The following printout was generated by Realtime captioning, an accommodation for the deaf and hard of hearing. This unedited printout is not certified and cannot be used in any legal proceedings as an official transcript.

Date: 8/5/2021

Event: Managed Long-Term Services and Supports Meeting

StreamBox

August 5, 2021
MLTSS
**********DISCLAIMER**********
THEFOLLOWING IS AN UNEDITED ROUGH DRAFT TRANSLATION FROM THE CART CAPTIONER'S OUTPUT FILE. THIS TRANSCRIPT IS NOT VERBATIM AND HAS NOT BEEN PROOFREAD. TO DO SO IS AN EXTRA FEE. THIS FILE MAY CONTAIN ERRORS. PLEASE CHECK WITH THE SPEAKER(s) FOR ANY CLARIFICATION.
THIS TRANSCRIPT MAY NOT BE COPIED OR DISSEMINATED TO ANYONE ELSE UNLESS YOU OBTAIN WRITTEN PERMISSION FROM THE OFFICE OR SERVICE DEPARTMENT THAT IS PROVIDING CART CAPTIONING TO YOU; FINALLY, THIS TRANSCRIPT MAY NOT BE USED IN A COURT OF LAW.
*********DISCLAIMER**********
-WST
>> CART PROVIDER: Captions will appear here. Thank you.
>> CART PROVIDER: Captions will appear here. Thank you.
>> LINDA LITTON: Okay, good morning everybody. I'd like to start the meeting at this point and I'm going to start with the call to order and the introductions. So let me get to the other one. There we go. I'd like to take attendance at this time. Is Ali Kronley on? Um, Cindy Celi?
>> CINDY CELI: Good morning, I'm here, thank you so much.
>> LINDA LITTON: All right Neil Brady.
>> NEIL BRADY: Good morning Linda, good morning everyone, I'm here.
>> LINDA LITTON: Good morning. David Johnson?
>> DAVID JOHNSON: Good morning Linda, I'm present.
>> LINDA LITTON: Hi David. Denise Curry? Not yet. Gail Weidman. German Parodi? Heshie?
>> HESHIE ZINMAN: Good morning, I'm here.
>> LINDA LITTON: Juanita Gray. Are you on Juanita?
>> Excuse me, she was on and then she dropped off and I have not seen her come back.
>> LINDA LITTON: Oh, okay, I knew I had seen her earlier. Okay well maybe she will pop back in. Lloyd Wertz? Matthew Seeley?
>> I thought Lloyd, I'm sorry, Lloyd is on but looks like he is self muted.
>> LINDA LITTON: Okay, well hopefully he will unmute.
>> LLOYD WERTZ: Sorry, I am here.
>> LINDA LITTON: Lloyd, how are you?
>> LLOYD WERTZ: I'm okay.

>> LINDA LITTON: Okay. Matthew Seeley? Mark Gusek? Mike Grier?
>> MIKE GRIER: Morning Linda, how are you?
>> I'm good, how are you Mike?
>> MIKE GRIER: Very good, thanks.
>> LINDA LITTON: Monica Vaccaro.
>> MONICA VACCARO: Morning, I'm here.
>> LINDA LITTON: Morning. Richard Wellins, I know is here.
>> RICHARD WELLINS: Hi there.
>> LINDA LITTON: Sarah Glasheen? Sister Catherine Higgins.
>>SISTER CATHERINE HIGGINS: She's present.
>> LINDA LITTON: Very good. Tanya Teglo? Okay. And William Spotts?
>> Linda, if you, gees I'm loud, um this is Matt Seeley, if you called my name already.
>> LINDA LITTON: I did.
>> MATTHEW SEELEY: I'm present.
>> Good morning Linda this is Gail, sorry I was a minute late. **>> LINDA LITTON:** That's okay, so you are here too. Anybody else that I called that was not on at the time?
>> LINDA LITTON: I'd like to go over the committee rules. Please keep your language professional. The meeting is being conducted as a Webinar with remote streaming. All Webinar participants, except for committee members and presenters will be in listen only mode during the Webinar. While committee members and presenters will be in the, to speak during the Webinar we ask that you use the mute button or understand this will help to minimize background noise and improve the sound quality of the Webinar. We ask that participants to please submit your, your questions and comments in to the chat box located in the go Webinar pop-up window to the right side of your computer screen. To enter a question or a comment type in the textbooks under questions and press send. Please hold all questions and comments until the end of each presentation as your question may be answered during the presentation. Please keep your questions and comments concise, clear and to the
point. Transcript and meeting documents are on the list serve and these documents are normally posted within a few days of receiving the transcript. Captioning and audio recording. 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 the conversation. This meeting is also being audio recorded. The meeting is scheduled to 1:00 pm and to comply with logistical agreements we will end promptly at that time. If you have questions or comments that weren't heard, please send your questions or comments to the resource account at ra-pwchc@pa.gov. For your reference. The account is listed on the agenda. Public comments will be taken at the end of each presentation instead of during the presentation. There will be an additional period at the end of the meeting for any additional
public events to be entered into the chat box. And the meeting dates are available on the Department of Human Services website. So that's it for me, I would like it move on to Patty Clark, director of OLTL, to give us information about the 2022CHC Waiver Amendment.
>> PATTY CLARK: Thank you Linda, good morning everyone this is Patty Clark and as Linda said I am one of the division directors in the OLTL policy Bureau. Give you a minute here to, to

share my screen. Okay so hope everyone can now see my presentation. This morning I'm going to be talking about the Community HealthChoices waiver amendment that we have been working on. So this waiver amendment is um will be effective January 1st of 2022 um we have a couple of things that we're changing, we're proposing to change in the waiver mainly we needed to change language um about transitioning the oversight of financial management services from the office of long-term living to become an administrative function of the managed care organizations and CHC. And since we were going to be doing an amendment um for FMS we decided to also do some cleanup on some of the service definitions we're revising some of the definitions themselves, some of the limitations and the provider qualifications for day services, personal assistant services or PAS, PERS, specialized medical equipment and supplies and vehicle modifications . and then finally we are proposing to revise am so of the waiver performance measures. So we will be publishing public notice in Pennsylvania bulletin on August 14th, we will then have a 30 day public comment period for written comments, that will be open from the day of the publication of the notice on August 14th until September 12th. Once that notice is published in the Pennsylvania bulletin all of the proposed changes will be able to be viewed by going to the OLTL waiver amendments and renewals page on the DHS website and then by clicking on the 2022CHC Waiver Amendment link in the additional resources box. And all of this information will be part of the public notice that you'll see in about a week-and-a-half. Once you go to the website where the information is posted you will be able to see a side by side
which compares the current waiver language to the poiposed changes. You also see um all of the different waiver sections or appendices there, you can open up each one of those waiver appendices. Any waiver appendix that we are planning to change will have a little asterisk by that waiver appendix. And then the website wills have a comment form that we are asking everyone to use when you submit your changes. When you use that comment form it really helps us to identify exactly which section of the waiver you are commenting on it, it really helps us to process the comments. So once the public notice is out there, stakeholders can provide comments on any section of the waiver um however due to tight time frames this year, between the end of the comment period and the October 1st date when we need to submit to CHS we will be focusing on comments specific to the proposed changes. Any other comments that we don't have an opportunity to fully consider, they will be considered
for future waiver amendments. Any comments that anyone on this meeting makes today? We are having somebody take notes but we do ask that just to make sure that your comments are fully captured if you would please follow the instructions in the um publication that comes out and submit your comments to the resource account and also use the comment form, that ensures that we are fully capturing what you intend to comment on. So now going through highlight some of the proposed changes we have for this amendment. As I mentioned the primary purpose of this amendment is really to focus on the changes in financial management services. These are the supportive services that are used if someone is a participant directed model and they employ their own workers, financial management services helps with participant employer to get time sheets submitted, to pay their workers and to deduct all taxes and everything that needs to be done in terms of paying the worker. So currently FMS
are provided by a vendor that's contracted through OLTL, beginning in January FMS Ministry

function of the MCOs MCOs have announced they have contacted with Tempus Unlimited to provide these services, serve announcement that went out on July 2nd which announced this information, a number of stakeholder meetings and there continue to be stakeholder meetings involving Tempus, OLTL to keep all of the stakeholders apprised of the progress. But because our waiver describes financial management services and the role of the FMS provider we have to make a number of changes to some of the appendices in the waiver to reflect this transition from OLTL to the MCOs we're also going to be making some changes just to a few of the service definitions to kind of cleanup some of the language. For adult day services we are proposing to remove language about payment rates for enhanced services, that's because the rates under managed care are negotiated between the MCO and
contracted providers and OLTL no longer specifies rates that need to be paid so removing reference to payment rate. For participant direct community supports and personal assistant services we are um adding some clarification here to state that all tasks under these two services are subject to a certain requirement, not just homemaker tasks. So we are placing, we are replacing the word homemaker tasks with personal assistant services, participant directed community supports to say that these are provided only for the participant, not for other household members and only when neither the participant nor anyone else in the household relative or informal caregiver is available, willing and able to perform some activities for the participant and no community or voluntary agency or third party payer is capable or responsible for their provision. So I just wanted to point out as I go through these changes for the service definitions, what you see in bold is
what is going to be changing. Also for participant direct community supports and personal assistant services we are clarifying that live in support workers cannot be compensated for solely providing supervision of the participant. So as you can see um in the presentation we are adding the phrase about provider, providers not being compensated for providing supervision to the participant if the worker lives in the same residence as the participant. Also for personal assistant services we are clarifying some of the activities that are part of overnight past services, we are adding some language to say that the overnight pass includes the following physical assistant or supervision with toileting, transferring, turning, intake of liquids, and prompting to take medication also the service plan must document the assessed need for the service beyond what can be provided through a PERS unit or TeleCare services. For personal emergency response systems services or PERS we
are adding a requirement to the provider qualifications to clarify that the provider must have the capacity to provide 24 hour coverage, coverage by trained professionals, 365 days a year. This just sets the requirement for um to have someone monitoring if a participant activates the PERS unit and needs help, there needs to be someone monitoring that service. We have three different provider types for PERS and we realize that we only had this requirement under one of the provider types and it really needs to be in there for all three provider types for PERS. For specialized medical equipment and supplies we are making one of the appendix K flexibility permanent by enabling participants to obtain PPE such as gloves, gowns and masks through this service. A physician's script will not be required to add PPE to the service plan but we also added language to say by adding this it does not supplant the OSHA requirement under federal regulations for agencies to

