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Date: 10/04/2022

Event: Managed Long-Term Services and Supports Meeting

>> This is Cindy sealy. Can you hear me?
>> Hello. This is jay.
>> Jay. Thank you. Appreciate it.
>> Good morning. Everyone. This is David Johnson. I will start by taking sub committee attendance.
>> Cindy celi. I saw you were present. Good morning.
>> Good morning.
>> Neil Brady. David Johnson is present. Gail Weidman. German Parodi. Heshie Zinman. Jay Harner.
>> Present.
>> Good morning, Jay.
>> Juanita Gray. Kyle Glozier. Lloyd Wertz. Matthew Seeley. Present. Mark Gusek. Mike Grier.
>> Present.
>> Monica Vaccaro.
>> I'm here. Good morning.
>> Good morning. Patricia Canela-Duckett.
>> Good morning, everyone.
>> Good morning.
>> Sherry Welsh.
>> Here.
>> And Tanya Teglo.
>> DAVID JOHNSON: Are there any committee members that I missed that would like to announce themselves.
>> Juanita gray. I'm here.
>> Good morning, Juanita.
>> Good morning.
>> DAVID JOHNSON: Are there any other sub committee members that would like to announce themselves? Great. Thank you.
>> The housekeeping talking points. Please keep your language professional. This meeting is being conducted in person at the department of education's Connor suite and as a webinar with remote streaming. The meeting is scheduled until noon. To -- I'm sorry. Let me try this again. This meeting is also being audio recorded. The meeting is scheduled until noon. Or until 1:00 to comply with the agreements we will end promptly at that time. All webinar participants except for the community 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 the background noise and improve the sound quality of the webinar, we ask attendees to self mute using the mute button on the feature -- or on their phone or computer or laptop while not speaking. Please hold all questions and comments until the end of each presentation. As your questions may be answered during the presentation. Please keep your questions and comments concise, clear and to the point. We ask participants to please submit your questions

and comments into the chat box located in the go to webinar pop-up window on the right-hand side of your computer screen. To enter a question or comment, type into the -- type into the text box under questions and press send. Audience members who have a question or comment should wait until the end of the presentation to approach one of the microphones located at the two tables. We have a lot of open microphones. To ask a question. The chair or vice chair will then call on you. To minimize background noise in the honors suite we ask that audience members. The capsest is documenting the discussion remotely. It is important for people to speak directly into the microphone and state their name and speak slowly and clearly, otherwise the captionist may not be able to capture the conversation. This is all -- this will also aid the captionist in recording who asked the questions and whom the responses need to be sent. When submitting a question or comment in the chat box, it is important for people to include their name in the chat box. Before using the microphone in the honors suite press the button at the base to turn it on. You will see a red light indicating that a microphone is on and ready for 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 to turn the microphone off. The red light -- 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 trying to transcribe the meeting discussion accurately. Public -- there's a public -- public comments will be taken at the end of each presentation instead of during the presentation. There will be additional period at the end of the meeting for my additional public comments. And they are to be entered into the chat box. If you have questions or comments that weren't heard, please send your questions to the resource account for your reference the account is listed on the agenda. Transcripts and meeting documents are posted on the listserv under the MLTSS meeting minutes. These documents are normally posted within a few days of receiving the transcripts. The 2022 MLTSS meeting dates are available on the department of human services website.
>> DAVID JOHNSON: This is David John sop. In the event of an emergency or evacuation, we will proceed to the assembly area on the corner of fourth and market. If you require assistance to evacuate, go the safe area located right outside of the main doors of the honors suite. Staff will be in the safe area and stay with you until you are told to go back into the honors suite before you are evacuated. Everyone must exit the building. Take your belongings with you. Do not operate cell phones. Do not try to use the elevators as they will be locked down. We will use stair one and two to exit the buildings. For stair one exit through the main doors on the left side near the elevators turn right and go down the hallway by the water fountain. Stair one is on the left. For stair two, exit honors suite through the side doors towards the back doors.S for those exiting the side doors turn left and stair two is direct le in front of you. For those exiting from the back door exits turn left and left again and stair two is directly ahead. Head outside. Turn left and walk down due berry Allie to chestnut and turn to the corner at fourth street and cross fourth street to the train station. Thank you.
>> MICHAEL GRIER: Thank you, David. As we're going to start the agenda, the first thing that we would like to cover is follow-up questions from our September meeting. And I'll go through them now. Okay. You guys will take care. Related to paper former, PRP, the sub committee member Matt sealy asked what is the process for HCBS chap survey participants to identify a proxy to assist them with completing the survey. OLTL would have the follow up.
>> Provided in the September meeting that explained the following. PHCBS cap survey allows a participant to select a proxy if a participant is too ill, frail, physically or unable or it is a survey participant is deceased. The interviewer will ask if anyone can help the participant to answer a survey. If a proxy is identified and available, the interview will be continue. If the proxy is not

available, a call-back can be scheduled if the proxy will be available at a later date and/or time. Data is captured with questions from the HCBS cap survey. If a participant was helped with a survey, who helped, how they helped and if the proxy was compensated.
>> This is German. How a proxy is selected.
>> I believe you might -- my question isn't clear. If someone is being surveyed, someone else can answer the survey for them. I'm asking how is it -- how is that other person identified? How do you know that that person is indeed their proxy?
>> So when the interviewer calls, they ask the individual if they would like to have a proxy. So if the proxy is there with the individual, the individual can identify that proxy. If the proxy is unavailable, then it would be arranged at a later date to have that proxy.
>> My confusion is the word proxy. It sounds like it is a representative. Someone else can answer the survey for them if they want to. Is that accurate? The word proxy gives me other implications.
>> No. You're right. Then I was stumbling on something that --
>> Okay. Thanks. Matt. Related to NHT and (name?) Shawna asked can be used to pull data on HCBS to go into [Indiscernible] due to lack of providers. Jamie said the information relate today this question would be researched and provided on the minimum data set.
>> Jamie -- Jamie responded that there will be a presentation on the minimum data set at today's meeting.
>> Thank you. Related to arpa spending updates, an audience member asked, has the department come up with a plan on how to distribute the unclaimed funds? Jamie said that the data is being collected on how -- on how much the unclaimed ARPA funds are left and that this information would be provided.
>> Jamie responded that around 5 to 6 payments for the ARPA plan are pending validation. Once those payments are processed, a final reconciliation will be completed.
>> Related to individuals impacted by the PHP an audience member asked, what are the number of individuals losing services per MCO? German said he would follow up on this item. And just before other people, this item, there are a lot of numbers and details to the answer and it is pretty long.
>> So the DHS unwindingly provided a data report with the CHC population broken out by MCO as of August 18th, 2022. But before we go into the data from the August 18th report, we would like to cover some of the top-line changes between the April 17th numbers that we provided at the September meeting and the August 18 numbers being provided today. Between the April 17th, 2022 report and the August 18th, 2022 report, there was an increase of 4,312 individuals and CHC maintained despite not meeting eligibility criteria. There was an increase of 233 individuals in CHC with HCBS. There was an increase of 343 individuals and CHC code 36 indicating they were in a skilled nursing facility. There was an increase of 3,745 identified dual individuals. There was an increase of 2,209 individuals in CHC who had not completed the renewal process. There was a decrease of 1,092 individuals. There was an increase of 908 individuals [Indiscernible] in facility code 36 indicating that they were in a skilled nursing facility. There was an increase of 2,393NFI dual individuals. This is the information from the data report with the CHC population broken out by MCO as of August 18th, 2022. 35,470 individuals with Ahmir house Keystone were maintained despite not meeting eligibility criteria or failing to complete the renewal process. 13,108 Ahmir health Keystone First schedules were maintained despite not meeting eligibility criteria. 1,331 of those individuals were in CHC with HCBS. 542 of those individuals in CHC put facility code 36 which indicates they're in a skilled nursing facility. 11,235 were NFI duals. 22,362 Ahmir health Keystone first individuals had not completed the

process. 6,949 of those individuals were in CHC with HCBS. 2,484 of those individuals were in CHC with facility code 36 indicating they're in a skilled nursing facility. 12,929 were NFI duals. 19,000 -- 19,430 individuals with PHW were maintained despite not meeting eligibility criteria or despite failing to complete the renewal process. 6,281 individuals with PHW were maintained despite not meeting eligibility criteria. 512 of those individuals were in CHC with HCBS. 5656 those individuals were in CHC with facility code 36 indicating they're in a skilled nursing facility. 5,204 were NFI duals. 13,149 individuals with PHW had not completed the renewal process. 2,684 of those individuals were in CHC with HCBS. 2,489 of those individuals were in CHC with facility code 36 indicating they're in a skilled nursing facility. 7,976 were NFI duals. 30,480 individuals with UPMC were maintained despite not meeting eligibility criteria or despite failing to provide renewal process. 11,236 individuals with UPMC were maintained despite not meeting eligibility criteria. 715 of those individuals were in CHC with HCBS. 529 of those individuals from CHC put facility code 36 indicating they're in a skilled nursing facility. 9,992 were NFI duals. 19,244 individuals in UPMC had not completed the renewal process. 4,172 of those individuals were in CHC with HCBS. 2,481 of those individuals were in CHC with facility code 36 indicating they're in a skilled nursing facility. And 12,591 were NFI duals.
>> Thank you very much for the comprehensive complete answer to that question. Related to provider credentialing the sub committee member Matt seely and public attendee asked, what is the anticipated time frame for credentialing? Each CHCMCO said that they would follow up with credentialing on the time frames.
>> PHW reported that the time frame for credentialing is between 30-60 days. UPMC reported that their anticipated time frame for credentialing is 30 days. That the provider file had no malpractice or sanctions. Aher health Caritas Keystone first submitted to the department for credentialing must be completed within 60 days of receipt of a complete and legible credentialing application.
>> And that concludes our questions and follow-up from the September meeting. I want to thank everyone for their efforts in doing that. I know that is a lot of work to do that. But it is greatly appreciated. Moving on with our agenda --
>> I have a question. Come on up.
>> Will that data go -- be sent out with the -- after that meeting, that information, what was just read.
>> Can you repeat the question, please.
>> Hi, Pam. We will share this information after the meeting.
>> All right. All right. Yeah. We will go ahead and move on. Next on our agenda is Jamie talking about the data on the transition of individuals into nursing facilities.
>> JAMIE BUCHENAUER: Okay. Good morning, everybody. I hope you can hear me okay. Chairs are not made for small people. Is that better? Good morning, everybody. Happy rainy October. A lot of the rain that I'm really tired of it after a wet soggy weekend. At the last MLTSS we got a request he from the audience. And the question was really around does the office of long-term living have an understanding of how many people are going into nursing facilities because direct care workers are not available obviously to provide services in their homes for individuals into nursing facilities. Obviously we don't collect a lot of data exactly about this situation. When we talked to our MCOs, they indicated to us and we should have talked to our staff a little more that there is a question on the MDS that actually gets to this information. And so we pulled this information pre-COVID and now to see if there was a significant difference in terms of individuals going into nursing facilities because lack of direct care workers or lack of individuals in their communities that were able to provide their care in their homes. So I wanted

