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Date: 08/02/23

Event: Managed Long-Term Service and Supports Meeting

>> MICHAEL GRIER: Grent.
>> Alley Kronley?
>> ALI KRONLEY: This is alley. I'm here.
>> Anna warn height?
>> ANNA WARHEIT: This is Anna.
>> Cindy Celi?
>> CINDY CELI: Good morning, this is Cindy.
>> Neil Brady? Gail Weidman?
>> GAIL WEIDMAN: Good morning.
>> Hi, Gail, good morning. German Parodi?
I wanted to announce that Heshe Zinman submitted his resignation as a member of the MLTSS subcommittee July 26 of this year. On behalf of the committee, I wanted to thank Heshe for his participation.
Jay Harner. I believe Jay is present.
>> JAY HARNER: Yes, present, sorry.
>> No apologies. Morning, Jay. Waw neat gentleman gray. Juanita Gray. Kyle Glozier. Laura Lyons.
>> LAURA LYONS: Good morning.
>> Good morning. Lloyd is excused this month. Matthew Seeley. Monica Vaccaro will be joining this month but later this morning. Patricia Canela-Duckett.
>> PATRICIA CANELA-DUCKETT: Good morning, everyone.
>> Good morning. Sherry Welsh may be participating but we will mark her as absent due to prior commitments.
And lastly on behalf of Tanya tegmen low, Carrie Bach. Being called present. Thank you.
Anyone I missed that would like to announce themselves?
Hearing none, I will hand it over to Mike.
>> MICHAEL GRIER: Thank you, everyone. I will go over to housekeeping points.
Being in this meeting is your consent of being recorded. Please keep your language professional. This meeting is being conducted in person at the Department of Education building honor suite and as a webinar with remote streaming.
The meeting is scheduled to 1:00 p.m. We comply with logistical agreements we will end promptly at that time. All webinar participants, except committee members, and presenters, will be able to speak during the webinar. It helps minimize background noise and improve sound quality of the webinar we ask that attendees self mute during -- self-mute using the mute feature on your phone, computer, laptop when not speaking. Minimize background noise we ask that committee members, presenters an audience members in the room please turn off your microphones when you're not speaking.
The captionist is capturing the discussion remotely. It is very important for people to speak directly into the microphone, state their name and speak slowly and clearly.
Please wait for others to finish their comments or questions before speaking. This will enable

the captionist to capture the conversation and identify the speakers.
Please hold all questions and comments until the end of each presentation.
Please keep your questions and comments concise, clear, and to the point.
We ask that webinar attendees please submit your questions and comments into the questions box located in the go to webinar popup window on the right-hand side of your computer screen. To enter a question or comment, type the text representing and press send. Those attending in person who have a question or comment should wait until the end of the presentation and to approach one of the microphones located two tables opposite the speaker. The Vice Chair or chair will call on you. Questions, comments, of a personal or individual nature should be sent to the resource account identified at the bottom of the meeting agenda. These items will be directed to the appropriate people for follow-up for attendance. Before using microphones in the room, please press the button. You should see a red light indicating the microphone is on and ready to use. State your name into the microphone for the captionist.
And remember to speak slowly and clearly.
When you're done speaking, press the button at the base of the microphone to turn it off. The red light will turn off indicating the microphone is off.
It is important to utilize the microphones placed around the room to assist the captionist in transcribing the meeting, discussion accurately. There will be a lot of time at the end of the meeting for additional public comment. Webinar attendees should enter questions and comments into the questions box and include the topic to which your question or comment is referencing.
To those attending in person, you should use the designated microphones in the room. We want to remind everyone that this meeting is a place for general information and questions but OLTL managed here. Questions and or comments of a personal or individualized nature will be redirected to the appropriate people for follow-up. Responses will be sent directly to the individual asking the question, if you have questions or comments, that weren't heard, please send your questions or comments to the resource account at the bottom of the meeting agenda.
Transcripts and meeting documents are posted on the list serve under MLTSS meeting minutes.
These documents are normally posted within a few days of receiving the transcripts. The 2023 MLTSS sub MAAC meeting minutes are on the Department of Human Services meeting website.
I will turn it over to David.
>> DAVID JOHNSON: The following of emergency evacuation procedures. In the event of an emergency or evacuation we will proceed to the assembly area to the left of the Zion church on the corner of fourth an market. If you are require assistance to evacuate, you must go to the safe area located right outside the main doors of the honor's suite. OLTL staff will be in the safe area and stay with you until you are told you may go back into the honor's suite or told you are evacuated. Everyone must exit the building. Take belongings with you. Do not operate cell phones. Do not try to use elevators, they'll be locked down. We will use stair 1 and stair 2 to exit the building. For stair 1, exit honor's swoo et through the main doors on the left side near the elevators, turn right, go down the hallway by the water fountain. Stair 1 is on the left. For stair 2, exit honor's suite through the side doors on the right side of the room toward the back doors. For those exiting from the side doors, turn left and stair 2 is directly in front of you. For those exiting from the back door exits, turn left and then left again and stair 2 is directly ahead. Keep to the inside of the stairwell and head outside, turn left and walk down dewperly alley and chestnut street. Durn left at corner of fourth street. Cross fourth street to the train station. Thank

you.
Mike mining thank you, David. We are going to move on to some of the July 6, 2023 MLTSS meeting minute follow-ups. We have a few follow-ups to talk about here but there is a number of follow-ups also on the list serve. So if they are not on there right now, they will be on there shortly.
Let's go ahead and go to the follow-upes from the July meeting. From the upwinding number, subcommittee member, Cindy Celi asks if THC unwinding numbers covered on July 5 of the OLTL update, are specific to home and community-based services participants, Randy Nolan from OLTL will follow-up.
>> Hi, this is Paula. Charles Terrell of staff management office for PA Department of Human Services responded that the numbers are for everyone enrolled in Community Health Choiceses.
Specifically, anyone in a CHC plan who disenrolled because of failure to provide documentation that we believe based on the data from Deloitte is basically eligible for Medicaid.
>> Thank you, Paul why. Audience member Caroline have a less co-asks, is there anything instruction to going outside the county when working with a direct care worker. Can TSS be provide he outside of the county. To which responded, generally speaking, Medicare and Medicaid do not provide services for out of county travel but that OLTL would confirm. Jeremy glover from OLTL is looking into this for a response.
>> Paula again. So the question actually was for if there are any travel limitations for going outside of the country.
And Jeremy glover confirmed that it cannot be provide outside of the country.
>> What's one letter? Sorry. I apologize. Thank you for the correction, Paula. Very polite correction.
Related to the common law employees, subcommittee member, alley Kronley asked if CLEs can receive a kind of financial reward similar to value based payment, the agency received if the electronic verification numbers reached a certain percentage of compliance.
It may be an opportunity to expand compliance. Janice from OLTL to provide a response.
>> Paula again. This response will be provided as of September MLTSS subcommittee meeting.
>> DAVID JOHNSON: Great. Sub committee member Ali Kronley asked, how does May 2023 agency enrollment compare to the same time. How does that number compare it other historical numbers as well? All MCOs spo provide a response with numeral statistics from January 2023 to May 2023?
>> Hi, this is Paula. So MHC, the number of participants authorized for agency pass only from January 1, 2023 through May 31, 2023, 4,184 participants. Number of new participants authorized for agency and self direct from January 2023 through end of May 2023 equals 37. And the number of new participants authorized for self-direction solely if concert with agency from January 2023 through May 1, 2023, total 34.
The respondent, number of new participants authorized for agency for the same timeframe, was 810. The number of new participants authorized for agency and self-directed path for the same timeframe was less than 11.
And the number of participants that were authorized for self-direction, in concert for the same timeframe was less than 10.
UPMC responded with the number of participants with agency path only, for the same timeframe is 3,648. Number of new participants who were authorized for agency self-directed path for the same timeframe is 47. And the number of new participants authorized for self-

direction, solely in concert with agency path for the same timeframe was 236.
>> JULIET MARSALA: May I add one caveat?
>> MICHAEL GRIER: You bet.
>> JULIET MARSALA: When we numbers less than 10, we will suppress that data and give you a general number of less than 10 just in case anyone was curious why we didn't give an actual number.
>> MICHAEL GRIER: Thank you for that clarification.
Moving on with the agenda. We will move to the Office of Long-Term Living updates. Juliet, are you ready?
>> JULIET MARSALA: I'm ready. Good morning, everyone. Juliet Marsala. Office of Long-Term Living updates.
If we can go to the next slide. We have a little bit of -- quite a number of things on our agenda today to go over and talk about listening sessions.
And the Community Health Choiceses update or lack of updates, licensing website, 2023 nursing facility rate, our dual eligible professional population Medicare and counter data. The reporting, Department of humaner is services money follows the person. Water assistance program. And reminder of the master plan on aging. So if we can go to the next slide. The statewide listening tour. All sessions were held earlier this month on July 19, 21 and 22. They included over 160 attendees. We had a great discussion and heard back from many participants that we hadn't usually heard from.
We had a few sessions yesterday, as I had to give a big thank you to road for freedom to central PA for posting for the session at her center in addition I would like to thank Tina Sidell. It is in a reremote location. She and members of her staff did a lot of staff. It was a packed house. Which is no easy feat. So we are truly grateful for their efforts and our team left there with a lot of very specific learnings about the needs of individuals in rule Pennsylvania.
Our last listen and learn session will be in central PA in Menno layen in Brooke view health center on August 9. We centerly hope that folks will continue to spread the word and support foiks in attending either of those session he on August 9. Participants were sent out to all of our providers communities and via list serve. If you have if I questions on that, please feel free to let us know.
We can go to the next slide and talk a little bit about the statewide listening tour common themes. Many and some of these should not be a surprise to anyone. There was a lot of feedback on the coordination. In particular discussions to lengths thin response time to not knowing who their response coordinator was. Not being able to easily access their supports coordinator. Having supports coordinators who were new with high turn over that individuals felt they were training about various aspects of the program and in addition to specifically about key things such as a lot to digest there. Another thing that is not surprising is frustration with medical and nonmedical transportation.
With access to schedule earn length of reaching staff and quality of drivers. And certainly looking into that. Heard about individuals who needed tie-downs to be transported safely. And drivers who had no knowledge of using tie-downs was particularly concerning.
And continued reports of delays and issues with transit passes or key cards. And not receiving reimbursement for out of pocket expenses when the key cards or transit passes are delayed on certain bringing that back and looking into those situations when they had arrived.
Vacations and medical equipment and delays in approval and installation.
Were brought up. And confusion with regards to the process and having to repeat different elements of the process and concerns related to when individuals needed specialized

