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Date:8/5/2020

Event: Managed Long-Term Services and Supports Meeting

- Test test test test >>> Should we give it a minute or two?

  I see more people are logging in.

  >> Yes.

  That would be a good idea.

  >> Okay.

  Thank you.

  >> Good morning, everyone.

  Nice to hear your voices.

  >> Good morning, Jill.

  Haven't heard from you in a long time, Jill.

  >> Will we ever see each other's faces again?

  >> I know, right.

  >> You can always use the video camera although I'm not a fan.

  I'm not either.

  >>You couldn't tell anyway.

  It's too girly.

>> Gosh, I wish I had those curls.

Good morning.

>> How are you?

>> This is rich wellings.

>>> Good morning, everyone.

Welcome to the subcommittee.

My name is Barb holder.

I would like to take attendance.

Be I call your name, please acknowledge you're on the phone.

Blair.

>> Good morning.

This is Blair.

>> Good morning.

Neil.

>> Good morning.

Hope everyone is safe out there.

>> Thank you.

David.

>> Good morning.

This is David.

>> Good morning.

Denise.

Drew.

Gail.

>> Hi, Denise curry is on.

I was having a hard time getting unmuted.

I apologize.

>> No apology needed.

Good morning, Denise.

>> Good morning.

>> Good morning.

Gail.

>> Just a reminder for those of you whoa are unmuted, can you please self-mute?

Did you.

Gail.

Armand.

>> I'm here.

>> Good morning.

>> Good morning.

Jim.

>> Jim.

>> Good morning, Jim.

Jesse.

>> Good morning, Barb.

I'm here.

>> Juanita.

Linda.

Juanitais on.

--

>> Good morning.

There we go.

Lynning da was on.

She was self-muted.

Luba.

Matt.

Mark.

Mike.

>> Good morning, Barb.

I'm here.

>> Good morning.

Rich.

>> Good morning, Barb.

>> Good morning.

Richard.

I believe he is on.

Barb, this is rich.

>> Yes.

I do see rich.

His name is popping up.

Rich wellings, thank you.

Sister Catherine.

Steve.

>> Here.

>> Good morning, Steve.

>> Good morning.

>> Tanya.

Carrie.

William.

>> Yes.

Good morning, everyone.

>> Good morning.

>> Good morning.

We ask that you please keep your language professional.

All the webinar participants except for the committee members and the presenters will be in listen only mode during this webinar.

While the committee members and presenters can speak during the webinar, we ask that you please use your mute button on your phone when you're not speaking.

This will improve the sound quality of our webinar.

We ask participants to please submit your questions and comments in the chat box located in the go to webinar pop up window on the right side of your computer screen.

To answer a question or comment, just type into the text box under questions and press send.

Please hold all your questions and comments until tend of each presentation as your question may be answered during the presentation.

Please keep your questions and comments concise, clear, and to the point our transcripts and meeting documents are posted on the ListServ and they're normally posted within a few days of receiving the transcript.

The captionist is documenting the discussion remotely so it's very important for people to state their name or include their name in the chat box and speak slowly and clearly.

Otherwise, the captionist may not be able to capture your conversation.

This meeting is also being audio recorded.

The meeting is scheduled to end at 1:00 p.m. if you have any questions or comments not heard, please send them to the resource account and for your reference, that account is listed on the agenda.

Public campeds are taken at the end of each presentation instead of during the presentation.

We always allow additional 15 minute period at the meeting for any additional public comments may be entered into the chat box.

Our 2020 meeting dates are available on the DHS website.

And with that, I'm going to turn it over to Jamie for the OLTL updates.

>> Can anyone hear me?

Yes.

>> Great.

Excellent.

I'm sorry.

I could not get go to meeting to work so I had to dial in and I was not sure if everybody was going to be able to hear me tonight.

I don't have a PowerPoint because I'm called in through my phone.

I gees.

Maybe somebody else can run the PowerPoint for me or maybe everybody has a copy of it I assume and you can see it in the go to meeting. So you can follow along with what I'm going to say.

Via the PowerPoint if that's okay. You do?

Excellent.

So sorry about this.

I spent the last ten minutes trying to connect so I apologize.

>> So happy August.

I can't believe it's August already.

The summer is slipping away quickly.

And I feel like I'm not taking time to enjoy the weather so I hope everybody else is.

So just to go to the agenda, I'm going to give an update on COVID-19 today.

Talk a little bit about enrollment services.

And then at the last meeting, we talked about racial disparity and we had a conversation asking the committee to give us some suggestions or some observations of any racial disparities they saw in the CHC program and any kind of suggestions that you had.

One of the things that the committees asked for was better data on I want to say the racial spread across the program and what the program looks like.

So we have that to provide to you today as well.

So with that, we'll get into the COVID-19 update.

I'm on slide four for those of you controlling the slides.

So we released and I think we may have talked a little bit at the last meeting about the appendix K transition plan.

So as the state was moving through the different color coded counties from red to yellow to green, the office of long term living was working on an appendix K transition plan on changes to our provisions as counties progressed through the color coded classifications.

So on June 26th, we released our plan, our transition plan that outlined the appendix K provisions and how we were transitioning back into a more normal state I want to say.

Now that counties had entered the green phase.

So I will say as the COVID-19 response evolves, it seems to change every day.

The guidance is subject to change.

It's based on lessons learned or due to a resurgence or other identified need.

So with almost everything else right now, this guidance is fluid.

We are evolving it.

So we require them to submit reopening plans to conduct face-to-face and telephonic assessments.

That was one area covered in the transition plan under the red phase, we were we were requiring assessments and the plans were not allowed to make any reductions to services.

As we entered the green phase, we were encouraging or strongly encouraging, requiring, the plans to start to conduct face-to-face assessments and in certain circumstances, the plan could conduct telephonic assessment.

And just plan accordingly.

So we had conversations with the CHCs and wanted them to community to us how that outreach was going when they were contacting participants and scheduling face-to-face assessments, how many participants were refusing assessments, and how many telephonic assessments they were conducting.

How many service reductions they were experiencing as well.

We are analyzing that data and it is submitted by the MCOs.

Just an update on that.

Really the only plan that has been actively outreaching to participants and conducting face-to-face and telephonic assessment aces at this point is Pennsylvania health and wellness.

They began outreaching to participants as of June 26th and they have been processing person centered service plan changes and reductions based on the assessments.

UPMC started the outreach to schedule the face-to-face or telephonic assessments just this week and so I think they've done some telephonic assessments and reassessments since the beginning of July with no reduction to current services.

And -- they also have done some -- there have been some concerns through service coordinators and their willingness to perform face-to-face assessments.

We've worked through and had conversations with the plans on those.

The CHCMCOs were in their reopening plans.

They were required to have training for their service coordinators and also outline kind of their PPE plans in terms of when a person was entering a person's home and doing a face-to-face assessment.

Those reopening plans were rather detailed.

So next slide.

We also wanted to give an update on the regional response health collaborative program.

The regional response health collaborative program was created by act 24 of 2020.

Act 24 provided funding from the federal cares act to obviously a lot of office of long term living providers but it also created this RRHCP program.

It was modelled after the educational support and clinical coaching program that the office of long term living was heading up which provided technical assistance and clinical support to -- through a number of health system partners to personal care homes, assisted living residents, and later nursing facilities.

So it was providing technical assistance sessions, webinars that are personal care homes and assisted living residences as well as nursing facilities could dial into and get the support that they needed to deal with the COVID-19 crisis.

The legislature really liked the program and obviously funded it with 175 million, so with that funding, an influx, the office of long term living and the department along with the department of health and PEMA worked 24/7 to set up the RRHCP program and funding in RF -- I think it was an RFA was released.

We evaluated it and made the funding award and as part of getting the RRHCP up and running, we announced I believe it was last Friday that the call centers, one of the requirements of the RRHCP programs were withal.

So they're -- operational.

So they're now able to add that operational and administrative support to protect residents and personal care homes and assisted living facilities from screened.

These call centers are available nor the provider -- for the providers on a 247 hour 7 day a week basis.

Facilities are encouraged to contact the RRHCP by calling the telephone numbers covering their specific counties where the facility is located.

So if you go to the next slide, it gives you an idea of the regions in the state and then the health systems that were the RRHCP regional partners in that area.

So, for example, in the southeast, Thomas Jefferson university in partnership with main line health and LeHigh valley is covering Burkes, Delaware, and Montgomery, Philadelphia, and Schuylkill counties.

In late may we have gotten many questions from stakeholders about when this RFA was going to be released so obviously it is released August 3rd.

I would check out this RFA.

It is posted on the E marketplace website.

The vendor will provide enrollment counseling and beneficiary -- bois need long term services and supports through the office of long term living.

So I believe that the respondents will have approximately 60 days to respond to the RFA and I would encourage everyone to check it out.

There are different dates.

I know there's going to be preproposal meeting that will be held.

I can't remember the exact date but it is listed on the E-marketplace website.

Also those who are possible respondents have the opportunity to submit questions about the RFA and that deadline is also listed in the request for application.

So I would encourage everyone to check that out.