provide PPE to their workers. For vehicle modifications we are making some clarification about vehicle that is to be modified that we are changing is in bold here. Modified maybe owned by the participant, a family member who provides primary support or non-relative who provides primary support to the participant. So what we're changing is for family member we are removing with whom the participant lives and instead we are adding who provides primary support. The changes to the vehicle modification service definition were a result of an OLTL work group with a number of providers and participants and stakeholders um that met about some of the vehicle modifications and they propose some of these changes. Second thing that we're doing in terms of vehicle modifications is proposing to simplify the language about five year vehicle age and increasing the cost threshold for vehicle modifications. So we're saying the vehicle cannot exceed five calendar years, and
must have less than 50 thousand miles for the vehicle modification requests over 5000 dollars, so that's increasing that threshold to 5000. Is the last change we are proposing is to some of our performance measures for administrative authority, AA5 measure, we are clarifying that the MCOs will report to OLTL on the contractual obligations met by the fiscal employer agent, this again is related to the changes for FMS we are also adding the contractual obligations are not met, OLTL will require the MCOs to develop a corrective action plan. For qualified providers, measures QP6, this will be a new performance measure to ensure providers receive training on an annual basis. And then finally for health and welfare, measure HW-4 we are clarifying that the measure includes both newly eligible and existing waiver participants and this measure tracks to make sure participants are informed of the reporting process for abuse, neglect and exploitation both that initial
and annual review. That's a quick overview of the proposed changes, again if you look for the public notice in the Pennsylvania bulletin on August 14th you'll be able to see a lot more information and see a clear comparison of existing waiver language and then what weare proposing. I think we have some time if anyone has any questions or comments I can take those now.

>> LLOYD WERTZ: Hi Lloyd Wertz here can you relate to us behavioral measures for health interventions part of the CHC plan that is currently in place?

>> PATTY CLARK: Um so I'm trying to think if we have any specific, performance measure specific to behavioral health. So the performance measures that I'm referring to are just for the home and community based waiver services. One kind of behavioral health service we have in the waiver is counseling, this would be a counseling service for participants and family members who might not otherwise qualify for the behavioral health services through the behavioral health managed care organizations so behavioral health is a very small component of the waiver because really behavior health services are obtained outside of the waiver. So I don't believe we have anything specific in the waiver to behavioral health.

>> LLOYD WERTZ: I would suggest that assessments that are done and then process by the service coordinators should indeed include commentary on behavioral health needs and I just wonder if any of those were addressed by a performance measure, thank you.

>> PATTY CLARK: Okay, thank you. Yes we don't currently have behavioral health measure um, a performance measure, thank you.

>> LLOYD WERTZ: Okay, thank you.

>> Patty this is Pat, I don't know if you want to have maybe Sharon or um someone talk about as part of the service plan and waiver performance measures,, the checklist to evaluate if the service plan is in fact addressing the need for behavioral health services and coordination for behavioral health services.
>> PATTY CLARK: Yeah I don't, yeah I don't know if she is available, I mean just briefly what Pat described is we do have a performance measure related to service planning and um part of that service measure is there is a checklist that the service coordinators and the MCOs must use to verify that all the proper information is captured in the service plan and in talking to the participant um and included in that would be any needs that the person has related to behavioral health. So that's a good point Pat, it is captured in that larger um service plan performance measure.
>> LLOYD WERTZ: Thank you.
>> Patty if there aren't any other committee member questions, I do have several from the audience.
>> PATTY CLARK: Sure, go ahead.
>> Okay the first one is from Brenda Dare under personal 50 services is the list for overs night services exhausted or can other tasks be performed overnight?
>> PATTY CLARK: I believe the language that we, it is not exhaustive, the language that we are proposing is that it includes those types of tasks.
>> Okay, thank you. The next question is from David related to vehicle modifications, if a non-relative is paid by PPL does this mean that they cannot own the vehicle?
>> PATTY CLARK: What is means is that the waiver, the waiver does not pay to modify vehicles that are, that are used by a person or owned by the person that is a service provider. So I'm not sure if that answers the question. So if, if the family member is a paid provider of service then the waiver is not, will not pay to modify that vehicle. If the provider, the family member is being paid to provide transpore takings.
>> Okay and I'll see if that answers the question now, thank you. Next question is from Katie, the comments due on the 12th or the 13th of September? The 12th is a Sunday and 30 days from the should be September the 13th, please confirm.
>> PATTY CLARK: Okay so the way we do our count with the 30 days is we do count August 14th as the first day because the, the notice is technically published on Friday dated before. So you have the full day of the 14th and then because August has 31 days it um, September 12th ends up being the 30th day. We don't do calendar days so the 12th would be the cutoff point for the comments.
>> Okay the next question is from Jeff, you know the changes in the vehicle modification policy age limit for vehicles that cost under 5000.
>> PATTY CLARK: The age of the vehicle, that number only applies if the cost of the vehicle modification is more than 5000F it is less than 500 0 there is no limit on the age of the vehicle.
>> Okay, thank you. The next item is a comment from ynn, would be helpful to see for the counseling that the CHCs are responsible for providing. I think that goes back to behavioral health where you mentioned just responsible for the counseling portion.
>> PATTY CLARK: Okay. A question from Holly [Name?] is it possible to receive the quality checklist for service plans? I'll have to check back to see what's available and if that's, if that's

available to be shared. We can check back on that.
>> And that is everything that I have received or actually Holly said just a sample of what is used. Which was a follow-up, that's everything that I have, I don't know if there is any other committee member questions or comments for Patty.
>> LINDA LITTON: Okay if there are no questions for Patty I'd like to bring up Daniel Sharar, Director of Office of Long Term Living burrow of finance. And he's going to talk to us about the fiscal year and the OLTL budget.
>> DANIEL SHARAR: Thank you Linda, can everyone hear me?
>> Yes, we can.
>> DANIEL SHARAR: Okay, great. Thanks. Good morning everyone um my name is Dan Sharar, director of finance for the office of long-term living. So I am going to talk a little bit this morning about the enacted fiscal year 2021/2022 budget, which is just recently enacted well I guess over a month ago r things stand with OLTL funding and provide sort of a high-level on where things are and how we're including the additional COVID related federal funding of from the American rescue plan act. So we can go ahead and jump to the next slide, just a couple highlights about the um 21/22 budget um and for those of you who atented, which meeting it was in the spring, but Jamie may have included or discussed some of these high level items when she also talked about our budget, what was a budget request at the time so just to reiterate some of these points um the 21/22 budget for OLTL programs reflects sound capitation rates for
continued operation of CHC, Community HealthChoices being obviously the largest of our programs and um we of coursework with the Actuaries to review the rates and develop Capitation rates specific to each program year, so we have to of course build those into the budget. Any changes or revisions in the rate development process typically result from either changes in the agreement, so a number of the things that Patty Clark may have just spoken about were items that we have to consider in developing capitation rates as well utilization changes, so the increases or decreases in services provided, enrollment numbers and the like. So the 21/22 budget continues to assume expansion in the life program, of course the long-term care, managed care appropriation if you are looking in the budget book of course life is also nationally known as the pace program. We continue to assume increases in enrollment in the life program. I will mention too um, at the outset here that the um
American Rescue Plan Act did include, and for those of you that may have taken a look at the enacted budget or have kept up on budget developments, OLTL did receive um an additional 282 million dollars from the American Rescue Plan Act funds to make direct payments to nursing facilities, personal care homes and assisted living residences, so these are very similar to direct payments the department sent out to that group of providers from the Cares Act Funding in 2020. This is sort of round two co-incidentally both of those rounds of funding, both cares Act Funding last year and American Rescue Plan Act funding this year were enacted through what became Act 24 so um just sort of a co-incidence there that Act 4 of 2020 was Cares Act funding and the similar second round of funding, if you will from the American Rescue Plan Act was enacted through Act 24 of 2021. So I'll show you where um I think we have um some of those numbers built in um on the long-term,
long-term care slide. Moving on to our pie chart this is really the picture is worth a thousand