equipment that were sort of outside of the norm of what is usually approved. For example, someone needed a lightweight wheelchair versus standard wheelchair for purposes of community employment or driving. Difficulties with getting those needs correctly related to obtain the equipment that works for them.
Lots of discussion with the virtual delivery options with appendix K, virtual services also ended. We have returned to in-person services. So there is a lot of discussion about what we learned about virtual services. How they can support access. And we are looking into those comments and recommendations as well.
You know, we have noted particularly in areas of virtual services, we were looking at sort of the data for that and have found that folks have not necessarily been indicating when the session was virtual or in-person. So we are following up on that.
Personal services, we heard about the impact on people and their everyday lives. And the need for increases in wages for the direct care workforce. Increases in training.
And increases in support and helping to find personal care attendants and individuals served have had to make hard choices about whether or not to have no one or to just have someone and just having someone means just having someone who doesn't necessarily do all the tasks but creates a little bit of increase safety. And that is a large concern.
And heard a lot about service authorization. Service authorization reduction and the need for additional explanation and detailed explanation that individuals can understand so they know exactly why hours are reduced or services were denied.
And there is a lot more. And so that is the intension of what we are doing with all of this information and this is other programs within Office of Long-Term Living as well. We will be summarizing a lot of the feedback and putting it out to the public shortly, once they all conclude. So probably near the end of September or early October we will be putting that document out.
So CHC request for applications. There are no updates as of today. I just put it on here for this meeting. The burrow of human services licensing. We are working hard on a new web site. Joshua has been leading the website. There Teresa Hartman's leadership as well. Excited to announce that schedule it launch on August 7, 2023.
And a provider webinar on the new website is scheduled for August 11, 2023. This is in line with Governor Shapiro's goal that ensuring that licensing across the board, across all of the state agencies is improved and easier so we are excited to announce that.
Next slide.
I wanted to give an update on the 2023 nursing facility rate. Proposed rate service, recently closed on July 24. Office of Long-Term Living received three comments with regards to the proposed rate notice. Majority of those comments were related to how the methodology is impacting rates. This is the methodology that is in the Pennsylvania code for quite some time. But it is impacted by the fact that the first COVID-19 cost report years are entering into that equation. We will share additional information with regards to the nursing that sit rates once the final rate notice becomes available. Certainly, we will be moving forward with the proposed rates. Unless we receive instructions from the general assembly that we need to change that rate methodology, in which case we will be prepared to do so.
Also very excited to announce, and folks who were on previous calls, may have heard my excitement, we have, or get to, announce that we have successfully incorporated our dual eligible special needs plan Medicare encounter data. She has led this effort with her and her team, our bureau director, this is a huge list through the years in coming. Super excited for what accomplishment. So Medicare encounter data dates of service is January 1, 2018 to current for Medicaid participants has been successfully loaded into the enterprise data warehouse. We will

assist up in analyzing the complete utilization of services for our Community Health Choiceses participants. Our Community Health Choiceses participants, 93% of those individuals have Medicare as primary payer as they are dual eligible for Medicare and Medicaid. So this is pretty huge for us to be able to see the whole picture of the medical extent in addition to the medical data is also available it sister agencies such as OLSA so we can also see full impact there with the health services.

Next one. Okay. So another big list is our managed care program annual report has been submitted. And this is a huge effort led by Jen hail, our bureau director of policy and many other individuals across the OLTL. This is submitted no more than 180 days after each contract year. And we submit based on each managed program by the state. You will see ones by OMAP, you will see OLTL. And it provides information in a lot of categories. And specifically the following 10. Program enrollment and service area expansions. Financial performance. Encounter data reporting. Grievances, appeals and state fair hearings. Availability, accessibility and network adequacy. Delegated entities. Quality and performance measures. Sanctions and corrective action plans. Beneficiary support system. Program integrity. We submitted this report to CMS on June 22, 2023. And the report is open and available to the public and posted to our Department of Human Services website at the managed care quality strategy page. Which is, you can type that in and at pa.gov and that should come up. There is a lot of information there for folks to take a look at.

Next slide.

So we are also excited to talk about the Department of Human Services money follows the person program. Pennsylvania will receive an estimated $42 million in federal funding for Medicare Medicaid services. To continue our existing and to support new capacity building initiatives. That make serving individuals in the community possible. So that it truly does allow us to continue to work on initiatives aimed at diverting individuals of institutions. The important thing to note is important the 42 million has to be shared across all of DHS's services. I wish I had it all, but by don't. And the Office of Long-Term Living has used our funding and it has been in the works for a while.

But it is active to provide training and nursing facilities with staff. Very proud partnership was tickled to make that possible. So wanted to note that here.

But the Office of Long-Term Living is also engaging with the Department of Human Services team at large to really make the best use that we have of that estimated $42 million to look at priority populations, housing, involved populations and others to see how we can best utilize those funds. Lastly, low-income household water assistance program reopened. Wanted to make sure that folks are aware of that and ask that you spread the word to help Pennsylvanians with low-income access to drinking water services. So the applications open in July, they will close August 11. Household may qualify if they rent or own their home and have overdue water waste water bill they are responsible to pay. And if the household is within those income limits for those household size and the office of income maintenance oversees that program but we wanted to be sure that that resource is known to all of our providers at MLTSS in case you come across someone with needs. Then lastly, we will continue to remind folks that Pennsylvania Department of aging, it is ongoing and going strong. They kicked off across the state. It has been well-attended. Everyone, including yourselves, are invited to contribute what you think should be planned priorities, goals, objectives and initiatives to support the highest quality of life for older adults.

There will be a lot of announcements coming out of the Department of aging with regard to in-person listening sessions across the common wealth. Across every county. And if you're not

able to attend one of those listening sessions, we encourage you and encourage you to share the opportunity to submit feedback to the agingplan @pa website or to ask for additional information. Those are all of the updates I have. Are there any questions?
>> MICHAEL GRIER: Thank you, Juliet. Any questions from committee members? For Juliet? Any questions for the audience?
Anything?
>> JULIET MARSALA: I did have one last thing. I did want to share, it is not on the updates here. That I have the pleasure to join the graduation of the first training of direct care workers, the front-line direct care workers. And completing, I believe, 32 hours specific training. There were 200 direct care workers who graduated. Very excited to spend time with them to see their craft, their skill in their profession under consumer directed services. That was on Monday. I wanted to say congratulations to those 200 graduates.
>> MICHAEL GRIER: Thank you.
Pam.
>> Hi, this is Pam. Hi, Juliet. Is there any kind of list to tell us where the place of list of places the plan is going to?
>> JULIET MARSALA: I don't have that list but I can go back and see and maybe this committee would be interested in ra presentation in money follows the person in an upcoming meeting when we are closer to that finalization of what is happening with that. We can certainly make that request.
>> MICHAEL GRIER: Great, thank you.
Any other questions for Juliet?
>> We do have a question in the back.
>> This is Shannon. This is from Elizabeth. Is there any discussion in raise in rates for hourly providers.
>> JULIET MARSALA: Right now the budget is still in a holding pattern. With the general assembly.
With regards to raising rates at this time, there is not.
I would encourage Elizabeth to bring that need to her representative and educate and inform them of that need. Because my understanding is that the ability to raise minimum wage did not pass.
>> No further questions.
>> MICHAEL GRIER: Thank you. Any further questions for Juliet? Thank you, Juliet, for the comprehensive update. Very much appreciate it.
Let's move on in the agenda. To Community Health Choiceses annual independent assessment by the University of Pittsburgh medical research. Dr. Howard Degenholtz.
>> HOWARD B. DEGENHOLTZ: We are conducting an independent evaluation in the choice of program. And I have presented this committee about once a year since we got started. I want to thank my team, Keri Kastner, John Yauch, Teresa Beigay.
The social and urban research.
And the health services research data center. We also have a team of quantitative analysts, Jie Li, Lingshu and Michael Sharbaugh. Damian just graduated. We are very proud of him. Evan Cole and Julie Donohue from the Medicaid research center.
An overview of our organization and the findings that I have here today. The Medicaid research center is at University of Pittsburgh. We have been conducting an independent assessment of the program implementation and impact. We use data from a wide range of sources. We place a high priority on parties paint voice. This augments what we learn from administrative data

including things like focus groups and surveys. We are in regular contact with the Office of Long-Term Living on our finding and we provide numerous reports to the Office of Long-Term Living. That helps verify and validate anecdotal reports that OLTL hears from other sources and can aid their decision making. We provide quarterly reports and annual reports and this presentation is based on our internal annual report for calendar year 2022 activities. I will share findings from qualitative key informant interviews that we conducted across the state. Interviews with nursing facility leadership, interviewers with program participants, interviews with home and community-based service providers. I might use the acronym HCBS. And allocate data. And might touch on a couple ancillary studies related to health. And I might add one more clarification that our team in 2022 referred to the independent assessment and that is a report required by CMS along with the federal waiver process under which this whole program operates. And we are engaged to produce a similar report for the second waiver and if you want to know what that means, I'm sure Juliet --

[Inaudible]

And the nitty-gritty of the regulatory requirement.

