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Date: 06/01/2022

Event: Managed Long-Term Services and Supports Meeting

Testing testing testing
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Okay, I believe the broadcasters started, good morning everybody, this is David Johnson speaking, I will take attendance
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Hello, this is Michael sitting in for Allie from Pennsylvania.
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Thank you Michael, good morning. Cindy?
>>
Present, thank you.
>>DAVID JOHNSON: Thank you. Neil Brady? Gail has a scheduled absence, German Parodi? Heshie Zinman?
>>
David, Heshie and her mom are having problems connecting.
>>DAVID JOHNSON: Thank you. J Harner? Juanita Gray? Kyle Glozier? Lloyd Wertz.
>>
Present.
>>DAVID JOHNSON: Good morning Lloyd. Beth (NAME)?
>>
Michael be joining us in a second.
>>DAVID JOHNSON: Mark Guset? Mike Grier I know you are present, Bridget Lowry on the behalf of Monica Vaccaro? Patricia Canela-Duckett?
>>
Present.
>>DAVID JOHNSON: Good morning. Sherry Welsh?
>>
Present.
>>DAVID JOHNSON: Any other subcommittee members that are present that I miss?
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Hello, this is Jay Harner, I cannot take myself off of mute there.
>>DAVID JOHNSON: Good morning Jay
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This is German Parodi.
>>DAVID JOHNSON: Good morning German. Any other subcommittee members? Great, thank you, Mike, I headed over to you.
>>MICHAEL GRIER: Thank you David, welcome everyone to June, can you believe we are halfway through the year already? We have some housekeeping items that I would like to go over as we start the meeting. Some of the things - some of the rules, please keep your language professional. This meeting is being conducted as a webinar with remote streaming, a webinar participants, except for the committee members and presenters will be in listen only mode. While the committee members and presenters will be able to speak during the webinar, we ask that you use the mute button feature on your phone when not speaking, this will help

minimize background noise and improve the sound quality of the webinar. We ask participants to please submit your questions and comments into the chat box located on the go to webinar pop-up window on the right-hand side of your computer screen. To enter a question or comment, type it into the text box under questions and press send. Please halt all questions and comments until the end of each presentation as your question may be answered during the presentation. Keep your questions and comments precise, clear and to the point. Transcripts and meeting documents are posted on the listserv under the ML TSS meeting minutes, these documents are usually posted within a few days of receiving the transcripts. The captioner is documenting the discussion remotely. So, it is very important to state their name or to include their name into the chat box and speak slowly and clearly. Otherwise, the captioner may not be able to caption the conversation. This meeting is being conducted - also being audiorecorded, this is to comply with logistical agreements, if you have questions or comments are not heard, please send your comments and questions to the resource account that is listed on the agenda. Public comments will be taken at the end of each presentation instead of during the presentation. There will be an Additional time at the end for Abba comments to be entered into the chat box. The 2022 ML TSS sub dates are available on the Department of human services website. So, I think that is it. The end of our rules and I would like to go ahead and move into the ML TSS meeting follow-ups to discuss we had some follow-up questions from our last meeting and we have some responses that are back. German, are you here, are you going to responding the answer to the questions?
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Hello Mike, it is Paula, I will be responding.
>>MICHAEL GRIER: Okay, all right. Lloyd asked, how would any skilled nursing facilities that were not able to attend the webinars be able to access the recordings? We will get back with a location of where those are posted.
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So, we are still searching and looking to see if those postings are available to the public and when we find that out we will post that information. And the other question dealt with how many people attended those and Marjorie was able to say the approximate count from Pennsylvania health care Association was that there was over 300 attendees spread out across the three webinars.
>>MICHAEL GRIER: So, Lloyd will still continue to follow up on that to find out the postings of the webinars. So, we will continue to pursue until we find an answer.
>>GERMAN PARODI: Thank you very much, I appreciate that.
>>MICHAEL GRIER: Jay inquired if we will no longer offer Medicaid services for equipment after July 1, 2022, he stated that a participant notated from a vendor that they will no longer be able to provide any equipment to participants if they are CHC -- (NAME) from pH W responded during the meeting that she did not think this was accurate and would work in internally with pH W SMP to get a response back.
>>
So, the response that was given to us was that pH W let us know that (NAME) Valley services located in Milton PA is not an active provider with PA health and wellness, the records indicate the provider has never been a contracted provider in pH W network. If the participant is currently active with another CHC MCL, and plans to transition to pH W affective July 1, 2022 pH W will follow their continuity of care process for participants transitioning from another CHC MCL during the continuity of care., PH W will assist the participant in locating an in network provider to maintain continuity of services.
>>MICHAEL GRIER: Thank you Paula. Jay, does that help clarify that little bit?
>>JAY HARNER: Yes, thank you very much, I will speak with them.
>>MICHAEL GRIER: Okay, thank you Jay. I had asked all three CHC MCO's how many

participants that they have employment in the service plans right now and during the meeting Denise from UPMC reported that they had 368 participants that had employment goals into their person centered plan, the other plants did not have the information in front of them. So, all we did have a response on that as well.
>>PAULA STUMP: Joshua (NAME) from pH W said that PHW has 81 participants that have an employment call on the person centered service plan. Jessica Wilkinson from America health Keystone said that for their plan as of April ops report submission they have a total of 400 and 22 participants with employment related goals, documented on their person centered service plans.
>>MICHAEL GRIER: Thank you Paula. And the fourth follow-up is Jay had made a mention to have the MLTSS subcommittee with the agency of choice that is currently a one statewide vendor and would make recommendations and acting Secretary Sneed that there be more than one vendor per agency of choice Mike Grier, me also said that during the meeting they would take the steps to move forward to recommendation. And just to update everyone, you should have been CCed on the vote and recommendation that we made that were to acting Secretary Sneed and also I attended the Mac planning agenda meeting, their agenda was packed last month. And I learned about some of the procedural processes to bring recommendation forward to them and I'll be doing that later on this month. So, just want to let everyone know that that is where we stand. And that kind of concludes our follow-ups from last meeting.
So, it looks like we are going to move into Money follows the person in a nursing home transition update and Rachel, is that you?
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So, Mike this is Jamie (NAME), may I just make one comment before we move into the MFP, I think you see at the very bottom of the agenda, I just want to make sure that all of the attendees and the members see it as well that the next meeting on July 6, 2022 will be held in person with the option of webinar and remote training.
>>MICHAEL GRIER: That is fantastic news Jamie, thank you. And yes I did know about that and I did see that and so everyone can make their plans, it is optional, it will be a hybrid, I think this new world that we live in, but thank you.
>>JAMIE BUCHENAUER: Absolutely.
>>MICHAEL GRIER: Thank you Jamie, and I appreciate your efforts with this, because I know not all of the subcommittees are meeting face-to-face and Jamie was very responsive to our request to do that, so thank you Jamie. Rachel, are you ready?
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It looks like she is on mute, I cannot hear her if she is speaking.
>>MICHAEL GRIER: Yes, I cannot either.
>>RACHEL SINK: Good morning, can you hear me now?
>>MICHAEL GRIER: Yes, we can.
>>RACHEL SINK: Okay, all right. Good morning, my name is Rachel Sink and I am with the division of community living initiatives under office of long-term living policy Bureau. I have been given some time to provide updates on money follows the person as a relates to nursing home transition. So, just to fill you in on a DR condemns, a lot of times we will hear MFP versus money follows the person and NHT in place of nursing home transition, if I could have the next slide please? A little bit of background, Pennsylvania has participated in MFP since 2008 and we have had it restarted fairly regularly since then, although there was a time and I think it was around 2020 that we thought it was not going to continue. However, in 2021 new legislation was passed and it was continued I believe now through 2023. And in March 2022 CMS did announce some changes to the funding. So, for states already participating in MFP they will be reimbursing the rate for the supplemental services. So, there are three types of funding for money follows a person, there is demonstration funding which is a match for home and

community-based services provided to money follows the person participants in the first 365 days after the transition out of a nursing facility. Just to let everybody know, money follows a person is not a traditional grant where funds are provided directly to individuals or directly to agencies, the funding is actually reimbursed for the funding they can used in community-based services and programs. The second type of funding is administrative, so those are things that can improve the systems that provide home and community-based services and can do various projects and the third thing is supplemental services. So, we have always had supplemental services under money follows the person enemies are things like one-time expenses that people might have went if they are transitioning like a security deposit or getting their household furnishings set up. But, there were some changes made to the so we will just go over that. The supplemental services are not otherwise allowable under Medicaid and they are only available for money follows the person participants, so this is an opportunity for Pennsylvania to receive a 100 percent federal reimbursement rate versus I think it was like 56 percent before. And many of the services such as the security deposit have always been provided under other programs, community transition services has existed to cover things like that, but it is also being opened up. If you could go to the next slide. So, for people who are money follows the person qualified which means that they have resided in a long-term care facility for at least 60 days and they are transitioning into the community via the consolidated waiver, community health choices waiver or the life program there are certain things that can be covered that Pennsylvania can get additional funding from the federal government four. Because of the fact that in Pennsylvania we already had a nursing home transition program and we were operating that independently of money follows the person, as a result money follows the person results are a subset of her total nursing home population. And so a lot of the services we do already provide, it is just a change to what can be reimbursed or how much can be reimbursed. If you can go to the next slide please. So, under this new announcement, the category of supplemental service category may include short-term up to six month housing assistance to bridge the gap between the transition and initiation of other housing assistance. So, prior it was only one time, it was only the security deposit that was able to be reimbursed through supplemental services of MFP. That does not mean that was the only thing that we covered, because we do have a nursing home transition tenant-based rental program for transitioning individuals and that does help with people who maybe do not have the income yet upon transitioning and need a few months covered, but we are never able to have that reimbursed by money follows the person, that was state only funds. Additionally there opening it up to include food security via thirty-day pantry stocking, so that is food, that is not something that was covered prior. Also payment of certain activities prior to transition like home modifications, pre-tenancy supports, community transition services and case management and excess of 180 days prior to transition. So, what that means is 180 days prior to transition, people who were in money follows a person would have been eligible to have the reimbursement rate for transition services provided, but now it is going back further. And of course Pennsylvania does and has provided transition services regardless of their funding, but hopefully we will be able to take better advantage of at this point because of that lifted restriction. Also, housing costs such as application and administrative fees to secure the housing. So, these are changes and it is being opened up to cover more things than it did before. If I can have the next slide please. So, another project, this is something separate from the supplemental, in fact this falls under administrative funding for money follows the person, but this is also going to be a MFP program is the nursing home training services which we will have a RFQ coming out very soon in the next month and was a vendor is selected, they will be providing in person nursing home transitions at all of the nursing facilities in Pennsylvania, and that will be open for staff and residents and residents families to attend to get basic information about home and community-based services and nursing home transition. This is something that we have heard there is a continued need for because people are causally going to and from

