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Date: 12/07/2022

Event: Managed Long-Term Services and Supports Meeting

>> SPEAKER: Can someone from the membership online speak so we can make sure we can hear you?
>> SPEAKER: This is David. We can hear you.
>> SPEAKER: Thanks, David.
>> SAM: Paula, do you have access to David? Hey, David, are you on the road? If not, I can do the attendance. If that's okay. If you are on the road.
>> DAVID: Nope. I am here in my office. Are we starting the meeting.
Good morning, this is David Johnson, welcome to the December meeting.
I'm going to begin by taking subcommittee attendance.
Is Ali Kronley present?
>> SPEAKER: Good morning.
>> DAVID: Cindy?
>> SPEAKER: Here. Thank you.
>> DAVID: Neil Brady?
Gail?
>> SPEAKER: Good morning.
>> DAVID: Hi. Good morning.
German Parodi? Good morning.
Heshie is absent today.
Jay Harner?
Juanita Gray?
Kyle Glozier?
Lloyd Wertz?
>> SPEAKER: Present.
>> DAVID: Good morning.
Matthew Seeley?
>> SPEAKER: Present.
>> DAVID: Good morning.
Mark Gusek?
Mike Grier?
>> SPEAKER: I'm here.
>> DAVID: Monica Vaccaro?
>> SPEAKER: I'm here.
>> DAVID: And Jay Harner is present. Thank you.
Patricia?
>> SPEAKER: Good morning, everyone.
>> DAVID: Good morning.
Sherry Welsh?
>> SPEAKER: Yes, I'm here.
>> DAVID: Good morning.
And Tanya Teglo?that I missed?

>> Juanita Gray I'm here.
>> DAVID: Hi.
Thank you, everyone. Pass it off to Mike
>> MIKE:
I will do the housekeeping point. Please use professional language. This meeting is being conducted in person at the Department of Education honor and Suite. And as a webinar with remote streaming.
This meeting is also being audio recorded. The meeting is scheduled to 1:00 p.m. to comply with the arrangements we have to end promptly at that time.
All webinar participants, except the committee members and presenters, will be in listen only mode during the webinar.
While committee members and presenters will be able to speak during the webinar, to help minute NIEZ background noise and improve sound quality of the webinar, we ask attendees to self-mute using the mute button or the mute feature on your phone, computer, or laptop when not
Please hold all questions and comments until the end of each presentation, as your questions may be answered during the presentation.
[Indiscernible]
Questions and comments in the chat box located in the go to webinar on the right hand side of the computer screen. To enter a question or comment, type in the text box under questions and press send.
Members who have questions or comments should wait until the end of the presentation to approach one of the microphones located at the tables at the end of the room.
The chair or vice chair will then call upon you to minimize background noise in the Honor Suite. We ask that committee members, presenters, and audience members in the room please turn off your microphones when you are not speaking.
The captionist is documenting the discussion remotely. So it is very important for people to speak directly into the microphone, state their name, and speak slowly, clearly. Otherwise, the captionist may not be able to capture the conversation.
This will also aid in the captionist recording, who is ask the questions and whom responses need to be sent.
When submitting a question or comment into the chat box, it is important for people to include their name in the chat box.
Before using the microphone in the Honor Suite, please press the button at the base to turn it on. You should see a red light indicating that the microphone is on and ready to use. State your name into the microphone for the captionist. And remember to speak slowly and clearly.
When you are done speaking, press the button at the base of the microphone to turn it off.
The red light will turn off, indicating the microphone is off. It is important to utilize the microphones placed around the room to assist the captionist in transcribing the meeting discussions accurately.
Public comments will be taken at the end of each presentation instead of during the presentation. There will be an additional period at the end of the meeting for any additional public comments to be entered into the chat box. If you have questions or comments that weren't heard, please send your questions to the email on your agenda.
Meeting minutes. Transcripts and meeting documents are posted on the list serve under MLTSS meeting minutes. These documents are normally posted within a few days of receiving the transcripts.
The 2022MLTSS sub meeting dates are available at the Department of Human Services website.

David, I turn it back over to you for the emergency evacuation.
>> DAVID: In the event of emergency or evacuation, we will proceed to the assembly area to the left of the Zion church. If you require assistance, you must go to the safe area right outside the main doors of the honor suite. The staff will be in the safe area and stay with you until you are told you may go back.
Exit the building and take your belongings with you. Do not operate cell phones or try to use the elevators. We will use stair one and stair two to exit the building. Stair one, exit through the main doors, turn right, and go down the hallway. Stair one is on the left.
Stair two, exit through the right side or the back doors. From the side doors, turn left and stair two is directly in front of you. For those exiting from the back door, turn left and left again and stair two is directly ahead.
Keep to the inside of the stairwell and head street. Turn left at the corner of fourth street. Turn left to blackberry street and cross fourth street to the train station. Thank you, Mike.
>> MIKE: Thank you, David.
And we are going on to the next item on our agenda, which is follow ups from our November 2nd meeting. We have a number of them. It's a little bit lengthy. Please bear with us. We will try to get through this.can provide a link to the bill language for act 61 of 2022 amending title 18 by adding the subsection 3142.2, institutional sexual assault.
>> Paula sent the link and will include the links with additional documentation on the December meeting list serve.
>> SPEAKER: Related to the authorization of hours utilized and a second data report, audience member asked if there is a second report of the data where OLTL is collecting and comparing total number of hours against total number of hours approved versus hours actually received. Randy Nolan said he would provide at the next meeting.
>> SPEAKER: Randy Nolan from LLTL discussed and we have no further update to provide.
>> SPEAKER: Related to the CAHTS survey for life, audience member Janelle asked if -- there is an update to OLTL potentially serving life participants with the CAHPS survey?
>> SPEAKER: Randy Nolan responded that the life program is working with the Medicaid research center, NSPH analytics to have the survey completed with life participants.
>> SPEAKER: Relating to the credentialing and accreditation, audience member Patty asked through chat whether the Department agrees and supporting the UPMC position on accreditation as a short-term proxy to identifying the potentially high performing PAS agencies. If so, why and what type of guidance will be provided?
>> SPEAKER: Randy Nolan from LLTL responded that the aKETation of past providers by the MCOs to ensure quality would be beneficial to the participants to ensure that they are getting the highest quality services. The Department would monitor to ensure that the process is done in an appropriate manner. And to ensure that network adequacy remains appropriate to meet the needs of the CHC population.
>> SPEAKER: Relating to the FAQs on ARPA payments, audience member asked about the FAQs on AARP payments to be updated to say that the funds can be used for other locations as the provider has.
>> SPEAKER: LLTL will have to work on the FAQs uplated online in the near future. Held send an update directly to Terry.
>> SPEAKER: Relating to missed shifts, subcommittee member Matt asked if it takes five consecutive missed shifts before following up with a participant. Excuse me. Let me stop. Matt asked why it takes five consecutive missed shifts before following up with a participant. And what constitutes a shift. This is a fairly long response, Matt. Just to let you know.
>> SPEAKER: So there were two parts to the question. What constitutes a missed shift, and what takes five consecutive missed shifts and what constitutes a shift.

So in response to the first question, why it takes five missed shifts, services before following up with a participant. PHW responded that according to the 2022CHC agreement, in addition to trigger events listed above, that the CHC MCO identifies that a participant has not been receiving services to assist with activities of daily living as indicated on a service plan for five consecutive scheduled days of service or more. And the suspension of services is not preplanned. The MCO must communicate with a participant to determine the reason for the service suspension within 24 hours of identifying the issue.
If a participant receiving an alternative HCBS in this five-day span during which activities of daily living are addressed, outreach by the MCO is not required.
If after communicating the MCO determined that the participant's health status or needs have changed, then the CHCMCO must conduct a reassessment within 14 days of identifying the issue.
CHW also added that if the service coordinator is aware sooner than five days, they are encouraged to assist in identifying the reason for the gap in care and what actions can be taken to mitigate risk.
AHC responded that once the service coordinator is notified of the missed shift, the service coordinator will attempt contact with a participant to follow up immediately.
The FC does not wait for five missed shifts. The five consecutive missed shifts is referenced because that is what initiates a trigger assessment.
UPMC responded that LLTL requires the CHCMCO to communicate with a participant if it is identified that a participant has not been receiving services to assist with activities of daily living as indicated on the service plan for five consecutive scheduled days of service or more. And the suspension was not pre-planned.
When the UPMC CHCFC is notified of a missed shift, regardless of how many it has been, their staff outreaches to assist.
Participants and providers timely reporting of missed shifts is critical to addressing and avoiding service disruptions.
So in response to the second question about what constitutes a shift, UPMC responded that they look at a shift as an event for service. AHC provided additional clarification of what constitutes a shift. Any block of time that is scheduled for a participant. A participant is offered a triggering event assessment. If five consecutive shifts are missed.
Service coordinators follow up with the participants following the identification of a missed shift to check on health and safety and evaluate the adequacy of the back up plan.
>> SPEAKER: Thank you, Paula.
Relating to sample size of the CAHCSHP survey, subcommittee Mike Grier asked how many participants CAHPSHP survey was sent out and how many participants responded.
>> SPEAKER: PHW responded a total of 3,322 surveys were sent out. A total of 746 surveys were completed. AHC responded that for AmeriHealth Caritas, there were a total of 2,744 surveys sent out. And 704 surveys were completed.
Keystone first had a total of -- sent out and 711 surveys were completed.
UPMC responded that out of their total 2700 surveys that were sent out, 712 surveys were completed.
>> SPEAKER: Thank you, Paula.
Relating to the validity of the CAHPSHP data, subcommittee chair asked how the vendor tests the validity of the CAHPSHP data?
>> SPEAKER: So all three MCOs were asked to provide a response. And they all responded that prior to fielding the survey, the national committee for quality assurance or MCQA requires vendors to generate test sample files. Analytics submit test sample fuels to review. They review the files, provide feedback, and ultimately approves the files, which ensures that

