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Date:7/1/2020

Event: Managed Long-Term Services and Supports Meeting

>> Good morning. We can hear you.

>> Tanya: Hey, Drew.

>> Drew: Hey, Tanya. How are you doing?

>> Tanya: Pretty good.

>> Drew: Look good.

>> Tanya: I'm trying. Should we turn on the light so it doesn't look so dark? Does that help with the light?

>> Drew: You look even better.

>> Tanya: I am going to take these stupid pills before the presentation that way I am not choking on them.

Just be here in case. Remember yesterday.

ba: Do you think we are good to go. I didn't see Jamie. She is on. I see her yes.

>> Jamie: I am here, hello.

>> Barb: Hello.

>> I think you are good to go, bash.

>> Barb: Hello everybody. Happy Wednesday. This is Barb Polzer. We will call the meeting to order. The committee members when I say your name could you acknowledge if you are on with us: Neil?

>> Good morning everyone. Happy July 4th.

>> Good morning, thank you.

>> David?

>> Good morning, Barb, this is David Johnson.

>> Good morning, David. Denise?

Drew?

>> Good morning,

>> I know you are there. Good morning.

>> Gail?

>>

>> Good morning.

>> Good morning, gail.

>> Ainman?

>>

>> Good morning, Barb.

>> Good morning. Jim?

>> Jim is on.

>> Good morning, Jim.

>> Good morning.

>> Jesse?

>> Juanita?

Linda? Luba?

>> Good morning, Barb.

>> Good morning.

>> Matt?

>> Mark? If you could please mute your phones.

Could everyone please mute their phones.

>> Mike?

>> Did you say me, Barb?

>> Yes, I did, good morning, Mike.

>> Richard Farr?

>> Present, thank you. Good morning.

>> Good morning. Richard Kovalesky? Richard Wellins?

Sister Catherine? Steve?

>> Good morning, Steve Gamble here.

>> Good morning, Steve. Tanya is here. Terry?

>> Hello.

>> Terry?

>> And William?

>> Yes, good morning everyone.

>> Good morning.

>> Barb: I am going to go over some housekeeping --.

>> Bash, this is Blair. I might have missed my name. Blair Boroch.

>>

>> This is Jesse Wilderman. I missed my name.

>>

>> Barb: We ask that you keep your long professional. This meeting is being conducted with a webinar with remote streaming all participants except the committee meetings will be in listen only mode during the webinar. While the committee members and presenters will be able to speak during the webinar, we ask that you please mute when you are not speaking. This is going to help minimize the background noise and improve the sound quality of the webinar. We ask that the participants please submit your questions an comments into the chat box located in the go to webinar pop up window on the right side of your computer screen. To he is noter a question or comment, type into the text box under questions and press send. Please hold all questions and comments until the end of each presentation as your question may be answered during the presentation.

We ask that you please keep your questions and comments concise an clear to the point.

The transcripts and the meeting documents are posted on the Listserv and these documents are normally posted within a few days of receiving the transcript. The captionist is documenting the discussion remotely so it is very important for people to state their name or include their name in the chat box and speak slowly an clearly. Otherwise the captionist may not be able to capture the conversation. This meeting is also being audio recorded. The meeting is scheduled until 1:00 p.m. and to comply with those logistical agreements we will end promptly at that time. If you have questions or comments that weren't heard please send them to the resource account for your reference that account is listed on the agenda.

Public comments are taken at the end of presentation. Instead of during the presentation. As always we have an additional 15 minutes reserved at the end of the meeting for any additional public comments. Our 2020MLTSS meeting dates are published on the website. With that, we are going to turn it over to Tanya who will give us a presentation on services my way. Good morning, Tanya.

>> Tanya: Can you hear me now?

>> Barb: Yes, we can.

>> Tanya: Okay. I am going to do a little bit of a follow up presentation on service my way. I last did a presentation -- we can flip. It is called services my way: Where we are now. We can flip that slide. I think you are going getting a lot of echo though. Okay.

First I want to go over a little bit of the progress that we've made -- I have made with services my way in the 3 years of 2 years since I last presented to you guys. One of the things I have been able to do since the last presentation is I have been able to start a work group in conjunction with the 3MCOs, PHLP, and different service coordinating entities and consumers and PPL.

Basically what happened with this is I created it after the first presentation. A member of PHAN came up to me. Her name was Erin. Now she works with nuns in St. Joseph. She came up to me and said hey can we start a work group with you because we really want to see consumers be able to gain more independence with something like services my way and we would really like to have you help us get this launched. Everybody has been very amicable in working with the work group and with the work group we usually meet once a month every third Tuesday of the month via telephone.

What I do for these meetings is I help create an agenda and I help facilitate the meeting and make sure it is running smoothly. Next slide.

Some of the things that we've done in the work group is we've helped develop new spending plans with PPL. We've helped with new training for service coordinators like I'm actually interviewed in the training module along with another consumer about what services my way can do. Other things that we have worked on and what we want the work group to be able to be is like a forum where people can bring issues or concerns or new ideas with services my way to the table. We wanted it to be a place where the MCO and anybody involved has an open and honest conversation about where we think services my way can go and what it can do and right now to the MCOs are developing flow charts to explain how they see the services my way process working. Next slide.

I've also been a lot of promotion an education in a variety ways. I have given presentations to PHLP. I have also done some work for the ODP side of things. I have written articles about services my way and I've even done a mini documentary type of thing with public partnerships explaining what services my way can do for people.

Next slide. Some of the obstacles that I see with services my way moving forward and some of the things that we've been trying to work out in the work group, too, and some of the obstacles that have come up the challenges with it is what are good wage allowances. Where an okay wage an where isn't one. We have been working on trying to make sure that people that are using the program are staying within a reasonable wage allowance.

We've also been trying to flush out a little bit more what can and cannot be purchased with services my way and when is it actually appropriate to use your services my way waiver and what other channels should you go through first.

One of the other issues with I think utilizing it especially right now has been COVID-19 because if you needed to purchase something that wasn't covered by your MCO, all of the paperwork and everything you have to do to be able to talk to a vendor about ordering something, that process would be extremely convoluted right now with the way the economy is and who is available to do what. So that's been a concern and a bit of a stumbling block because everyone is more focused on trying to make sure that you have the appropriate help coming in the door and not knowing how all of that is going to change from day-to-day.

I'm not saying things with services my way should be put on the back burner as far as that is concerned, but I am saying base basic priorities need to be met right now. The other obstacles that is being worked on is have the consumers have a real idea of how the purchasing process goes and how to utilize services my way with the changing MCO system. Now it is fully implemented. Before it wasn't. These are all things we are still working on and still really trying to get a feel for. Next slide. I think Services My Way can have a positive feature. What it will come counsel to is education with the consumer and MCO to make sure the consumer is okay, here is what you can do and here is what you can utilize it for and here is what you can't. I still think it gives the consumer a great deal of freedom. Like I said before in the last presentation you still have that -- you still have the ability to schedule

people when you want them to come in. You still have the ability to set the wages. You still have the independence to say okay, you need to go here. You need to go there. And you have the ability to say when you need to utilize more hours one woke versus another week.

I'm hoping after -- now that the implementation of CHC is done I am hoping to generate interest among consumers. I know it has taken a while because service coordinators are still being trained and stuff on Services My Way under the MCO system I am really hoping that changes in the future and I'm hoping once, you know, COVID is done with, it doesn't become an obstacle to the growth of Services My Way. I will continue to make sure that this program grows and develops however I can and whenever it is in my power to do.

I do want everybody to keep in mind that all of this takes time if I remember still looking for a way to have more of a voice in how your care goes and you want to be more in control of all of that, you can do this right now. You don't have to wait to change your models. You can start talking to your MCOs and your service coordinators and everything to see if it's going to be a good fit for you. Okay. That's the presentation pretty much because really what I wanted to do is just give you a quick update open what has been going on with it. Thank you.

>> Barb: Thank you, Tanya. Does anyone have questions? I don't see any right now. We have some comments that it was a great presentation and people appreciate it.

>> Steve: This is Steve Gamble. Do you know about how many people are using the Services My Way model in CHC?

>> Tanya: I haven't received new numbers but last I knew like when we did this last time it was like 26 people in the Commonwealth. So it's not widely used, but I still think if people want -- people want more choice and they want a more stable workforce, this is something that people need to look into. Yeah, there is more responsibility with it. But I think the tradeoffs are still pretty good ones. But I'm not saying we don't have work to do under the CHC system. We do. And what I would really like to see is us to be able to get the -- to get to be able to know for certain what will be covered under like the MCOs versus what can Services My Way be used for so people know. Because part of what you have to do with Services My Way is you have to be able to plan how you are going to need to utilize your budget. If you know, okay, your insurance will come this and not this, then you kind of know what you can use with

Services My Way versus what you can't. I think we have to refocus our efforts on that a little bit so we know -- so we know how to explain to consumers how to best utilize the model. Does that make sense?

>> Steve: Yes. Each of the plans included in the Services My Way handle in the handbooks?

>> Tanya: Yes. Services My Way is actually part of the -- was part of the attendant care waiver in the past. Each MCO has to offer Services My Way.