Next slide.

So the racial disparity evaluation, in follow up to the committee, we were asked to provide kind of the race and ethnicity for the community health choices participants by participant category.

So we have a number of charts and actually some really nice visual maps that show the breakdown of our populations by race and ethnicity and they fall into the different categories.

So just looking on the left-hand side of the slide, we have the different race categories and then we have columns that show the long term care, the percentage of statewide total and long term care home and community based SKFSs, NFI, and then the second to last column totals them by all CHC percentage statewide and then we added another column which shows the 2019 census total so you can compare the CHC percentage total to the state wide census total to see where we are in terms of brakedown of the CHC program.

So obviously on this slide it's most interesting I think that the populations served by CHC does not exactly match the census total as you can see.

I think there's some big differences in terms of the population served by CHC in terms of white and black.

Asian measures up pretty closely as does American Indian.

We do have a large population in CHC that seems to be other or system default and we do have an unknown.

So we do have people when -- we do have people when submitting information to -- this isn't either clearly defined by the participant or clearly selected or it's not entered by the CAO.

So next slide.

Sop this slide shows just the breakdown of non-Hispanic and Hispanic populations in the CHC program and as you can see, the columns show the same data, the long term care home and community based services, NFI and CHC percentage total.

So these match up a little closer to what the census totals are showing in Pennsylvania.

Next slide.

We provided these maps so we can see what the populations look like across Pennsylvania.

Obviously for long term care most of the African-American population is centered in our major urban areas in the state so Philadelphia and the counties that are around the Philadelphia area, Dauphin county and Allegheny county.

So not much of that population is in I want to say the traditional T area.

But if we look at the next slide, this is the percentage of long term care for.

>> So sorry.

Technical issues.) So with that, I think I'll open it up for questions but one of the questions I would have for the committee is based on the information provided.

I wanted to follow up with the committee and see if you had any recommendations for the office of long term living for the community health choices program.

>> This is Juanita.

Can you hear me?

>> Yes, I can hear you.

>> Yes.

You asked did we have any recommendations.

Absolutely.

I think we need more participant input and developing all of this.

It seems as though it's more difficult for us to receive better care and better use of our -- of these services.

It's very difficult to DPEEL with the service coordinators and we're met with resill Janz for any kind of increases and services and payments for direct care workers.

The services are developed because of our disabilities and we seem to be not being adequately taken care of through the services and I see that you were talking about the programs developed through the COVID.

It all seems to be benefitting both of our disabilities where we need the care.

We need the services to be increased on our behalf and for us to be able to utilize and that's not happening.

>> So in terms of a conversation, can you give me an example?

I think that would help me better understand --

>> Yes.

Through the COVID, I got sick.

I had fever over 103.

My direct care provider stayed with me all night to break the fever because it was an emergency.

I'm sorry.

I'm getting winded because I have other problems.

[Indiscernible Audio] service coordinator.

We asked them could I have another extra hour each day --

no, week.

-- extra hours a day, a week, so seven hours.

They took me through a hard, long process in which I said I have -- they turned me down and put my service claim wrong.

They put wrong information in and I never got my service plan.

Mistreated me.

And it's not the first time and I wasn't able to get through to the office of long term living.

They directed me to an in house process to complain where it just pretty much didn't make any sense to me.

They defeated me at every cause and I wasn't able to get through to get anything but I just felt as though we wasn't -- she wasn't able to get justification that we needed because the system is a work of force -- the system isn't working for us.

It's working against us.

The participants are the sick persons.

It never got resolved on my behalf.

They treated me as though I was bothersome and they turned it down and lied in the COMPLAPT and never got no results.

And I wrote in to the panel because I wanted them to know they're using this tactic and behavior.

And I seen in the last meeting where the panel wanted to get rid of the subcommittee.

That would not be fair because our voice would be silent.

We can't have that happen.

I don't think it's right.

As if there wasn't us disabled in this program when we exist.

And I don't think that should happen.

So, therefore, we're not getting any increases and have never gotten any increases since she worked for me and takes care of me and they do the hard work.

Yes, y'all do the hard work of legislation.

It's wonderful.

We needed this.

It was worse when we kept going to the hospital.

But now we're home and people are taking care of us and they can't be treated properly or compensated properly and this is happening with the service coordinators providing false information to y'all about how they treat us.

They mistreat us badly.

>> Okay. Thank you.

Your example was helpful.

>> Thank you so much.

>> This is rich wellings.

She's a consumer so I have a quick observation.

I wonder who her service provider is and if her service provider is present, can we ask that service provider to get back to her in 48 hours?

>> It's a legitimate complaint and obviously she's concerned about the quality of the service provider so what can we do about it?

>> Thank you so much.

>> This is Pat.

Among we heard Juanita mention the plan and I believe Jen is on.

Maybe Jen wants to respond and maybe connect with Juanita.

>> Maybe somebody is on mute.

But we can definitely follow up with Jen.

>> All right.

This is Rich again.

I had another observation.

I don't have act stows the slides right now but is the racial or ethnic disparity a question of CHC membership, EG, people now on the plan relative to census or is it the services those people are receiving relevant to the census?

>> So we didn't look at volume of services.

We just looked at the racial make up of who was in the CHC program and we did not even break it down by plan.

>> Okay. So this is my two cents.

Not solve it here but given, I think, America's wake up call to racial disparity, racial prejudice across the board, I think it's up to this committee or another committee to close that gap and I don't know specifically in one minute what actions we should be taking additional outreach.

Phone calls.

What's the reason for it.

I'm going to suspect many --

there might be a divans of awareness in the program.

On the part of potential participants or those that can offer -- but I think services for people who are eligible for those services when there is that disparity, I think that requires some sort of effort to close the gap.

Had rather than it just exists.

I don't have an answer of the best way of doing that.

But I think that's up to the service providers and we ought to be looking at and reporting on that as time goes on.

>> This is Jim.

I'm not sure I understand what the gap is.

I mean, the -- I'm not sure that the data shows that there is or isn't a gap unless I'm misunderstanding the data.

It sounds like some of the issues raised this morning were more operational than racial disparity unless I misunderstood.

Is there a specific data that shows that there's denials of service based on race?

I didn't see that in the data and I apologize if I didn't interpret it correctly.

>> No.

And we didn't show service denials or anything by race.

It was -- this was just the make up of the CHC program.

When we talked to the committee earlier, they were really interested in seeing kind of by race where people were receiving services in the CHC program.

It's what we provided visually across Pennsylvania where people were in what counties by race in the CHC program.

>>> I thought everyone eligible for CHC fangs either notified, picked a provider, or was assigned a provider.

Everyone who was eligible was signed up regardless on the phone race, correct?

>> Correct.

I think really -- and this is just my -- I would be interested in the committee's input or if they see it differently if the I think what I saw looking at the racial data of the slides was that primarily, the population served by long term care was white just based on where in the state you lived so most people in the T were in long term care facilities and then for home and community based services, it's the population served with African-American in the more urban areas of the state.

That makes sense.

That stood out most to me.

I'm wondering is it a cultural thing.

A racial thing?

That most people in urban areas are in home and community based services and if you're in more rural areas of the state, you're primarily in a long term care facility.

>> Overlaying the socioeconomic -- [Indiscernible Audio] all kind of fall into whether someone becomes -- has [Indiscernible Audio].

>> This is Blair.

I think one of the things too when you look at data, it's very hard to discern between cause and effect and what's -- might be based on ethnicity, race, driving it versus going along with the geography so if there are fewer nursing facilities available saying Philadelphia and there's also more services available, is that the driver or maybe it is more driven by culture, race.

It's hard to tell.

I think in my mind regardless of the reason the most important thing we think about, one of the most pressing topics of the day is that whatever the reason that people working in MLTSS whether they're MCOs or they're on our subcommittee we strive to be as diverse as the population that we serve.

And have this broad range of diversity of thought and that we get good ideas and input from our employees at the MCOs, people in the subcommittee, those in OLTL that represent the diversity of the people we're serving.

I know there's some positions, probably open positions for the subcommittee in the future and I think we should strive to mirror the diversity of the CHC population.

>> That's a good idea.

>> This is Jesse with the CAU.

I appreciate the work that the department is doing on this.

I think it's a really important topic that we need to begin to broach and I think a couple of other just ideas that if we wanted to go kind of a level deeper on this, one is understanding the race --

outcomes by race and ethnicity.

Because enrollment is one piece of it but understanding that there are different outcomes in terms of people's interaction with the services.

That's probably harder to capture but we are doing a whole -- I know [Indiscernible Audio] itself and being able to get the evaluations done by race and ethnicity [Indiscernible Audio].

So it might help us understand enrollment and also if there are challenges with the program --

around race and ethnicity and people are getting the outcomes that they want.

I think I mentioned this before but the -- also understanding the workforce, similar kind of data like this around the long term care workforce both in the community based setting and the nursing facility setting in particular but because I think as other folks have mentioned that making sure that the --

does the workforce reflect the population that we're serving or are certain groups overor underrepresented in the workforce that one of the questions that I have that you raised about the urban home and community based services, rural long term nursing facilities, I think it would be interesting to get to the bottom of why that is and I suspect some part of it may be accessibility of the workforce and who is providing the different workforces.