nursing facilities and not everybody knows that nursing home transition is out there that we have services to assist with transitioning. So, the trainings will provide the general information about nursing home transition and home and community-based services and how to access the services. And I believe that is all that I had. So, we were going to leave some time for questions, so if anybody has questions.
>>MICHAEL GRIER: Any questions from the committee members?
>>
Lloyd here, are there specific plans for the transition of an individual from the nursing home to their own home in the community that would include those who are receiving behavioral health services into the nursing facility and would need to receive that into their new home in the community?
>>RACHEL SINK: Yes, when somebody is transitioning, that should be a part of the planning process is to look at what supports they need that they are getting what they need in the community and that they will still need and to make sure that all of those things are arranged for their transition.
>>LLOYD WERTZ: So there is work for the behavioral services for providing work in their homes?
>>RACHEL SINK: I am not sure I 100 percent understand the question - were asking about who is providing the services two specifically?
>>LLOYD WERTZ: It would seem to me that there would be folks hopefully getting outpatient services unity skilled nursing facility as their residence in that facility, however when they transition to home, I think it would be more difficult to provide those services into their homes, is there a direction toward providing that or will the individual be expected to get to an outpatient service provider site once they transition?
>>RACHEL SINK: Okay, so your question is the ease of access and your contrasting between services being brought to the person in the facility versus the person actually leaving their home to get services in the community?
>>LLOYD WERTZ: You got it.
>>RACHEL SINK: Okay. I am not sure the practicalities of how that works, I'm not sure if there's anybody else who does, I do not know like what specific behavioral health services like maybe some of them do go to the person's home, maybe some of them they have to access by going someplace else, but I'm not very knowledgeable about that, I'm not sure if there is anybody else on who is.
>>MICHAEL GRIER: Do any of the NCOs want to respond to that?
>>JAMIE BUCHENAUER: This is Jamie and Lloyd I understand your question, I think it depends obviously on the services that are offered in the county and by that behavioral health organization and obviously the individuals Medicaid and it depends on obviously their individual situation, so I think in many cases services, behavioral health services are brought to the person and in other cases obviously the person travels out of their home to access their behavioral health services, it just depends. But, I do agree with you that as part of the NHT process and planning to transition from a nursing facility to a home that should be accounted for in that process.
>>LLOYD WERTZ: Yes, just so it is being considered, there may be a potential of getting services in a home by a given provider if there could be an arrangement where the rates to do that are reasonable. But just so it is being considered as a person transitions, you have somebody who is mentally healthy enough now to consider moving and being transitioned into a home into the community and the services that brought them to that point may be attenuated based on the availability of in-home behavioral health services, I just hope that is being considered in a transition process in collaboration with the behavioral health organizations that are involved in a given county.

>>JAMIE BUCHENAUER: Yes, Lord we agree with you, it should be taken into consideration during the transition process.
>>LLOYD WERTZ: Thank you.
>>MICHAEL GRIER: Thank you Lord, any other questions from the committee members? Rachel?
>>GERMAN PARODI: This is German, is there a target goal for this fiscal year for the transitions through the MFP program?
>>RACHEL SINK: There is a goal that is set for the managed care organizations, yes.
>>GERMAN PARODI: Thank you Rachel, is that information on hand or will it be forthcoming?
>>RACHEL SINK: I would have to look to see what the exact number is, I could get that information to the group though.
>>GERMAN PARODI: This is in German, thank you Rachel and I am sure this has been created, if you could also share the previous years - lot 2008, but what has been the goal and the number of transitions to understand how the program has actually been effectively meeting expectations?
>>RACHEL SINK: I can look into doing that, thank you.
>>GERMAN PARODI: Thank you.
>>CINDY CELI: Hello Rachel, I had a question about the vendor for targeted in person services for nursing home staff residents and families and facilities, is that a vendor that would just give a very high overview of transitions and benefits for folks going home? Or what kind of in-service training would that encompass?
>>RACHEL SINK: Yes, that is correct, it would be a very high level overview so that people are aware that the services exist and how to access them. It would not be going into the weeds, because the audience would preferably be individuals who maybe were not aware of the program or were confused about who to contact to access the services. So, this would just be to get them started in to get the word out to as many people into the facility as possible.
>>CINDY CELI: Thank you.
>>MICHAEL GRIER: Other questions for Rachel?
>>PAULA STUM: ,If no other questions, I have some into the chat.
>>MICHAEL GRIER: Gray, go ahead Paula.
>>PAULA STUM: This question is from Cindy Celi, how do we receive a RFQ for trainings in nursing facilities?
>>CINDY CELI: Thank you, I did ask Rachel that, thank you.
>>PAULA STUM: Okay.
>>RACHEL SINK: The RFQ will be posted and I'm sure, it is PA marketplace that that is posted on? Somebody who is more involved may have to correct me if I'm wrong, but I think it is via the marketplace that the RFQ's are posted.
>>JAMIE BUCHENAUER: Yes, that is correct Rachel, it is E marketplace.
>>MICHAEL GRIER: Any other questions in the chat Paula?
>>PAULA STUM: I have one other question and I apologize if this was already answered, will there be a RFP for the training vendor?
>>RACHEL SINK: It is a RFQ technically. That is request for quotes.
>>PAULA STUM: And do we know when that will be?
>>RACHEL SINK: I'm hoping that it will be posted within the upcoming month.
>>PAULA STUM: I have no other questions regarding that presentation.
>>MICHAEL GRIER: Very good, thank you very much Rachel, that is very interesting as a presentation and it looks like we have some additional funds to support people moving on to nursing homes, so that is great news. Thank you.
>>RACHEL SINK: Thank you.
>>MICHAEL GRIER: Can we put the agenda back up? thank you very much Rachel. We will

move on into the agenda to value-based purchasing, Abigail and Wilmarie, you two from office of long-term living, you guys take over.
>>WILMARIE GONZALEZ: Hello, can you hear me?
>>MICHAEL GRIER: We can, thank you.
>>WILMARIE GONZALEZ: Awesome, thank you so much for having the conversation, Abby is on, but she has graciously asked me to try and cover some of these slides, I am the Bureau director overseeing the quality infrastructure specifically for the CHC program, I know many of the participants on the call. This presentation today is really to begin a conversation about moving into value-based models or arrangements with providers and we also need to recognize that since we do have participants on the call that it really is an initial conversation and we are going to try our best to explain a little bit more about value-based purchasing and what it means and what the value is when I want to go ahead and start on the second slide or the next slide. Where really it talks about again, this slide you will have seen it, we have used it in many platforms and it really is sort of a snapshot of what the quality infrastructure is for our community health choices program. Many of the components of our quality infrastructure we have presented at the MLTSS sub, we have heard about the data on the monitoring side and ensuring the MCO's are compliance. We have talked a little earlier on when we started our journey with the implement seat of CHC on ensuring the MCO's met network standards and that was early implementation for each of our days in and our state, we have presented information about complaints and appeals and I know that we have also shared information about critical incidents. You have heard a little bit about in previous presentations about something that we are starting out this year and that is the nursing facility quality strategy and talked a little bit about the learning network and establishing quality incentive programs. And so it really does come at a very good time where we are now steady-state in our state with our MLTSS program and it really is to again not only drive quality, but really drive quality of care and support the value of services that are participants are receiving. You have heard from Brian (NAME) in presentations in the past few years about what our consumers are telling us about the services they are receiving the other surveys that we have shared on the data. The AC BS (SP?) has kept a and that is very important, Pennsylvania is one of the few states in the country that not only has the federal required survey to monitor the MCO's, but also we have that secondary survey that really allows our participants to share their experience of care. On how their care is being delivered by each of the MCO's. We have talked a lot about some of the data that we are collecting with any managed care program, we must have AET walk and I know that we have done and presented information in regards to Abby Coleman with the measures that the MCO's are submitting with the accredited organization and there is a lot of conversation about what we are doing with quality for the program and not only pushing quality, but really making sure that the value of services that are participants are receiving are important to them and really important to really making sure that we not only support the care they are getting, but if there are other things they are getting, if they continue to live in place in the community or in a nursing home that again we are keeping track of those things and we are expecting our MCO's to do the same and we I have already shared some of the information on some of the performance improvement projects for the PIP's and I am hitting a lot of these factors because we talk a lot about all of the things that we have been doing in the past few years as we each and every year have not only implemented the program, but also recognize that now that we are steady-state it is really identifying those things that still need to be completed to meet some of those quality infrastructures that we together have worked and talked about, because this is something that while we have identified many of these factors as a part of our CHC program, there has been a lot of feedback both at the MLTSS sub macro from members and audience but also when we released our concept paper a few years ago where many of our disciplines and advocates and stakeholders have said hey, if you are going to bring in a MLTSS program in Pennsylvania, here

are some things that we certainly want to hear because this is where the survey comes in, but really important to educate our providers and consumers that in a managed care program, there are a lot of requirements in order to be able to be successful and implement a program effectively in our state especially, in Pennsylvania. The one block here that really identifies our conversation is value-based models and arrangements. This really supports a lot of the things that we have been talking about for the past few years and it is a good time now to start talking about arrangements with not only the MCO's, but these are arrangements between the MCO's and our providers and I will not talk too much about this last piece, but we have heard a lot from the Medicaid research Center entities are the presentations that Doctor (NAME) has presented from MRC or the University of Pittsburgh that kind of talked about that external evaluation of the CHC program, this is something that has been going on for a number of years and we have reported on a lot of this information on an annual basis as to what stakeholders and our participants are telling us again about CHC and the effectiveness of the program in itself. So, the next slide just really again begins the conversation about value-based purchasing and for purchasing of not repeating it I'll just put VBP and it will not be a tongue-tied, but Jamie and Jen (NAME) have talked about moving to the approval process and I know that we have already announced that it is with CMS, but we certainly wanted to make sure that we identified some information that we have incorporated in the current agreement with regards to VBP. This is where language has been put in our CHC agreement to really spell out shifting care from just services which is usually what you hear in a fee for service model which is a model that we had in AC BS programs and moving more into a quality of value and I'll keep repeating quality of value a lot, because it is something that is important for a program and it is something that many of our stakeholders have shared and a lot of the feedback we have received for the past few years and really the driving quality and value of services not only for our consumers, but certainly for our providers. The VBP models or arrangements really are a collaboration between each of the MCO's in our providers. To continuously improve that delivery of care and again these are all keywords that you will hear over and over and over again and recognizing that we do have consumers on the line and I want to make sure that they understand that part of this VBP approach is really again to drive delivery of care, poker care for our participants in our program. At the end of the day it really is to talk about arrangements between the MCO's and the providers and these are negotiations that the MCO's and our providers will be talking about, good quality of care means incentive. Delivery for the care that they are providing to our consumers and each of our MCO's will be presenting in more detail later this morning. On each of their perspectives. The final point of this slide is really on not only do we want to make sure that our MCO's are creating those arrangements, those payment arrangements between them in our providers, but we also want to make sure that we are measuring the impact of those arrangements with regards to those quality of care and quality of life to cements. The next slide again very high level, it just talks about why we are transitioning the providers from that fee for service into the value of services that are being provided as opposed to just providing services and again really measuring the care that our consumers are receiving. So, value-based purchasing is a little bit complicated because again it is between the MCO and each provider and so it is developing those arrangements between the two parties to really make sure that it is effective. And the last point to this and we will talk a little bit more and again this is all informational and we are certainly - and again this is the beginning of the conversation, you will certainly hear a whole lot more in the next coming months about this topic, because I think it is really important. But, the next slide is really to talk about some of those payment strategies that we have laid out on some of those models that I think are going to be important to support again at the quality of care, the efficiency of the services that are consumers are receiving. Reducing costs obviously and addressing social determinants of health. So, this
really just talks about the various strategies, there are three levels of risks for the payment

