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Date: 09/06/23

Event: Managed Long-Term Services and Supports Meeting

>> Good morning, everyone. This is David Johnson speaking. Can the subcommittee members attending in person hear me?
>> We can hear you.
>> Can anyone hear me?
>> Yeah, David, we can hear you. We're going to go ahead and get started with the meeting now.
>> If you can, please bear with us just a moment. We're going to have to troubleshoot our audio here. Apologies for the delay.
>> Hey, Mike, this is Jay. I can hear you fine.
>> We're having some audio difficulties on David's end. So I will go ahead and do the roll call to get us started. And we'll go from there.
>> Hi, Mike, can you hear me?
>> Yeah, we can hear you. You want to go ahead?
>> I'm happy to do roll call now. Not sure what the issue was, but I can hear you all now.
>> All right. Very good. Go ahead, David.that the broadcast hasn't started.
>> It might be a hang up on your computer. You might need to leave and join. It has started.
>> Okay.
>> Thank you for that.and understanding. This is David Johnson. I'm going to take attendance for this month's subcommittee meeting.
Mike Grier.
>> Ali Kronley.
>> Good morning. This is Ali. Can you hear me?
>> I can hear you, Ali. Good morning.
>> Great. Thanks. Good morning.
>> Anna Warheit.
>> Good morning. This is Anna.
>> Hi, Anna. Good morning.
Cindy Seeley.
>> Good morning. This is Cindy.
>> Hi. Good morning.
Neil Brady.
Gail Weidman.
German Parodi.
Jay Harner.
>> Present.
>> Hi. Good morning, Jay.
Juanita Gray.
Kyle Glozier.
Laura Lyons.
Lloyd Wertz.

>> Present.
>> Hi. Good morning, Lloyd.
Matt Seeley.
>> Present.
>> Good morning, Matt.
Monica Vaccaro.
And on behalf of Patricia Canela-Duckett, I believe we have Arianna Tarpinian?
>> Present.
>> Good morning, Arianna.
Sherry Welsh.
>> Here.
>> Hi. Good morning, Sherry.
And on behalf of Tanya Teglo, Carrie Bach.
>> Present. Good morning. Thank you.
>> Hi. Good morning.
Are there any subcommittee members I missed that are able to announce themselves?
Thank you, everyone. I will pass it off to you, Mike.
>> MICHAEL: Thank you, David. I will go ahead and cover some talking points.
This meeting is being recorded. Your participation in this meeting is your consent to being recorded.
Some committee rules. Please keep your language professional. This meeting is being conducted in person at the department of education honor's suite as a webinar with remote stream. The meeting is scheduled until 1:00. To comply with the agreements, we will end promptly at that time.
All webinar participants except for the committee members and presenters will be in listen only mode during the webinar.
While committee members and presenters will be able to speak during the webinar, to help minimize background noise and improve the sound quality of the webinar, we ask attendees to self-mute or hit the mute button feature on their phone, computer, laptop when not speaking.
To minimize background noise in the honor suite, we ask that committee members, presenters, and audience members in the room please turn off the microphones when they are not speaking.
The captionist is documenting the discussion remotely. So it is important to speak directly into the microphone, state your name, and speak slowly, clearly, and concisely. Please wait for others to finish their comment or questions before speaking. This will enable the captionist to capture conversations and to identify speakers.
Please hold all questions and comments until the end of each presentation. Please keep your questions, comments clear, concise, and to the point.
We ask webinar attendees to please submit your questions and comments into the questions box located on the Go To Webinar pop up window on the right hand side of your computer screen.
To enter questions or comments, type the text under questions and include the topic which your question or comment is referencing and press send.
Those attending in person who have a question or comment should wait until the end of the presentation to approach one of the microphones at the two tables opposite the speaker.
The chair or vice chair will call on you. Questions or 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 to follow up with the attendee.
Before using the microphones in the room, please press the button at the base of it. You will see a red light indicating that 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 are done speaking, press the button at the base of the microphone to turn it off. The red light will turn off indicating that 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 time allotted at the end of the meeting for additional public comments. Webinar attendees should enter questions and comments into the question box and include the topic in which the question or comment is referencing.
Those attending in person should use the designated microphones in the room. We want to remind everyone that this meeting is a place for general information and questions about OLTL managed care. Questions and comments of a personal individualized nature will be redirected to the appropriate people for follow up. Responses will be sent directly to the individuals asking the questions. If you have questions and/or comments that you haven't heard, please send the questions or comments to the resources account identified at the bottom of the meeting agenda.
Transcripts and meeting documents are posted on the list serve under the MLTSS Meeting Minutes. These documents are normally posted within a few days of receiving the transcripts.
The 2023MLTSS sub Mack meeting dates with available on the Department of Human Services website.
I will turn it over to you, David.
>> DAVID: The following are emergency evacuation procedures.
In the event of an emergency or evacuation, members in the honor's suite will proceed to the area to the left of the Zion Church on the corner of fourth and market. If you require assistance to evacuate, you must go to the safe area located outside the main doors to the suite. OLTL staff will be in the safe area and stay with you until you are told you may go back to the honor's suite or you are evacuated. Everyone must exit the building. Take belongings with you. Do not operate cell phones or try to use the elevators.
Members in the suite use stair 1 and 2 to exit the building. Stair 1, XIS through the main doors on the left side near the elevators. Turn right and go down the hallway by the water fountain.
For stair 2, exit through the side doors on the right side of the room or the back doors. For those exiting from the side doors, turn left and stair 2 is directly in front of you.
For those exiting from the back door exits, turn left and left again, and stair 2 is directly ahead.
Keep to the inside of the stairwell and head outside dune Dewberry Alley to Chestnut street.
Turn left to blackberry street and cross fourth street to the train station.
Thank you.
>> Thank you, David. As you can imagine, we have quite a few follow ups from the presentation of last meeting. So bear with us as we go through this. And remember that not all the questions are in this list that I'm going to go through. They are on the list serve.
Related to money follows the person fund, audience member Pam asked where the MFP money is currently or will
Juliet Marsala, deputy secretary of the Office of Long-Term Living said she did not have that list on hand, but she could go back and obtain the list. And OLTL could look into having future topic that covers the MFP project.
>> Paula contacted Sheila. Sheila agreed to present on the program and disbursement of funds at the November 1, 2023, MLTSS subcommittee meeting.

>> Can we blow up the --
Okay.
Related to participant experience interviews, subcommittee member David Johnson asked what the codes are for the information on slide 12, patient experience interviews concerns, of the Medicaid research center, the MRC, presentation. Dr. Degenholtz from the MRC responded that he did not have the information handy, but would look into it. Dr. Degeholtz TRO provide the codes used to create the chart on slide 12 of the MRC presentation.
>> This is Paula.
Dr. Degenholtz responded there were a total of 451 concerns reported. Of those 451 concerns, 292 could be categorized as access, 89 as service, and 46 as each category, there were several possible sub categories. The tables showing the frequency of each sub category will be provided on the MLTSS meeting minutes list serve shortly after the meeting today.
>> Related to home and community-based services provider perception, subcommittee member Matt Seeley asked what the numbers, slash, rates were in the previous years in reference to slide 15. Or what were in the previous years in reference to slide 15, HCBS provider survey perceptions of community HealthChoices? Dr. Degenholtz replied that he did not have that handy, but that it was a little bit lower. Held provide the numbers and rates for the previous years.
>> This is Paula.
Dr. Degenoltz responded that the medical research center calculated the percentage of providers who agree somewhat or agree strongly with the following questions. Has community HealthChoices approved access to care? Has community HealthChoices improved quality of care? And is community HealthChoices critical to your organization's future?
In each response, the rate has increased or stayed 2020/2021 survey and were mostly consistent in the most recent two years of the survey. Rather than read the chart out loud, the chart is going to be provided on the MLTSS meeting minutes list serve after the meeting today.
>> Thank you, Paula.
Related to participant directed XERNS interviews, subcommittee member Ali Kronley asked if there was a way to break out the data from the interviews for the participant directed participants. Dr. Degeholtz to report back the data to the participant experience interview responses for the participant directed participants.
Wow. That's a mouthful.
Paula?
The doctor responded this is the subject of ongoing analysis by the medical research center. Unfortunately, this will take several months to complete. MRC can report on this later in 2023.
>> Related to the MRC key findings in durable medical equipment, audience member Pam asked if we could go back and look into getting more reports on what is happening with the DME situation in relation to the MRC key findings page on page 6 of the MRC presentation. CHC is beneficial in providing equipment and supports and services to participants. Pam stated a lot of people she knows does not agree with that statement. The doctor to provide information related to that key.
>> This is Paula.
Dr. Degenoltz responded that based on the key informant interviews, the durable medical equipment providers in quarter 42021 and quarter one, 2022, most of the eight providers reported improvements in several areas of dealing with the CHC plans. The areas of improvement included communication, billing, rapport with MCOs, financial impact, and service coordination. Providers also reported that CHC participants in skilled nursing, personal care,

and assisted living facilities have been the past. Providers reported that service coordination plays a key role in streamlining processes for DME. When individual service coordinators are deeply involved in the process, successful DME placement has occurred.
>> Related to the department of human services transportation, audience member Jeff asked for an update on the DHS transportation study at a future meeting. Randy Nolan from OLTL to follow up with the Pennsylvania Department of Transportation to see where they are at.
>> This is Paula.
Randy Nolan spoke to John Taylor at Pennsylvania Department of Transportation about the report. The report is still in draft form.
>> Related to act 150, audience member Bridgette Henry from Me for You home Care asked in chat if all providers know about Act 150 and who to bill. Ryan Dorsey from OLTL to provide a response.
>> This is Paula.
Ryan responded that yes, providers should be aware of the act apply 150 Program just as they would be aware of the Community HealthChoices and OBRA programs. If a provider is already enrolled with OLTL under CHC or OBRA, they could request to add Act 150 by submitting an updated provider enrollment information form and submitting that along with a copy of their current license to OLTL's enrollment resource account -- it's listed on the board. And it will also be listed in the meeting minutes list serve.
Once the request has been submitted and processed and updated, approval notice will be issued to the agency. If a provider is not enrolled with OLTL, they would need to complete a new application and the application can be accessed at the following link. Promise enrollment PA.gov.
Billing would be completed through promise for Act Department of Human Services site for billing at the following link. Promise, PA.gov.
Our training vendor will offer training to new agencies if needed.
>> Related to closed cases, audience member Renee Slifkin asked in the chat what is the time frame turn around time for a county assistance office to reopen a case if the termination of service notice was appealed timely? And who would this be escalated to if the CAO is not responding to a request to reopen the case? Kristen Mckinney to reach out to Carl Feldman from the office of income maintenance nor a response.
>> This is Paula.
Carl responded that five business days is the official procedure for CAOs to take action on a 1768 that services is working on revisions to its policy to specifically require a three-daytime frame for reinstating benefits. An escalation can be directed to the Medicaid or long-term care ombudsman.
>> Related to service coordinators, subcommittee member Matt Seeley asked what the diversity numbers for service coordinators are. All three CHC-MCOs to provide this data.
This is Paula.
>> AmeriHealth Caritas Keystone First responded 739 are female, 95 are male. 16 did not disclose their gender. Two are native American Indian, 18 are Asian. 545 are African American. 79 are Hispanic. 200 are white. And 16 did not disclose their ethnic group.
PHW responded 368 are female. 61 are male. And 4 did not disclose their gender.
186 are African American. 199 are Caucasian. 35 are Hispanic. Five are Asian. And eight did not disclose their ethnic group.
1 is American Indian or Alaska nay TUF. 14 are Asian. 173 are black or African American. 36 are Hispanic or Latino. One is native Hawaiian or other Pacific islander. 12 are two or more