>>

>> We do have a question from the audience. Peter fitzpatrick who is a observer an volunteers asked Tanya if you could explain a bit on Services My Way functionality. How do your members interface with Medicare advantage plans.

>> Tanya: I don't use Medicare advantage so I'm not -- I'm not sure on that one. But I think as long as you're on a CHC waiver you can choose Services My Way as something you want to be a part of, if that answers the question.

>> Okay, thanks. I think as long as they chose Services My Way, then the plans have the requirement in the agreement to coordinate with Medicare. Maybe that is something we can ask the plans later if they have experience along that line. There is another question from Catherine Rodansky. Sorry if I miss pronounced your name. Is there outreach that you would like to see across the state?

>> Tanya: Yes. Like I said, I have been trying to do that with various entities over time. But what I would like to be able to do one of those days is maybe be able to get all 3 of the MCOs willing to let people like myself actually do presentations for consumers about Services My Way. This is something that we wanted to do before as part of the work group but we are told we couldn't yet because the MCOs had to be trained as part of something with OLTL first.

I think now that all of that has happened, I would like to be able to do something in conjunction with all 3 of the MCOs to ensure that more is being done to let people know about Services My Way and what it can do.

Again, I also think, too, before we do that, we need to flush out what you can and can't do with service -- with the Services My Way part of things. Like it needs to be better established now that we are under the MCO system.

>> This, jamie: This is Jamie. It sounds like in meeting with the MCO to talk about the issues you want to talk about before setting up the training would be helpful. I just took a note. I'm not sure if Randy is on the call to assist an hopefully get a meeting together to talk about Services My Way.

>> Tanya: Good.

>> Randy: I can do that.

>> Tanya: Thank you.

>> Barb: You are passionate about it. I saw the smile.

>> Tanya: If Services My Way is there and it is supposed to give consumers choice and goals and everything else, then we should be utilizing it in that fashion. Because that's the point of it in my humble opinion that is.

>> 2 of the questions I don't know that you will be able to speak to. I may jump to the third one an circle back. We may need to get input from the MCOs to get their thoughts. The next one that I am going to check in on is from carry Kelly. Would you consider working with other PATH provider to hire family members?

>> Tanya: What I have always done is I have hired my own workforce. Your own workforce can be anyone you want I think as long as you are not can be as long as you are not married to them is what the rule is. So yeah, you can as a direct care worker, you are in charge of who you hire under Services My Way.

>> Sellers: Thank you. Jeff was asking how many providers do service my way are contracted with OLTL and/or OLDP and what number of counties is service my way available?

>> Tanya: I am not sure in the past. Now that it is under CHC, Services My Way should be available to anyone anywhere because it is part of what the MCOs have to offer. Is what I would think on that.

>> Jamie: Part of his question which I don't know the answer to is where people are around Pennsylvania that are using Services My Way. He wants to know if anybody provides with an service to provide services. Thatty don't know offhand.

>> Tanya: I don't know that one for sure. But I mean, I was always under the impression or given the idea that when you are on Services My Way, it's your responsibility as the employer to hire your own workforce because that's part of what is being -- sorry. Being in control of an open budget model means and is that is part of your responsibility as the employer to handle that kind of stuff.

>> Sellers: Here is a great question from Rebecca shepherd who might help folks understand. What is the difference between Services My Way and the consumer-directed model for home an community based?

>> Tanya: Under the consumer accepted model PPO sets the wage within a certain range. Under Services My Way you do. Under Services My Way, like I said, you have more -- you have more of a choice in goods and services that you need or want. You can manage your budget to make sure that in your savings that you have money to do those certain things. Now, I know under the new MCO system they are really trying to provide more services so you don't have to use your Services My Way budget. But under Services My Way, what you are supposed to be able to do is, you are supposed to be able to have a discussion with your service coordinator and be like, okay, I need to go try x, y, or z to help myself. As long as you have backing from a medical professional maybe or someone in your life to explain why it is beneficial, then you can usually get that done with Services My Way. Part of what

sometimes you need to do is provide a letter explaining or documentation explaining why something is needed to help you.

>> Sellers: Okay a follow up question from Peter Fitzpatrick wanting to better understand the program. Is Services My Way limit today personal services versus medical services or is it broader?

>> Tanya: Services My Way you can use it for a variety of services. Like if there's a therapy that usually isn't covered by your insurance or something, as long as it is beneficial to you, you should be able to utilize your Services My Way budget to help you do that.

A lot of it as long as -- it is based on the individual a lot of it. And that's why you have your service coordinator there to help assist you in whatever the individual scenario might be. And then they could tell you whether or not something -- you can do that with your budget or you can't.

>> Sellers: Yet. Just a little bit of follow up. So Kristin from OLTL indicated that the majority of service my way participants are located in the southwest and northwest regions of the state. So the western part of the state seems to have a higher penetration rate and also Jill pointed out that OLTL can request a report from PPL that would provide information about where participants are locate that had use Services My Way as a follow up and share that.

>> Tanya: I do want you guys to know that follow up presentation is already being planned. Not all of the training modules and everything were ready yet to be shared. So I couldn't cloud that today. Stuff is still being launched and set up and utilized. So that's why I couldn't show you the spending plan models and all of that kind of stuff.

>> Sellers: Our last question I have and Tanya, you have about 5 minutes I think before you have to leave for an appointment.

>> Tanya: Yeah, I know.

>> Sellers. To ask the MCOs. This came from Pam. Thanks for the update. Do you have an they are telling about Services My Way are they trained to identify participants that might be interested in Services My Way. I don't know if you have an initial reaction to that, Tanya. I thought we could ask the plans regarding their training.

>> Tanya: I can give you my initial reaction. I don't know if all of the service coordinators have been trained as of yet. But based on how like -- based on how the system was before, they should have already been -- think should have already been identifying participants that would have been good to use this program. I don't think enough time is necessarily maybe spent on it, on each home visit because it is not something that is widely discussed yet. I think maybe there needs to be more emphasis on it from service coordinators when they come into people's homes an stuff and when they do their evaluations and they ask people, okay, do you want to use this.

But I don't know if all of the service coordinators have been trained enough to be able to do that yet or not.

>> Sellers: Okay. I am going to ask the MCO to speak to this. I will go to Jen an then UPMC.

>> Tanya: Thank you guys very, very much for giving me the time up to date you on this today. I am sorry if I flew through things kind of fast. I wanted to give you an update on where we are with all of this. There will be more to come. I'm just not sure when yet. Okay? Thank you.

>> Barb: Thank you Tanya: I love you presenting on this because you are so passionate about it.

>> Tanya: Just know that I am trying to do ash I'm trying to do the best I can.

>> Barb: And we appreciate that. Next up we have have Jamie Buchenauer give us the OLTL update.

>> Jamie: Sure. Good morning. Before I even start, we had talked about showing the website. We were made aware yesterday of a new opportunity put out by the federal HHS, human services -- Department of Human Services. I can't even think what HHS stands for. The federal HHS. They were releasing $15 billion in funding for Medicaid providers. Now the Medicaid providers would have to apply directly to HHS for actually CARES Act funding. Pat has the website up and shown here.

We within the Department of Human Services at the Pennsylvania level are working on getting more information out via our Listservs and possibly more widely to let providers know, Medicaid providers know about this opportunity that they can apply via it looks like via the directions on this website for additional CARES Act funding relief. I just wanted to make you aware of that opportunity.

For Medicaid providers it looks like another funding opportunity especially if you didn't receive funding previously. The way I read the funding opportunity here, and I did do it very briefly, but individual providers would be able to apply. So it looked like physicians, nurse practitioners, other long term living providers that maybe didn't receive funding before wobble I thinkable to apply via this process.

Just note that application deadline is July 20 so it is a pretty quick turn around. But more information to come on that definitely.

I don't know if you want to go back to my presentation. Was there anything that you wanted to add on that?

>> Sellers: I think you hit the highlights, Jamie. It was just important to flag the opportunity so the providers can make sure they request the funding.

>> Jamie: So hopefully we will have more information to release soon. So good morning. Thank you for having me at the MLTSS sub MAC today. I am happy to be with you. Welcome to July. I can't believe the summer is flying by this quickly already. It was just May1 and then it was June 1. I can't believe we are already into July.

Next slide. The first thing I wanted to really -- here is the agenda. I want to give an update on committee membership. Some updates on COVID-19 efforts and then hopefully an open discussion with the members of the committee on the evaluation of disparities in the long term services and supports programs. So let's start with the committee membership update.

next slide. As I was working through the transition with Kevin on the deputy secretary position, one of the questions and one of the issues that was brought to light was that members were I want to say terming on the MLTSS and what we wanted to do about it. Given the situation that we're currently in, obviously we are in a pandemic situation a bunch COVID-19. We're meeting remotely. We are not meeting in person. It's been a little bit more difficult I think on my end at least to communicate to people because everything is being done electronically or via the phone. There is no chance for in-person communications.

We decided that for the several committee members that have terms ending in August we would just continue their terms until December 31, 2020 if they were agreeable to do that. We didn't want to have to worry about terms ending and finding new members and then reappointmentses and acquainting new persons at this point in time with committee membership.

