develop and implement quality initiatives and innovative strategies. We said the nursing facility strategy at the last MLTSS meeting involving quality incentives for nursing facilities and also a learning network to a company that . This touches on what Secretary Sneed commented on earlier . I believe that we presented in the MLTSS meeting in the near future . Recently we had Covid 19 initiatives to provide emergent responses and facilitation to the nursing facilities and personal care homes and each MCL implemented and developed Covid 19 vaccine clinics holding large numbers of members and ensuring transport and facilitation with pharmacy and fascination early on to a highly vulnerable population. We have several combined projects in Africa other offices and departments under that as well. Next slide. We can save the questions to the end which may be more effective , I wanted to let Doctor Clark, McAllister and Butler present briefly as well but this is an overview of the medical directors role and we are here to work with you and improve quality of care as much as possible. I will turn this over to Doctor Crystal Clark from UMPC .

>> DR. CRYSTAL CLARK: Thank you so much Dr. Larry Appel, good morning everyone and good morning to the subcommittee members and also the audience attendees . My name is Dr. Crystal Clark, I am the chief medical officer for community health choices UMPC. I wanted to talk typically about the role about the role of the medical director and participant safety this morning. If you could go to the next slide . I like to start off with a story if I could . This is a recent case . We of course not shared any personal details to maintain the person's privacy, but I thought it would be very instructive and trying to help you hear about the cascading events that sometimes happen that pull the medical director into a robust safety program that goes throughout the CHC program. We get a placement was 72 and lives with her daughter and her young grandson. Her daughter is her caregiver and the participant has diabetes and kidney disease . She requires dialysis three times a week. Recently she had a series of incidents that impacted her safety . She had a hospital admission because she had problems with her electrolytes after missing dialysis . After that was stabilized , she

needed to go to skilled nursing facility for a brief stay to regain some of her ambulation skills . She returned home after the physical therapy goals are met and the service coordinator reached out to the present and the caregiver after she returned home for the nursing facility that the part of the service coordination role to touch base with participants when transitioning care. - - Reached out to see if there was a change in context information during that brief admission. It had not put the skilled nursing facility shared that the Christmas last dialysis was now five days ago. Just to remind you, this placement requires thousand three times a week so she was overdue. The service coordination team reached out to the CHC medical director to discuss the prioritize next steps for safety. I'm highlighting this because service coronation team is very equipped with handling critical incidents meaning our planned emissions and transitions in care. If there's a situation where the precipitant can be facing imminent danger or harm medically, they often reach out for medical opinion a consultation . In this particular case, the service coordination team had already planned to do a safety check which was to go to the actual residence and make sure they can make contact with the president of the caregiver to determine their safety. In reaching out before leaving for that visit, we just talked about the potential situations they could walk into since this placement was now overdue for dialysis and to have a low threshold for engaging the precipitant in a call to EMS if needed. As it turns out when the service coordinator arrived, both the participant and the caregiver were at home . The participant was in bed confused and disoriented . The caregiver, her daughter did disclose that the participant had refused to go to Dallas since arriving back at home from the school nursing facility . The caregiver also self disclosed that she was recovering from Covid and she was very fatigued and didn't have the energy to fight with her mother to go to dialysis . Because the participant was so confused and disoriented, she was not an advertisement to tell us what she wanted us to do or not to do and we have a conversation with the daughter that we found it best that we call 9-1-1 to be seen and sort of situation. The daughter agreed and called 9-1-1 and the advertisement was taken to the hospital animated and her electrolytic situation was taking care of but unfortunately she had a cardiac event in that time. I'm giving you a concrete example of the existing safety mechanism that we have in this program but one clinical input can really help the service coordinator prioritize in the most effective manner , some of the things that we do to maintain precipitant safety is to review political incidents and critical incidents can be a serious injury that results in emergency visit or hospitalization or unfortunately death . It can be abuse whether that's physical, psychological, sexual or verbal . It can be neglected, it can be caregiver neglect or self-neglect . In this particular case , you have a participant was refusing dialysis on her own, she had no cognitive impairment at her baseline in her assessment so this was a decision she was making . We have to look for neglect