This is a graph that displays how the different methodologies inform each other and I will just move on to the next slide for key informant findings from interviews with stakeholders. This is 29 interviews we conducted. Mostly with nursing facility operators.

But I'm going to show interviewers with nursing facilities, home care agencies, equipment providers and transportation providers. This is through the calendar year of 2022. From provider perspective in 2022, we -- providers were generally optimistic about the ability of the program to provide equipment or services that program participants need. They did report that there were lingering issues from during the pandemic that caused delays in obtaining the equipment.

That was still ongoing in 2022. In thinking back to the transitions of CHC, the way we designed our study was that we conducted interviews in each of the three implementation region. Southwest, southeast and the northwest and central parts of the state. Before, during and after the implementation of the program. So in 2022, we were still following up with providers and stakeholders with regard to the final phase of the implementation even though it had been implemented in 2020. By 2022, our expectation was that the implementation, that had been accomplished. And generally speaking, the providers of 2022 reported that things were going fairly smoothly.

There were some comments regarding transportation that relative to the programs at CHC had at a level of complexity or transportation providers. I think this has been well disseminated with regard to the brokerage model that was implemented. And there was concern from transportation providers about the actual rate of utilization of their services and feeling that the volume of service had dropped off to some extent. And we also were, we also documented in 2022 the beginning of MCOs implementing incentives for the verification accuracy. I think you heard more about that.

Next one. 2022 we conducted interviews with a number of nursing facility operators. This is part of a fairly complex study of nursing facilities that we conducted. And it was an update to a study that we conducted in 2019.

In 2022 we interviewed nursing facility residents, administrators and other members of the leadership team in about 18 different nursing homes around the state. And I just want to touch very, very briefly on, I want to touch on findings from the nursing home administrators in this presentation today, a report on interviews with nursing home residents is still pending at OLTL.

The interviewers with the nursing homes cover the program. The program put in place to incentivize nursing home to improve quality of care. This is in conjunction with long-term care

learning network and we also asked nursing home leadership about transitions. As we just heard, the money follows the person, that continues to be major issue and of high interest.
As I said, we did conduct interviews with nursing home residents at each of the 18 facilities regarding their experience regarding the cap of the nursing home instrument and also nursing home resident quality of life and those results are not available yet today.
The nursing facilities were distributed across the state. We interviewed three nursing homes in the southwest. Three in the southeast. And seven in the central area and had profit, nonprofit and government homes in each region. Some preliminary findings from the leadership interviews, early in 2022, we found that a nursing home administrators were not really aware of the quality incentive program or long-term care learning network though going by the numbers it is very high when we just reached out to a random sample of nursing homes leadership, they were early in 2022 a few of them had not heard about that program.
But by the end of the calendar year 2022, the program pretty well disseminated. The program and working network. So even though it got started at the beginning of the year, the rollout sort of took through the full year to reach everybody.
And the major, major finding from the nursing home leadership is probably a shortage of significant challenge in 2022.
I will provide some brief findings from a product we call the participant and care giver experience interviews. These are interviews we are conducting with random sample of CHC program participants. The follow-up is defined to represent all three rhymeons.
Also, to prep accident older and younger users according to services as well as adults actually eligible and did not use long-term services.
About 1600 program participants and the southeast and central region of the state. Topics included health status, quality of life and access to care.
To the next slide, I will just provide just a very brief summary. One of the things we do during these interviews is in addition to asking people about their health status, we also give participants the opportunity to identify any concerns regarding the care and services and make sure the concerns as soon as possible to determine the action, whether it is operational, in regard to program, for example, program eligibility or a concern we forward to the participants MCO. So that is the 1600 participants that we interviewed during 2022 we have 230 individuals gave additional information about concerns to their -- their opinions were not fully -- and the individual with more than one issue. So 451 specific concerns from the 230 individual participants.
The majority had to do with access to care from the bar charts. Over 60 to 70% today do with access to care. These are things like they needed a piece of equipment but did not get that equipment. Or they wanted to get a PAFs and they didn't have PAFs and they wanted more hours and didn't have the hours and things like that. Next, second category, had to go with the quality of services they received. Some issue or concern with their care giver or something like that.
And then the smallest category had to do with communication. Primarily having to do with their service coordinator. We have every year of since the beginning of the implementation, conducted a survey of home and community-based providers. And the purpose of the capture of the provider experience is the Community Health Choiceses program. Basically their perception of the impact on quality of impact on participants and collecting data on COVID. The impact of COVID in 2022 we completed with a we call way find of the survey in the winter. So that January/february of 2022 and we launched a wave 6 of the survey in 2022 which ended in early 2023. A couple highlight from focused on wave 6 which is the most resenting finding. So

supplemental payments that Federal Government made available to the state to distribute to providers and we found that of the services, providers survey, about 30% report having to apply for payments and about 12% indicate they had not applied and were planning to. We asked what they were planning to do with those provider payments, and in supplemental payments that the chart, you can see the most common had to do with getting vaccinated or sick pay for workers with COVID and wave benefits. And about 30% would use funds for retention bonuses and about 40% for sign-on bonuses. Next slide. So this is the little bit out of context.
But these are some questions we have been asking for several years about, do you consider Community Health Choiceses to be critical no your community's future? Do you consider Community Health Choiceses improved quality of care or access to care in Pennsylvania? What we found here that was, what I'm reporting here on this chart sb that percent of providers reported that they either strongly or somewhat agree with that statement and while the number of for critical organizations future, that kind of makes sense and providers that depend primarily on the program for their revenue.
And really importantly is the numbers for improved quality of care. These are the highest numbers we have seen in six years since the survey. This is actually quite positive in tirms of provider perceptions of the Community Health Choices program.
[Inaudible]
>> HOWARD B. DEGENHOLTZ: I don't have that handy.
[Inaudible]
[Inaudible question]
>> HOWARD B. DEGENHOLTZ: About 50%.
So before, what we saw across all three implementation regions, is preimplementation, providers were optimistic and then in year one they, optimistic and then as they reach year 2 and 3, they adjust and report positive findings. So what we see here is basically under water in 2021 but by the end, by 2023, it was general positive.
So next few slides have to do with analysis of --
>> MICHAEL GRIER: I apologize to interrupt you. . Would it be possible to pause for questions for the first half of your demonstration before going into data.
>> HOWARD B. DEGENHOLTZ: Certainly.
>> Apologies. Regarding the participant care giver interviews. Participants with identify any concerns regarding care services that are responses or forwarded to OLTL to determine appropriate action. Is there data on the, I guess, categories of responses from this thinking regarding participants --
[Inaudible]
>> The question is, can the slides be put on the screen. This is slide 12 with the title participant experience interviews concerns.
>> HOWARD B. DEGENHOLTZ: In talking to OLTL about publishing a version.
>> Are you able to disclose what the codes are?
>> HOWARD B. DEGENHOLTZ: I don't have any.
But for example, these are the broad categories and within each category we have coded each ofs to responses more specifically.
>> For follow-up, trying to get an understanding, thinking about the experiences, not to elevate the experiences of any one, but trying to determine whether there is a distinction between a subjective disagreament with the program as it is agreed upon by the contracts in the agreement versus an experience that is perhaps a violation of the contract.
>> HOWARD B. DEGENHOLTZ: So in this part of the survey, people aren't asked specifically,

are there any issues of concerns that are not addressed to your satisfaction. So essentially, it is surveillance of unresolved issues.
But we can't adjudicate whether they are an issue of perception versus an issue of outside the contract. So a lot of it is people saying I can't get a hold of my service coordinator. So we don't know if that is true or not. We just know that they shared that concern with an independent research and then we share and we also confirm that they give us permission to share their name and identification information of OLTL, then at OLTL will then start a process to see, to essentially substantiate that concern. So a lot of this I have requested a home modification for example, and I'm waiting for my home modification for the past number of months. We will pass that concern along to OLTL. They will pass it along to the appropriate CHC plan and let them go and see what is actually going on.
>> I appreciate it, thank you. I appreciate your flexibility to pause for questions. Are there other questions for Dr. Degenholtz for questions from the subcommittee?
>> Hi, good morning.
>> You need to turn up your --
[Inaudible]
>> Slide 2.
Let's trouble shoot.
Let us trouble shoot, Ali.
>> ALI KRONLEY: Thank you. Just wondering if the participant interviews, the participant experience interviews, include the participant directed participants and if so, is there a way too break data out based on that?
>> HOWARD B. DEGENHOLTZ: That is a really great question. So we do have the ability to identify is a directed services users. And we can report on that. Yes. That is in the plan.
>> ALI KRONLEY: Cool. Super exciting. Interested in that. The other question about the use of the COVID funds. I saw the numbers around folks did apply and intend to apply. Is there any effort to track how those dollars were spent. How they were received and spent. Particularly in terms of impacting the workforce.
>> HOWARD B. DEGENHOLTZ: We surveyed providers and in the general many workforce and so that is what that chart shows on the right.
And for oversight and overlap.
>> ALI KRONLEY: Are wage increases not on the list?
>> HOWARD B. DEGENHOLTZ: It just didn't come up, I think. I think by gave an other category and it wasn't very common.
>> Question for Juliet.
I'm interested in following up on what the doctor was saying there. What OLTL --
[Inaudible]
Can you ballpark some of that.
>> Can you turn on --
>> JULIET MARSALA: So Matt Seeley is interested in issues from 512 with information with access and other concerns that individuals have and report back to the committee. Is that correct, Matt?
>> And Dr. Degenholtz, if you could turn off your mic, please. Thank you.
>> MATTHEW SEELEY: Many.
[Inaudible]
>> JULIET MARSALA: I don't know right now.
Many for accuracy.