>> >>> Next up, pattedty will talk to us about the 2021 CHC waiver amendment >> Thank you very much.

I'll take a minute here to share my screen.

Okay. Can you hear me and also see my screen in.

>> Yes.

>> Okay. Good.

Well, good morning, everyone.

This is patty Clark.

I am a division director in the OLTL policy bureau and this morning I'm going to walk you through some proposed changes to the community healthed choices waiver.

As a reminder, the waiver serves individuals in CHC who are eligible for long term services and supports and they receive their services in the home or the community rather than in a nursing facility.

So the proposed amendment will be effective January 21st shall, 2021.

The purpose is to revise service definitions.

Some of the liltations.

And some of the provider qualifications for the waiver services.

We're also adding clarifying language to services provided by stakeholders.

The fiscal employer agent [Indiscernible Audio] Praktis Praktis L.

We're updating electronic visit information and verification.

We're revising some of the waiver performance measures.

The ideas for the changes in the waiver, they come to us throughout the year from various stakeholders such as advisory committee members.

Providers.

Participants.

The MCOs.

Provide suggestions.

And also advocates.

OLTL staff sometimes offer suggestions to changes in the waiver and this could be based on questions that they receive throughout the year.

If we get a question numerous times about a service, we may decide just to add the information about that service directly into the waiver because we feel maybe this service definition needs to be clarify sod let's just add the information directly into the waiver.

A public notice fangs published in the pep pen bulletin on July 25th.

We're now in a 30-day public comment period and that is open until August 24th.

Proposed changes can be viewed by going to the 2021 community health choices CHC waiver amendment page.

Any comments made today during the meeting will be noted by the OLTL team but we also ask you to send in written comments so they're fully captured.

Send that to the department aces resource account which is RA-waiverstandard@PA.GOV.

So when you go to the web pages and this information is in the public notice as well as on the web page itself, what I'm going to do is bring my screen over here to show everyone.

When you do go to the web page for the waiver information, there's a summary at the top.

Let me scroll up.

You can see this is the page with the amendment information.

And as you scroll down, you'll see a side by side which compares the proposed changes in the waiver to the current language.

And then you'll see all of the different waiver sections.

These are all appendixes.

You'll see all of those listed.

If the appendix has an asas --asterisk, we're proposing a change.

At the bottom of the page you click on this link and that will bring up the waiver comment form.

So the presentation today is divided into two sections.

The first is to go over some clarifications that we're adding to the waiver.

What this means is we're just adding some detail to the waiver service definitions but we're not really proposing to make a major change.

Again, I mentioned earlier that sometimes we get questions throughout the year and we might want to add some detail to this service definition just so people understand exactly how the service is to be provided.

So for system services we're adding a clarification that the services to be provided at a one to one ratio so one participant to one provider.

This includes behavior therapy.

Cog if I tav rehabilitation.

It should not be a group session with multiple participants in the session.

Sphere assistive technology we're adding language to support the use of smart home technology such as tablets and leche Trovanic communication devices and hubs.

These items were previously approved when requested in the waiver so we thought we should just add some detail to say that these are included in the service.

And what's in boled is what's being added on the presentation.

We're clarifying that the service is intended for individuals moving from an institution or other provider operated arrangement to a private residence where the participant is responsible for their own living expenses.

Also if the security deposit requires payment of the first month's rent, that can be included under community transition services.

And finally the services for expenses incurred up to 180 degrees following fireman situation.

>> For nutrition consultation, we're removing some duplicate language from the service definition.

And also adding that services working -- individuals working for a home health agency must be a registered dietitian or a certified nutrition specialist.

This is in the services my way model.

We are modifying the service definition to align with language in the personal assistance service definition.

Because participant directed community supports is essentially just passed but it's in the services my way model.

For personal assistance services, we are clarifying how and when transportation may be provided by the worker and how the costs associated with transportation are covered.

And we're clarifying that pass workers living in the same residence as the participant cannot be paid to perform household chores unless they're completed solely to benefit the participant.

So we don't want the waiver to be paying a worker to do their own laundry or clean their own personal areas.

The service should be directed at the participant.

For the personal emergency response system service, we are define what constitutes a unit of service which is a one time installation fee or the monthly monitoring fee.

And we're clarifying some of the costs adding that the cost of training participants is included in the charges for installation or the monthly monitoring fee.

Also the maximum units per calendar year are one installation fee and 12 months of monitoring.

And then the provider may not charge any additional costs over and above the installation and monthly monitoring fees.

For vehicle modifications, these must be obtained in the least expensive most cost effective manner and when a vehicle is purchased and it already includes the adaptation, the waiver does pay for the adaptation itself but not for the vehicle.

So what needs to be done in these circumstances is there has to be a breakdown of the purchase price of the vehicle versus the adaptation and so we've just added some language that this breakdown is provided by a vehicle modifications contractor.

So now I will move on to some sub -- substantive shapings in the waiver.

With assistive technology we're adding a new provider type of equipment technology and modifications agency or specialist.

So that this provider can supply smart home technology.

For some of our employment services including career assessment, job coaching and job finding, adding sorrow cakesal rehabilitation counselors as providers.

For participant directed goods and services, we're expanding the provider type to include individual vendors, businesses, and independent contractors.

Throughout the years we've received a will the of questions about what this service entails and realized maybe our service description could be a little bit more descriptive so we've added some detail to that.

We've also added a requirement for an independent neuropsychological or neurobehavioral assessment to receive the service.

And the reason for adding this was we were trying to support the service coordinators who may not have the expertise to be able to decide whether or not somebody needs this service so having that assessment is a good indication that the participant would benefit from the service.

And then for cog rehab, the last change is adding licensed occupational therapy assistance as providers of the service.

For community transition services, we are removing the service coordinator as the provider type.

Now that service coordination is an administrative function of the MCO.

And we are expanding the provider type of the independent vendor to include landlords, utility companies, and retail establishments.

If they have certain qualifications and two years of experience WSH they would be a certified environmental access consultant.

A certified living in place professional.

Or someone who has an executive certificate in home modifications.

Weaver also adding that the contractor must ensure that the dwelling is structurally sound and accommodate the proposed modification before doing the modification.

Also contractors must be conflict free.

-- with the Americans with disabilities act.

And we want to ensure that the contractors that are doing these home adaptations, they do have experience with accessibility modifications.

The reason for this change is we want to ensure that whatever adaptation is put in place that it's going to be something that the participant can use for a good amount of time and it would not be something short term for the person.

Also, rent to purchase vertical lifts and stair guides may be rented as long as the rental cost does not exceed the purchase price.

The waiver will not cover duplicate adaptations or repair or maintenance.

And then within the waiver service definition we usually include a list of items that are covered by the state plan because the item is supposed to be covered first by the state plan and if the state plan doesn't cover it, then the waiver can cover it.

So some of those items that we're adding include wheelchair lifts, stair glides, ceiling lifts, and metal ramps.

This is because the office of medical assistance programs has sent in a state plan amendment to the federal government and they are asking to have these items included in the regular state plan.

So if CMS approves that, then individuals will get these items through the state plan and not through the waiver.

And that's all something that the MCO handles I think for participants a lot of times that's behind the scenes.

They may not even be aware of how they're getting the item because the MCO kind of manages all that as far as the payment mechanism for getting the item.

For personal emergency response systems, we're updating the service definition to include some of the newer technology.

Such as GPS technology.

Specialized medical equipment and supplies we're adding to the durable medical equipment provider qualifications and we're adding an optional assessment by a certified assistive technology professional.

Currently, an independent evaluation is needed for specialized medical equipment and supplies.

And that evaluation is done by an occupational speech or physical therapist.

And so we're just adding this optional assessment for certain pieces of equipment.

The optional assessment might help to determine the exact piece of equipment that somebody needs.

This is our last slide.

So for appendix B we're amending the responsibilities of the fiscal employer agent.

The FDA.

We're removing the requirement for a support broker.

That's because the duties that had been designated for the support broker are in practice really being conducted by the FEA and service garde Naters.

-- coordinators.

For our performance measures and these are quality measures that we report back to CMS, the centers for medicare and medicaid services, it helps us gauge how we're doing in our waiver with quality.

We're removing the outreach and education vendor performance measure because this contract was in place only through the implementation of CHC and now that we've implemented phase three and are statewide we no long veer that contract in place.

So we're moving it from the waiver.

And then finally we're addings a performance measure for participant preventive care visits.

This is something that CMS wanted us to have in the waiver to have at least one measurement of a participant's physical health and so we will just be tracking if people are going to the regular doctors visits for preventive care.

So that is everything that's being proposed.

And as of right now these are just proposed changes.

We look forward to getting comments from members of this advisory committee as well as the general public and providers participants on the proposed changes and if you have suggestions for other changes to the waiver, we would be interested in hearing about them.

So I guess now I'll take some time for if anyone has comments about the changes, I would be happy to take those now.

>> Yes.

This the Juanita again.

How are you?