whether it's possible to neglect or caregiver neglect . We have to look for if there's any expectation or restraint being used in any kind of service interruption. Those are the types of things that are constantly reviewed for an hour CHC participant . Again, where the positions come in as many of these incidents may rise to an imminent threat and in addition to standing meetings we review critical incidents, patterns involving a potentially harmful event , we have an emergency meeting that is multidisciplinary in addition to revisions who have pharmacy , we may have care management in addition to service coordination , we may have compliance. We have a multi-splintered team that sees if there is anything we can do to make an impact on disbursement safety . The emergency medical service referrals, service corridors are capable of knowing when an emergency service referral or EMS call would be appropriate. In this particular case, the medical director steps in to help the service coordinator understand what they might be experiencing or walking into so it helps them plan and ask the appropriate questions if

the situation needs to be escalated very quickly. Although protective service referrals, again. These are issues particularly around potential abuse, neglect, expectation or abandonment. We work very hard for the direct care folks to make a referral . They see it firsthand, those referrals, the detail is really important. If they are not clear or unwilling, the medical director with the service coordinating will make a suggestion or referral needed if the participant is in imminent harm. The state transitions in care, again. Excellent team that knows how to do this. We have standard protocols but if there is a case where it's not in line with what the policeman wants, sometimes positions call them to help the team understand if we can follow the precipitant's wishes and maintain safety or not . The last point I will make about this is that we do everything we can to be person centered and let dispense make their own decisions . We will continue to do that. In this particular case, I will use this as an example, initially the participant was impaired. She had not had a office and was confused and disoriented. That particular moment, others had to make decisions on her behalf to keep her safe. Once she was back to her baseline she was perfectly capable of making her own decisions and decided she wanted to determine return home and not to a nursing facility even though her daughter felt that might be a better place for her but it was the participants wish and she was very much in charge of her faculties and her preference was to return home which she did and we have continued to support that family. Those are a few examples of how medical directors are involved advertisement safety and now I will turn it over to Dr. Susan McAllister from AmeriHealth.
>> SPEAKER: Can ask a quick question about your scenario? I'm a little confused first of all the medical jargon , so Mrs. X, I think you said abuse, neglect or abandonment and she was cognitively stable or whatever the medical term is, if she voluntarily did not want to go to dialysis , that is it within her rights or whatever right?
>> DR. CRYSTAL CLARK: Yes. Sorry that was confusing, my point was at the time that we arrived she was impaired . She was not cognitively intact, in fact she was disoriented so decision at that point we cannot understand or be clear or be safe that her decisions about missing dialysis previously for what she wanted to continue to do now. We do call EMS and she went in .
>> SPEAKER: She went and where?
>> DR. CRYSTAL CLARK: The hospital.
>> SPEAKER: She got a office at the hospital? What the dialysis is the cause of , I'm not a doctor, what is the cause of the confusion and all that stuff ? Would she still be able to refuse that?
>> DR. CRYSTAL CLARK: Once she has the day off is, the confusion and disorientation should clear .
>> SPEAKER: On talking before that. If the cause is not having dialysis for five days because the individual confusion , what the medical director and the team allow her to continue not receive analysis?
>> DR. CRYSTAL CLARK: We would call EMS to have her evaluated at a hospital for her own safety which is what we did .
>> SPEAKER: Dr. Susan McAllister, if I provide a little bit of color I think your many patients like the one you described and for audience , dialysis is a form of life support. When kidneys fail in places like to go on dialysis, they are going on a form of life support. It is end-of-life or hospice conversation , is not the same as deciding maybe when they don't feel like going to physical therapy or not feeling up to it you will take in a couple of hours in her stomach feels better. Patients will have to go on dialysis are going on a form of life support. When they like to knock on dialysis , the conversation about end-of-life care. The stakes are very high .

>> SPEAKER: Both get to my question. My question is if the individual has made it clear they do not want dialysis because of not having dialysis their cognitively impaired , then descended to the hospital and the refusing analysis and their emergency care. Sounds like they are at the end of a decision already .
>> SPEAKER: That was a great point you bring up the I think the patients are feeling that way, the conversation with her provider before they like to start going to the provider can take them off the care, put them on the right care so they are not suffering up dialysis and also dash Doctor Clark Kamal handed back to you, my apologies for interrupting .