sampling is conducted in accordance with the MCQA requirements.
Health plans generate a sample frame for each survey sample. If applicable, the health plans arrange for an MCQA certified health care effectiveness data and information set compliance auditor to validate the integrity of the sample frame.
During collection and prior to final data submission, MCQA requires SPH analytics to complete a data submission to IDSS, during which time quality audits are conducted.
Post fielding MCQA conduct a record review selected electronic images, of mail surveys and recordings of telephone interviews of the analytics final data.
>> SPEAKER: Thank you, Paula.
Audience member asked AHC what the definition of some refers to in reference to slide seven of their presentation that states that some of the participants are still reluctant to have face to face visits.
>> SPEAKER: AHC responded that between January 1st, 2022, and May 29th, 2022, they have seen the following in terms of participants that have completed a face to face assessment with the service coordinator broken down by region.
In the southeast, 14.1% were completed total assessments completed 98,335.
In the Lee high capital area, 24.1%.
In the northeast, 43.1%.
In the northwest, 38.8%.
Southwest, 36.5%.
>> SPEAKER: Relating to cultural competency on slide seven of AHC's presentation, audience member asked if there is any -- excuse me. If there is cultural incompetentcs does the MCO suggest to the participant which MCOs?
>> SPEAKER: AHC responded they would not suggest to participants which MCOs. They would work to find a provider in a network to meet their needs.
>> SPEAKER: Relating to provide availability, audience member Karen asked through the chat if the CHCMCOs are able to provide a way for providers to notify the CHCMCOs that the provider has available staff in certain areas.
>> SPEAKER: PHW responded they utilize a broadcasting process to notify providers within the HAA exchange, informing them that a participant is in need of past services.
In this process, PHW includes participants' demographics, service needs, and their service coordinator information.
Providers are notified of available opportunities to provide services to PHW participants.
In addition, the providers want to share that they currently have available capacity in a specific area, they should contact their assigned provider relationships representative to provide this information.
If they are unaware of who the provider representative is, they can reach out to PHW provider relations at PA health wellness to get this information.
Also, if additional capacity represents a change in their reported available full-time equivalence, they should notify their provider relations representative of this change.
AHC responded that providers with available staff outreach to the provider network management PMM team and give information on their availability, such as geographic L location and available days and times. The team sends this information of service coordinators within that region.
UPMC responded they start with another provider as identified through the participant choice process. If participants are not familiar with providers, UPMC introduces them to local providers in the geographic area of the participant. If the participant does not have a preference, UPMC broadcasts to several providers at a time until the broadcast is accepted. It is sent to providers approved by the service area by county as specified in the portal.

Therefore, any provider who has staffing availability can accept the authorization.
>> SPEAKER: Thank you, Paula.
Relating to dual population data, audience member Janice asked through the chat if the CHCMCOs have data on what percentage of their dual population are seeing PCP's and specialists that are in the network of their CHCMCO locations. All three CHCMCOs were asked to respond.
>> SPEAKER: PHW responded among the -- 79.64% used in network. However, there is a lower in network use among the unaligned dual population at 66.29%.
AHC responded that for AHC, CHC93.5% of eligible align participants and 84.3% of currently eligible unaligned participants utilized in-network providers since January 1st, 2022.
For Keystone first, 95.6% of currently eligible aligned members and 86.2% of currently eligible unaligned members utilized in-network providers since January 1st, 2022.
UPMC responded that among their align duals with PCP specialist, they see approximately 99% using in-network provider for this year.
>> SPEAKER: Thank you, Paula. I know that's a big chunk to bite off. I really appreciate everybody bearing with us with the follow ups from the November meeting.
That said, we will move on to the next item on our agenda. And that's appendix K unwinding with Jamie.
>> JAMIE: Good morning, everybody. Happy holidays. I don't think we meet again -- well, I don't think this group meets again until after the holidays, right after the holidays. We come back from the new year and have a meeting, I think when I checked my schedule.
We wanted to bring something to the committee's attention and get feedback. This really isn't a reporting issue. We're seeking feedback on this issue.
The office of long term loving has the appendix K waiver flexibilities that continue to be in place in both the community health choices and our overall waiver.
We have had discussions internally in the office of long term living about ending these waiver flexibilities early. And when I say early, I mean the flexibilities are currently in place until six months after the public health emergency ends. Many of you may know that the public health emergency is currently scheduled to end, I believe, in January of 2023. I don't know if exact date. I'm looking at German. 14th. He's going to give me the exact date. The flexibilities would remain in place for six months after January 14th, which would have them end in July of 2023.
We have indications from HHS, the federal government, because they haven't given us a 60-day notice that they plan to end the public health emergency in January that it is potentially going to be extended another 90 days potentially until April around the 14th of 2023.
So obviously, that would further push out our appendix K flexibilities.
I'm sorry, you can go to the next slide. And then go to the next slide. I'm sorry, I didn't check what was on the screen behind me.
So -- and then the next slide as well.
So when we talked internally at the office of long term living, the biggest concern is where we saw the most area of I want to say reverting to normal is really around the in-person assessments. And the work that the CHCMCOs and service coordinators and waiver programs do to, one, assess and reassess participants. And honestly, check on them and ensure their health and safety in their homes when they're receiving services.
So we ideally would like to end that flexibility. And we have floated the date of April 1st of 2023 to end the ability to do those remote assessments and reassessments by our community health choice MCOs and service coordinators in the over waiver program.
Many of those individuals, you may recall in 2020, when the public health emergency first started, were in process of moving over to community health choices. In some cases, if they

have not wanted that in-person assessment, there is a chance that they may not have been seen in their homes in potentially two to three years.
And so for that, we're concerned in the office of long term living that that represents a significant issue. If you're not seeing individuals, how are you assuring that they're receiving the services they need?
Obviously, talking to them on the phone is helpful. It would be more helpful if you could see them via video. But some individuals don't have that capacity or capability.
So returning to in-person assessments and reassessments would be ideal sooner rather than later.
But that's something we want to get feedback on.
One of the things we wanted to remind the group of today is all of the flexibilities that are in place through the appendix K waiver. So on the screen, and hopefully you're looking at your computers if you're not here in the room, on the screen behind me is all of the flexibilities that continue to be in place due to the appendix K.
So it is not, obviously, just the ability to do assessments and reassessments via telephone at the participant's request. But it is some other flexibilities as well.
So I don't want to read these. But I just want everybody to be aware. We do have the ones that we continue to hear about, at least in the office of long term living, are we do have a very few number of people that continue to receive their personal assistance services by the staff as legal guardians and persons with power of attorney. We review those in the office of long term living at least every three months to reauthorize that. We're keeping a close eye on exactly who is receiving that flexibility.
We know that that will be something that will have to end. And we keep reminding individuals of that. Due to the public health emergency, we understood some people did not want additional workers in their home because of the compromised state of the participant. So we allow that flexibility on a case by case basis.
We understand that there may be some services that continue to be provided remotely. We hear about the adult daily living services most frequently. But we are aware from time to time that there may be some other services that are provided remotely, if indeed somebody in the home is ill, mainly due to COVID. But obviously at this point in time, it could be flu or RSV or even a cold.
And then I know we have heard on an ongoing basis that residential and structure have been proved in individual homes from time to time.
Going to the next slide, we did allow flexibility in qualified staffing reassigned to different types of services.
And obviously, here in the middle of the slide is where the remote initial FEDs were conducted via video conferencing, annual reassessments, and remote comprehensive needs assessments.
Obviously, remote monitoring of the person centered service plans with face to face is usually done face to face. And then the team meetings. We know that that has been done telephonically.
And not a whole lot about retrainer payments that we are aware of.
I wanted to bring it to the group's the tension. I didn't know if anybody wanted to provide input at this point in time to the office of long term living. Or you can send it to any of our policy staff or myself that has been working on the -- obviously before we would end the flexibilities, we would give 60 days notice officially by sending out a list serve. I'm not sure if we would send something in the Pennsylvania bulletin. Jenn, if she's on the line, she can correct me or clarify that. There would be an official public comment period. But I wanted to get the feedback even before we actually took that formal step.

I will pause if anybody would like to say anything.
>> SPEAKER: Jamie, hi. Good afternoon. Good morning, sorry. Good morning. This is Jenn Hale. I wanted to add a point in clarification. We typically would not put something in the Pennsylvania Bulletin regarding the ending of the flexibilities. Historically, we have provided a list serve message with direction and guidance on transitioning from those flexibilities or flexibilities that are still in place.
So this would be a good time and opportunity to provide feedback if people have feedback on ending those flexibilities. Thanks, Jamie. I just wanted to add that.
>> JAMIE: Thank you for the clarification, Jenn.
>> SPEAKER: Any other input for Jamie?
>> SPEAKER: You said you were going to be looking for feedback and all that stuff. When is that? Now?
>> JAMIE: Now would be helpful. You're welcome, obviously, any time from now until when we had planned to, I want to say give notice in January. If you want to send an email to myself, Randy, Jenn, or the office of long term living, we will take the feedback.
We're also going to discuss this in the consumer subcommittee later today. That meeting is from 1:00 to 3:00 today. And Jenn will be making a presentation on this same topic. And it's on the agenda for the LTSS meeting next week, obviously wanting to provide stakeholders the opportunity to provide feedback as well there.
>> SPEAKER: Yeah. But the whole thing with the in-person -- the annual things, the service coordinators do, I use the word ideal as they are actually in person with them.
I just find that to be very problematic. I think it's a benefit to a lot of people with disabilities around the state that may not have -- I understand the technology. I just had a service coordinator -- like two weeks ago. And nothing against the service coordinator or the individual, but really it's almost like a box checked. Yes, I was there. I went and saw him. He's alive. Okay, bye.
I'm just questioning the, you know, calling it ideal that they're there. Don't I have the ability to say no to that? Why do I have to waste my time with that?
>> JAMIE: So in the community health choices and the over waiver programs, the assessments and reassessments have to be conducted in person without the appendix K flexibilities. So the service coordinator needs to meet with the person and go through that comprehensive assessment process. That usually takes, I'm told, upwards of two hours to go through that entire process. It may look different for Act 150. So it is a long process.
The benefit is that the service coordinator actually sees the participant and sees their home environment. And often meets some care givers that are present with the participant at obviously the participant's request.
>> SPEAKER: I'm not understanding why wouldn't you push to have that -- you're saying it's a federal requirement, the in person?
>> JAMIE: It's a requirement outlined in our federal waivers, yes. And I will tell you, what we have heard anecdotally, obviously, we do conduct telephonic -- or the service coordinators conduct telephonic assessments at the participant's request. The participant has to prefer and request that be done telephonically.
We run the risk of somebody doesn't actually see the participant. And I have heard from time to time that going through the assessment process, the participant will say, oh, I'm fine. I don't need any services.
It is. But when it puts them at risk of health and safety --
>> SPEAKER: Isn't that their right, though, as well?
>> JAMIE: Well, unless it's putting them at risk of health and safety issues, which you wouldn't normally see if you didn't meet with the participant face to face.