So I just want to pause there. I didn't know if anybody had any questions about this. But I hope that it makes sense given the current situation that we're in being I'm new to this position and many of you I think have some experience with this committee that serving until December 2020 will be very valuable, continuing to be valuable to the department.

Anybody have any questions or comments?

>> Barb: It's Barb: Any particular reason why December 31 was chosen as the extension date?

>> Jamie: Actually, Barb, I'll be quite honest with you not really except it is the end of the year and we thought we would reevaluate what is going on with COVID and the

committee in 2021. I am hearing that hopefully things will be looking up in 2021. Hopefully we will have a, you know -- I'm blanking. Hopefully we will be having a -- I can't think of it. Obviously with COVID -- with the situation with COVID, I am hoping it will be changing in 2021 and that we'll have the opportunity to go back to in-person meetings. Things will hopefully be getting back to a more normal state. So that's really the only reason that date was chosen.

>> Barb: Okay, thank you.

>> Jamie: Okay. So if no one has any additional questions, we'll go into the COVID-19 updates. So to give everybody an up date -- if everybody could mute their phones, that would be great. So the center for Medicare and Medicaid services approved our temporary changes to the CHC waiver beginning March 6 in response to COVID-19. And obviously that was our appendixK. As the situation begins to change, all counties in Pennsylvania have now gone to the grown phase and we begin to ease restrictions on work and social interactions. We looked at the Appendix K provisions. We came up with a plan in the office of long term living to look at which ones need to be phased out and how participants can be safely served and providers and service coordinator can take proper precautions to serve our populations.

So what needs to be changed going forward and what needs to remain as counties transition to green an stay green. Next slide.

Our Appendix K transition plan also covers what happens as counties may as we may see in the future, I don't know, as a county goes from green to red or possibly even the yellow status. So the following slides will highlight some of those changes. We'll go over the more I want to say changes to the transition plan that would he have been asked a lot about.

We did send out the transition plan to phase out temporary changes on June 26. I believe it went out through the Listservs. I would encourage all to take a look at it. We have met with different stakeholder groups on parts of the plan and we have met with the MCOs to talk through the implementation of the plan.

We continue to have those conversations because we know that some of this is fluid. This is an ever-changing situation and I think much like we are seeing in Allegheny county, we are having some increases in COVID cases. So our first and for most issue is to keep people safe as we go forward. Next slide.

So one of the changes is waiver services and person-centered service plans. When a county enters the green face the CHC-MCO may begin conducting comprehensive need reassessments that were missed due to the public health emergency and services can be adjusted based on the outcome of the assessments.

We are asking that those assessments be in-person wherever possible. The CHC plans can start doing the comprehensive assessments. Next slide.

We're asking the CHC-MCOs to follow the established comprehensive needs assessment process prior to I can Manying any service reductions on the participant's person-centered service plan. Services that were increased or provided in a modified manner they are considered temporary increases or changes. So in order to keep those temporary increases or changes, obviously the CHC -- MCO would need to consider those going forward. Next slide.

When a county Enders the grown phase service coordinators should monitor participants and their person-centered service plans through face to face contact whenever possible. Monitoring of participant and person centered service plans may be done remotely when risk factors may be present in the participant's home. We had a lot of conversation with the stakeholders about this. First and for most everybody has the health an safety of the person in mind. Many were concerned about service coordinators reentering people's homes.

We balance this with the guidance with the fact that it's really hard to do a person-centered service plan and assessment via telephone and actually via web conferencing. Our clinicians advise us thought the person really needed to sew the person and see how they had possibly changed, had their needs increase, had their needs decreased. It is very hard to make those types of assessments via telephone or possibly offer a web conference. Next slide.

So the initial level of care assessments using the FED that take place in the participant's home should be conducted face to face when possible. Assessments may be conducted remotely when risk factors may be present in the participant's home. Health and safety is first and for most.

We are asking the assessors to follow guidance issued by the independent assessment entry for resuming face to face assessment and maintaining safe behavioral practices as defined by the CDC and Department of Health when doing so. So people should be having PPE and maintaining safe distancing. We want to keep people safe when resuming these in-person visits. Next slide.

Next slide.

>> Obviously the nursing facilities have had the most difficult struggle with COVID-19. And so as a county moves to the grown phase, we are still going to require the initial level of care assessments using the FED that take place in nursing facilities to be conducted remotely using a phone or video conferencing.

Obviously assessors should follow guidance around visitation in nursing facilities issued by the CDC and Department of Health. The nursing facilities guidance was issued by the Department of Health I believe last Friday. So some of those facilities may begin to open to visitors. But there are many conditions and steps that a nursing facility would have to go through in order to allow visitation. So we know that those initial level of care assessments may be able to be done in person but many of the facilities may still be not allowing visitors.

Next slide. We're asking the service coordinators to receive education and training from the CHC-MCOs on how to evaluate individual risk factors and protect themselves from potential exposure according to guidance issued by the CDC and Department of Health. So annual reassessments including the needs assessment should be conducted face-to-face when possible and reassessments may be conducted remotely when risk factors may be present in the person's home. Next slide.

So the annual reassessments including the needs assessment that was delayed beyond the 365-day requirement and this would have been due to the COVID emergency, must be completed no later than 6 months after the county has transitioned to green or the issuance of the policy whichever is later. The comprehensive needs reassessment should be conducted face-to-face when possible an reassessments may be conducted remotely when risk factors may be present in the participant's home.

One of the things I want to know here in our conversation with the MCOs we really asked them when they are contacting participants and asking to schedule the face to face, we're asking for feedback that they are getting from the participants, how many are hesitant to let people in their homes to conduct those face-to-face visits and the reason and the rationale that they are providing. We want to make sure that we are monitoring what is going on. If we have an overwhelming number of participants that are hesitant to let people conduct those physician-to-face reassessments that we are working with the CHC -- MCOs on that issue. Next issue.

>> The appendix K transition plan for personal protective equipment. We are allowing gloves, groups and masks to for participant use to be abdomen continued by specialized medical equipment and supplies if no other source was available. This was the same as when counties were in the red or the yellow status and this flexibility will continue for the duration of the appendex K approval period regardless of the county's status. Next slide.

Respite in licensed facilities may be extended beyond 29 consecutive days without the prior approval of CHC-MCO in order to meet the participant's health an safety needs. When a county transitions to green this flexibility continues if the need for additional respite as a result of COVID-19. Prior approval of CHC-MCO is required when in the grown phase for the duration of the Appendix K approval.

When a county enters the green phase, spouses, legal gardens and persons with power of attorney may no longer serve as paid direct care workers. Participants will be expected to resume using their existing direct care worker or a replacement worker if necessary. We did have conversations with stakeholders on this issue. So they were concerned obviously about the availability of the existing direct care worker or replacement worker.

We asked a couple of groups for feedback on the amount of people that were actually hiring spouses or legal guardians during the COVID-19 emergency period. So we found overall in those that we asked it was less than 100 people. Obviously we distribute ask every single person. So I would assume that the numbers are a little higher. But it didn't appear that this change, meaning no longer allowing spouses or legal guardians to be a huge impact on the population, meaningless than a hundred or maybe a little more than a hundred people may have been impacted.

So we will work through those issues as we go forward. Next slide.

So we only covered in this presentation some of the issues in the Appendix K transition plan we encourage everybody to take a look at it. The other items covered in the transition plan are expanded settings where services may be provided, modifications of license you are and other requirements for settings where waiver services are furnished, incident managing reporting requirements and retainer payments to address emergency-related issues. We do have office of long term living staff on the phone that obviously can help in answering any questions that we have or that you have on the Appendix K transition if we have questions at the end of the presentation. Next slide.

We're having technology issues.

So the next slide really should talk about personal care homes and assistive living residences. We just wanted to give an update that last Friday on June 26 we issued 2 pieces of guidance to personal care homes and assisted residences one was the universal testing. Actually intermediate care facilities were included in the order. They must perform baseline testing on all residents and staff by August 31.

The guidance also provided assistance by way if a facility was struggling meeting that August 31 time frame or just really had questions or issues with who was going to be performing that testing, what to do once the testing occurred, they can reach out per that guidance. They could reach out to if they need assistance with testing. Also the guidance mentioned the regional response health collaboratives will be available to assist with the testing once they are set up and they are operational which should be in the next few weeks. So that is the universal testing requirement.

The reopening guidance went out the same day. It gives -- it gives personal care homes and assistive living residences the steps that they need to take to allow visitation or to allow their members to start rein gauging in the community. So that guidance is helpful and available as well. Next slide. I'll pause here and see if anybody has any questions about the prior portion of the presentation. The next slide and item thatty want to get to is really an open discussion. So it may take a little bit longer this seems like a natural plays to pause and take any questions.

>> Sellers: I have several from the audience unless any committee members have any first. Nope. Okay. So the first question I have is from Theresa Hartman for service coordinators in Philadelphia county we have begun scheduling face to face visits to start after 7/3 when Philadelphia moves to green. Now they are modifying those orders. Did that affect conduct being the visitors in person.