races. 418 are white.
>> Thank you, Paula.
Related to certifications, audience member Siatta asked what certifications do CHC-MCOs recognize to identify MIE NORLT or women-owned businesses? Anna Keith from Pennsylvania health and wellness, Missy from AmeriHealth Caritas Keystone First, and mike Smith from UPMC said that they could provide that information at the next meeting. All three CHC MCOs to provide certifications recognized in relation to identifying minority or women-owned businesses.
>> This is Paula. All three CHC-MCOs provided the approved third party certificate entities. Those links will be provided on the MLTSS meeting minutes list serve shortly after the meeting today.
>> And I thank all of you for bearing with us through questions at the last meeting.
Juliet, I apologize for being late in turning this over. I'm sure that you're ready. We will turn it over to Juliet for OLTL updates.
[Indiscernible]
>> I see nothing with regards to Randy's attire. I am blocking it out of my mind. It's a blank -- Okay. For folks who have joined us virtually, it has been requested that I describe Randy Nolen bureau director's attire today. Which I will describe as a tribute to the Pittsburgh Steelers. He is wearing a Pittsburgh Steelers blazer, yellow and black stripes with the Pittsburgh emblem, in addition to a matching Pittsburgh Steelers tie. Not to be remiss about pointing out his Pittsburgh Steelers socks. For those of you who have not been able to join us in person, this is what you're missing.
All right. To make up on time, I will try and be brief in the updates.
The first thing that I wanted to talk about with regards to the OLTL updates is the Department of Human services fiscal code that was passed by the general assembly. This code directs the Department of Human Services on key elements of our budget.
So within the fiscal code, things that are worthy of note are the continuation of the long-term care council funding. So that is continued within the fiscal code.
And so you will see that there's a repeal of previous language in the long-term care council act of November 24, 2015 updated with updated language.
In addition in the 2023-2024 budget implementation, the legislative special payments are included. They are at the general assembly's discretion. Not OLTL's. So they have included four legislative special payments, which direct OLTL to take action. We will submit the state plan amendments and process the payments upon approval by CMS.
In addition, at their discretion, they have included a nonpublic nursing facility Medicaid day one incentive and DOI payment. This is at the general assembly's discretion. They have included it this year. Payment is two installments of $8 million state funds plus the federal match. Depending on the timing, the total payout will be either $36.052 million pay dates through December 31, 2023. Or $34.873 million, pay dates January 1, 2024 or later.
In addition as a continuation, the general assembly has included the nonpublic nursing facility case mix rate setting. The general assembly has chosen to direct the department of human services to use the data base costs and peer group prices for determining nonpublic NF case mix rates for state fiscal year 23-24. The Office of Long-Term Living are continue to apply the AERTly acuity adjustments to nonpublic NF rates in 2023-24 until the CMS approves the state plan amendment OLTL will continue paying the April 2023 rates. Once approved, those claims will have to be readjusted.
In addition, the general assembly appropriated sufficient funding to reimburse ambulance fees at the greater of Medicare rates or Medicaid rates, as updated in the bulletin 26-22-07.

In addition, in the budget implementation, there has been a request for analysis of wages for direct care workers so that no later than six months after the enactment of the general appropriation act of 2023, the department of human services shall complete a report analyzing the wages for direct care worker providing services to the department of human services, OLTL and beyond.
In that report, it shall include the following. The average wages paid to direct care staff by each program office. Whether wages are attributed to staffing shortages and resulting in waiting lists. And the department of human services shall submit the report to the chairperson and minority chairperson of the appropriations committee of the senate. The chairperson and minority chairperson of the appropriations committee of the house of representatives. The chairperson and minority and others.
There is a lot of focus on that.
Any questions?
No? Okay.
Moving on. We wanted to highlight the Office of Long-Term Living data dashboard. It has been out for quite a while now. But we are realizing that not a lot of folks know it's out there. So the Office of Long-Term Living data dash is a collection of documents regarding current OLTL enrollment data, market share between MCOs, and other frequently requested information. This is particularly important for new health care agencies that want to learn more about community HealthChoices population.
So as you can see here, we have the data brief from July 2023. August should be up shortly. From this, you will see that the total community HealthChoices enrollment is 423,536. That is both the NFI and NFCD population.
And the total CHC and home and community-based services enrollment, this is the NFT folks in the community receiving services, that is 121,891.
And the total community HealthChoices long-term care enrollingment, these are individuals residing in nursing facilities, 42,442.
So this gives you a sense of the numbers of individuals served in community HealthChoices. In addition, you can see the monthly enrollment by zone and by managed care organizations. This will give you a sense of where people are residing and being served across the five regions of the Office of Long-Term Living.
In addition, it also shows enrollment in the other OLTL programs. So our identify for service programs, the OBRA, 586 individuals.
And our Act 150 program has 1,025 individuals served as of July 2023.
As you can see, the OBRA enrollment is going down. The Act 50 enrollment has gone up slightly.
The total enrollment in the living independently for the elderly program is at 8,088 as of July. That enrollment has also increased.
So it is available on the PA.gov site. You can see data for other department of human services programs if that is your interest as well. But we wanted to highlight the data dash so folks who are interested in community HealthChoices or other OLTL programs can know how many individuals we serve across the commonwealth.
We hope to include additional data elements, but those will be coming in the future.
Okay. So moving to the public health emergency unwinding. We do not have specific data for the Office of Long-Term Living to share. We hope to have that in upcoming MLTSS meetings. It wasn't able to be ready to be shared today.
However, as of July 2023, Pennsylvania has nearly 3.6 million people covered by Medicaid.

Since the beginning of the unwinding period, DHS has maintained 337,089 individuals on Medicaid. And CHS as a whole has closed 184,758 individuals. And of these, 104,242 were no longer eligible for Medicaid. And 80,516 were closed for procedural reasons such as failure to respond. Again, these are not OLTL numbers. These are numbers for the Department of Human Services overall.
And if you look nationally, what that looks like as of August 29, 2023, we look at the Kaiser family foundation data, among the states that are reporting the Medicaid unwinding data, Pennsylvania has among the lowest percentages of Medicaid closures for procedural reasons. So we rank the fourth lowest at 43% compared to the national average, which is 74%.
We continue to monitor the PAG unwinding and want to ensure that everyone responds to their Medicaid eligibility requests and requirements. I know our managed care organization partners have been doing a great deal of effort and work in education in this area. In addition to our managed care organizations.
So that continues on.
I just want to highlight for folks in the annual adult protective services report that covers fiscal year 21-22 has been published on the department of human services website. It was published on August 15th. That report covers various statistics from the program. It includes the numbers of reports of abuse, negligent, exploitation, and abandonment by countiment it outlines the number of reports investigated, the severity of the investigations, how many were sub constant created and includes information on legal guardianship. The reports can be found at this website here.
In addition to some follow up on the statewide listen and learn tour, I'm grateful to all of our community partners for hosting sessions, for allowing us to come out and spend time with you in your community. We will be providing a summary of the sessions hopefully by the end of September that will be distributed out on all the list serves.
And we'll be speaking about them in the upcoming meeting in October and beyond.
Just as a reminder, the listen and learn tours are about all things Office of Long-Term Living. I am grateful to have had the opportunity to meet and learn from so many of the stakeholders in our community.
Another update is from the Pennsylvania Department of Education. We just wanted to highlight a policy change because it does impact the MLTSS community. It's a small but important change.
So the Pennsylvania Department of Education has updated their policy so that individuals will have access to free appropriate public education through their 22nd birthday. Typically, it has been through their 21st birthday. They have made this change to the 22nd birthday. The reason this is an important to MLTSS is because MLTSS services start at 21. So we wanted to ensure that folks were aware supports coordinators were aware that individuals served through MLTSS could also still be in school.
We just wanted to highlight.
Lastly, not on -- if RFA update. I wanted to be clear that we have no updates on the request for application. There are no --
[indiscernible]
Any updates to the RFA will be posted to the E-marketplace where there was some interesting conversations about the status of the RFA. I'm here to let you know, no updates.
Any questions?
>> Any questions for Juliet?
From the committee members?