>> SPEAKER: I get that. Isn't it my right to live the way I want to live?
>> JAMIE: It is. But it's definitely easier for service coordinator to determine the person's home environment and if they can potentially do the things that they say they can do if they actually see them.
>> SPEAKER: I guess I want to say that the only one that I don't want to see carried through is the consumer visit one. Because I think that we need to be in person face to face quickly. I think that that has affected a lot of people's recertifications. And the number of hours that people are granted.
I think if the service coordinators actually saw them instead of only their head shot, they would understand that the reduction in hours that have taken place are not fair. And so I am a proponent for ending that one and getting back to normal as quickly as possible.
But keeping all the other ones in place. Because we have a lot of issues operating because of COVID. And people still have a great degree of fear.
>> SPEAKER: If I may, this is Sherry. I would like to point out that different people function in different ways. And I think that some people function without the in-person better. Just something to consider.
>> SPEAKER: Any other input for Jamie?
>> JAMIE: And like I said, there's many other opportunities to provide public input. I don't want to put everybody on the spot today. But just know it's on our radar, and we are taking stakeholder feedback on this issue.
>> SPEAKER: Lloyd here. Just wondering if there's sufficient staff at the service coordinator level to accomplish doing all assessments in home at this point?
>> SPEAKER: Or public transit, which is what you represent with staff shortages in the public transit world too.
>> JAMIE: So Lloyd, I think you're referring to enough staff in, obviously, the service coordinator realm to do those assessments and reassessments. And the requirement is, honestly, that the assessments be done in person if we didn't have the appendix K waiver if place. And so we would give notice, obviously, that we were going to end that flexibility. So if, perchance, the service coordination entity or managed care organization did not have enough staff, they would need to when they returned to an in-person requirement.
>> SPEAKER: I mean, what's supposed to be in place and what is during this time of labor shortage could be two different things. But I get your point. Thank you.
>> SPEAKER: Any questions from the audience committee members? Any additional input for Jamie?
>> JAMIE: One more thing while I have everybody's ear.
So the Department of Community and Economic Development asked the office of long term living, and actually the department of human services to do PR regarding an affordable connectivity program. The program actually allows and helps households struggling to afford Internet service by providing $30 a month of a discount on broad band service and a one-time discount for hardware like laptops, desk tops, or computers.
The office of long term living will be sending out more information via list serve. I wanted to put it on your radar. If you know of individual families or households that would like to have broad band and struggling with the cost, there is a program out there. And we will soon be providing more information about that.
>> SPEAKER: This is German. May I?
>> SPEAKER: Yes, go ahead.
>> SPEAKER: Thank you. Jamie, moments ago, you were speaking and you mentioned about consumer choice and consumer direction. In such spirit, I would like to make a motion for subcommittee to oppose OLTL to CMS to amend the state's waiver to allow agency with

choice model to proceed in Pennsylvania unless it includes at least three vendors per region to preserve consumer choice and control.
>> SPEAKER: Yes, thank you. Did everyone hear that that's on the committee? Okay?
>> SPEAKER: What is a region?
>> SPEAKER: German, Matt is asking what would be classified as a region?
>> SPEAKER: This is German. I believe the state right now splits the state into three regions. Is that accurate?
>> SPEAKER: So we have a motion on the table to bring opposition to agency with choice, the way it's written right now because it lacks at least three vendors in each region.
All right. So there's a motion on the table for the MLTSS to bring opposition to that because of limited choice.
>> SPEAKER: Didn't we already do this?
>> SPEAKER: We did. But everything that was done then goes away with the new RFP. That's my understanding, Matt.
>> SPEAKER: We have to respond to the secretary basically saying thanks, but we don't care.
>> SPEAKER: Can I give everybody an update on where the agency with choice? Many of you know there's a procurement, which is currently stayed due to two appeals to Commonwealth court due to the denial of protest by the Department.
So it is currently obviously with Commonwealth court for a decision. And while that process is taking place, the procurement --
The agency with choice -- I'm sorry, the community health choice and the over waivers with agency with choice, that amendment, I believe the public comment period just ended. And I can't remember -- December 14th? I'm sorry. I should remember the dates, I just don't.
>> SPEAKER: I'm sorry, Jamie. I was going to confirm it is December 14th for the waiver comment period. That's the last date.
>> JAMIE: Perfect. So that is still open for public comment.
I will just let everyone know that if the option is not available in Pennsylvania, meaning at what point the waiver would be effective, the effective date of the waiver, the agency with choice would have to be available in Pennsylvania because of the procurement issue, it's very likely that the waiver that is currently out for public comment would not be able to go to CMS with the agency with choice provision. Because we wouldn't be ready to implement those provisions as of the April 1st effective date of the waiver.
However, obviously, still taking public comment on those provisions at which point in time we would be ready to implement agency with choice in Pennsylvania. Obviously, the provisions in that waiver amendment would have already gone through the public comment period. So we would already have that feedback and that process in place.
>> SPEAKER: Good morning. Tom from liberty resources in Philadelphia.
It's our understanding that all of the previous comments, including opposition to the AWC model, was accepted. But now sort of expired. And with the application to CMS to amend the waiver to allow the AWC model, that reopened the comment period which closes December 14th.
So all the opposition that was previously made sort of needs to be renewed as people still feel strongly about it. And that's why a new motion needs to be renewed and discussed and provided to OLTL and CMS as part of the public comment period.
>> SPEAKER: Thank you, Tom.
>> SPEAKER: It's still right.
>> SPEAKER: Thank you.
>> SPEAKER: Just for clarity purposes, is the motion pertinent to the waiver amendment?

>> SPEAKER: Were you saying it's going to be delayed regardless? Is that what I sort of heard you say?
>> SPEAKER: Yeah. After you said it, I was like boy, I'm confused by what I said.
So due to the procurement of being stayed right now, yes, it is delayed. Agency with choice is delayed.
We cannot send the provisions of agency with choice that are contained in the waiver amendment to CMS for their review and approval, or review basically, until we are actually ready to -- and we have a date to implement agency with choice. Due to the procurement being in a stay, we can't move forward with putting agency with choice in place and providing a date that that service will be available for participants. So we're in a holding pattern.
Jenn, is there any clarity that you can provide?
>> SPEAKER: Yeah. Hi, Jamie. I think that you did a good job.
So you are correct, CMS requires for things to be in place in order to approve and have an effective date.
I think during the last council meeting, I did indicate that if individuals have comment on the inclusion of agency with choice in the waiver, that this is the opportunity and the public comment period to reiterate those comments.
What will help the Department, we are required to obtain public comment. So this is the public comment period that will be applicable to any waiver amendment that includes agency with choice down the line.
I hope that makes sense. I don't want to deter anyone, even though it may be delayed from the labor, I don't want anyone to not comment if they have comments. This is definitely the time to provide comments on the waiver amendment.
I hope that makes sense. If you have questions, let me know.
>> SPEAKER: Just quick question. So the agency with choice would not be included in the waiver amendment that -- with the other waiver amendments that were proposed at this time, is that correct?
>> SPEAKER: That's correct. We plan on sending the waiver amendment that is currently out for public comment to CMS in late December for an effective date of April 1st. We have to pull those agency with choice provisions out because they will not be ready to be effective as of the April 1st date.
>> SPEAKER: So any public comment that you receive today will be pertinent to the current design of agency with choice. But that design could effectively change based on the legal process that's ongoing.
>> SPEAKER: So the public comment is on the waiver provision. So I can't speak to what may happen. But if you heard Jenn, I think she is encouraging everybody to provide public comment on all the provisions in the waiver.
There is likely not a need for another public comment period, should we have -- should all of the procurement issues be resolved and us move forward. So comment now, please.
>> SPEAKER: We have a motion that all of the previous comments be applied to this application period? I'm happy to second the motion. But, I mean, can we just cut and paste? It seems like a simple motion. I would like to motion that all previous comments be applied to the application period of CMS as well.
>> SPEAKER: Yeah. I will have to check in to that, Matt. I don't know if we can do that.
>> SPEAKER: Don't they do that -- I mean --
>> SPEAKER: Right.
>> SPEAKER: Just to confirm, it's possible that this is the only opportunity to make a public comment on the agency with choice plan. So that's helpful.
And I wondered how the delay would or could or has impacted the actual CHC agreement

between the state and the plans. Will that be modified as well? Is it already signed?
>> SPEAKER: By some. And so while it may be in the CHC agreements, obviously it would be the decision of the office of long term living to require the CHC-MCOs to implement certain provisions in that agreement.
If the Department hasn't made those provisions available, obviously, we're not going to enforce those provisions of the agreement.
>> SPEAKER: But the agreement itself will be modified as a result of any delay?
>> SPEAKER: No.
>> SPEAKER: Thanks.
>> SPEAKER: I'm not exactly sure what's happening with the motion that's on the table, but I want to go on record as saying that the disability community I represent disagrees with a single vendor for agency with choice.
And multiple vendors, it's not the concept of agency with choice that we disagree with. It is the single vendor model of agency with choice that we disagree with.
So I don't know where the motion stands. But I just want to go on record as saying that.
>> SPEAKER: Right. We have a motion and a second. In reference to agency with choice opposition against one vendor. German, I think you said minimum of three in each region?
>> SPEAKER: This is German. Yes, I did put the motion in the chat where organizers and panelists can see it. I will read it again. And we can discuss it. I think I did get a second.
But as I presented a motion to oppose OLTL's applications to CMS to amend the state to allow agency with choice model to proceed. Unless it allows three vendors per region in Pennsylvania to preserve consumer control and direction.
>> SPEAKER: Thank you, German. And we have a second?
And David, I would like to go ahead and call for a vote.
>> SPEAKER: Okay.
>> SPEAKER: I think the last time we did this, you kind of went down the entire attendance sheet and asked and people gave their response.
>> SPEAKER: Sure. Just one moment, Mike.
>> SPEAKER: Okay.
>> SPEAKER: This is David. I will review the member attendance list and get responses to the proposed motion.
Ali?
>> SPEAKER: This is Ali. Can you hear me?
>> SPEAKER: I can.
>> SPEAKER: Yeah. I don't exactly follow the language here of the motion. So I'm not totally sure how to vote, I suppose.
But if it's what Tom is saying that this is a moment about renewing our opposition to agency with choice, I would say we represent the direct care workers in the participant directed model right now who are in strong support of the state's plan to create an additional choice for participants to direct their own care. I think it's a critical element of solving the workforce crisis that we're all acutely aware of, by creating options for participants and creating choice and adding an option that allows direct care workers to access health insurance. Which the currently direct care workers, 15,000 of them in the state of Pennsylvania currently have no ability to access at all.
If for that reason, the members strongly support agency of choice. We support it with a single vendor. I don't know if that's a yes or a no on this motion. I'm weighing in that's the position of the existing participant directed workers in the existing program.
>> SPEAKER: That would be a no. Thank you, Ali.
>> SPEAKER: Cindy?