>> Jamie: That is a really, really good question. We talked about that as a department this morning because it is affecting not only obviously service coordinators going into people's homes but it is also affecting our reopening guidance that we issued for personal care homes and assisted living residences. It actually affects the guidance that the Department of Aging released regarding adult day programs. So we are having internal conversations an we hope to have something back very soon.

I think when we issued our guidance and obviously the reopening guidance for the facilities, we didn't envision that the counties would take a different path regarding reopening or what the county would allow at their level.

So I want to say more to come on that.

>> Sellers: Okay. And then the next question is from Pamela Silver: Can you clarify what risk factors would be allowed to do be done remotely. Is it when someone in the household is in a high risk group or does it apply when someone in the household has potential COVID symptoms or exposure?

>> Jamie: So that's a good question. I'm hoping Patty Clark with weigh in from the office of long term living. I would assume -- go ahead, Patty.

>> Patty: I am here. Yes I can take that question. This is Patty Clark with the policy bureau in OLTL. So the risk factors that are referenced in the transition plan are the COVID-19 risk factors put out by the Department of Health an CDC. I think probably a lot of you if you have gone to the doctor recently or done any type of visits outside of the home you have probably been asked about some of these risk factors. The examples would be if somebody in the home had traveled outside of the country. If someone in the home had a COVID-19 diagnosis or if they were having symptoms. Those are the types of things that we would consider risk factors. Does that answer the question?

>> Sellers: We will see if we get a follow up. Drew.

>> Drew: I have a follow up sort of to that. It has to do specifically with guidance on cognitive rehabilitation therapy and behave or therapy services that are provided by telerehab currently. As counties transition to green, we understand that the policy says that those types of services should transition to face-to-face where possible and participants may continue to receive the services remotely via phone or video conference for the purpose of social distancing when it has been determined that they can actively participate and benefit from receiving those services remotely.

So I guess one of the questions I would have is there may be some circumstances where it's not possible to social distance properly while providing those services in person and can those services therefore then be continued as telerehab?

>> Patty: This is Patty. So I think what you are describe, Drew, is what OLTL had in mind. Depending on the environment where the face-to-face the cog rehab service would have typically been provide it had that environment isn't set up for social distancing then the service could continue to be conducted remotely.

But the goal is for the provider to set up the environment so that services can be eventually resumed on a face-to-face level. At this time OLTL is not putting in place permanent telehealth type services for the waiver. That's something we need to look into in the future. Right now we don't have eye way to put that in place. Right now the goal is face to face.

>> Drew: Thanks, Patty for that clarification. I would want you guys to be aware that Pennsylvania Department of Health is con ducking a pilot on rehab services that started before COVID. If we can keep you advised of the results it might help you make future decisions about that.

>> Patty: Yes, that would be great. We definitely want to get as much information as possible about the success of services being conducted remotely through telehealth.

>> Sellers: She had a follow up in absence of the risk factors that you mentioned the CHC should not be using telephone assessments to reduce everyone is ises is that correct?

>> Patty: The expectation is if possible the assessment should be conducted face to face.

>> sellers: Shawna. Had a question. For the risk factors what if someone is medically fragile like an existing ventilator user

>> Patty: The risk factors that we mention in the transition plan are specific to the COVID-19 risk factors. I guess in some ways we kind of consider most of the individuals in the waiver programs to be medically fragile. They obviously have conditions that make them a

little bit more medically fragile than someone who is not in the waiver. So that is not something that we are looking at as a specific risk factor for an indication that a face-to-face visit should not occur. The expectation is that the service coordinators and the assessors would be using safe practices in terms of social distancing and masks and hand washing an taking all of the proper precautions in order to do the home visit.

>> Sellers: Then the next question moving on to a different topic from Pam Auer. With the continued growing number of people in nursing facilities getting COVID what is the plan to assist getting people services in an expedited way to allow people who are in danger in quickly. There are people that want to go to their family or safe situation such as high tells and dorms as quickly as possible.

. [hotels

>> Jamie: Others from OLTL can jump in. If a family member wanted to take their loved one into their home from the nursing facility, I know that they were able to do that and we were still allowing for some changes obviously as the person would loaf the nursing facility and go into the community to suppo them in the community. Where we struggle is the nursing home transition program is finding and visiting that person in the nursing facility. Finding housing. I have heard about some of the hotels or the dormitory style suggestions. I'm not aware that in mass anyone has left the nursing home facility and transitioned to hotels. I know -- I think we would work with those on a case by case basis to put services in place.

>> Sellers: Okay. Then the next question is from Kevin Thorn ton. Can you expand on the provision of PPE? I spoke with the service coordinator this week who said it would not be available to someone receiving waiver services because those items are available in stores at this point regardless of the person's ability to afford those items. Thank you.

>> Jamie: So as we were -- under the Appendix K for red and yellow we were allowing those items to be put on a person's service plan under the specialized medical equipment. Patty can correct me if I am wrong. I believe that we are still allowing that as we transition to the green phase.

>> Patty: Yes, that's true. That is continuing. And within the Appendix K when we say that PPE is available under the waiver if it is not available through other services, we mean other services where it would be provided to the participant not where the participant has to purchase it. If the participant has to go out and purchase it themselves, that's really not something we intend to have happen if that's the only way that the person can get it, then they should be getting that through waiver funding.

>> Sellers: Okay. And then Pam Auer had a follow-up question. Jamie, you talked about the case to case basis for the nursing home transition to other settings. Pam was asking who would be the best person to notify when they run into those type of cases?

>> Jamie: Pam, you can definitely reach out to me an then we can get members of the office of long term living team involved depending on what the issue is.

>> Sellers: That is all of the questions that I have received unless another committee member has any. Okay. I think it's back to you, Jamie.

>> Jamie: Great. So I really envision this to be an open discussion. I think part of my down fall is I don't watch the news on an ongoing basis. To me the news is somewhat depressing and I wish I did watch it more. But over the last month there obviously have been many events that happened across the United States and even within our state that showed and highlighted some disparities and racial biases across the nation and our state.

And so as a department we have begun talking about social and racial biases in our programs and within our department policies. Part of that evaluation includes a real conversation with our stakeholders who are involved in our programs about what their perception, what their perceptions are on the social and racial biases in our programs. So I think from a staff perspective or a management perspective you look at these programs. Then to really understand what is going on and evaluate any disparities we need to talk to the stakeholders and obviously the participants in the programs.

So we brought this up last month to the long term services and support sub MAC. We had a really good discussion about social and racial disparities in our programs. You can go to the next slide, Pat.

So one of the things when we asked this question what would the committee like to secluded in the evaluation of potential racial and social disparities and long term services and support programs one of the things that they brought up that would be initially helpful is I want to say a map or just some representation of what and where different populations are across the state that are in our long term services and supports programs. So a map of what our populations look like. So we are working in the office of long term living on that data. We have the data county by county by race, who is enrolled in long term services and support programs. I would like to map it out so it gives members a better opportunity and a better visual to see that data.

The other issue that came up that we talked about was that the long term services and supports program was actually -- I'm sorry the long term services and supports committee was really going to give us some written recommendations on potential racial and social disparities to give the opportunity to the office of long term living and the department, the ability to evaluate and make any changes to the program based on the disparities. So I'll open it up at this point to give the committee the opportunity to ask questions or just consider the question and what you would like to see considered.

So there is no thoughts about what the committee or the audience would like to sew included in an evaluation of potential racial and social disparities? We are obviously conducting this -- we want to high light any issues we have and adjust our programs accordingly.

>> Blair: Hi, this is Blair Bororoch: The most important metric that we use to evaluate metric and quality to cross that cross the race and ethnicity on enrollment to see how those metrics vary across different race and ethnic groups and identify where we see disparities much like we are doing on the medical side with looking at quality data and gaps in care and metrics. How LTSS would be very interested in see do we see disparities there.

>> Jessie: Jesse. I I am happy to hear that the department is going deep into this. It is a critical and essential issue is in every part of our society and the services we provide and a approach to it. There is also a workforce component to this too that over lays obviously with the participant experience and the participant disparities in terms of the programs and access to the programs along racial and social lines and also the work force access to living wage jobs and better associated with the program and so on. I think there's some challenges and correlations around race and social experience. So that would be another area that we might want to try to look at in the programs. Also delivery of programs and how that's impacted by racial a social bias and those kind of things.

>> Jamie: I will just add to Jesse's comment. I did see obviously -- he brought up a good point on the workforce. When looking at obviously the direct care workforce, there is definitely a preponderance of I want to say workers to be in certain categories. So obviously with evaluating kind of the racial and socio disparities working at the workforce and how the workforce is impacted. Thanks for bringing that up.

>> Steve: This is Steve Gamble. I think it would be helpful to understand the implications for those with limited English proficiency and their utilization of community services during the pandemic. Especially with the barrier, language is a barrier limited English proficiency. I think it is something that we should be talking about.

>> Mike: This is Mike Grier from PCIL. I just want to say that I'm fully in support of what was said. It is an absolute critical necessity for our folks that are being supported in long term support services and we need to ensure that this is -- that we would certainly play a part in any sort of planning process that you guys would deem necessary. We really need to address this.