strategies that each of the MCO's will be developing between them and the providers as I mentioned before they will be categorized between the low, and performance-based contracting and you have medium risks which are shared savings and shared risks and bundled payments and then finally the high level which is really global payment. And so the next slide, we can get a little bit more into that low risk and performance-based contracting when you look at that it is really again moving away from the fee for service contract where used to exist or not exist in the form of penalties and payments, linking the providers with their performance and so each of the MCO's will not only be laying out what those arrangements will look like, but also determine some of these quality benchmarks and it will be - as they design these models, they will have to then work with us at OLTL to really make sure they understand what those arrangements are. Did somebody say something? Two the next slide is more of the medium risk and again that this is all informational. Because, again I know this is the first time you are seeing this information. And under the medium risks or these payment strategies we have laid out three categories as I've said before, one will be the shared savings and one is the shared risk and be shared savings is a supplemental payment with providers to reduce the healthcare spending level and annual cross benchmarks, it does get a little bit more complicated, but each of the MCO's will be able to talk a little bit more in depth about some of their perspective in some of these medium risk models and how they are planning on designing these between themselves and each of the providers. And again onto the shared risk side it really is about payments to providers being able to reduce not only the spending relative to cost benchmark, but also defining the subpopulation and also really making sure that at least they are looking at working with the providers to look at historical data by the consumers that they are serving and again adjusting risk and so avoiding things like hospitalization etc. And I think that will be really important. The next slide again is talking about the bundled payment and get -- and again this is a medium risk strategy and we have laid all of these strategies within the contract and each of the MCO's are required to select which model they are using, design it and also submit to the office to really make sure that they are following the things that we want to see to really make sure that we are avoiding things like hospitalization etc., but really making sure that the good quality of care continues to be received by our consumers and ultimately our providers will have an opportunity to tap into that incentive payment based on good quality of care. And so again, the final payment is another strategy that really supports that as well. The final VBP strategy is High-Risk which is the next slide and really this is more of a global payment. This one really is identifying a complete strategy that covers all of the services rendered by the provider hospital and health system and again being able to create and develop that arrangement between the MCO and the provider of services to really make sure that again they continue to provide good care for our consumers and ultimately provide and get the incentive from the provider because they are providing good quality of services. And again, there are other data sources that we will be looking at and again when you think of the previous slide that I talked about with regards to the quality info structure, the surveys will tell us how well the care is being provided, our consumers will directly tell us whether or not they feel that the services that they are receiving by their MCO by their service correlator etc. is to their satisfaction and I think that that is really important. That is really what we are striving to do. The next slide and again this is starting this year of course, the MCO's are required to have that 15 percent of medical portion of capitation and I will knock into too much detail because again I recognize that there are consumers on the call and I want to make sure that again they understand that our approach and goal in creating such an opportunity for our providers is to you know be able to support those providers that are doing very well and also incentivize those providers that would like the opportunity again to tap into the incentive model between the MCO's and them and ultimately impacting our consumers as I said before what the department will do is measure the requirements between us and each of the MCO's and each arrangement that the MCO's develop must be created with quality

benchmarks and financial incentives of course and really making sure that providers understand what those arrangements are and also be clear that if there are any penalties that that is clearly stated as well between the arrangements that the MCO's and the providers are putting together. With that, again I don't know if anybody has any questions, but certainly each of the MCO's will have an opportunity to talk a little bit more about their models and perspectives and I would like Doctor (NAME) and Doctor Kelly to take over this part of the presentation to again not only introduce each of the MCO's, but to facilitate the conversation because we do have providers on the call as well that they may be interested as well in learning a little bit more about each of the plants and what their perspective is etc. So, with that if there are no questions alternate over to Doctor (NAME) and Doctor Kelly.
>> Thank you Wilmarie very much and thank you all for attending this morning.
To have willingness to learn and begin the discussion about value-based purchasing. As Wilmarie noted, value-based purchasing into this program has significant potential to positively impact the participants experience. VBP initiatives are also a relatively new aspect to care for the LTSS community in Pennsylvania. So, we are all excited to begin this and at this point as Wilmarie mentioned, we are pleased to have representatives from each of the CHC MCOs to talk about their approaches to value-based purchasing. If we can go to the next slide.
So, the MCO's are each going to talk about their initial plans and their experiences and perspectives on these arrangements. And again we are excited to initiate this discussion and begin talking about the exciting work that is going to go on. So, with that, I guess I would like to turn it over to American health Keystone who looks like they are first to present on this.
>>
Good morning, can you hear me okay?
>>Yes, we can.
>>
Thank you Doctor and thank you Wilmarie for that introduction to value-based purchasing. I am Frank (NAME), director of operations
>>
Hello Nikki, how are you?
>>FRANK SANTORO
I am Frank Santaro (SP?) and I want to thank you for the opportunity to present on value-based purchasing, I'm hoping that my presentation gives you an idea of how we are approaching value-based purchasing into the CHC program and to make sure that participants receive the right services at the right time. Can you go to the next slide please I want to begin today to give you a sense of the scope of our program.
>>FRANK SANTORO: The CHC program is a statewide and we have a presence in each of the five zones. We have about 172,000 participants statewide which includes 91,500 participants into the southeast where we are known as Keystone. And according to the Pennsylvania Department of human services website, the CHC program for all three MCO's has an involvement of about 396,000 participants. That is a big number. About one of every 22 Philadelphians over age 21 are participating in the program. If all of the CHC participants formed their own city, it would be the second largest city in the state. Exceeding the population of Pittsburgh by 32 percent. And I bring this up to make a point. The state of Pennsylvania and the federal government through CMS has entrusted the care of 396,000 people to the MCO's in Pennsylvania.
They have also trusted us to use the money allocated to CHC wisely and to bring value to the program. Value-based purchasing speaks to the triple aim of healthcare. Which is to improve healthcare experience, two, improve the health of individuals in the population and three, improve the care of healthcare. And what I was thinking about today, I was thinking about value in purchasing. Or to put that around, purchasing value. And I realize that I do this almost every

day of my life. And I was thinking that many of us on this conduit as well. And specifically I was thinking of the example of dining out. You know, when you go out to lunch or dinner. We all have different thoughts on what quality or value are that we get at a restaurant on and we may measure that on our own value system. Maybe it is the portion size, maybe it is a selection of the side dishes, or better yet, maybe we measure quality in the freshness of the meal. For example, if somebody's meal at the table is served cold, we may choose to send it back. That is perceived as poor quality. Same thing with finding something in our food. Or getting a burger with Swiss when I asked for American cheese. And as our meal goes back to the kitchen and we set the table and talk and wonder, why can't they get it right? What is going on in the kitchen? Or is it the waitstaff? Is it the kitchen staff? There is surely something they can do here to improve performance. Maybe they need to have better training classes, maybe they need to have team huddles before the shift. Have better signage or label on the cheese, is there anybody looking to see if that entrée has been sitting there for 20 minutes and that is why it is Cold? What we are really asking is if there are best practices they can implement to make a difference. Are there better practices they can put into place so I can have a better experience and receive better quality. And if we inquire later, maybe we asked the manager or call the next day to the restaurant what we thought of the quality of food or level of service, not necessarily for us, because we may not go back there again, but so that the restaurant can raise their game, so the next people going there can get better quality. And if we have a great experience and we receive value and the level of service we perceive is high quality, then what do we do? We reward that establishment. We rewarded them in several ways. We tip well. We may rewarded the waitstaff for being attentive and making sure that we have gotten what we ordered and making sure our Ice-T was full. Two, we will go back, we will reward that establishment as they get repeat business. And thirdly, we tell our friends. They get more business, because they are perceived as giving value. So, purchasing value to the extent of the supermarket, cable company, phone carrier, we incorporate value-based purchasing in many aspects of our lives. But, we do not necessarily think about value-based purchasing and healthcare. But, we should. We can and we are. We can create programs that drive quality in the healthcare experience. Creating models and programs that incentivize providers to provide the right service at the right time. To provide high quality service that improves the participant experience and improve outcomes for all. Next slide, please.
So, we are moving from volume to value. In value-based purchasing we move away from that fee-for-service model where providers are paid separately on a per service basis regardless of the quality of service that is performed. Value-based transitions from purchasing service to purchasing care, where cost efficient, quality care and improved outcomes are not only earned, but rewarded. And that is what Wilmarie was talking about with incentivizing. Value-based purchasing drives provider performance and prevent hospitalization or rehospitalization and be structured so the participants get the right care at the right time. Next slide, please. So, who benefits in the VBP arrangement? I would say everybody on this call. Participants, because they have increased satisfaction with their experience and their quality of life. I would also throw in there their caregivers and family members. Who have better experience in their life because their loved ones are receiving higher quality. Effective providers also benefit, they see incentives in the arrangements that we will be creating with them and they may also find operational administrative efficiencies and they will identify and incorporate best practices and they may even have a higher skill set which may lead to staff retention and patient stability. Certainly MCO's will have enhanced relationships and collaboration with the provider community, reduce or positively affect the growth of the total cost of care and increased satisfaction of participants and caregivers. And certainly the state of Pennsylvania which will have enhancements to the long-term sustainability of the CHC program through the reduction of cost, credit population health outcomes and increased program efficiency. And who should think

about engaging in a VBP engagement? All of our service providers. This is an opportunity to be creative, to be collaborative whether you are a nursing facility, personal assistance service agency, nursing home transition provider, engaged with us, engage with each other, engaged with state organizations, to identify best practices and ways to drive quality and outcomes. Next slide, please. So, this slide really talks about the approach of value-based arrangements and provider collaborations. We really need to think about the measurements that we are selecting, what do we think are the measures that are meaningful, impactful and realistic? And the impactful part is really what we need to stress, we want to make a difference and raise all boats. And so we are looking at different measures and looking at our experience to make a true impact. One of the approaches that we are looking at this through potentially avoidable hospitalizations. Whether they be a UTI or congestive heart failure, or dehydration to identify and implement programs and educational opportunities and skill training that will decrease hospitalizations. Every hospitalization that is avoided or otherwise does not happen, there is a savings there and we can incentivize our providers to implement programs to affect hospitalization. We are also looking at performance. What are the appropriate targets? Are the providers and outcomes measured against themselves? Are we measuring providers against each other? Is there a range or set target? So, we are really looking at those types of questions in developing a value-based program. And also, can the MCOs and providers control the outcomes and then be accountable for them?
Data collection, data collection and reporting can be challenging for organization, we ask ourselves, what is feasible collect? What data sets are complete, accurate, timely? When looking to create these measures? Financial models. What is the appropriate level of financial reward and also financial risk for a diverse provider population? We know that there are some providers who are bigger in scope and can take on more risk, we note that there are some that are smaller and may not be as comfortable with taking on so much risk. And then innovation, what does a VBP model look like when we collaborate with various providers? It will be different for a nursing home that will be for a (NAME) agency or a PERS provider and we need to always remember that the provider community is very different in that respect.
So, that is the end of my presentation. I am not sure who I'm supposed to pass it off to. Or do we open it for questions now doctor?
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Yes, thank you Frank so much for the overview related to AmeriHealth perspective and approach to VBP in your example related to dining out and all of the other things that we do because they really did help put this into focus. Yes, if there are any questions or comments for AmeriHealth at this time, please ask the questions.
>>MICHAEL GRIER: Any questions from the community members for AmeriHealth on the value-based presentation? Paula, do you have questions in the chart? -- Chat?
>>JERMAYN GLOVER: Hello, this is Jermayn, as focus primarily on reducing hospitalizations as their measurement?
>>FRANK SANTORO: No, we - that is one of the main focuses, but we do have other focuses that we are designing now.
>>JERMAYN GLOVER: Okay, can be MCO's talk about the plans for VBP regarding nursing facilities?
>>FRANK SANTORO: Certainly from a merit health and I will let the other NCOs talk, we do have a quality program that is in place with the state and nursing homes
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>>FRANK SANTORO: We are leveraging the foundational work that OLTL has put in place for nursing homes and building upon that.
>>JERMAYN GLOVER: Thank you. Okay, we have a few more coming in. Are you able to

