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Date: 08/03/22

Event: Managed Long-Term Services and Supports Meeting

>> SPEAKER: Good morning. This is David Johnson. Thanks for bearing with us. Can any committee member announce themselves so we can test the audio?
Bear with me one moment, and I will start taking the attendance.
Good morning, this is David Johnson. I will start by taking the subcommittee attendance. Is Ali Kronley present?
>> SPEAKER: This is Ali. Good morning. German Parodi. Juanita gray? Kyle Glozier. Lloyd Wertz. Good morning.
Matt Seely. Good morning.
Mark Gusek.
Mike Grier, present.
Monica Vaccaro.
Patricia.
>> My, this is Monica. I'm here.
>> DAVID: Good morning, Monica.
Sherry Welsh.
Tanya Teglo.
Are there any committee members that I missed that would like to announce themselves?
>> SPEAKER: Cindy. You cut out for a second. I didn't know if you called my name.
>> DAVID: Thank you. Good morning, Cindy.
>> This is Gail.
>> DAVID: Good morning.
Any other members that would like to announce themselves? Great. Thank you. >> SPEAKER: We'll follow up with housekeeping.
Please keep your language professional. This meeting is being conducted in person at the Department of Education building. And it is a webinar with remote streaming.
This meeting is also audio recorded. The meeting is scheduled until 1:00 p.m.
If you comply with logistic agreements, we will end promptly at that time. All webinar participants except for the presenters and committee members will be in listen only mode during the webinar. All of the committee members and presenters will be able to speak, but we ask that you use the mute button or feature on your phone when not speaking. This will help to minimize the background noise and improve the sound quality of the webinar. Please submit your questions and comments in the chat box located in the Go To Webinar pop up window in the bottom right hand side of the screen.
So enter a question or comment, type into the text box under Questions, and present 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.
To minimize background noise in the honor suite, we ask that committee members and presenters and audience members in the room please turn off your microphones when they are not speaking.

Audience members who have a question or comment should wait until the end of the presentation to approach one of the microphones located at the tables. Or if you're sitting around the table with us. Just kind of raise your hand.
The chair and vice chair will then call on you.
The captionist is documenting the discussion remotely. So it's very important for people to state their name and speak slowly and clearly. Otherwise, the captionist may not be able to capture the conversation.
When submitting a question or comment into the text box, it's important to include your name in the chat box.
Before using the microphone in the honor suite, press the button on the base to turn it on. You will see the red light come on indicating that the microphone is on and ready for use. State your name into the microphone and the captionist -- and remember to speak slowly and clearly.
When you are done speaking, press the button at the base of the microphone to turn it off. The red right will turn off, indicating the microphone is off.
Any 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 additional public comments to be entered into the chat box.
If you have any questions or comments that weren't heard, please send your questions and comments to the resource account listed on your agenda. Or reference, like I said, it's on your agenda.
Transcripts and meeting minute documents are posted on the list serve under MLPSS meeting minutes. These documents are normally posted within a few days of receiving the transcripts.
The 2022MLPSS meeting dates are available on the Department of Human Services website.
>> SPEAKER: This is David Johnson with the emergency and evacuation procedures in the events of an emergency or evacuation. Proceed to the corner of fourth and Market. If you require assistance, go to the safe area located outside of the main doors of the suite. OLTL staff will be in the area and stay with you until you are told you may go back or you are evacuated. Everyone must exit the building. Take your belongings with you. Do not operate cell phones. Do not try to use elevators. We will use stair one and stair two to exit the building. Stair one, exit through the main doors on the left side near the elevators. Turn right and go down the hallway by the water fountain. For stair two, exit the suite through the side doors on the right side of the room or the back doors. For those exiting from the side doors, turn left. And stair two is directly in front of you. Turn left and left again and stair two is directly ahead. Keep to the inside of the stairwell and head outside. Turn left and walk down the alley to Chestnut Street. Turn left at the corner of fourth street. Turn left to blackberry street and cross to the train station. Thanks for your attention.
>> SPEAKER: Thank you. We did have some follow up questions from our July MLTSS meeting that we will let the committee members and the audience know about.
During the OLTL update presentation, an attendee asked to see the matrix for the nursing facility quality incentive program.
>> This is Jermayn Glover. To follow up, Abigail said that the program metric has been updated through the new deadlines. The metrics are as follows. Percentage of short stay residents hospitalized after an admission. This conversation is obtained from data.
A percentage of high risk long stay residents with pressure ulcers. This is obtained from the data set.
Number three, percentage of long stay residents experiencing one or more falls with major injuries. This is obtained from the minimum data set.