>> James: This is Jim. I would just mention on the workforce side we are going to do some of that analysis. I think it would be important to assess the financial impact of that on providers and reimbursement. I know when we locked at some of the changes, the living

waning legislation we would have needed 15 or 18% increase in our reimbursement to hit those targets. The state has been very reluctant for any increase in reimbursement for many, many years in long term care services. The money would have to be available, you know, and it would be very important to make sure we understand the economic impact of those changes as well.

>> Sellers: Jamie, if no other committee members have any comments or suggestions we will have some from the audience. We won't have time for all of those. We can send those over to you as part of a follow up. I guess we have about 6 minutes to stay on agenda. The first is from rose OLTL social determinants of health an how that supports people of any race.

Jamie: Good point.

>> Sellers: Asking can you share baseline data and new consumer enrollment with regional variances broken down by the different ethnicity and social impact. Similar asked is it possible to give data on hours and service reductions to help identify any disbarties in race, ethnic bias that may impact service plans.

Lloyd Werts had a comment. The edge California occasion committee recently convened to determines a means of allocating scarce medical resources I had feed the area depravation index in which folks living in healthcare is more limited than others that measure could be helpful in that regard. Then Bridget had a comment. This is a hugely positive move. Would love to see individuals with cognitive issues without obvious physical disabilities looked at, represented, considered. Social attitudes towards the disabled can be a large barrier to over come. Amy, as data is collecting on authorization of services such as the amount of hours approved, number of people transitioned from nursing home, home mods et cetera, track race, ethnicity to see if there are any disparities in the amounts and types.

And then j Jessie foster. More data needs to be collected in terms of how people are able to access the program from information from LTSS and applying making sure patients have access to providers and understand the programs. As commented a lot of people without LEP struggle to apply an understand what they are rights and benefits are. And thank you for taking on this initiative. I think Faudey suggested using MDS demographics and assessment.

>> Jamie: I was writing all of those down. Those are really good suggestions. It made me think of -- one of the things we talked about internally as the office of long term living staff was taking a look at the enrollment data. So we wanted to see obviously where different maybe racial or social groups fall out of their enrollment process. Is there anything that we need to do in our enrollment process to tweak it because certain racial or social groups are falling out or not being eligible or not completing the enrollment process for some reason. Is there something that the data will tell us there.

I think a lot of your suggestions are along those lines. So with limited English proficiency are there people that are falling out of at least the enrollment process or once they are en rolled something is going on with their services. Is there an opportunity to look at how we are providing services for that group. So very good suggestions.

>> Sellers: I believe Heshie had a suggestion.

>> Heshie: When we looking at social determinants of health how are we include orientation and identity? Do we ask questions about orientation and identity? Order to be inclusive people who are LGBTQ?

>> Jamie: That's a really good question. I don't know the answer to your question. I'm not sure if any of the others in the office of long term living know that answer.

>> Heshie: With regards to COVID we advocated a commissioner on the Governor's commission on LGBT affairs we added the inclusion of sexual orientation gender identity data to be included when looking at the numbers of people who -- numbers of people affected by COVID. I don't believe that we asked about orientation and identity on any intake forms. I am wondering at what point are we going to begin ask about orientation and identity so people who identity with the LGBT community will feel like they are part of the mix in terms of who we're reaching across the Commonwealth.

>> Jamie: You bring up a good point. If we are not asking the questions it is hard to know what the issues are and what the data is saying regarding nice issues that may come to light:

>> Heshie: Exactly. I think that is the point. We're not asking the questions. So there is no way to identify who is a member of the LGBT community or whether they disclose or not disclose. We need to be asking -- we need to be including data in our data collection. It's that simple. If we want to say that we're -- if we want to say we are inclusive and we are reaching all populations across the Commonwealth, you got to collect that data as well.

>> Jamie: Good point.

>> Sellers: Jamie, I had a few other suggestions. Trying to stay on schedule, those will be included in the information that gets sent over to OLTL so you will have a list of everything.

>> Jamie: Great. I thank everyone for their suggestions and their feedback on this very important topic. So if you have any additional information that you would like to share with me, please feel free to put it in the chat box or obviously send me an E-mail.

>> Barb: I was going to suggest if there is anybody else that has any comments about this or questions, Pat, could we also send it to the RA box afterwards? I think this is a question that takes some thought behind it. And maybe people need to process and will come up with something after the meeting.

>> Sellers: Sure. We can send -- Jamie, do you have the mailbox at the end of your PowerPoint? It normally is. Okay. So we will post the RA mailbox address in the chat window so everyone has that if you want to send any additional suggestions or comments.

>> Barb: Thank you, appreciate that. Thank you, Jamie, appreciate your presentation.

Jamie: Thank you.

>> Barb: You're welcome. Next up we have Dr. Howard Degenholtz. He is coming back to give us an evaluation update.

up million come back.

>> Howard: Thank you. Let me share my screen. Can everybody see that? Okay. Great. So thank I very much for having me back on the evaluation let's see if this works. So I'm going to start by giving an overview of our work and then a brief overview of the evaluation and then I'll get into some highlights of findings. To refresh everybody's memory and if you haven't heard me present in the past. The med kale research sender which I am a faculty member at the university of Pittsburgh is conducting a 7 year long evaluation of the community choice program. They are an outside evaluator. We are looking at the evaluation and the impact of the program on the participants.

We are using multiple methods to address these questions from a wide range of data sources. We have put a high priority on participant voice because participants what they tell us Augustments what we can learn from administrative date and as you will see from my slides coming up a bunch constructed a lot of focus groups and surveys and interviews with consumers as well as analysis of administrative data. We are in regular contact with the office of long term living with our findings. We have biweekly status calls with office of long term living. And we provide them with an independent analysis. The goal is to help

verify and evaluate what OLTL is hearing from other sources. It will help in decision making in realtime.

To give you a sense what I will be presenting today I will be lead off with some findings that really just recent about the impact of COVID-19 pandemic on participants and providers. Then I am going to shift into some data from telephone interviews with participants addressing several topics having to do with their experience with their home and community-based services and the health plan overall. I will also present some find beings from focus groups that we conducted in the phase 3 region over the winter of 2020 before everything went sideways with the pandemic.

Next I'm present some findings from interviews qualificationsive and and candidate he Tative. Just to give everybody a schematic of our evaluation we have multiple data sources. Starting from the upper left corner we conduct focus groups with participants an we've done that every year in the winter as phase 1 went live. We had focus groups with participants. We do the same thing in the southeast when phase 2 went live in 20 is the. In 2020 we just wrapped up focus groups with participants in the phase 3 region.

We have been conducting telephone interviews with participants and care givers and this is a longitude studly where we recruited and interviewed them over a 3 year period. For this presentation I will supplement data that we collected with additional information from participant surveys conducted by the managed care organizations using what is referred to as the CAHPS and CAHPS health insurance.

Those data are collected by the MCOs under their contract requirements for the overall quality management strategy. As an outside evaluator we have been been given access to those data files an we have combined it with our own data collection to present a more complex picture of what is going on.

Next we have been conducting qualitative interview was a wide range of stakeholders that is the yellow box key interviews with stakeholders. We have been in the blue box we have been conducting surveys of LTSS providers and that is bifurcated into the nursing facility sector and also the wide range of HCBS providers which includes everything from service coordination entities to PIAS providers. Finally we have access to administrative data Medicaid care claims med care claims. The his store cool level of care determination files the NFED and intra healthcare data sets.

So I'm going to move now to present some hot off the presses findings about could the. Just by way of back ground, in March we were asked to halt all data collection because of the pandemic and activities going on by OLTL and Department of Health to address the pandemic. We were asked to stand down our interest vies and data collection because of the burden that was being placed on participants.

We finally restarted our data collection in mid May. And when we did that, we had the opportunity to add several questions about COVID-19: So on the left of the slide we asked providers and this went out to HCBS providers. We had 90 complete interviews -- surveys that were completed on line. We asked them about the impact that the pandemic had on their operations.

So of the 90 providers that responded to our survey in the 3 to 4 week period, we had 27% had experienced a client with COVID-19. Nearly half were -- over half refused entry to a client's home at least once. 28% reported that they were unable to get PPE. And 37% had that have refuse to enter a client's home. And 1 in 5 had at least one staff member that was diagnosed with COVID-19.

Over half reported lost revenue. And slightly less than half reported that they had applied for small business loans. We asked them next about what was going on within the past week of completing the survey. In other words, the first 2 questions were about going back to the beginning of March. We also wanted to get a snapshot of how things were going right now. So about -- so this is somewhat positive news. It says their ability to provide care in the past woke compared to before the out break, 73% reported that it was unchanged or better. However a significant fraction said that they were worse off than before the outbreak. So we followed that up with asking about specific needs that they were facing over the past week. 20% were reported inadequate staff. 11% reported inadequate PPE. 13% reported inappropriate or inadequate training.

There were some open ended comments and the most salient from one respondent that reported that they were an adult day provider their center was closed which had castcade.