to follow up and share this data with the committee. So I already got into the background a little bit. Yeah. There you go. So we can go to slide three. Yes. There you go. So this is what the question looks like on the MDS. It is in section F, and I was hoping it was bigger on your screen than it is on mine because it is very hard to read. It is actually question it is primary reason for admission. It is midway down there on the screen. And the question really reads, you can see it on the screen, primary reason for admission. If you go to the next slide, these are the reason that's are provided. Obviously for the response. And so you can see the different reasons that somebody is answer why they entered a nursing facility. Going back to the last question, this question is only asked for new admissions. Obviously if somebody was already in a nursing facility, they don't get this question again. So if you go to the next slide, I have the 2018 responses here on the slide. And you can see by and large the primary reason for admission is short term rehabilitation or skilled care. That is that 06. The second is 01, obviously that means a significant change in functional status of the person. So those that answered this question in 2018 and obviously through the time period is change in the availability or status of primary caregivers or 04, difficulty in arranging or paying for in home care or support. So you can see in 2018 obviously these responses, 03 and 04, were about 1700 and about 300 on -- in 2018. So we pulled the data just to see in 2019 obviously if -- the responses were about the same in 2018. And you can see they were. About 1700 and about 272. So that remains steady. And obviously the primary reasons people were going into nursing facilities was, again, 06. And that was short term rehabilitation or skilled care. So now we get into 2020. And I want to say the most significant thing about the 2020 data was just the volume of responses.
>> You didn't show the 19. It was still on the 18.
>> JAMIE BUCHENAUER: Sorry about that. You can take the data for 2019. This is, again, pre-COVID. It is pretty consistent with the 2018 data. If you go to the 2020 data, and that is the next slide, I think what you will see most significant about this data is the volume of responses. Many less individuals actually going into a nursing facility in 2020 as compared to 2018 and 2019. The overall numbers are greater in 2018 and 2019. Those numbers fall in 2020. But obviously again looking at 03, 04, about 1200 -- 1250 responses on 03 and a little over 200 responses on 04. And then moving along to 2021, which is the most complete data we have, obviously the numbers of people going into nurse tag silts starts to climb a little bit. But the numbers remain pretty consistent in terms of 03 and 04. The number of people going into nursing facilities due to lack of primary caregivers. We put this data together, if you go to slide 9, great, on a chart to you could see across the years how the responses to 03 and 04 have changed or have not changed. And they have remained pretty consistent. Meaning the 2021 numbers are pretty consistent with the 2018 and 2019. Obviously 2020 took a dip there due to the overall dip in individuals entering a facility in 2020, which is understandable. So I thought this was interesting to show. We're not seeing anything for 2021. Obviously we don't have 2022 data yet. When we would get it, we would take a look at obviously this question and the responses to this question. Zeroing in on 03 and 04. So I wanted to share that with the committee and follow up to a question that was asked at the last MLTSS. The other thing. And this was not on the agenda that I actually wanted to share with the committee. I'm getting my paper out because it just came to my attention today were some opportunities that were made available by the Department of Labor and industry. And I'm just going to read this to you. I didn't have a chance to really read it and kind of think about it myself. So the Department of Labor and industry announced the availability of approximately 4 million adollars in funding for the Pennsylvania partnership. We will be supporting programming through the competitive award of grants up to 250,000 to support industry partnerships across the Commonwealth to improve economic

growth while preparing workers with training for their current positions and future advancements. Projects through this grant should identify workforce education and training and economic development gaps, coordinate regional needs to support industry needs, identify public and community resources to address industry identified needs and increased collaboration among businesses with a targeted industry sector. Eligible applicants include local workforce boards, nonprofit and nongovernmental entities, educational and post secondary educational organizations, labor organizations, business aowes sayings and economic development entities. The grants close on October 28th, 2022. And then the Department of Labor and industry also announced the availability of approximately $2.5 million of funding for the school to work program grant awards. Establish a school to work program through the competitive awards grants in partnership with the schools in the Commonwealth to support the establishment or enhancement of a workforce development partnership between schools and employers, organizations or associations to create a pre-apprenticeship pathway. This MGA seeks applications to support the statewide initiative. Grant awards may not exceed 250,000. So I only bring up those two opportunities. I know we had a discussion at the last Mitt Romney eabout obviously direct care workers and the path to provide training and support to encourage individuals to enter and -- to enter obviously the workforce in this area and create a pathway for them to I want to say advance. So just some opportunity that's I wanted to make this group aware of. Any questions?
>> This is jay. I have a question.
>> You have to be quicker, jay.
>> Can you go back to the slide that had a summary. So I'm terrible at math. But I'm counting, what, like 7,000 people? Something like that. 6,000, 7,000 people that are technically what I can see in the nursing home not because they want to be. But they were there because they didn't have staffing, right? Ultimately that's what that means.
>> You're adding up.
>> 1700, 1700. I don't -- I didn't calculate it. But approximately 6,000 people. 1700, 1700, 1200, 200, 200. I don't know if it is not. But over the course of three years, you have about 1700 people there. What I'm asking, are these people flagged or prioritized to get out of there since they don't seem to want to be there.
>> JAMIE BUCHENAUER: So that is a good question. I don't have any further data on what results in -- comes out of that nursing home stay. Meaning if they stay there or if they ultimately leave.
>> People are identified though to someone.
>> JAMIE BUCHENAUER: Yeah. They're on -- obviously they're on the MDS. There are questions on the MDS that identify if the individual would ultimately like to leave a nursing facility. And I'm not sure how they would have answered that question. We didn't pull that information. Also I would add that these are not specifically Medicaid eligible individuals. Obviously we didn't break it down in terms of -- many times when they enter the nursing facility, they're not Medicaid eligible but they become eligible through their stay. We didn't pull that information.
>> I get that. You're showing us there is no great change in the number of people going into nursing homes because of staffing. I see that. But that doesn't change the fact that they're still going into nursing homes because they don't have staffing.
>> Right.
>> Right. So I would think this is still a pretty good indicator that something should be done about that.

>> JAMIE BUCHENAUER: Right. Well -- and what I can say is that I don't know how many of these individuals were MLA eligible or receiving community based services. I can only show you at this point it is not taking a huge uptick in terms of people entering facilities because of lack of staffing.
>> Yeah. I get that.
>> Thank you, Jamie. Jay, are you ready?
>> Yes. Thank you. So just a follow-up on these numbers. Again, I'm a quadriplegic, I work full-time. I live this every day. And with my job, I take phone calls every day. And I'm not -- I'm not going to argue with your numbers, Jamie, but what I see in the real world, those numbers are not -- are not what we see with people calling looking for help. In my situation, my family and friends, they would never let me go to a nursing home. So they do things for free. They help -- they help. I'm not the only one. There are plenty of people in the state that go through this. But I think those numbers right there goes against everything that we're talking about. If you're saying people are not going into nursing homes because of lack of workers since COVID is just not true. And flies in the face of our argument and fighting for better benefits, higher wage. If I'm a politician and I see the numbers like that, I'm going to say nothing has changed. Why do we need the increased benefits and the pay raise. It goes back to we keep talking and nothing happens. And here we go again. Round and round and round. 2022, 2008, 2002. Again, I see this every day. I have people calling every day, begging for workers. Really crying because they're saying I have nobody here. I'm going to a nursing home. And they're never going to come out. And we have to make changes. But those numbers are not right. There has to be a different way to calculate it. Figure it out. But there is no way that those numbers with what we face in this state and our aging population. Subpoena we're getting older every day. That people are not -- people are going for lack of workers. Matt lives it. We see it. There are no workers out there for $11, $12, $13 an hour. Again, we need to stop talking and start doing. I work for an agency and we do a lot of talking and not a lot of doing. And it frustrates me. But I'll get off my soapbox. Sorry. Thanks.
>> JAMIE BUCHENAUER: Yeah. Jay I wasn't sharing the numbers to say it wasn't a problem. It was a problem pre-COVID and I think it remains a problem today. I was showing the numbers to say it's no more of a problem than it was before COVID. I think we faced a workforce shortage pre-COVID. We continue to face a workforce shortage. We have done a lot of things to try to support the workforce during COVID. I think I made the statement, COVID was absolutely terrible. I'm not going to say it was good. But there were positives that came from -- that came from obviously what happened during COVID. We got the cares act funding. We got the ARPA funding. So we were able to, the department of human services department of long-term living pushed funding out to support our workforce. You know, I'm hoping that it made a difference. I really am. But I understand that it continues to be a problem today. It didn't -- you know, the problem is not solved.
>> Good morning, Jamie. I have a quick question. It's Patty. I just wanted to clarify, are these numbers for all skilled nursing facilities in Pennsylvania?
>> JAMIE BUCHENAUER: I believe they are, yes.
>> Thank you.
>> Thank you. This issue exists at a very high level within the behavioral health system. And I just believe there needs to be a little bit more research into -- if it really has not changed due to COVID, then I would have a question about why that is the case with this workforce versus the other ones of which we're aware. I mean you're waiting six to nine months for a community mental health appointment with a psychiatrist today. And that has to do with the availability of