>> DR. CRYSTAL CLARK: I was good to say, when you're in a situation with a person's life is in jeopardy and he sent her to the hospital, yes she did get Alice's but allowed her to be clear. Then the decision, she not put any formal decisions about not want dialysis anymore. That decision is made , it is absolutely respected . A whole different set of supports can be put in place back in that person's wishes . If those types of decisions are not on record because if you don't dialysis as Dr. Susan McAllister said, you are looking at dying. It's a life-sustaining process. For all those things to have not been discussed with the participant and put on record , we can't take the chance that they may have changed their mind at some point . Now that she was delayed, those conversations can take place and those decisions can be recorded and their wishes can be respected the highest level without jeopardizing or making a mistake about what her final preferences were .
>> SPEAKER: Thank you.
>> DR. CRYSTAL CLARK: Dr. Susan McAllister, I will turn it over to you .
>> DR. SUSAN MCALLISTER: Good afternoon everyone, my name is Susan McAllister, I am the chief medical officer. AmeriHealth . I've had the privilege of serving since the beginning of the CHC program. I joined this endeavor back in 2017 and it has been quite some time since I've spoken . I'm happy to be better today there to do that will give you a few examples of Christmas we have served and explain how your insurance plans work together and answer questions you might have. Lastly I would like to thank you for the privilege of serving the CHC program . I'm going to take two examples of expense we have served and walk you through how we observe them . I also called them - - I will tell you about Mr. X who has a traumatic brain injury . The service coordinator met him out in the field and identified his care and referred him into our complex care team and behavioral health team. Our initial support with him focus on maintaining independence in the community. We provided him with a local behavioral health resource to independently schedule follow-up and initial visit. Upon follow-up we saw you not follow through with scheduling and was struggling for memory challenges from traumatic brain injury . At that point recorded a three way call with the local County mental health and through this coordination it allows Mr. X to connect with his mental health resource . We coordinate the services and facilitate access to behavioral health resources for the person to be served. Another similar story - - . Pardon the background noise. This slide story is similar. Miss Y is a non-English speaker would support . Given the severity of her needs, we contacted the behavioral health managed care organization . The behavioral health MCO is the insurance company that we work with on behalf of RCC precipitants . We work with them to locate providers near their home. We are able to contact the provider for her, review her need and the services wanted and give her options within her area . The challenge at that point is to provide access to mental health provider in her native language. We work with the provider and the BH MCO together intake and at that point the provider was able to accept her but not provide services in her native language for the initial appointment. At AmeriHealth we were able to reconnect to the provider , provide translation services and facilitate the

employment quickly . Working together we were able to urgently provide connection services with the provision of language services. Mr. X and this is why stories are to the many Christmas we service for unmet needs. We aim to provide connections to services across the Commonwealth while minimizing the challenges for participants. Next slide please. I will if take a moment to walk you through how your insurance plans work together . Isaiah went through the cases , sometimes it might sound like we are making telephone calls and setting up appointments. I want to walk you through what happens behind the scenes and how it all comes together so we can provide what we aim to provide as frictionless care and coordination . The work we do behind the scenes is all about coordinating when it comes to behavioral health services, some services are covered by Medicare , some are covered by Medicaid and some services are covered by your BH MCO. Understanding your coverage and coordinate with the right folks at the right time is how we help you. If you will see two boxes, one on the left side of the screen and one on the right side of the screen. Within these boxes are circles that stand for the type of physical have insurance you might have being Medicare and/or Medicaid , the coverage you might have and the behavioral health insurance that you have. Each participant at the three plans sir have some combination of these insurance coverages. The box on the left show the combination of insurances that most participants have . - - Rep Hunter Medicare insurance. For participants with Medicare, this is the insurance that covers your doctor visits, hospital stays and medications first. Your CHC is your Medicaid . When you have Medicare and Medicaid, Medicare will cover the services first and Medicaid will cover the service a second. The dark blue circle illustrator behavioral health MCO. Many mental health services are covered through the behavioral health MCO. Lastly if you have benefits this is shown as the gray diamond. For contrast, some of you have combination of insurances like the box on the right. In this case your CHC MCO covers your medical visits, hospital stays and prescription and the behavioral health MCO covers your mental health services. Knowing the combination of the insurance product that you each have and coordinating them to facilitate access management with our daily work and we aim to serve you well.