words I think of course Community HealthChoices is very much the largest, the OLTL programs now that we're in our second or 2022 will be our third full year of state wide implementation for CHC. I always kind of refer to pie chart as the Pacman chart, maybe I should change the color on the CHC portion of the pie to yellow, it's very much to me anyway it reminds me of the old Pac Man game, anyway as you can see this slide represents the overall funding for OLTL programs in the neighborhood of 12.9 billion CHC being 12.3 billion of that. The life program or long-term care manage care coming in at 366 and a half million and the long-term living appropriation um around 500 million. If we look and breakdown those appropriations individually, I believe this is the first one we will look at on the next slide. CHC is of course the managed um or the medical assistance manage long-term
services and supports program so, when you look at CHC in the budget materials they are budget book this is our capitation payments to the CHC managed care organizations, also includes the grants and contracts that OLTL has to fund um for um additional operation of the program. So Capitation obviously being the largest portion of that the grants and contracts are not a small amount either um these slides I think we have shown similar slides in the past, this is just a comparison of what was available including any supplements from the 2021 fiscal year, in comparison to what is enacted in the 21/22 budget. Overall you can see CHC program continues to grow the lines in federal funding include some of the additional funding that we are receiving um through the family first corona virus response act so, when we budget for the federal lines of funding um some of you may remember going back to um spring of 2020, families first corona virus one of the initial pieces of federal
legislation to address the COVID public health emergency one component of that legislation was an increase to the federal um MA percentage, the rate at which the federal government shares in eligible MA expenditures, so the normal FMap rate usually around 52% in Pennsylvania the um Family First Coronavirus Response Act bumped that percentage up by 6.2 percentage points. When you look at the federal funding lines you'll see that we have accounted for that additional funding in those lines. The next slide is long-term living appropriation, this um appropriation includes the OBRA and Act 150 Programs, also includes remainder fee for service components nursing facility expenditures so there's um there are still um relatively small percentage of overall cost that is are paid for nursing facilities through fee for service, these are many times individuals who are receiving services, enter a facility and receive services but they are still going through the Alp
rolement process to be enrolled with the CHC, MCO but the nursing facility is still eligible for reimbursement on the cost before the participant or the individual is fully enrolled with an MCO. So um overall just a quick look at what was enacted versus um the 2021 available um, again this slide on the federal line I think is where we're seeing the 282 million um in payments that will go out um as a result of the American Rescue Plan Act. So just a quick note about this because I think in previous versions of these slides we may have um tied the numbers directly back to the amounts that were listed in the Appropriations Act and you'll actually see if you look closely in the Appropriations Act which was senate Bill 255 this year. 282 million dollar line is actually in own specific appropriation for more or less for accounting purposes but we have included it on this slide just to illustrate the overall funding. So including that you see there's an increase of in total about 178 million. And last but certainly not least the long-term care, managed care

appropriation which is the life program as I mentioned a few minutes ago, the life program has an overall increase compared to the fiscal year of about 22 and a half million this did include an increase um for life providers effective January, I'm sorry July 1st of 2021. So kind of a last note or summary, we're still going through the what's known amongst the budget folks as rebudget which is taking the enacted, the enacted appropriation amounts um from the general appropriations bill and [audio cut out] finalizing the numbers working with Governor budget office to summarize the numbers but overall numbers don't change of course, what's enacted in the general appropriations Act are the total appropriations, rebudget is more of a budget office kind of exercise, but we're still finalizing that but we're also reviewing and working through our proposal or our plan
for um the additional 10% F-map funding that we're receiving as a result of the American Rescue Plan Act. So the 282 million that I mentioned um was specifically earmarked for nursing facilities personal care homes and assisted living residences, however there is also the provision that increases the F-map percentage for home and community based services by ten points and Department of OLTL has submitted its initial proposal to CMS I believe we did get some feedback from CMS approving portions of that plan. I believe we also have the high level version of that plan um posted on the website for anyone that may want to look at that. So that's um more or less the overall update that I have for everyone um know budget necessarily isn't the well sometimes it is the hottest topic um but that gives you an overview of what's been enacted for the 21/22 budget and happy to take any questions. It looks like we may have one in the chat here. To the question in the
chat is in the American rescue plan Act how much or how much funding or dollars were allocated to HCBS? So that is um something that we're continuing to um do some analysis on um to determine what our total pot of funding will look like. The one sort of, I want to say the one additional feature or benefit that states have through that additional HCBS funding is that any of the plans or uses of that funding that can be implemented um by I believe it is April 30th of 2022 are eligible for um I believe refer to it as reinvestment funding, so basically we can, we can if we can implement plans um we're eligible or the spending is eligible for additional 10% bump through April of 2022. Of course in total states have I believe it is 2020, the end of 2024 um to have those ARPA funds allocated and then I believe the expenditures can the funds can actually be spent through the end of 2026. We're still looking, as I said, sort of finalizing the details of what goes into or what
will be the final product on those initiatives were looking at for the funding, a big part of that is um funding for direct care workers, past workers. We have a number of other line items in the proposal um that we submitted to CMS um so we're still sort of analyzing the funding and of course to the extent that any of those initiatives are part of involve CHC MCOs we will of coursework with the actuaris to include consideration for that in capitation rate development. Pat, any other questions? (speaking simultaneously)
>> Yeah, if you can go back to the um long-term care facility slide. Yeah that one. It looks like there were approximately 70 million dollars, more dollars available from the State under the 2021 budget than under enacted 21/22 budget obviously appears those were supplanted by federal funds which I didn't think was allowable for the use of those funds. Am I just mistake in that?

>> DANIEL SHARAR: The federal funding, the increase in the federal line is the 282 million that um part of the ARPA, rescue plan Act that went to States for um for States to determine, it is really COVID related expenses, so very similar, a lot of the provisions of that bucket of funding that is made available to states through the rescue plan Act are similar to the that were placed on the bucket of funding that states received last year through the Cares Act. So COVID related expenses, um with the Cares Act we're not permitted to um fill budget holes essentially or budget gap watershed that funding, but you know this federal funding is going out to the providers and my team is working on the calculations, the allocation amounts for each of the groups of providers, actually the amounts in total were um were set by the legislation by Act 24 um by provider type um we are just doing the calculations to determine um, you know, how much each provider is eligible for um at an
individual provider level. We do plan to put that information out on the website and inform providers um of their eligibility. The process for distributing those funds will be very similar to we will work to ensure as many of those providers eligible for funding are aware and we wanted to make sure we get that funding um out to as many of those providers obviously that are in need of the additional funding. Additional funding was also a result of claims run out from prior years when maybe the 2019 year when um some of the phase 3 zones, you know, the facilities that were in the third days of CHC implementation, so northwest, northeast and we have high capital may have had fee for service claims that were still um in process for reimbursement, so I think that may have also contributed to the slightly higher um amount in the 2021 budget compared to 21/22, so we no longer have the um, we're paying fewer and fewer um of those remaining fee for service claims.
>> I'm sure the committee, far better fiscally than mine, I just didn't want to see us head toward 70 million dollar exception somewhere down in the future.
>> DANIEL SHARAR: Right, absolutely. No, no, I am confident that to the rescue plan Act.
>> That's a good plan, thank you.
>> DANIEL SHARAR: You're welcome.
>> Excuse me Dan, I have a few questions, the first one is from Catherine Weber, sorry I think I missed the time line, can you repeat the time line for ARPA which a state has to distribute and then when providers other entities have to use it and just so I understand ARPA funding is not included in the 21/22 budget.
>> Okay, yeah a couple, couple different pieces to that question, so um the ARPA funding that is the result of the 10% increase in HCBS um is is not specifically um listed on these slides or included in these slides. Now the 282 million that was from the Pat you would have to remind me of the fund or the name for that bucket of funding um --
>> (speaking simultaneously)
>> Similar to through the Cares Act now it is through the state and local.
>> Yeah the state and local um I can look it up.
>> Yeah this is Jamie, I just call it the bucket of ARPA funds that were allocated directly to the state government to use as they saw fit and as they would appropriate. So they had a lot of flexibility in how they were going to appropriate that bucket of funds. I don't have any specific name for it but Dan you are exactly right, the state legislator appropriated 282 million for nursing facilities, personal care homes and assistant care residents, those funds are not

incorporated in the slide that you have up.
>> DANIEL SHARAR: Well Jamie I think they are on that federal fund line in that 396 million, which was, and I apologize was a slight revision from the version that we had discussed previously. So that may be why you are, you were thinking they were not on that line.
>> Okay, got it. So I changed it up on you, I apologize for that but um so I guess back to the question about timeline um so for that, that bucket the 282 million um that we're distributing or providing to nursing if silts, personal care homes and assistant living residences, we sent out an initial message about that, our timeline is really targeting early fall to get those funds distributed. Just a matter of, working through the allocations and we're well on our way in doing that. The process will be very similar for as I said how we distribute care act funds if you are nursing care facility and you receive the Cares Act payment through one of your regular promise remittances, that's how you would see the ARPA funding, if you are not enrolled in the MA program um there will be acceptance form similar to the form that you may have used for the care's act funding, so send that form into us and we will process the payment and those payments are issue via check, so just
as a matter of working through about 1200 or so invoices it may take a little time, but certainly, we are going to process those payments together as quickly as we can. In terms of timeline on the overall rescue plan Act funding so that's the part that um the language is a little I think fuzzy in how the federal government describe it is but basically the funds have to be obligated by December of 2024 and spent by the end of 2026.
>> Pat or Jamie; correct me if I'm wrong on that but I believe that's the timeline.
>> Yep Dan that's my understanding.
>> Uh-huh, uh-huh.
>> Okay.
>> Dan do you want to talk a little bit, I think Catherine may actually be with a home health agency how that's working through CHC, separate from the Nursing Homes and personal care homes?
>> DANIEL SHARAR: The additional CBS funding you mean?
>> Uh-huh, yes.
>> DANIEL SHARAR: Yeah so as I said, OLTL has number of initiatives that working at and looking through with additional HCBS funding that we will be receiving. For HCBS providers to the extent that um we're talking about increases for past workers, that would be something that we plan to work with the managed care organizations, the CHC, MCOs and that's a component of the capitation rate development, so we kind of build that account for that in rate development um of course then the individual providers negotiate rates with, with the MCOs, we are looking and I don't know um how much detail we sharing at this point Jamie about the directed payment options around that.
>> Yeah Dan since the plan isn't overall improved by CHS yet we don't have any definite plans to share other than what we publicly submitted to CMS um a couple of weeks ago now that they are still in approval process on, we're working on obviously updating our plan and in hopes of sharing additional information with CMS and the stakeholders, but it's not ready yet.
>> Right, yep. Thank you.
>> Okay um so the next question I have is um from Margaret, a home care agency, as was