>> SPEAKER: I am going to ask to abstain. I am not very involved in understanding the AWC model. So I am going to ask to abstain from a vote. I am not sure I'm well enough versed to say yes or no.
>> SPEAKER: Thank you.
Gail?
>> SPEAKER: I'm going to also ask to abstain. I am not as versed in this topic as I should be to make a decision on this.
>> SPEAKER: Thank you.
German?
>> SPEAKER: Yes, I support my motion.
>> SPEAKER: Jay.
>> SPEAKER: I'm going to abstain.
>> SPEAKER: Juanita?
Lloyd?
>> SPEAKER: If it's agency with choice and there's only one provider, it doesn't seem like choice to me. I will vote in favor of this motion.
>> SPEAKER: Thank you, Lloyd.
>> SPEAKER: Matt?
>> SPEAKER: Aye.
>> SPEAKER: I'm sorry, Matt, I couldn't hear what exactly you said.
>> SPEAKER: He said yes.
>> SPEAKER: Thank you.
Mike?
>> SPEAKER: Yes.
>> SPEAKER: Monica?
Patricia?
>> SPEAKER: Yes.
>> SPEAKER: Sherry?
>> SPEAKER: I think the language of this motion is confusing. I don't think that there's choice if there's a single agency. I support consumer choice at all levels. So whatever that means, I'm not sure. So that's where I stand.
>> SPEAKER: A yes. Thank you, Sherry.
>> SPEAKER: I apologize, Sherry. I appreciate your comments. Could you clarify whether that would be characterized as a support, a no vote, or abstention?
>> SPEAKER: I'm going to abstain. I think the language is confusing. So I'm not sure which direction it is. So I apologize.
>> SPEAKER: This is German. For clarity, my motion is for there to be multiple providers, vendors, for service. The agency with choice. Options in the region, instead of what it currently is proposed, one provider only.
>> SPEAKER: I would agree with that.
>> SPEAKER: This is David Johnson. I abstain.
And we do not have a response from Juanita or Monica. Juanita, are you on the line?
How about Monica?
>> SPEAKER: Yes. I thought I gave my response as yes.
>> SPEAKER: Thank you, Monica.
Okay, Mike, that should conclude the vote here.
>> SPEAKER: What do we have as a total, David?
>> DAVID: One moment. We have six votes in support. We have five abstentions. And we have one no vote.

>> SPEAKER: So the motion carries.
I thank all of you for the discussion and input into this motion.
I want to go to our next agenda item on the meeting.
Living independence for the elderly, the LIFE program. Jonathan Bowman from OLTL.
>> JONATHAN: Good morning, everyone. Thank you for having me here today. I am with the office of long term living bureau coordinated and integrated services. I'm the division director for the division of integrated care program. And one of my roles is to oversee the living independence for the elderly program. Also known as the LIFE program.
So today -- we can go to the next slide, please.
I am going to do kind of a one on one refresher on the LIFE program. Go over again kind of the history of the program, the eligibility, the services that are involved in the program. Touch a little bit on the interdisciplinary team. And how services are care planned. Also going to go over access to LIFE services. And explain some of the differences between the LIFE program and other programs offered by the office of long term living. And then a few statistics to show where the programs are located.
And then at the end, if there's any questions, I will be happy to answer those.
So the LIFE program has a pretty long history in Pennsylvania. The first programs were implemented in 1998. So we are well over 20 years into the program in the state.
The program is actually based on the federal program all inclues you have care for the elderly. If you do searchs nationally, it's called PACE.
In Pennsylvania, we call it the the LIFE program because when the program was first implemented in Pennsylvania, there was already a PACE program in existence through the department of aging, which is the pharmaceutical program.
So Pennsylvania was a little different and went with the term LIFE program.
And just the mission of the program, kind of what it's all about, just to wrap it up. The program existed nationally for over 40 years. First programs were piloted in San Francisco area.
But the federal regulation kind of sums it up at 62CFR, to enable frail older adults to live in the community as long as medically and socially feasible.
So this really is a home and community-based service option for older adults.
Next slide.
So eligibility for the program, this program is for individuals who are age 55 and older.
Individuals have to be determined to be nursing facility clinically eligible or NFCE for the program. This determination is done by the FED and the local area agency on aging.
They also have to be determined to be financially eligible or able to privately pay for the program and services.
So the financial eligibility is done by the county assistance office.
We do have a small percentage of individuals that choose to private pay for the program as well, which would be categorized as Medicare-only individuals.
And another one of the eligibility criteria is that individuals have to be able to live safely in the community at the time of enrollment. And this is done by the local LIFE program that is enrolling the individual. The criteria that they are permitted to use has been streamlined. It's outlined in an agreement between the state, the federal government, CM S, and the providers. So they have a specific list of criteria that they are able to use to determine whether or not an individual can be safely served in the community.
And then the last criteria is that individuals have to reside in an area that's served by the LIFE providers. As I mentioned earlier at the end of the presentation, I will show a map, and you can see where services are currently being offered. Next slide.
So the model of care is really to focus on the frail elderly. Again, as I mentioned, all

individuals in the program are nursing facility eligible or nursing home eligible.
The model the different. It integrates the Medicare and medicaid services. And funding through monthly payments. This is a captated model where each program received a monthly capation from the state and federal government. And then they are able to use these funds that they receive as a risk pool to pay for services needed by the individuals in the program.
The providers are at full financial risk for anything medically, socially, long-term services and supports, pharmaceuticals, anything needed by an individual, they're at full risk for those services.
And that's really the incentive to keep the participants as healthy as possible.
And there is really an interdisciplinary team approach to how services are managed and delivered.
The LIFE provider themselves are responsible for coordinating and managing all of the participants' health and service needs.
And this is done through the interdisciplinary team. If we go to the next slide, I will give a brief overview of what the interdisciplinary team looks like.
So on the left side of the screen in the first column there, the IDT members that are involved in developing an individual's care plan.
And these 11 members listed here are the minimum required IDT members per CMS federal regulations.
So at a minimum, the IDT must include a primary care physician, registered nurse, master level social worker, physical therapist, occupational therapist, dietitian, registered therapist, home care coordinator, personal care attendant. Even the drivers are included. The drivers providing transportation are key in identifying in there's a change in condition or a specific need that an individual may have. And then the LIFE center manager and/or director.
I want to mention that these 11 disciplines that the are listed here do not necessarily have to be 11 different individuals. Some of these roles can be held by one person. For example, if the OT also does PT or something like that. They can have the same role covered by the one individual.
And just on the right hand side, there's a little bit about care coordination. I won't read down through all of these. I want to call out there are daily update meetings. Every morning, the LIFE programs have a morning meeting with their staff and interdisciplinary team to talk about potential changes and condition, updates to care plan center needed in order to ensure that the individuals are able to remain in their homes as long as possible.
Next slide, please.
So just to go through the services that are offered by the LIFE programs, and again, these services, the specific services are determined by the interdisciplinary team and what the care plan actually looks like.
But the LIFE program covers primary care services, community-based services, acute care, long-term care, pharmaceuticals, all behavior health.
So any typical Medicare-covered services typically covered under parts A and B, they are all covered by the program. Long-term care, home and community-based services, or nursing facility services, either short term or long term, are provided by the LIFE program.
Pharmaceutical services, the LIFE programs are all enrolled as a Medicare part D provider. They provide pharmaceutical services. And behavior health services. It is a key component to the LIFE program. And all of them are in addition to the acute, long-term care, and pharmacy services, they provide the behavior health services which really helps for them to be able to coordinate care across all aspects of the individual's needs and ensure that they're cared for appropriately and able to remain in their home.

There is in-home care. The providers each are required to have a day health center. So each of the providers that operates across the state has at least one day health center where individuals are transported to and from the center. And there's a clinic, rehab services, recreational services, meals, and personal care services.
And then the providers are also able to provide services in the home as well. So they do a lot of home visits and provide home care and home health services.
Next slide, please.
So just about how to access life services. LIFE is the enrollment alternative to community health choices. This is only if it's available in the area where the individual resides. And if the individual is eligible for the program.
This is a voluntary program. So individuals have to voluntarily elect to enroll in the program. And they can enroll at any time and also choose to disenroll at any time.
And transition information that's provided, LIFE is always included. And LIFE information is also sent out to individuals who are receiving home and community-based services.
Every June, we send out a LIFE flier for individuals so that they're aware they may be eligible for the LIFE program.
And I just want to bring up a little bit about the independent enrollment broker and the function that the independent enrollment broker has with the LIFE program. Pennsylvania was one of the first in the nation, probably the first state in the nation to coordinate our LIFE enrollment through the use of an independent enrollment broker.
So our independent enrollment broker processes the enrollment for our LIFE program. To enroll in the LIFE program, an individual can make contact with a LIFE program directly. And then the LIFE provider will work with the broker to have the individual enrolled in the program. Or the IEB can refer individuals to a LIFE provider. So if they receive phone calls, inquiries about long-term services and supports, they can refer an individual to their local LIFE program if they're interested in receiving more information about that.
Next slide.
So just a few distinguishing components of LIFE. The health provider, which is the LIFE program, ensures and manages care across every setting. As I mentioned earlier, this is Medicare or Medicaid covered services. Pharmacy, behavioral health, whatever it may be, this is done by the LIFE program.
And the care manager, where you would think of a care manager in a different program, this is a full interdisciplinary team. This is a full 11 disciplines that are meeting pretty much daily to discuss their individuals on their team and the needs of those individuals, services that they may need in order to remain in their home.
So the LIFE program itself is both a provider and essentially a managed care entity who receives payment for services, provide, administration services. But they also employ individuals providing services directly to the individual. So it's a little bit different from that aspect.
And then finally, there is no limit to -- there is no benefit limitation condition relating to amount, duration, and scope of services. Essentially, there's no fee schedule for the LIFE program. There's no list of services that can or cannot be provided. It's really up to the individual's needs and what the LIFE program determines is needed in order to keep an individual safe and healthy.
Next slide, please.
So here is a map of LIFE services across Pennsylvania. Pennsylvania is one of the largest PACE programs in the nation, both with number of individuals enrolled in the program and geographic service area that we offer services in across the state.
So here you can see we have services in quite a few -- most of the counties across