>> Good, how are you doing?

>> I'm okay. I'm listening.

And since I am a participant of the services, I do have some questions.

I noticed a lot of the changes to me seem to be taking out of the hands of the participant and putting them into so many other I think -- I thought we were moving away from that and it seems to be reverting back to putting it in the hands of persons outside of people we choose to take care of our services.

Kind of taking away our power again.

I'm opposed to a lot of the changes so that the whole entire committee and persons involved in the -- like you said, in the changes or the medicare and office [Indiscernible Audio] I wanted everyone to be able to read my thoughts.

Because I can't express it all right now.

I want to say it to be clear but I did see a lot of the proposed changes taken away again from where we move add way from already and it seems like it's going back again.

>> Okay. Is there a specific change that you think that would show that?

>> Yes.

Getting certified nutritional specialists when I was in the hospital, I was worse off in the hospital than I am in my home.

The nutrition wasn't better.

I just felt as though [Indiscernible Audio] to have that.

It's wrong.

Take [Indiscernible Audio].

You couldn't get better until I got home.

>> Okay. Thank you.

I think -- I mean, I hope participants don't have the impression that any of the services are forced on them.

I mean, they're all available through the waiver and some of the qualifications that we've added we just want to make sure that, for example, if you're getting nutritional counseling, that theperson that's providing that service for you -- the personal providing that service to you is qualified to do it.

That's what we're trying to do here.

I appreciate your comments and I hope that you will submit them in writing.

Thank you.

>> I will.

I just feel a lot of things are being implemented to take away the personal care of, you know, home care and put it back into some other persons that don't know necessarily would know what's best for us.

That's what I was saying in the beginning where we need to be part of these changes.

Okay. Well, thank you for expressing that and we look forward to seeing your comments and the comments of other participants.

We do agree that we need their voices to be part of this process.

Thank you.

>> Okay.

>> Hi, this is Jim Piper.

I want to compliment you for adding some additional technology options.

I thought that was, you know, a very positive thing.

When we consider worker shortages other things to be able to use and pay for some technology just seems like a real positive change.

Just --

>> That one is absolutely.

>> Thank you, Jim.

Prop it's Barb.

Is the smart home technology defined further?

I know you're just giving us an overview but 50I78 just curious if there's some very definitive language in there.

Yes, today's presentation was really just point out to people what the changes are and if you go to approximate website with all the documents and pull up the service definitions document, that's where you'll see more detail added in there so there is more detail.

>> Thanks.

If the committee members don't have other comments or questions I do have some from the general audience.

Okay.

>> One participant was wondering why no group counseling is allowed.

>> Okay. So that's the way it's designed within the waiver itself for -- I mean, in general, for someone who is in the waiver to get behavioral health counseling, that is available to them through their standard behavioral health services through medicaid and that would -- typically it comes from the behavioral health managed care organizations.

It's a whole different system or way that people get their normal behavioral health services.

So I believe group counseling is available to people.

They would just get it through the behavioral health managed care organization.

And then within the waiver itself we really just have some very minimal services related to behavioral health and counseling is one of them.

And just from what our experience is in terms of what people need that they're not getting from their standard behavioral health service, that's what we've added to the waiver.

So the one-on-one counseling is what is the -- what we've identified is needed for waiver coverage.

>> Okay. And then a similar question from someone is as to behavioral health counseling and the limitation of one-on-one staff to patient ratio, this may be limiting for those with substance use problems as these are often addressed effectively in a group setting or those with live experience can directly confront and challenge the participant when necessary.

Thank you.

So I think it's a similar answer.

If you can just confirm that service would be available through the behavioral health managed care program versus community health choices which would cover any one-on-one counseling.

>> Yeah.

That's right, Pat.

There's a full array of behavioral health services that are available who are in CHC and those come from the behavioral health managed care organizations.

So what I'm talking about today is just a small amount of extra services that are available for somebody if they're in the waiver program.

But your full array of services are going to be obtained through the behavioral health managed care organizations and that includes treatment for addictions as well.

>> Okay. And then the next question, does other provider operated arrangements include homes or people are living in a home care agency where all residents have waiver and share the services.

Some call these places a share care home.

>> Yes.

That could be an example.

Another example might be if someone is in residential relabation within the waiver and they're going to be moving into their own apartment and that would be another example of how the service could be used.

>> Okay. Then the next question, can you please define I did MRI Kate adaptation --

duplicate adaptations are not allowed.

>> I mean, it would be doing the same -- I mean, the same adaptation at the same location.

You know, one example might be if someone needs like a stair lift or a stair glide. We might just approve and they have like two sets of stairs within the home.

We might just approve one set of stairs to have the lift added to it and not to have it on all sets of stairs within the home.

That might be an example.

>> Okay. Thank you.

>> The next squeaks from Amy for home adaptation.

Why prohibit installation repair and maintenance of elevators if that is what is needed by participants to move within their homes and access kitchens, bathrooms, and bedrooms.

Some have had elevators installed under OLTL waivers.

How will these be repaired if they break down if OLTL is contracting the home adaptation benefit it should minimally require MCO to provide maintenance and repairs to items paid for by CHC plans even if that item would not be currently cover.

>> So I think that in terms of repair if someone has an existing elevator, I think the plans and OLTL would just be looking at these on a case-by-case basis to see what type of options might be available for the personal to ensure that they could get up to the second floor if needed.

And I believe the reason that elevators are being removed is I think it's really honestly it's a cost driver.

I think with the current budget climate it's just -- very few of these have been approved in the past but we want to clarify that we don't intend to include them as a home adaptation.

I think if you really think about it, a typical home that someone has whether it's someone who is in the waiver or not in the waiver just someone out in the general population most homes do not typically have elevators in them so it's a cost driver not to have these included by the waiver.

But to look for other options for the person whether it would be a stair glide or some other option for that individual.

>> Okay. Thank you.

>> Okay. So, Matt, you have a question?

>> I do.

In the presentation on the service definitions, can you tell me if deaf blind will finally be addressed?

>> To add that into the pass service?

>> Yes -- well, no, not the pass service.

Services for deaf/blind.

They don't necessarily need [Indiscernible Audio].

>> Okay. It's not currently in the proposed changes if you have a recommendation for what -- for a service and the provider of the service, we would appreciate receiving that information.

>> Is this Jamie?

>> This is Patty Clark.

>> Okay. I mean, that's a good response.

However, my -- the person that I took the place of, we've been talking about this now for years.

Not months.

Years.

So I mean I think you guys have some definitions already that have been provided.

>> Thank you.

We will take another look.

I mean, if you would like to provide a general comment but we can also take another look at that.

I do recall a suggestion in the past about that addition to the waiver so we can take another look at that.

>> Thank you.

>> Okay. The next question, the proposed changes requiring a neuropsychological evaluation in order to receive CRT services will definitely prevent people from being able to access services.

There are not enough neuropsychologists in the state for and in each region who will accept medicaid reimbursement for a full evaluation.

A neuropsych evaluation provides testing data and does not typically include functional implications of deficits.

Using this tool to educate service cowshed Naters about --

providers is not going to solve the problem.

FSHZ and the next question is -- I lost my place.

Sorry.

Okay. To clarify, is chapter 2600 personal care home nonskilled considered a nursing home?

Are participants eligible for the waiver would be in fact eligible.

>> We do have individuals that are in residential -- the residential rehabilitation services and the provider is licensed as a personal care home.

That's the typical way that someone who is in a personal care home would be enrolled in the waiver.

I mean, we have some -- we have a clarification that we've provided to the MCOs about allowing people in personal care homes to get waiver services.

However, if they did, the individual, the participant would need to pay their own room and board costs in the personal care home because that's not part of the waiver.

And if they lived in a personal care home, they would -- the personal care home itself would need to allow outside providers to come in because within the waiver, participants get a choice of their providers so re can't limit a participant to only getting services within the personal care home.

So I guess pot Tom line is we do have an allowance for it in the waiver but it's unlikely unless somebody is getting residential rehab it's unlikely they're going to be served in a personal care home.

>> Okay. So I think just to summarize that, residents of personal care homes are eligible to receive the waiver services only if they're getting residential rehab services.

>> Yes.

Currently, that's the only way that people are being served in personal care homes.

>> Okay. Great.

The next question, do any of these changes direct greater scrutiny of an attempted increasing of population in health services by the CHC given this very slow up take of these services, it is a concern that this has not been addressed at some measure in this proposed amendment.

Thank you.

>> In terms on the floor an up if I can in behave I don't recall health services, we'd be looking to the primary way that people get that service if they're in CHC which is through the behavioral health managed care organizations.

We were not gearing our waiver to provide more behavioral health services, that's really not the primary way that people are to get behavioral health.

So we are working with the office of mental health and substance abuse and I know that the CHC-MCOs and the BHAV I don't recall health MCOs are working collaboratively to seven sure that people who need behavioral health services they get them from the managed care organizations.

>> Okay. Another question.

Slide number four, what ratio must be provided for [Indiscernible Audio].

>> What ratio.

Let me go back over the slides.