psychiatrists but also the availability of community workers doing behavioral health services. It is hard to understand how that would not be reflected in this workforce. So I guess my question to you folks at OLTL is how do you justify that within your own thinking that it really has not changed due to COVID? And are there ways to mine the data that might give us more indication of that reality or in fact you're right, it is no different. It hasn't changed. And everybody just wants to work in this field so that's why -- I don't know what the reasoning would be for that. But I'm wondering if there is an opportunity to do that within your offices.
>> JAMIE BUCHENAUER: Yes. I just want to say, this data doesn't show that the workforce issue is any more or less of a problem in 20,000 -- from pre-COVID. What the data shows is that individuals are going into the nursing facility for the same -- essentially the same reasons. But obviously that goes to the fact that there may be heroic efforts going on in families or in neighbors and friends keeping individuals in their homes and communities. You know, what we don't have or I'm looking for suggestions on is trying to quantify the status of the workforce. And obviously we know anecdotally because we hear a lot of -- we hear a lot from providers that it is very difficult to get workers. It is very difficult to attract workers. It is very difficult to retain current workers. But trying to quantify that is where we're at. You know, I don't have the -- you know, I don't know how to quantify how significant the problem is pre-COVID and post-COVID.
>> Isn't there a way to look at unused hours?
>> JAMIE BUCHENAUER: Meaning what individuals are authorized for and what is actually used?
>> Yeah.
>> JAMIE BUCHENAUER: So, you know, I'll let some of the CHCMCOs answer that question. From our conversations with them, they're seeing authorized hours actually uptick. There's not like a bigger gap. Meaning I think -- and the CHCMCOs in the room should actually answer this question. I think what we typically is that a person used 80 to 90% of their authorized hours usually. In the conversation that's I've had with the CHCMCOs, individuals are using up into the 90s in terms of percentage of their authorized hours used.
>> I don't talk with consumers. I don't work at a CIL. Like jay, I'll use myself as an example, within the last month, there are weeks that I will use half. I'm not in CHC, I'm in 150. But it across the board. I have used half of my hours because there is no availability of staff. And I assume jay is even worse if family and friends are doing it. I have to agree with jay a little bit that it looks like the data doesn't really match what is being seen out in the field.
>> JAMIE BUCHENAUER: Yeah. And I don't know if if some of the CHCMCO's want to comment on that. I'm speaking from memory and I will stand corrected.
>> You're correct.
>> Deputy secretary Jamie Buchenauer is correct. We are seeing a higher percentage of utilized hours for participants across the board. That doesn't mean, to your point, that individual cases -- individuals are using less either because of staffing or may have a hospitalization or they're using like 50% at a given time. But on average the -- you know, we used to see in the mid-80s as far as authorized versus utilized. Now we're seeing it in the low 90s.
>> Let's just say for --
>> This is David Garrett. From UPMC Community Health Choices.
>> Thank you, Dave.
>> Can you just explain that again? The 90% versus the 50% of individuals on average.
>> So overall, we will use I guess the round number. If someone is authorized for a hundred hours of services, the average person utilizes about 90 to 92 hours out of that 100. That means some individuals are utilizing all 100. But some individuals may be utilizing 50 of that 100. But

when you look at, you know, the tens of thousands of people within the program, on average they utilize, you know, 90 to 92% of their authorized amount.
>> All services. That would be across the board.
>> [Indiscernible]
>> Not just past. Not just personal assistant services. So the delivered meals and things like that.
>> Just a reminder as folks are addressing the committee, if they could please state their name for the transcriptionist.
>> This is David Johnson. Quick question. I'm not sure if you have the answer to this. I'm looking for the primary reason for admission. And it is not an insignificant number of people or individuals, none of the above. Apart from affirmative choice, are you aware of what some of the above reasons would be.
>> JAMIE BUCHENAUER: I'm sorry, David. I don't know. I would have to check with our staff.
>> DAVID JOHNSON: Thank you.
>> Hi. This is Jess from amerry health. We're not seeing that people are not using their hours. It is like an isolated case. Case by case.
>> Go ahead, Lloyd.
>> So while we have a couple of folks from the [Indiscernible] what efforts is -- what is impacting your ability to find contractors and for your contractors to perform based on the contract expectations and requirements or is it just not happening in your world?
>> To answer your question, so our numbers are very similar to what David shared. We do have providers in fact we have a provider -- he is in [Indiscernible] Tom can address some of that. It is not always what we see where you don't have workers. What we also see is individuals turning away services because they have other things going on. They're more involved in their community and they may not need some of the safety services that might have been built into their plan. But I mean by and large we're not seeing so much in the way of not being able to find a provider while there are issues with that. But our providers have been doing a very standup job finding workers and incentivizing workers. And the value-based initiatives are also helping with that. Tom, do you want to speak to your experience?
>> Good morning. Tom Rowe, executive director of liberty resources. We have a home care operation that serves between 400 and 450 consumers and one of our biggest challenges is recruiting and retaining direct care workers. The rate, the hourly rate, the lack of health care and the rate not taking into account the need for overtime really make it difficult to retain caregivers. But we try our best and we hope that future rate setting by LLTL takes into account expenses such as health care, overtime and other typical benefits of employment that the rest of the workforce across the country traditionally get. We're losing workers to Amazon, target. You have heard this story. Where they're getting a higher hourly wage than health care. So we try to fulfill as many of our shifts as we can. And we are doing a pretty good job. Getting new workers and direct care workers as people move out of nursing homes is a huge challenge.
>> Thanks, Tom.
>> This is David from UPMC again. Similar to what (name?) said we work with our providers to look at capacity to be able to fill shifts. If there are areas of the state -- some parts of the state may be more challenging at times. The rural areas, for example. But we do work with them to identify, you know -- you know if they're concerned with capacity and what we can do to support them in retaining and getting additional workers into that area. But it is an ongoing effort with our providers to ensure that we are meeting the needs of the participants. And, you know, I think -- you know, during the early parts of COVID, when a lot of the workforce were getting COVID and

they had issues, there was definitely a higher percentage of missed shifts. But it is something that we continually monitor and work with to make sure that the shifts meet our participants needs.
>> Thank you. James.
>> Are we good on time with our panelist? I know Jennifer hale is slate and Laurin Wanner is slated to speak at 11:20.
>> This is Laurin Wanner I'm ready to go.
>> Can we check if missy wants to respond, missy (name?)
>> I guess the question is I understand we're a bit over time with our agenda. Laurin, are you able to present after Jennifer Hale's update on the CHC or OBRA waiver amendments or do you have a time constraint.
>> LAURIN WANNER: No. I'm available.
>> MICHAEL GRIER: Okay. Thank you. Jennifer, are you ready.
>> JENNIFER HALE: I am. Thank you, Mike. Good morning, everyone. This is Jennifer Hale with the office of long-term. I want to make sure that everyone can hear me okay.
>> MICHAEL GRIER: We can hear you fine.
>> JENNIFER HALE: Perfect. Today I will be presenting the proposed changes for the CHC and OBRA waiver amendments. As we go through the presentation, you will see items highlighted in yellow. This is done to make it easier to identify the specific language change that is being added to the waiver. We anticipate the proposed changed being presented today will be published in the Pennsylvania bulletin for the official 30-day public comment period in late October. I think we had hoped that that would be out by the timing of this meeting. However, it's still going through the GHS review process. So, again, we hope to have this officially out for public comment in late October. We wanted to ensure that stakeholders had an opportunity to provide comment verbally during this sub committee meeting. Any comments made during the meeting will be documented and accepted as public comments. And we just ask that comments be focused on the changes being proposed to the waiver.
Next slide, please. So before moving through some of the changes in more detail, here is an overview of the major changes for this amendment. First the CHC waiver amendment will have/proposed effective date of April 1, 2023. The purpose of the amendment is to add agency with choice as a financial management services model for the participant-directed services of PAS and respite. We are also amending the following service definitions. Benefits counseling, nursing services, occupational therapy, physical therapy, and speech and language therapy services. We are proposing to modify the service coordinator and service coordinator supervisor qualifications to align with the CHC agreement. And then also proposing to add a performance measure to monitor the agency with choice vendor.
Next slide, please. So first is agency is choice. OLTL is proposing to add the agency with choice model with FMS for again the participant-directed services of PAS and respite. With this amend., OLTL will formally add AWC as a model of FMS. Right now FEA is the only recognized model of FMS in the waiver today. Adding agency with choice as a model of FMS will affect appendices A, C, D, E, and H of the CHC1915c waiver. I will go into more detail on the appendices. Because it exists, the information is the same. We're including the agency with choice vendorsa responsible party as well. There are no changes or requirements and agency with choice will not change any of the requirements for services my way. Under agency with choice, the participant selects and directs their worker but is supported by an agency that provides the administrative functions to the direct care workers recruited by the participant. Offering this additional option is a benefit to those participants that wish to undertake some level

of employer authority or employer responsibility or self direction while retaining the support of an agency for others. Next slide, please. So first up is appendix A which is the waiver administration and operation. So to this appendix, we are adding agency with choice as the -- as a model of FMS. And also adding under agency with choice the participant is the managing employer and OLTL adds language to explain the participant's role as the managing employer. So here on the slide you have the highlighted items. This is being added to the appendix. The participate or participant's representative serves as the managing employer. And then managing employers are responsible for activities that include but are not limited to selecting and dismissing direct care workers. Referring qualified direct care workers to the AWC vendor for hire. Directing the responsibilities of their direct care workers. Scheduling and arranging for backup services with the assistance from the agency with choice vendor as requested. And training the direct care workers to meet participant needs. Additionally under this appendix, OLTL is adding the responsibility to manage the agency with choice agreement. And we are also adding a performance measure. It will be called AA, which is for administrative authority, 8 for OLTL to monitor and measure the agency with choice vendor's performance. Next slide, please.

So next up is appendix C, which is participant services. So we are adding language that the agency with choice vendor will be required to complete criminal background checks just as the F/EA is required to do so now much as you can see here, this is the current language in the waiver. And then we have highlighted the addition of the agency with choice vendor. So all of these items will be applicable to the agency with choice vendor. And I'm not going to read through this slide. This is language currently in the agreement. We just wanted to showcase where we have the language, we're simply adding that the agency with choice vendor is also a responsibility party. This is just a continuation of the appendix C participant services. Add language that the Agency with Choice Vendor will be required to complete child abuse clearances just as the F/EA. And also add language that the Agency with Choice Vendor must ensure service delivery matches the units authorized based on the PCSP. This is similar to the F/EA requirement. This language is currently in the waiver. What we have highlighted is the addition of the agency with choice vendor. And the second paragraph, the second highlighted item just the responsibility of the Agency with Choice Vendor in terms of submitting claims to the CHC-MCO and the MCO ensuring that the units are available based on the authorized PCSP. And as an additional check, OLTL will review encounter data from AWC FMS participants regularly to ensure that services have been provided based on the PCSP and that rates paid are correct and only for authorized services.