We will definitely come back with more of an answer to that question.
>> This is Anna. Can I ask a question about slide 12. Who is included in that? Is that CHC? Nursing home? Just one setting?
>> HOWARD B. DEGENHOLTZ: Thank you. This covers participants who live in the community, both the users of HCBM and nonusers of HCBM.
>> Any additional questions at this time? For Dr. Degenholtz?
Okay, go ahead, Dr. Degenholtz.
>> HOWARD B. DEGENHOLTZ: Okay, slide 17. We have been tracking LTSS status. We track the overall enrollment, that the yellow shaded section of this graph. And then we have broke it down into home community based services, which just choosing 2017 as a starting point, increased by 23%. The nonLTSS population increased by 24%. And the nursing home population by our analysis decreased by about 25%. Next slide.
And that transitions to what you see in a, what I call, a rebalancing analysis.
This is a statewide number. We reported this in past broken down by region.
But basically, in the -- broken down by age group. This is the percentage of people who are LTSS users. Users of long-term user support. Percentages in home community services versus a nursing home. Blue bars represent the 21 to 59 population. And you can see prior to Community Health Choiceses launching in any part of the state, around 80, 82% of 2016, 2017. Then that increases to by the end of calendar year 2022, 90% of people in the community home services versus nursing home. Orange bars are older adult population. You can see hovering around 40% but then in 2018 that steadily increases to now before 59% by the end of 2022. That is consistent with the decreases and nursing home.
Next slide. We track over all total medical spending from 2016 to 2020 based on availability and this is total spending on all categories.
And you can see that it basically steadily increases but it is black in 2020. That is due to COVID. Then we broke that out into nonLTSS spending, home and community services spending, and nursing facility spending. Actually at this chart shows it broken down by region.
So you can see which regions are relatively more expensive in terms of total spending.
This is the effective Community Health Choiceses on per person per month average Medicaid spending. It is broken down by region.
And there you can see basically that it trends in the orange line is southeast and you can see basically it was trending up until you get to the 2018, 2019. Where it is kind of hard to see on the graph but it slows down slightly from 2018 to 2019 with CHC. It is implemented and as I said before, it is basically where the beginning of the pandemic here. The blue line is, you can see, steadily increasing but it slows down after 201 and the gray line, which is the third implementation zone, you can see that unfortunately that is compounded with the COVID-19 pandemic but it also, so it simply, from 2019 to 2020, is compounded with the pandemic.
The next chart focuses on HCBS spending. This is broken down between the younger population and older population. And what we see here is that in the southwest from 2017 to 2019 you did see the three lines are on the same trajectory.
But after implementation, it basically flattens out. The growth rate flattens out. If you look at the orange line, it actually bends slightly between 2018 and 2019. And these graphs don't really show the effect of the limitation of the third region just because we don't have the 2021 data handy.
And you can see the same thing in the older adult population where you see the oranger line bend slightly. You can see it is on a trajectory going upward but that slows down in 2019 and in the south west it flattens out dramatically.

So I will turn to the next chart. And then come back to the analysis. Sorry for asking people to -- sorry if it seems like I'm jumping around a little bit.
But we have done a bunch of research on the major priority of choices there is an expansion of benefits with regard to behavioral health that occurred along side implementation of Community Health Choices. Major change being the access to behavioral health challenge association. There is Medicaid and Medicare claims data. Although as Juliet mentioned, we did not have access to the counter data for this analysis. So it is limited to the CHC enrollees who are in Community Health Choices and in traditional fee for service Medicare population. Right now, this shows that this is a little bit more than a third of Community Health Choices and what could be considered a serious mental health. Either major depression or the premium of people living in nursing facilities, that number is actually much higher.
About 63%. We have fail sis of views of behavioral health services. These findings are very very small but we reported them to OLTL. They needed to be tracked. One, it seems like we basically focused on the population of people with severe mental illness because that is a higher priority. We saw a slight decline in the use of primary care and specialist with people with severe mental illness alongside the implementation of Community Health Choices. We didn't see any changes in having emergency department visit or optlyization rates.
On outpatient health use is mixed. And some regions going up and some regions seem to be going down. That is things like psychology services. And it did seem like in-patient hospitalizations are increasing slightly. We don't have any -- we don't really know the reasons for these changes but we share these patterns with OLTL so that it ends with the --
[Inaudible]
[Inaudible]
>> CHC led to decline in primary care physician and any idea why that would be?
>> HOWARD B. DEGENHOLTZ: Unfortunately, I don't.
And just to put that into context, that is just among people with the severe mental illness.
>> Right. 63%.
>> HOWARD B. DEGENHOLTZ: And those findings are driven primarily by the nonnursing home population. Because access to primary care in the nursing home is very different construct than in the community.
[Inaudible]
>> HOWARD B. DEGENHOLTZ: Yeah, just for the record. No, I don't have any anecdotal evidence.
But it is something we are continuing to review as it continues over time.
>> And the slide you were on, in this second region, can you go back a couple of slides.
>> So the last thing I want to share are announcements that we did regarding the Community Health Choices of program that go on it broader initiatives regarding racial and ethnic disparity in health care needs and health care outcomes in Pennsylvania that my team and my colleagues are doing on an ongoing basis outside of Community Health Choices but for the Medicaid program. The question that we have, that we wanted to ask and look into was, were there any, are there any, differences in community service use in the Community Health Choices population that might be contributed to race and ethnicity. And one of the things that we observed is that there is a difference in one very specific measure, which is focusing on PA sfntle hours. One of the things calculated that I didn't share, with data on this today, is the average hours of PAS service on by day, we report and track over time, but what I'm showing here is the hours of personal attendance service or per person per day service broken down by race and also showing that over time. So what happens with this statistic is that if we just

focused on the more recent years, you can see lines, and we will focus on nonHispanic black and black which are orange and gray lines in the middle of the graph, you can see that that line is actually higher. There is a line for white nonHispanic white participants and there is about an hour per day basis and there is higher utilization of personal service among racial minorities. That is the opposite of what we usually see in terms of active care issues.
Regarding race and ethnicity. So the question we have been asking ourselves, is when adjusting for disability, because there are not just in Pennsylvania but there are low trends associations between race and levels of disability.
This is difficult to track and we continue to analyze this question. We can't fully answer it. We are really just asking it. So the first question on the left is the person on the left just shows that first of all, the hours of care on a per person per day basis are with the level of disability. So more disabled people use more home care. Which is what you would expect. And both in the older adults and in younger population.
And when we look at the, trying to find by region, you can see that there is a difference rate actually is more focused in the southwest. And this is a little bit of a confusing chart.
But it shows on the right, the one-hour difference I'm describing is it exists in both the younger disabled and old are disabled in the southwest. In the northeast the difference is smaller.
We didn't have data for the central region on this chart. So this is something that we're continuing to look into. We don't have anecdotal evidence or understanding. It is not simply due to differences in underlying disability between racial and ethnic groups on average but it it something in the pattern of care.
So I will finish up. We have a number of deliverables in the Office of Long-Term Living.
We have a full report on the nursing facility study. And our overall external evaluation of the QIPP earn learning network. And a full report on HCBS provider survey and we are expecting an analysis on the participant survey that I mentioned before. And the last slide is my contact information.
Thank you.
>> MICHAEL GRIER: Any question from committee members.
Or audience?
>> Hi, --
[Inaudible]
My question is for --
[Inaudible]
As far as the --
[Inaudible]
For the MCOs, as well as -- for provider perspective and participant perspective, when it comes to the participants having the right to have a choice and their care, and when it comes to the actual MCO actually stating that the care is to be provided within the network, that kind of limits their choice to their provider. In addition on the provider perspective, OLTL we have to wait, you know, x number of months to get into say OLTL. Then you have a waiver and it is a couple of other wavers. However you cannot service a client or participant with just that waver. You have to in turn with the waver in conjunction with the MCO. So that is a roadblock. So have you this waver but you can't do anything with the waver because have you to be in the MCO and the MCO is saying that they are not accepting any provideis at the present time. So where do you go from there and how is that fair to the participant and provider?
>> May I start? Thank you for coming and providing public comment. From the perspective of Office of Long-Term Living, the Office of Long-Term Living stretch providers for enrolling in

Medicaid for individual to eligible and meet our criteria for becoming an enrolled provider. The common real j, the office of long-term living is willing to work with any willing and able provider within our waver program. We we talk about participant choice of agency, it is the choice of they have multiple choices that they can choose from.
And so the managed care organizations are responsible for building networks that have choice and access for individuals to get services. It is not about unlimited choice for agency or providers and that their choice of provider agencies. So those are very different things.
On our website and the Office of Long-Term Living we provide information to providers that let them know that enrolling in our Medicaid program does not guarantee that they will be enrolled or allowed into managed care organization networks. That is a decision for managed care organization to determine for themselves when their networks are adequate to meet regulation. Every agency or every provider that they tell their network may add an additional administrative cost to them to oversee and ensure those providers are also being monitored to meet all regulations and requirements that they have. So again, for them, it doesn't necessarily mean they have to allow any providener their network. They just have to ensure that they have enough to meet the needs of the program.
That is information that is on their website to let folks know that doing one doesn't guarantee entry into another so I will give you examples. I was a small business owner myself. So I know the challenges of starting a business.
In the southeast region, some of the MCOs or one of the MCOs has over about 1400 home care agencies. That's a lot.
That's 1400 home care agencies that they have to monitor, oversee, regulate. That's a lot of close. So they close their network in the southeast region. For them, 1400 is enough. That is their decision.
OLTL is not going to force them. That's not our goal.
>> As far as their being 1400 and MCOs, is it also the numbers that 1200 participants coming in daily?
>> I don't know where you are getting that number from.
>> The number that you stated as far as there being 1400 providers, how many participants come into the program a day?
>> I don't think I know our daily enrollment number.
But it is not 1200.
>> Do have you a record?
>> No. You can look up the data dash and look it up.
[Inaudible]
>> Jill can give that you number. Usually serving over 430,000 individuals.
But again, not all individuals need home care support. I understand when you are starting a if you business and you want to gain access entry it can be disappointing it know access is closed and is not allowing providers in a certain category.
But prior to, you know, certainly as you do your market research, imagine you called them because you know those providers networks have been closed, right?
>> Right. It is disheartening about certain business. This is actually for the participant as well as the provider. It is just morale. So in reference to also the gentleman when he spoke about the racial disparity. And in my findings, the research that I did, the majority of the providers are Caucasian. And yet majority of participants are African-American. So in 2019 when Donald Trump passed the law for insurance to become prior advertised that was modern day red lining so it stopped a lot of African-Americans to providing and who in turn was at liberty from