provided for consumers, why have I been paying to provide from the beginning and I have asked my service coordinator for PPE help, she said it was our responsibility.
>> So Dan, I'm not sure if you want me to answer it or you want to answer it?
>> DANIEL SHARAR: Well I guess I'm just trying to understand the context of the question. Maybe you do a little better than I do Jamie, um --
>> Yeah I, yes I was thinking that her question was she was paying for PPE and she asked her service coordinator if there was funding available and the service coordinator seemed to say it was her responsibility. This is separate than anything that was in the budget or in the um ARPA proposal. Just to note that as part of the appendix K um Community HealthChoices waiver flexibilities, we did provide um the ability to add PPE to the participant service plan um and so I know there was some confines about adding PPE to the personal service plan, there had to be um, you know, the participant couldn't obtain it any other way and then it could be added to the participant service plan so, that is an option um I'm not quite sure, we would like more information on that case as to why the service coordinator didn't indicate that was an option for the participant.
>> If I get any additional information I can pass that along. I'll move on to the next question from Dana, wouldn't it be clearer if we compared what was budgeted for 2021 verse what is is budgeted for 21/22 comparing available to enacted or different measures.
>> DANIEL SHARAR: Well I guess I would say the available reflects the final numbers for the 2021 fiscal year which includes any additional funding that through supplemental as part of the 21/22 budget enactment, so and that respect at least from my perspective I see that they are two columns are comparable, basically just looking at um maybe available isn't necessarily the right word to have there, maybe that's confusing on my part so I couldn't perhaps revise that on future slides but um we really are comparing the enacted budget um to what is sort of the final enacted number from the prior fiscal year. I hope that makes sense.
>> Okay so going on to the next question Dan it's from um [Name?] are past agencies also eligible for the funding and I think that's what you were just talking about in response to an earlier question.
>> DANIEL SHARAR: Yeah so personal assistant providers, potentially receive additional funding to the extent, it is part of the proposals that as Jamie mentioned were still um pulling together um from that additional 10% um in um federal funding for home and community based services. Yeah that's different from the 282 million which is limited just to the nursing facilities, personal care homes and assisted living but yes there is a separate bucket of funding if you will for the home and community base providers.
>> Okay, thank you. The next one is from tery Hen ning asking if it you or Jamie can share more detail which part has been approved by CMS and which ones are still under discussion.
>> So this is Jamie, thanks for that question, at this point in time we cannot, we're working on more detail to provide to CMS around in hopes to get a I priewfl here soon on our ARPA plan and at that point we would be, we would be sharing that information um with the general assembly and stakeholders as well.
>> Okay and then um tery also had a question about when the PPE question relating to a consumer or participant service plan having added to it, how does the participant actually get it? Is it provided by the MCO, agency provide it would be, would it be reimbursable if PCS --

>> So tery I'm thinking in that scenario that it would be added to the participant service plan, the PPE for the participant and then it would be provided by a DME um agency or potentially even a home health agency, whoever is approved to provide that DME or medical supplies.
>> Okay. And that is all of the questions that -- [audio cut out] their committee members.
>> LINDA LITTON: Okay so the CHC MCOs to talk about their part.
>> Okay, great. So we have a little extra time um since Dan finished a little early, so the MCOs have um until about 12:30, about an hour and 15 minutes and um I guess Jen, you want to go ahead and start for AmeriHealth?
>> Jen: Oops.
>> Hi Pat are you able to hear me?
>> There you go.
>> Jen: Oh good, all right. Well good morning everyone my name is Jen Rogers, the Director of Long-Term Services and Supports program management and quality in AmeriHealth so, today I'm presenting um HealthChoices, benefits overview um with caveat that HCBS, meaning home and community base services centric with the aim of just educating the audience on the 32 services available under the LTSS benefits package. If it's okay with the audience I would like to hold questions until the end um so next slide please. So today we're going to be talking about the Community HealthChoices LTSS or long-term care services and support benefit package, we'll talk a little bit about our plan added benefits and then how service coordinators assess and connect participants with services and support, we will also discuss our interdisciplinary care team who is comprised, who makes up that team and what their function is plan and we will end by talking a little bit about how we
as a support helping participants connect with community resources or the right services and the right setting to impact outcomes as found on our social determinants of health questionnaire. Next slide please. So I, excuse me, so we organized our presentation today into domain and I like to think about the CHC, LTSS benefits as an amazing service offering that really addresses whole person care and whole person approach to independent living so we look at the bolded headers here, we want to support community engagement and luckily the CHD program and the benefits available help us promote community engagement for our participants. We also want to support employment and empower people to explore employment opportunities and to use their benefits to do that, we also want to support independence and home so I want to talk a little bit about just summarizing what that means and how that comes together so through the person's interplanning process it is
the service coordinators job to orient CHC participants to the whole service offering, all the LTSS benefits available to them under the CHC program. Living, explaining what that is and that it entails either half day or full day of attending um a program in the participant geographic area and hopefully meeting their cultural preferences in that too and it is an alternative to receiving services in the home, it's getting out, engaging with their community um being with other folks um that are in similar circumstances to their own. Community integration, in the same vein this is really supporting social engagements um life skills and being out in the community with a right level of support needed to do so independently as possible but to have someone there with you to support um whatever your goals are for engaging in your community. Community transition services really tailored to helping folks that are residing in nursing facilities move to

community base setting um this includes um the help and support of the Nursing Home transition coordinator, security deposit, household setup for goods and services, it is a really flexible benefit that um makes that transition um either Nursing Home or other um congregate setting to the community achieved more easily. Non-medical transportation is another great CHC benefit, it is different than the medical assistance transportation program that really is available for Medicaid recipients to get to and from non-emerging medical appointments, non-medical transportation benefit is used to help participants get to and from church or seeing family and friends or Bingo or bridge game. So service coordinators need to be attuned to listing what is important to the participants and how do we authorize the right services to meet their goals and um a lot of times that includes the non-medical transportation. We have the medical transportation covered but the non-medical
transportation is critical to um meeting participants needs. Supporting employment and empowerment, moving on to that so the employment um related benefits are benefits counseling, career assessment, employment skills development, job finding and job coaching. So as we can see here that's a pretty robust service offering for our participants to engage in and exploring what makes sense to them, where they are or benefit counseling. I'm sorry for employment services. Moving on to supporting independence at home, we have listed here home adaptations, Assistive Technology, past eradication, personal emergency response systems, rather, vehicle modifications, specialized medical equipment and supplies, home delivered meals and additional consultation, as service coordinators look at the whole person and what their needs are, that's the part of the discussion where we talk about all these other great benefits that are available to participants um as needed.
So we look at this and kind of group these services as what can we do to promote independence and living at home safely um independently and for as long as possible. Moving to the next slide please. Continuing on in that category of looking at whole person care and um exploring services that meet whole person care, we would be remiss if we didn't also mention that the CHC program also offers everything listed here for supporting personal care and health needs. This includes nursing, a home health aid, physical occupational speech and language therapies, which are available, personal assistant services and participant directed goods and services and participant community support that's our participant directed um service offering as an alternative to agency model care. We also have residential habilitation in the program, structured day services, which are a little bit different than the adult day service offering which we spoke to earlier, behavioral therapy
and cognitive rehab also available under the CHC benefit after service coordinator has explored or the benefits offered under the manage care organization has been exhausted. Same goes for counseling and telecare. Next slide please, moving on in the presentation to our plan added benefits of course the adult benefit package that is required of us as CHC MCO but offering offering supplemental services for oral health kit um the vision includes participants being eligible for routine eye exam and scheduling that eye exam is super important for maintaining um physical health, we have no cost smartphone it is loaded with 350 minutes of talk and unlimited texting capabilities for participants to qualify. Also offering wellness program, that includes video visit watershed a care manager and our Bright Start maternity program which is program supporting participants in the program um prenatal care. So moving on to specific