Please. Having walked through the - - . The map in front of you was provided and shows the five behavioral health MCO's in the state and the counties that they cover. When we coordinate services for you, we work with your local BH MCO as well as the coordinators and case managers you might have your other insurers. Next slide please. I hope through this session I've been able to help you gain a better understanding of our program and how we serve each day. I'd like to thank you for the privilege of serving and we are happy to take questions.
>> LLOYD WERTZ: Thank you very much Doctor, interesting behavioral collaboration and coordination . They consistently hearing about reaching out and the stories that are presented involve individuals who have behavioral health conditions and I appreciate the fact that you are focusing on their. We hear very little about quantitative data like how many people actually assess behavioral health needs and happily found to need them one of those results ? How can we best said about to offer a care in a coordinated manner . You refer for a couple times to the case manager and it occurs to me that prior presentation we had about the number of PCPs , I wonder if the case manager also has a copy of that service plan so they can be at least some presence of coordination and provision of whole person healthcare which we believe in behavioral health field anyway to be the most effective in supporting the entire individual. There is the head and the body and the neck interconnectedness to define ways in the most coordinated way possible. Can you share any light on the quantitative question and how those collaboration efforts are achieved ?

>> DR. SUSAN MCALLISTER: Thank you for the questions, I will try to unpack those and we can follow up with details. This is best for assessing behavioral health needs. We assess all of our participants with their service coordinators when we do - -. We also assess for unmet behavioral health needs in each and every participant undergoing an assessment. The quick answer on how many participants are assessed for unmet behavioral health needs, the answer is all of them. Although that identified as having unmet need in the behavioral health MCO . I do have those numbers at my fingertips will be happy to work with the team to get that back to the committee .
>> LLOYD WERTZ: Can you shed light on when there is a behavior health manager involved, to the case manager get a copy of the service plan?
>> DR. SUSAN MCALLISTER: The behavioral health case manager will meet together to service a care plan for the participants. It goes a step beyond sharing the care plan. As a coordinated meeting between those that serve the participants.
>> LLOYD WERTZ: So the behavioral health case manager does indeed get a copy of the service plan in place as it is updated?
>> DR. SUSAN MCALLISTER: I don't know the details of the update and how often it is meant but I know that our teams meet together and review the plan .
>> LLOYD WERTZ: That would be really good to know if the case manager has a copy of the plan. You never know when there might be need to reference it and there's no coordination team meeting on the schedule.
>> SPEAKER: That's a very valid point. We can take a look at the data related to this . Whenever we talk with the behavioral health MCO they do appear to have access to the service plans I think your point about getting data around that is a good one . We also have Doctor Butler from Pennsylvania health and wellness . Craig? Doctor Butler? Not sure if Doctor Butler will be able to speak . If not, perhaps we can invite him back .
>> SPEAKER: This is an hour, I am trying to make sure he is not needed or having technical problems on his side .
>> MICHAEL GRIER: Please let us know what you find out Anna .
>> SPEAKER: He may have left and come back in a different way .
>> SPEAKER: Just moment , I'm checking on him .
>> SPEAKER: In the interim while we're waiting, if anyone has any questions they would like to ask , let's go ahead . If he comes back on people back out of that .
>> MICHAEL GRIER:
>> SPEAKER: He is reconnected, he is trying to get admitted .
>> MICHAEL GRIER: Thank you Anna .
>> SPEAKER: He is showing and muted to me.
>> SPEAKER: Dr. Larry Appel, when you take any questions .
>> DR. LARRY APPEL: If there are any questions ….
>> SPEAKER: We have one question for Dr. Larry Appel. When - - share with PCP ?
>> SPEAKER: Hang on just a second. Each of the clients can comment through consent to share the plans with the primary care physicians , there is documentation of that in the process agrees to that information being shared with the PCP . I will let Doctor Butler percent and if there is time we will have each person briefly pointed the process. Dr. Craig Butler, are you able?