elaborate what else you are focusing on?
>>FRANK SANTORO: There are a number of things that we are focusing on and although they have not been submitted by OLTL, we are looking at measures around EVV which is electronic visit verification and we are also looking at some bundled payments for different provider types.
>>JERMAYN GLOVER: Okay, next question is and I don't know if we want to have an answer now and just have it be one that the other MCO's can help, please provide an example of VBP with a provider.
>>FRANK SANTORO: Will assuming that HCBS has the authority, I think preventing hospitalizations is something that a PAS, personal assistance agency, could help identify the risks or when a participant may be experiencing certain signs and symptoms and to get them to a doctor or seek medical care prior to them going to a hospitalization. So, I think about as a HCBS and an example.
>>JERMAYN GLOVER: And what is the timeline for VBP to be able to implement that?
>>FRANK SANTORO: Well, we have submitted a proposal on one provider type II OLTL, and I want to say yesterday, but I think all of the health plans are working towards getting all of their proposals into the state, if I'm not mistaken, it is July 1 as a submission date, and Wilmarie, could you correct me on that?
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Yes, this is Doctor (NAME), and yes we have had some submissions and we are looking for some more finalize submissions as of July 1, so you are correct.
>>FRANK SANTORO: Thank you doctor.
>>JERMAYN GLOVER: Okay, the next question, it is Scott (NAME) - why has it taken so long to start the VBP process? We are now four years into CAC and VBP has been a part of the plan, seems like to be starting a process.
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And this is Doctor lapel (SP?) and certainly we will halt this kind of questions that are more general until the end so we could have each plan participate and present, and certainly we will go through the answers to this as well.
>>JERMAYN GLOVER: Thank you. Will providers get a list of the things that the MCOs will be providing for VBP?
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This is also general as well and we will make sure that we review all of these at the end.
>>JERMAYN GLOVER: Okay, this one sounds like it is for OLTL, could you elaborate on the foundational work OLTL has put in place regarding quality? Did you also want to do that at the end?
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Yes, we will do that at the end as well.
>>JERMAYN GLOVER: Okay. And that is all we have from the audience.
>>MICHAEL GRIER: Jermayn if you could just put those questions in the parking lot and at the end of the presentation we will come back.
>>JERMAYN GLOVER: Yes, I will flank them.
>>MICHAEL GRIER: Thank you. Doctor Lapell (SP?) back to you.
>>DOCTOR LAPELL (SP?): Thank you Frank and AmeriHealth and everyone, we certainly will enter discussions at the end, we just want to keep the focus specific to each plan so each plan has time to present and we could have discussion and the next plan to present will be Pennsylvania health and wellness and many thanks and turn it over to them.
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Thank you Doctor, this is Anna Keith, can you hear me?
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Yes we can.

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Okay, next slide please. I want to thank Mike and David, Wilmarie, Jamie and Doctor (NAME), everybody listening, we are really excited to share this for PA health and wellness, I will go through, it is a little bit of a different presentation, I will go through what we are doing at PHW, I cannot get to the specific details due to privacy and contracting requirements that we have, but I think I have given you enough of a flavor in this presentation that you will have a good idea of what is going on at PHW and how we are approaching value-based purchasing in our program. So, one of the questions we are asking is the planning for Pennsylvania with our VBP model. We have seven OLTL approved programs as of January 1, 2022, these are presented to the state and we were very pleased that our programs are welcome and we got a lot of support from OLTL on the direction we were going.
Each program is focused on some key areas that I want to share, quality, which when we talk about quality in a value-based purchasing model we move more into quality and less into transaction. So, in a world where a provider would send in a claim and paid for the claim, identify that they did the service, the basic service that was a fee for service model, as we move into value-based purchasing we are talking about rewarding providers for doing that step. Identify what the plan is needed to address, working as a provider with the partner and delivering the quality of care at a level that exceeds the expectations of what you would find in a fee-for-service environment and that is really exciting because we want individuals who are enrolled in this program to experience a level of quality that they may not have had in the past in a fee-for-service model. The improved delivery of care and how services are being provided and how staff is being trained and what we are measuring and how providers are delivering on them. Performance-based provider incentives that make it worth the provider time to actually engage in the program. That is really important. Because, if the provider does not see the value in participating, they will not come to the table and be a partner. Improving the quality of life of the individuals that are enrolled in a DC AC program by identifying ways that we can improve these outcomes and brackets done to the providers we contract with. And incentivizing value over service, what is the participant receiving? What is the level of quality moreover the quantity. And that is where we are headed. Next slide, please.
So, let's get into this. As I shared, PHW has seven programs and the first being a nursing home program. The incentive was designed to support a payment structure and incentivize timeliness of service, the activities that support a successful return to the community and how we address social determinants of health that are out there not being managed , something as easy as a snap application for an individual and amenity healthcare metrics. Has the COVID vaccine been completed? Does the person have a flu vaccination? When they come out of the nursing home, in addition to that, ensuring that the pieces are in place for the individual when they come out of the nursing home to remain out of the nursing home. We do not want recidivism back, so we have to work with our partners to the stunt. The partners that we have in the program, we have I will say almost 7, we have six for sure, but of those partners that are in the program they are on board and receive a payment structure that rewards them for the timeliness of the various activities in this model. And we are seeing great results with our nursing home transitions and the longevity of the individuals that are coming out of the nursing facility. Another program is our service coordination. PHW has outsourced service coronation since we began the CAC program in 2018 going from 250+ service coordination agencies down to nine PHW has a value-based agreement with each of these agencies to not only meet the state standards that are identified in our state contract, those quality metrics are the key to not only PHW being successful, but also the state meeting its CMS requirements, so in partnering between OLTL, our health plan and our service coordination partners we work together to ensure that we can achieve fluid standards and in working with NCQA accredited agencies PHW is not only meeting but in the case of at least five of our providers we are getting very close to exceeding

our state metrics. And the others are coming along. Next slide please.
The point of care program, this is a brand-new program that we launched in January of this year, and point of care is designed to decrease health risks and increase the lessening of gaps in social determinants that a person may be experiencing that drives them for increased needs for care. Not only hospitalizations, but additional services that they need simply because the eyes were not on that their health risk may include, and we know that social determinants of health drive about 70 percent of the increased health issues that a individual may have. So, by taking a program in designing around whole person care and not just of the community-based needs of the person, but also working with their healthcare provider, our internal positions, Medicare plan and looking at the Medicaid only population and working with these individuals that are identifying in our metrics that they are at risk of increased cost due to potential hospitalizations or specialized care, we are able to get in front of that and address those social determinants needs to our predictive modeling tools to bring down those costs. When agencies we are working with, we have two specific providers at this time in this pilot program - when we work with them, to get an incentive payment for delivering on those reduced metrics. The next programs are electronic visit verification programs. This one is really around not so much use of EVV, but in incentivize provider to not only use EVV, but also to keep their eyes on the services that have been authorized for an individual and ensure that the services are being met. An individual who is authorized for a certain level of care should be receiving that level of care. So, we are incentivizing our home care providers, any and all home care providers that are enrolled in our program as a contracted provider have access to this incentive program. So, we are really excited about it and this first round of those payments are coming out soon in the next month. So, we are really excited about the organizations that have met the standard. Next slide, please.
Care gap closure, that program is a program that was designed to improve the metrics of the healthcare program as defined by healthcare effectiveness data and information sets, what you will hear is HEDIS, and this measures our identified measures that are called out through CMS and the health plans work towards addressing those measures with all of the enrolled notice of Vince in that plan. PHW has partnered with home care agencies to help HEDIS measures year after year which drive an individual to have increased healthcare costs or increased needs. So, by getting in front of these and educating the participants and getting their care gaps closed we will have quality of life for the individuals enrolled in our health plan. Another program, one of our last one so that I will share with you has to do with transportation, this is our only cost sharing program for value-based purchasing and it is designed to create efficiencies within the transportation benefit identified in a CHC program while ensuring that there is no abrasions to the participants transportation and that standards are maintained if not increase.
And then finally our primary care provider healthcare metrics is one of our primary outcomes and this has to do with primary care providers who are incentivized with healthcare metrics identified through HEDIS 's measures.
So, how is the experience of a value-based purchasing models leveraged from other entities within our enterprise and brought into Pennsylvania? What I want to share was a number of value-based purchasing programs that are a part of the LTSS models across the enterprise, the (NAME) enterprise that we are a part of, these include remote monitoring programs to close care gaps. Nursing facility transitions of care. I'm sorry - personal-care performance incentives. Nursing facility gold card program, which has to do with tiered levels of referrals for nursing facilities that are producing metrics above the standards that have been set and home modification programs and some of the opportunities in other states, skilled nursing facility quality incentive programs, very similar to the program we are partnering with OLTL to engage with our nursing facilities here in Pennsylvania. Quality incentive metrics for home care providers and nursing facility five star quality programs is in one of our states and quality incentive payment programs for nursing facilities to achieve transformation and that has to do