Next slide, please. So, again, this is the agency with choice information added to appendix D. Appendix D is participant centered planning and service delivery. We add that the Agency with Choice Vendor is responsible for submitting reports to monitor service utilization. So to the existing language, we add that the Agency with Choice Vendor assists OLTL, the CHC-MCOs and their service coordinators in monitoring service utilization for participants who are self directing their services using this model. Additionally we added that the Agency with Choice Vendor be required to provide monthly reports to managing employers, the CHC-MCO and the service coordinators to display individual service utilization. So, again, the addition here is the Agency with Choice Vendor and then also in addition to common law employers, we added managing employers. Next slide, please. So we have appendix E. And this is the most revised appendix relating -- relating to the addition of agency with choice. And appendix E is participant direction of services. So just a note that there will be a public comment period that I mentioned at the beginning of the presentation for the proposed amendment that will include additional

details or detailed information about the specific changes to this particular appendix. Because there are several. But a high-level overview of the proposed changes to appendix E are adding Agency with Choice Vendors responsibilities and describe the participant's role as the managing employer. Add the agency with choice responsibilities regarding orientation and training for both participants and direct care workers. We have added language around the agency with choice responsibilities for personal representatives. They are similar to that of the F/EA. Add the Agency with Choice Vendor and procurement process. And then add the scope of the agency with choice model of FMS. We also added information that the F/EA and Agency with Choice Vendor must report on service utilization. I talked about that a little bit in the previous slide. And then obviously we have to outline and add in information on OLTL's monitoring responsibilities of the Agency with Choice Vendor.
Next slide, please. So we split this out in two parts because I think we had gotten questions previously just on the training aspect. So this is still appendix E. And the Agency with Choice Vendor is responsible for providing orientation, excuse me, and training to the participant and the direct care worker. Orientation and training materials are developed by the AWC vendor and are approved by OLTL. And at a minimum must include the following. And here on the slide we just list the orientation and training materials that must be developed and provided. We also indicate that these materials are to be provided to participants within 14 calendar days of the notification that the participant has chose the agency with choice model of FMS. And prior to the participant's receipt of services from the direct care worker. And then orientation and training materials must address the roles and responsibilities of the participant as the managing employer, which includes information on selection and referral of potential direct care workers, training by participant for direct care workers on how to meet the participant's needs. Determining direct care worker schedules and responsibilities. And managing the work performed by direct care workers in a supervisory capacity. Next slide, please. And so this slide is really outlining the vendor -- the Agency with Choice Vendor responsibility for providing orientation and training to the direct care worker. And we have the direct care worker orientation and training, again, with a time frame so this is being done in a timely manner and prior to service being started. And then just outlining the requirements that documentation must be maintained to verify that a direct care worker's completion of orientation and training. And train direct care workers in accordance with PA regulations. And then also we include the training in terms of program responsibilities and requirements and then obviously including but not limited to EVV requirements.
You can move to the next slide. Thanks. So previously it was recommended -- I think it was actually at an MLTSS meeting that a comparison chart might be helpful for stakeholders to understand the differences between the models. So we put this together to illustrate the differences and highlight where the agency with choice option may provide more support to those who wish to engage in some level of self direction. But like I said towards the beginning have some support with some of their related tasks. So these responsibilities are laid out in the waiver amendment in the appendices that I just went over. And, again, the activity is on the left hand side. And we go through the traditional agency model. The agency with choice model, and then the fiscal employer agent model. And so we outline who is responsible for each of those activities on the left. This is obviously part of your packet. And because we're, you know, low on time here, I won't go through all of this. I feel like you can read it. But if there is -- if there is a request for me to go through this, I'm happy to do that. Again, I just -- we thought it might be helpful to better understand the roles and responsibilities in terms of the three different models. So it was asked and we thought it was a good recommendation to create a chart. And so we

wanted to drop that directly into the presentation. So I hope that is helpful for stakeholders to kind of take a look at.
You can move to the next slide. And, again, these are just -- this is just a continuation of the tasks. And then the responsibilities across all of the models. Next slide, please.
So that concludes the changes related to agency with choice. The next major change is to benefits counseling. So OLTL proposed to amend the benefits counseling service definition to remove the requirement that participants must access office of vocational rehabilitation or OVR services before accessing benefits counseling in the waiver. OLTL has found that benefits counseling from OVR is not comparable to benefits counseling in the waiver. Therefore OLTL is removing this barrier in the service definition so participants can access the waiver service sooner.
Next slide, please. So for nursing, physical therapy, occupational therapy, speech and language therapy, we are making the technical edit in response to the cares act amendment. To sections 1814a and 1835a of the Social Security act. The nurse practitioners and physician assistants in addition to physicians may prescribe and order the following services. So although it was a federal change we talked about DMS about this and we need to make it a waiver amendment. So this is just following the federal changes. Next slide, please. So for the service coordinator qualifications, you can see we just kind of charted it out here. And, again, the charge I is highlighted. So this language exists. What is being changed is highlighted and/or crossed out. So for the first block, service coordinators, we removed the requirement to have practicum experience in order to meet the qualifications. This was a comment that we received on a previous waiver amendment. So we wanted to make sure that we made that change. And then the next is for service coordinator -- coordinator supervisors must be an RN or have a master's degree. This is just a correction to align with the CHC agreement. Next slide, please. So that concludes the changes to the CHC pre posed changes for the CHC waiver amendment. Next I'm going to briefly go through the OBRA waiver amendment changes. They are very similar. So it probably won't take as much time. But next slide, please. So again the OBRA waiver amendment will have the proposed effective date of April 1, 2023. The purpose of the amendment is to add agency with choice to amend the benefits counseling service definition. To amend the responsibilities of the fiscal employer agent by removing the requirement to have a support broker because the support broker activities are being provided by the F/EA or the service coordinators and would be duplicative. We are revising some of the performance measures. Removing a performance measure related to the oversight of the F/EA because the information is already captured in the performance measure that exists. So there is duplication. And then we would be adding a performance measure for OLTL to monitor and measure the Agency with Choice Vendor's performance. Next slide, please. So I will briefly go over these. The proposed addition of agency with choice to the OBRA waiver is the same as for CHC with some exceptions. Obviously there is no role for the CHC-MCOs in the OBRA waiver and we have updated the OLTL bureau names and responsibilities. The benefits counseling change is the same as the CHC waiver. And then for the nursing, physical therapy, occupational therapy, and speech and language therapy -- sorry, that is a mouthful -- we made this edit to -- we were able to get this edit into the amendment that was just approved. And then appendix H has been updated in the OBRA waiver to reflect the current quality improvement strategy. So OLTL has consistently improved its quality improvement strategy but has not made the aupdates to appendix H recently around quality to reflect these practices so we are just making those updates. Next slide, please. Again, amending the responsibilities of the fiscal employer agent by removing the requirement for a support broker. This was something that was something made

to the CHC waiver that was effective January 1st of 2021. And so the rationale is the same. So we are making that change now to the OBRA waiver. Next slide, please. I just want to talk a little bit about the public notice and comment period. Again, any comments made today will be accepted as official comments for the public comment period. Next slide, please. And then just some information. Public notices for the CHC and OBRA waiver amendments will be published in the Pennsylvania bulletin. We are hoping that they will be published in mid to late October. I'm thinking late October at this point. There will be that official 30-day public comment period for written comments. And then after the publication of the notices, the proposed changes can be viewed by going to and we have listed and embedded the link where you will be able to find the waiver documents. So we will also as we have done in the past send out a listserv announcement when those public notices are published. We will make sure that we send a listserv notice announcing that these materials are online as well. And then just a final comment specific to the OBRA waiver. The public notice will include the proposed rates for the agency with choice and respite services. So I think that concludes my overview of the waiver amendments. And I'm happy to take comments or questions at this point.
>> MICHAEL GRIER: Thank you, Jennifer. We have folks coming up.
>> Thank you, Miami. Tom from liberty resources in Philadelphia. A couple of questions on the AWC part of your presentation, the amendment to the waiver will -- will OLTL be including the public comment that's have received, including or also including the opposition to this model, including the sub Mac and the Mac?
>> Tom, that's a good question. So this is separate. So anything that we may have received up until this point we just -- we can certainly take into consideration. Although the feedback that we have received related to agency with choice. But we do ask that because this will be the official public comment period after those notices go out, that you make those comments either written or verbally so they're part of the waiver comment period. I hope that makes sense. Obviously I understand some of the comments and all of the recommendations that have been put forward. We just ask for it to officially be part of this waiver comment period that you make those again in either writing or verbally.
>> Okay. And will those comments be included with the application?
>> Yes.
>> Okay. Second question, with the AWC application for the amendment of the waiver, if OLTL decides in the future to add more than one Agency with Choice Vendor so that there is choice to consumers, will that require another amendment?
>> Yes, it would.
>> Okay. And last question, you mentioned the AWC rate. When is that expected?
>> JENNIFER HALE: That will be part of the public notice that is published in the Pennsylvania bulletin. And we are hopeful that that will be published mid to probably late October. But this month. The month of October.
>> Jennifer, will that rate include a cost of health care and overtime?
>> JENNIFER HALE: The rate does account for health care. It does not account for overtime.
>> Okay. Thank you.
>> JENNIFER HALE: Thank you.
>> Jeff.
>> Good morning. This is Jeff from Pennsylvania cil. Can we go back to employment. I wanted to clarify something.
>> You just passed it. There you go. So what is the MCO's responsibility for employment in this proposed -- what is being proposed as a change to the waivers, if you can clarify that?

>> JENNIFER HALE: I think so. There are responsibility -- I mean, they are to be part of the person centered planning process, talking to participants about any type of employment goals. So that responsibility does not change. If someone expresses an interest in employment or has a goal, we just -- we have removed the barrier in terms of if someone really needs education. In terms of the benefits counseling that we offer. That that would be able to be provided right away without having to refer the individual to OVR.
>> That doesn't change inform the -- my understanding is there is an OBL in terms of funding and collaboration.
>> JENNIFER HALE: It does not change any of that.
>> Is that correct.
>> JENNIFER HALE: That is correct. It does not change any of that.
>> So is there anything to improve the numbers for particularly CHC? Probably a little better. But the numbers have been very low on community based employment. Particularly for CHC. I don't know if there is anything -- I see what you're saying here. And I know what you're saying. But is there anything that we're doing to actually improve the numbers,.
>> JENNIFER HALE: I think we're hopeful if individuals can take advantage of benefits counseling without having to go through the OVR process, that that might move the needle on employment competitive and integrated employment. That is a hope. But that is part of why we made this change.
>> Okay. And my last question is on something that I haven't seen here. And that's transportation. So there are no proposed changes in this waiver in terms of addressing any of the transportation. I thank Randy nolan for collaborating on the webinar we had with the CHC-MCO. We saw a number of counties don't have contracts and the options are more limited for people in CHC are rural areas with transportation. There is nothing in the pro he posed as far as addressing transportation, is that correct.
>> JENNIFER HALE: That's correct. There is nothing in the proposed waiver amendment around transportation.
>> Okay. Thank you.
>> Pam.
>> Pam center for independent living central PA. One question, in the CHC you're changing who can sign off for the therapies. Are you going to change in the waiver application through AIB or whoever will do it in the future the patient certification form to match that? Because right now it can't be a physician's assistant or another individual like you're adding in for the prescription. Will that change? And my other question I guess not directly related to the amendment. Oh, you want me to wait to hear what you have to say to the first one and then ask my other question?
>> JENNIFER HALE: Yeah, Pam. That would be great. To your first question, there will be no changes to the physician certification form that we use for eligibility and enrollment. Those standards still apply. This is really specifically specific to those therapy and nursing services in the waiver.
>> Okay. It just makes sense that you would change it. It is such a pain in the butt for some people who can't maybe get ahold of their doctor but they get their physician's assistant or the nurse practitioner. But I guess that's for another amendment, another time. I would like that to be noted that it needs to be done, to be updated. My other question, OWC is going to include health care, I guess. If I understood what you were saying to time correctly. So if that is being offered to the AWC and the rates, will the other home care agencies get that match, whatever AWC would get in the rates an improvement or increase, will other home care agencies see that