Pennsylvania. And we are working to ensure that there's enrollment option into the LIFE program in the counties that are currently not being served. We just posted a notice in the Pennsylvania Bulletin for interested applicants to apply if they're interested in becoming a PACE organization or LIFE provider in those counties. So areas not colored in, they are the areas we are currently not offering services, but hopefully soon we will have services and LIFE as an option in these counties.
Next slide.
And again, this is just another version of that map. There's red dots on the map. I'm not sure if you can see that. That's actually where the centers are located. As I mentioned before, every LIFE program is required to have at least one day health center in their service area where individuals can come to the center for services. That's what the red dot is on the map there.
And this is a population density map. So just want to call out also that Pennsylvania was one of the first states in the nation to offer a rural PACE model. So we offer PACE services in very rural counties. And we have done so successfully.
Next slide.
And just some more numbers here. Pennsylvania, as I mentioned, one of the largest PACE networks, programs in the nation. We have 19LIFE provider organizations in 54 counties out of our 67. And we are working to have LIFE services available in all 67 counties.
We have over 60 centers, which were the red dots in the previous slide.
And we're currently serving 7,800 participants in the program. Which is small compared to some of our other programs, but nationally, we are one of 32 states that offers the PACE program. And the 7, 800 individuals are over -- I think they're around 15% of the PACE participants served nationally. So we have a pretty large share of the PACE participants nationally.
Next slide.
So this is just some resource information if you're interested in learning more about the LIFE program or want additional resources. If you go to the department of human services website and type in the key word life, it will bring you to the life website.
Also, the Pennsylvania LIFE provider alliance has a nice website where you can locate a LIFE program. Their information is there. The national PACE association because this is a national model. They have information on their website as well.
And then obviously, CMS because the program is under federal regulation. CMS has plenty of information on the program as well.
So I think that was it. I can take any questions if there's any questions.
>> SPEAKER: Any questions from the committee members? Audience members? Thank you for the presentation, Jonathan.
>> SPEAKER: Hi, Jonathan. Thank you for the good presentation. This is Lloyd.
I wondered about the financial responsibility on the part of the commonwealth for the individual enrolled in the LIFE program versus the CMC program through an MCO.
>> JONATHAN: Okay. I'm not sure if I fully understand your question. Are you asking the cost difference? Or are you asking about the oversight?
>> SPEAKER: If you have an individual who is enrolled in an MCO, which is part of the CHC program, there's a certain cost for that individual based on the contract that you make with that MCO.
In the case of an individual enrolled in the LIFE program, what is that cost? And how does it compare with those in the CHC programs?
>> JONATHAN: So I can't speak to the actual cost difference. The way the LIFE program is set up, the rates that are paid to the PACE organizations or the LIFE providers is outlined in

the state plan. And we have two capitation rates paid to the LIFE programs on a monthly basis for every individuals enrolled in the program. Those rates are for dual eligibles. And the other rate is for Medicaid only individuals.
Every individual, regardless of -- if they're a dual or medicaid only, they receive the same payment to each provider every month.
So we don't pay based on individual acuity or individual status. Every individual receives the same rate.
>> SPEAKER: Is it cheaper from the Commonwealth standpoint --
>> JONATHAN: Oh. No, but I can say that the LIFE program, the federal requirement is that we have to provide justification for a PACE organization to operate in a state that at that cost would otherwise be -- the costs are less than would be otherwise served in a different program.
>> SPEAKER: But it is a per member, per month.
>> JONATHAN: It is a PMPM, correct.
>> SPEAKER: I think, and Jonathan highlighted this, Lloyd. This is Jamie. The LIFE program is the provider and the payer. So they're actually providing services to the members and reimbursing the services that they don't provide.
In CHC, it is a managed care organization so they contract with providers. It's slightly different. Obviously, providing similar services, but different models.
>> SPEAKER: Okay. If the LIFE program closed tomorrow and all the individuals had to be served under the CHC-MCOs does the cost impact to the state go up or down?
>> JONATHAN: I don't know that.
>> SPEAKER: Okay. Thanks.
>> SPEAKER: Can we find out that answer? I would like to know that answer. Not now. But a follow up.
>> SPEAKER: We can follow up. And obviously, LIFE is an all inclusive model. We would have to take into account the -- services. Because -- it's harder than to just say capitation to capitation. We don't know the plan they would choose. There's many factors.
>> SPEAKER: Thank you, Jamie.
>> SPEAKER: Hello, this is David Johnson speaking. Thank you for your presentation.
We have heard from some long term care that the transition from a LIFE program to community health choices or the opposite can be a bit difficult. From the office of long term living's perspective, what is the responsibility of the independent enrollment broker to help ensure there is a smooth transition, particularly from a LIFE program to enrolling in a CHC plan?
>> JONATHAN: The independent enrollment breaker are responsible for making sure the eligibility are met.
And they are responsible for obtaining the individual's care plans so they can pass that on to the gaining MCO.
One of the complications that we do deal with in the transition process is the federal guidelines and dating rules around the enrollment and disenrollment time line. So the LIFE program in federal regulation only allows individuals to enroll on the first of every month and disenroll at the end of every month. There is timing issues that we need to work through in coordinating some of the transition. Which I think a lot of times ends up being one of those points of contention when an individual either wants to leave or move to the provider. They are versed in that and works with the individual to ensure a seamless transition as possible. And either enroll or disenroll at the appropriate time.
>> SPEAKER: Appreciate that. I was unaware of the federal regulations. I can appreciate it might be a case by case basis. If I'm not mistaken with community health choices plan

transfers requested before the second day of the month would go into effect -- and after that, the month after. If a benefit period of a LIFE program contacted the IEB toward the end of the month asking for a transition, what would be typical? Or what would be communicating given the federal regulations and disenrolling from the LIFE program at a certain time?
>> SPEAKER: This is Randy from the office of long term living.
The first part of the question there's no set date in the month in enrollment in CHC. There's a formula for that. It's usually the second week of the month you get the request in and you're good for the first of the next month, if it's later.
And we also in CHC have the ability to expedite an enrollment. We can expedite that if we have to.
Under the LIFE model, it's a little bit different. We are locked in to the first of the next month. We have had a number of participants that come to us on the 30th of the month and say they want to disenroll from CHC and go to LIFE tomorrow or vice versa. We try to work with that. But sometimes there might be a gap in the services until we can get everything done.
>> SPEAKER: Understood. And I appreciate the clarity on CHC plan changes. It sounds like it's a case by case basis and the IEB communicates and do what they can. But if there are missing component parts, I guess the application or the requirements that could cause delay, I imagine.
>> SPEAKER: Yeah, it could. If the person is coming out of one program into another, we need to make sure the services are appropriate. The LIFE program has an extensive number of assessments to make sure that people get the services they need. We always try to encourage people that are currently in the LIFE program, if they're looking to move out of the program, they do it. So there's a time period to make sure there's other services in place. Same way with CHC. We try to do that.
And we have different things of continuity of care that they're supposed to provide services. We work on the continuity of care plans to ensure that people get services and get the program they want to be in as soon as possible.
>> SPEAKER: Last question. I really appreciate this. Would it be possible to get data -- is it -- data surrounding the length of time from transfer request from LIFE to CHC? And whether any exceed, I guess, a month period? Would that be possible data to get from the IEB?
>> SPEAKER: We can ask them. If you will send a request in, we will take a look at it. I'm not sure what they would have. We can take a look and see if we can get a request date and a transfer day.
>> SPEAKER: Great. And I can follow up by email with a more specific question. Thank you very much.
>> SPEAKER: That would be great and make it easier for us to know exactly what you're asking for.
>> SPEAKER: Thank you.
>> SPEAKER: Lloyd again for Jonathan. Do you have an estimate of the percentage of individuals enrolled in a LIFE program who receive behavioral health services?
>> JONATHAN: I do not. We can get that for you. But I don't have that number.
>> SPEAKER: Okay. Thanks.
>> SPEAKER: Great. Any other questions from committee members or the audience members for Jonathan? Randy?
>> SPEAKER: Mike, I have a question through chat.
>> SPEAKER: Go ahead.
>> SPEAKER: Jonathan -- data on the numbers of people who have switched to CHC and vice versa, perhaps --
>> JONATHAN: I think we can get that.

>> SPEAKER: Great. Thank you. Is there anything else, Paula, in the chat?
>> SPEAKER: That's all I have in chat, Mike. Thank you.
>> SPEAKER: Any other questions for Jonathan?
[Indiscernible]
>> SPEAKER: They sometimes do. They are asked. Because this is a voluntary program, individuals have to voluntarily enroll and voluntarily disenroll. They do that through a signature on the disenrollment form. Sometimes they will list a reason for disenrollment, but not always.
>> SPEAKER: Can you give us an idea of what the reasons are?
>> JONATHAN: Sure.
>> SPEAKER: As far as transitioning from CHC to LIFE, I'm not sure we collect reasons on that. I can ask. And we would probably tell you three or four things right now of what the reasons are. But we can go back and take a look and see what the top three are.
>> SPEAKER: Thank you guys.
Any other questions for Jonathan or Randy while we have them? We have them held hostage here.
Thank you guys.
Next on the agenda is the overview of OLTL HUTenned security sites.
>> SPEAKER: Good morning. This is Jennifer Hale in the office of long-term living. Janice is out unexpectedly today. So I am going to do my best to cover the material on the home and community-based settings final role.
Next slide, please.
Just as a matter of quick background, I think we have talked about the settings rule many times in this committee. In January of 2014, the centers for Medicare and Medicaid services issued a new rule that established requirements which detail acceptable qualities and characteristics of settings for Medicaid home and community-based services. Primarily provided or only provided under the 1915C waivers.
The rule established cry tier at that to evaluate settings in which home and community-based services are provided.
The CMS rule was effective on March 17th, 2014. And originally required states to demonstrate compliance by March of 2019 due to the public health emergency, the CMS extended the due date for compliance to March of 2023.
Just quickly again, a little bit more background. The purpose of the rule was to ensure that home and community-based service settings are integrated into the community as an alternative to institutional care. And to ensure each service or setting is home and community-based, not institutional. Each service setting location must be integrated in and support full access to the greater community. Be selected from and among a variety of service setting options. Optimize autonomy and independence in making life choices.
Next slide, please.
Facilitate individual choice in selecting both services and service providers. And ensure rights of privacy, dignity, and respect and freedom from coercion and restraint.
So next slide, please.
CMS did outline in the final rule and also in subsequent guidance that they have issued that the following are presumed to have institutional characteristics. And those would be settings or services located in a building that is also a publicly or privately operated facility that provides in patient institutional treatment. This includes intermediate care facilities, nursing facilities and hospitals. Also, services and settings in a building located on the grounds of or immediately adjacent to a public institution.
And lastly, any other setting that has the effect of isolating individuals.