added specific added benefits, so we also
offer in home support and services to help participants who aren't approved for the LTSS um benefit package to avoid Nursing Home stay, what we're talking about here is our community dual membership, those individuals that don't meet the level of nursing facility clinically eligible at this point in time, but are potentially at risk of institutionization which we, to mitigate where we can. Also to supplement our community transition services we have welcome home benefit, which helps the LTSS membership who is approved for um Nursing Home transition to move from the nursing facility to home. It is just another supplemental um benefit that covers anything and everything from pantry stocking to um household goods and items, we also see um used for duplicate IDs and birth certificates and housing applications, so it is really great that it's kind of flexible benefit that we can tap into as needed to support that transition home, also about our
caregiver support programs, health apt launch inned our Southeast zone and looking to launch it state wide in the future, the features include videos and articles um available checklist for caregivers to use with participants to kind of map out and organize themselves on daily routines. It offers guidance on how to care for certain medical conditions to prevent infection and information on how to interact with the health care system needed go to information is available on the Quil app, former and informal caregivers can tap into as they wish. Next slide please. So we talked a little bit earlier about how do service coordinators connect services and support, so we know that in CHC program, 32 available LTSS benefits unlike the waiver system if you are qualified for CHC, you are found to be nursing facility eligible you are, you are um able to tap into any of those services that you like and it is your service coordinators responsibility to help you identify needs, write
goals and then find right service provider um in the right type skills and frequency and duration that support you and your independence. So the tools and resources that we use in Community HealthChoice include the home care tool which is our comprehensive needs assessment, we also leverage the care patient health questionnaire um to see if there are any needs or um areas that need addressing through the behavioral health services or supports. We um also administer social determinants of health questionnaire and that's important to, there is overlap there with the comprehensive needs assessment but it's important to talk again whole person care so, we're looking at um ways to close any areas of need regarding food insecurity, safety, employment um and education. And including health literacy which is also important. Our service coordinators are trained to use motivational interviewing techniques um, they are trained to conduct observational
assessments of folks. Make sure that they are putting the participants and members of their participant, person-centered planning team at ease to have a productive, safe conversation about what is important to them and what's important for them to maintain their independence and to best use their LTSS benefits. Our um service coordinators are as a tenant of this program are also, to engage and interact with person-center planning team. So as members are of the participants appointment in choosing um but we want to breakdown silos where we can and make sure that we're talking about back-up plans, talking about the role both formal and informal of people that are important in participant's life and how they fit into person-centered plan and how they are using and accessing their LTSS benefits. Our service coordinators have

access to case rounds which is our interdisciplinary care team, we will talk a little bit about that on the next slide. Our person centered whole
approach, so our service coordinators are trained in um person centered thinking and how to effectively offer choice for whole person care and not get caught up in one avenue of a participants life but to make sure that the over arching goal is to promote independence and to prolong, community living. In order to access our community resources across the commonwealth we have integrated Aunt Bertha, gives people pause but also known as findhelp.org, a way for service coordinators and participants alike to do a Web search, geographic in geographic area, excuse me, to find resources out there. It could be anything from local farmer markets, haircuts, accessible dental offices, assistance with applying for benefits including supplemental nutritional assistant program benefits, we call that SNAP in Pennsylvania, so it is a great resource, it is available in our platform that all service coordinators use and also available for anyone on this call to use and explore to find up to
date resources that are local in communities across the commonwealth. Next slide please. Is so our interdisciplinary care teams the goal is to support service coordinators with access and availability care team at large, both clinical and non-clinical to help them do their job which is again help achieve in healthy community living while utilizing these benefits. By creating a space where service coordinators are able to tap into subject matter expertise of the multidisciplinary care team t allows and creates a space for troubleshooting, idea generation, developing and kind of teasing out interventions and also for resource sharing, for ways service coordinators to go back to participants and propose a course of action or service or engagement that would be helpful to again that overarching goal of maintaining independence in the community. So our care team is health care, our conflict case management, our team of registered nurses, our CH chief medical officer, CHC
director of pharmacy, housing coordinators, the service coordination management team and of course the directors of service coordination. So service coordinators are trained on how to present a case round so that we can quickly get to the root of what is being presented and offer up ideas and again about expertise. It is a great way to idea share and um hopefully positively impact outcomes for our participants. Next slide please. So supporting social determinants of health our service coordinators are trained to assess, SDOH again is voluntary questionnaire that participants can complete. We then have created our system where someone triggers for an areas need that can be integrated into our goal planning module in our system. So it is not doing things um kind of in a vacuum or a silo, but really looking at how do we, how do we flow from this conversation to what shows up on your person-centered point. And then it is of course the participants choice if they want to
work on a goal that's identified or a need that's identified or would like to defer it and how they prioritize that, that is of course up to the participant. Leveraging the services under LTSS benefit offering as well those community resources shows up on the person-centered service plan and how that participant is connected to those services again is the role and responsibility of the service coordinator. So by completing the SDOH questionnaire and again social determinants of health, sorry for using the acronym, service coordinators are able to gain information from the participant to really hone in on those areas where that person centered whole person approach to care and service can happen. So we talk about things like what's important to you regarding

employment or volunteerism, what about your education, your education goals, your housing goals, are you experiencing food insecurity, transportation needs you have that aren't getting met through whatever is
going on in your life today and helping you get to and from the places helpful for you. We also talk about behavioral health needs and community resources. Next slide please. So I actually thought there was one more slide, I apologize, thank you Pat for allowing me to present today F time permits I'm happy to answer any questions.
>> I know Mike Grier, you submitted a couple of questions in the chat box, you should be unmuted if you want to go ahead and ask those.
>> MIKE GRIER: Okay, thank you Pat. I just didn't know if we were just going to do it through you or not, but that's all right. Um hi Jen, um when you guys were talking about employment services within CHC, is that after the consumers have tried or attempted to go through OBR or in addition to that?
>> Jen: Hi Mike good to hear from you, great question, I think in the beginning our agreement stipulated we go through OVR first. That's not the case first, that can be done in conjunction um with um, with the um exploration, if you will, of the employment services. So one of the things we look at Mike is if a participant has a goal, an employment related goal then with the supportof our employment um specialist um Sheparded through the process, whether going through OVR, Office of Vocation cl Rehab, tapping into those resources, finding out the status of the participants if they are engaged with OVR or not and if they are not then we go through and kind of navigating what the next employment services that makes sense. So we really want to see that we're matching participant that is have expressed goals related to employment with appropriate service offering whether through OVR or through the CHC benefits.
>> Okay, thank you. And second one is just because I don't have the knowledge of it.
>> MIKE GRIER: You were which you were talking about the utilization of phones you were, you mentioned something about if they qualify. What type of qualifications are you talking about?
>> Jen: I think the qualification, I think Mike, we have had this conversation in the Nursing Home transition call that is after it call, there really aren't, really aren't hard to meet qualifications here um but they have to qualify from Medicaid which our CHC membership does. I think the challenge is, especially during COVID Mike is getting those phones folks that reside in nursing facilities, it is one of the things we talked about in the group of the call following, really no hoop jumping if you will. If participants are interested in getting the phone they can call the participant line and get connected with that.
>> MIKE GRIER: All right, thank you very much Jen.
>> Jen: Uh-huh.
>> Any other committee -- questions?
>> Yes, I have a question, this is Monica from Brain Injury Association of Pennsylvania.
>> MONICA VACCARO: Je in, first of all I think it goes great the service coordinators are responsible for presenting all of these benefits to their clients. I think that's, that would be really helpful. You said something that I didn't quite follow and it was about the need for CRT, rehabilitation treatment or therapy to have been exhausted before other things come into play. Can you just review that?

>> Jen: Hi Monica, if I did there might of been a misstatement, I apologize but always the service coordinators responsibility I think we all know that the waiver or benefits should be last resort, if it is not offered or if it is not available, or if it is exhausted we are good to go with authorizing that services, whether CRT, PTOT, what have you through the participants benefit as long as it is deemed a clinically necessary to independence and um participants um um (sigh) level of care. So to be clear the manage care organization don't, they don't have to exhaust the CRT, we do that for behavioral therapy, I think that's where I may have gotten tripped up on the slide.
>> Thank you.
>> Okay so Jen I do have some additional questions but try to go make sure that we give each of the MCO about same amount of time, I'm going to go ahead and switch over to PHW and help, ask Anna to go through, may circle back after if time remaining at the end or carry those questions over to the additional public comments. Thanks.
>> Good morning, can you hear me?
>> Yes.
>> That's great Anna, thanks.
>> Annna: Of course, this is Anna, CHC program manager for PA Health and Wellness, we can move on to the next slide. I want to give you just a Jen did a great job on a real overview of the 32 services and how those are approached with service coordination, um when we were looking at the, at the benefit highlights um I wanted to share with you specific areas that PA Health and Wellness has created unique programs to help connect participants even more to the 32 services or at least specific services that seem to be most um requested within the benefit package under CHC. So first of all, if you were a PA health and wellness participant or service coordinator or a provider looking for what the definitions of each of the services are those can be found on the PA Health and Wellness website, it can also be found on page 78, page 78 of the 2021 um PA Health and Wellness participant handbook, you can also call our participant services line at
844-626-6813 if you have any questions or you want, if you are PA Health and Wellness participant and would like a copy, hard copy of the handout we provided in multiple languages and um we can get it out in the mail to you. So next slide please. All right. So a few of the services that PA Health and Wellness have found parties Pabst to be the most interested in and ask questions on, we created some unique differences to them, one thing adult daily living services. When COVID took place or happened and then the appendices K came out, we had to make modifications how we addressed appendix K and, so PA Health and Wellness for individuals interested in adult day whether they are receiving some of those services at home or if they are receiving them in at an adult day center um if they run in, if providers run into difficulty then we have created um an additional role at PHW with the liaison that adult day providers can reach out to the liaison or um if a participant is
having challenges and service coordinator has questions, for adult day and that person will help connect them, with authorizations and making sure that the services are defined as appendix K as prescribed um all of those areas being metaphor the services to go in authorization to be developed without a problem. Or any delays. PA Health and Wellness for Assistive Technology we couple of years ago created a relationship with Tempel University and the TechOwl program,