same.
>> JENNIFER HALE: Pam, my understanding -- and I don't have all of the specifics for the rates. But my understanding is they were developed similarly to the agency. So the same factors that go into the agency rate were used to develop the agency choice rate. So they should be the same.
>> [Indiscernible]
>> JENNIFER HALE: Yeah.
>> MICHAEL GRIER: Any other committee members, audience members have questions for Jen?
>> I'm just confused with what you just said. I mean how are they going to be getting the same rate if one is offering more? Or am I reading that wrong?
>> JENNIFER HALE: You're not reading it wrong. And I'm sorry I caused confusion. I don't know if Jamie or Michael want to weigh in as well. But they will be different. My understanding is the components used in [Indiscernible]
>> But agency doesn't offer health care.
>> JENNIFER HALE: Some do, I guess. But it is not affordable.
>> JENNIFER HALE: So I think we accounted for certain benefits. I'm scratching my head. I'm thinking that agencies offer some type of benefits to their workers depending on their part-time or full-time status.
>> It is offered but you almost have to eat up your whole check to pay for it, my understanding of the direct care workers that I have. None of them have it because they can't afford it.
>> JENNIFER HALE: Understood.
>> MICHAEL GRIER: This is Michael. The portion though that is paid for -- that is in the rate for the agencies to use is calculated the same as the agency with choice as it is in the agency model. What is the employee's responsibility I guess is up to the employer at that point. So the calculation is the same as far as benefit availability. For example, I pay against what the Commonwealth also pays. So I understand there is a payment on the employee's end. What that percentage is, I guess is up to whatever the employer -- whatever percentage the employer pays and the benefit type.? So wait. What you're saying is that the agency with choice can regulate agency. Health care component of it is basically the same
>> The calculation for the rate includes benefits, correct.
>> MICHAEL GRIER: Any other questions for Jennifer? Thank you, Jennifer. We're way, way behind on the agenda. So kind of bear with us. Laurin, are you ready?
>> LAURIN WANNER: I am.
>> MICHAEL GRIER: Great. Thank you. If you could introduce yourself to the committee and audience.
>> LAURIN WANNER: Hi. My name is Laurin Wanner I'm with the OIM which is the office of income maintenance, the bureau of policy medical assistance for people with disabilities unit. And I will be going over Medical Assistance for Workers with Disabilities and the introduction of the new MAWD eligibility group Workers with Job Success. Next slide, please.
The ticket to work and work incentives improvement act of 1999 is a federal act that provides the states with the option to establish two federally funded medical assistance eligibility groups for working disabled individuals. These eligibility groups are workers with a disability and workers with a medically improved disability. Pennsylvania opted to add both eligibility groups to the medical assistance program with legislation enacted under the tobacco settlement act. On January 1, 2002 they were implemented what is now called the MAWD program. Pennsylvania later expanded the MAWD program on December 28th, 2021 under act 2021-69 of July 1st,

2021. The third eligibility group is called Workers with Job Success. Workers with Job Success is not part of Pennsylvania's Medicaid state plan. It is state funded eligibility group under MAWD. Next slide, please. So let's go over a little bit about MAWD and who benefits from it. MAWD is an MA program that allows individuals with disability to work, earn more, and keep full health care coverage. Pennsylvania chose to further expand and protect health care for workers -- for working disabled individuals by adding Workers with Job Success eligibility program to the MAWD program. WJS provide muddy sippents an opportunity to earn more and save more all while keeping their full health care coverage. Additionally individuals can earn more and still be eligible for the home and community based services. Individuals exceeding 300% of the federal benefit rate may be eligible for HCBS through the MAWD program including WJS. Unlike other medical assistance programs muddy sippents are required to pay a monthly premium. Next slide, please.

So when does WJK start? Well, it was -- as we stated previously, WJS eligible was add today MAWD with act 2021-69 of July 1st, 2021 and became effective December 28th, 2021. However, because of the families first coronavirus response act requirements that federally funded MA cannot be closed and premiums cannot be increased during the federal public health emergency, nobody is transitioning to WJS until the federal public health emergency is over. Next slide, please.

So here are the basic eligibility requirements for Aumaud eligibility groups. To be eligible Formad an individual must be a Pennsylvania resident, a U.S. citizen or eligible non-citizen, at least 16 but under 65, employed and getting paid, which includes self-employment. Disabled according to Social Security administration requirements. And that -- the exception to that is we do not follow the earning requirement for SSA. And willing to pay a monthly premium. And that only applies if the monthly premium is under $10. If it is over $10, they do not pay one. Next slide, please.

So now we're going to go over the additional eligibility requirements for each of the MAWD eligibility groups. For workers with a disability which is by far the most pop will yous MAWD eligibility groups, the additional requirements are financial only. Require that the individual have countable moply income at or below 250% of the federal poverty income guidelines or FPIG and have countable resources of $10,000 or less. With workers with medically improved disability, the requirements is the individual must have countable income at or below 250% of the FPIG and countable resources of $10,000 or less, just like workers with a disability group. However there are additional requirements that include working at least 40 hours a month and earning at least minimum wage. And having Aumaud eligibility in the workers with the disability group be discontinued because they have a medically improved disability that no longer meets Social Security's definition of a disability but is a severe impairment as determined by medical professionals. For WJS, the additional eligibility requirements is that the monthly income is more than 250% of FPIG or less than or equal to 600% of the FPIG. And countable resources are less than or equal to $10,000 at initial eligibility. It impacts MAWD as a whole. And we will go over that in subsequent slides. The final requirement is that the individual must have received MAWD in any MAWD eligibility group including WJS for the previous 12 consecutive months and that includes partial months. Next slide, please. Taking a closer look at MAWD's financial eligibility requirements. For this slide we're going to go over the financial requirements Formad workers with a disability and MAWD workers with a medically improved disability groups. For these MAWD eligibility groups, countable income must be at or below 250% of the FPIG. The income of the spouse is counted when determining MAWD eligibility. Earned income deductions and work expenses related to impairment are used to dermad eligibility. This means if an

individual's gross income is over 250% of the FPIG they should still apply because income deductions can make the countable income below the limit. Countable resources must be $10,000 or less. Resources of the spouse are counted when determining MAWD eligibility. Resources are not excluded from MAWD when there are dependent children under the age of 21 in the home. We will go over more of this later. We note once an individual receives MA in the workers with disability job eligibility group. The countable resources may exceed $10,000 for eligibility groups. And here is a snapshot of the 2022 250% FPIG monthly income limit and the resource limit that is fixed and does not change on an annual basis. In ex slide, please.
So now let's take a closer look at WJS financial eligibility requirements. For the WJS eligibility group countable income must be more than 250% of the FPIG and at or below 600% of the FPIG. Who is counted is the same as the workers with disability and the workers with a medically improved disability eligibility groups. The income of the spouse is counted when determining eligibility for WJS. Earned income deductions and work expenses related to the impairment are used to determine WJS eligibility. Countable resources must be 10th thousand dollars or less the first time an individual becomes eligible for WJS. Again, how countable resources is determined for WJS is the same as the workers with a disability and workers with a medically improved disability group. The resources of the spouse are counted. And resources are not excluded for the WJS individual when there are dependent children under 21 in the household. Once an individual is eligible for accountable resources must exceed $10,000 in MAWD. This is a permanent resource exclusion from MAWD. We will go into more detail how this works in a later slide. And this is a snapshot of the 2022 6% hundred percent fpig monthly income limits and the resource limit of $10,000 at initial eligibility. Next slide, please.
And now we will go over a list of the common income deductions Formad. This is not a full list. For a full list see the med Cal assistance handbook section 316.5. Unearned income expenses which are expenses paid to be eligible for or receive unearned income, including but not limited to transportation costs, bank fees and attorney and court fees. The standard income deduction of $20 which is applied to unearned income. If there stakeholder no unearned income, it is applied to earned income. The standard earned income for each working individual of $65. Impairment-related income expenses included but not limited to attend apartment care if needed to get ready for work or while at work. Payments for medical devices and prosthetics needed to work. Earned income deduction is also applied. And this is half of the remaining earned income after all deductions have been applied. Next slide, please.
Okay. Now let's go over a previous WJS recipients and how their resources are effectively excluded from MAWD. The new policy is once an individual has received MAWD in the WJS eligibility group their resources are not counted when determining continuing eligibility for WJS. Additionally if the WJS recipient later becomes eligible for the workers with a disability or workers with a medically improved disability group under the MAWD program due to their countable income decreasing to 250% FPIG or less, the individual will continue to have no resource limit in MAWD. In practice, how this works is the individual will be reviewed for federally funded MAWD in the workers with a disability or workers with a medically improved disability group. If the individual's countable resources are over $10,000 or they do not provide verification of their resources, the individual will be placed in a state funded version of the workers with a disability or workers with a medically improved disability group. Federally funded MAWD should be reviewed first so federal funds can be claimed if possible. We would like to note here that resources are excluded for previous WJS recipients only when determining eligibility for the MAWD program. If the individual moves from any MAWD category to a different MA program in which resources are counted, the individual must meet the resource limits for

that MA program, including MAWD with Medicare buy-in. Next slide, please.
Now let's go over the premium requirements for the MAWD eligible groups. The individuals who receive MAWD in the workers with a disability or workers with a medically improved disability eligibility group are responsible to pay a monthly premium that is 5% of the individual's monthly countable income after deductions as long as it is over $10. Spousal income is not counted when determining premium. Next slide, please.
For WJS premium requirements, there are two possible premium tiers. WJS individuals are either responsible to pay a monthly premium of 7.5% of the individual's countable income after deductions, again, spousal income is excluded when determining premium. Or required to full a cost monthly premium that is currently set at $948. An individual is responsible to pay 7.5% of the individual's countable when it is more than 250% of FPIG or more than 450% of the FPIG and their most recent federal 1040 tax form is less than $125,944.84. Household countable income is more than 450% of the fPIG and annual adjusted gross income on their most recent federal tax form is $125,944.84 or more. That number was determined using the 57,000 compounded with SSA cost of living adjustments since 2000. This amount is referred to as the 2022 MAWD cola adjusted gross income maximum amount. It will increase whenever there is an coal and may change on an annual basis. Okay. Next slide. Okay. Now we will take a look at an example of an individual who appears to be income ineligible Formad but income de dubs is used to determine the countable income Formad she is eligible. In this example we will show how the individual's premium is determined based on 5% of her countable income. So in this example Mary 59 years old is applying. She is lives with her husband Paul. Paul is retired and gets $2,000 a month in Social Security. Mary is disabled and gets $800 a month in SSDI. Mary also works and earns about $1,200 a month. On the surface their income is $4,000 a month, meaning Mary would be over income limits for medical assistance. However, when you apply the income deductions, she does qualify Formad. And so what you do is you take her $2,800 from Social Security, take off the $20 unearned income deduction. Take the $1,200 earned from work and subtract the $65 earned income deduction and you end up with a countable monthly income of $3,347.50 which is less than the 250% FPIG for a married couple. And then you would calculate out 5% of Mary's income only which comes out to 67.375. And you round down for a premium of $67. Next slide, please. So now we're going to take that same household exam examine show you how they might transition to WJS and what the income premium calculation looks like. WJS uses the same income calculation deductions. In this example the premium calculation is the same but at 7% .5% of her income. Mary is now a little older and she was previously approved Formad and has been for the last 12 months. She still lives with her husband Paul and Paul receives $2,050 per month in Social Security. Mary is disabled and received $850 per month in Social Security. But she has a new job and now earns $3,000 a month which puts her over the eligibility. It is under 600% of the FPIG so she is qualified. You take off $20 for unearned income. $65 off of the earned income and divide that by two. And you round up with a countable monthly income 4347.50. Because the countable income is less than the FPIG, it does not have to be verified. Her monthly premium is 7.5% of her income only which comes out to $172.31. And you round down and it is $172. Next slide, please.
So now we're going to take a look at a WJS individual responsible to pay the full cost monthly premium. The full cost premium is only a possibility when the household is over 450% FPIG and the annual adjusted gross income is equal to the COLA maximum amount of $125,944.84. So we have Carmen who is 37 and disabled and working. She got MAWD in the WJS eligibility group with the 7.5% premium for the last 12 months. And her income has gone up from $10,000 to $12,000 a month. And she has $4,000 in checking and $11,000 in savings. Because her