Next slide, please.
So just a quick recap of OLTL's overall approach to compliance. OLTL did conduct provider self-assessments. And then the OLTLQMET teams conducted follow ups. Some of those follow ups included the QMET site assessments. OLTL developed a tool to use for each provider site in a category to be reviewed.
And just a quick note, the standard tool was recently provided as part of the state-wide transition plan that was released for public comment. So if interested stakeholders want to take a look at that tool that is used by the QMET to assess clients at each site, it is public. It is on the Department's website. And it is part of the statewide transition plan.
The tool was used to review the provider's physical site. And also included a review of the provider's policies and procedures.
And we also developed an OLTL final rule panel to coordinate the review of findings.
And then the QMET teams followed up with providers to ensure that any findings were corrected through a corrective action plan.
Next slide, please.
This slide is just in addition, this is also -- most of this information is included in our statewide transition plan. We did adjust our provider enrollment application to include questions that capture requirements in the rule. So any new provider interested in ruling with OLTL has to meet that criteria.
That information is also part of the statewide transition plan. It was included after public comment as part of the statewide transition plan. So the public has an opportunity to review the questions that OLTL is asking at the time of enrollment.
We also established an email resource account for providers, participants, stakeholders, advocates, and others to communicate with us on sites that they feel may not be compliant. Or ask any questions about site compliance with the settings rule.
Next slide, please.
So I think the main focus of today is as we are nearing the final stages of demonstrating compliance to CMS, we have identified those OLTL HCBS sites that need to go to CMS or be submitted to CMS for heightened scrutiny. Because they fall into one of the CMS categories of having the presumption of institutional characteristics. So those categories that I mentioned earlier.
Just to review kind of the process for heightened scrutiny, we did issue a bulletin in December of 2021 that outlined the heightened scrutiny process.
OLTL's QMET conducted on site or virtual assessments of each provider site where three or more participants live or receive the services. This included an in-person or virtual inspection of the site, a review of the provider's policies and procedures, and direct observation of services when possible.
Each site was then submitted to the OLTL final rule panel for approval. Sites that had components that were out of compliance worked through a corrective action plan. Once the corrective action plan was approved by the final rule panel and the panel agreed the site fell into one of those categories appropriate for heightened scrutiny, the provider was sent a letter giving them the option of working with OLTL through the heightened scrutiny process.
And just a quick clarification so that everyone understands. Providers that were identified for heightened scrutiny and went through the process that I outlined have been determined by OLTL and the panel to meet the requirements that are set forth in the final rule and believe that they can overcome the presumption of being institutional like. Except for obviously they are in one of those physical locations that is unallowable by CMS.
So when we submit for heightened scrutiny, we are submitting and attesting to CMS that we have reviewed those sites, we believe they meet the rule, and we're providing evidence to

CMS that indicates why they meet the final rule criteria.
Next slide, please.
So right now, we do have our sites out for public comment. You can find them on the Department's website. We have identified nine home and community-based providers that are appropriate for heightened scrutiny. Of those nine providers, six are identified because they are in a building on the grounds of an institution or actually in the institution.
All six of these sites are adult-based sites.
Three are found to have the effects of isolating due to provider's location and components of the service provision.
Two of these sites are residential habilitation sites. And one is a -- we have on the department's website provided a summary of each site. And the link is provided here. In that summary, it has the expected outcome, the questions as part of the QMET survey tool. And then the evidence that the Department has in terms of submitting to CMS.
So during this time, we are asking for public comment. We would like very much to know if people are in support of this site or there are concerns that maybe that we're not aware of that we need to be aware of.
There is a comment form on the website. So interested parties can provide comment on the standardized form.
Next slide, please.
So this is just information on the public comment period. We are asking for all public comments to be submitted by December 19th.
And then there are multiple ways to provide comment. They can be submitted writtenly. And the information on where to send those is here on the screen. And they can also be submitted via an email account. And that email account is also here.
Next slide, please.
The last thing I want to mention before we get to the resources page or slide is I believe it was in July of this year that CMS conducted a webinar on their kind of recalibrated strategy for compliance with the final rule.
And during that webinar, they provided information to states on the ability to request a corrective action plan. So this slide is just letting you all know that Pennsylvania has submitted a request to CMS for corrective action plan. We have not received any kind of approval yet. Our request was acknowledged by CMS.
And what we -- we did that because we wanted to ensure any additional time for review and approval of all of the heightened scrutiny sites that we will be submitting to CMS.
So we don't anticipate the need to close any sites at this time. Which would cause participants to be moved. If any sites are not approved by CMS for heightened scrutiny, OLTL will work with participants to choose an appropriate alternate site.
At this time, again, we don't anticipate that happening. And as a precautionary measure, we did submit a request to CMS for a corrective action plan just to ensure that we have any additional time it takes. Because again, we have to submit these sites for heightened scrutiny. And we want to allow them the time to review and approve.
And then last slide is just information on where you can find the final statewide transition plan. It's also located on the same site as the sites for heightened scrutiny.
And then just some links to the CMS guidance regarding the final role.
So I think that's it for my presentation. Again, just kind of wanted to give an overall summary of where we are at with heightened scrutiny and letting members of the committee know that it's out for public comment.
I'm happy to take any questions or comments at this time.
>> SPEAKER: Thank you very much, Jenn.

Any questions, comments for Jen n from the committee members or audience members?
>> SPEAKER: And if there are any questions or comments, feel free to email the RA account.
>> SPEAKER: Okay. You have the contact information. And thank you very much, Jenn, for stepping in and doing a great job on that part of the presentation. We appreciate it.
>> SPEAKER: Absolutely happy to. Thanks, everyone.
>> SPEAKER: Yep.
And next on the agenda is the electronic visit verification update Q and A with the CHC-MCOs. Looks like Pennsylvania health and wellness, AmeriHealth Caritas, Keystone First, and UPMC.
So Pennsylvania Health and Wellness, you're up.
>> SPEAKER: Good morning. This is Cynthia parker with Pennsylvania health and wellness delivery systems operations director. Thank you to the OLTL team on the webinar and those there in the Honor Suite.
We attempted to provide a high level overview based on the questions presented to us by OLTL. If you go to the next slide, I will get started.
Our policies. PHW EVV personal policies. Our main policy execution is about identifying common EVV errors. That's a big of a bread crumb trail for us. Not only does it allow us to communicate effectively regarding the services and those needs for corrections or when providers out of compliance, it also alerts us to those instances where we might be alerted to prevent fraud, waste, and abuse.
Of course, most of the providers are compliant. And tend to be corrected easily with effective communication.
What we look for, overlapping services. Services that cross. Utilization of an unauthorized phone number. There is a phone number that is part of the profile. And that is the number we're expecting to be utilized for services.
Service delivery and an unauthorized location. The location of services is part of the overall profile that can be changed from time to time for different reasons. But we look for those to align.
Overlapping claims that coincides with overlapping services, of course.
Other exceptions where the claims do not meet the business rules.
And most instances, we're expecting a clean claim. What that means is we don't have provide any follow up, missing information, or third party contact.
So we look out for that as well.
Noncompliance enforcement is most effective through reporting. So the first piece is to receive effective reporting. And then we can then provide due diligence for noncompliance enforcement.
Next slide, if you would.
Our experience. This was the question on lessons learned. Our EVV experience. So I reached out to some of the people closest to the actual process. And I got a consistent message.
Frequent communication is the key overall. Frequent communication of the EEV standards in place.
Those key elements are the type of service performed. That should be straight forward. Individual receiving the service, participant, date of service, when the services were provided. Location of the service delivery at the established location on the profile. Be it at the home of the participant or at another designated location within the community. Individual providing the service. The time the service begins and ends. Notification of missed visits or missed services. And that's very important. Especially for compliance purposes.

And the need for continued education. Not all agency model providers comply with the basic documentation requirements. There again, we have to enforce communication. We give that at the plan level in instances. And we also get that support from HHA, our EEV intermediary.
And then the questions presented specifically. What happens if the GPS KOORD NANTs are in the community when the shift starts and ends? I'm sorry. But that there is a participant wants to start.
I didn't read that properly.
What happens if the GPS coordinates are in the community when the shift starts and ends, but where the participant wants to start. I'm not sure. I think we have a typo. But the answer I am sure of. If the address is other than the address in the member's profile that is registered when the shift starts and ends, we cannot link to the visit if the address is different than what is in the profile.
However, though, the agency does have the flexibility of adding a common community start and end location. They would call in to HHA and make the change within the member profile. So there is an option there.
Next slide.
What happens if the participant does not have a land line, only a cell phone, and the direct care worker does not have a cell phone?
HHA does offer the FOB service, which is basically fixed object device is the acronym. The FOB device is an option in these cases.
The intermediary HHA would bill the MCO for the FOB device. And that would be used as an alternative. There's a very small fee. That is a service executed pretty infrequently. But it is available as an option.
Okay. Are there any questions?
>> SPEAKER: Any questions from committee members? Matt?
>> SPEAKER: Just on the -- I don't know, A or one on your slide.
>> SPEAKER: I'm sorry. I could barely hear you.
>> SPEAKER: What is a common community location?
>> SPEAKER: It could be a church. A home of someone else that is related to the individual or a close friend. A place that might be frequented. But it could be another place within the community. It could be registered in the profile. Could be a community center.
>> SPEAKER: Anywhere the participant wants to be?
>> SPEAKER: As appropriate for the services, yes.
>> SPEAKER: I'm curious about the phrase common. It makes it sound like it's approved. Do you know what I'm trying to ask?
>> SPEAKER: There is freedom of choice. It would be an appropriate setting for the services, right, it would have to meet some kind of criteria in terms of cleanliness, location, safety within the community. But yes, there is freedom.
Does that answer your question? No?
>> SPEAKER: Other questions for -- great, thank you.
>> SPEAKER: Yes, sir.
>> SPEAKER: Next up, AmeriHealth Caritas, Keystone First.
>> SPEAKER: Good afternoon. This is Frank, director of plan operations. Can you hear me okay?
>> SPEAKER: We can hear you great.
>> SPEAKER: Great. Thank you for the opportunity to present today on EVV or electronic visit verification. I will be presenting on some of the lessons learned and also addressing those two questions that were posed to the CHC plans.
Next slide, please.