providing and stopped them from being able to earn money and become providers inside the agency. So to speak to your point, it is not a personal matter, but this is matter for all people. And what is coming about is it is becoming about red lining issue the same as with the homes where people would be able to live, and red lining and it is almost the same but again this economical and trickles down to poverty for certain communities. So in 2019 there was an influx of African-American providers coming into said agency and they cut off the entity.
>> Maybe managed care organizations can come up and answer when their provider networks were closed and also their, speak to minority diversity and women-owned businesses.
>> Minority is not it. The gentleman is speaking about nonHispanic, black and white. White women, black women, that's totally different.
>> It is minority and women is separate.
>> I'm not speaking to that. I'm saying majority of provide rs are Caucasian. Regardless if it is a white woman. White woman is nothing to do with that minority. I'm not saying a white woman is not considered a minority in this country.
I don't want to go into that topic. However what I'm speaking of is black people who are actually minority and who have had less advantages. In society. And as far as influence about minority, being black woman is double minority.
>> I can appreciate that being an Asian woman certainly and I see at microphone. Thank you.
>> Sure. Thank you, Juliet. In health and wellness, our numbers, I wouldn't have the numberis off the top of my head, Juliet.
But happy to get them before the next meeting. We have a number of small diverse businesses providing home care, especially in southeast region. We are not closed completely with our network. Across all of the counties that report counties. We feel like we could strengthen the bench.
But it is mostly if the southwest. Those are the areas where we have seen a little bit more robustness.
But it doesn't open the door to the southeast.
The southeast we have a well over 600 providers and very diverse.
We have met with providers representing community. And there is more diverse districts and broughtes this providers on the call and they have been very supportive and we have a number of network tracking.
>> Thank you. Representative from UPMC peace health. Before you start I want to make sure captioning is set up.
A moment for the laptop to restart.
>> I want to confirm the captionist is adding their caption to the transcript, correct?
[Inaudible]
>> In the interest of time I want to make sure we end on time with the remaining items on our agenda. I want to confirm the captionist is still adding to the transcript which will be available while germane's laptop restarts. I will continue and emphasize that anything said here will be on the meeting transcript and the screen here is by the honor's suite should be up momentarily.
>> I might ask that we take a pause. I wouldn't want to assume anyone's access needs.
>> Looks like we are up.
>> Thank you, everyone, for your patience. Please, proceed.
>> Thank you.
>> Thank you for you why question. Many.
[Inaudible]
>> If they are closed at this point.

>> We do have over 1400 providers in our network.
I believe I don't have the number of small diverse off the top of my head but we are contracted with small diverse businesses for different functions.
>> Representative from UPMC.
>> David Garrett. From Community Health Choices. We also have a close network currently with over 1100 past providers throughout the state. We do get applicants to come in for providers to evaluate whether they do bring additional choice or options to support participants and ensure that the network that we have represents participants in the state. We do review all applications to --
[Inaudible]
>> And where would participants and provide rs be able to find information or transparency to be for ratio of providers and if regards to all three MCOs?
>> Can you state your name for me so we have that on record?
>> Yes.
[Inaudible]
>> How many providers are specifically by diverse businesses in the categories that you are seeking potentially and looking over to the specific reporting as it relates it small diverse businesses within the network.
You will have to come up.
>> Can the MCO's come up and negotiate with data on the ratio that you are asking for.
>> So I can tell that you the providers are on hold with medical assistance and with long-term living that is not information captured and it has come up in the past. We have looked at trying to report out trying to report entirety of an old providers and that specific information that being said, and each one of the MCOs may be able to add additional information there as they are equity accredited and part of that accreditation is that they should be capturing that information and drafting that across the network because part of having an accredited organization, health equity accredited organization is making sure you are ensuring health equity, ensuring you are a provider network and it is diverse and we are currently looking at tracking accessibility with provider locations as well as additional languages spoken by providers and that type of thing that is something that we are being asked to start providing information on how we are tracking and monitoring health equity across organizations. It is definitely a work in progress. That's where we are now and like I said, it is not when we enroll provider across medical assistance.
>> With the sub committee and questions regarding provider networks and managed care plan. Looking at the agenda, no further questions for Dr. Degenholtz for his 2022 evaluation.
[Inaudible]
>> We absolutely can pose that question to MCOs. It is worth follow-up and can be added to presentation and further comment. I know that Dr. Degenholtz on our agenda, are there further questions for Dr. Degenholtz?
>> We have some in chat.
>> Okay. Jeff Heisman.
>> This is Jeff Heisman. A question for your presentation but also something I haven't seen in DHS in general. For Asian-Americans. The department does a good job and what is presented to MLTSS and DHS groups, captures African-Americans, Caucasians, Hispanic but not much for Asian-Americans. Is there any adjustment in the future? We have a report on thousands of Asian-Americans at this point. So if you figure 15% have disability population, I'm sure some of the DHS programs. Thank you.
>> HOWARD B. DEGENHOLTZ: I will answer briefly. Our Medicaid self-reported data, we

consider to be good, but not perfect. We have done some analysis and in asking for reports directly. The challenge with Asian-Americans is that in the CHMB population and it becomes very difficult to have statistically robust findings for Asian-American versus other, versus nonHispanic white, white, nonHispanic, black and black population. Like you saw earlier, there are rules regarding suppressing findings, and what the number is smaller than 11. We unfortunately run into that with Asians. The other issue that comes up is the geographic distribution of graphics in Pennsylvania are clustered in the southeast region and in Philadelphia and the population entered and that's where centers are. And it makes it technically difficult to report on a race issue, race or ethnicity issue, that is not also a geographical issue.
So we know that there are differences in the patterns of care and quality of care across different parts of the state. And it is hard to hang all that from a race and ethnicity and racial and ethnics and report formally in a geographic community. So all that is a long way of saying, I wish we could do better on that. When we report out, we end up with small numbers that we are not confident in.
>> So you think some of that is related to some of outreach in getting feedback and some of the adjusting measuring instruments or there seems to be a large population of central PA. You don't have to go far it see that. And in the state of 400,000 people and they are all in the south.
>> HOWARD B. DEGENHOLTZ: It is really a function of who is in -- we are focused on the fraction of people in the Community Health Choices program, which is not a random example of the general population of the state of Pennsylvania.
So in other words, if 10% of people in Pennsylvania are Asian, just to pick a number, that's just a guess, that's not saying that's the number, we wouldn't necessarily expect 10% of the people in Community Health Choiceses to be Asian or any other group. Because of just a wide range of different reasons. So I don't know if that is a satisfying answer.
But you know, we do the best we can without getting into rules that are set up to protect privacy and confidentiality when you are reporting on small groups of people.
Thank you.
I mean, I'll be very honest, I have a number of Asian-Americans and first generation Asian people that I work with that are on routine and when we lump groups together, we are sitting around the table and saying, we know that we are lumping together people statistically that are not the same and we are glossing over important differences. And we have to sit around the table internally because we have a diverse team and we are saying, and internally, we feel like we are not giving voice to the experiences of that diversity. So we are very cognizant of that issue both internally and the statistics of the report.
>> Before the chat, we have another person.
>> I have an additional suggestion about providing the --
[Inaudible]
If you want to wait.
>> MICHAEL GRIER: We will go ahead and come back. Any other questions of the doctor? In the chat?
>> HOWARD B. DEGENHOLTZ: Is there a comment in the chat?
>> Question comes from Amy loudenside. 35% of -- referring to slide 22.
So the 35% of people with SMI, is their data on SMI on community based services?
>> HOWARD B. DEGENHOLTZ: So 35%, that number I believe is across the entire program. And then the 63% is the specific for nursing facility residents.
And just going by memory, NFI, nonhealth care population, has a significantly higher rate than the other population.