The audience?
>> This is Shanrika. We do have questions in chat.individual program offices typically don't pay DCW directly, do you intend to include wages paid by individual providers to caregivers? Can you talk a little more about how you see the wage study working?
>> JULIET: Terry, thanks for the question.
So this is fairly new in that it was passed on August 31st. So we will get back to the broader community with additional details about how the wage study will be working as this is a DHS-wide effort.
>> This is Shanrika again. This request is from Garrett.
The OLTL data dash also include a break out of population by county? This was a recommendation at the recent HCBS conference.
>> JULIET: Yes. We can break it up by county. If the numbers in the county are such that they do not meet the requirements of the data elements, the county numbers -- but we are looking into additional data elements to include on the data dash.
Yes, we can look into breaking it out by county.
So if a county serves fewer than ten individuals, we wouldn't say a number of individuals served in that county to protect their identity. We would suppress that. You would see an asterisk or something of that nature.
>> There are no more questions in chat.
>> JULIET: Thank you.
>> Thank you. Any more questions for Juliet?
You must have done a good job, Juliet because there's no questions.
All right. Thank you very much for the presentation and the update.
Next we'll move forward to the next item on the agenda.
Is there someone on the line?
>> Yes, I'm here. Can you hear me?
>> Yes, we can.
>> Okay. Yes, I'm Randy Loss. I'm a human service analyst in the policy bureau. Many of you probably know who Ed Butler was. I replaced him as the Employment First lead. What I would like to do is walk us through a document that was the effective date was April 1st of this year. And it was issued June 14th of this year.
So benefits counseling waiver amendment, if somebody could click to the next slide, please.
So what happened was in this amendment, it updated the Office of Long-Term Living employment related service bulletin regarding the centers for Medicaid and Medicare approval to benefits counseling requirements in the Pennsylvania community HealthChoices 1915C waiver. It removed the OVR referral requirements for this service.
So the reason we had done this was Office of Long-Term Living requested the waiver amendment to ensure participants were able to access benefits counseling in a timely manner. What was happening previously was the OVR referral requirement included up to 120-day wait for a participant to receive services of any kind, including benefits counseling, before the services would be deemed unavailable through OVR and could be sought through waiver services.
What we had done basically was asked CMS, our federal funding source, was to speed up the process for benefits counseling.
So if somebody could move to the next slide, please. Thank you.
Specifically from the bulletin, page five, as required by PACHC1915C waiver, MA waiver funded benefits counseling may be only provided after it is documented in the service plan that benefits

counseling services provided by WIPPA program were south and determined that such services were not available because of ineligibility or wait lists that would ROULT in services not available in 30 calendar days.
Basically, we ask for and got approval for if the WIPAs the ticket to work phone line if they said that WIPA services were not available within 30 days, that allowed us to use waiver funding services for those that were receiving waiver funded services to be able to provide benefits counseling services.
Next slide, please.
Also, a side note in regards to the same bulletin. If requested by the participant, service coordinators are required to participate in OVR support team meetings when a participant is receiving services through OVR. We wanted to clarify that if the participant is asking for support from the service coordinators that needs to be offered so that they can help them with the employment process.
Second bullet, employment considerations such as job retention, support planning must be included in participants' individualized and emergency backup plan. So we wanted to make sure too that if something happens as a person is proceeding through the employment process and say they lose their job or something like COVID, for example, the pandemic occurs, is there a backup plan put in place?
And the bulletin has a guide for employers to discuss employment with participants, called guidance in conversations about employment for OLTL participants.
Next slide.
And this is a snapshot from that guidance document. We see here a couple of bullets that the service coordinators are supposed to take in consideration when working with individuals, participants receiving services. First bullet under the employment first policy, the first consideration and preferred outcome of publicly funded long-term services and supports for working age Pennsylvanians with a disability among other things shall be competitive, integrated employment, which is basically working in a community minimum wage or better and working alongside nondisabled peers.
As such, OLTL is requiring service coordinators to talk with the participants about employment, ensure participants are made aware that counseling is an employment -- Pennsylvania is an employment first state. And OLTL is focusing on fusible employment and community outcomes for home and community based waivers, procedures, policies, and practices.
Again, another snapshot from that document. Service coordinators are expected to talk about employment and employment related goals with all working age participants in OLTL home and community based programs. As a follow up to the conversations during the person-centered service planning process and subsequent participant monitoring, SCs will document the conversations as appropriate. This resource is intended to support the activity identified and required in the OLTL bulletin employment related services.
Service coordination entities need to ensure the participants understand their response to any facet of the employment initiative and it will not impact the delivery of home and community-based services. This needs to be reinforced on an ongoing basis.
Next slide, please.
I know I blew through that. And I just want to say Randy, thank you for your support of our team. Appreciate it. Even though I'm not there today, appreciate that.
Does anyone have any questions on the amendment to the employment services bulletin?
>> Any questions from committee members for Randy?
Or the audience? Go ahead.

>> Good morning. This is Jeff from Pennsylvania SILC.
You mentioned about employment. And the question is both in OLTL and the question, I know, Randy, you -- do we know how many individuals -- employment might be OLTL participants? I think the assumption is that everyone is under ODP. I'm not sure that's correct. But I'm not sure that it's not. I was wondering if that's something that has been verified or if it's something the departments could collaboratively look at?
>> I hate to ask, Jeff, could you repeat the question? Part way through, you broke up a little bit.
>> Can you verify if there are any individuals receiving OLTL services are still in -- employment or workshops? The assumption of most people is that everyone is in employment is in ODP participant. But I'm not sure that's the case. Maybe it is, maybe it's not. I would be curious.
>> To my knowledge, I know that when I was working with office of mental health and substance use services where individuals receiving services -- in regards to OLTL participants, I don't know if they are receiving -- or if they are in shelter workshops. My guess is not. I can definitely reach out to the MCO employment leads and find out if they have information in that regard. I will go back and take this question to my supervisor, Ryan Dorsey, and find out if there is anything in our data system that would tell us that. I don't think there is. But I can double check on that to see if there are folks in shelter workshops that we're working with the MCOs to see that those individuals are working toward moving out of those to community integrated employment.
>> And just to clarify, I know this is an MLTSS focus, the question goes to basically any OLTL programs.
>> Sure. Sure.
>> Thank you.
>> Right. Yeah. We can definitely research that. I don't have an answer at this time. We can make sure that we can get what information we have available by the time of the next meeting.
>> So this is Juliet Marsala. To add to that, what I can say is OLTL doesn't recognize sheltered workshop as a there should not be OLTL services funding any services within those settings. Whether or not there are participants in those settings for other reasons, we can certainly follow up on that.
>> Thank you for that clarification.
>> So the employment services were a major addition to the waiver when CHC was introduced. We're grateful for it. However, seven years later, we have less than 1,000 people in the program.
Can we as we have a new person, welcome, by the way, good to have you with us. But can we educate the consumers that this is a back to employment rather than saying that the ultimate goal is integrated employment, there are three other services that proceed the functioning and the integrated employment, including exploration and training. I think it scares a lot of us away from saying yes, we're interested because we don't understand what might be the outcome. Can we look at how we can educate and inform additional of the pathway to employment that these services include rather than just focusing on the ultimate outcome?
>> RANDY: Yes. In fact, the MCOs do provide training to the service coordinators in regards to what does it look like. Employment is not the same for everyone. And if you look at the community integrated employment is, for an individual that has a significant disability, it might be one hour a week. In the community, it's competitive -- excuse me, a minimum wage or better. Because of the nature of the disability, they might only be able to work one hour or several hours a week. It's not the same for everyone. So yes, that's one thing that I think is important to make sure that the service coordinators are aware of, that the MCO employment leads who

work with the service coordinators are aware of that it doesn't look the same for anyone. Is that what you're getting at?
>> Yes. But also the fact there's an opportunity for job exploration and training rather than just the employment. It's a pathway to integrated employment rather than just employment piece, which is what the ultimate deliverable is. We understand that.
>> Let me explain something. The coordinators are trained in person-centered planning as part of person-centered planning is meeting individuals where they're at in pursuing their goals. That could include volunteering, it could include discussions about interest in readiness, school, work, any life activity whatsoever.
So while there are five very distinct employment related services, supports coordinators should be talking with participants and meeting them where they're at, regardless of whatever their goal may be in terms of what they want their activities in the community to be. To be along the spectrum of volunteering, it could be along the spectrum of discovery, exploration, et cetera.
Service coordinators are also trained to inform individuals about all the aspects of the office of vocational rehabilitation resources. For example, OLTL does not pay for training, per se, but there are opportunities in OVR and other public benefits that could assist someone to pursue education or other career activities.
I just wanted to clarify that.
>> Lloyd?
>> So is there an expectation for --
Is there an expectation for the number of people who will participate? If so, how has that been established and how is that being tracked on an ongoing quarter by quarter or year by year basis?
>> RANDY: Let me see if I can repeat what you asked, Lloyd. You're asking to we have information that tells us how many participants are receiving services and what are the outcomes of those services? Is that what you're asking?
>> I just wondered if we walked into this component of the CHCs are our eyes open with an expectation of what will we be able to achieve or if that's being developed and if so, how, and when it will be implemented?
>> RANDY: Each of the MCOs do have an expectation and we receive data from them on a monthly basis and they have metrics and goals to meet. So we have been tracking that information. And as necessary, we can provide technical assistance to them, we can pull them aside and say here's what we're looking at in terms of your data, can you help us understand this a little more effectively.
So we do look at the data monthly in regards to what the MCOs are doing, what the service coordinators are doing in regards to employment services for participants who are receiving services.
In many cases, a lot of the individuals are being referred to OVR first. In OVR situations, there is no order of selection, many of the individuals receiving services from OVR. So there are those instances where individual may not be eligible for OVR services. There may be some mitigating factors that are causing that. So the individuals.
But I can say that a majority, I would say over 95% of the individuals are probably receiving services from OVR at this time for employment related supports.
>> Okay.
>> RANDY: We do have the data. But I can say the numbers are low. But I would say that a big, big factor is the fact that the majority of individuals, because of the nature of the disability, they're going to to OVR for services.

>> So perhaps that information can be shared in a future meeting so that we'll understand the context in
>> RANDY: Yes. That's something that we can definitely look at.
>> Thank you, Randy.
>> RANDY: Sure.
>> Any other questions for Randy? From the audience? The committee members?
All right. Thank you very much, Randy.
>> RANDY: You're welcome.
>> Next we're going to move on to the LTSS health care effectiveness data and information set measures. Abigail, and she happens to be here face to face. So welcome.
>> ABIGAIL: Good morning, everyone. Thank you for having me. Sorry, I'm trying to face the audience. That's as far as my mic goes.
My name is Abby Coleman, I am the director of program analytics with the Office of Long-Term Living. And as was introduced, I am going to present today on our long-term services and support HEDIS measures. And there are four of them with three of them having subset measures.
Next slide, please.
And before we jump into the data, there are some things that I want to address up front.
First of all, you will see at the bottom it says MY19. What MY19 means is it's measurement year 19. So it's for the calendar year of 2019. However, those are reported in the following years, so in this case, 2020. So that's what the MY at the bottom means.
I also -- you will also note that AmeriHealth and Keystone First are reporting separately because they are accredited by the national committee on quality assurance who collects the measures from the MCOs. So that's why they're reported separately. And of course, I'm sure most of the people on this call and in this room are well aware that CHC rolled out in three phases. And Keystone First working in the southeast will never have measurement year 2019 for these measures.
So just a couple of things that I wanted to point out before we get started.
So the first measure we're going to look at is the comprehensive assessment and update. We have the data for all four MCOs from measurement year 2019 to measurement year 2022, which was of course reported in 2023. They were just reported in June. So these measures are relatively new.
You can see that -- so first, this measure is looking at anyone who has had a comprehensive assessment that included nine core measures and that assessment was done timely.
Some of the measures include activities of daily living, documenting acute and chronic conditions, current medications, assessment of cognitive function, assessment of mental health, safety concerns, et cetera.
And you can see year over year as a state, we are improving. We have come a long way since our first measurement year in 2019 to where we're at in 2022. All of our managed care organizations saw improvement over this last year. And are really doing pretty well in terms of measuring getting assessments done that include all the right things and are done timely.
Next slide.
So this is a subset of the measure. And in order to have gotten a numerator hit on this one, meaning you get it counted, you had to have met the first part of the measure. You had to have the nine core measures.
For this one, there are additional measures where you had to have met 12 additional items that the assessment included.