We were conducting surveys via telephone. Different steps they had taken as individuals in response to the pandemic. Nearly -- you can see I sorted these on the prevalence. Nearly everybody report that had they were keeping a 6 fast distance wearing a mask out doors, avoiding high risk people. Washing their hands more often. Avoiding crowds, using more hand sanitizer. Avoiding people, whether it keys down to using a mask in doors that was about half. About half had canceled a doctor's appointment. Slightly less than half reported using telehealth. A third had canceled the dentist 1 in 5 had canceled in home caretaker in response to the pandemic. This gives us both I think a consistent picture between the participants and the provider perspective. We are continuing to collect these data as time goes on. I think we'll be -- those particular surveys will be closing shortly. So this is preliminary but I think this is pretty much close to the final.

Questions.

Now I want to turn to what's referred to as the CAHPS home and community-based services survey. We incorporated this into our data collection strategy with participants. This is a nationally developed instrument for measuring participant's experience with

home and community-based services. It is conducted over the telephone. There is a whole bunch of questions and the answers to those questions are combined to create what's referred to as composite scores. And those give you a look at the category of service coordination and then the broad category service delivery.

Soil be presenting findings on those 2 topics. Now we collected data before CHC in phase one southwest region in late 2017 late 2018. Phase 2 in late 2018 to early early 2019. After it was implemented the managed care organizations were required to collect their own data annually using the same instrument. Their surveys were conducted in the southwest in the fall of 2018. Since they are required to do it annually they collected another round of data in the fall of 2016 in the southwest as well as in the southeast regions so. What I am going to show you is data from before CHC and after CHC on the same instruments and the before measures conducted by our tomorrow at et mid okayed research and after collected by managed care organizations.

First I am going to share with you some demographics about the program participants. This is important it gives you a little bit of a snapshot of the demographics and the next slide will have a couple data elements about their health status. The key take away here is that there are some slight differences between the pre-and the post samples. And that has to do with the way the data were collected. But in general the age breakdowns are pretty similar. The gender breakdowns are pretty consistent. There are some slight differences in the racial composition of the sample when you move from pre-to post and obviously there are big differences between the southwest and southeast in terms of the racial composition.

Turning to the health status of participants, just to simplify this we just calculated the percentage of people who reported being in for health status both physical health and mental health. That's using a simple question how would you rate your excellent? Excellent, very good, fair or poor. Before CHC in the southwest that was about 27%. And it is slightly higher post CHC at 30%. And notice south east the me CHC measure is about 30% rating their general health as poor. Pretty consistent in the post CHC period.

When it comes to mental health, we collected different -- the MRC data were collect I differently than the managed care organization data. So our measure used what is called the PHQ9 which is a measure of depressive symptoms. The managed care organizations used a simple how would you rate your mental health excellent, very, good, good, fair poor. So we tried to combine these data but what you will see is about 18% of people report some depressive symptoms but when you ask the question a different way, you only get 11% reporting that their mental health is poor.

Now, turning to the service coordination composites both before an after CHC what we did we put on the left set of graphs that is southwest in phase 1. The blue bars are before CHC. The orange bars are for 2018. The gray bars for 2019. So in the southwest there are 3 data points because there was 2 years of data after CHC was implemented. You could see that from the before interviews the before CHC it goes up to the orange from the blue to the orange. It goes up and inners it of case managers helpful it goes down slightly. If you look at choosing services that matter to you you see a different story. It declined from CHC by 2019 it seems to recovered. The item about personal safety and respect that improves after CHC it seems to be consistent in 2019. Then the question about planning your time and activities this is the lowest overall. It seems to be on an upward increasing trend. Turning to the southeast that is phase 2 implementation. We see a

similar pattern case manager is helpful.

>> Using services seems to decline slightly. Personal safety and respect seems to improve and planning your time an services seems to improve.

So this survey will be repeated in late 2020, fall 2020 so we will be able to eat this analysis with an additional wave of data.

I should mention that Brian McDade this data the a a prior meeting. The big difference the blue bars collected by our team.

The next slide shows similar composite. This has to do with the staff that are helping you the people that are helping you. And the first composite reliable an helpful. That declined but it is on an upward trend. That same pattern is present with staff list and communicating. Transportation slightly improved in 2019. In the southeast you see the same general pattern the delight declines. Transportation appears to have improved from before CHC to after CHC.

The next data elements what is called the CAHPS health plan survey. The previous day a were about your home care services. What I am going to show now are about your health plan. So this is collected in the same way. The data are all reported from the managed care organizations and I am going to be comparing them to a national benchmark because the MRC did not collect these data at all. So the question is -- we are going to talk about the overall ratings and overall ratings are done on a 0 to 10 scale. I am going to report the percentage of people that gave the 9 or 10 out of 10. What we call the top box. I will just present 4 different measures how would you rate your healthcare, how would you rate your doctor, how would you rate your specialist and how would you rate your insurance plan?

So as you can see about 58% of people rated their healthcare as the best. That was above the 50th%. How do you rate your doctor, above the 35percentile nationally. The same for the specialist. It is slightly lower about 2/3 of participants rated their health plan as the

best. That was above the 75percentile. In general the take away here is that the CHC plans are out performing nationally -- national for Medicare and Medicare. There's room to improve. Next I'm going to turn to reign findings of focus groups with participants and care givers in the phase 3 region. We conducted 22 focus groups in the northwest, northeast and Lehigh capitol region. We were at 8 different counties this work was conducted in February of 2020.

So I am going to give you some high level findings that came out of these focus groups. So one issue that was raised was that the paperwork that people had received was somewhat confusing. That there was misin public meetings about enrollment and switching plans. On the positive side one participant reported that the DSNP customer service was quite helpful. It is interesting to see where people turn. DSNP is the Medicaid advantage or special needs plan. With regard to service coordination, one participant indicated that their new service coordinator is great but doesn't know everything. And one of the things that we have heard consistently is that new service coordinators or service coordinators when the plan is newly implemented they try to be helpful if they don't know all of the program rules they have to go back and forth to the MCO to get their questions answered so it takes a long time to address issues because they are

consistently constantly having to call them back. In phase 3 and we saw this in 2018 and 2019 as well that medical providers are not aware of CHC that is despite extensive efforts. It is still very difficult to reach physicians and clinics to find out about this. This is some confusion. This has come up every time of the interaction between their Medicare and the need to choose eye new PCP under the community health choices plan. So that continues to be an issue where there is confusion there.

On a positive side no problems with receiving their medications or co-pays. One reported having gotten home modification and some things they needed. When we had session was care givers the information sessions and packets were great and that the overall changes were seamless.

As always with focused groups mixed picture. People that had challenges and people that have reported very positive experiences with the overall change.

Same with our qualitative tools I want to report on findings from a qualitative interviews that were conducted. In the calendar year 2019 up through the present for reasons that I stated above we have not had -- we were shut down in terms of our qualitative data collection for a significant part of 2020. But we did get a couple of interviews done late 2019 and early 2020.

So provider organizers that we talked to, and this is generic category that includes home care, area agency, nursing homes, without identifying any specific organization, they

report that had some long-standing payment issues are being resolved that the MCOs have been providing additional training and improved communication with providers. And one thing that we have noted is that there's been a pretty substantial increase in the number of home care agencies. We have seen this in the data that OLTL has shared with us and we have also had that reported to us from the advocacy organizations. And some have reported that some positive changes with regard to the enrollment broker we are able to schedule in home assessments at the time of the referral. That is reducing some gaps in the overall enrollment and eligibility process.

There are some challenges that remain. There are time gaps and service authorization for DME. That means the time between it is authorized and the services can be delivered. There is long waits for home modifications and some challenges with regard to out of network providers. There's been some challenges and service coordination from the triple A to the MCO and area agency on aging participation. We know that's been a long-standing issue and as phase 3 came there was some continuing confusion in that regard.

And finally this was one finding that we observed. That there seems to be a disconnect for people that are in a nursing home who are also in home and community-based services. For people that receive a home and community-based service they have a coordinator if they are hospitalized in a nursing home for some period of time, they might have a different service coordinator that is assigned to the nursing home population. The nursing facility management report that there is often a disconnect between the service coordinator who is covering the facility experience and the service coordinator who is covering the community services. And that can potentially lead to some challenges in successful discharge and return to the community.

So we misconducted in 2019 a statewide survey of nursing homes. We conducted -- we used on line survey methodology to reach nursing home administrators statewide. And we restricted that to nursing homes that were accepting Medicaid and we sent a personalized E-mails to each of the administrators. Out of 627 possible nursing homes we got 203 surveys back about 32%. Most were from -- 103 from the northwest, northeast LCAP avenue. A third from the south west and 35 from the southeast.

Some observations from this survey that respond he is not in the phase 2 area appeared to be more prepared that be the phase 1 indicating some improvement in the overall implementation between phase 1 and phase 2. The facilities expectation to benefit financially from the program was generally consistent with our understanding of the policy that they expected that the program was going to be -- was going to work for them in terms of payment rates. There were some elements of concern that we needed. In particular with regard to behavioral health services under CHC nursing facility residents

should have access to the behavioral health managed care organizations and there seemed to be some pretty wide spread challenges where nursing home operators were not aware of the change and how to access those benefits for their residents we reported that to OLTL and there have been efforts to address that. With respond to transitioning to the community. 63% of facilities in the

phase 1 area reported that there had been some efforts to transition long-stay residents to the community. It is an open question whether this will represent an increase over the pre-CHC activity in that regard. We asked nursing homes about their perception of their interactions with the office of long term living and with the managed care organizations. One interesting thing we found here remember this was conducted in the summer of 2019. So the phase 1 nursing facilities had been on CHC for about a year and a half by that point. The phase 2 had only been about 6 months no the program. And phase 3 hadn't started yet.