we are work withing a state wide initiative to get individuals knowledgeable about the try it before you buy it program, if they are interested in expanding independence through Assistive Technology. We are also working with our partner at Tech Owl to create an AT tool that would identify disirvet types of Assistive Technology available to individuals that's coming up so they could look at a hard copy of the document or on the website um to get more information about the Assistive Technology opportunities that
are available under the waiver that they could access um we're really excited about this because any and all opportunities to advance independence of our participants is um really beneficial. Next benefit counseling, often benefits counseling for development, as we all know employment is a huge driver for greater independence of people with disabilities, the more opportunities for employment without it really impacting a percent's benefits is critical so for benefits counseling we encourage um participants to just go through the benefits counseling um process it's painless, allows the participant to learn more about what they can and can't do, how it would impact their benefits. Through that PA has worked with all of our service coordination partners, we have identity cytize subject matter experts within service coordination partners, we have ten subject matter experts one loathed in each of our service coordination contracted partners and they are
responsible to ensure training and education around the difference five employment services that are available through the waiver to their service coordinator through process of PCSP meetings or have questions about the employment they can get those answers to them quickly. We focus very heavily on benefits counseling and career development, those are two areas really preliminary of an individual wanting to look at employment and what they need to do to get the ball rolling and how they would work with OVR as well. One of our key partners is JEVS in Philadelphia particularly, JEVS won an award called the Tesla Foundation Award, THW was contributor to that, we put funding and support towards the Kessler opportunity that would help close to 200 individuals better access employment and JEVS is working closely with us on this initiative. So under that program we get information to the participant that is are supported in the Philadelphia area that have interest in
employment, connect them with JEVS as well and then they go through their specialized employment program to help people get more independence. Next on my list is community integration for years I would say well before CHC began, PA Health and Wellness had a strong relationship for centers for independent living state wide working with [Name?] Mike's group and several across the state. We really begun to infuse community integration into what we're doing with our Nursing Home transition. We believe strongly that an individual that's more connected through community has greater opportunities for social integration, getting connected with their churches where the grocery store is, the postoffice, if they would like to attend a senior center. Any and all ways that a person can feel much more aligned with the community that they are now living in or if they come out of a hospital or change where they live, resident they are eligible for community I want graduation for up to
90 days and PA will actually stem that and in some cases when the request is needed to um span the service to further assisting the individual and connecting with the community. The very excited about this, start to go see some traction here that doing a lot of education and we have identified ourselves in each region that will help us with community integration when Nursing

Home transitions come up, and that's been happening since the first of the year. Non-medical transportation, we are all familiar with transportation program through CHC and individuals who are eligible for non-medical transportation. We have done a number of educational um pieces within our service coordination teams, so that individuals know how to access non-medical transportation. Understanding that it really does help them connect more to their communities, it just seems to be part of PCSP as to what they want non-medical transportation to do for them and they should have no challenge
in getting that authorized. Next slide please. Mentioned CHC we have the wireless service, Jen spoke to that.S is defined here, page 65 and 66 on the service, the my health rewards program is appropriately awesome, actually rewards individuals for the health care um management and when you receive your My Health Pays card that rewards individuals for um getting cervical cancer testing, rectal preventative testing, breast cancer screening, immunizations and other lab tests that alert the Doc and the participant if there is any conditions they need to be looking for. So if you want more information you can get that information from our participant call center um but My Health Pays doesn't have stipulations on what you can use the funding for, from alcohol, fire arms and tobacco cannot be purchased with your My Health Pays card but it can be used for those items listed here on the slide. Also vision benefits beyond your regular Medicaid coverage, PHW also has another 100 dollars added for glasses or contacts, which participants as well. And then we do provide dental kits upon request, those can be provided to service coordinators to um take to participants or we can also, next slide. Service coordination for people waiting for these services, was approved for extendedded benefit, expanded service that offers service coordination to NFI participants that are at risk and needing access to resources. At times that can be they are waiting for LTSS services um and sometimes it is just a short-term connection to resources in their community. We do provide above and beyond Medicaid benefit, the waiver benefit also in place additional thousand dollars for Nursing Home transition to community needs and then we have our wellness programs that include home delivered meals after hospital stays, we have a smart start baby program. Our health library that's expanding even further with um materials that will be
provided to service coordinators to distribute to participants when they do their annual visits. We have our community connect resource which is our under the, platform and anyone can really access that PA Health and Wellness manages platform that you put in your zip code and it was all the resources in your community from um a health equity stand point, has been looking at how those resources might have limitations to them so we can really outreach to um providers and community support programs, CDO that can help fill the gaps. Then you have a 90 day prescription refill program when things are not on Medicare. Next slide. And there is Jen's last slide. So that's it for me. Are there any questions?
>> From Carrie, hi Anna question for you about service coordination for people waiting for LTSS service, give some examples of how this benefit is operationalized, how does Pennsylvania Health and Wellness identify that beneficiaries that might benefit from this service can consumers ask for it if they are, for some case examples to maybe better understand the benefit and how it is used.
>> Yeah, yeah, no problem there. So we um stratify the membership for individuals that have had high risk, they've been in the hospital in the last six months, high pharmacy costs or identify

through assessment we can also see where there might be huge SDOH health deficit, when those pieces come together they are risk stratified so, if they hit a risk score that would say wait a minute this person is probably needs some outreach, they are identified as nursing facility ineligible but because of their age, their condition, their um hospitalization rate we need to do some outreach for them and so we refer them to our service coordinator who goes out into the field and does a check on the individual and let's them know about their community resources and um addresses if it there is anything they need for support more than what they have. They could be alone in their home at risk and so it is a concern of ours that if they are at risk we are getting them
connected with whatever they might need. But that's how we identify them David, it is through a risk stratification.
>> Thank you.
>> Yep. Any other committee member questions in no? Okay. I have one from um, Amy, are there, are the rest and home delivered meals benefits after hospitalization for people who are NFI as well?
>> Yes.
>> Okay. And I don't have any other, trying to just wait a second here see if anything else ops up. Um actually and I'm going to hit one that is one that would be recycled back to Jen for AmeriHealth there was a question from Diane Ross, Jen mentioned the Quil health app and she is wondering if that is being used by all MCOs or just keep them first, so is PHW using that?
>> No.
>> Okay.
>> Not at this time.
>> Jen: Hey Pat it is Jen, hi yeah hi Diane, hope you are well. That is just a specific and very exciting for us at this time, so thanks.
>> Okay thanks Jen and thanks Anna, that's I think everything we have so I guess then we will turn to Mike Smith for UPMC.
>> Mike: Yeah thank you Pat I'm hoping you can hear me, just confirm?
>> Pat: Yes, yes I hear you thanks Mike.
>> Mike: I got the last slide deck here and um it really just um there is a lot of mirroring that's going on between the benefits that you'll see from all three MCOs, little difference in the value added benefits um just wanted to mention that pretty much have the same benefits for physical health and home based services, so just as a, you know, reminder to everybody that we, that those are sort of standardized across the plans um as part of the program so I just wanted to mention that. Next slide. Just really wanted to just level set sort of like Jen did a little bit with the, how this, how you get to the services. We have an assessment tool, the home care we talked about that in the past in some of our service coordination discussions um and we, we have an assessment category that is are listed there some of the major ones but then we add at UPMC, I'm sure the other plans do as well, some additional questions around employment, employment interest and um go and things
that are will get us to goals that somebody might have in when a person-centered plan around the, around services and um then, you know, when and where is it just complete, we talked about this in the past as well, typically this is something that I think is happening face-to-face

um we all know under appendix K that there is a telephonic option that is available to folks but at the UPMC really emphasize trying to get to see people face-to-face if at all possible, when we say face-to-face, obviously with COVID sort of um protocols in place, right. So we're calling in making sure people have don't have a fever or aren't sick um all wearing face coverings and we're safe when in the home. We try to do a lot of the work over the phone and then go out and visit the person to verify and visit the home and see if there is any environmental issues and things that we want to confirm that we couldn't do telephonically. So it's been a bit of a challenge in this
environment, but one that I think we involve up to and then we have um assessments can be completed on an annual basis, when there is trigger events request if somebody is hospitalized or changing care, a lot of different ways that assessments can be conducted. Next slide please, again just wanted to sort of touch base on identifying, you know, what we're trying to identify in our PCSP is something that is really reflective of the individual um, work collaboratively with the participants and their teams to try and develop their goals and understand if there is gaps in care and services and just as a, you know, we don't have PCSP for NFI population, I think it is important probably for all of us just mention the NFI population a little bit more in discussion today as they are the non-nursing facility ineligible folks that are part of this this program that have both Medicare and Medicaid. We reach out to them and complete health risk assessments and trying to identify gaps
and care for them as well. And then we developed a service plan so that we can authorize the services that are most needed um and coordinate benefits as stated there. Next slide please, so I want to give a little bit of highlighted some of the more um prevalent services on the screen here but I really wanted to spend more time on service coordination just in terms of the way UPMC has stratified um our service coordination is, you know, all three zones and we have um a medical director that's available to our Senior Directors in all three zones and we have a behavioral health coordinator, housing specialist, employment folks much like the list that Jen went through and we have folks that are working on quality in each of the zones. So pretty robust under-pinning and support available to the service coordinators um some of the employment services that, you know, the employment skills development, benefits counseling job finding and job coaching as we mention in
the past and some of these calls um we have a team of folks that's available when these, when individuals identify and that assessment as we talk about earlier, that they are interested in employment we're very excited about this, we started this early last year um unfortunately in the midst of COVID I think it has been a little bit of a challenging, but we have an employment team that is available to our staff so if they get to the point where somebody needs to engage OBR and/or has a complex employment strategy um including getting, making sure people get benefits counseling and that type of thing, we have a team of folks that support our SCs and actually will engage the participant in helping them navigate some of those, some of those challenges and so that they can get to services that they need. The LTS benefits that are listed here, you know, there is a physical health benefit I think we have all focused much more on. Almost TSS side because that's important to this
group um but they, for service coordination um or for LTSS benefits there is the need for the service coordination um and those service coordinators it is something I wanted to mention