Number four, percentage of long stay residents appropriately given seasonal vaccines. This is obtained from the minimum data set.
The percentage of long stay residents assessed and appropriately given the pneumonia vaccine.
Number six, percentage of long stay residents who received an antipsychotic medication from the minimum data set.
And ratios based on the general data.
>> SPEAKER: Thank you.
Related to choosing nursing facilities, Pam asked about the reasons why people were going into nursing homes. That it would be really interesting to know why people are leaving homes if they are in homes or community-based services.
>> SPEAKER: And Abigail responds to this one and said it's not feasible to create this report because the information is not captured on the data set report.
>> SPEAKER: Related to home and community-based services improvement grant eligibility, Matt asked why are personal emergency response systems providers not eligible for the quality initiative grants?
>> SPEAKER: Jennifer Hill responded that the provider types for the quality incentive funding identified by utilization and number of providers.
>> SPEAKER: Related to money follows the person in nursing home transition from June, follow up response, Amy asked in reference to NHT pay for performance goals for 2021 out of more than 1,000 transitions that were completed, if each of the CAC MCOs reached their individual goal of 300 transitions?
>> SPEAKER: Rachel responded to this one saying that the only MCO that did not meet the goal as reported in the 2021 transition goals was THW. There were only three transitions short of the goal. Based on the typical report of underreporting, she feels it's likely they met the goal and did not report it at the time of the tally.
>> SPEAKER: Mike shared the comment that they are still hearing from consumers who are reporting longer than 15 -- we're working on it.
For those of you listening in, we're trying to get the clerk straightened out.
>> SPEAKER: Speak really loud, Mike.
>> SPEAKER: Okay. Vice chair David Johnson said they are still hearing from consumers who are reporting larger than 15 to 25-minute wait times. He asked if there was data available on call abandonment rates and if it could be provided to the subcommittee.
>> SPEAKER: The call -- from June 20th, 2022 to July 26, 2022, was 6%. And he provided charts for daily call volume, speed of answer, and average talk time. These charts are in the handouts on the webinar.
>> SPEAKER: And vice chair David Johnson asked how Tempest was calculating the average call wait time. Does this include individuals who called, hung up, or opted to be called -- to utilize the call back feature.
>>
>> SPEAKER: It includes the average time it takes to connect the call to an agent for the inbound call, connect to an agent on the callback feature, and time to aBrandon averaged together. This includes the call back feature.
>> SPEAKER: Very good. Thank you, Jermayn. That's some of the follow-up.
And now the agenda. And the first thing we will hear about today is the public health emergency unwinding. Kirsten McKinney and Jermayn Glover.
>> SPEAKER: Good morning. This is Jermayn, the division director or communication