countable monthly income is less than the 600% FPIG and resources are excluded because she already received MAWD in the WJS eligibility group, she continues to be eligible for WJS with a full cost premium. When you deduct and divide it by two, you get a countable monthly income of $5,957.50 which is over the 2022 450% FPIG for a one-person household. So the CAO will request her 1040 tax form which will show her annual adjusted income is $133,000, which is more than the MAWD COLA adjusted gross income maximum amount of $125,944.84. She is eligible for WJS but must pay the premium which is $948. Next slide, please.
And we've got one final example. This example is about a former WJS recipient who now qualifies Formad in the workers with a disability eligibility group. Diego has received WJS in the past but he hasn't worked for the past two years. He stopped receiving MA. He applies for medical assistance. He has Medicare and receives $1,000 per month in SSDI. He babysits and ears $50 a week. Because his countable income is less than 250% FPIG and his resources are excluded Formad, he is eligible Formad with a 5% premium. The same calculation. So get a countable monthly income of $1,147.50 which is less than the 2022 250% FPIG for a one-person household. He is income eligible Formad. And because we wound down to $57 for his monthly premium.
An individual can receive MAWD in the works with a disability group with a break in MAWD coverage. This is different than the other two eligible group. If an individual received WJS at some point in their past their resources can still be over the muddy source limit and they can receive MAWD. And this resource exclusion is only for MAWD. In this example Diego's countable income is less than the MAWD income limit. But because his resources are over the resource limit, he does not qualify for slim MAWD instead he is eligible in the state funded workers with a disability group. Next slide, please. Pennsylvania's WJS expansion benefits and individuals who qualify for HCBS and working and earning income. Individual who's are functionally eligible for HCBS can receive HCBS in the eligibility group if they meet requirements of anyone, disability and employment. Two, are willing to pay a monthly premium. And three, have received MAWD the previous 12 consecutive months. This is how it works today for individual who's can receive HCBS and MAWD workers with a disability or MAWD workers with a medically eligible. Muddy source and income requirements are used to determine whether someone is financially eligible for HCBS. This means that HCBS individuals who qualify for WJS can earn and save more and maintain their vital services. Fair consideration and spousal impoverishment do not apply to individuals receiving HCBS in any MAWD category including WJS. If the muddy sippent enters an LTC facility, the individual must be reviewed for eligibility in a long-term care facility category of MA, utilizing the income and resource limits for appropriate LTC category. Upon admission to the LTC facility, fair consideration and spousal impoverishment provisions apply. If muddy sippent who is receiving waiver services no longer meets eligibility requirements for MAWD, then the individual must be reviewed for eligibility in an HCBS category. Fire consideration and spousal impoverishment as well as HCBS requirements will apply. This is a reference table of MAWD eligible group, the program status codes, how the adjusted gross factors in and whether the MAWD budget is federally or state funded. Note the new status codes created due to the enact of WJS are highlighted in yellow. Next slide, please. And this is another reference table of all applicable FPIG amounts used for the MAWD eligibility. Next slide, please.
If you want more information on MAWD, please check out the MA handbook chapter 316 MAWD. The WJS ops memo published on July 1st, 2022. And the MAWD page on the DHS website which has lots of helpful materials including Aumaud brochure, Aumaud FAQ, MAWD online payment application and Aumaud WJS FAQ. Next slide, please. And for reference, this is

just a glossary of the abbreviations used throughout the presentation. Next slide, please. And this is our contact information for myself and Nikki Blythe at OIM policy for any future questions or issues. Okay. And now I'll open it up to any questions.
>> MICHAEL GRIER: Thank you, Laurin for the -- excuse me -- comprehensive presentation. We do have some questions for you. Jeff.
>> Hi. Clarification on what you're talking about with MAWD. So this is what is in effect now currently, correct? And just to clarify, I think there were some delays on the MAWD legislation. It was [Indiscernible] bill passed last year because there were certain things that you couldn't do because of the public health emergency. For example, you couldn't raise premiums even though you're allowing more people to buy into the program because the public health emergency restriction on the federal level, you weren't allowed. What you're talking about, this is what will be in effect now, not following the -- when the public health emergency declaration ends; correct.
>> LAURIN WANNER: Partially. The WJS is technically in effect as of December. However we can't -- like you said, we can't enact anything until going forward until the public health emergency ends because of the premium changes and potential category changes. So it is in place. And we're working on a plan to figure out what to do with anybody that might fall through the cracks when the public health emergency does end or how to make sure that people are in their correct eligible groups.
>> Okay. And what you just mentioned pertains to both the state and the federally funded MAWD. In our state they refer to it as Medicaid buy-in program.
>> LAURIN WANNER: Yes, it does apply to those as well.
>> Okay. Thank you.
>> MICHAEL GRIER: Any other questions from the committee members or the audience? Great. Thank you, Laurin, for the content -- for the presentation again.
>> LAURIN WANNER: Thank you.
>> MICHAEL GRIER: You're welcome. CHC network provider enrollment, search and network monitoring. Pennsylvania Health and Wellness, you're up first.
>> Good morning.
>> Good morning.
>> I'm Dennis moody from Pennsylvania Health and Wellness. I'm going to walk us through the slides here and turn it over to our team with us. I have Steven Morrison and (name?) with me. Next slide, please. I have been asked to go through a brief walk through of the enrollment process. Before starting the process, providers can contact us multiple ways. There's no wrong way. They're instructed to complete what we call a CIF, a contract information form. Basically when we receive that, we do a quick check on basic information. They have a promise ID, any sanctions, especially if they're providing locations. The provider is then, assuming there are no issues that come out of that process, the provider is given an application to complete. The provider submits that application along with supporting credentialing documents which are determined by provider types. So there are different credentialing requirements depending on the type of provider they are. Those items are then validated. When they come in. Those are some examples of what the key ones are. If you could switch to the next page. After submitting the application if it all appears in order, a contract is created. We send that contract electronically to the provider. The provider profile is created in the system. Once we receive the signed contract back and all of the credentialing information submitted for processing, upon the completion of the enrollment process, we will notify via letter to the provider that they are active in our systems. As was mentioned earlier in discussions that normally takes between 30-60

days if we have all of the necessary information.
From a network adequacy standpoint, we do multiple things to validate that we have adequacy within our network. The most significant activity there is we utilize a tool called quest analytics where we evaluate roughly 50 specialties in each county and determine if there is activity Queasy available via time and distance associated with that. You can flip the slide, please. This is just a pretty picture. This is really part of the quest analytics tool. It is extremely detailed tool. So we have 50 specialties we look at by counties. And there is 67 counties. There is detail level down to those -- for those 3400 combinations of counties and specialties that we look at to make sure that we have adequacy based on the state's requirements for time and distance. If by chance there is any what we call gaps in those, not hitting at least 90%, quest analytics tool supports us with information on additional providers that we can target to go and increase that adequacy. For -- in reality, the majority of the -- of any gaps that we have at this point are related to providers not existing in those specialties in a given time and distance requirement. Next slide, please. This document really highlights the additional things that we do. What I talked about so far was providers reaching out to us. We're also going the other direction, looking out for additional providers. The kinds of things that do that are the time and distance that we have already talked about. Practitioners or facilities rendering Kara fill ated with in network providers. We take that seriously. If an individual is going to hospital A, that the individuals that work with that hospital are affiliated. We look at the utilization that we have that may come from single case agreements. We will always do a single case agreement if we identify some service that our existing network doesn't support and we will contract with those. We work with our brokers and salespeople on a medical products. It is about 90% of our -- 95% of the members are dual eligible. We want to make sure that -- and at least our Medicare program. We also do internal tracking. A lot of what I just talked about applies to both physical health and LTSS providers. But we also do tracking with our service coordination and nursing home transition process. We review on a monthly basis to determine if they bring to us any issues that they're having with provider types and work with them to then outreach for additional support. This is the last page. Really this is additional network adequacy. We do annual reviews when we pull in our consumer assessments and health care providers systems CAHPS information. We look at complaints and appeals regarding network adequacy. We look at things like out of network services. We talk about cultural and linguistic. Since we are certified you have to do that on an annual basis and take it to the quality committee. We do track all of this on our systems. Because networks constantly is changing. And what is adequate today may not be adequate next week when a hospital closes. So we do good tracking on the information so we can respond to those things quickly. I can certainly answer any questions or if you want to do the demo.
>> Thank you for the presentation. Any questions?
>> Lloyd.
>> Early on in your presentation -- thank you for your presentation. Early on in the presentation you noted the availability of behavioral health care staff. And I wondered how you would determine a sufficient number of those staff to be available for your organization in serving the MCO clients.
>> Can you roll back to that slide.
>> Yeah. It was way early. There you go.
>> Okay. Yeah. We do a couple things for CHC program we're not -- the MCOs are not accountable for that. So that was really probably a slip in the slide. No. We do contract with behavioral health providers for our other lines of business. And including our Medicare lines of