Thank you.
As I'm sure most of us know, as of January 1st, 2021, personal care services were subject to EVV or electronic visit verification. That included personal assistance services, respite, and participant-directed services.
As of January 1st of 2023, EVV is scheduled to be required for home health care services. These services were identified as audiometry services, diabetes, training, home health aid, licensed practical nurse, and registered nurse services.
Preand post natal assessment and monitoring. And your therapies, your physical therapy, occupational therapy, speech therapy services.
As we talk about lessons learned, and as PHW said, I spoke to -- and one size for EVV does not FUT all. There are diverse communities and stakeholders that are involved in the various aspects of the EVV process.
For example, you have rural versus urban stakeholders, agencies, et cetera. You have small providers versus larger providers who may have more band width with things like technology. You have different language and cultural differences in the participant population, et cetera.
Another lesson learned or challenge is it really goes beyond claims. EVV touches many aspects of the community health choices program and requires subject matter experts or expertise from various functional areas of the organization. It's not limited to claims, encounters, your information technology or IT, special investigations unit, provider relations, and service coordination all use or have a stake in EVV, each functional area has a focus and input into the success of EVV.
We also are working with multiple entities and/or systems to validate data and determine the root cause of the rejections. And that has created challenges that are and must be addressed.
And timing is everything. The timing of the receipt of EVV and claims data needs to be aligned with HHA, sand data, and the MCO.
And there are nuances to consider. Address, place of care issues, phone issues, early or late or missed clock ins and clock outs, et cetera.
Thank you.
And these are two questions very similar to the answers that PHW gave.
What happens if the global positioning system, GPS coordinates are in the community when the start shift end date that is where the participant wants to start. If the address is not listed in the participant's HHA profile, the EVV clock in or clock out will not link to the visit. The personal assistance service or PAS agency provider will need to determine if there is a frequently used address. And I actually had the word common in here, and we changed that. But if there is a frequently used address or location in the community where the direct care worker starts or ends their shift, the agency/provider can add that community address to the participant's profile in HHA exchange. Which allows the PAS agency or provider to link the EVV clock in data to the visit.
If it's an infrequently used address, the agency or provider can manually confirm or add that visit in HHA.
And what happens if the participant does not have a land line, only a cell phone and the DCW does not have a cell phone? Similar to PHW's answer in this case, the managed care organization can facilitate for a FOB device to be utilized in the participant's home.
The DCW presses the FOB button to generate a unique code or token ID for each clock in and clock out.
The DCW needs to submit that code or token ID for the clock in or out when they are next able to call in that visit information to HHA.
Alternatively, the PAS agency provider can call in that token information to HHA.

Thank you. And any questions on my slides?
>> SPEAKER: Thank you for the presentation, Frank. Any questions for Frank from the committee members or the audience here?
Thank you, Frank.
Next up, UPMC.
>> SPEAKER: Hi, everyone. Can you hear me okay?
My name is Josh. I work with UMPC's network department as a senior manager of LPSS services. I'm here to address the two questions. I appreciate you having me.
So as an overview, UPMC health plan follows the PA department of human services general guidelines and bulletins and everything online as a resource.
And then a point here is that we also do have our own provider manual. And that is the link. Unfortunately, it said UPMC health plan. I will be happy to provide that and my number.
And the additional details are posted on the portal for the providers part of participating with their number.
And UPMC health plan collaborating on the monitoring through the following processes. Network oversight. Providerer monitoring oversight. Fraud waste and abuse monitoring. It's a team approach.
Participants are able to receive personal assistance services in the setting of their choice. Probably the most important slide I have here. Obviously, barring program exceptions, which include hospital and nursing facility, unapproved out of state travel and out of country.
The providers are encouraged to service participants at their choice of setting as identified in the PCSP, regardless of the exception status of the EEV visit.
To answer the question regarding the start and end in the GPS piece, if a visit begins and ends in the community in a location, this is a location that's not identified as a primary residence in the system of record. This is generally our internal case management system. The encounter is regarded as noncompliant. Manual exception to the DHS, PCS bulletin. Any circumstances the GPS location, the start/end location is recorded on the smartphone, it will not align with the customer's service delivery location. That's the approved point of care.
Next slide, please.
Providers should maintain a current EVV policy. So this is really just a best practice slide for our provider population. The best practice, the care giver should revert to recording the missing EVV visit and encounter details in an alternative format, which should be signed by the care giver. And notify the exception and the administrator should notate the exception in the EVV platform of record.
And providers should outline the action steps for applicable stakeholders to verify the exception and ensure proper recordkeeping.
Noncompliant manual exceptions to EVV are factored into the ago congratulate EVV compliance percentage we monitor on a quarter basis. A simple example of this is a provider performs 100 visits per quarter, 25 being noncompliant manual exceptions, the provider is considered 75% EVV compliant.
Obviously, we're still paying the claims if the documentation supports that particular encounter. But we review this from a network perspective on a quarter basis. We're looking for an EVV compliance threshold of 50 or more.
And we will begin asking for corrective action plans effective 1/1/2023.
A secondary service address can be added to the participant -- basically, the nonprimary location. So we can add and will add additional locations. We would like those requests through providers. And we want to obviously engage the participants. We want to add them to the dialogue here to add the secondary locations.
Next slide, please.

Similarly, additional land lines can be added for services received at locations other than the home, the primary service location. And providers and participants can request these using the same process in the previous slide.
Audit and monitoring process for GPS coordinates. Just a point here that allowances are made for GPS coordinates in the community, as long as the marked tasks and duties correlate with the services outside of the home. This is more of the auditing process internal or special investigations unit team.
They will be looking at those encounters to ensure, for example, the care giver clocks in with the GPS coordinates in the community, for example, pharmacy, the task duties include shopping or transportation. So something that actually corresponds with that encounter.
If the care giver clocks in with the GPS coordinates outside of the home and all of the mark task duties are home based, for example, vacuuming, we would not accept and seek recovery.
So basically, you know, if you're in the community, a community task --
[Indiscernible]
Often situations where the GPS coordinates outside the home are identified by monitoring and audit teams.
These teams take into consideration the participants' address HIS, possibly tied to the prior address causing mismatch after care giver and participant pins.
EVV policies for providers incorporating a land line mode should establish a process for establishing the participant's phone type. This is best practice. Ideally no less than the new intake and annually. Providers are advised to closely monitor the land line, ensuring that interactive voice response, call in, call out associated with the visit are initiated at a land line as the registered locations only. It's put on the providers to ensure these are done properly.
Care GIRs should be advised to provide notification captured back to the provider.
If the participant only have a cell phone and the care giver does not have a cell phone, they are entered as manual visits and regarded as noncompliant, again, for the PA bulletin.
Providers should revert to record the details. And I stress here, the skill, type, and duration frequency of the service delivery as a legible format. They're reverting to using time sheet, having the care givers sign off on those.
And I stress the scope. We have a lot of providers not providing us the scope details. This is a record reported for that particular encounter.
Next slide, please.
Here is a picture of the FOB device. This is the HHA's variant of the device.
We do obviously allow the fixed object devices if you have a third party system. But if you're a provider using the free version of the HHA system, we can have you request those through providers. Again, these are in the primary point of service to a fixed location. And pretty simple to use. You use a cell phone or land line. And use that particular number and you can report out those.
Next slide, please.
This is just a rehash of what we mentioned. Noncompliant manual exceptions not added to the EVV compliance ago congratulate total.
And audited monitoring process for the acceptable methodology. The provider monitoring team refers to providers back to the waiver citation. And the provider monitoring team must validate a PAS visit to ensure the location of the visit. This is a reminder that our provider monitoring team will obviously review this stuff during their every two year monitoring visits.
Next slide.
Lessons learned. Providers consistently indicate that the participants no longer have a land line or PAS agency employeeing the care givers do not have smartphones. Make sure you

have a good policy on hand and that you're training the care givers to the best of their ability to use those modes properly.
Providers often do not realize the care givers must mark the duties of the visit. This goes back to the scope. A lot of systems allow direct entry into those. If yours doesn't, you have to record scope of work still.
In some cases, providers indicate they're following the plan of care in place after the most recent assessment.
And often care givers are indicated as working long hours on a consecutive basis. Some care givers indicate working 19-plus hours a day, seven days a week. Make sure the policies align with allowing the processes. What I have seen through general monitoring is providers with good policy often do the best at recording those higher averages.
Next slide, please.
Any questions?
[Indiscernible]
>> SPEAKER: Speak into the microphone so everybody can hear you.
>> SPEAKER: 75% of the visits are in the community. You're issuing a corrective action plan to the provider, correct? What are they going to do about me wanting 75% of my visits --
>> SPEAKER: The providers -- the threshold is relatively low. It's greater or equal to 50%. If they're under the 50% threshold, which does happen, don't get me wrong. It does happen. So we're looking at the providers on a quarterly basis to ensure that they're doing the best they can.
And then the managed care organization and the data per the bull Lynn, to engage the provider, educate them, and figure out what's going wrong. And potentially issue a request. Because they have to follow that mandate. It's a requirement now.
>> SPEAKER: I'm sorry. Can I interject here a minute? In order for the captionist to record the questions and the answers, if we could speak into the microphones. Because we're not capturing the conversation. Thank you.
You're right, Matt. All mics can't be on at the same time. And if we have a problem hearing the question, it might be to repeat the question before we provide the answer. Thank you.
>> SPEAKER: We're looking at that -- so it's not an individual participant. We understand there are going to be exceptional situations that would require, obviously, a special look at that situation. These are aggregate numbers. Your provider would have multiple participants. And those exceptional instances would be in compliance percentage.
>> SPEAKER: One more question. And I saw the thing about if you're in the community and at the drugstore, you should have in your care plan shopping or something like that. I mean, I noticed that -- I assume the care giver is doing the same thing. At the end of the shift, they just check all the boxes. I shopped. I went to the moon.
>> SPEAKER: That is a very good point. We ask obviously these encounters are indicated as accurately as possible every individual time. We don't want them to check all the boxes just to check all the boxes. We want them to specify what was done for the participant at that given visit.
>> SPEAKER: I'm just saying that doesn't happen. In my experience, they just check everything.
>> SPEAKER: John?
>> SPEAKER: I want to wait until everyone asked questions of Josh. My questions have nothing to do with the specific MCOs in the state currently. My questions have to do with Pennsylvania's policy on EVV.
The regulation that Josh cites and many others have cited. I think we need to take a second look at that. Or a third look or a fourth look. Because it's not working.