And so you can see even with the additional elements being required, or managed care organizations are still doing well. As a state, we are seeing year over year improvements. We're at 91.9%. Our goal for 2022 was to have each of the managed care organizations be at 77% based on the previous year's data. And you can see that all of our managed care organizations are exceeding that goal that was set for this measure.
Next slide, please.
So the next measure is comprehensive care plan update. And it's exactly what it sounds like. The number of members who had a comprehensive care plan developed. Again, looking at specific core items, again, requiring nine of those core items. And that their care plan was developed timely. So those are the two components.
Some of the things that are included as those four measures are that there has to be at least one goal for the participant, whether it's medical or nonmedical. They have to have a plan of care that will meet the participant's medical needs. Functional needs. They have to address needs due to cognitive impairment. And so on.
So those are the types of things that need to be included in this person-centered care plan for this managed care organization to have met this measure.
And again, state other state -- year over year, not state over state, you can see that we are improving and as a whole, the weighted average for this state is 85.2%. And that most of the managed care organizations are seeing improvement on this measure from the previous year.
Next slide.
So this is similar to the assessment measure, a sub measure of the previous one had to have met all of the requirements for the previous measure to be eligible to say you met this measure. And it's a very similar concept where for this measure, I believe there are nine supplemental items that you had to have met. Again, being timely with getting that PCSC in place. And again, improving year over year the goals for this particular measure was 77%. And as a state, we have exceeded that for calendar year 2022.
Next slide.
So this measure is exactly what it sounds like. Did the managed care organization share the PCSP with the primary care practitioner. This does not have to be a physician. It could include nurses or other folks considered a primary care practitioner.
And again, as a state, we are improving year over year. You will see that UPMC has a couple of years of data missing. Unfortunately, their system at that time was not able to capture what was shared. That's why the data is missing there.
But again, year over year, we are seeing improvements at the statewide level. Our goal for this measure was 55%. And we're currently at 67.2%.
There is no sub measure for this one, so we will move to the next slide, please.
And the next slide and the final two measures, this one is looking at rea-assessment after an inpatient discharge. This would be the number of members who had the reassessment, including the core measures discussed in the first measure and in also completing that reassessment timely after they're discharged from an inpatient stay.
So this one, again, we're seeing year over year improvement as a state. We had a minor drop off in 2021. But went back up in 2022. And we are currently at 46.9%. We had a goal of 38% for this particular measure.
Next slide.
Okay. And so this, again, is a sub measure. And this is combining both the assessment components and ensuring that the is in place including the elements I have gone through on the second measure. So again, year over year, we're seeing improvements. You had to have met

the first four measures in order to have met this measure. So it follows that we also saw a small drop off in measurement year 2021 since we saw a drop off in the core measure.
So that is my final slide on LPSS measures.
I'm looking at the time. It's 11:09. And I am supposed to start VBP at 11:10.
So I was told that I should take questions during the additional public comment period. Is that still how you would like me to proceed? Or do you want me to take questions now?
>> Why don't we do questions now? Just because it's fresh on everybody's mind. Then we can move on.
>> ABIGAIL: Sounds good.
>> Any questions for Abigail from the committee members or the audience? Go ahead, Lloyd.
>> When you establish an annual projection of the, I assume success, is that done in concert with the MCOs or by the OLTL?
>> ABIGAIL: It was done in conjunction with the managed care organizations.
The Office of Long-Term Living proposed goals to the managed care organizations and allowed the managed care organizations to provide feedback and input on the measures. We propose manage care provide feedback and the department ultimately made the decision.
>> Follow up after discharge at only 47% of compliance.
Also -- I assume this data is self-generated by the MCOs and then given to you folks?
>> ABIGAIL: No. So these measures actually go through the HEDIS audit. We have an external quality review organization who sub contract with an auditor. The auditor will go in each of the managed care organizations and review the data that they are using to ensure that they're sound.
Before the managed care organizations are allowed to submit that to MCQA, which is the national committee on quality assurance -- the managed care organization can't just go in and say we got 40% on this measure. We want it to say 80%. So there are some controls in place.
And I do also want to address the re-assessment after inpatient care. A lot of what the issue is here is that Medicare is the primary payer for inpatient stays. And so we have been working with the managed care organizations to ensure that when that participant is going home because so many of our participants are dual eligible, that that managed care organization is the Medicare managed care organization is providing that notification to the CHC managed care organization.
We have also be working with our managed care organizations to join health information exchanges where they can get admissions, discharges, and transfers. The number will go up by that fact alone that they will get the notification of the discharge sooner.
We're very hopeful that between care coordination efforts, we're going to see that continue to rise.
>> I certainly hope -- it seems to be the point in which you're more likely to lose someone to an institutional setting is right after discharge when they get back home.
>> Absolutely. We want to see those reassessments and services getting in place as soon as possible after that person is discharged.
>> Thank you very much.
>> Other questions from the committee members or the audience?
>> Hello. So I saw on the slide that the MCOs are sharing with physicians. My name is Robinson, I represent a home care agency. And where I find that is that the plan of cares are not being shared a lot of the time with the PAS agency, in which we're the ones rendering the services. Of the agencies for ourselves, we do our own plan of cares. But it tends to conflict with what the SCs are doing. There seems to be a disconnect. You're sharing with the physicians and not the agencies rendering the services who could also help prevent these hospitalizations

are recurring.
So is there a slide on or a statistic or numbers on MCOs sharing the plan of cares with the agency?
>> ABIGAIL: No, there isn't a measure. These are national measures. So they weren't developed by the Office
>> Abby, if I may?
If I may, Mike, can we have the MCOs come up and describe how PAS health care agencies should get access to care plans that they are seeking?
>> Certainly. Who wants to go first of the MCOs?
>> Good morning, everyone. My name is Joe Elliott. I'm the director of LTSS with PA health and wellness.
For the home care agencies to receive the plan of care, we have operationalized a module in HHA exchange where the service coordinator can upload the plan of care directly to HHA exchange. And then the home care agency would have access to that. We work with the service coordination entities on a regular basis to make sure that the plan of care is loaded. I know we're not at 100%, but it's an ongoing effort between the plan and service care entities to get it loaded.
>> Thank you.
>> Any other MCOs?
>> Next MCO?
>> Yes, I am unmuted, thank you.
So thanks for the question. The organizations can gain access to their -- to participant approved when the participant goes through the person-centered planning process, one of the things we ask is can we release this information to your physician and providers that are providing your care. If they answer affirmatively to that, we post that information on our provider portal. And you can talk to your provider, your network representative to gain access to that.
But I know that there are hundreds of points of access to that from PAS agencies who go out and regularly pull down those PCSPs and the service plans.
>> Great. Thank you, Mike.
>> Why is the burden on the PAS provider? Why isn't that actively done? Waiting for the PAS provider to pull it down?
>> So information is available on -- we provide also information travels through from HHA regarding the services as well. But it's not the full -- it's not the service plan that we provide out on the portal. It's available there with more robust information.
But if you are just looking for guidance on what types of activities the participant needs and things like that, that's transferred over through the HHA portal.
And the other thing is the participant should always have a copy of this in their home. And that's another place that there's access as well.
>> Hi. AmeriHealth Keystone. Our answer is kind of the same. It's available upon request.
>> So the provider has to request it.
>> Does anybody think this is a problem? I think it's a problem. I'm an Act 150. But I can't tell you how many providers come to me and we don't no what we're doing for you. If you're doing that in Act 150 and you have to pull it down.
>> So that's the first thing that needs to happen is the participant needs to provide approval to access the full care plan or different elements of the care plan. It's at the direction of the participant, first all.
So I think encourage the MCOs the process for ensuring and protecting that information.

Not going to require the participants to share every single one of their care plans with everyone.
>> I'm not sure if this is helpful. Coming from a PAS agency, for the ones we do not have the care plan, we use the old service authorization form as a guide to build our own and often run it by the service coordinator and say does this look good. Or the participant, we have that had a nice list of ADLs that were a good guide and helped justify the scope of practice for our participants and the caregivers.
>> Thank you. Go ahead, George.
>> George. Advocacy for many years and looking at programs --
[Indiscernible]
>> Okay. The personal experiences are probably the best things to illustrate this regionally. Transportation has been a huge issue trying to schedule the rides immensely difficult and immensely problematic. I was due to go see my dentist about a month ago. The trip was scheduled. The provider came and picked me up to take me to the trip.
It happened to be the same address -- in a different town. The driver told me that I was going to Philadelphia to get my teeth cleaned. I directed him to my place locally, got it done.
But the provider could not be reimbursed for the ride because it was not appropriately set up. We'll call it a victim of AI.
Additionally today, I gave to me -- a letter that I got from -- that my data has been breached. All those who used meals data has been breached.
[Indiscernible]
We're looking to have people live independently in the community, but we can't provide a number of things and the metrics of what we're doing. And we jeopardize the people in the community in many ways. Obviously, programmatically, things are not working well. I tried to address those to Randy Nolen and have not heard back from him.
Frequently talk to Juliet about them. Those private are the ones that are the ones -- and the issues that can be explored and illustrated rather than data collection you're doing. The data collection for most of us are extremely --
[Indiscernible]
Government, most of us are allergic to it. Those that aren't are a nerd.
And additionally, if I could, those things that we hope for the safety and ask what the department can do to make one safe. So when your data has been breached, a letter -- if Mike, you can put it up, I don't know. When your data has been breached and you get a letter stating we're going to give you a protection for one year. And by the way, you figure out how to interact with those who have stolen your data and monitor it comes a too far feeling for many of us.
What is the Department going to do to ensure basic safeties so that people can live independently in the community?
>> Thank you.
>> So George, I will get back to you on that question with regards to the data safety and data breaches. Our contracts have requirements with regards to what all our providers are required to do to ensure that their systems are as secure as they can be. I can certainly forward information about those requirements to you.
I just want to caveat also that right now we're taking questions with regards to the HEDIS measure presentation. But I will certainly give you additional information on the data security breach. The moms meals breach, I believe, occurred in March. And certainly while we want all of our systems to be as secure as possible, we always know that there are new tactics and bad players trying to find out new ways to take advantage of that data. It certainly is ongoing battle that everyone has a part in trying to protect the data as much as possible.