business.
>> So in the slip in the slide, there are people that will fall through those cracks and I worry about those people. I'm a behavioral health advocate. How is it that you are able to determine the availabilities of services that are needed provided by you for folks who also have mental health issues. And is there a way that you gauge that? Is there a quality method? How do you know that is being done adequately by your organization.
>> Make sure that I'm answering the right question here. You're asking how we are validating the behavioral health organization?
>> I'm interested in how you're coordinating and the services provided by your organization is being received and used by the person with behavioral health issues. How do you figure that out.
>> I think you're really -- it is more of a care management question. So Anna can probably --
>> Question is a good question. But it goes back to the initial assessment of the individual. So all of our CHC participants under the contract go through a health care screening. And there are questions regarding behavioral health, physical health and cognitive. Those trigger further review. If an individual is identified as having behavioral health issues, we have a behavioral healthysa on on our team. And that person would be engaged with care coordination to identify and discuss with the individual if there is additional support needed. If it is identified that that is the case, then the liaison and the behavioral health care coordinator that we have on staff would coordinate with the BHMCO to have a referral placed. And that tends to be the case. When they're an LTSS participant, that care coordination plan in addition to part of the PCP would identify the needs of the individual including community based services that may not be part of the CHC program. Or if there is a referral made to behavioral health. While that coordination could improve just our system in general the service coordinator is ultimately responsible to work with the team to get that individual the support that they need.
>> Is there a way that you monitor that?
>> Yes. The assessment tool and pull out individuals that have identified with behavioral health condition. And then the PCSP would identify those with LTSS what has transpired to assist them of any kind of behavioral health needs that they have.
>> Okay. Thanks.
>> Yeah.
>> Good you brought her.
>> She brought me.
>> Any other questions from the commit memes or the audience?
>> Thank you.
>> Excuse me, Mike. This is German. I just want to mention that each CHCMCO will do a quick demonstrator of navigating to the website to do a provider search. So if you want to [Indiscernible] you can.
>> Do you want to come up here.
>> What we do, we will go to the [link] once you have reached the website, you would go to the top banner. And you would click find a doctor. Once you're going to find a doctor, you need to select the correct health plan which is the Community Health Choices Medicaid. Response selecting Community Health Choices Medicaid, you can go by city, county or zip. We can use Philadelphia county. As you type it in, it will give you options that will pop up. Just select Philadelphia. It will ask you to select the network again. What you would do is from the dropdown you would select Community Health Choices. Then hit continue. Now here you would get into -- there's a couple of ways to do the provider search. If you know the name of your

provider, you go by provider name. If you know the specific specialty you're looking for or if you know the provider's MPI. Also on the right-hand side we have a couple of popular searches where you're looking for a really good one is primary care physicians or urgent care. Pediatrics really doesn't fall into this demographic of our population. For here let's just look at primary care physician. From this on the left hand side there's a couple of filter options. You can narrow the network down. Right now we're at a 50-mile search radius. That is the default set for our site. On the right-hand side, it would give you some quick information about the provider. If they're accepting patients. If you were looking at Elizabeth carazo, there is show more details. Just giving a quick information of the gender, the age limit. Also -- you can also hit view map. If you want to get more detailed and give your specific address, you can narrow the search down. So this is the quick way to search for primary care physicians. If you wanted to search for a different provider type, you would hit search again. At the very top. Let's jump to laboratories. Now for Atlantas we can go from provider type specialty. Now, this is the easy search. If you just start typing in lab -- independent laboratory. It will give you search options. And you're going to rinse and repeat. As you go down the list of providers you're looking for, this is the quick simple easy way to use our find a provider. Okay. Thank you, everybody.
>> Thank you PA health and wellness. Next up on the agenda is AmeriHealth Caritas/Keystone First.
>> Good afternoon, everybody. Can you hear me okay?
>> We can hear you fine.
>> My name is Megan (name?) and I'm the director of provider network management. I'm going to provide on the community health choices provider network provider enrollment search and network monitoring. Next slide, please. Once a provider has received all their licensing from medical assistance, their identification number and related documentation enrollment to practice in Pennsylvania Medicaid, the provider would submit a contract request for review and consideration. If the provider's contract application is approved, then the provider is assigned to an account executive to outreach to the provider. Once contracted and credentialed, this likely takes up to 60 days, the provider is set up in our system as a participating provider and they have an assigned account executive that reaches out to them and sets up their provider orientation for any questions or concerns that they have with the program. When a provider submits a contract application, we take the following into consideration. Network adequacy. Is there a need for that type of provider in our network. And then the participant request. Has the participant requested this provider to be in the network for the care that they would like? And then also for participant care, are participants seeking care and obtaining a single case agreement. We like to contract those provider as well. Next slide, please.
>> And we also monitor network adequacy in the following ways. We use geographic access, geo access, quest analytics as well. We review the reports annually and we also review them if there is a significant change in provider participation. If have a hospital closure, a specific type of specialty that we pro received a provider termination on. We will do the termination reviews on a monthly basis. Should we find a potential adequacy issue, then we target recruitment for that specialty type. And we continue contracting providers where there is a known potential gap. For example, dermatology. Next slide. Are there any questions on that before I start the demonstration?
>> Any questions? I think you can move forward with the demo.
>> Okay. What I'll have you do is go to our website which is AmeriHealth Caritas CHC.com. Then go to find a provider. Scroll down. Right about the middle. Search. Choose location. Harrisburg. All right. So we're looking for a home and community based provider. Then go to the

far right place of -- I'm sorry. I'm having difficulty seeing. And choose adult day. And this is a list of the providers that are adult day. On the left side, you're able to see a map as well as if you would like to modify the distance of your results. Right now it is 25. If you want something closer, you can make those changes. And then if you click on the first provider, adult day services, it gives information about the provider. Their telephone number. That they have a website that they have provided to us. We add that as well to our website. Scroll down. If there are any other services that the provider renders are also included within the search. If you jump back and want to look at another provider in the area, the same function would occur. Were there any questions?
>> I don't know if this is feasible but there is no way to provide reviews or ratings? Because I imagine there's a lot of providers.
>> That is correct. That is a great recommendation. I can take that back and see if that is something that we would be able to add. I'm thinking of more of a commercial. But yeah I have seen that.
>> Directed to all three.
>> Thank you AmeriHealth next up UPMC.
>> Good morning, everybody. Can everybody hear me since I'm working remotely?
>> We can hear you.
>> Okay. Great. Thank you. My name is Andrea Ferrell, the senior director for UPMC health plan over our provider network for ancillary and physical health. So thank you for having me. I'm going to skim through this presentation a little bit just because a lot of what has already been said our presentations do tend to mirror. So if I can go to the next slide. So, you know, one of the things that we were asked is how does a provider apply to UPMC health plan. If you go on to our website which is UPMC health plan.com we have a dedicated providers page. And each one of those pages are now broken down to medical, dental, vision and home and community based service providers. You would pick depending on what provider type you are. If your looking at home and community based service providers, we would click on to that link. And there is a -- there's an entire section there that is an electronic pre-application that the provider completes and sends the to us. In addition on our website you can find other information such as our appointment -- our important announcements, our provider manual, our policies and procedures and access to our secure provider online. Next slide. Okay. So this is just a quick example of what that looks like. You go to UPMC health plan providers and you can pick between medical, dental, vision or home and community based services. Next slide. Once you get into that section, you would scroll down to the bottom of the section. And each one of the pages has a join our network. As you can see when you look over on the right-hand side you would provide the type that you are. So this is a very simple preprocess where you go in and give us the information that you need to understand that you are interested in applying and being a participating provider for our network. Next slide. Okay. So I already submitted my electronic application. What next? So each department will take their application to review the information that comes in and ensure that the application is clean. That we have everything that was needed. UPMC health plan does use an electronic application. Once the pre-app is received it is sent to you electronically. And those applications are -- because they're electronic, they are very adamant in making sure that you submit a clean complete application. But sometimes we don't have all of the information. That is always key. In general we have a 48-72 hour response time once we have that submitted. Those responses can be varying. They can be a request for additional information, they can be approval of your application which would be then sent to contracting, et cetera. Some of the things that can delay an application, rate

negotiations that we must have with providers. Any type of changes -- request of changes can delay. And then we have the additional steps that one of the MCOs talked about. All applications go through an extensive department review through the UPMC fraud team to ensure that there was not a reason that we would not contract with that provider. And in addition all of our providers are required to complete a disclosure of ownership documentation. All of this must be in before we move to the contracting process. Next slide.
You know, I'm going to -- I'm just going to scroll here kind of quickly because we did talk about this. This specifically talks about the medical saying that the majority of medical providers, physicians, specialists, the home health, et cetera, when I say medical, those are all of the providers I'm speaking of require credentialing which we like to say that it can take up to two months for completion. But usually it is within the month as long as we have a completed application. Once credentialing is completed, the contract is sent to the provider. And, again, the time frame for that varies based on the -- based on any rate negotiations or contract changing. Ancillary, when I say ancillary, I mean everything other than a hospital or a physician or home and community based services. So that would be your lab, home health, et cetera. Basically follow the same process. Usually completed within ten days. And then we have that credentialing time frame if they are credentialed. And then the execution of the contract would depend on any negotiation that's have to occur around that actual application. If there is a denial, every application is reviewed based on adequacy, which we will talk about in a moment. And any gaps in care or services within those areas. Next slide. Dental, the turn around time usually from receipt of the completed application to decision is about 25 days. And then that turn around to finalize the provider contract is about 35 days. That is the same if there are rate negotiations or contract language changes, that can definitely lengthen the are she is time. Home and community based services. We usually turn those around in about a week. We have someone monitoring all application requests regularly but at a minimum every Monday and Friday to ensure that we have all of the information that we need. Once it is approved, it goes through most of the standard steps that any other provider goes through. Such as the fraud waste and abuse provision that I talked about and the -- the documentation of ownership has to be completed and sent back. Once that all occurs, the contract is sent out to them. Same situation on a denial as I discussed on the ancillary. Each is reviewed to determine network needs and decisions are made from there. Next slide. Nursing facilities are also handled the same way. There are varying different nursing facilities because most of the facilities are already participating for other products. So in general we are usually only looking to add an amendment to add the CHC product and the LTSS services. We then have to go through any reimbursement or negotiations or contract negotiations. A denial if it is going to occur usually would be a result of race or contract red lining, et cetera, that delays us. However, you know, we do always review the area for any request that we get. Next slide. So how is adequacy determined? UPMC health plan uses the department of human services standards to monitor adequacy. The standards are listed here. These are standards that we use for our physical health providers. And then for our home and community based service providers the standard is a minimum of two providers within a county when available. So we -- we exceed that by far unless it is a very rural county and the providers are not there to assist. Frequency of review. We also use quest, which I think the other two MCOs said they use. With he have that refreshed weekly and it is monitored by our team to ensure there are no adequacy deficiencies that -- following the DOH standard outline above. And then we also use the OPS5 report which we are required to send to the PA department of humanizers advices, DHS, annually, based on participating CHC providers measured against CHC membership.