with reduced fall risks, improvements to medications, fewer bed stores, more mobility and a number of those areas of a nursing facility that folks consider to be eyes on to ensure residents have quality of care.
Next slide, please. The final question has to do with perspectives on payment arrangements that incentivize providers to deliver high-quality care. And I shared a little bit of that with you in each of the programs that we are offering to our providers, a pay for performance is probably our number one area. You perform, you get paid more, bottom line. In those come through in the metrics that we are measuring at the health plan. Shared savings models are very interesting to us in the value-based space, rate enhancements, we are going in that direction in one of our programs, bonus payments, we are providing in one of our programs and tier 1 provider status, when a provider produces quality over other providers, there needs to be rewards for that. And so PHW has engaged in this in the homes care space.
Next slide, I think this is over, so with this I will open it up for questions, Doctor Lapell (SP?) if you have everything and anything you have gathered.
>>DOCTOR LAPELL (SP?): Yes, thank you so much for a very cooperative overview of PHW's activities and the approach and background and resources available, I really appreciate it. Yes, if there is any questions for Anna and PHW, that would be great, I guess let's do those questions that are specific to Anna and PHW to at this point and we will take more of the general questions related to value-based purchasing at the end.
>>MICHAEL GRIER: Committee members, do you have any questions for pH W? Ed Anna thank you for the presentation.
>>LLOYD WERTZ: Are you able to share the survey results from the other states in which the programs that you mentioned have been implement it? Surveys as far as the parts of the participant satisfaction with services into those areas? Is there something that can be shared at this time or that you might share in the future.
>>ANNA KEITH: I would not have those available to me, I would have to do some serious digging, the best I can do is tell you that I can inquire about some information from the states that are in those programs. But, we do have enterprisewide value-based purchasing committee that meets every two weeks and they have been for a long time and at each of those meetings, the different health plans share what they are working on and what has been successful. They do not really get into the minutia of those details, but it is certainly worth asking about it if I can get it, I'm happy to share.
>>LLOYD WERTZ: Thank you, I appreciate it.
>>ANNA KEITH: Yes.
>>MICHAEL GRIER: Other questions from committee members connect --? Jermayn I'm assuming you have questions in the chat -
>>PAULA STUM: This is Paula, nothing in the chat -
(MULTIPLE SPEAKERS)
>>MICHAEL GRIER: (CHUCKLE)
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This is Bridget Lowery for the brain injury Association, I was just wondering, hello Anna, you talked about some of the incentives that are being developed or are currently being used, are they being done per service or per provider? How does that work?
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Each provider has to perform, so whatever incentive we have for example, a home care agency that is working with us on our care gap program, it is per provider and they have a scorecard that we have developed and we rate them against one another, there are well over 100 providers in that program and we launched in January. So, they keep coming in, we have new ones every month that come onto the program, but we do, we compare each one to the others and identify which are performing and which are not, and those performing are identified.

>>BRIDGET LOWRY: Okay, thank you.
>>PAULA STUM: Hello Mike, I have a question document through the chat. Hello, could you talk about the scaled nursing facility quality incentive program that you said you are developing with OLTL?
>>ANNA KEITH: The one on the back page, that was an enterprise that one of our other health plans are doing. Our nursing facility program - is the one OLTL is completing now with training with the nursing facility employees to improve quality metrics are a part of the three MCO's working within the project. Doctor Lapell (SP?)'s baby.
>>DOCTOR LAPELL (SP?): Yes, and we did present the nursing facility quality incentive program and we will be happy to provide at a later date sort of a more comprehensive refresher - extensively we do have seven managers in an accompanying learning network that we are working with the CAC MCO and he nursing facilities and the associations to develop some best practices and improve nursing facility quality on these measures including decrease in readmission, flu vaccination, influencer vaccination, preventing falls with serious injury, pressure ulcers, and decreasing the use of anti-(SP?) medications and UPMC is all a part of that as well.
>>MICHAEL GRIER: Anything else in the chat Paula?
>>PAULA STUM: Another question came in, why are they not including NHT providers in this? It's.
>>ANNA KEITH: You would have to reach out to me directly by email, we do have our NHT providers that we worked with for several years in the program. But, if there is a NHT provider interested in more information, you can definitely email me and I can put my email address in the chat and we can get you more information.
>>MICHAEL GRIER: Yes, if you could do that Anna, that would be great.
>>ANNA KEITH: Yes.
>>PAULA STUM: I do not have anything else.
>>MICHAEL GRIER: Thank you Anna.
>>ANNA KEITH: Thank you.
>>MICHAEL GRIER: Doctor Lapell (SP?), alternate back to you.
>>DOCTOR LAPELL (SP?): Thank you so much Michael and everybody for a good discussion. And now we have UPMC presenting their perspectives and ideas on value-based purchasing SOI alternate over to UPMC.
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Hello Doctor Lapell (SP?), this is Brandon Harris from UPMC, can you hear me?
>>MICHAEL GRIER: Yes we can.
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Fantastic, Mike, great to hear your voice as always. So, good morning everyone, it is still morning for a little bit longer, we are really excited to be able to present a little bit about some of the work that we've been doing around value-based purchasing and some of the success we have had.
We are really made this commitment and something that we really believe in and want to continue to expand as we go forward into this as well. I am the caboose, because alphabetical order always gets us in that position, so a lot of this could be repetitive to what we are body talked about, but I want to be able to give a high level overview of some of the efforts that we have underway, obviously there is a lot more coming down the line, this is something that we spend a lot of time and energy on as an enterprise and lots more is coming. But, but I want to talk a little bit about what we have done up to this point, because we've actually started on a value-based path well in advance of the requirement. Because, again it is something we truly believe in, so let's go to the next slide please.
So, really I think as everybody has outlined, the whole intent of moving from volume to value is really the intent to be able to incentivize providers to make sure the care is as best as it can be.

And really increase the quality of care of the folks that we serve. That is really the end goal here. And it is something that we truly believe in and are excited to be able to bring to the table here. We have a long history of diplomatic successful value-based purchasing programs across the Commonwealth. A lot of it is obviously on the physical health side, but it has really been with providers at all levels. Hospitals, primary care, behavioral health providers, with our skilled nursing facilities, as well as getting into a lot of specialty care, and we look at a bunch of different arrangements there to really be able to do that. And our vision overall is really looking at how we can bring that value not only to the Commonwealth, but also to the folks that we serve. It is really something that we view as a primary goal of all the work we are doing across the board. And one of the big things, we have really been an early adopter. And not just in the CAC program, but across the board. For CHC, it actually started as some of our efforts well beyond the requirements that OLTL put into place in 2022 and we actually implement it successful programs in 2021 mainly around nursing home transition, we moved our all to value-based payment arrangements and our personal assistance providers and really be able to better support our providers, especially through these troubled times with COVID. Obviously that strange things significantly accreted loss of issues, but again this is something that we view as an incredibly important thing to do and where we bring our value not only to the Commonwealth, but also again to the individuals that we serve, because at the end of the day if we can incentivize providers to provide better care, that means people are getting care in the most appropriate setting and being able to retain their independence and really be supported into the communities that they were to be served in. So, we really view this as a true mission across the board and it is something that we have put a lot of emphasis on moving forward and we continue to do that as we go forward so, next slide please.

So, as we all talk about, value-based payment arrangements really take all kinds of different forms. They are everything from pay for performance to really having a provider take on full risk and really help to support and manage the members in the participants in the best manner possible, the one thing I would say though is that it takes a lot of work. Movement between these various categories here on the slide, it does not happen overnight and you really need a lot of buy-in and understanding from the providers. It is not something that can happen really easily and really the approach that we take is really about building a partnership. And obviously we have a little bit of a bias in this being a provider owned health plan, but really the relationship between the provider and health plan are really the critical elements to really move in this direction, because you cannot do it alone. You cannot drop something on everybody and expect them to be able to move the needle the way that we want to. We really need to build a partnership and the partnership is really critical for us and these types of arrangements cannot be one-sided, because we have to work with the providers to make sure they understand what this means. And ultimately make sure that there is not a negative impact to the providers, but the participants. At the end of the day, you want to have positive outcomes here to really drive towards the overall clinical outcomes that we want to get to. And we really want to get that drive towards better quality of care. And again, we can do that through any number of needs. And really support the providers to be able to do that. And I think COVID has really just strained life in general, but it has really strained a particular a lot of our LTSS provided to the max, we talk about nursing providers as well as home-based providers as well, the movement has been strained because of some of the challenges that have been happening. And one of the big priorities is how can we get additional resources to those providers to help support them to be able to move to these various models? And that has been a very big focus through this, because with those additional resources, better care can be provided. You have an ability to really retain your direct care workforce which we know is really consistent with better quality of care.

So, it is really something that we have seen a lot of challenges over the past year, but that also

provides an opportunity to really double down and find better ways to support and bring that value to those providers and ultimately the individuals that we serve. So, if we could go to the next slide - Edward would talk about LTSS arrangements, LTSS services are really unique when you compare this to a lot of the other traditional value-based payment arrangements that are out there in the ether, with specifically physical health as well as behavioral health. And it has been something that has not been widespread until CHC came to the table. And some of the challenges that we see in this and it is not just a Pennsylvania issue, but these challenges are nationally as well. You know, there is a lot of challenges around capacity and limited data. Data is obviously a very important piece to really support these types of arrangements and you need to have objective information so that everybody has an understanding of whether walk into one of these arrangements, what is actually going to happen. You want to have that transparency for both sides to make sure that you understand that. And really one of the other big challenges when we look out a lot of the CAC population, there is a limited opportunity to get a return for some of this because of Medicare being the primary payer for most of the individuals that we serve. A lot of the information does not necessarily get to us, so it is really hard to collect and back to the point of making objective measures clear. They create a lot of significant challenges for that. And then obviously I think nationally we have seen a lot of movement to have a national quality measures it we have had some over the past few years really start to come forward, but there are national measures historically that we can look to to really try towards this. And some of the providers yes, we have a little bit more, but in a lot of the HCBS settings, it has not been as clear upfront which creates struggles of how we get to that partnership in those various elements. So, it has created a lot of these challenges, but again we have an opportunity now with CHC at the table with a lot of the engagement that we have with our provider networks and the individuals that we serve to really find ways to model and incentivize these things in the most appropriate manner possible. But, again, we want to make sure that it is feasible. A lot of providers come to us and they say oh, we can take a risk, we can do all kinds of different things, but when we actually get down into the details about what that actually means, the conversation turns very quickly. And you want to make sure that you have both sides agreeing to what this looks like to move this forward. So, we are really trying to make sure that we can start on the path and really build our provider network to be able to drive down that longer-term and more extensive value-based payment arrangements that we have there. So, we want to make sure that we can do that in a affective manner and that everybody walks in with a clear understanding of what that means. And then also looking because there is other things beyond just financial incentives, but other things can we provide that can actually help provide better care for our population? And sometimes it is just information. Sometimes it is just data that would not normally come to a doctor's office or another type of provider, it really helps them divide better quality of care. And so it is speaking about a holistic approach to how we develop these types of arrangements and I think that has really been a large share of the focus that we have brought to the table. So, with that I will go to the next slide, please.
So, really the work that we have done up to this point, obviously our overall goals, how do we better support our participants and approve their experience? And I think that is really at the heart of everything that we do. We want to be able to provide the best care possible to the individuals that we serve. And that is at the core of all of our discussions around value-based payments, how is this going to impact the quality of the care that our participants are going to receive? So, we want to make sure that that is at the core of it. And so how do we really more strategically aligned with our provider networks? And provide rewards and incentives that actually align with better quality of care? And one of the big challenges that we have and a lot of regards is transparency. A -- and a lot on the LTSS side, we do not get as many claims as we hope to, so how can we get better insight to really build models more effectively serve that and that has been a lot of it and in that process