So I will get back to you on additional information and certainly send you resources where you can find out more information about what the Commonwealth is doing.
>> If I could further. I haven't gotten moms meals for at least two and a half years. So they continue to keep my data even though I was not interested in their meals whatsoever and explained that very explicitly to them.
To keep data obviously it makes it a jeopardy to hang on to data. And those metrics of what they're supposed to do, obviously, they're not doing it. Obviously, the things that OLTL needs to do to oversight seems to be lacking. So the oversight by OLTL would certainly be greatly enhanced in the programs by having an actuality of doing oversight.
>> Appreciate your feedback. I will follow up with you on your individual situation.
>> Thank you.
>> Thank you, Mike. Hi. This is Corin. I was part of the OLTL world, went to ODP world. And reacclimating to the OLTL world again.
Listening to the conversation about having access to the person-centered plan, I have a question. On the ODP side of the world, they have the annual meeting with the team. At that team meeting is who the individual wants at that team. So for ODP world it was the provider, the supports coordinator, family members, whoever was supporting that individual was at that meeting and gave permission to who could have access to that plan and then the supports coordinator would send the finalized plan to those who were included.
My question is is that the similar process that OLTL uses for person-centered planning all who is supposed to be at the plan, including PAS, and having input with the participant or with the individual to have permission given to have that plan handed out right away?
>> The participant chooses their support team. They are not required to choose a PAS agency representative on that team.
Are there any other questions related to HEDIS measures in the presentation?
>> All right. If none, we will move on to value based purchasing. Abigail, you have double duties today.
>> ABIGAIL: Good morning, everyone, again. Abigail Coleman. Next slide.
Okay. So we can skip the agenda. We will try and make up some time here.
So today I'm going to be talking about value-based purchasing and I think many of you are aware that calendar year 2022 was our first year of value-based purchasing and implementing that in the Office of Long-Term Living. So just to level set a little bit, I wanted to go through some of the definitions around value-based purchasing just so we're all talking the same Lingo.
The first one is value-based purchasing payment agreement. That's a tongue twister. This is basically the arrangement that the managed care organization has with their provider. It specifies how they're going to pay their provider in the event that they would be getting additional bonus dollars.
Value-based purchasing models are the models that the managed care organizations develop as a way to organize and deliver care. And they can set up different models on different topics and different things. We'll go through some of that in some of the later slides.
And value-based payment strategies refers to the mechanism that the managed care organization uses to pay their providers. And there are five of these. And again, we'll go through these in a little more detail in the coming slides.
Next slide.
So value-based purchasing in Pennsylvania these models are critical for improving quality of services. That's really the primary intention is to drive quality.
But also efficiency of services, reducing costs, and addressing social determinants of health. So

value-based purchasing models are important.
Next slide.
So this is just a visual that shows the different levels of risk related to the different strategies. We're going to go through them in detail. So next slide.
So the first one is performance based contracting. This is the lowest risk of value-based purchasing. This is really where there are incentive payments and/or penalties linked to provider performance.
So typically something like this might look like you look at a measure and you can either provide an incentive for a benchmark, incremental improvement, or there could be penalties related to that.
Next slide.
The next slide is shared savings. So this would be the case where network providers could earn money back if they can reduce their health care spending. And the managed care organization is required to prospectively or ahead of time develop their benchmarks for that cost spending, which must be based at least in part on historical claims.
So this can either be risk adjusted or not. And then if there is a savings realized, the provider would share in those savings along with managed care organizations.
Next slide.
The next one is shared risk. This is very similar. Shared savings is -- there's no penalties involved. This one is where there are shared losses with the networks. The providers would share those losses as well.
And then the final medium risk strategy is the bundled payments. And these payments include all payments for services rendered to treat a participant in their identified condition during a specific period of time.
So you might be familiar with HealthChoices. We have a maternity bundle. That would be an example of bundled payment example.
And the final one is the global payment. This is considered a high risk type of strategy where it is population based. So that even though -- it covers all services rendered by the network provide, hospital, or health system by the participating MCO.
Next slide.
So now to get into the specifics of value based purchasing in the Office of Long-Term Living, this is a chart of value-based purchasing models by strategy by MCO.
You can see that almost all of the strategies that the managed care organizations are using are the performance-based type measures. That makes sense. It was our first year. So that makes sense.
We do have each of the managed care organizations that implemented a shared savings model. And you can see that none of the managed care organizations at this time have a shared risk bundle payment or a global payment.
I will note that although AmeriHealth and Keystone First are listed separately, they're both using the same model. So there really are 15 different value-based purchasing models in Pennsylvania for 2022.
Next slide.
Some of the topics that the managed care organizations are addressing through these VBP models are PAS, nursing facility quality. All three of them have a nursing facility quality model. A lot of them are building off of the nursing facility quality incentives.
Other topics include addressing transportation, hospital quality. The use of EVV and improving the use of EVV. High touch pharmacy. And of course one of the core care coordination.

Next slide.
So for calendar year 2022, as I mentioned before, this was our first year of -- that might be a typo on there.
The managed care organizations were required to have 15% of the medical portion of the capation expended through VBP. And 7 and a half of the long term services and support spent for value-based purchasing.
So we do have the results for 2022 that were submitted in June. And the results are that none of the managed care organizations met the 15% on the medical spend side. They were within striking distance anywhere from 89 to 99% of the requirement was met. But it didn't quite get to that 15% that we were looking for in that first year.
On the other hand, on the LTSS side, all of the managed care organizations well exceeded the requirements of the 7.5% spent. Some of them exceeded it by almost ten times the requirement. So next slide.
For next steps, requirements for 2023 remain unchanged because obviously we didn't have the data to know where the managed care organizations would fall, if they would meet the requirements for the medical spend. We wanted to have the final numbers.
For 2023, the numbers were unchanged for the requirements. The managed care organizations will be required to have 15% of the medical capation and 7.5.
We had discussions with Mercer to discuss to 2024 requirements and if there were changes required. So those requirements will be forth coming.
And then finally, the managed care organizations will be submitting their models for calendar year 2024 in October. I would imagine that we will see some tweaking of the current models. Some of the models were pilots. So perhaps expansion. So some things to look forward to for 2024.
And if there's time, I will take any questions.
>> Any questions from the committee members for Abigail on value-based purchasing?
>> ABIGAIL: All right. Thank you very much.
>> Thank you, Abigail.
We'll move right on in our agenda to informing and supporting new participants in the option of participant directed services.
AmeriHealth Caritas, you're up first.
>> Hello. Good morning. Can everybody hear me?
>> Yep, we can hear you.
>> Awesome.
Good morning, everybody. I hope everybody is staying opportunity to speak with you about our philosophy on participant-directed services.
So I will jump right in so we can go to the next slide.
>> Go ahead for the transcriptionist, can you announce who you are?
>> Sure. My name is Marcus Hicks, I am a director of service coordination with AmeriHealth Caritas and Keystone First.
All right. So I want to start by talking about the service coordinator's role in the self-directed model of care. As a side note, I am going to refer to service coordinators as SCs throughout the remainder of the presentation.
So at this point, SC should have regular contact with participants. Part of said contact will sometimes involve the completion of a comprehensive needs assessment which most of you know as the NRI. The purpose of this comprehensive needs assessment is to get to know the participants and determine what long-term services and supports can best meet your needs.

So as most of the folks on the call know, this can be a pivotal, albeit lengthy process. Once the information is collected and tabulated, the SC and the participant, along with members of the participant's person-centered team end up working in conjunction to create an appropriate person-centered service plan.
So while that person-centered service plan houses a lot of comprehensive information, which is inclusive of any services and supports the participant might be utilizing, one of the primary services that we often see requested and utilized is of course personal assistant services.
So the SC would be educating the participant on different models of care available that impact how those personal assistant services are administered and delivered.
Those models are the agency model, which is typically seen as the more traditional method of service delivery where a participant utilizes a personal assistant service agency and a caregiver hired by the agency to provide care.
The alternative model, which is highlighted today, is the self-directed model of care. This is when a participate essentially acts as the administrator for the process. That means the participant is responsible for locating personal assistant service caregivers, as well as doing any interviewing, hiring, managing tab sheets, and a litany of other things.
So we can go to the next slide.
So during the SC's conversation with the participant, the benefits of both models are typically reviewed. Ultimately, this education is to help the participate maintain choice and to make sure the participates can make a more informed decision about which model actually works better for their needs.
As that discussion progresses, there are times when the SC can encourage the use of self-direction if this suits the participant's needs and wants.
You will see some of the circumstances here on this slide. Those can range from the participant having the desire to self-direct employment of caregivers and maintain a greater sense of independence and control over how that care is delivered. To it being an advantage to utilize self-direction in areas that might be historically difficult to staff.
To a participant simply wanting a caregiver that they had in mind to hire prior to the service plan being implemented.
There are a myriad of circumstances that may not have been mentioned here that might make self-directed model of care more sensible.
So we can go to the next slide.
As sort of a summary of things that I went over, our role as is MCO and administrator of service coordination of course play an integral role in supporting the use of self-direction when it is something desired by a participant.
During each of the SC's reviews of the person-centered service plan, the SC is always going to discuss the appropriateness of services and how effective those are in helping participants maintain independence as well as health and safety.
While we do discuss the option to utilize self-directed care at the initial assessment, it's something that subsequent review during each conversation about the service plan.
So this serves to ensure that participants are always going to be aware of their ability and their right to switch from agency model to self-directed model and vice versa at any point in time.
That choice is always confirmed prior to a service plan being signed. And the service plan is milled out to the participation for finalization so they have a copy for their records.
All right. And then next slide.
To assist us in supplementing that education around self-directed care options, we are going to be including an article on self-directed services with our next participant newsletter.