So as you might expect, the percentage of nursing facility operators that were extremely satisfied with communication either with the MCO or OLTL was heavily weighted to the phase 1 area followed by phase 2 and phase 3. One important thing to note, it is 38% were extremely satisfied. That suggests again some room to improve communication between the nursing facilities and the managed care organizations.

In addition to surveys of nursing homes in 2019 we did an intensive focus study of nursing homes where we actually selected nursing homes to go on site and do site visits and interviews in person with top management as well as residents and family. We selected nursing homes from all 3 regions. We selected for profit and not for profit. Government-owned facilities and also we split it between large and small. That's like over 120 beds an under 120 beds. We interviewed not just the administrator but the director of nursing. And any top management staff that they thought had interacted with the CHC MCOs that could clear include their chief financial officer or teach technology officer or could include their unit managers. We let the nursing facilities nominate who would participate in the interviews in addition to the administrators.

between younger and older participants and in 6 facilities we were also able to reap a sample of family members and represent environments. Those were interviewed by telephone.

Some findings from this, when we talk to nursing home administrators, remember this is back in the summer, late summer of 2019. They reported on challenges with regard to transportation. We know there were changes in the way transportation was going to be paid and authorized and delivered for nursing home residents. But it did continue to be a

challenge with confusion with the southeast where they had not started CHC yet. There was regards with service coordination and nursing facility transition as I alluded to previously where it was authority just not clear that service coordination was intensive enough to transition back to the people for people eligible. On a positive note they reported that billing was much more efficient and that they were getting paid well and quicker. That was a consistent finding.

When he with talked to nursing home participants most of them reported that they had not been actively involved in selecting their CHC plan. We did not separate between short stay an long stay. We did restrict our sample to people that were on Medicaid. So if people were on a Medicare stay and then -- were not CHC eligible they would not have shown up on our list.

And then nursing home participant awareness of service coordination was well. It was not widespread. When we talked to family represent environments consistently they said only 10% of residents had selected their own CHC plan. In contrast to the residents this was not surprisingly family members reported that they knew who their relative's service coordinator was and how to contact them. And service coordination had been relatively consistent.

So, again, it is not surprising that service coordinator for residents are in reasonably good contact with family and family represent environments even if the residents are not quite dialed into that. Turning to our her says with HCBS providers we have completed 2 waves of this survey the third wave is in the field right now and that's where those COVID data came from. The first wave was conducted statewide in late 2017 before CHC was implemented. The second wave was conducted late 2018 around the third wave like I just said started in late 2019 and we are just finishing it up now.

The office of long term living is a sifted us by providing contact service for HCBS providers. We sent personalized E-mails to conduct the online survey. So just some highlights or findings from this I think I have presented some of this data previously to this group. HCBS providers reported high levels of contact and awareness with CHC. 83% received some type of communication. 30% had attended a webinar. That in general and this was a positive finding between 201 and 2018 that satisfaction with OLTL in the southeast had increased between the 2 waves. That satisfaction with communication with MCOs increased in the southeast but unfortunately seemed to decrease slightly in the southwest. The majority reported timely payments. With about a third slightly more than a third having some dissatisfaction with billing. So there is some room for improvement there. The providers provide that had CHC was critical to their future and that they planned to participate in this

.

Service coordination in contrast to direct service providers were much less positive about CHC and their future outlook. That is not surprising as we know what is going on with the independent term service coordination entities.

Next I'm going to turn to some quantitative findings that are drawn from administrative data and what I'm going to do is present just some big picture points about rebalancing and the friend in rebalancing over time. This is a very important finding. It shouldn't be too surprising to people. If we look back historically from 2013 through 2018, the panel on the left is for the age 21-59 adults using HCBS services and as we know that group has traditionally and historically had very high rates of HCBS relative to nursing home. Let me be clear. This is the percentage of LTSS participants in HCBS so the denominator is being in HCBS or nursing facility. So this is the percent age of people who are using LTSS in the community. You can see it averages high 80s to over 90%. In the southwest it is relatively flat about 80% although it does seem to pick up just slightly in 2018. In the older adult poplation, as we know historically that rate has been much lower

just over 50% in the phase 2 or southeast region increase to go just over 70% by 2018. In the southwest region phase 1 the blue line starts at a little over 30%. Bit by the end of 2018 it is just over 40%. So all of these lines including in the phase 3 area are trending in the right direction.

The key -- we want to ask the evaluation question we have is was there a change between 2017 the last year before community health choices an 2018 the first year of community healths with regard to this important rebalancing trend? Can we attribute that to the phase 1 experience versus the other parts of the state. In other words, was manage the care making a difference.

So what this shows is just the change in percentage of HCBS participants from 2017 to 2018. This is based on the numbers from December of each year but it's consistent if you use the full year of data. You can see the blue bars are the younger adults and the orange bars are the older adults.

In phase 1 it is positive. So it goes up for both groups of people. And what is interesting if you look at the phase 2 and phase 3 regions as we saw from the graphs on the previous slide, the trend is towards more HCBS, greater percentage of people in HCBS, but the growth in phase 1 is stronger than the trend in phase 2 and phase 3. We will continue to monitor this with 2019 and 2020 data. But this is a positive finding with regards to the overall implementation of community health choices. That is it seems to have continued that trend and perhaps even accelerated it.

Now, the next slide has to do with the use of personal attendant services. Excuse me. And this is measured in hours of service per person per day. I'm going to show you the trend from 2016 through 2018 broken down by those same age groups and separately for each phase of the state. I want to call your attention first to the yellow and gray lines on the left for the 21-59 population. You can see from 2016, 2017, 2018. The average hours per person per day goes up from 6.5 to close to 7.5 and 7 and 3/4. The blue line the first managed care that blue line is on the same trend from 2016 to 2017. But then in 2018 it's basically flat that is not change from 17 to 2018. If we look panel on the right the older adults we see the same thing, the trends in hours per per per day goes up and up an up in phase 2 and 3. If we look at phase 1 we see that the 2018 level is essentially unchanged from the 2017 level. Now I want to make the point before I

move to the next slide that this is not adjusted for individual risk. However, we should recognize that these are cross-sections so anybody that -- so anybody that is newly aging into the population. That would account for increase in hours. This is actually -- this includes new people who are younger entering the population in each year because these are not static populations. The next thing we looked at was adult daycare use for all 3 phases for 2016 through 2018. This slide shows that there's been a downward trend in the use of adult day over the 3 time periods.

It's hard to say whether this can be attributed to the implementation of community health choices in the phase 1 region. There is a drop off between the orange bar in phase 1 for 2017 and the gray bar for 2018. There are also drop offs in phase 2 as well.

In terms of home delivered meals this shows a drop off between 2017 and 2018 and this is just the percentage of people using home delivered meals. Here we are just focusing on the aging population and you can see in phase 1 a slight drop off whereas in the other parts of the state during the same time period it was either slightly increasing or unchanged. So there is something to pay attention to with regard to home delivered meal use under managed care.

So to wrap up, HCBS utilization in 2018 shows controlled growth in PAS hours but potentially drops in other service categories. However, the satisfaction remains high and shows improvement from 2018 to 2019. We see improvement in satisfaction with regard to transportation services as well as however there is opportunity for improvement in planning your time which is intended to be a measure of personal-centered care planning in.

Phase 2 we expect to see the same general pattern of improvement in 2019 as we did over the 3 years of data in phase 1. When we look at the health plan measures we see improvement in all 4. I'm sorry we see generally positive findings in all 4 categories with regard to rating of why you are health plan. Finally when we talk about nursing homes we are definitely areas for potential improvement with regards to communication, service coordination and transition to the commontician. We can open it up for questions.

>> Sellers: Borb if any committee members have questions. I have several from the audience.

The accessing and use of behavioral health services by the CHC population. This is an area of increased resources that were offered and not being used at any expected level by the participants. Why not and what can be done to address and correct that reality? I don't know if you had had any input.

>> Howard: I will say that we have been looking at this measure, looking at the issue of behavioral health services very carefully. We know there are expanded benefits. We have been tasked to exam whether there are changes. So the data that I have presented so far have just been survey data on this point. So we are looking at this using administrative climbs data for 2018 and eventually we'll have 2019. But maybe I can turn it over to OLTL and they can provide just a real brief summary of steps they have taken to work with nursing homes and other providers to communicate in response to those findings to communicate the availability of the new benefits.

>> Sellers: Brian, do you want to speak to that?

>> Howard: I can address it from my observations just to keep it moving. My understanding is that in addition to communicating the availability of the benefits the office of long term living has worked with all 3MCOs as well as the DSNIPS in the state to prepare plans and submit plans for identifying -- for how they will improve coordination with behavioral health with the behavioral health managed care organizations my understanding is that the office of long term living has taken this issue very seriously and has been working with the managed care organizations to encourage them to improve access to behavioral health services.