>>> And we maintain internal policies which are audited to ensure that we are meeting the standards above.
>> Next slide. How often is it monitored? I basically said we look at it a minimum weekly. And as needed. So any time that there is a gap in service identified any time that we have a request from any other area or department such as internal UPMC, department of human services, CMS, any of those will trigger us to make sure that we don't have any gaps in care. Home and community based services. We will look if we have provider terms if we have service coordinators who are telling us that there is an area that they're having difficulty placing or finding services for a member. And then we will also use the personal assistant services shift reports to help us identify if there are under served shifts or any trends in specific areas. And again we do use quest as our tool to monitor our adequacy. Next slide. Okay. So I'm not sure who is running the computer for this. But you can either click on that link to open our website or you can type in -- I can tell you what to type in when you're ready. Oh, and you're there. Good job. So this is our general page. If you look on the top sort of in the middle you can see the find care. If you click on find care. So this will bring up our general find a provider as we call it. So there are two ways to look as you can see. You can use a specific member ID which would take you directly to your specific plan. So it is very detailed. We're going to use I'm just browsing. If you can click on that. Okay. This is the care you're looking for. Click on the dropdown. We have medical, behavioral health, dental, vision, home and community based services. If there is no preference, you can pick whatever one. Home and community based services if you would like. Okay. And then the next dropdown says what plan you have. They only have Community Health Choices. And then find a provider. You can do this by a varying of different ways. Search for name if you're looking for a specific provider. But most times we search by type. So if you click the next dropdown for filter, that is as you will notice very specific to home and community based services providers. So we try to make it simple once somebody picks what they are looking for that those are the services that come up. You can pick any one. When you look at your address you can do this as specific or as general as you want. I see that 17101. I'm not sure where that is at. And then hit search. Now, you can just hit search and it will pull it up with that. Just hit search. Or will it not work? Let's add -- can you add 15219. I'm not sure what that zip code is there. And then hit search. Oh, you need a specific address. Okay use 600 grant street. Pittsburgh. Grant street. Do the second one. Right there. Now hit search.
>> Okay. When you look at this, you can see that the home community based providers all come up. We have the map on the right-hand side which is helpful in somebody identifying exactly where they live. On the left hand side you can see we have a list of all of the agencies. It looks as though that brought up about a hundred providers. Up on the top you can see it is telling you that you're searching for past providers within 20 miles. You can go less than 20 miles if that is preferred. You can juggle that however you prefer. Can you click on Avondale care group. Okay. When you click on the provider, it brings you to the specific provider and gives you more information on them. It shows you where they are. You can get your direction and print it. It has their phone number and tells you how far away it is from the zip code and address that you put in so it gives you a little more detail. This is a continually growing page. This is our home and community based page. If you were to pull up a physician, you would see additional options such as if they're handicap accessible, whether they are -- whether they're open and taking new members whether they speak languages and things along that line. We chose to look up home and community based services. But if you look up and use this directory you would then see additional information when you start going under hospital or physician because then you can see a longer list of services, et cetera. Any questions? Is that a sufficient

search.
>> I have a question. Do you have a generic ID that you can see how stream lined it is for a member.
>> I don't have a generic ID but I can use mine. If you -- I don't have that memorized but I will have it for you in two seconds. I am so sorry. I didn't have a direct ID ready for you. It is -- it is 0(013)973-8301. We will do something different this time. Let it go the way it is. 15219. You can use that. That's fine. And then hit search. What you can see came up here. The same thing that you saw before. When you look up on the top section, you can see when we're working on a PCP or specialist, we have a large variety of dropdowns that can help you choose what it is that you're looking at. We are looking to enhance the home and community based services to add some of these that are appropriate. Not all of them are appropriate. But if you go down and just click on the first doctor that came up. Now you can see it brought you in much more specifically as to what it is that you're looking for. Now, what you can't see on here is using my ID I am a UPMC employee obviously. So this is getting very specific to my plan which means that I now know that I can definitely go to this provider. If it was a Medicare search and they were on a limited network, Medicare plan, they would only see what they were able to -- whoever they were able to go to. Any questions?
>> Any other questions for UPMC? From the committee members or the audience? We have one here for you. Go ahead, Lloyd.
>> Just a quick question. I'm sure somewhere along the line you found that you had an inadequate network based upon the measures that you use. Are you able to share with us just briefly what happens when you realize that and what actions are taken to address that network inadequacy. And an idea of the time frame that is involved in that process.
>> Again, I'm going to talk to time frame first. Time frame can definitely vary for many reasons. Just based on whether, you know, the service type, where we're at, is it rural, is it urban. But in general, we would address it immediately. And the ways we would address it, we can use home and community based services let's say. And a service coordinator happens to come to us and says we cannot find a providener this area, et cetera. We would then go out. Do our due diligence using the DHS provider website. So we would understand all providers that are currently participating with a DHS promise ID which would be an appropriate provider for the service. And then we have our provider account executives that we would have conducting outreach calls. We are a team. We all make calls. It depends on what we need. And it would be similar for if it was a physician or if it was any other type of provider, that is exactly how we would handle it. Start that recruitment process based on the area and the physician account executive that would be over that area to assist. Time frame would depend on the -- a lot of things. The contracting time frame and all of those types of things. But we would and have done numerous times a letter of agreement with an out of network provider to make sure that they can get services and the provider is able to be reimbursed as if they were an in network provider.
>> Any questions for UPMC? Thank you very much for the presentation. I'm sure we do have things in the chat. I haven't -- I haven't done a great job at keeping our agenda to the time frame. But I'm let you go ahead.
>> I was just going to maybe suggest that we can take questions from the chat, reach out to the appropriate people and follow up with them.
>> Okay. That would be fine. Right now, let's go ahead and move into the additional public comment section of the meeting. I'll open up the floor.
>> If anybody has any, we will go ahead with the chat. I want to go back to the beginning of the

meeting to jog everyone's memory. So the first question I have is about the MDS. Does the MDS the evaluator to identify multiple reasons for if there are multiple contributing factors? So I'm sorry. I had to phone a friend. According to Randy Nolan, you only get to -- you only get to select one response.
>> We will verify.
>> We will verify it. Okay. Next question. Is there a way to validate the level to get information on the level of need and whether more consumers with higher need are making up the percentage? That's back at the beginning. It is from Shawna eakin. I'm thinking those would be MDS. Do you want to read it again?
>> Yeah. I'm thinking about it. So out of the data of the individuals that were entering the nursing facility, looking at -- if they have higher level needs.
>> Uh-huh.
>> We will have to check into it. This is from (name?). Do we have any indication of start of services and proportion of individuals who are able to get all of their approved hours after services start?
>> So I assume this is going back to the conversation that we had the CHCMCOs on the use -- on the authorized hours and the utilization of services or hours enumerated on the care plan. So I don't know if the CHCMCOs track when the hours are authorized and when they start. And then the other question was whether more consumers with higher needs are making up the percentages. I think that was for the previous --
>> Oh, okay. Do we have any indication of start of services and proportion of individuals who are able to get their approved hours after services start? A hundred percent of their services? At what start date? So we can follow up with the CHCMCOs if they can provide and track that data. Unless, David, you would like to --
>> Sorry. Anna and I were going back and forth. But not all of that information is to be contained on OPS23 which is when someone is assessed and the time frame between when the services are initiated and the -- it was recently added when the services begin. So I don't have that information available with me right now. But that information is generally available.
>> Thank you.
>> Another question here for the MCOs. Are the MCOs using utilization data to identify participant who's are underutilizing their hours perhaps to target them for additional support with staffing?
>> You guys might as well stay at the table.
>> (name?) the question is are we tracking underutilization. We are. We do track that as well as overutilization. That is how we manage our services. If we identify someone who is underutilizing, for example, missed visits, the contract requires that five missed services require a trigger visit of the service coordinator to go out and check on that individual and do a face-to-face determination if they're needing services, other services, if something has changed in their home. If they have relocated. There's a number of six or seven different areas where it would trigger us to look into a new assessment of need and a new PCSP. And we utilize the missed visit report to determine that underutilization.
>> [Indiscernible] let me back up and say that. We follow a similar approach where we utilize the reports as well as the regular contacts to evaluate how they're using the services and have conversations with them if we need to reevaluate the level of services that they're authorized for if they need a different service if what they're authorized for isn't meeting their needs.
>> (name?) can you hear me?
>> Yes. We can missy.

>> Okay. Great. I was having some issues with mute earlier in the meeting. I agree with the responses from Anna and David. We're also used the missed visit report to checkup on participants within a day of their missed visit and make sure that they're okay. We think the one resounding theme that I'm hearing from all CHCMCOs is we're checking with the participants frequently. As soon as we're made aware of missed visits so we're not delayed in evaluating any needs that they may be experiencing.
>> Thank you.
>> This question pertains to (name?) please clarify child abuse clearance not only for AWC but regular home care. Is it still conducted when a child is present at patient's home or to be done for all employees?
>> Yeah, Paula. This is Jennifer hale. Child abuse clearances are required when a minor child resides in the participant's home.
>> Next question. Can nurse practitioners and physician assistants order behavioral health services in the new waiver amendment?
>> JENNIFER HALE: So this is Jen again. The change is really only applied for nursing services, occupational, physical, speech and language -- speech la and language therapies in the waiver.
>> Next question is from Catherine Weaver. When was the last rate analysis for past services?
>> JENNIFER HALE: This is Jen again. I would have to take that back. I'm not sure. So that will need to be a follow-up.
>> This goes to the MAWD presentation. Can you be eligible for MAWD if you aren't working?
>> This is Laurin Wanner. No. Unfortunately MAWD does have an employment requirement. It can be self employment. But you have to be employed and earning income.
>> This question is for the MCOs. Once the MCOs have contracted with providers, how do they monitor which providers are actively accepting patients?
>> It is Andrea from UPMC. I can answer that if -- if that's okay?
>> Go ahead, Andrea.
>> Sure. Sorry. I couldn't get myself off mute, which everyone says about ten times a year this year -- now. So we would monitor the physical health side. So physicians. We have continual meetings with our physicians. At least -- at least once a quarter our provider account executives are talking to the physician groups either in person or catch-up via e-mail, et cetera. Every time that they go out to meet with them, they are updating the information that is in our current provider directory. In addition we are continually requesting to have providers go and update -- they can update it themselves on our website. So that's how we would start tracking that. If a provider came to us and said they were no longer accepting new patients, for example, we would go in and update our directory accordingly.
>> Thank you.
>> Another question referring back to the --
>> Our response would be largely the same.
>> Same with AmeriHealth.
>> This question goes back to the MAWD presentation. How is the MCO going to know if someone is a Former WJS recipient for purposes of excluding resources?
>> Sorry. I don't think I heard the end of that. Unless Nikki wants to grab it.
>> I can take this one, Laurin. This is Nikki Blythe. There is a system -- in terms of the system, there's a history check that it does when the worker is processing it. But they're also to review the case to make sure whether resources should be counted or excluded.
>> I have nothing else, Mike.

>> MICHAEL GRIER: Any other comments, questions from the audience or the committee members? With that, I think we're adjourned. Thank you, everyone, for your attendance. Our next meeting is November 2nd. And it will be at this same location. Thank you all for your participation.
>> You're welcome.