How can we professionalize the workforce and really support him as best as possible? And a lot of programs really create clear accountability, and so reduce unnecessary care and really keep folks and individuals independent in a living and being served in the places that they want. And I think really when you look at that, with those goals, we have really walked into this to really drive towards that and a lot of the VBP's that we have developed, they do not completely oversee CHC, but a lot of the programs we have a pharmacy program that really provide support for those individuals, that have lots of prescriptions because a lot of our population does.
And I mentioned earlier, two of the big ones that we really started well before the requirements were around our personal assistance providers and really having over 500 of our providers receiving incentives around that and moving all of our providers into value-based payments, so we are body seen great success with this and we are really just excited about how far we can take this to really build upon some of the work that has already been done, so with that, I think that is the end of my flight, so Doctor Lapell (SP?), alternate back to you and if there are any questions.
>>DOCTOR LAPELL (SP?): Brandon, thank you so much, it is great to hear UPMC's experiences and at this point I think we can take any questions specific for UPMC and then go into some general questions and then take any others. So, Michael alternate over to you related to UPMC.
>>MICHAEL GRIER: Thank you Doctor Lapell (SP?). Committee members, any questions for UPMC?
>>LLOYD WERTZ: Yes, Lloyd again, sorry, Brandon, given that CC pH is such a large player in this across the Commonwealth, I wonder if there are any insights between the UPMC and the organizations that might positively impact this process of leaning towards value-based purchasing and provision of care?
>>BRANDON HARRIS: Well, I think we have obviously a great relationship Lloyd with your point to community care, but that has actually been one of the big things that we have been talking about as we look to the future here, what other types of arrangements can we get into to really develop along those lines and I think this is where the nursing facility side really comes into play. We do work with all of the behavioral health manager programs, but we have been having some conversations with community care around how can we address some of the unique needs of our participants both in HCBS settings as well as nursing facilities. So, in the next coming years we will be able to roll some of those things out, but ultimately that will be on the behavioral health side, because at the end of the day, they control the behavioral health dollars, but we can do some things in conjunction with them to really drive towards those points and outcomes. And that I think is one of the ultimate goals that we all have.
>>LLOYD WERTZ: Thank you.
>>MICHAEL GRIER: Any other questions for UPMC?
>>PAULA STUM: So, Mike, this is Paula, I have questions for all threeMCO if we would like to do those now.
>>MICHAEL GRIER: Yes, that would be great. Go ahead.
>>PAULA STUM: Okay, the first question I have here, could each of the MCO discussed their plans to increase workforce measures into their VBP?
>>MICHAEL GRIER: Brandon, would you like to go first since you are talking already?
>>BRANDON HARRIS: Sure. Sure, I will jump into it. I think that is actually one of her big things that we've been spending a lot of time focusing on. Workforce is obviously critical to all of the LTSS services and we are really looking at a number of things whether be it through some of the incentives and some of our value-based payment arrangements to really looking at other means to support the direct care workforce, because ultimately if you do not have a direct care workforce that is capable and able to provide the care, you're not going to be able to keep folks

independent and safe at home. So, we have regularly been spending a lot of time trying to look at how we can build incentives and other mechanisms and metrics into some of our value-based payment arrangements, we're not quite cracked the code completely yet, because I think we do not always get data onto the direct care workforce, but it is definitely something we have really been spending a lot of time on, because we have to either be able do it through training or other supports to keep that direct workforce engaged and competition has gotten incredibly difficult for providers to find staff to fill shifts. So, we really want to find ways to make sure that we are able to continue to provide the care that individuals need to stay independent.
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Great, thank you Brandon and Frank from AmeriHealth? Frank, are you having trouble getting on or on mute?
>>FRANK SANTORO: I am sorry, I was on mute and therefore a moment, can you hear me now?
>>MICHAEL GRIER: Yes.
>>FRANK SANTORO: I agree with Brandon, acquiring, retaining staff is difficult and can we do a measure and help incentivize providers to increase the retention of staff? There is a number of measures that one could probably incorporate in off the top of my head I am thinking about a measure around missed visits in perhaps where a PAS agency is not able to fulfill a visit, a scheduled visit to a participant, because they do not have appropriate staffing or folks call out or they do not have a replacement for that PAS worker, perhaps to incentivize them through a financial incentive to be able to retain and have appropriate staffing levels so that folks are not left without care. You can also look at staffing levels in a nursing facilities for example. So that way participants are receiving appropriate levels of care in a nursing facilities. These are just two examples I'm picking up off the top of my head.
>>MICHAEL GRIER: Great. Thank you very much. And also, Anna from PHW, anything else for this?
>>ANNA KEITH: No, this is happening with our value-based programs to share our EVV program but I'm happy to take you back to our team that is working on this as well and brainstorm other options that may be out there and what providers may be doing in other states.
>>MICHAEL GRIER: Great. Always good to get the feedback and see if we can't develop that into something. So, great question, thank you.
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Yes, Doctor Lapell (SP?), I just encourage everybody, there is a question coming from the participants that are in this meeting, I really encourage you to take a look at it and do a deep dive and see if we can work that into our value-based contracting, thank you.
>>MICHAEL GRIER: And we would certainly second that.
Great, Paula, other questions?
>>PAULA STUM: Yes. Could each of the MCO's talk about how participant home care will be included in VBP?
>>MICHAEL GRIER: Okay, sure, yes, we will ask each MCO to give any perspective on participant directed home care , I guess we can change the order up a little bit and so AmeriHealth, Frank, would you like to go first this time?
>>FRANK SANTORO: Thank you, this is probably the biggest challenge for me this morning. Because, I do not have an answer for that, VBP works really well when you have a large population and every participant who has self-directed service is there CLE or Commonwealth employer as opposed to an agency, so it is a level of complexity that is difficult to have measures when you have just one or two employees if you will taking care of a participant, but that does not mean you should not strive for increased quality. We are working with an entity to create all three MCO's are doing this to create a training program which is a 32 hour program which is been written into the CHC contract to offer 32 hours of additional training to workers to

increase quality of service that they provide to participants, so although it may not be a VBP program through a MCO, there is a initiative to create the quality of service date of the consumer directed program.
>>MICHAEL GRIER: Great. Thank you Frank, very much. And Anna from PHW?
>>ANNA KEITH: Thank you, we have explored this in one of our VBP's that we are doing in a care gap program, we have not been able to get the logistics together, but there have been conversations around this and we are still trying to figure it out so we can include that part of our service model in this program, we are not there yet in transparency, but I can tell you that we are looking at how it would work.
>>MICHAEL GRIER: Great, appreciate that Anna, thank you and Brandon? From UPMC?
>>BRANDON HARRIS: I was going to say did I have a career change? No, this is something we spent a lot of time, obviously we have done a lot of work on our past VBP said historically, until we transition into the new FMS vendor Tempest, which I will talk a little bit about shortly, I think it has been a little bit of a challenge to do that, but it is definitely something that we are trying to see what options we have to move in that direction, because it is an important piece of the overall program and we do not want to leave it out to be able to provide some of those VBP elements there. But because the participant is the employer and you don't have a licensed agency, it creates a lot of complexity, so we are just looking at what that could potentially look like, but we have had some early conversations with Tempest about what that could look like, but would we get to that transition, we can really open up those opportunities.
>>MICHAEL GRIER: Great, thank you so much Brandon. Okay, Michael, how are we doing on time?
>>MICHAEL GRIER: We are fine.
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Okay. Paula, do we have more questions for everyone?
>>PAULA STUM: Well, I would like to post this question here to Mike, we do have a presentation that is scheduled at 12 and the speaker will be calling in, so I do have a few more questions, but was wondering if we want to go to the financial management services presentation or if we want to continue with the questions?
>>MICHAEL GRIER: Is the person right now online Paula?
>>PAULA STUM: He appears to be.
>>MICHAEL GRIER: Okay, let's do the FMS presentation and then we'll come back to these questions after that. Along with the open public comments.
>>PAULA STUM: Okay, thank you.
>>GARRETT BEAUREGARD: Good morning, this is Garrett Beauregard, I was asked to give a short presentation about the transition from TPL to Tempest for the financial services and so I prepared a few slides with some detail, I'm actually here in Pittsburgh at our on-site or in person session here, lots of activities and I'm trying to find a quiet spot, I hope people do not hear too much back on noise. Let's go ahead and go to the next slide.
So, I thought we would start off with a little bit of a look back in terms of what we have done to get ready for this day. We did not put an entire litany of the dates, but back in January 2021, OLTL decided or notified the MCO's that this function would be handed over to us as opposed to the vendors of OLTL, and the implementation work really started in June or July. And since then we have had 11 stakeholder meetings, we have another one coming up on this Friday and we sent out at least 11 letters and we originally sent them out in July notifying the population of the transition, we have had 62+ broadcast which include email, text, Robo calls and that has been happening since February of this year and the OLTL team has been working with us and they have been using the Listserv system and they have been well attended and I think a large part because of these Listserv messages. We have conducted, by the end of this week we will have conducted 17 in-person events, so there were seven informational sessions in December

and again as of tomorrow there will have been 10 in person sessions in nine cities, there were two in Philadelphia because of the volumes that we had. Tempest has been running daily Q&A sessions, daily EVV training sessions, daily helpdesk sessions and has been since November of last year, and PPL has been involved in they have been engaging on our website and on the portal and into the call center. And Tempus has been doing about calling tried to reach people who have not engaged with different packets and for all three MCO's the service core leaders have been working and also in meetings
With participants or CLE and their direct workers to particularly help around packets and just to make sure everybody is aware that this is happening, so when we look back, we saw there is a lot of stuff that we have, next slide please.
So, just a quick status of where we are today, we have had over 18,000 packets returned to us and that accounts for about 79 percent of the common law employers about 74 percent of the direct care workers, I do want to point out that there are about 2000 direct care workers who have not entered time since October 1 of 2021. They are still showing as active with TPL and so we are pulled them out of the packet calculations because we want to make sure that if they do work, we will be able to handle them and we will give them a hug when they need to enter their time, but we have decided to pull out because this gives us a more accurate picture of the truly active workforce. Tempus is now responsible for taking all enrollments both in terms of direct care workers and taking referrals for new employers. The final handoff is going to happen on June 6 and so on June 3 PPL which is Friday - PPL stops their work in process enrollment and they will do a data transfer to Tempus. Last week we mailed out the TVV or IVR letters to all of the folks that we think will be using that system as opposed to the EVV app which is about 40,000 and those should have been received by people starting pre-much on Tuesday depending on where they are located, but we have expected everybody will have them by the end of the week.
Tempus is ripping up the call center staffing, there are 20 additional temp staff that is coming into the program right now and going through training. And then working with OLTL and PPL to enable a system for those folks who are going to start their transition this Sunday, they will get blocked on EVV - excuse me PPL's system, we want to make sure that there is a clean cut and no confusion about where folks and workers should be entering their time. Next slide, please.
So, just in terms of how to get ready for the transition, right? So, for the folks that are on the phone, if you working with participants in working with representative employers and direct care workers - step one is to complete and send in the packets and there are multiple ways to do that through Tempus's website, you can call service core leaders and work through the details to get that set up. The TCW's will be using the app for time entry and the portal for manual entries or corrections or they will be using the TVV or IVR system and common law employers will either use the portal or the phone system, the TVV IVR system, -- the CLE's all not be using the apps, and that is one thing that is different. And making sure that everybody gets their EVV system setup particularly for the direct care workers, so looking for the welcome emails and annkisam is a no reply system and so we encourage everybody to check their junk or spam folders to search for those emails because they have a link there that you can click to go ahead and register and set up your credentials. We encourage everybody to attend the training sessions, it is not mandatory, but we encourage everybody to attend one or to do on a self-serve basis, go to Tempus website, there are multiple videos in multiple language onto the website for the EVV services and there are also PDF files and help guides for various functions in the EVV system. And for those folks who are going to be using the phone system, the TVV or IVR system, they should be aware that they look for the email - it is not a email, it is a paper letter going to their home and those folks should look for that because that will have the phone number and not pin that the use to identify themselves and has instructions for using it. Next slide, please.
So, I wanted to talk about what to expect through this transition which has begun, but it really