>> Sellers: So then the next question I have is from Amy. Were the providers asked about COVID providers of personal assistant services or other in home services?

>> Howard: Yes. I don't have a breakdown of the types of providers that respond today our survey. There were 90HCBS providers that did respond to questions about COVID and that includes PAS providers.

>> Sellers: Are you collecting any behavioral health data?

>> Howard: As an outside evaluator we have access to Medicaid data that includes mental health data. We have that in our wheel house an we are analyzing those data.

>> Sellers: And then -- we will send these along over for follow up off line. Just to mention asked some specific break out around some of the data you presented today. We will pass that along to OLTL for follow up off line. I think that is all of the questions that I received related your presentation. I don't know if there is any other questions from committee members.

>> Barb: I haven't seen any come through.

>> Howard: Questions filtered through OLTL my E-mail is on the screen if anybody has any follow up.

>> Barb: Thank you Howard.

>> Mike: This is Mike Grier. Will the presentation on on the website on the OLTL website?

>> Barb: Mike, they post presentations on the --

>> Howard: It is in the meeting notes for today's meeting.

>> Sellers: It is available to download in the handout section.

>> Mike: Thank you.

>> Barb: Next up we will open up for questions for the CHC-MCOs. Do any committee members have questions for the MCOs? It

No. I am going to circle back. I had one that really was at the end of Tanya's presentation and so Pamela was asking about the CHCa-MCOs to identify participants that might be interested in Services My Way and also offering Services My Way as part of their LTSS options. We'll start with Jen Rogers from Amerihealth.

>> Jen: It is Jen. Can you hear me?

>> Sellers: Yes.

>> Jen: Thank you for the question and thank you to Tanya: I think she had to hang up. That was a great presentation for address the question a bunch built in questions about Services My Way in our plan of care and also in our checklist. Just as a reminder to the service coordinator who is facilitating the face to face meetings that this is an option in Pennsylvania and to share information with participants and the team members about

how it works and provide space in the conversation to answer any questions. So we also have on boarding and service coordination training that covers the Services My Way as defined in the CHC agreement. We are leaning on the task for to finalize the training because for our plan we are ready and open to receiving that training once it is passed the approval process with the OLTL policy team. So once that is finalized I know Tanya is eager train our team an we of course would be very open to that.

>> Sellers: Anna, how about for PWH?

>> Anna: Can you hear me?

>> Sillers: Yes, thank you.

>> Anna: Thank you, everyone. Just to piggy back. We have representatives that attend this Services My Way meetings and we're anxiously awaiting the vetted training that we can send out to service coordinators it is such a valuable program and we would really like to see more momentum from consumers accessing it. So without reiterating what Jen said we are in the same place and just waiting for that training to get launched. We were doing it on a regular basis and then it was pulled into revamp it a little bit. So that's about all I have to add.

>> Sellers: Thanks, Anna. Then I will go to Mike Smith from UPMC. Would this be something you would be able to speak to?

>> Mike: Can you hear me? Great. Very good. So we're also participating in this work group as well. I think we have preponderance of folks in the program right now if I am correct on that. I think not only do we have prompts in our systems to make sure the coordinators talk about Services My Way, we also have a couple of designated specialists on board that we're trying to foster so that the complexity of that program and the way it operates we have somebody a bunch a couple of folks in the regions that are specializing in it as well to Mike sure they can help out service coordinators and make it effective if people choose that.

>> Sellers: Okay. Thanks, Mike. So the next question that I have for the MCOs is from the Yvonne. Her is do the MCO have a plan to help increase enrollment at adult day centers? Let's talk with Anna this time.

>> Anna: I love that question because we see such value with adult day centers. But given the current climate that we have and still awaiting guidance for centrist in those programs I think it is a little too early for us to have an outreach strategy to drive membership while we are in such critical COVID times. That's what I have got.

>> Sellers: Mike, how about for UPMC?

>> Mike: I would agree with what Anna said as well. I would just add that we were pre-COVID working on a strategy to do some active outreach on the program and really start to -- we have been looking at and around liesing membership to date and trying to figure out ways to grow the service as well prior to COVID. So post COVID we have been sharing the correspondence from the office of -- the Department of Aging with our staff. We continually provide updates on the openings. We have reached out to too sill Tate communications with them how to move things forward as soon as the various day cares have their plans in place to do that. So we're trying to be proactive. Again, I think to Anna's point it is pretty tough in this environment right now.

>> Sellers: Jen, how about for Amerihealth care.

>> Jen: The only thing I would add to what Jen an Mike contributed to the question, by also looked to the adult day centers and their collision asked us to get communication with updates and changes and any service offerings or new rules and requirements that the adult day centers are incorporating to get that information to our service providers so they are entered no person-centered service planning meetings informed and able to answer questions so as to not obviously deter people from resuming adult day or trying adult day because if anything we have learned through the pandemic socialized isolation is a real thing. What whatever we can do to mitigate fear and anxiety and trepidation, we lean on the adult day centers to help us do that when we are talking with participants.

>> Sellers: Okay. Thanks, Jen. At this time, Bar, that is all of the questions I have for the MCOs.

>> Barb: Wow. All right. Before I let everyone go I wanted to let the committee members know that the MACC is evaluating the current structure of the subcommittees and they are going to be making a recommendation to DHS. For instance they are looking at the fee for service subcommittee and with the move to CHC is there still necessity to have that subcommittee continue?

>> So as I hear more I will definitely share with you.

>> Sellers: Go ahead. I'm sorry. I do have some other general comments that weren't specific for MCOs that came that came in for the public comments.

>> Barg: Go for it.

>> Sellers: The first one from Daniel. Structured day services return to their original facilities and program formats there will be limitations to the number of participants who can receive service simultaneously due to the social distancing requirements and physical limitations at our facilities. As a result this will lead to a reduction of services for

individuals. Will we be able to provide structured day programs in participant's homes or vertically to complement the structured day services in our original facilities?

Jamie, I know Patty had to leave. I don't know if anyone else from policy is able to speak to that if you don't know, Jamie. It looks like we have also lost Jamie. So I think we'll have to -- unless landy is able to spoke to that.

>> Randy: This is Randy Nolen. Yeah, we should be able to. We have talked to the MCO that we know there will be limitations on the amount of people going back to adult daycare. Some will not want to go back or some will want to go back 2 days a week based on capacity. Unless we have fully discussed the second part if they can continue to provide telephonic services to those individuals. If you forward me that question, I will talk to the policy folks about that. From the MCO perspective what are you thinking to making sure that people that have adult daycare services are not going to be able to go back fully? How are you going to ensure that they get services?

>> Sellers: Mike, do you want to answer that one first?

>> Randy: We understand that people are going to be coming back in staggered approaches. We have actually let our that have know in the weekly updates to expect that correspondence and back and forth with the various adult days and that if there are services already in place to augment the original reduction or change, that those would remain in chase you would have to coordinate if 2 days a week they are going in you would have to reduce -- basically adjust the path for those 2 days. The authorization is still sitting there on their plan. They are in good shape to do that. We can be flexible around all of that. Work with your service coordinator on it.

>> Drew: Barbara, could I clarify Dan's question? It wasn't about providing that service telephonically. It was about providing that service in the residents. That was the standard that was relaxed during COVID. And so if this is talk willing about structured day not adult daycare. If you can only accommodate so many people in a structured day program, I think Dan's question is can he still continue to provide structured day in the residents for those who cannot be accommodated in the day program space?

>> Go ahead, handy. **>> Randy:** I have to check with policy to see what guidance is on that. If you send me those is eyes we will get answers out to you.

>> Sellers: We will send that one over on the follow ups, Randy.

>> Randy: Okay.

>> Sellers: I guess do either Amerihe alth or P H.W. have anything to add or wait for the clarification from Randy.

>> Anna: I would prefer to wait for clarification from Randy.

>> Sellers: Jen?

>> Jen: Same here. Thank you.

>> Sellers: Sure. So there was another question here from Yvonne. She wanted to add that their center provided virtual programming for 4 hours a day on Zoom which was not reconsidered. Will the MCO consider reimbursing for virtual programming? This is probably also something that policy is going to need to follow up on. I don't know that this is part of the current -- currently approved Appendix.

we will send that one over as well.

B ar, this was back to Jamie's presentation. Jessica asked is DHS or OLTL have an update on the release of the services RSA and new case management system integrated procurement.

>> Randy: This is Randy. We did put it on hold because of trying to coordinate with the case management system work that is being done. We reevaluated that. Right now what our plan is is to release it at the beginning of August. That could change if something else drastically changes in the system. Our goal right now is to release it in August.

>> Sellers: Okay, thank you. Barb, as of this moment that is all of the questions I have.

>> Barb: All right. Well, at that rate I'm going to wish everybody a wonderful Fourth of July holiday. Our next meeting will be August 5. It will also be a webinar and remote streaming. Thank you everybody for participating and have a great day. [meeting ended at 12:43]