again about this slide is these are the services, but the service coordinators are also engaging in discussions with um the dual eligible special needs plan from Medicare um we have care managers who are available to our service coordinators when somebody has fee for service Medicare and there is a challenging issue that needs to be addressed and obviously the behavioral health coordinator that I mentioned earlier and his team is available to the service coordinators for discussions around behavior health needs for individuals and we have done some really terrific stuff with when we're doing our assessments and working with participants setting up return tasks and working with participants to see if they are following up on the behavioral health recommendations and goals within their plan
that is are done almost automatically in our system so that we were reminded to check in with them, see how the interactions are going on their, talk to PCP, talk to behavioral health manage care company, are they engaged in services, do they need any help with that and follow-up after the referral after the process is started so very exciting, you know, use of technology also things on this list not every day items just actually had a big training for entire ST staff on Assistive Technology might be electronic system that enables somebody to who has, you know, limited mobility or control of various appliances to setup systems in their home to help them with, you know, navigate security systems and lights and things of that nature technology is not just on our service coordinator but we have, you know there is a need for independent evaluation and certified professional sometimes physicians prescription for depending on what we're looking at there. So lots of um, lots
of really good things can come out of that, as well specialized medical equipment and supplies which we are also part of this um we often times will have engage physical therapists, occupational atheropis to help us with the evaluations and moving through that process as well. Of course on our list is obviously one of the key community integration and um important factors to the one of the main goals of this program in general which is the opportunity for those who are to return back to the community from Nursing Homes and we have long-standing relationship with um several independent living partners, center for independent living partners to help us with that process and um we have been actively engaged in that since the beginning of the program. So I think, I think those are the main um points that I wanted to add in addition to what everybody else had spoke to again um this is, this is sort of the laundry list. I think one of
the things that some people may not be aware of, but financial management services, you know, we sort of tack that into the participant directed um model that's an administrative service sort of like service coordination um but it makes that model work, right. It's the under-pinnings of how that, how those services are provided. So very important um aspect of the program as well. Next slide please. So you're going to see, you know, several of these items I think we might have a little bit more detail in some of our slides in terms of the benefit amounts um this is directly from our benefits um book I think that's correct. I'm pretty sure that's correct we have, this is exactly how we have them layed out in our benefits guidance on the Web and when it is provided to individuals and community and I think one of the key factors or just something I want to call out right off the top is we don't have a cell phone benefit but we will definitely help people access federal
cell phone benefits available through the federal government. We are actually looking at a way

to work with another vendor to see if we can do
something a little more in this space, we really think long-term technology, smartphones in the community are really critical um as we go through some of these other benefits that I'm going to talk about, you'll see why. So we have an additional 500 dollar dental allowance it's not, you know, just want to remind everybody there is also um dental services and benefits through the Medicaid program but this is additional 50 0 dollars I think it is really critical that folks know we are really looking hard at this, we trained, done additional training sessions with our staff. We have a new dental administrator um who is working with us to improve our network because we really believe there is significant downstream impacts for dental care for participants and, you know, um we're looking to reengage them, you know, reengage participants about those downstream impacts um of poor dental hygiene or follow-through on visits.
That's one of the areas if you remember back um last month we had presented on um our Caps survey and we had, you know, less than stellate numbers on the number of folks taking annual visits, us up on annual visits and stuff like that. So that's an area that we are really putting some emphasis on as well. The vision allowance, this is a benefit that's in addition again to routine um visits and remember I think Jen mentioned, you know, we try and tap into the Medicare benefit wherever possible um but, you know, these extra benefits are available um to cover things beyond the routine exams, the first set of frames you get and specialized exams part of the Medicaid benefit. And then, you know, extended coverage for past services. This is a unique service I believe to us at UPMC and so the service really assists you with the seeking not he will gibilityd, if you are seeking eligibility and have a pending application while waiting, this is a service we can make
available to you through our service coordination, assessment and we'll go out in the community and how do we identify those, I think that was an earlier call just to anticipate that um we do some stratifications but we also look at people that are um using, utilizing hospitalization information we get or are getting state wide from a lot of the hospitals and ERs that are using the health information exchange um if you think of the state as, you know, a person and you think that there is a like a line running right down the middle of the person, you think of it as a backbone where your ribs are attached or whatever and everybody is communicating about 70% or more of the hospitals and ERs in the state are communicate to go that backbone, call health information backbone and then there is networks of organizations that attach that backbone and we get informational feeds from them when somebody is using the hospital service or ER and that's, we'll typically engage those folks
um based on that admission or discharge from the facility to try and help them quickly and that's where this, you know, this benefit could come into play in helping them. So largely used for our NFI population, nursing facility, will say instead of saying the acronym I'll say the words. So um that is available for folks that are looking to move over into the NFCE or nursing facility clinically eligible status because of health changes that they might be experiencing in their lives and then um medical, Medicaid redetermination assistant is another one of our benefits, we actually have a team of individuals that track on a monthly basis um actually we have 90 days worth of information but um we typically are really pressing at 30 day mark if we see somebody that is going to be losing their eligibility we're going to be reaching out to this team, reach out to our service coordinator and for some reason again, you know, complex situation um, you

know, needs really significant
you assistance, we will actually have members of this Medicaid um redetermination assistance program actually have folks engage in support folks for making sure they get back on to the service so they don't lose eligibility. And if they do lose eligibility this, a team of folks wills help make sure that people get back as quickly as we can possibly get it back to them. Then we have health coaching benefit, largely telephonic service available for folks and it can help them with stress management, smoking cessation, weight loss for example, helps them come up, helps people work to establish some clear goals around um those areas and others where they might want to work on something that they need assistance with around their health. To help them make changes that last and keep them motivated um so health coach will reach out to them and set up a schedule and um help them overcome, obstacles that might keep them from achieving their goal around health. Then we have the AnywhereCare
during COVID we tried to help people down load on to their smartphones, going back to the cell phone comment, you know, smartphones and cell phone technology is really a driving factor communicating with participants and engaging with good health care options, access to care when concerned about leaving their home or just want some advice provides 24/7 access um to live, you know, individuals who can help them and so it is a really been a nice fer nice nice application for people to use during this time for sure. Next slide please. As stress management program is really more of an online kind of program available to individuals that might want to work not with a health coach but do something on their own and then there is an enhanced community benefit which I believe you saw I think PHW has the same benefit, maybe even AmeriHealth as well just an additional thousand dollars towards community transition activities that's available um under the Nursing Home transition
program then we have some in home palliative care supports that are available as well. Next slide please. I just wanted to highlight this service, you know, I believe both the other plans have a value added benefit um that's available through their, through their work but um we also have in ours we have a program that really is technology friendly and uses an application um to work with the caregiver and participant in their home um and it provides a daily stipend for the participant to help them, you know, make sure they are engaged sorry I said participant I metaphor the living caregiver um that is available for the living caregiver provides them with sort of resources on demand to help them with coaching, there is education on various various medical conditions and skills training that might be helpful, some in home visits associated with it meeting around circumstances they might find themself in. If you see in a graphic there quite a bit of engagement now with, I think some of those bimonthly home visits based on participant and family, you know, caregiver in home caregiver or needs and wants. It is a really nice value added benefit I just wanted to give it some time on its own here an highlight um with that I will that's the last slide I believe in my presentation, any questions?
>> Any committee members have any questions from Mike?
>> Hi Mike this is [Name?] Carrie, similar question these bridge services to seek or someone with pending LTSS application and might be eligible for some services whiling practice and how identify consumers and what services might be available.
>> Well if you go back a slide there Pat um it, or two slides, sorry, for NFI individuals who may be circumstance where it is clear that returning to the community prior to having LTS benefits

would be something they want to do and in leaving, you know, in their effort to leave the services we would work to get an application in pending status and start the eligibility and then we can go ahead and start some basic services typically assess for that participant, you know, so that they can return home as quickly as we can get the services back in while we are working on eligibility. Based on targeted, I was explaining health information backbone and how we get information. If we see somebody who is an acute state and may benefit from um an application right away and working through the application process we can start that and then we can go ahead and work with them on getting the services in place.
>> Thank you I appreciate the response and quick follow-up, I imagine hospitalization or discharge from rehab nursing facility part of the most common occurrence, are these services eligible for someone NFI has this acute experience but is otherwise just living at home in the community.
>> Yeah that's really what they are intended to do, try to be a quick fix so the person can get back to that home environment and maybe with help of wrapping in Medicare home health benefits like PTOT and speech, post-hospitalization we can actually help participants return back home with the additional past benefit that's mentioned here in conjunction with Medicare benefits um sometimes all they need is the Medicare benefit, right. But sometimes they need just a little bit more because recoverying and trying to get back on their feet and so we're looking at, definitely looking at somebody that would probably have a longer term need um for this but certainly we go out and work with families.
>> Thank you.
>> Earlier in today's meeting I heard a reference to counseling that was providing for folks who do not qualify for BHCMO services first time I heard that actually I just want a couple of things, what's the volume of those counseling services, I didn't hear it mentioned in any of those presentations from from the three MCOs, what level staff are used to provide them and is there a way the volume of those services can be shared to get a grasp on how much of those is actually recognized as a need
>> So I'm, I'm not quite sure if I got your question completely um but I will, I'll take a shot at it and if you, if you want to weigh in here. I think you were talking about the BHMCO services and then there is counseling services that are available through the waiver and looking for sort of how often those are tapped, is that what the question was?
>> Yeah --
>> Yeah really haven't heard about those --
>> So it is very low um utilization the counseling services and waiver benefit because we're looking again we got to get basically referral to the Medicare benefit um as part of the BHM, any work with behavioral health we're trying to use that Medicare benefit um as well the local county BHMCO for their benefits and predominantly that's where those services are delivered so they don't often get to our counseling service in the waiver it is very, very low utilization from our perspective but I don't know um if the other MCOs want to chime in here.
>> Hi Mike it is Jen, just to, to Lloyd's question and to clarify because you asked about staff qualifications again I'll reiterate we do see low utilization for reason Mike stated, based on service description available in the CHC agreement um it's used primarily for things like adjustment to new diagnosis, for people without SMI diagnosis so again our goal is to assure