management in the bureau policy of OLTL. This presentation will be done by Kirsten, she is working on the -- what the group that's working to unwind the public health emergency. She will go through this. We're going to limit this to the scope of OLTL and THC. We won't go broader. If you have questions at the end, I will address them. I may have to defer some to the larger group working to unwind and get back to you at the next meeting.
You can go ahead.
>> SPEAKER: If we will be able to go back to ask questions about the last thing later? Or are we able to ask questions or respond to later?
>> SPEAKER: Why don't we wait until later to get caught up here. All right?
>> SPEAKER: Good morning. This is Kirsten McKinney. This is COVID-19 public health unwinding. We will talk about the unwinding of PHE. The office of long term living. Becoming a PHE helper. PHE helper portal. Commonwealth of Pennsylvania application for social services or COMPASS. Community partners. And we will wrap up with questions you may have.
So unwinding the PHE.
What is the PHE? The PHE is an official declaration made by the U.S. Department of Health and Human Services, a federal agency, when a disease or disorder presents an emergency to public health, or a PHE otherwise exists due to significant outbreaks of infectious disease.
In 2020, the COVID-19 pandemic was declared a public health emergency. They typically apply for 90 days at a time and they can be renewed by DHHS. And this has been a public health emergency renewed several times.
So when does PHE end? It is not certain as to exactly when the PHE will end. The earliest date by which it could end is believed to be October 13, 2022 S.
Why is this important? After the PHE ends, anyone who is found to be no longer eligible during their scheduled renewal for medical assistance or failed to complete the scheduled MA renewal, will be disenrolled from the coverage. The vast majority of the participants receive MA and the MA eligibility has been maintained for individuals who would otherwise be ineligible during the PHE for most people, unless they have a situation such as having passed away or asked to end the MA coverage.
There is a responsibility to ensure participants are well served throughout the PHE and after it ends.
So what is the Department of Human Services doing to end the PHE? Multiple DHS offices and other commonwealth agencies are working together. The office of income maintenance, the office of received eligibility is leading the joint effort to unwind from the PHE. Other offices are actively involved in helping things go smoothly as well. Right now, as the PHE unwinding is near, DHS and other agencies will increase communications to ensure the information is available when it's needed.
The communications we're currently focusing on are capturing updated contact information, promoting increased use of COMPASS and the mobile app to help stay informed, and update personal information.
And we're encouraging individuals to opt in to text messages and E-notices for COMPASS. Down the road, communications will shift completing renewals and what happens when someone is no longer eligible for MA. Reconsiderations, appeals, referrals to CHIP or Pennie. And you can visit the PHE landing page for E voluming information regarding PHE and DHS efforts at the website.
So when will we know more? The federal partners committed to giving states 60 days notice prior to the end of PHE. At this point, the 60-day notice would be provided no later than August 14, 2022. Information about the day the PHE will end will be XHOOUBTed through several

channels, such as the DHS PHE landing page, the DHS helper portal, when we will cover later in the presentation, list serves, email messages, texts, et cetera.
DHS is working to ensure all individuals affected have the information they need when they need it.
OLTL's role. In the portion of the presentation, I will focus on what roles have been thus far in respect to the PHE ending. We will cover staff involvement, communication to staff, and interaction with stakeholders.
Jermayn Glover is the OLTL lead for the PHE unwinding. There is staff from multiple areas involved in the end of the COVID PHE meetings. 14 other staff involved in the end of PHE meetings in the areas of communications, policy, operational impact, and systems impact.
These OLTL staff members have an internal monthly meeting to discuss the projects with each other to ensure that everyone is on the same page and addresses questions and concerns before they become an issue.
Jermayn Glover gave a presentation to the OLTL staff during the May all staff meeting to inform them about DHS's preliminary efforts with the unwinding and introduce the PHE website.
A message was sent to OLTL staff on July 29th to give an update on the PHE and their role in the unwinding of the PHE. They continue to provide updates to staff over time as more information becomes available.
OLTL has shared information on our list serving about the DHS helper portal related to the unwinding. As we receive questions from stakeholders, we're utilizing staff from DHS and other agencies to vet answers and make sure the responses we give are accurate and consistent. We will continue to share the information with the stakeholders throughout the list serves and other establishments of communication.
Participant-level data from April 17th of this year was shared to give them a lead on which participants target communication related to renewing the information with. And the partners will coordinate on the data for these numbers.
OLTL is also communicating with the CHC-MCOs about the unwinding on a biweekly call. We plan to have them present in September on the approach to the PHE unwinding.
So the PHE helpers. So what is a PHE helper? Trusted partner to assist in the PHE unwinding process through their means of connection to individuals that will need to renew MA benefits.
Anyone can become a PHE helper. You don't have to be a company or organization, just someone who wants to be informed and help inform others. They will use the helper porten to send the regular communications on the status of the unwinding and help the individuals get covered under the PHE ends.
How does the helper help? With the end of the public health emergency, many Pennsylvanians will need help understanding how their medical assistance benefits may change and what to do to renew their benefits.
By using the communication channels, like social media and newsletters, the trusted messages out to the neighbors and community members, PHE helpers can help the community.
When an individual or organization signs up to be a helper, they will receive information via email about to support them in the effort.
How do you become a helper? First, fill out a simple online form on the PHE helper website.
The form will generate an email to the email address given. You can confirm the address by walking through the prompts in the email. Congratulations, you are a helper.
Now to walk through the sign up process together.
So you can complete the form on the website. Or you can open the sign up form
[inaudible]