>> Thank you. This question is from Pamela waltz. Did you use the plain black Latino in participation levels?
>> HOWARD B. DEGENHOLTZ: Thank you for that question. That something we are continuing to analyze.
>> Are you able to add to continuing to analyze?
>> HOWARD B. DEGENHOLTZ: Sorry for being vague. Ants to that is we have an outside independent evaluator. We have access to a lot of data that includes Medicaid claims data that we use to track Medicaid enrollment data that we use it track eligibility and race as I mentioned before. And the challenge is bringing into that the functional data level of disability measurements. So as people are aware, the Office of Long-Term Living implemented a new assessment instrument that along side implementation of Community Health Choices that started in 2018.
So we have had access to those data as well but there are, across the 2018, 2020, 2021, there are various technical and data quality issues that we have been grappling with with those data. So our ability to do controls analysis of the association between disability and path hours for different racial and ethnic race is constrained by those data. So continuing to work with OLTL on understanding and improving the quality of those data so that when we do have something to report on race or other that we can -- it is something we have been continuing to work on. A pretty major effort internally. And those findings will be shared with OLTL, reviewed internally, and reported.
>> You can bring that slide back up? That was talking about that.
I'm trying to fill in the blank here.
I think we were talking about the hours.
24.
>> This one?
>> No, the one that said varying disability.
>> This slide.
>> Is it trying to say that --
[Inaudible]
There is more at the table than your report --
>> HOWARD B. DEGENHOLTZ: Yeah, okay. What this slide is showing is that nondisabled black useets on average about one hour per person per day.
Mostly in southwest. The difference is smaller in the southeast. And we also do see -- we don't really see the difference in age-adjusted disability between blacks and whites.
But we do see that the blacks are younger. Which is consistent with other research. In other words, African-Americans have earlier onset of physical disability.
For various reasons. We don't really need to go into here --
>> You are talking about --
>> HOWARD B. DEGENHOLTZ: Acquired disability, yes. So in other words, like you sigh -- in other words, if you look at older adults with, say, two activities of daily living, limitation he from two areas of activities of daily living, the white population tends to be older than the black population.
You see what I'm saying. If you look at people with the same disability, the African-Americans are somewhat younger than the white population because they are acquiring the disabilities earlier this life. Earlier in the aging process than the white population.
And generally speaking, the Hispanic tend to have similar disability to the Caucasian population. But Hispanic, Latinos, tend to bounce around some n some categories that are comparable to

the white population.
So controlling for disability more complicated because you have both disability and age effect and the persistence of the difference in civilization and access to care issue.
So anyway, it runs contrary to this area of research.
>> Thank you.
We have an didigsal question from Janice minor. How does the --
[Inaudible]
>> HOWARD B. DEGENHOLTZ: What is the question?
>> How does the diagnosis --
>> HOWARD B. DEGENHOLTZ: Thank you. The diagnosis for the general population we use Medicaid claims data and Medicare claims data we we are looking for, for example, the calendar year 2019, we look at all of the medical claims for an individual and determine whether or not there is a claim with a diagnosis code for either major depression, depressive disorder, bringing in bipolar disorder and two disorders in a calendar year to be categorized as having the, to meet that definition of 35%, you have to have -- you have to meet the definition for either depression or bipolar or schizophrenia in the calendar year. I believe these data were from 2019.
>> Thank you. We don't have any additional questions.
>> MICHAEL GRIER: Thank you. Go ahead, come on up.
>> A quick question.
I think this is for OLTL.
But based on your first, one of your first pages, talking about the ME and it says that the -- many beneficial h providing equipment support and it says, supply chain issues during the pandemic caused major delays in obtaining equipment. A lot of people don't agree with that, don't agree with beneficial. Maybe it is more of a question for OLTLs, should we look into that or get more reports back on the situation. Supply chain issues during the pandemic causing delays but we should be past that now and people are having trouble getting -- can we have more information on that. And another question is another topic about the et tie. Can I understand you correctly? The number of etfide.
>> HOWARD B. DEGENHOLTZ: Growth in the -- let me see if I can just take it from memory. Here is my general sense.
Over this time period, which stood from before CHC was implemented in 2022 that the program is serving more people.
Substantially more people across all categories. NFI and we will say waver.
And growth in NFI, I estimated at about 24% increase in terms of induplicated individuals over that time period.
And the people in home services and not in the nursing home.
[Inaudible]
>> You can turn your mic on?
>> It is not on.
Thank you. The NFIs from the community, what is causing -- what are you seeing that is causing it to appear there is more people being ineligible.
It would be good to know more about what you are saying in the NFIs. Why are they determined ineligible for the community? Can I get more of that on that?
>> I'm not saying that there are more people ineligible. I'm just showing that we are using that as short hand to identify there are people who are users who are duly eligible for Medicaid and Medicare. That population has been growing. And factors there are just general population

growth over time. The aging of the population so a greater percentage of people are over age 65 so that maybe that is eligible for Medicaid and Medicare and might also be something, some economic shifts over time with more people becoming reaching the Medicaid income eligibility test over time just due to broader economic trends that have nothing to do with health, per se. I'm not saying anything about the rate at which people are determined to be eligible for HCBS or not.
So really what this is showing is the, what I would say, the impact of Community Health Choices in terms of really shifting the location of where people receive long-term service support to the home community based setting and that is what the next slide shows, I think, as well.
The nursing home population has been relatively flat or declining. So the growth on HCBS has been people becoming eligible for the first time and becoming essentially needing a level of care, living in the community, and when they first reach out for services, they are getting into a waver program and getting home care as opposed to going to a nursing home and my understanding if that was the goal of Community Health Choices was to really make care available for people in the community.
>> Thank you. I misunderstood that number. Thank you.
>> HOWARD B. DEGENHOLTZ: Thank you.
>> MICHAEL GRIER: Thank you for the presentation. Go ahead, Matt.
>> Real quick. PreCOVID spending was like 6 million. And I saw COVID spending --
[Inaudible]
Something like that.
>> HOWARD B. DEGENHOLTZ: In 2019 about 8 billion and in 2020 basically the same. Sorry, 2019 about 8 billion, and 2020 about 8 billion.
>> Are you expecting that to decline in coming years?
[Inaudible]
>> HOWARD B. DEGENHOLTZ: I don't know if I want to answer that.
I mean, in my independent assessment --
[Inaudible]
>> HOWARD B. DEGENHOLTZ: Yeah, that is from like 2016.
>> PreCOVID.
>> HOWARD B. DEGENHOLTZ: Yeah, but has nothing to do with COVID. Just the trend in 2016 which is way before Community Health Choices, way before anything.
>> Oh, all right.
>> HOWARD B. DEGENHOLTZ: The reason we have the chart going back that far is to show that really the -- as far as you go back, Medicaid spending for the populations that in 2016 was potentially eligible for Community Health Choices. Spending on that population has been growing over time. And even under Community Health Choices and that, you know, that fact is well understood and the instruction of managed care is intended to bring its own predictability to the spending and the COVID-19 pandemic might suggest that for, you know, for a variety reasons, that we all understand, there really was a lot of decrease if utilization of medical care and I really can't comment on 2021 or future total Medicaid spending.
But a lot of factors that lead to continued increase in spending in the United States, not just Pennsylvania, not just Community Health Choices. A lot of factors have continued to play, pharmaceutical costs, hospital costs. A lot of those things cost more every year. So we would expect, separate from Community Health Choices, trends in medical spending in the United States continues to increase.
>> MICHAEL GRIER: Sorry, but we have to move on to the next agenda item.

We appreciate your coming and talking with us today.
Next up we will talk to CHC, MCOs, question and answer session related to the MRC report. Anyone want to go first
>> Michael, I saw a recommendation to diversity in the provider. I would like to give them the opportunity to respond.
>> You bet.
[Inaudible]
>> This is Q&A.
>> Just Q&A.
>> Thank you.
>> My comment will be brief. Thank you.
>> No problem.
>> Department of Human Services and Department of general services has a long standing commitment to encourage use of minority businesses, in procurement processes. One thing we notices of the last health choices of procurement in 2019. Not Community Health Choices, but health choices in Medicaid. And asking if use of small diverse businesses on the provider side could be counted towards and the answer from general services was no. I'm not sure why they wanted encouraging support.
But with Community Health Choices and home community based service on that model we hope that they would not take the same stand and --
[Inaudible]
And encourage them to allow patients to be counted towards MCO commitments to those.
>> I appreciate those comments and will take them back. Thank you.
>> You're welcome.
>> Thank you very much.
>> I have one statement. In reference to the comments --
[Inaudible]
In reference to there not being a lot of data for Asian population. What I wanted to add to that was in regards it some research I did, a lot of the Asian population that are participants receive their care from Asian providers. And as well as the receive their care from Asian providers and when you get to the African-American or black communities they receive their care not from black providers but however from white providers which has disparity and cultural understanding as well.
>> Can I add something.
>> Sure.
>> With regards to networks and providers and they may be identified it is important to identify small diverse and its owners and minority of owned providers. Every individual in the Community Health Choices program has a choice of of which agency they get their services from. So every provider in the network and if they want to find a provider that is Asian owned then they should ask for help to find a business with a home care priority and ask and say I want to bring my services and have attendants from an agency that a minority owned and their support coordinator can help find providers that help meet their criteria. If there is a minority owned agency the support coordinator required to help them find a Pooh vieder that meets their needs culturally, linguistically, and to their preference within the network.
>> Right.
But that is not able to be done, because as I say, from the beginning of what I was saying, is that if they don't, if the providers are not allowing to be in the network and as sid, since 2019,

majority of providers coming in weren't black. That limits choices. A lot of them say that support coordinators are not allowing them to choose, say, black business. With the Asian community, as you know, because you are Asian, as you know, that with the Asian community and some of my agents that I know, all of their participants are also Asian, may be because of the language barrier or maybe because that's what they choose to work with or maybe that's how they got filtered through the system. However, that is not the case when it gets black people. And hopefully we will be able to get data. Because majority of the providers that are Hispanic also are also Hispanic. Because of language or whatever the reason, however when it comes to the black community, their providers are majority white. They are not Asian providers. Nor Hispanic. They are white providers. Because they do not have access to have the black providers.
>> So if you know of anyone who is looking for a black owned home care agency, and is not being helped to find one, or that any of the managed care organization, I would like you to have them call our participant hot line.
And we will help ensure that that happens.
So anyone who wants to have that situation, if they feel like they have asked their support coordinator and they are not responding, I would like to know about all of those individuals so we can ensure that happens. The other thing that is important to note, we talk about access, is that consumers, participants, members, also have the option to hire their own attendants through the consumer direction model.
So participants can choose to become an employer of attendance directly and then the first o information provided and the first option presented in all of our community health person programs. So the individual who may be Asian or LGBTQ2A, have full control over who they hire and deliver their services.
>> Right.
But it is not reflecting in the data. And like around people here, they didn't have access and --
[Inaudible]
They didn't know how many providers they had in the network which is a a bit concerning.
It comes off as unethical. And it is a part of the requirement for there to be --
[Inaudible]
>> To clarify what they are saying is they didn't know off the top of their head but they would be happy to come back and report that information out. I don't want to misremember. So Anna?
>> Thank you, Juliet. And I hear your concerns when I speak to providers trying to enter the network. Juliet I'm hoping to head off and MCOs will not have data report. It was not required to give the ethnicity to have the owner of a provider, any provider.Ing if we are beginning to see if the provider will give it. What we found in our network is many providers don't want to give that information.
Because they feel they will be experiencing discrimination from potential participants when they are selecting a provider. So the providers say, I would rather not give that information. As we are developing our health equity positioning and following a lot of guidance from VH srntle and work done across the common wealth, that is something that we are enhancing our provider network when those providers are provincial. If they would like to get that information.
But as of today, I can tell you, we would not be able to give fair report. I am, for example, interested in collecting that data from research that you are referencing. So we can better understand where that lies in what part of the common wealth. I say it is mostly in the southeast. We have those in the southeast would want to get on a call with their constituents and share the information about entering our network and we work with them and a lot of our good providers do come on to the calls and share think experience working with pa health and wellness.