>> DR. CRAIG BUTLER: Can you hear me now? I apologize for the technical difficulties. Just by way of introduction, my name is Craig Butler. I'm the chief medical director with PA health and wellness. I'm relatively new to PHW and the MLTSS world. I'm climbing the learning curve but I'm not new to managed care. Either back and is an orthopedic surgeon so I hope my clinical perspective is valuable to the team of medical directors which has deep experience on MLTSS. If we could go to the next slide please. I was asked to share a story centered on the medical director role in care management.

This is a high level outline of a particular percent is basically a 52-year-old - - primary responsibility for physical health as well and manage that. He's receiving home and community-based services. He was recently hospitalized due to a systemic - - resulted in blood pressure drop . She is an extremely heavy lady , she cannot walk in the iconic swelling and exacerbated an extreme swelling that resulted in skin changes and shared multiple deep ulcers on both legs. She also had a deep ulcer on the backside where she laid most of the time in bed . She had chronic lung disease and chronic kidney disease that require analysis . Next slide please. So, there were some extreme difficulty and barriers to discharging her from the acute hospital environment. She clearly demonstrated a need for a long-term skilled nursing and was in fact as we mentioned before, we have seen with dialysis which also which is an added degree of difficulty in finding a replacement. We actually have the opportunity to send out over 132 skilled nursing facility referrals and if you're familiar with the volume in the state, you realize that is more than half by almost anybody's counts. Unfortunately, most of them would not accept the present due to the need for structured transport to and from dialysis and the combined complexity of her size and the wound care needs. The person is clearly describe had a large number of skin wounds in the legs and backside in these wounds in and of themselves almost a full-time job to maintain with extensive daily treatment routine that was required . At the time he looked at her, she clearly did not meet the long-term criteria for placement in a long-term acute care facility. This is a clinical factor that was rendered and she was not due clinically to meet those criteria. Her husband voiced he was unable to care for her in her current needs. Next slide please . This is a little busy but this is where the axiom of their is no I in team really applies and is specific to the medical director role in a CHC MCO. We are part of the team are in care management you can see in this diagram starting at the left , we heard on a mission of this participant was in the hospital. We immediately mobilized into dysentery care team start looking at her post hospital pathway and out into disciplinary team sometime included components of the CCU that you heard earlier from Heather Clark . They see the subcomponent of the adversary team which engages in those outreach efforts that I spoke to, they were looking for a skilled nursing facility to play certain after discharge from the acute hospital stay . In this third step is a rare time where it is in fact the medical director who leads a team effort in reaching across to speak with the facility position to find out the details they are not always included in the medical record that might impact his patients cared on the road and will specifically the appropriateness of any placement you might assist in delivering. The participant was in initially as an intermediate stage even though they did meet a long-term criteria was transferred under a single case agreement at a lower level of care we were able to get them to agree and understand that she did not meet this criteria , they would render and take care of her and meet her needs while she was there and we agree to basically manage that through a separate contract to facilitate this one-time placement for someone that is not necessarily media establishment criteria. We were able to then engage to get this number Medicare coverage. She qualified and we were able to secure that but that is a process, we then continued with a transition care team and we finally were able with a combination and time and effort to get her placed in a skilled nursing facility and we continue to successfully transfer . The into dysentery team still continues to reconvene even after we have a discharge in a skilled nursing team to facilitate transportation to a day off the center and continued wound care. This is a feel-good story that does and in a good result . My early learning and exposure it says that this is not uncommon . A team focus is almost mandatory, I don't think a medical director alone could ever do this , although we have an important role and it feels important to emphasize that this is a

team effort and is a team effort that we mph W really appreciate in our efforts to serve you all . I am happy to entertain any questions .
>> LLOYD WERTZ: I feel a lot better about this feel-good story and photo somewhere along the way that there's a behavioral health assessment done for a woman who is now no longer able to return to her home and her husband . Was determined and how without dealt with if it was found to be an issue?
>> DR. CRAIG BUTLER: If need the is established a referral is made made . I do not go into those details and quite honestly I cannot recall the detail was from a need assessment and witness of the Brisbane to utilize the services .
>> LLOYD WERTZ: It would be good to know that. If I was told I cannot come home to my own home and my wife , depression may crop up along the way for this care stream but thanks.