Oh, in terms of whether it has to be a one to one ratio, I mean, typically, typically personal assistance services are one to one, one participant to one pass provider, we do have some individuals may need two pass providers to help them with certain things depending on their mobility needs.

So that is from time to time approved that you would have two pass workers for one individual.

However, we don't intend for the waiver to have one pass worker serving multiple participants at one time.

It really is supposed to be a one to one ratio for pass.

>> Okay. Thank you.

And did I see that FCs now need to be RNs.

A botches in a specific field or have three years of experience as a CHC coordinator and if so does this mean current FC that don't meet this will no longer be able to do SKFS coordination?

>> -- service coordination?

>> We're not proposing any changes to the service coordinator qualifications.

We had made some changes a couple of years ago and honestly I don't remember offhand the specific requirements are but it should be in the waiver documents that you find

online to look at the current requirements that's not something we are proposing to change at this time.

But as I mentioned it was changed a few years ago.

>> Okay. And then the next question is from Kate baker.

And I believe it's how about lifts and I think she mean approximates is that covered.

>> Platform lifts.

Yeah.

I'm not sure about -- I don't know if this would be like a lift into a home from the outside getting into a home.

I think they are typically covered.

But I think it's probably on an occasion by case basis looking at the personal's situation to see what they would need.

>> Okay. Thank you.

Then next, will deaf/blind services be included in these amendments.

Which I think you indicated there's not -- that's not a service that's being added but but it sounds like you were going to look at that.

>> Yes.

That's right.

>> Okay. Okay. And that was all of the questions that I've received.

And it's right on time.

11:30, Barb.

11:31.

Wrap.

>> All right.

-- all right.

Thank you, Patty.

We appreciate your presentation and your time to take questions from us.

That being said, we're going to move into the CHC-MCO Q&A session.

I'm not sure if any committee members have questions that they want to present first before we open it up to the rest of the audience.

Or maybe the MCOs are going to have an easy day today.

So I do have -- I have some, Barb, that came in that are MCO related.

Let me just go down through here.

I guess I believe we now have Jen Rogers unmuted.

If we wanted to start circling back on that.

I apologize, Jen, if we didn't get you unmuted in time.

Can you hear me?

This is Jen.

>> I can hear you.

Yes.

So my phone is going in and out.

Is there a question specific for me to answer?

>> So I thinks just to summarizesummarize -- the best we can do is take it off line because it is a specific participant issue.

So if Ms. Gray is on the line still, I will personally make sure her service coordinator reaches out to address concerns and I apologize.

I just was having some poor connect tavty when she was speaking earlier.

But we will follow up with her.

>> Okay. And then I have one of a -- there's a question and suggestion from Rebecca Cole related to the example Fer all of the MCOs.

Is there an ability for the CHC-MCOs -- an emergency or short term issue.

The MCOs will make this change and then when the emergency situation is resolved, the MCOs would resume the former care plan levels.

Some kind of guidance is needed to ensure participant services too soon this would address difficulties with protective services when a person meet needs temporarily higher service levels.

>> So this is Jamie.

I'm not sure if Patty is on the line still or not.

We do have a process in place for temporary increases.

The process also outlines what needs to happen when the participant -- when the testify rare services are going to end giving the participant an opportunity to contact their CHC plan and service coordinator and let them know that they still need the testify rare services or not.

So I guess was it a question or was it just a statement saying there is a temporary process in place?

>> I think it was a suggestion, Jamie.

There was a question.

Is there a process to do a temporary increase when there's an emergency.

I think you answered yes.

>> This is Juanita gray.

How are you?

>> Good.

You had a question, Juanita?

>> Yeah, I did.

I'm going to comment on just what she had said.

It's not just an individual.

And also that process is the problem is what I'm talking about.

The process is the problem.

And the outcome of the process is the problem.

So we never get what we need the increase has ne'er been given and that's the problem.

The internal problem of how they handle it and so it's never taken care of and then it's like you're being shut out and what they do with the process is, like, to me, pretty much such a harassing process.

And then the outcome is against the participant consumer.

Not for the consumer.

So there is a serious problem with how to handle those.

Very problematic.

>> So I'm not sure if that was a question or, you know, I think we can follow up on your specific case and determine what the issue was.

>> I ditty twice.

It's still the same outcome and I just feel as though it's not being handled properly.

And the set up is wrong and that's why I said we need to have more control over how the system is -- it's not being it's not feasible for us right now.

It's consumers.

>> I don't know, would it help to hear from the plans what their process is for emergency increases?

Maybe we can start with Jen and then hear how the other plans are handling requests for emergency increases.

>> I can send in what happened to me.

It's not just me.

It's been not helpful and information that they put into panel was improper and it wasn't even what I asked for.

This internal problem.

Abusive services to me is what they did and they don't want to adequately give the participants and the consumers services.

Ute doesn't feel like it's right.

It's taking it away from participant directed services and what our services and needs are.

I just hear a lot about what everybody's going to do.

We need our voices to matter the most.

This is our hope.

>> Okay. So, thank you, Juanita.

Jen, can you talk about AmeriHealth.

I know you're going to follow up with Juanita off line on her case but generally can you talk about AmeriHealth's process when you receive a request for an emergency increase.

>> Sure, Pat.

Thank you.

So obviously the CHC-MCOs follow the CHC agreement and the process outlined by OLTL.

To be specific, if there is an identified need or request for emergency increases or changes to services, it's included in the service plan.

It requires obviously contact by the participant with their service coordinate tore make those changes to the plan but it does have a specific end date.

So I want to be clear that when emergency situations arise, there's a start and end date in the -- [Indiscernible Audio] on the person centered service plan.

We have to follow the same process for providing notice for appeal rights.

And so that would come by letter to the participants and also communicated telephonically by the service coordinator.

So I hope that's helpful, Pat.

>> Okay. And then for CHW, I think, Anna, can you speak to that?

>> Yeah.

Sure, Pat.

When we have an individual that is in need of additional services per the contract, they can request those -- a new asessionment be completed.

We also have a service coordinator go out in the event of a trigger visit which means something has changed in the person's environment and requires a new assessment and discussion with the consumer about what they may be needing.

And then per those needs and the services or the informal supports that individual has within their world, the service coordinator can support, make a recommendation and in some cases request an integrated care team meeting with additional support from the physician and nurse, et cetera, if there's medical issues that are present and ensure that, that individual has the appropriate care to keep them in the community.

>> Thank you, Anna.

And then for UPMC, I have mike Smith.

Mike, are you -- it shows that ow on but I'm not sure that you entered the audio and are unmuted.

So it seems like he may not be.

I know David and Brendan also --

if one of you could speak to your emergency increase process.

>> Pat, can you hear me?

>> Yes.

I can hear you, David.

Yes.

>> Sorry.

I was trying to -- the phone wouldn't work so I had to come in through the computer.

For UPMC, we have a temporary process starting with the assessment for the participant.

Under normal circumstances, it's the face-to-face but currently it can be done telephonically.

And then we set services up depending on the circumstances for the participant.

Anywhere from two week to two month time period.

Depending on what the needs are and then we regularly connect with the participant to evaluate the continued need of those services.

>> Okay. So then we'll change direction a little bit.

This is from Lloyd and it goes back to the racial disparity.

Is there a recognition in dampss of housing, living circumstances from minorities when determinations are reached as to home modifications for additional services to be delivered to those who might be more vulnerable because at 19 [Indiscernible Audio].

I guess in the question would be in your service planning process, are your service coordinators considering some of those types of issues that they may have as they think about developing the service plan and this time we'll start with understand from PHW.

>> Thank you.

I had to unmute.

That's a good question.

I was probably -- I would probably need to take that back to our service coordination leaderships to whether or not that consideration is included but at first glance on the question, I would say that the consumer is really driving where they wish to live and what happened needs that they have.

And then the service coordinator works with community organizations, different house progress vieders, for example, is housing to help them meet that need.

We've seen that with nursing home transitions which has been pretty successful as they're navigating finding someone a place to live where they feel the most comfortable but, again, it starts and finishes with that consumer.

>> Okay. Thank you.

And I think mike is now unmuted.

Mike.

UPMC.

>> Can you hear me?

>> Yes.

>> Great.

We're going to have to repeat the question.

>> Okay. Sure.

Sure.

So there was a question like that in the service planning process.

Is there a recognition of differences in housing and living circumstances for minorities when determinations are reached as to home modifications for additional services delivered to those who might be more vulnerable to COVID-19 or other con co --

contagants.

>> Good question.

Generally speaking, we're using the same process.

We assess the environment that the person is going into whether it's nursing home transition or the current living circumstances.

We look at housing strategies broadly for participants to make sure they're in adequate housing.

That they have the necessary environment to live in is safe and healthy and it's an environment that -- of their choosing.

And I think, you know, in terms of we also look for issues of safety if the person doesn't feel safe in their home because of the neighborhood or the circumstances that they find themselves in.

We've certainly put in place a housing strategy plan for that person.

I'm not sure if that gets exactly to the answer.

I think it's a complicated question.

That it would be helpful to take back and I did hear the tail end of keystone's answer.