But I am interested if there is contrary information out there.
But we do have service coordinators who ask that question of participants would he they want certain providers.
Foreign language, Russian, Cambodian, if they want a female or male as a care giver.
And then our referral team works very hard to address and fulfill that requirement.
And to my understanding, they have done a really good job.
But again, there is a lot of choice out there. To fill requests.
>> So where does it state that there is a rebust choice opposed to just a close. It is my understanding that they understand to their knowledge that they have the right to choose? Clearly it is not the case. If it is a choice or robust choice or a choice, kind of like, within the network.
When it is stated they have a choice, that it doesn't come off as being, you know, ethical. At the very least.
>> I appreciate that perspective. We need to offer choices within our network.
It is not that Juliet shared, it is not an open choice across any willing provider as much as it is we have developed a network. We have requirements. We believe we do everything we can to offer diversity in those choices. Across that network. We have four counties. We want more robust diversity within the four counties that are open in our network.
[Inaudible]
>> So our rational, reflecting choice coming in as providers. We want more diversity around our network which is why we --
>> In north county, there is not even --
[Inaudible]
I have look need that as well.
Yes, that's true.
[Inaudible]
>> We have diverse providers across the common wealth. Several everyone ising the Philadelphia area who have expressed and are moving toward across the county who have a need for capacity.
>> I know. I too have. However, it is a -- what it is, is it does allow -- think may tend to go ahead and do that but also, like what I'm saying, is when it comes to black women and men, they have to jump through hoops. To make it fair, and because you know the population, and you know that the population is in the black and it is fair to have more providers and black people and more --
[Inaudible]
Then bring together and then have you a fair --
[Inaudible]
And racial demographic and a portion of having someone to and to make a living and --
[Inaudible]
That is not fair. And this is not -- again, ethical. If you are willing to do it, you can --
[Inaudible]
>> You can turn -- apologize, but can you turn up your microphone? Thank you.
I want to acknowledge and appreciate the public comment here and subcommittee as Matt mentioned and there is opportunity for us to request additional data and additional conversation. So I will open and close diversity and to overall get greater understanding on cultural confidence and managed area plans. I want us to open up the floor to ask questions to managed care plans regarding the results from Medicaid research center. And I do have one to start. I am curious if

each of the plans can respond to the findings present bid Dr. Degenholtz, there are many reports and this findings may not be complete and I'm curious as to whether they individually have made any adjustments or responding to specifically to any of the kindings within the report. I know that is a broad question and so a brief overview would suffice. You are already up here so if you wouldn't mind responding for PHW.
[Inaudible]
>> I wonder if you could respond and diversity and support -- and --
[Inaudible]
>> JULIET MARSALA: I'll take that one first and then move over to David. As you know, PHW outsources our service coordination function across the common wealth.
Those providers do provide regular reporting of diversity based on the work of this committee a couple of years ago main three years ago when the committee invested a lot offings inner in how service coordination would address these participants and provide that information about service coordinator so there is another choice in that regard. So we do collect languages ethnicity, choice of gender. We collect all of that information and when participants are enrolled they are asked if they have a preference. So we do have that information.
Does that suffice your question or do you want more information?
[Inaudible]
>> JULIET MARSALA: I don't have that today but I can get it for you. David, to your question, we really enjoy seeing the results of the report. It speaks to the success of OLTL and Pennsylvania in starting to see the positive effects of managed care and balancing health. In getting in the community, the investment that's been made into service delivery and while I still see there is work to do, given we have this pandemic that put us pause on a lot of things, and I really think that the biggest take away for us was that this is working.
And so really, everyone should feel celebratory and congratulations to OLTL in how they've worked with us and see how it is done.
>> Right.
>> Hi, I'm Jennifer with PHW. I want to congratulate you and encourage you to engage with the research. One of my goals when I was Deputy Secretary of Community Health Choices was engaging with the research center to do the research. And to continue along studies and it really has not been robust research on the impact of MLTSS. I'm really glad to see you and I'm very happy and I hope I have friends that are very happy about the continued launch toward the health care system.
[Inaudible]
>> Yeah, I really like the project that is going on. I wish Jill hadn't left. She was one of the architects in the foundation contract. For long-term care laning network. The network is doing great work in training nursing homes and training nursing home staff to provide better quality pair and I would encourage this continue. Because we still have people continue and to answer your question and the trend and it is not going to get cheaper because of the aging baby boom coming into the system. They are aging into long-term care.
But I would encourage you to continue with a foundation contract or at left the learning network and that is to provide training and make improvements in quality of care and nursing.
>> Is there anything else?
>> Thank you. Thank you very much. Representatives from AmeriHealth care.
>> Hi, Melissa wheatland. I will address your question first, Matt, with diversity. I don't have the answer off the top of my ahead. I can get that for you. We have diverse coordination staff. We also have an opportunity for service coordinators to actually receive a fee differential for being a

service coordinators. We also have internal staff have w a very diverse background with service coordinators and I know that there was a question too on providers and I just want to say that the provider we have in network do an outstanding job of hiring people within the community of which they serve and I think that's important that direct care workers that are filling into communities or part of the communities and understand different cultures of those communities. And I just wanted to give a shout out to providers for making sure that they are retired people. The study was fantastic. I was excited about the rebalancing information in the presentation. And I would like to congratulate OLTL on the study. CHC has done a lot for Pennsylvania and the work done there. As for as changes on the part of the study, there were recommendations that were part of Dr. Degenholtz's presentation that we are taking very seriously.
One thing I have heard come up a few times and within the presentation is really knowing who the service coordinator and having contract and doing work on I.T. personnel to enhance the number of portal and one way they can have ongoing access to service coordinators need and contact information.
And we also did a campaign of making sure that we distributed magnets for refrigerators. We are evaluating and we are interested in improving the service that we provide.
[Inaudible]
>> Thank you.
Thank you.
MRC.
>> Is Mike Smith. Do you hear me?
>> Yeah, Mike, we can hear you fine.
>> Terrific.
So I will answer the question on diversity of our service coordination is in line and associated with the participants that we serve. We have a very diverse staff that we fleck the communities that they are in. We are very proud of the fact that we have a number of bilingual staff as well as majority and minority black staff in southeast area in the communities that we serve. We are always looking to maintain and grow diverse population or diverse group of staff that will serve the people in the communities that they're at. So that we can certainly make sure we are, that goes for racial diversity. Enjoyed getting a copy of this and reviewing it. We too are making strides to make sure that we have accessibility to service coordination services, access to the ability to community with our staff. In addition to things added there by missy, we also have tech tag for opportunities which is a tag that can be placed on the back of a computer or the back of your telephone. In addition to that we are doing a lot of work with the FCC lifeline program to expand the use of those phones significantly and when UPMC participants are signed up for the lifeline phone through our relationship with the organization called pulse works, they get all of our telephone numbers, adult protective service numbers, several apps from UPMC applications, downloaded toes this phones. In addition to that we also provide technical assistance to make sure the applications can be utilized by participants not only through service coordinators but through tech assistants. So we are really trying to expand and close the digital divide for how to access us and information regarding the participants we serve and their ability to really communicate with us more broadly. And in terms of the other aspects of the report, what I really enjoyed about the report as well was not only are we making great strides in the rebalancing of the program. We are also, and the data is, you know, I think misstated and it is lagging, but the data is showing that we are having an impact.
But it is also very consistent with data that we are seeing at UPMC. We we look at and follow the trends associated with a lot of these activities that we are discussing today, and consistent

with what we are seeing in the caps and so really good information that is here. Really showing the positive impact of the program. We know we have a long way to go. Although MCOs would say there's work to be done. Always work to be done to improve the program. I think that's been a lot of good work done here and OLTL is to be commended for their continued off or the here to not only improve the program but to have it done in such a way that we have a study and solid independent review of how it has occurred. So you know, that is really a lot of good information here.
>> Thank you very much, UPMC.
Any other questions from the committee members or audience for the MCOs?
This is a question and answer period.
Anything?
>> Hi, this question is from sue. Sorry.
Sue Ellen zane. My question is for OLTL. OLTL policy states this participants cell phone is allowed for purposes. It it is used for telephony, how is GPS data captured?
>> JULIET MARSALA: Sounds like a very technical question and I don't want to get it wrong. We will provide the answer at the next MLTSS how that is captured.
But any med guess is GPS coordinates at the time of capture.
>> Yes, sir?
>> Yes, on 360, a large discussion about --
[Inaudible]
There are multiple certifications to being --
[Inaudible]
The path may be easier if we would know what certification the MCOs recognize. So that they could get the qualifications. And show them as the benefit to application -- my question would be, what certification do they recognize for being minority? Or what is their advice?
>> Thank you.
Are there any MCOs able to respond to this question here?
>> Anna. The credential process for network entry follows the guidelines that we have been provided by the state. That's within contract and within the CMS criteria. Additionally, to meet that criteria, there are some recommendations and credentials you complete and provide that evidence and we can --
[Inaudible]
>> Thank you, Anna.
>> Hi, AmeriHealth care. I will have to bring that information back. I don't have that at my fingertips.
>> I would say that, this is Mike Smith from UPMC. I would say the same. We would like to take this question back and provide additional information. By say the small and diverse business requirements are the ones that are established and classified by the state. So I think that's a state designation and then we work with those small and diverse businesses as part of our agreement.
But we will take the question back and get more information. Thanks.
>> Hi, my name is CJ Weber. One of the questions that we have received and we are experiencing ourselves is that we have participants who become ineligible, could be because of the paperwork. A whole multitude of reasons. This question is for OLTL and Juliet as you said from the listening session, one of the challenges we face is that service coordinators say one thing and then others say another thing. So we have had participants, their doctors get the correct paper and coordinator say oh, I notice that you have retroactive eligibility. For example,