>> SPEAKER: Have a question about these , your conga theaters primary care team and I get – my clinical experience and all that stuff but what about practical real-world experience dealing with people with disabilities ? What I'm driving at is these teams that you have , is there any possibility of having people with disabilities on these teams ? I would probably say more so at the front end of the into dysentery care team but also the medical review team that evaluated services that were made . Is there any possibility of participant advocates being of those teams ?
>> DR. CRAIG BUTLER: From the OLTL side, we often will reach out to advocates that situation or assessment we feel to require what you are suggesting to get input on persons looking living specifically with the conditions being discussed so we can get the real world perspective . I will also let Doctor Butler answer to see how they get real-world experience as well .
>> SPEAKER: I imagine none of the doctors that have been analysis . They have never had to sleep in a chair overnight because the direct care worker didn't show up. I brought this up a number of months ago , there are things you can't learn from a book .
>> DR. CRYSTAL CLARK: This is Doctor Clark with UMPC. We talked about engaging with the facility that tremendous experience with this, we do actually have some staff who have some physical disabilities that are part of our CHC team. We have the person advisory committee members who provide quite a bit of insight about how we think about and plan for innovations in the space . We do try our best to get the perspective but we are always interested in welcome and taking suggestions like you said so you can take that back and consider as we go forward .
>> SPEAKER: I will specifically recommend the medical review team. If you are going to reduce hours , that could be a conversation of additional perspective that is needed .
>> SPEAKER: Great. Dr. Susan McAllister or Dr. Craig Butler, or any other comments?
>> DR. CRAIG BUTLER: No, the previous comments are well taken . On how to operationalize that given the timeframe around the decisions and processes .
>> DR. SUSAN MCALLISTER: Is Doctor McAllister, I will add on and echo Doctor Clark's comments. We certainly take input from our present advisory committee very seriously . We do have staff or physical disability and do try to see our participants to the length of the service correlator's when they're in the home and on the community so he insight to what the person is experiencing and be empathetic towards that . Thank you for your comments.
>> MICHAEL GRIER: Any other questions from the committee? I can say well we have the physicians , what Matt explained something that is not new . We have continually tried to advocate particularly for on committees that are making decisions about service hours, reductions and things like that . If you have the ability to have some of the disability on the committee they will be able to articulate very clearly what a reduction of 10 hours a week means because they have lived it . There's a number of people who

were volunteered to say if you ever do something like that, just please contact us . We're not trying to be a dead drum but we truly believe that in order to make informed decisions , you have to be able to have all the things together which is kind of what you guys are saying . I think it's really important that some consideration gets given to that.
>> SPEAKER: Hello, this is Juanita Gray, can I speak? Thank you so much, we have to commend you on that . That's exactly what we wanted , someone that has a disability to make the decisions as well I just wanted to clarify that, I wrote in about that issue about the deduction on hours and making the decisions that was harming a lot of us and people there on the program, the participants . They did not take into account how much he was hurting them.
>> MICHAEL GRIER: Any other comments from the committee members? Do you have any in the chat?
>> SPEAKER: Yes, we have a few. First one - - nursing facility to set this participant and interaction is unnecessary.
>> SPEAKER: We have a pretty extensive network of skilled nursing facilities . I think the difficulty in placement has to do with the large demand of resources this participant needed to attend to her daily needs combined with the logistics and demands of transporting to and from dialysis . When you add the structure to it and all the other components to replace it extremely difficult. We come knocking at the door and try to understand it but the degree of difficulty and challenges associated with a lot of the facilities that was actually placed.
>> SPEAKER: Do NCOs track people like the - - described to the time they may transition home?
>> SPEAKER: The short answer is yes.
>> SPEAKER: Was the long answer?
>> SPEAKER: I don't know if I have a long answer for you. We tracking people, there is an ongoing effort to look at any one in skilled nursing facilities for potential transition to a home . In this particular case , the participant husband did not feel like you to take care of the home . He did not feel like she could be reasonably supported giving her needs .
>> SPEAKER: Nursing home to nursing home is considered a transition?
>> SPEAKER: No .
>> SPEAKER: I must have misunderstood your question. We're looking for opportunities all the time of people in nursing homes to transition with home delivery services where they can live in their home. This particular case a participant did not want that option . Husband did not feel like you can maintain her at home and did not want to try that option .