Additionally, self-direction is going to be a topic during our participant advisory committee meetings that are scheduled in September. You will be able to see the dates on this slide. I will allow a few seconds just for folks to see in case anybody needed to take it down.
All right. And the last slide is just for questions.
>> Thank you, Marcus. We'll go ahead and move on. Can you stay on the line so if people have questions, they can ask you? I would like to get through all three of the MCOs first.
>> Absolutely.
>> Thank you. Next up, PA health and wellness.
>> Good morning. Can you hear me?
>> Yes, we can hear you.
>> Great. Okay. Good morning, everyone. My name is Olivia Martin from PA health and wellness. I am the senior director of long-term care and service coordination here at PHW.
Next slide, please.
Okay. So I would like to start by reviewing how our SCs begin the discussions surrounding the PDO model or the participant directed option model.
During any encounter assessment or during regular outreach, the SCs do touch on satisfaction and effectiveness with their current services if services are in place.
They also touch on their interest in pursuing the participant-directed model. The participant-directed model does allow more participant choice and control over their personal assistance services so they may live as independently as possible within their communities.
So with the focus on keeping our approach always person-centered, which choosing a provider for personal assistance, both agency and PDO are discussed with the emphasis on PDO allowing for more independence with choosing their direct care workers, scheduling the hours, and handling the worker's time cards. The PDO model can also help with geographic areas that can be difficult to staff with agency staff because they may be able to use a caregiver that is already providing care.
If the PDO model is chosingen, they work to help identify if additional support is needed to self-direct their care. They work to find out if there are any specific direct care workers in mind. And the number of workers needed to ensure that quality care is being provided.
So regardless of the model chosen, identifying an effective backup plan in the event of a direct care worker not being available is also an important discussion to have.
This is also reviewed regularly at each person-centered service plan review outreach, along with the goals.
Next slide, please.
Okay. PHW offers numerous training sessions and resources for service coordinators. We have job aids that outline specific processes related to the internal PHW work flows and job aids specific to tempest processes and their training resources. We supply reports weekly and monthly to the SCs to monitor activity and help them identify any barriers that their participants may be having that may need extra support, training, or assistance from the SC.
If a concern is identified such as a participant over or possibly underutilizing hours or issues with direct care workers clocking in and out, the SC can outreach immediately to provide support instead of waiting for the next scheduled outreach.
Next slide, please.
Okay. So what if the PDO option is chosen? The participant and their direct care workers must understand and be capable of a few things with the model.
The participant is the employer of the direct care worker. They are referred to as the common law employer. They are responsible for the hiring and possibly firing of the worker and reviewing

and approving all time sheets after ensuring that they are accurate.
Tempest is referred to as the financial management system or the FMS system. It's an external agency that processes the time cards. There is training for participants and their DCWs available through tempest to ensure that they understand their individual responsibilities and how to navigate the tempest platform.
Once the common law employer and the DCW have provided all of the necessary information and the PDO authorization is in place, they're considered good to go.
Next slide, please.
Okay. Another option for the delivery of personal assistance is through the services my way model known as budget authority.
This model does differ from the PDO model as this does involve managing a monthly budget on top of being the common law employer. The budget is calculated based on weekly authorized hours and the regional rates for personal assistance. This budget can be used for personal assistness and also for goods and services.
So we are continually reviewing and updating the education materials for services my way to ensure alignment across all three MCOs. We work as a coalition to develop additional trainings.
Next slide, please.end.
>> Right.
>> Thank you.
>> Thank you for your presentation.
UPMC?
>> Hello. Can everybody hear me okay?
>> We can.
>> Terrific.
So mike Smith here from UPMC. Next slide, please.
So just wanted to talk a little bit about our approach to participant direction, just a reminder to folks, this participant direction is a core element of this program. It's a service delivery model. It allows participants to have choice and control. It's the first option over traditional agency model that we try to pursue with participants.
It is a combination we just heard Olivia talk a little bit about, participant-directed paths and also the budget authority offered under services my way. And these must be discussed with participants during assessments and person-centered planning sessions.
Next slide, please.
So we just wanted to -- this slide is a graphic to say there's some core components here. It's the service coordination. It's the direct care workers who have to understand the model. And the participant obviously at the center of the communication and understanding, along with our financial management services. Tempest is our financial management services provider.
Next slide, please.
So as discussed in the previous presentations, we really have an opportunity to start to get to know somebody at the assessment process. This is a conversational process designed to learn what the person needs, wants, what their circumstances are in their lives. That's an opportunity that could potentially lead to discussion about the model.
But the main emphasis of the model is really provided during our person-centered planning process as we unfold what services that participant may need.
So there's a lot of different services that are discussed and goals and barriers discussed to services in terms of getting them on to a service plan. And as part of that process, we're going to discuss when somebody needs help this in the home, this option specifically services my way

and participate-directed personal assistance services.
So those are part of the planning process.
And then as we determine if those processes are interesting or that model of care is interesting to a participate, we're going to go into the details that were provided in some of the other presentations around this is an opportunity for people to learn more about what it means to hire, train, discipline, and terminate provider, their direct care worker. What are the benefits of that too. To engage in a discussion about being in control of your services and supports. And obviously, budget authority options versus just a straight forward common law employer, which is what you would be if you are employing a direct care worker.
And what your opportunities are to get those services provided.
And then we would be discussing the role of Tempest in all of this. And we have some information that we can provide as a lead behind if people aren't quite sure.
Next slide, please.
So we provide some direction on -- in our personal assistance services handout. We include information on participant direction. We obviously provide participant information is discussed during not only the person-centered planning process, but as participants sort of explore the idea, it's almost like employment which we talked about in the earlier part of this MLTSS meeting. It's really an exploration. Sometimes in sort of learning and providing information, there is information in the handbook. And then we're working -- we review information on Tempus and how financial management services work.
Next slide, please.
So just some information about what we're currently doing around this space. We would like to see this model of service expand. Right? This is a critical model of services when there is service providers that are unable to obtain staff. But it's even more so important because it provides participant control and gives them the option to select the people that work for them, train them, and really empower them as part of their own care planning process and service delivery.
The direct care worker training has been instituted. So we have options now for the DCWs to get some additional training and compensation for that that's available through the program. All the MCOs have access to that.
And all three, as mentioned before, MCOs are working with Tempus to develop additional educational materials.
And UPMC is also developing specific leave behinds on participant-directed PAS, not just one included with our regular PAS oversight, but also one that's targeted to participant direction, as well as services my way budget authority.
That's some of the information. It's very similar to what you heard from the other MCOs. But it's laid out a little differently. And maybe the process of going through provided you with some good information about how we're attempting to make sure this model is provided as a choice right up front and emphasized. And also what we're doing to move it forward and advance it.
Thanks.
>> Thank you, Mike.
Now you have heard the three presentations on the supporting new participants in the option of participant-directed services.
Any questions from the committee members? Matt?
>> I will be honest. I don't know a lot about services my way. I am curious, I think it was the presentation before this. Did you reduce the number of hours you have and higher rates to the direct care workers? Did that make

>> For services my way? You have full budget authority. So yes, that is something you can determine that you want to do.
>> Other questions from committee members?
Audience? You guys must have done a great job in presenting if people don't have questions.
>> We have questions in the chat.
>> There you go. Go ahead.
>> What criteria does participants need to meet to be able to direct their own services? How often is this evaluated? Are there -- to ensure the caregivers' family members managing persons do not take advantage of the program for strictly financial purposes? This question comes from Carolina.
>> I will have one of the MCOs respond. If the other two have additional information to add, please add it.
>> Good morning. This is Olivia Martin from PA health and wellness.
First part of your question, I think it depends on the individual. There are a lot of participants who enjoy having the oversight to direct their own care. There are some participants due to possibly cognitive impairments or limitations along the lines of the ability to provide that oversight and management that could pose a barrier to directing their own care. In those cases, the agency model would most likely be the most appropriate.
The second part of your question, I think I missed some of it. Do you mind repeating it?
>> Sure. This is Shanrica. I will repeat.
What price area does participants need to -- criteria does participant need to meet to direct their own services? How often is this evaluated? Are there procedures in place to ensure the caregivers or managing persons does not take advantage of the program for strictly financial purposes?
>> Okay. So the service coordinator has sort of a cadence of how often they are to regularly reach out to their participants to check on their progress toward their goals, to review their service plan, to see if they are having any issues with their providers or with their services. And also reassess.
So they do have to reassess annually. That's basically completing that whole suite of assessment, including the NRI, to help build their service plan. That service plan does include a lot of those goals.
The cadence they are to reach out is quarterly as a minimum. Some participants speak to more frequent than quarterly. Some depending on the situation and the participants' preference, they may want outreach monthly.
At a minimum, that is checked in on on a quarterly basis.
So the reporting that I had sort of touched on in the presentation, we do provide information to our service coordinators. And it kind of provides a sneak peek into how the hours are being utilized to look and see if there is overutilization, which could possibly require another assessment, maybe the hours that are authorized are not appropriate for the participant. It could be underutilizing.
This helps to inform the ongoing conversations. It's also through EEVUs we can take a look to ensure that things are looking appropriate when it comes to punching in, punching out, and all that data we're seeing on our end.
>> Any of the other MCOs want to add to that? Thank you, Olivia.
>> Yeah, sure. I will add to it. This is Mike Smith from UPMC. A couple of things I want to point out. Those tools that Olivia was talking about that we can definitely support and look at those tools as service coordination to ensure that we're helping the participant in seeing what kind of

utilization patterns are there. And their capacity to do this service if they have a capacity to designate somebody to, they can have a designated representative so that they have somebody who is helping them with this process and it's not they're out on their own.
There's also training associated with this. And for the common law employer, which is either the designee or the participant themselves, the DCWs are trained as well. They receive training in the program.
EVV is utilized just like it is as part of the direct care process. So they are trained on that as well and how that all works.
We provide budget management tools and reporting to help the COEs. And even if there is an issue with utilization or concerns about utilization, there's letters sent out alerting them to that fact and the SCs also receive a copy of that so they know if there is any kind of need to go out and re-educate or talk to somebody about these services.
>> Thank you.
Anything else AmeriHealth? Go ahead.
>> This is Marcus from AmeriHealth. Nothing in detail to add. Just to add that we do conduct a caregiver stress index that's used for informal caregivers. And it can also be used for formal caregivers just to see if any additional assistance is needed so we can help in preventing burn out.
>> Thank you, Marcus.
>> This question comes from LIN Whitener. It can be hard to have these discussions with service coordinators who are not thinking about this as a positive model. We have been asked to switch models away from participant direction and into an agency, even though there has been no issues. The service coordinator's excuse is they think that the DCW can get paid more without explaining the issue of overtime and live ins having a prorated way rate. And how annoying it is to deal with Tempus. How are the service coordinators being trained to encourage or offered as a first choice or viable option. We have to actually fight to stay in the model.
>> Thank you. Let's go -- how about we go with UPMC first and then AmeriHealth and then PHW.
>> Well, actually, if there is a situation, we do regular training with our staff. As a matter of fact, we annually train our staff to provide this option. We emphasize this regularly to our staff in updates we provide throughout the year and in different trainings that we provide.
So we have a significant emphasis and really an interest in seeing this model grow.
And we know that the way that the overtime is now working within Tempus is better than in the previous provider. The tools that we have, we believe within the approach that we're using with our FMS providers allowed us to gain better insight into utilization and support of participants.
So if there is concern about utilization or -- and I don't know the specifics and I don't want to get into the specifics of any individual situation, but if there is concern about support needed by the participant with regard to this model, we want to provide it every chance we can to keep it in place. And if the sense is that that's not happening, certainly talk to your service coordinator, talk to your -- you can ask to speak to somebody at our call-in center and raise this up as an issue. You can file a complaint easily just by calling member services and indicating that this is the circumstance for UPMC. That's the process you can follow.
>> Next we'll go to AmeriHealth.
>> Yep. Thank you for that. I agree with a lot of what Mike said. And appreciate the feedback about some of the interaction with service coordinators. I can't say the curriculum that we use to train our SCs. We do tell them to offer participant model first. So again, I appreciate that feedback. We will definitely take that back and address that with our team.