I think it would be helpful to take back and dive into that and sort of unpack it a little bit more.

>> Okay. And so that was actually Anna who was speaking so I will go to Jen to see Jen if you have any input from the AmeriHealth connection.

>> I would feel more comfortable if I could get the question in writing and providing a more comprehensive response because I'm not able to follow the conversation.

>> Sure.

We can slide that for follow up.

-- flag that for follow up.

It sounds like all three MCOs want to go back and have internal conversations about how you're looking at those types of racial disparities and individuals who may be more vulnerable.

>> Okay. So the next question that I have also relates to racial disparities and there was a question about -- this may also be something that we need to follow up with.

What is the breakdown of your staff similar to the way Jamie went through the demographics and the participants.

There was a question around your ability to provide input on what your staff looks like.

In particular, you're probably for the service coordinators.

And unless any of the three of you would happen to know that off the top of your head, I think we'll just flag that question as well which was from Lynn cooper as part of the follow up.

Okay. Then the next question that I have is from Connie.

How do the MCOs decide which providers to call when looking for a provider for a participant.

We sometimes get to go weeks without getting a referral and other times we get three or more referrals a day.

And mike, we'll start with you this time.

>> Yeah.

[Indiscernible Audio]

we have a provider directory that we help participants within a geographic area look at the providers available to them.

We don't really, you know, have no control over who picks us where so that can drive, you know, sort of our ability to --

the providers sort of getting a referral from us but on top of it, you know, the visibility of the provider and the word of mouth and things of that nature are really critical for the selection of the provider.

So if we have five providers within a five mile geographic area of a participant, for instance, if that participant knows of a particular provider and is happy with them, they may select that provider from a provider directory.

We really can't direct people to these -- to providers and so it's a hard thing to provide that participant choice and --

per provider I'm saying.

It has to be guided by the actual participant in making the choice and that's typically how if we have DPSH if we don't have somebody that's available necessarily in a particular area, we can broadcast that or if the participant first choice is not there we'll go to the second choice and so forth.

It's really about making sure that you're visible in your community and making sure that people are aware that you're an available option.

>> And, Jen, how about for AmeriHealth.

>> We're very careful to make sure we're following the participant choice guidelines for CHC.

Doing our best to support participants in finding out information to make an microphoned decision.

So I wanted to -- that's all I wanted to add but the process is the same.

>> Okay. Great.

And Anna, anything that you want to add?

>> Thanks, Pat.

No.

I would say that our process is fairly similar.

We work with the consumer on where they're located to help narrow that down depending on the provider type.

For example, if it's home care where the number of home care agencies in the state.

It's not surprising if the provider says they don't get a lot of referrals during a certain time since it's saturated so much in the field that other types we just work with the area and and our find a provider site.

>> Great.

Thank you.

We're going to switch gears a little bit and the next one relates to coordination between the M [Indiscernible Audio]

which I think actually come up in some of the earlier conversation.

And we'll start with you, Jen.

What efforts are being made to assist older adults in accessing much needed mental health and substance use and abuse services.

They're needed now more than ever.

And this is from Lynn cooper.

>> Hi.

I absolutely agree with that statement.

And I'm quite proud of our team for collaborating and reaching out to our BHMCO partners during COVID to hopefully come up with and be kept abreast of basically our service coordinators and VH coordinators.

Kept abreast of the changes in service delivery and options basically available to to all participants regardless of age during the COVID-19 outbreak.

So we absolutely agree with you that we're in this together.

That there is increased need now feeling the effects of isolation and guiding because of the situation we're living in so we've worked closely with the BHMCOs to get the training and information needed to keep our service coordinators informed so that they can help connect participants to services.

I want to add that we are also collaborating -- the contact information that the OLTL team has provided with -- for us to make sure that where med care is primary, that connection happening.

So I hope that helps answer the specific question.

Specifically for those over 60.

>> Okay. And Anna, can you talk about PHW's efforts to improve utilization of behavioral health services for the aging population.

>> Yeah.

I echo what Jen said.

Really important.

We have a behavioral health coordinator, Heather Clark.

And she's closely aligned with [Indiscernible Audio] and we've done training even recently.

In the last two weeks.

This has been bubbling up a little bit more as of late with a lot of questions from not only service coordinators but home care agencies about how to align more closely with the BHMCOs and consumersconsumers struggling with health conditions.

We have a pager we've equipped service coordinators with and have started sharing with home care agencies and on our next meeting with the Pennsylvania home care association we'll share that with them so they can get it out to their membership as well.

>> Okay. Thank you.

And mike, how about for UPMC?

>> I'll let David jump on that one.

>> Okay.

>> Thank you.

>> Just want to echo a lot of what Jen and understand said about coordination with the DCM as well as the behavioral health MCOs.

We meet regularly health MCOs and are working to develop stronger contacts particularly for older adults.

Medicare is such a major factor in providing the services and in one of the biggest things that we're working on is improving the data sharing so that we can coordinate and have visibility into the utilization by expanding that -- 60% of all of our LT assessments utilize some form of behavioral health SFSZs in the last year and we're working to expand and look into the different access area ways that and are working close gli the behavioral health MCOs and have kept in close association with them during the COVID-19 time and working with them through expand and look at tell health options to really continue and further expand the availability of services to older adults and persons with disabilities.

>> Okay. Thank you.

These are all general.

Okay. So this may also include some input from OLTL but we'll start with you, Anna.

Please provide more detail who is responsible for ensuring compliance with local building codes and the ADA.

Who is responsible for inspecting for home -- Monday nestly I'm going to have to take that one back.

It's pushed toward inspection.

I'll need to find out.

I'm not sure how we go about with the inspection piece and if we subcontract for that to be signed off.

>> Okay.

And mike, how about for UPMC?

We're going to have a -- we have a team of folks that look at all the home modifications that are being worked on throughout the network and I think the question is interesting because have you to think about local code enforcement which we do not control so there's going to be localize folks that are going to maybe get involved in a particular oversight and that would be built Intel the proposal, the bloter proposal that's submitted by the vendor who gets the work, they would be responsible for making sure code

enforcement is adhered to so when you're making a modification, that would probably be my first answer and certainly we can just take that back and make sure there's nothing else to add there.

Thank you.

>> Okay. Thank you.

Dan, how about for AmeriHealth.

>> We'd be held to the same codes as anyone else and would be dictated locally.

>> I mean, I think the important thing is that we do have a process and specialist, excuse me, but ultimately our service coordinators are involved throughout the process and are final signoff is required of the participant for measuring their SFLGS with the job if that's helpful.

>> Okay. And I see Patty is still on.

Lester also indicated that this is also in the waiver changes.

I'm not sure if there's anything you want to add or comment on related to this.

It may take patty a minute to get off of mute.

So we can always circle back on that.

Okay. We will circle back.

I'll go to the next question then.

Is the new authorization triggered by the MCO to the provider to communicate the end of the emergency service increase that occurred during the state of emergency in Pennsylvania?

No updated authorization has been received since the end of if state of emergency do providers continue to -- at increased emergency levels until told otherwise.

And if you could start off, mike.

>> Yeah.

So, yeah.

We'll renew those authorizationations as emergency services may still be needed.

I'm thinking particularly of our adult day centers struggling to reopen and I think we just learned in a department of health discussion in Philadelphia that they may not reopen until January but so in that circumstance we might have done a temporary emergency increase because of the shutting down of the program but we would then reauthorize that to adjust for the fact that they are not opening and we always emphasize and I don't know if Andrea is on the call if she has anything to add to this answer but riders should be regularly reviewing their authorizations and not just looking for notification --

what's available arch paying attention to those authorizations in the system is just a best practice.

I used to be a provider and so we regularly check on eligibility and authorizations.

>> Okay. And Andrea is on a call.

>> I do not.

I just follow what mike said and that is true.

We stress to the providers that they are following their authorizations and contacting the service coordinators for HHA if there are questions.

>> Okay.

Thank you.

And then AmeriHealth, Jen or Chris?

>> Pat, it would be the same former health in keystone and, again, we want open lines of communication between a service coordinator and the provider agency especially in a temporary situation so that everyone is on the same page.

>> Okay. Thank you.

And Anna.

How about for PHW?

>> Thanks, pat.

I think Andrea and mike captured exactly what PHW's process is so I don't have anything additional to add.

Okay. Great.

Thank you.

So the next question is from Peter Fitzpatrick.

He's a presenter regarding medicare fraud and abuse.

The topic equally relevant to CHC.

How do the MCOs provide fraud information to their beneficiaries.

With COVID-19 there's been a huge increase in fraud.

And I guess Jen -- well, Jen or Chris, can one of you speak to this for AmeriHealth?

>> So, Pat, I'm so sorry to do this.

I'm happy to answer but I'm having a hard time hearing the entire question.

I understand it's regarding fraud or allegations of fraud.

>> Right.

>> Yeah.

So the question just the quick summary, Jen, is how do you educate the participants on fraud because there is concern that it's increasing with COVID-19.

>> Okay. All right.

Thank you for that.

So I think this is the t the same between all three plans.