gets into high gear starting on Sunday. So, this Sunday the schedule A workers will start entering their time and folks who are on the schedule B a week later on June 12 and Tempus will have a call center hours on the fourth and fifth, Saturday and Sunday, Tempus normally does not offer weekend hours for the call center, but they have found some volunteers from their crew inquire number have stepped up and so on this Saturday they'll have hours from 830 until 4:30 PM and they will have staff available from 7 AM until 8 PM on Sunday, that is a live staff, and starting on Monday the sixth, they will have ongoing extended hours from 7 AM until 8 PM with an increase in crew and I have my numbers here - it is going to be something like 23 - 30 staff on at the call center next week and it will ramp up after the 12th we will have over 40 staff on phones helping folks. And that will consist of what Tempus calls consumer relations, and these are folks that will be available on an ongoing basis to help folks with any questions and have the enrollment specialists to deal with enrollments and then we have the EVV specialists and they have been very very busy at these on-site sessions helping people get their apps set up. To be very very frank, the wait times are going to be long, they are already long right now and even as we ramp up staff, the wait times are going to get longer. There is just nothing that we are able to do about that. With any type of transition like this, particularly with technology, when other people are going to call in with questions and the intent here is that all of these calls are wanted done.
We want to make sure that they have the email that they registered with and once they hang up, we want to make sure that they have all of the tools that they need to go ahead and enter their time or approved times so they're not having to constantly call back, we're not try to get people off of the phones quickly, we are trying to be very thorough about it and make sure that when they are done, they do not have to call back. So, again on an ongoing basis, long-term, we do not expect that Tempus will have any issue in handling calls and keeping their wait times low, but there will be very long wait times during this transition . We should also point out that Tempus does have a call back feature which has been in place for some time now where if somebody cannot wait on the line, they can request a call back in many people are familiar with this, when you call a big company or airline or something like that, the system will call you back, it is working right now, we have a quite high percentage of people who do not answer those calls right now, but we encourage folks that if they do requested a call back, that they look for that Tempus number and answer it. So that they can get the help they were looking for. Next slide, please.
All right, just kind of final here, just to reiterate our goal, all along here as we go through this transition we have stated our number one goal is to really make sure
We avoid any missing paychecks for direct care workers. We know that this is a vulnerable population and people count on these -- we have A laser focus on that into the end, we have spent the last several weeks working through policy exceptions and so we have identified and prepared workflows for all of the situations for people calling in for example, a direct care worker has entered their time for some reason the employer is unable to approve the time because they have set up their EVV account or for whatever reason we will have a way to handle that. And so as it says here, we have policy exceptions for time entry requirements and once that policy exception is for time approval requirements, they will not be there forever, this is just a stopgap measure, and ultimately we will intend to get into a fully compliant EVV mode, but right now we are more concerned about is getting time entered and being able to approve that and make payroll. And we will have online and phone based EVV support and for the portal, that is really our focus right now. That is our focus to make sure that people have the ability to approved times to make sure we do a good job of approving payroll. That is really the end of my presentation, there are a couple of other slides on here to help out with some of the acronyms and some additional detail information that folks are welcome to go through, but I can try to take questions here for as long as folks would like to make time available for that.

>>MICHAEL GRIER: Thank you Garrett, any questions for media members on FMS? Garrett, I do have one, you said that it is - the calls anyway times will be long and you said it very long, does that mean 20 minutes? Does that mean two hours? Does that mean - I think that it would help for the folks that are listening to kind of get an idea - and I know you cannot answer this - each situation is different, I understand that, but the general what would determine to be a long call? Like in length of time?
>>GARRETT BEAUREGARD: Yes, again - probably all of the worst cases, it is completely dependent on the number of people that are calling in at any given time, the actual length of the call I think he can be upwards of 15 or 25 minutes to be on the call with an agent working through their EVV set up and making sure that they get their questions answered and any packet enrollment information that needs to get through and that is a length of time that you are actually interfacing with Tempus, the wait times are going to be very long, it could be half an hour, it could be an hour, it could be two hours, it just depends on how many people are calling, and that is why Tempus has set up the automatic call back feature, we know that workers are very busy taking care of participants and that many of them work a second or third or even 1/4 job where they are handling customers and that it is just tremendous inconvenient to wait for that one, so the automatic call back feature is therefore the purpose to understand that these calls probably always come back at the most inopportune time, but the Tempus staff is dedicated, we have been working very hard to get prepared for this and to make sure that everyone on those phones understands what they are supposed to do when somebody calls and says I need help with this. But, I really cannot forecast what those wait times will be without really seeing the volumes.
>>MICHAEL GRIER: Yes, I mean - it does sound like, I mean the goal of the call is to be completely done with everything when you hang up. And that is - that will lead to longer times I am sure -
>>GARRETT BEAUREGARD: It will end the alternative is to try to get people off of the phone as fast as possible which generally means they're going to hang up, look at the phone and go I don't understand and then turn around and go back in the queue anyway a really long time, that does not make a lot of sense to us, so we have chosen a path that we are going to work with these folks on the phone as long as they need to be to get their skills ready to go so that - we are teaching them to fish instead of giving them the fish, so we want to make sure that they are ready to go and do not need to call back.
>>MICHAEL GRIER: Thank you. Any other questions from the committee members? Do you have any questions in the chat?
>>PAULA STUM: Yes, I have two.
>>MICHAEL GRIER: Go ahead Paula.
>>PAULA STUM: First question is that we have clients who are very anxious about not having received the IVR call-in number, would you be able to share that number?
>>GARRETT BEAUREGARD: I don't have it it would not do any good without the pin number, those letters have gone out, like I said they have been mailed out on the 26th and 27th of May, they should be arriving in mailboxes now. I would suggest that by the end of the week if those have not been arrived, I would call Tempus and the weight will be long, but they can help either send the information or give the phone number and the pin number together and the letter went out with some instructions as well saying how to use the IVR which is also on the website, but the phone number alone is not going to get you anywhere. And just as a reminder, that letter will come from Tempus unlimited, so everybody look in the mailbox from that.
>>PAULA STUM: Okay, the second question I have is - is there any reason why recent FMS training sessions did not include Northwest PA and Northeast PA? Or Harrisburg region sessions?
>>GARRETT BEAUREGARD: We did one in Harrisburg, we did one in Redding and York, we

were guided by a heat map and I did nothing to find that, but the Northeast like in the Scranton area did not have a large population to indicate that on top of that we were expecting Tempus to have their office in the Taylor PA which is near Scranton and they have just been suffering from a complete inability to hire people for those sessions in fact we have Tempus's HR manager here in Pittsburgh today and she is trying to - handing out cards to direct care workers who may be interested in taking a part-time - not part-time, a 50-50 work from home, work from office job, HHA has engaged a staffing company to help with that and those resumes are starting to flow now. We went to the highest concentration of population that we thought we could get to within the four weeks that were available to us.
And we were evaluating whether we wanted some additional sessions in June, and if Tempus does not have the office set up by then, then that is something that we could look into.
>>PAULA STUM: And the last question that I have for the FMS is if somebody is following a pay schedule A with PPL, will they submit their time with PPL for the pay period ending on June 3?
>>GARRETT BEAUREGARD: Yes. The pay period actually ends on June 4, sorry, Saturday. And they would enter into their time in PPL time for care system through Saturday and then on Sunday if their working hours, then they would then switch over to the EVVY (SP?) app on Sunday.
>>PAULA STUM: Those are all the questions I have in chat for the FMS. And Mike I will ask for your guidance on how you want to go back into the value-based purchasing questions for all of the MCO's.
>>MICHAEL GRIER: And Doctor Lapell (SP?), if we are ready for the questions, we can move into the next segment of our agenda. Thank you Garrett.
>>GARRETT BEAUREGARD: You're welcome, thank you for the invite.
>>MICHAEL GRIER: Yes, thank you very much.
>>DOCTOR LAPELL (SP?): Yes, that would be great if we could go back to the questions for all of the MCO's.
>>PAULA STUM: Okay, this what I have is what is the timeline for value-based purchasing to be implemented?
>>DOCTOR LAPELL (SP?): I think we touched on this before, we have begun the process and subprograms are already started and we have had some initial submissions and we do have each plan has at least one program that we have approved and others are pending and we have a July 1 deadline for further submission and we will have more programs implemented over the course of this year and of course there are still some equality strategy measurements, that year is this year, so it is already going on and more is coming down the line shortly.
>>PAULA STUM: Okay, great. The next question is for each MCO, please provide a concrete example of VBP with a HCS provider.
>>MICHAEL GRIER: I think we have covered that one, did we cover that one before?
>>DOCTOR LAPELL (SP?): I think we came pretty close Michael, and if there are other questions, but we get to those first?
>>PAULA STUM: Okay. Next question, will providers get a list of things the MCO will be asking providers to measure for VBP?
>>DOCTOR LAPELL (SP?): I think what we can say is that each plan will have arrangements with providers and as we monitored the arrangements, one of the things that we look at is the clarity of the communication and be programs and so as far as a particular list, it may be more that we are just looking at ensuring that there is clarity between the MCO and the provider and exactly what will be incentivized.
>>PAULA STUM: Okay, thank you. The next question, could you elaborate on the foundational work OLTL has put in place regarding nursing home quality?
>>DOCTOR LAPELL (SP?): Sure, and again I think we touched on this already, the OLTL has the nursing facility quality strategy which incorporates two elements including a quality incentive