As far as any specific concerns with our plan, just please, please reach out to us internally, and we can get into the specifics and the details of it. So we can course correct.
>> Thank you, Marcus. PA health and wellness?
>> Hi there. It's Olivia Martin.
So I think along the lines with the annual training that we do require on this, we also provide refreshers. But this program ultimately is participant centered. So ultimately, it is the participant's choice. It's not really so much about encouraging one model over the other. But more information sharing and promoting the use of the model that they choose is best for them. So I just want to also stress that participant-centered focus. And I know that's consistent across all three MCOs.
>> Great. Thank you.
Tom?
>> Yes. Thank you, Mr. Chair. Tom Earl from liberty resources, the center for independent living in Philadelphia.
Just a couple of comments and a recommendation at the end. We have observed a significant decrease in the participant-directed model or the consumer-delegated model. Where it used to be well over 20,000, 22,000 participants statewide. And traditional agency services were significantly lower. And as centers for independent living, we have always encouraged consumer-directed models. And I think a major flaw in the system in the Commonwealth today is the lack of choice. And there used to be a number of FMS providers in Pennsylvania, many of whom were centers for independent living who had the boots on the ground and the support to provide not only to the direct care workers, but also to the consumers on how to manage their services, how to ensure and improve compliance and clocking in and clocking out. We have seen a total shift where now there's so many PAS agencies, month of them who are not mission-driven, are for profit, are not providing the level of training to either direct care workers or their consumers.
And we see with many of the centers for independent living that do the what is essentially an agency with choice model what we call consumer delegate and model where the consumer gets to hire a family member, relative, neighbor, friend to do their services. And we hire them, enroll them, and provide the training. And we are seeing an EVR compliance rate in that model that is pretty significant. It's not perfect, but it's over 80%.
And in contrast, we're seeing the consumer delegating the participant-directed model, which at this point I think is hovering around 30% EVV compliance. And something is not adding up. And I think that the lack of popularity in this model is we used to have just PPO that had major problems and was the subject of the auditor general's task force and investigation, payment problems, lots of implementation issues.
And now ironically, I believe that PPL was just awarded the contract to do OBRA. And why that decision was made is beyond me.
But we really encourage OLTL, the Department of Human Services to look at what is causing sort of this disparity. Why is the participant-directed model not more popular and at the levels near or where it used to be compared to years ago when there were many choices for your FMS provider versus today where there's only one choice. I think that's part of it, part of the problem or the challenge.
The other challenge is the supports coordinators. There are far fewer supports coordinators entities in the business. We're one of the surviving ones, Liberty Community Connections, our sister agency. And case loads used to be 30, 40, maybe 45 consumers per supports coordinator. And now with the shift to Medicaid managed care, the case loads have been

through the roof.
And I know there was a number of comments submitted recently to the department and either recommendations that case loads be capped at 50. You just cannot get quality supports coordination when supports coordinators are run ragged. It's just a very difficult job. Especially in urban areas, the retention and turnover rate of supports coordination should be one of the measures of network capacity as we look to improve MLTSS going forward.
And we really would like to see increased choice in FMS providers statewide. And we think with that and increased training and increased paid training, the rate structures for any of these models across the entire population, whether it's traditional agency, agency with choice, or consumer directed model, the rate setting, there needs to be a payment that will sustain the direct care worker to attend the trainings and be paid while they attend the trainings.
The current rate for agencies doesn't support that. So we ask that these things be looked at. And also a study or a report or something that looks at why there's been have increased the competition and the strains on the to improve and increase the use of the consumer model. Thank you.
>> Thank you, Tom.
>> Can I speak? This is Juanita Gray, how are you?
>> Yeah, go ahead.
>> Hi. I'm so sorry, everyone. I have a very bad cold. So I just wanted to thank the last gentleman that was speaking. I wanted to add that there has not been an increase in rate for the workers in the consumer participant models as of yet.
I agree with everything he said. And I'm so sorry, I'm very sick today. But I just wanted to let them know that we should go back to where the consumers had more control over their services instead of the new way things are changing. There's been a lot of difficulty in the services. And it has taken a toll on our services. I do like the consumer choice model better. Thank you.
>> Thank you, Juanita.
Anything else in the chat?
>> Yes. This question comes from Carolina.
Who is the financial management service providers? Are there more than one?
>> So under community HealthChoices, the financial management services vendor that works with all three MCOs is Tempus.
In the fee for service program where OBRA and Act 150 resident under the Office of Long-Term Living services, as Tom noted, the vendor is Public partnership. So that remains the same.
>> We have an additional question from Amy. For the MCOs outline the shared savings arrangements that they each have, including the service provider type in these arrangements and how a provider qualifies for shared savings?
>> This time, let's start with AmeriHealth and go to PHW then UPMC.
>> Can you hear me?
>> Yeah, we can, Marcus.
>> Can I loop back around to just gather some information and give appropriate feedback on that?
>> Sure. PHW?
>> I'm sorry. This is Olivia from PHW. Could you please repeat that question? I just want to make sure I'm understanding the question.
>> Sure.
Could the MCOs outline the shared savings arrangement they each have with the service provider type and these arrangements and how a provider qualifies for shared savings?

>> Okay. Yeah. Thanks for that question. That's really a great question. I think I'm going to have to loop around and also gather some information. Happy to provide that.
>> All right. UPMC?
>> I'm going to follow suit with the other two MCOs and say we can circle back with that. I do think that one of the slides in the VVP presentations outlined member of different providers that are engaged. I believe the nursing facility providers were mentioned. Care coordination was mentioned. Some of the programs were outlined there, generally speaking. And a lot of these programs are really designed to benefit agencies and organizations to improve outcomes for participants.
To the extent we can share this information, we will circle back and work with OLTL to respond. Thanks.
meeting.
Anything else in the chat?
>> No more questions in chat.
>> Any other questions from -- I missed you. Go ahead.
>> Ali conly with the united home care workers of Pennsylvania. We represent the participant -- the workers and participant directed system. And also several of the CILs across the state and mission-driven agencies.
Just want to echo Tom's comment and our concern about the shrinking participate model we have seen. And what we're really hearing from the workers across the board is a lot of break down at the service coordination level in terms of how people are educated and made aware of participant direction. Our experience is there's a lack of popularity, there's a lot of people that want to hire the --
[Indiscernible]
I thought that was good to hear in the presentations kind of a -- we're all on the same page that the person-directed model is the model that offers the most independent and community inclusion and most empowerment. To hear a commitment from the managed care partners to make sure that first choice and grow the model. I want to lift that up in the presentations as well and appreciate that.
>> Thank you.
>> Any other questions for the MCOs on the presentations supporting new participants and the option of participating in participant-directed services?
>> We do have an additional question in chat.
>> Go ahead.
>> This question comes from Janice Mineheart.
What is the mechanism for CHC plans to share participant plans with --
[Indiscernible]
>> Let's start with PHW and then UPMC and AmeriHealth.
>> Hey there. It's Olivia from PHW.
So we actually do share the care plans with the PCPs in two different ways.
So we share them in our provider portal that our PCPs can access every time that PC -- SP, excuse me, is updated.
And also for our nursing facility residents, we do share that PCSP either in a printing at the facility and sharing with the facility staff and providers. Or also via mail, we do have the technology to mail that out once it's finalized.
Now as far as getting permission, the participant is informed that their care plan will be shared with the PCP. And if they choose not to have that shared with the PCP, the SC will not share

that with the PCP. But generally, it is agreeable to share the PCSP with the PCP. Sorry about so many letters there.
>> Yeah. This is Mike Smith. Thanks, Olivia.
As I mentioned in our presentation, we do have a process where we engage the participant and request their permission to share with the -- not only the physician but also the providers, other providers supporting them with care.
And our PCPs also have network representatives that can help them with getting access to the portal as well. And we do training and education and outreach to our practices as part of education and training around the fact that these are available. And we encourage them to utilize them and trying to coordinate and support the overall coordination of services for participants that's coordinating between our physical health providers as well as our support of services providers.
I hope that answers the question.
>> And this is Marcus Hicks from AmeriHealth. I think Olivia and Mike did a pretty good job covering. We do share the PCSP through the provider portal. We have account executives that help with education around accessing the portal.
As far as sharing, we inform participants that we will share and we will not if that's something that they let us know in terms of preference if they do not want us to share it.
And the SCs can mail the PCSP to the PCPs if needed.
>> Thank you all for your comments.
Any other questions in the chat?
>> No. We have no additional questions in chat.
>> Any questions from the audience? Or board members? Go ahead.
>> I know that we have said this many, many times before, but I also just want to bring it up again that, first of all, I work for Voices for Independence. I'm a person with a disability who utilizes services. I'm going to speak as a provider. Offen times, even when we have access to that P -- the service plan, sorry. I was going to get my letters mixed up. Often when we do an intake with an individual, it doesn't match up at all. They tell us all kinds of different things that they would like and need.
So we try to communicate that back and forth with the MCOs. But just to keep that in everybody's mind when we're talking about the service plans. They don't always match what that person needs on a daily basis.
>> Could you identify yourself for the transcript?
>> Sorry. Carrie Bach. I am the proxy for Tanya Teglo.
>> Thank you. Go ahead.
>> Hi. My question is for the next agenda.
>> You mean the additional public comment? Okay. We'll be with you in a minute then.
>> Okay.
>> Any other questions on the presentations by the three MCOs?
All right. Seeing or hearing none, we'll move into the next agenda item, which is additional public comments.
Go ahead.
>> Hi. My name is Saida. My question is what is the -- in reference to number of participants enrolling monthly or quarterly?
>> So the information about enrollment can be seen on the data dash website that we presented earlier in the Office of Long-Term Living update. So you can see that information is publicly available and the changes over time.