Pennsylvania is one of 15 states that say consumer cell phones cannot be used for EVV. There are 22 states currently who allow for consumer cell phone usage to record EVV clock in and out. And then one state that in March will be implementing consumer cell phone usage for EVV clock in and out.
Some examples include Arizona, California, Delaware, Hawaii, Illinois, Indiana, Louisiana, Maine, Maryland, Minnesota, Mississippi is the one that will be coming online in the spring of 2023. Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oregon said you must use a cell phone. Utah, Washington, and Wyoming.
These are states that currently allow the consumer to use cell phones as device to record their EVV clock in and clock out.
I want to -- I just want to go on record, again, as saying last meeting I asked that we examine this policy. I did receive, and I'm sorry that she's not here, I did receive an email from Jamie saying that she was working to get the program offices together. I wanted an update on that today. Doesn't look like I'm going to get it.
But I really -- I think that we need to look at this policy as it relates to discriminating against people with disabilities and their ability to move freely in the community where ever they choose to go.
You know, we have been a leader in home and community-based services for decades. And I think this policy holds us back.
I do want to make a comment about the FOBs. Because I am, and I think many others in the disability community are, opposed to the FOBs because they forced the individual to start and end their shifts at the place of residence. And that does not give people the flexibility to live the life that we wanted home and community-based services to enable to us to do.
So I don't know if anyone who is currently here from OLTL, I guess Randy, I'm looking at you, has any update for me on the conversation between the program offices. But I really do feel that if we have that discussion, it needs to include -- it needs to include a member from the provider community. But also, a consumer of services so that our lives can be explained in detail on how the system really works and holds many of us back.
>> SPEAKER: Yeah. I will go back and check to see if the meeting has been set up between the multiple program offices. Your points are very valid. We will go back and have that discussion.
>> SPEAKER: Should I expect an update from someone?
>> SPEAKER: Yes.
>> SPEAKER: Yep. Paula, could we make sure that we have an update for Shauna in the next meeting?
>> SPEAKER: I will get an update before that.
>> SPEAKER: Thank you.
>> SPEAKER: This is Jeff from Pennsylvania SILC.
With the home health care provision of EVV going into effect January 1st, 2023, a little over three weeks from now, is there anything that providers and consumers should expect to see or do differently briefly? I haven't heard anything as far as congress doing any changes or anything like that for states. I don't know if you can offer any comments or follow up with an email on that.
>> SPEAKER: We did send that out, yeah. We confirmed it? Okay. We will check on when the ex-tense will go out. Extension from 2023 to 2024. We'll check on when we will send a list serve out about that.
>> SPEAKER: Thank you.
>> SPEAKER: Thanks.
>> SPEAKER: Just very briefly piggybacking on Shauna's comments about the EVV and

Pennsylvania not allowing the use of the consumer's cell phone as a point of clock in or clock out.
As OLTL form lates a policy around this, they really should look at the community integration language of title 2 of the ADA. And in particular, OMSTED. You know, our civil rights for people with disabilities under the ADA guarantee us to participate in all aspects of the community, not one location versus another location.
Imagine the lives of people who are able to bodied having to report where they are or common places of interest. It's absurd. And we really need to update that policy. It should be a community integration mandate under title 2 of the ADA. And it's an easy policy to fix: I mean, all the states Shauna cited are ahead of us. Let's catch up. Thank you.
>> SPEAKER: Thanks.
>> SPEAKER: Hi there. This is Elizabeth Vaughn from OLTL. I wanted to speak to really quickly some of the EVV questions.
Like Jenn mentioned earlier, Janice is out of office today. So she would be able to give a better idea about the policy side of that.
But I did want to just mention a couple of things.
The first is the reason behind our policy of the use of a land line. I can't speak to what other states are doing, but I know that the reason that a land line is required for Pennsylvania is that CMS requires location for the capture of EVV visits. If location is not captured, then that visit is not compliant with what CMS mandates for EVV.
And because GPS coordinates cannot be captured with a land line, the idea behind that is that if there is an address that is associated with that land line, then that fulfills that CMS requirement.
Like I said, I'm not sure how other states are kind of getting around that. Or how they are basically making sure that they're compliant with that location requirement. I can take that back to our EVV steering team to see if there's maybe any way that we can communicate with some of those other states.
But as of right now, that's not something that we are going to be able to change easily.
And then the other thing I wanted to mention was that OLTL was granted -- I apologize, DHS was granted the good faith exemption from CMS for home health care services. And that communication with details should be going out any day now. It's just been held up with making sure all the language is correct.
And then I apologize, I forget what the other question was. If any other EVV questions come in, I might be able to assist in answering those. Thank you.
>> SPEAKER: Thank you. Shauna?
>> SPEAKER: I forgot one thing. And I will say that and then I want to respond to something that the person who just spoke said.
Until we get this committee together to figure out how we're going to implement this new EVV policy, and I want to remind you that this started because I have done research and I have 177 consumers that don't have land lines. And in some of our areas, our attendants don't have adequate cell phones or adequate cell phone coverage to be able to use the app. So that's what started this.
My next point is that until we figure that out, could OLTL ask that the MCOs suspend enforcement of the collection of money from providers because we may have a situation where our consumers don't have a physical land line or have voice over Internet phone service, which is not considered a land line. It may be plugged into your house, but it's not considered a land line.
So I'm asking that OLTL consider suspension of the collection of money from providers. Because we're at a quandary. And I'm asking too that when you form this committee,

because I think -- I believe that the MCOs are just doing what the regulation requires. I'm not certain that they agree with it, but they're doing what the regulation requires.
So I'm just asking that we all come together and develop a policy that works for the state, the MCOs, the providers, and the consumers whose lives are greatly impacted.
>> SPEAKER: Thank you.
>> SPEAKER: Thanks. I wanted to lend my voice of support to the comments made. Some of the policies that are currently being enforced are tied to the home and not enough to the community. We support the use of a consumer cell phone. And in particular, I did want to clarify, I think the attention there is because often times, the consumer cell phones can support the applies that allows for the collection of the GPS coordinate.
Just a couple of quick other points. I think some of these issues -- well, let me back up.
Any policy that penalizes a provider or consumer providing services in the community should be reconsidered. That includes GPS out of range concepts that potentially, even if still reimbursement, requires a manual edit. I don't think the state has a GPS coordinate limitation. I think the state just collects the GPS coordinates and ensures there is one. Do you think if that's accurate?
>> SPEAKER: That's correct. OLTL collects -- we just collect the GPS coordinates. We don't have a specific requirement for what the location has to be.
>> SPEAKER: Right. That would solve from a provider and consumer perspective if that could be eliminated and eliminates a lot of the negative compliance issues. It's a matter of making sure you're collecting it and would allow for a consumer cell phone to be used and clock in and out in the community when appropriate and desired by the consumer.
And one other thing. We get this request all the time or comment all the time. I think providers and consumers would also be greatly benefited by increased support from the plan, the state, the service coordinator perspective to make it clear to all participants that EVV compliance is a federal requirement, a system requirement, and that sort of going from one agency to another or one plan to another is not going to solve that problem. It's a requirement that exists.
Thank you.
>> SPEAKER: Thank you, Terry.
I think we have already slid into our next agenda item, which is any additional public comments. Paula, I want to ask you, do we have anything in the chat that we need to address?
>> SPEAKER: I do have two questions in the chat for UPMC.
>> SPEAKER: Okay.
>> SPEAKER: The first question, is there a reason that UPMC only contracts with MAGA agency only and refused to contract with small home care agencies?
>> SPEAKER: I think that's a question that probably needs whoever the questioner is for UPMC to reach directly out to them. I'm not sure that's something we want to discuss openly here.
>> SPEAKER: And the second question is is UPMC giving out -- a message for EVV compliance?
>> SPEAKER: I can't discuss the specifications. But we have a value-based program that does promote adherence to the compliance.
>> SPEAKER: Thank you.
>> SPEAKER: And that's all I have in chat.
>> SPEAKER: Okay. Go ahead.
>> SPEAKER: Hi. My name is Tommy from Clinton county, T zone MLTS. I am a CHH CHC participant. Thank you for hearing my public comment from participants.

I have a couple of questions that I am hoping to get a little clarification.
The first one is how long does it take to get a manual wheelchair after submitting all necessary documentation needed to the MCO?
>> SPEAKER: I mean, that can vary. It's something that we should work with the MCOs on. We know we're having issues getting stuff in because the supply chain is an issue. It's something that the MCO should be on top of. So I don't know -- there's reps here. I don't know if you want to talk to them. And get particular information so that they can look it up and see where you're at in the process.
>> SPEAKER: Okay. And the second question, are catheter kits, especially the self-contained, no longer covered under the CHC?
>> SPEAKER: There's been no change to any coverage under the program. If you were getting them before under CHC or your medicare plan, they should still be covered. Again, if your MCO is here, reach out and talk to them.
>> SPEAKER: Okay. Because I was denied by my secondary, this is AmeriHealth.
>> SPEAKER: Okay.
>> SPEAKER: I don't know if somebody from there can talk to me afterwards.
>> SPEAKER: Is there someone from AmeriHealth here? Yeah, in the back corner.
>> SPEAKER: Thank you for your comments.
Any other additional public comments? From the committee members or the audience? Must be that holiday season. Everybody is quiet.
Paula, there's nothing additional in the chat?
>> SPEAKER: No, Mike, we're good.
>> SPEAKER: All right. Well, if there's nothing further, any additional public comments, I move that we adjourn our meeting. Everyone have a happy holidays. And we'll be back here on January 4th for our next meeting. So I thank all of you for your attendance, particularly the folks here in the Honor Suite. And I thank everybody for listening in. I appreciate everyone. Thank you.