program and a learning network. The quality incentive program identifies six measures and a staffing measure and I'll double check those numbers and again it goes over the several MDS measures also related to staffing and is accompanied by a learning network to enhance best practice development all the way for each measure and beyond that, to really develop a learning community along the nursing facility providers and that learning network has gotten off to a very good start with a high degree of participation, we have had several webinars focus on some of the topics related to the equality and incentive program and we offered some excellent speakers and also had some focus webinars for specific populations.
>>PAULA STUM: Okay - this I'm not sure if it is more of a question or comment, but I will read you how it is written - if there is time, will you please review slide number 10, the 15 percent of the medical portion of the capitation to be expended approved via VBP and the comment is to thank the three MCO's for the excellent presentations.
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Sure, thank you so much and I'll start this ad Wilmarie, Jamie or others, feel free to add in. So, what we are looking to accomplish is we are looking to have there be a certain percentage of the medical portion - all of the expenditures of the capitation payment to be extended through value-based purchasing arrangements. And so we have some numbers developed and what the percentage should be. And that percentage may vary over time, but where we decided to start was to have 15 percent of the medical spend capitation payment be through VBP, or value-based purchasing and 7.5 percent of the long-term services payments through a VBP arrangement. And that is just so we have some work to start in terms of the overall portions.
>>PAULA STUM: Okay, the last question here is for FMS and I think Garrett has left, so if somebody else could answer this question - if a caregiver fails to utilize EVV, how will Tempus verify hours worked?
>>JAMIE BUCHENAUER: Yes, if he has left, maybe we can get back to the person who has asked the question on the response. I think Garrett had touched on it that there was a telephone system that individuals could utilize if they got a letter and a pen, but obviously we would want to make sure that that person has the correct information and so either Michael (NAME) or Garrett get back and get the right response.
>>MICHAEL GRIER: And Jamie, if we could just have that in our follow-up questions for next time so we can just have all of the committee members know that as well , I think that would be great.
>>JAMIE BUCHENAUER: Absolutely and Mike, I just want to announce on Friday, June 3, there is a FMS transition stakeholder meeting that the office of long-term living will be holding, again with Tempus and each of the MCO, I would encourage anybody who is interested in the transition or however many questions like this to attend the stakeholder meeting, I know that Garrett and the CHC MCO and our OLTL experts will be attending that meeting and on hand to present information and update the group on any updates they have on the tradition.
>>MICHAEL GRIER: And should they go to the Tempus website to register for that?
>>JAMIE BUCHENAUER: The office of long-term living did send out an announcement and we can let everybody know about that meeting and how to sign up for it.
>>MICHAEL GRIER: Okay, thank you Jamie. Paula, do you have any other questions?
>>PAULA STUM: I think I have one more. Where we talked about following up here at the end. And I'm looking for, and scrolling down through. Actually, this one is for Jamie, asking about why has it taken so long to start the VBP process .
>>JAMIE BUCHENAUER: Thank you Paula and the asker of the question, so obviously, community health choices started to be of limited in 2018, and it took until 2020 obviously to fully implement community health choices. So, knowing that there was a lot of planning and transition going on, not a good time to roll out some new requirements for our CHC MCO or our providers. 2021 was kind of our first year of a steady state and so we started talking about

value-based purchasing in 2021 with our CHC MCO and honestly provider groups, 2022, we were right to be clear writing these requirements into the agreements and start our CHC MCO and with our purchasing agreement that you can see on this screen. We did not want to push it and make it overwhelming too soon, especially with implementation and COVID, but definitely wanted to start in 2022 as we had one year of steady state under our belts and it was a good time to roll this out.
>>MICHAEL GRIER: Is that all of the questions that you have Paula?
>>PAULA STUM: I just had another one I came in. They are asking that we repeat what was said about the 2022 base year for nursing facilities. In I'm not sure if that is referring back to slide 10 - may be the asker could specify for me.
>>DOCTOR LAPELL (SP?): I think that relates to the nursing facility quality strategy and the base year, it was 2021 and the improvement measurement year of the improvement is now. 2022.
>>PAULA STUM: Okay, I have nothing else.
>>MICHAEL GRIER: Paula, you know when you are asking the question, I said about the HCBS question and I thought that we had covered it, I was mistaken. What we had done is you had read the entire question and led Doctor Lapell (SP?) said we will cover that later and I somehow thought we recovered it, if you could read that again and Doctor Lapell (SP?), maybe we could take a job at getting more specific on that. Thank you.
>>PAULA STUM: All right, let me find it. Okay Mike, the question was for each MCO, please provide a concrete example of VBP with a HCBS provider.
>>DOCTOR LAPELL (SP?): Gray, Paula, thank you so much. I guess we will start with Anna, PHW, so Anna, any answers to a concrete example for HCBS providers for VBP?
>>ANNA KEITH: I think I gave seven of them but I am happy to give you more specific example when I entered it with a care gap program working with a HCBS provider, we have over 100 of them in the home care space that are helping us to identify and close gaps in care for our enrolled HCBS participants and they are doing pretty well.
>>DOCTOR LAPELL (SP?): Gray, thank you. And Brandon? From UPMC?
>>BRANDON HARRIS: Sure, we have two big ones, obviously our personal assistance VBP it is where 500 of our providers are getting incentive out of it.
And all of our nursing home transition are in that as well, so we have been doing a lot there.
>>DOCTOR LAPELL (SP?): Excellent, thank you so much and Frank from AmeriHealth?
>>FRANK SANTORO: Yes, I also given the example of a PAS agency being a community-based service and to avoid hospitalization where the PAS agency could train their workers to identify issues that a member may be having to avoid hospitalization.
>>DOCTOR LAPELL (SP?): Gray, thank you so much.
>>MICHAEL GRIER: Thank you for all of you to responding to those specifics, are there any other questions regarding value-based for the MCO 's or the OLTL? From the committee members or the audience?
>>PAULA STUM: ,This is Paula, I have no other questions in the chat.
>>MICHAEL GRIER: Great Paula, thank you. Then, then we can move to the next item on our agenda which is the open public comment. Jamie, would you like to kick this off and then I guess we can respond to questions as they come in?
>>JAMIE BUCHENAUER: I'm sorry Mike, did you say you want me to get off?
>>MICHAEL GRIER: This is just an open format, is there anything that you would like to tell the committee or the audience before we start this?
>>JAMIE BUCHENAUER: No, I actually shared my meeting about the in person meeting at the beginning, so yes - I don't have any additional comments.
>>MICHAEL GRIER: Okay. Thank you. Any comments from the committee members or the audience that is listening? I will ask the committee members - we have been asked by OLTL to

also if we have ideas of things that they would want - that you would like covered in the upcoming meetings if you guys could just email me some ideas and then I could talk it over with OLTL to see if we can get on the agenda through the upcoming weeks?
>>PAULA STUM: Hello Mike, I have a question that came in, how do we project agency with the choice in our provider operations?
>>JAMIE BUCHENAUER: I think that is a question for me, so how will agency with the choice affect current - I'm sorry, did you say agency operations?
>>PAULA STUM: Current provider operations.
>>JAMIE BUCHENAUER: So, I guess I really cannot quantify impact yet, obviously we are working to make agency with choice and option in our community health choices and overall waiver programs, and so for those of you who are maybe not as familiar, agency with choice would be another way to provide personal assistance services and so currently a participant can choose the participant directed model of care or they can choose an agency model of care and it would just be adding an additional choice so participants could choose an agency with choice model of care where the participant is the co-employer within agency. The participant chooses their workers and those workers become an employee of the agency. So, it does provide another model of care for personal assistance services.
>>PAULA STUM: So, Jamie on that same note, the next question is are there any other updates for agency of choice.
>>JAMIE BUCHENAUER: I do not have any other updates.
>>PAULA STUM: Okay, the next question is for UPMC, can UPMC provide more detail on its PAS value-based purchasing arrangement? What are the arrangements and measures? For example, our PAS measures are to prevent hospitalizations.
>>BRANDON HARRIS: I cannot get into a lot of detail given the nature of these VBP arrangements, but we are not targeting hospitalizations at this point. The goal is really incentivizing providers to really build transparency into the system. So -
>>PAULA STUM: Okay, next questions are concerning agency of choice. First question is - will those interested in selecting a caregiver still be able to utilize current agency model services?
>>JAMIE BUCHENAUER: Yes.
>>PAULA STUM: The next question is - my understanding that with the agency of choice model, are the providers given additional funding to cover over time? And is that statement true?
>>JAMIE BUCHENAUER: So, I am working on recollection here, we are working on obviously ratesetting for the agency of choice model and so - I believe that we will have more information to share on that in the near future.
>>PAULA STUM: Okay, and the last question I have here is why is agency with choice necessary if it is already done by agency providers and why is there a limit to one provider?
>>JAMIE BUCHENAUER: So, I think we have already received this question in different forums and so honestly the goal of the office of long-term living in the Department of human services is to offer and to support our direct care workforce. We know that we have workers out there who are in the participant directed model who want access to healthcare benefits, paid time off and so agency of choice is an option, it is an option, it is not required it is an option to give individuals in a CAC and their workers in additional I want to say way to receive personal assistance services giving additional benefits to workers. So, again it is an option. So, that is our goal. The other question that I see is why limiting it to one provider? So, we used our current, I want to say we use our current experience with our financial management services vendor and obviously it is beneficial for the state to have one vendor implemented in the program, at least initially so they can oversee and understand how the agency with choice would be working and so that was one of our goals here and it is easier for us to manage one vendor initially.
>>PAULA STUM: Okay, another question came in for AWC. Would AWC have a different rate

and why?
>>JAMIE BUCHENAUER: I think I talked about that before, we have not determined a rate and that information will be forthcoming.
>>PAULA STUM: Okay, I have no other questions.
>>MICHAEL GRIER: Other questions from the committee members? Paula, still nothing in the chat?
>>PAULA STUM: I have one and again I will apologize if this was already asked, this question deals with the Tempus - curious how has returned to face-to-face assessments going and do we have any figures on how many assessments are in person versus telephonic now?
>>MICHAEL GRIER: Are there any MCO 's that can respond to that?
>>
This is Mike Smith from UPMC, we are up, we did
Notice that with this latest surge of COVID we have a little bit of a backslide right now.
>>ANNA KEITH: Hey Mike, this is Anna, I don't have the information in front of me, and so I'm not sure if we can bring that to the committee next time?
>>MICHAEL GRIER: Great. Thank you Anna. Any other comments? Paula, anything else in the chat?
>>PAULA STUM: No, I was wondering if AmeriHealth would be able to answer that last question?
>>FRANK SANTORO: This is Frank, unfortunately I do not have the information in front of me, but I can bring that back also.
>>MICHAEL GRIER: Very good, thank you. Paula, that would just be on one of the follow-up questions that we will have for the next meeting.
>>PAULA STUM: Exactly. And I do not have anything else in the chat.
>>MICHAEL GRIER: Any other questions by the committee members? I hear nothing, I will accept a motion for adjournment.
>>DAVID JOHNSON: Sorry, I have a problem taking myself off of mute.
>>GERMAN PARODI: I have a second, if we can talk about community services versus which ones are also for the institutions? If we can have that list, that would be great and understanding there is no time for that I have a motion to adjourn.
>>MICHAEL GRIER: No, German, that is an excellent question, just from the MCO 's what you're looking for is incentivized home and community based types of things? It does not have to be for the actual provider that is doing it, but just the differences between not and like nursing home or institutional care?
>>GERMAN PARODI: Yes, basic, HCBS and nursing home. Nursing institutions, the whole gamut. At the top level that would be very good as a visual.
>>MICHAEL GRIER: Yes, excellent, excellent question. For the MCO 's. Any other questions? All right, well I think everybody for their attendance today and if you were to travel, next time we are going to be face-to-face that Jamie announced at the very beginning, it is also a hybrid meeting, so you will have dial-in capabilities, but our location would be the honor sweep first floor 333 market Tower Harrisburg PA. So, in the event that folks to come to the meeting, I will see you there and thank you all of you for your participation today, I greatly appreciate it, thank you! Paula, you and Jermayn as well. Awesome work today.
>>
Thank you, take care.
>>
Thank you, goodbye!   R