Reporting fraud is ex-police sitly outlined in our participant handbook so that's reviewed during face-to-face visits or during the pandemic obviously telephonic assessments and contact with participants.

Hopefully, that answers the question.

>> Okay. Great.

So all I ask, Anna -- I'll ask Anna or mike is there anything additional that you want to share?

>> Go ahead, mike.

>> So I think that's exactly correct.

I would say that during phone contacts that are regular during COVID because obviously we're making sure that in addition to telephonic assessments and reassessments with you we're doing calls regularly to participants to check in on their wellness.

Those are the opportunities for that discussion as well and we -- I would also include that participants we've -- we contact them through mail that we can be bringing them you to speed on that type of thing.

Actually, we have another mailing going out shortly and this will be a reminder to me to put something in that mailing about making sure that they're communicating with us, the plan regarding any contact because it might be fraud if they're concerned about it.

They should not be giving out information without knowing and identifying the person on the other end of the phone or through email.

>> Okay. Anna.

Is there anything you wanted to add?

Somme.

>> I can echo what Jen said about our handbook and it clearly identifies the fraud, waste, and abuse.

We also did training on it and recently in the past 30 days we've done a training with about 500 service coordinators and how to identify it and record it appropriately.

So that's about all I can add.

>> Okay. Thank you.

That is all of the MCO-specific questions.

I think everything else that I have is more general and and/or related to OLTL updates.

>> Okay. Is there question from any committee member?

>> Hey, Barb, this is mike.

I have a couple questions to bring up on behalf of pickle and its membership.

I'll do the first one and then I'll wait and do the second one.

What is OLTL and the MCO's plan for in person service coordinator visits?

I know we've talked about that but in fact it's resuming.

We went through that with PA health and wellness but I'm interested in hearing from both AmeriHealth and UPMC and how are you going to both mitigate the risk of COVID-19 exposure to both this consumer and the service coordinators and also what metrics are OLTL using to decide whether it's safe to resume visits and/or pause them going forward.

>> Okay. Tuss, mike.

Do we have -- thank you, mike.

Do we have Jen or David or mike who wants to respond?

This is Mike.

We have very concerned about this.

We know that staff are uncomfortable.

We know consumers are uncomfortable with our return to the field and so we're taking this very seriously and as a matter of fact, the communication of participants I just mentioned is to talk to them broadly about us returning to the field so they know what [Indiscernible Audio] so we have put in several measures basically support staff and keep them safe as well as the participants safe including social distancing, masks, use of PPE in order to be in the home.

One of the first things we want to do, the first line of defense in any screening participant is not only a participant on the initial contacts.

[Indiscernible Audio]

and Jen, from the AmeriHealth perspective.

So I think for the most part I think they -- to what but also add that threes -- on the transition plan and providing guidance.

So for AmeriHealth and keystone, that information and our process and training is forthcoming.

As we look to phase in across the XHTH are resuming face-to-face visits.

Mike, you had a second question?

>> Yeah.

Well, to end on that first one, I'll ask this second one as well.

Also, you know, maybe Jamie could touch base on the metrics they're using to determine what is safe and what's not, what's resuming and in the event that there's a spike in the cases, should there be put on pause, I'm just starting to hear what OLTL is using for that.

The second question is are consumer directed models have FMS -- sorry -- or PPL direct care workers going to be saving $3 an hour hazard pay increase.

>> Okay. I think that was a question for me.

I'll jump in here.

This is jail from the office of long term living.

So your first question is regarding the office of long term living monitoring what's going on in the counties and will we be updating our guidance accordingly.

So the guidance or the appendix K transition plan was based on the red, yellow, green indicators that the governors administration was using to I want to say to codify the different counties during COVID-19.

All counties have been moved to green and so for our guidance, all counties will currently be in the green status.

We do know that some counties have made independent decisions about I want to say if their county is open or not open and we are looking at that but have not made any changes to our guidance to date and it is under review.

>> Thank you, Jamie.

>> We do have provisions in place especially for service coordination.

We suggest that service coordination services should be provided face-to-face.

But they can be provided telephonically if the conditions warrant.

>> Okay. Thank you.

>> And then the second question was regarding hazard pay and I'm sorry because I was focused on the first DWEGS, I missed, you said something about hazard pay and $3?

>> Yeah.

In the consumer directed mod lid, are the direct care workers going to be receiving $3 an hour hazard pay increase to COVID-19 hazard pay grant program.

>> So let me start by saying there are a couple of programs that are available to provide some sort of renewed payment to direct care workers that I want to say are in play here so I can't say affirmatively, yes, or no.

First, act 24, the cares act funding provided $28 million for direct care workers in the participant directed model.

That funding came to the sufficients of long term living to distribute and the office of long term living is in the process of distributing that fund, those funds through PPNL to direct care workers, we are hopeful that those funds will go to direct care workers in mid August and the funding was distributed based on the number of hours worked. Now, I don't believe they would be receiving an additional $3 an hour.

I'm not exactly sure what -- how much per hour the direct care workers will be receiving.

I can check into that and get back to you.

I just don't have that readily available off the top of my head.

There's also a different I want to say hazard pay funding program opportunity that was made available through the department of economic --

department and economic development pardon me, and I believe that was if $3 that you were speaking about.

So I do know that the office of long term living and PPL were not able to app ply for funding on the direct care workers behalf.

We had contacted the department of community and economic development and we were not I want to say eligible employers or we department fall under the definition.

I do believe -- I thought Jesse was on the phone and I didn't know.

I believe you made application on behalf of direct care workers and he can talk a little bit more about that but I want to say statewide I'm not sure that there was an application that was submitted on behalf of direct care workers.

There's another program that's being made available by federal HHS that will -- that is available for COVID-19 payments and we're in the process of determining if direct care workers are eligible for that federal opportunity and I believe fiscal intermediary PPL was checking if they can make application on behalf of direct care workers in the state of Pennsylvania.

So that is under review or consideration.

>> Okay. Thank you.

>> Jamie, this is Jesse.

Just to what you were saying.

The training and education fund which is an educational entity applied on behalf of the [Indiscernible Audio] for the hazard pay grant the state program through department of community and economic development so the answer to that is yes.

I mean, obviously it's a grant process.

There was an application submitted on their behalf.

My understanding of the grant requirement and I didn't get too deep into the weeds on it will you tell is that the people most likely to get limited funds are people in the hardest hit counties by COVID.

People under $20 an hour.

So we took the I think 20 hardest hit counties around the state and applied on may've of the direct coworkers in those counties with the expectation that those are the places that DCDE is most likely to fund based on their requirement for the grant.

>> Would you be able to provide us those counties because I have to tell you just from -- we are getting tons of calls from both consumers and attendants wanting to know if they qualify when they're getting this money.

So if we could put out what counties, that might help and we can just say that we're waiting to hear if we did get training the entity did get the grant.

>> I can certainly -- yep, I can certainly follow up off line with you on that.

I do want to -- Jamie mentioned it but there's also the -- we anticipate as Jamie said and the representative has been communicating with the department regularly about the distribution of the cares funding as well which is a different -- which is money that was allocated through act 24 and that is another -- people may be a little confused about how much hero pay is coming from where so the more we can help get that information out directly to direct care workers and work with you and others to do that so they understand what's for sure coming and when from where to reward people for their work during --, that would be great >> Thank you.

I would appreciate that >> You're a good guy, Jesse.

>> I did get a few more questions in that conversation from the audience.

The first is actually a joint statement.

What is the state and the MCOs doing to increase the low pool of aten -- attendants?

I don't know, Jamie, if you want to respond or let them respond first?

>> So I need to get back to you on strategies we are taking to increase the pool of attendants.

We've had conversations with many of the agencies that provide direct care workers in an agency model and it -- they admit that it has been extremely difficult during COVID-19 getting -- recruiting and retaining staff.

If the person was on board prior to COVID-19, the person probably continued working throughout the emergency period but the ability to recruit new staff has been extremely difficult and they really talked about the picture and what's going on.

First of all, people are scared.

Obviously direct care work is entering somebody else's home and have you to feel comfortable with that and confidentable with the situation that's going on in your own home.

I mean, are you at risk?

Is a family member you live with at risk?

The other issue they presented to us is the financial incentives made available to individuals during the COVID-19 emergency period.

I think that the federal government released funding to assist people obviously with financial issues during COVID-19 but those financial incentives made it very difficult for people looking to recruit new staff to get the staff meaning some people are making more money staying at home so it's hard for those people to justify understandably so exposing themselves to the COVID-19 danger and obviously going back to work for less money.

So those were some of the concerns that were voiced I think in our conversation.

I don't know if others have anything to add.

>> So I'll start with Anna.

Are there special specific strategies that EHW is undertaking to try to address this?

>> I can echo what Jamie said is absolutely what we're hearing.

I can also tell you that while we've heard that there's concerns with the agency model recruiting folks, we've not run into situations where we cannot find an available agency to provide supports to an individual.

So while we recognize that we are keeping in touch with Terry henning and we meet every two weeks with a group of home care providers to hear how they're addressing things but beyond them just telling us that it's been difficult to recruit, we're not seeing it on any types of --

we're not seeing it effective on gaps of care yet.