>> Thank you.
And with that data, because I did miss a few of it, was that data by county?
>> The data specified by region. We are looking into additional data elements. Let me pull it up for you. I don't know if we can go back to that slide from the PowerPoint presentation.
So on this slide here, you can see the enrollment by plan for the month, so the total enrollment community choice program.
The next slide.
In this slide, you can see it by each of the health zones, the five zones within our state. So you can see the numbers for each of the zones and areas.
And you can also see the data dash by different programs, the fee for service program. OBRA waiver, act 150, and the LIFE program. It's reported by zones and not by county. We can certainly take a look at providing data by county. Although some county data will be suppressed because of the number of individuals served won't meet the threshold.
>> Thank you.
And do you have data on the providers, on the enrollment of the providers, how the providers come into the network?
>> As we shared, the community HealthChoices organizations oversee their own provider network. So we are not collecting data on their individual networks. We monitor them on their network adequacy.
>> At the last meeting, they said they were going to obtain that data and have it for this meeting.
>> We talked about the race and ethnicity of the service coordinators by Matt Seeley. That was reported out.
>> Yes. I'm referring to providers, not the support coordinators.
>> As we mentioned in the last meeting, we are not collecting the ownership demographics of providers, so there wouldn't be data to report out on the ownership demographics of providers. I think that was shared at the last meeting.
>> And does the managed care organizations have any date on their openings for enrollment PAS?
>> So I want to go back to -- can we go back two slides? There we go.
So I just want to highlight here for folks on the data dash. I tend to think there's a misperception that the kind of individuals served under community HealthChoices, while 121,000 is a large number, to help put this in context for home care agencies. If there are 1,400 home care agencies just serving AmeriHealth Caritas in southeast Philadelphia, because this is where a lot of our requests are coming from, if we look at -- I'm sorry, the next slide.
Okay. So let's just take Keystone First for an example in southeast Philadelphia with a total enrollment of about 100,000 individuals. They have reported 1400 home care agencies. That's an average, if everyone got the same amount of people, of 71 participants per home care agency. That's not a huge number.
AmeriHealth Keystone First reported they have enough home care providers to serve the individuals in if southeast. Currently, if it was divided up equally, every home care agency would only serve 71 participants. Not a lot of participants to a home care agency.
I just bring that up to highlight that the network is adequate for the southeast. There's no reason for an MCO to reopen that network.
>> My question was for the MCO.
>> That's fine. AmeriHealth Caritas? Would you like to answer about when you might reopen your network?
>> At this point -- go ahead, Frank. Sorry.

>> Hi. Frank Santora for AmeriHealth Caritas.
At this juncture, we do not have an anticipated date to be opening the network for PAS agencies.
>> UMPC?
>> Yeah, this is Mike Smith. I don't believe our provider network person is on the call. As I think we reported last time, we do not have any intentions of opening our network right now.
However, we do look at every application that comes in for all services and review them for what might be needed. We have adult day program, for instance, that may be needed in a particular area that we would like to see expand.
So we encourage folks to submit their interest to us so that we can look at what the needs are in any given county around other services.
>> Hi, this is Joe Elliott. We update our website monthly with counties that have open network. Right now, West moreland county is the open network for PA health and wellness if you have adequate home care workers to serve additional participants currently and have a physical office in that county or adjacent to that town.
We don't have a need or plans to open in another counties at this time.
>> And another question that I have is -- why is it that you take data on the ethnicity of the consumer, but you don't take data on the ethnicity and/or the population of providers?
>> UPMC?
>> So this is Mike Smith again. I don't know if our -- I don't think our provider network folks are on the line. We have I believe tried to collect that in the past and not had success with it. And we are required to collect the information. We actually receive information on people's ethnicity, race and ethnicity through the OLTL information that's collected at the point of entry.
So when -- and it's also collected on a lot of our other tools. And so where regards to the providers, I believe we have tried to do this in the past and have not had much success with it. So it is a an ongoing discussion I think as to whether or not providers will want to provide that information to us consistently. Whether they think it's themselves beneficial to say one way or another. And so certainly open to continuing dialogue on the matter as we work with OLTL on this.
>> Thank you, Mike.
AmeriHealth Caritas Keystone First?
>> Hi, it's Frank again. I agree with those comments that it's not -- certainly not something that we collect today. There are providers who would not be willing to share that information.
And additionally, the focus is generally on the cultural competency of the worker going to the home to support the participant, not necessarily the owner of the entity. Thank you.
>> PHW?
>> Hi, this is Joe again. I would agree with what Frank and Mike both said. Additionally, we do collect information regarding small diverse businesses. But I believe that's probably the only place that we could rely on that data whenever there is a registry.
But again, it is a place where we are actively looking to continue to collect information where available when we get cooperation.
>> And I just want to add there are federal requirements to collecting participate data, demographics for the Medicaid program.
>> Thank you.
>> You're welcome.
Any questions from the committee members?
>> Hi.

>> Go ahead.
>> Hi. This is Lisa -- my question is for Abigail.
In your presentation, one of the DDP in Pennsylvania, and you highlighted that the program should be based on quality as opposed to volume.
So my question is do the MCOs have to follow those guidelines? When creating their programs?
>> Yeah. The idea is to drive quality. So the MCOs develop models and then they submit those to the department for review and we provide feedback.
They have various ways of measuring quality, whether it's through key metrics or cost savings, et cetera. And so yes, that's how they would determine if they are in fact driving quality efficiency cost savings.
>> Okay. So the reason I asked the question is because I was on a provider call a few weeks ago, maybe two weeks ago. One MCO was talking about their programs. And it was specifically based on volume. That's why I was asking if the MCOs can deviate from what you outlined earlier or should they be basing the programs on value?
>> I'm not sure the specifics of what you're referencing. I'm not sure if the managed care organization who was presenting knows. I'm happy to look into it.
>> Okay. I'm just curious because I thought it was kind of unfair to alienate smaller agencies from being able to participate in this program because it's based on volume and size.
>> Oh, so you're saying that they -- they are allowed to choose a subset. They do not need to include all providers. They may choose a subset based on certain criteria that they come up with. And I think I mentioned in my presentation that some of these programs are still in pilot mode. And so again, the managed care organizations can specify who they qualify to participate in their value-based purchasing model.
>> But you did say it's based on value and not on volume? Or quality and not on volume, correct?
>> Yeah. You should be driving quality.
>> That was my question. That's not what this particular MCO said. And that's fine.
>> But I think the difference is they might only be including providers of a certain size. But at the end of the day, the driving --
[Indiscernible]
Are not required to include all providers in all of the models that they may or may not be eligible for.
>> Okay. All right. Thank you.
>> Questions from committee members? Open forum.
Audience? Do we have anything in the chat?
>> We have a question in chat from Lynessa.
Why isn't data about the MCO network adequacy being collected?
>> So we do collect data on managed care organization network adequacy. There are operations reports that the managed care organizations need to provide to the Office of Long-Term Living regarding their network performance and their network adequacy to track.
>> There are no additional questions in chat.
>> Any other additional questions from committee members? Ali?
>> I wasn't here at the beginning of the meeting so I didn't get a chance to do a hat tip -- appreciate the outfit today. I want to get publicly on the record.
>> I have to commend this group on the amount of patience and time it took to get those words on the record.

>> Go ahead.
>> I have my comment -- this is Aida again.
If the MCOs have so much free range to choose who they can -- or let's say like you were saying about the volume and the value in reference to how they service, they have a lot of choice.
So my question is why are they awarded that choice that the participants are not awarded as they are the ones who are bringing in the monetary value to the insurance companies?
>> So the value-based purchasing arrangements are with providers, not participants.
>> Right. But I'm speaking on with the MCOs having the choice, they have a lot of choice in what and who they choose for -- for what you said. What I'm saying is why is the participant not awarded the same range of choice? Even when it is says they are allowed to pick a provider, but the provider has to be in network. They are not allowed to pick a provider who they would like to have for them as their choice. And this person would be they need their cultural needs. And that is the direct care worker going to the home that they're more focused on. And they're focused on the direct care worker to work with them -- however, the direct care worker doesn't have the last say as the actual owner of the company to what goes on within that company. They are just doing the work.
>> That doesn't pertain to value-based payment.
So participants do have a lot of choice within the community HealthChoices program.
Participants have the choice to hire their own attendants directly and be their employers directly.
Participants and consumers do not have to go through an agency to hire an attendant that will meet their cultural needs.
Consumers in the services my way budget authority can choose to work with agencies that will be able to best meet their needs, be that network or out, that meet the criteria of the services program. That's not a very large number.
Participants can choose within the organizations within the provider network. I would say having 1,000 different agencies of choice is not really a choice restriction.
The question to whether or not the Office of Long-Term Living is going to require MCOs to work with any willing and able provider, we are not going to do that at this point. Every time there's a new provider that comes in the network, that's an additional monitoring cost and administrative cost. Each of those costs add up and ultimately takes away from the service dollars that could be spent on participants.
We have met and continue to meet the sort of federal network adequacy requirements. At this point in time, provider. That community HealthChoices was put in place during implementation. And the MCOs have shown that they have the availability to meet the network adequacy standards.
>> Thank you.
>> Any additional information in the chat?
>> No, there are not.
>> We will certainly entertain a motion for adjournment.
>> Oh, I'm sorry. There is a question that just came up.
>> Sorry
>> Okay. How does a provider get access to the service plans regarding brain injury providers? How would they get access to services -- sorry, the question is a little bit jumbled up.
I will read it word for word.
They answered the question regarding -- I will read her original question.
Can there be discussion on access to plan of care? Can it include all providers like BI

providers?
>> So if I may clarify the question. My understanding is correct. We did answer the access to care for providers in the context of home care agencies in particular. So if the managed care organizations can confirm whether or not the process would be different for other home and community-based services providers with regards to the provider portal access, HHA exchange access, et cetera. Is there a different between home care agencies or other home and community-based service providers in terms of access to care plans.
>> This is Mike Smith from UPMC. No. If a participant allows us to share, we do not articulate or get into if they have a provider on their plan, the request is request we share it with all the providers, as well as the PCP. We will allow that as long as they're allowing us to do so.
So anybody who is receiving any service can go out representatives that can help folks learn how to do that. And you can just write into our provider email account and just ask for help there and we will get you somebody to help you get that information.
>> Yeah. I think Mike covered it well. We don't differentiate between the two and the PCSP can be shared upon request.
>> And PA health and wellness?
>> PHW, we're pretty much identical to AmeriHealth and UPMC. It doesn't differentiate on our release form and during the discussions.
>> Are they able to confirm we answered the question?
>> Yes. She thanks you guys.
>> Thank you.
I will say again, I will entertain a motion for adjournment. I already saw the hand go up, Matt Seeley. And I will accept his motion.
Our next meeting will be October 4th, 2023, right here at this location.
I thank all of you certainly for coming and attending. And thank you for the robust conversation today. Everybody stay safe.