someone might become eligible July 1 and on the 28 we hear they are retroactively eligible from July 28 to the 1st. They have a that you weeks back of eligibility. With our family caregivers they claim oh, I've been working that entire time because we live together so I've been doing services and the service coordinator tells the spa family, care giver and participant, well tell them you can do time sheet because you are eligible for service possessesome we have this discussion between the service coordinator, participants and family members, the care giver, and I just wanted to get information substantial o on eligibility and if we could have guidance on how coordinators are trained on that situation. One, we want to make sure we are compliant. Because by are not that. And we are constantly the bad guy. Trying to uphold the rules and then they feel like a coordinator is telling them together different. Has anyone heard that from providers and can give us guidance on how to deal with that.
>> JULIET MARSALA: Couple questions for clarity. One, is that this is a new enrollee or someone enrolled and then was found ineligible and determined reeligible?
>> Been on services for years so they've been enrolled in the program.
>> JULIET MARSALA: When we talk about the eligibility we are specifically talking about eligibility verification that goes through promise?
>> Yes.
>> JULIET MARSALA: Then also verify that individual drop was related to renewal requirements and they received notification and you go through and have an individual that dropped CAO eligibility.
>> Yes, you're reading my mind.
>> JULIET MARSALA: Okay. What I'm going to say is have you sent those individuals to Randy?
Noland.
>> This just happened literally last week. I was going to bring it up on the call tomorrow. We are seeing it more and more at the unwinding. We run eligibility everyday.
That is task and we have a copilot.
But we notice everyday probably five people that are ineligible.
>> JULIET MARSALA: That specific thing interests me. We want to make sure that doesn't happen. As someone is going through the consideration process, there shouldn't be necessarily a drop. So you know, this may not be something that we have control over.
But I would like to know who those are so we can look ates this cases in our office and then come back and respond.
>> The majority of situations get rectified by paperwork issue es. Some don't qualify financially. Which they are off services.
But I think the real question for MCO side is, how do we -- how are you educating service coordinators so they can get partnered with us in this and not say, just do a time sheet. You get services. Just live with them. I feel like it is such a hot topic and we are all trying to do the right thing and it just moo makes it difficult. We don't have someone in our corner backing us up.
>> JULIET MARSALA: Absolutely. A couple of things. And the first one is ineligible and they weren't informed they were ineligible. And I'm not quite clear how we go back and say they worked.
>> Aagree with you.
>> JULIET MARSALA: That needs more exploration. If the person was determined ineligible, it was communicated to hem by the agency, and call made to service coordinator, authorized within, verified intelligible and they add hard time understanding.
>> I totally agree. Just making sure we are all on the same page.

>> JULIET MARSALA: I would have hard time understanding how a time sheet gets created at a time it was verified by all parties when it was ver tied at the time there was ineligible status.
>> Thank you. You confirmed my thoughts.
But I appreciate that. Thank you. Oh, and the second thing, I think I alerted all of the players and I told Randy, the exchange compliance reports are down. I'm not sure if everyone is aware of that. It seems to be an exchange, I acknowledged that. We are trying to get those fixed. Right now it seems like ma are theo of people have a hundred percent manual idity.
There was an update week of July fourth. It seems that update changed things. I happily alert people when I get an e-mail back from HHA but he said it was data import issue. And it is for --
>> JULIET MARSALA: So there are a lot of nervous providers worried about payment status. And they will probably likely want to hear from you on that through your office.
>> Thank you.
>> Thanks, you too. Follow-up?
>> You said something before and I think I misunderstand.
>> There is a small business and criteria qualification.
Your company has additional requirements for that?
>> Oh, Matt, yeah, sorry.
Requirements for credentially with a network.
There are basic criteria. Not just anyone and everyone can provide an adult day care, for example. You have to meet certain criteria to be adult day care. There are basic requirements. To have that credential, it comes with a process that happens at the state level to receive that certificate and then that does demonstrate the entity of at least 51% minority.
>> JULIET MARSALA: The common wealth is interested in supporting and there is a whole office dedicated. The bureau of diversity and inclusion and small business opportunity that oversees the service and the state recognizes and we put out in our program regulations. Whether they are small business or small business --
[oh, I didn't hear your question.
>> My question is you have criteria expectation beyond that.
And there is a question for MCO as well. From PJ. If you could respond to that as well.
>> PJ, what were your questions ?
[Inaudible]
>> I will make that one simple. We don't know the background of the person and why they are redetermined and retrod. Could be pay back. Could be a lot of things. We just have to make it case by case. I agree with Julia. No one calls and says here is a case to respond to. Tell me why and then we can help you.
But unfortunately that wasn't done. We educate service coordinators extensively on all of these issues. At the end of the day, that is usually a case by case.
>> Thank you.
[Inaudible]
>> AmeriHealth.
>> Hi, I can't look at you when addressing you but I want to thank you for calling MCO when identified and working with them to directly try to resolve all of participants in specific situations. I agree with analysis that this is new where we are in a period of time when there is a lot of redetermination going on. I think we are see variety of examples and we will be taking them one by one.
But hearing that this has come up and a concern with home care agency, we can get some education out to service coordinators in advance to you are aware to bring these situations back

it supervisors and trouble shoot.
>> Great. Thank you. UPMC.
>> Yeah. We are doing essentially the same thing. Made a net as we were discussing this and hearing the conversation. Mike Smith from UPMC. We regularly communicate with our service coordination department, all of our staff, communicate out information based on this and other things as a matter of course. By, you know, we are at some of listening sessions and have our articulated to our staff the kind of issues that July yet brought to this meeting today.
So any kind of issue around provider abrasion and these circumstances we can definitely educate out on once we have a handful of information and it really does offer on these cases, often times it does come down to a one to one discussion to really understand the significance of and how pret to activity can occur every time. So I appreciate Juliet's response to bringing back to OIM too to look at what is happening with the eligibility requirements. There is a lot of folks that are in the mix here and we just look forward to working with OLTL staff, providers, and everyone involved, participants, when these issues come up to try and get them resolved to the best of our ability. It is a real challenge to train to a multitude of circumstances that can occur that would result in these kind of discussions or issues. So we really try and get it very sis sink and concise for your staff so they know how to move toward.
I think the best case for them is if they have a question and don't have an answer to say, I don't have an answer right this minute. I will bring it back to you once I've taken this to my leadership once I have my computer adviser to review. We have network teams and folks that can help with this beyond just service coordination. And so, there is a lot of folks that can work through these issues and we will definitely be looking at the types of issues that come out of this discussion and bring it to our staff so they are as best educated as possible.
>> Jeff from Pennsylvania. My question is on transportation. And it is a by to MTM with the trail path and with any comment and still hearing it from some of the resources there and if they are consumers or not and getting access to trail path in a timely manner and -- gnawed.
>> Oh, well okay, I can share.
>> This is Randy from OLTL. A month ago we had a meeting with all three MCOs, PENNDOT and CPS to talk about the issue and laid out issues they had with the trail pass and the two MCOs to deal with and MDM and we are supposed to resolve this so I guess you can give an update for AmeriHealth and PHW where you are working with and make sure the trail passes are being appropriate in a timely manner.
>> Thank, Randy. Health and wellness. My update would be that we are getting back with you on that. We have not had an escalation of concerns. If there is an interest who is experiencing trouble with the trail pass, we need to get the name of that individual so we can research what is going on with that.
>> Hi, AmeriHealth Caritas, there were issues with the letter L looking like the number 1. So letters needing to be manually entered.
Like Anna, any time an escalation is addressed, if there is a particularrite immake sure they are in touch with us so we can make sure it is getting resolved.
>> Thank you. And one last request. This is for, I know we are at time, can we get an update on the human services transportation site? I know PENNDOT led CHS and how it would impact the CHC population and looking at recommendations maybe in the fall some time? Thank you.
>> This is follow-up. PENNDOT and see where they are at or have a discussion with them.
>> I heard in one of the MAAC meetings that feedback for PENNDOT so maybe they are still reviewing it or whatever.
>> Thanks. Is there anything in the chat by any chance?

>> Yes, a comment rather than question. Coming from Amy. An eligible and retroactively eligible for reconsideration. Like other medical services received during period in which retroactive eligibility is put up, if a person received a certification to be able to have the provider working and agency billed for it. It is very common especially when friend and family are providing care for those services to be provided. And we advise people to track their time. We also know that some home care agencies keep services going knowing they will be reinstated allowing this is critical to prevent procedural and other determinations from disrupting access to services. EVV should not be a barrier in this case. There is an additional question.
And this comes from Robinson. Agencies are using their contract with AmeriHealth Keystone First. Can they be prevented from using their contract?
>> Sorry, we will get back to that. We are at 1:00. In keeping with logistical arrangement, I have to say we are adjourned. Thank you to all of the folks showing up face-to-face. We have almost a full house. So very much appreciatate it. We will see all of you next month, September 6. Same bat time. Same place. Thank you, everyone.