So just hoping that we can find solutions and to support them as much as we can.

And, Mike, I'm not sure if this is you, Andrea, or someone else.

>> I'll take a stab at it.

I think I would echo what Anna just said and I would also just add to the mix that we often part of CHC in general we always sort of accept [Indiscernible Audio] to SFEE there's an [Indiscernible Audio] if there is some type of -- even when there isn't an available issue in general it's another option.

[Indiscernible Audio].

>> Okay. Thank you.

And Jen or Chris for AmeriHealth.

Anything to add?

>> Hi, this is Chris.

No, there's not much more to add.

We're on the same position we're hearing the same things and working together with the agencies.

We understand it is a challenge right now to find new employees and individuals to pick up the cases but we're not hearing gaps or concerns at this point.

>> Okay. Thank you.

So the next question is Peter Fitzpatrick.

Many of our beneficiaries have CHC coverage but don't require a regular case manager.

It sounds like this is the dual eligible non[Indiscernible Audio] population and I find they have almost no understanding of CHC or knowledge of when to reach out.

How are they informed and so for this one and I don't know starting with Mike or someone else on UPMC, maybe you want to tabling about your participant orientation.

>> Yeah.

Certainly we do provide participant outreach at the beginning of the program if they have full knowledge of information about the program.

We also have a telephonic care manager that has -- that are available to those individuals that they can outreach to.

So between the orientation at the beginning which provides them with all the available benefits of the program and so FOESHTH, they're given our member services number so that they can contact and get a telephonic care manager if they need one to address issues.

We also monitor, you know, we have regular health risk assessments that are provided for those folks where we collect those annually and reach out to participants based on those assessments and in addition to that, we sort of monitor any issues that are occurring that we can track.

There is some data lag and issues fingerprint around par unaligned participants in the program that we're working through and the sharing of data information but we're also looking at their utilization of physical health benefits and what's going on with their services that way as well.

So wee have a lot of ways not only from them reaching out to us but us to be monitoring activities on that side to see if there's an opportunity for us to help so between the seasments, the orientation, and the follow up that we can do when there is a hospitalization or some other interaction that's impacting the participant that we can reach out to them and talk to them about other benefits.

Obviously the LPSS benefit may be necessary if somebody transitions from one level of service to the other and we would help them connect with the IEB and that type of thing as well.

So that's generally what we do.

>> Jen, on the AmeriHealth side again, this is for the --

>> Can you hear SNE.

>> Good.

All right.

So I don't think I have a lot more to add to what Mike just described other than just kind of the opportunity we are in now that CHC has fully implemented to strengthen the coordination and helping our community membership understand what is available to them and then as Mike said, helping them through where it's appropriate, the IEB process and understanding the benefit package it comes along with the nursing facility clinically eligible status.

>> Foe cushion so much on implementation in three different places across the state we have this opportunity to strengthen our engagement with those folks.

Anna, I guess I'll do a little bit of a twist because I think the feedback was that it seems like [Indiscernible Audio]

workers coming in contact with that they aren't aware of CHC.

Are you through any types of survey or outreach identifying the well community duals knowledge level.

>> Gave me a twist.

>> I give you a twist.

Yeah.

Making sure you're paying attention.

[LAUGHTER]

>> We don't do a survey to the community that way.

Mike outlined it really well.

At last the exact same process we have.

The only additional piece I would say that we made the decision to do is make sure that everyone of our consumers have a hard copy of our participant handbook -- in that document sop they get sent to them and they can go through it and they can contact our participant services line and then we can coordinate services much like Mike said if there's a hospitalization or if there's questions they have funneled to the right department to help them identify or even get support to the -- we offer as a value add fen fit service coordination to community well duals that may identify as someone who need additional

supports and we can do some short term services and connect them with resources that might be available that they qualify for.

That's probably the only thing I add.

Thank you for the twist.

>> You're welcome.

You're welcome.

Thank you.

Okay. So, Barb, that is all of the MCO-specific questions or comments that I have although we have some general ones related to Jamie's presentation or other items.

>> Okay. Do we want to entertain those questions?

Or not?

>> Sure.

Sure.

I guess do any committee members have any other questions or comments before we move to that?

Nope.

Okay. So these first couple are specific to OLTL.

How does the latest RFA enrollment services differ from 2018 and 2019.

Was that aban stened because of a protest?

And I know Mike was -- but I don't see him.

>> Right.

And I'm sorry.

I don't know the answer to that question about how they compare.

So we'll have to get back to you.

If we can.

And give you information about that.

I know since it's an active procurement, we may be in the blackout period I'm not sure that question is covered under something we can answer or not.

>> Okay. Great.

Thank you.

The next one and this may be something that Jill can help with.

Are there any updates on the ECM system integrator bid release date?

If so, what type of bid will this be, for example, an RFP or an IPQ?

I don't have a timeline on that.

I know it was pushed back because of COVID so we're looking at an extension on that probably at least six months out or more.

But we can follow up and get additional information to send out to the group.

>> Okay. Great.

Thank you, Jill.

And I have a few regional response collaborative program related questions.

I don't see her now so I will ask these and it may be something you have follow up on.

Since the RRHCPs are funded with cares act funding will they discontinue operation in November of this year and this is from Lloyd.

>> Sop the funding will end, yes, by tend of November, early December.

We are talking about how to continue some of the RRHCP services if necessary but under the funding would end, yes.

And what is the purpose of the call centers for the RRHCP if they don't assist individuals in nursing facilities to go to a safer environment?

The purpose of the call center is to be a 24/7 resource and any other licensed CH SPROSHGS vieder to call, say, a facility has a breakout.

They can give them information on infection control.

They can give them clinical guidance, consultation.

If it's an emergency situation the RRHCPs can funnel that information via the call center up to get emergency response on site as soon as possible if necessary.

So it fulfills that function.

>> Okay. Thank you.

The next item is I'm going to make it more of a comment fromfrom -- demonstrated disparity pointed in a direction of [Indiscernible Audio].

Thank you for that, Michael.

The next question is -- with the EVB public meeting postponed, I would like to know what the deadlines are given the pandemic.

We are having trouble getting responsesiveness FRP [Indiscernible Audio].

>> So we can take that one back and let our staff that are working on EVD know.

My understanding is that none of the deadlines have been moved due to the COVID crisis.

My understanding also is that the EVB deadlines are in federal legislation and in order for them to be delayed or pushed back, it would take federal legislation and to date that has not occurred so we are still trying to comply with the deadlines I believe it's January 1st, 2021, to get the EVV system up.

It is up and running now but we need to comply by that January 1S, 2021 date so our deadlines are to hit that federal deadline.

>> Okay. Thank you.

The next question is related to the racial disparity.

SIMV the -- there is lack of diversity all around.

>> You know, we can take that back to the office of medical assistance programs.

I par tis palateed in the last meeting.

I didn't see that this conversation was on the ageneral dopp but I may have missed it.

We can follow up with the office of medical assistance programs.

The next question is from Pam and I think this is probably a combination OLTL and MCO question that it may be good for Randy to help answering.

We are continuing to have coverage when a waiver person admits to our nursing home CHC waiver --

>> [Indiscernible Audio].

>> Randy, just to summarize because you broke up.

The physical health plan would be responsible.

I think there's a slight nuance in this one so if it's somebody who is already enrolled in CHC how does that work.

So if I'm in MCOA and I'm either a community dual or community based waiver until I'm found eligible for long term care services, I as a nursing home should wait until I get the notice that I have been found long term care eligible and my enrollment changes and then I would build that CHC plan for day 31 through whenever the decision is made.

Is that correct?

>> The question was eligible and they were in the CHC program in the community [Indiscernible Audio] then you would build the CHC-MCO from the date of admission >> Okay. Thank you.

I believe other than -- and I don't know if Patty silly still with us or not.

I'm here, pat.

>> So Lester Bennett had a question and he was I guess one of the waiver changes relates to or it does relate to him using the vendors to do the home mod and running information about who is responsible for doing the inspection on that home mod to make sure it's compliant with any local codes or ADA.

The MCOs responded they were going to go back and follow up on who was responsible for that and I think Lester wanted to know if OLTL had any input related to that.

>> I mean, my initial reaction would be it would be the -- in terms of an inspection to see if it meets codes would be P done as part of the modification itself.

Is that the question?

>> This is Randy again.

Any time that a home mod is done I mean it's the responsibility of the contractor to ensure that it's ADA compliant.

As a registered contractor, they have a responsibility to ensure that whatever work they bill if they're billing something for an individual that is ADA compliance, it's a responsibility.

>> Barb, that's everything that I have >> Okay. Thank you, Pat, for facilitating that QA session.

Regarding the racial disparity, I know it's probably going to take the committee members some time to digest the slides that were presented.

So if you have any suggestions or requests for data that you would like, please don't hesitate to drop me an email and I can reach out to OLTL for that.

If there are no other questions, I thank Patty and Jamie for their presentation and our next meeting will be September 2nd.

And it will also be a webinar remote streaming.

So thank you, everyone, and please be safe.

- Chat