>> SPEAKER: Home to nursing homes called transition?
>> SPEAKER: No, that would be for the nursing home to her home , that would be the transition we are talking about . In this particular case you turn off an acute care hospital and then we transition to her temporarily to a skilled nursing facility.
>> SPEAKER: The next question is related to Dr. Larry Appel presentation, is an individual case - - ?
>> DR. LARRY APPEL: How does the individual case? Is that the question?
>> SPEAKER: Yes .
>> DR. LARRY APPEL: So, there are several methods depending on the case . If it's a situation of an assessment , there is a review process . Another was a level of care assessment there is a review process by which most discrepancies to the clinical review team , this currently being between the physician certification and the assessor , if it's an emergency medical assessment , pretty much all of those come to the clinical review team and then it is an assessment related to a service plan production or a service plan change , then there are several ways . There is sampling, we do that , grievances . The

monitoring teams monitor these as well and consumers as well can call through I believe they can contact OLTL as well. All of those doors resulting cases, the clinical review.
>> SPEAKER: There was a question involving the case that is examples, please explain what services PHW is providing - - in the hospital ? Did she want to have a long-term placement ? Did PHW discuss providing full-time nursing at home ?
>> SPEAKER: Unfortunately I am relatively sure, I just joined the plan in November so we'll have a good familiarity with a lot of the interventions that took place ahead of my tenure and that whatever the timeframe where they would've happened. I apologize, I can circle back if you have an interest in knowing within the bounds of affecting the person's privacy.
>> SPEAKER: We have one for Jamie if she is still with us. What is the timeline for procurement of the CHC program? What will that process look like? When will the process take place?
>> SPEAKER: We are certainly meeting internally took the reprocurement of program. He will go to the same steps as before so there will are opportunities for comment and input the process . We have not yet assigned to the timeline yet . Hopefully within the next month or so we will start putting the timeline together so we get the information out so we have opportunity for the public and dispense and whoever else to provide comment . It's a work in progress so we not the full-time one yet.
>> SPEAKER: This is from Catherine from as of March, NCOs are classifying - - as the enemy and the question is - - causing issues. But the common wondering if NCOs funding source . So anyone can confirm that is the case as of March with that change.
>> SPEAKER: I don't have the answer, I apologize.
>> SPEAKER: Is now considered as estate plan option . I believe this occurred in the change. Because of these home accessible being put on the state plan . We include in the state plan of the program before it was not so anyone in the program is eligible which includes things like - -. It changed the process a little bit but the NCOs have to look at when they are assessing people's needs. Because a look at the health and safety , we start to look at the capabilities of supplying an essay situation to do that. When the change comes to the factory added an estate plan under the program prior to that one of the home adaptation options under this waiver program itself and that was available for our public population. Now it is being added to the state plan it can be utilized - - services through CHC or choices.
>> SPEAKER: That's all I have in the chat at this point .
>> MICHAEL GRIER: Okay. I want to thank the physicians for the valuable input . It was very good to hear the stories and the collaboration . I think you can hear from our voices that we want to be supportive of making sure that all folks need to be at the table and the consumers voices are heard as clearly as possible and softer at their own personal care . Thank you very much for for presenting to our committee today . The next thing on our agenda which we have five minutes for is any kind of additional comments for anyone outside of the committee that's participating in the meeting ?
>> SPEAKER: You pull that up maybe we can pull that afterwards to everyone but with the potential of the public health emergency ending , they are asking Stacy put in their plan and they can continue 12 the 14 months after the public health emergency including telehealth and telework so we hope that Pennsylvania will be updating and if they can share it then that would be great, thank you.
>> MICHAEL GRIER: As soon as you find any information we can distribute that. Any questions or comments from anyone ?
>> SPEAKER: Nothing new in the chat.
>> LLOYD WERTZ: I do know is happening but happy to move to adjourn .

>> MICHAEL GRIER: I was going to ask for a motion to adjourn. Is there a second?
>> SPEAKER: I will second .
>> MICHAEL GRIER: Alright. Thank you. Meeting is adjourned, I think you all for your participation today . I look forward to the next meeting and I really look forward to the meeting in June so we can be face-to-face. Everyone have a good day.