that the program is last resort, but with caveat of course we want to see people connected to the right services. Right level of service, so I hope that is helpful but I just wanted to make sure Lloyd knew it wasn't service coordinator providing the service, it would be service coordinator you authorizing the service through the LTSS benefit and the provider would need to meet the staff qualifications.
>> So it's directly contracted by the MCO with somebody or somebody else does this?
>> So we contract um with a network of providers that are authorized to provide that service with the benefit if that makes sense.
>> Okay each one contract watershed a different organization, each MCO?
>> I would imagine there is overlap in our network, Lloyd, um so yeah if that's helpful.
>> LLOYD WERTZ: Okay, thank you.
>> Any other committee members for Mike? If not I have some from the audience Mike, go to those. Two from Amy, the first question she had is how does assistance with Medicaid redetermination differ from the existing requirement that a service coordinator coordinate efforts to complete activities necessary for the participant to maintain LGSS eligibility.
>> Yeah Amy, sorry I was trying to get off mute here. It really is an augmentation of that, allow some additional resources to be available to support the participant um as I mentioned in the presentation sort of difficult um, difficult applications to file trying to help them more significantly with that process um that's what those folks are doing with regards to that augmenting the service coordinator role and support for that.
>> Okay. And the next question is can you talk about the palliative care value added benefit and how it differs from the adult hospice benefit um if Medicare does not cover palliative care in the home will UPMC provide it to a dual if it eligible and then finally if Medicare does provide palliative care will UPMC cover the cautionary?
>> That's a loaded question, lots of points could cover there, the palliative care benefit is really the cover those that do not have Medicare and so that's, that's the real um, you know, real emphasis of the program. We will be engaged in using the, engaged in using the Medicare benefit whenever possible and there is no cost sharing for that and we look at each case individually for those things.
>> I think you hit most of it, I think the piece you didn't hit if Medicare wouldn't cover it then would that be covered under the value added benefit? I'm not an expert on this one but I would say, you know, the way we have it structured I believe it is just for those who do not have Medicare. And we certainly could look into that further.
>> Okay and Amy sent a follow-up question how is the palliative care different from --
>> Well you know what I'm going to let Andrea on the team has offered to jump in here and talk a little more about this, thank you.
>> Hi it is Andrea, think of the palliative care benefit as care that somebody needs in approximate between using acute home health and before hospice. So they are not quite ready to go into hospice, they don't qualify for acute care but they definitely would benefit from some medication management, some social services, things along that line where the member would still benefit from receiving the care. Is not ready to go in hospice, they are outside of palliative care program. So what, what we would cover it for CHC would be if the member was a full um Medicaid CHC member. We would not cover it under their secondary benefit for CHC um but we

would cover it as a benefit for somebody who was a full um CHC Medicaid member that would be in need of those services. We do have a full policy wrapped around it on in the providers understand um when the member would be um appropriate for palliative care.
>> Thanks Andrea, if there are no other questions from Mike I'll circle back and there were a few follow-up questions for Jen and then we have some questions for the um additional public comment. Just to start, excuse me, Dave I know you had a follow-up question for Jen.
>> I did thank you, hi Jen, wondering if you can expand upon these services for those who have, NFI applying for, just provide some case examples or better clarity as to how these are operationalized.
>> Hi David, thank you. So our, value added benefit, can you hear me, am I still --
>> Yes, you are good.
>> Oh, okay, all right. Thank you. So it really is an identification and then that's done through our welcome calls and outreach to our community identify population we encourage them to complete the with us and if they score a meeting or could benefit from LTSS our next opportunity is to Shepard them or help them through the NFC um LTSS enrollment process and as you know that's not a function of the plan, that's done with independent broker. But in the interim um our service coordination team or care management team would be able to authorize um a personalize systems at a limited amount it is not full fledged LTSS because again this is currently on paper not eligible but we don't want to see them lose their homes or go into a nursing facility while in that enrollment process with the independent broker. So lighthouse keeping um, companion services, checking in, things that can be done by authorizing a home health or personal assistance services is what we're talking about
here. With the objective of them obviously assessing the person and do become eligible for LTSS to take advantage of the full gamut of the 32 services offered under their LTSS benefit. I hope that answers your question.
>> It does, thank you Jen.
>> Okay and that's also answered one of the questions I had. The last specific question for you Jen is from Amy [Name?] you notice that routine vision exam is a value added benefit but routine vision exams are required under adult benefit package, is there an aspect to your vision benefits that is in addition to what is available under the adult benefit package?
>> That's a great question and, no there is not.
>> Okay um so then I had some questions um for actually for all of you we may rotate through those, the first one is from Cindy Celi and she was asking about your percent of face-to-face visits versus telephonic visits to date from the MCOs, so Jen since you are already on, if you want to talk about your percent and then we will go to Anna and then like
>> Oh Pat I don't think I have the most up to date in front of me --
>> (speaking simultaneously)
>> Sure, Randy.
>> This is from long-term living, last report I have was through the um end of end of July, July 26 report in every other week for the month of July AmeriHealth done a little over 33% of the assessments face-to-face, PHW over 13% and UCMC over 20% and face-to-face at this point in time. Still a lot of participants very, people coming into their home so they are doing telephonic at this point in time so have been increased every month um increase over, PHW increase of 3%,

UPMC increase of 4%, so seeing increases every month with it.
>> Okay, thanks Sandy. And then the next one um really would be for um for from Renee, Medicaid determination assistance, UPMC offers support to their members to PHW and AmeriHealth offer the same. This is specifically being asked by facility provider.
>> Jen?
>> So excuse me the, that is a requirement and um responsibility of the service coordinator um to offer that support and we see that on the ground level especially coming from Nursing Homes and going to the community-base settings our teams advocate that the waiver code be flipped and applications so take audiorise services as appropriate when people move from nursing facilities to community-based settings um and I don't know if the question is do we do anything above offer on this, that would be no our team and trained on exactly what the process is for reapplication as we are notified when that is coming due with participants that would be an outreach to the participant to engage them to see if they could use any assistance from their service coordinator and earlier part of my comment back attuned to that during the transition process and work with OLTL and others including our Nursing Home transition partners to make sure that on day one the waiver codes are open for
community which is in our system called Wave20, for those of you that didn't know parties papt accurately, no longer residing in nursing facility, different codes but they are community living now and um that kind of Admin processes is done, so it doesn't create any down string issues for them engaging and utilizing service.
>> Anna, how about PHW, only thing I would add to what Jen said, dedicated nursing transition team and then when our boots on the ground partner is our community, our Franklin living and beyond that the process is the same to ensure that no one falls through the crack in the process of getting through the facility
>> So that support would incude just nursing facility residents staying in the nursing facility.
>> Correct.
>> Um I think that likes like all of the questions related to your presentation, then I do have some additional um commets for public comment. I'm not sure if there is any
>> First one I have, and um this would be specific for you um why is there a delay in regard to UPMC support coordinator submitting authorization into HHA exchange within a timely manner, agency is been able to contact these coordinators directly um always told that a task will be sent to the service coordinator to contact service coordination does not um and then delayed response from network managers as well.
>>
>> MIKE GRIER: This is Mike, sorry to hear you are experiencing that issue, certainly um there is ways to escalate that within the call system if you have concerns, there is also resources within provider services um that representatives that can help you if you are engaged and having difficulty with that, certainly um we shouldn't be a delay, if they give us specifics we can definitely track that down um and try and work through it for you so if you want to provide, off line drive into that, because it should not really be happening.
>> Is there an update on the um enrollment services --
>> Yeah Pat this is Randy from LTL, the update is blackout period and we cannot discuss it.
>> Thanks Randy.

>> Yeah just to add to what rapidy said this is Jamie, we will continue to be in, before we have a contract in place. Just wanted to let everybody know that.
>> Okay then the next item is a comment from Cooper to all interested downstream cost of dental issues was mentioned and it is so true we believe that there is a very large downstream cost for untreated mental health substance abuse disorder on many levels, seems save everyone a tremendous amount of money and individual family stress and grief. Thank you for your consideration.
>> So to answer that comment is 10% correct I mean a lot of issues with dental, mental health systems conditions do have downstream cost associated with, we are very seriously um trying to move forward with providing behavioral health services both in nursing facilities and in community-basis terms um we're having repeated conversations and working with the mental health and substance abuse who overseas the behavior, contracts, we're working with the nurse associations um so we're trying to coordinate and open up these services a lot more, so yes I agree 100% we are trying to push these services forward
>> Okay. And I don't have any other comments or questions at this point unless there are any from the community members. So Linda I guess I can turn it back over to you.
>> LINDA LITTON:
>> This is Luba f there are no other questions I just wanted to thank everyone for their participation and um particularly the presentations that were provided with such information and excellent PowerPoints and on that note I would like to adjourn the meeting.
>> Thank you everyone.
>> Thank you, bye.
>> Thank you bye.