Another window will pop up with a message alerting you to confirm your email address.
You will then get an email that asks you to confirm your subscription to the helper porten. If you do not see the email, check the spam folder. The email content may look different than what is on the slide if your email displays the content without the graphics. Click on yes. And a window will pop up in your Internet browser.
You will confirm you are a human, and receive a notice that you have been subscribed to the mailing list. From here, you can either close the window or continue to explore the DHS website.
When you sign up, you will receive communications from the DHS containing suggested messaging, key dates, social media graphics, printed materials, tool kits, important dates, and more. At the bottom of the PHE helper portal web page, the organizations can also find out how to become a community partner.
Let's talk about the COMPASS community partners.
What is the community partners? Community partners are community-based agencies, organizations, coalitions, and other groups that wish to help Pennsylvanians submit applications for health and human services. Community partners can be hospitals, church groups, sponsors of the national school lunch program. Organizations that meet the criteria to be a community partner and want to take the next step can use the link at the bottom of the web page to register or learn more.
Registered community partners have access to a centralized location to help them manage their applications.
If you are an MA provider and you use your MA provider number when filling out the application, you will receive notices of your patients' eligibility, including the MA ID number for billing purposes.
Being a community partner allows you to submit and track all applications in one location. E-sign applications on behalf of applicants, access saved and submitted applications for up to 180 days, use statuses of the submitted applications, submit documents electronically on behalf of applicants and reaccept YINTs, view quick reports of applications, view detailed reports of applications through search function, view messages from DHS headquarters, and access forms, links, and other publications.
This slide contains helpful links on what web pages we mentioned throughout the presentation. And any questions at all for us?
>> SPEAKER: Any questions from the committee members?
>> SPEAKER: Good morning, this is David Johnson. You had mentioned that there will be referrals to partners. Is -- going to be listed as a referral for those losing medicaid eligibility?
>> SPEAKER: I will mention that as background, this presentation, because we want to make sure that all the information we give is accurate and consistent with all the offices within DHS and the other agencies that are working with this. This was reviewed and approved for content. It wasn't mentioned. Let me take that back and confirm.
>> SPEAKER: That would be great. Thank you.
>> SPEAKER: Committee questions? Audience questions? I thought I saw your hand. You good? All right. Go ahead.
>> SPEAKER: This is Patty. Will there be trainings or guidance for the community agencies? On becoming a COMPASS and even after?
>> SPEAKER: For becoming a community partner?
>> SPEAKER: Yes.
>> SPEAKER: If you go to the website and use the link that's there, it has information there on the top of the website. There's detailed information on what a COMPASS community partner

does.
COMPASS is OIM. I can find out if there is any other that OIM has and let you know.
>> SPEAKER: Thank you.
>> SPEAKER: OAM?
>> SPEAKER: OIM.
>> SPEAKER: OIM. That's what I was referring to.
>> I think the captioner is having trouble with some of the acronyms.
>> SPEAKER: Go ahead, Monica.
>> SPEAKER: In the chat box came a question. Are MCOs who are community partners in COMPASS for assisting participants with the renewal, do we need to register as a PHE helper? Or are they already considered PHE helpers since they are currently assisting the normal medicaid renewals and apps? Are MCOs who are community partners in COMPASS for assisting participants with the annual MA renewal, do they need to register as CHE helpers? Or are they already considered PHE helpers since they are currently assisting with normal medicaid renewals and apps?
>> SPEAKER: In order to become a helper, an individual would have to go to the assistance website, click on the become a helper link. And as described in the presentation, go through the process to actually become a helper.
Even if someone is already a community partner or helping people with applications, it would be beneficial to sign up on the helper portal to see all the information that is being shared so that they're up to date and inform the participants or anyone else affected by the PHE unwinding.
>> SPEAKER: Thank you.
>> SPEAKER: Another question in chat came in from Matt. Any sense if they will extend the PHE? Also, how many are expected to lose eligibility?
>> SPEAKER: As to extension of the PHE, there is a federal website where emergencies are listed. They let us know via that website if the PHE has been extended. As mentioned in the presentation, we have been told that we would get 60-day advance notice if it will not be extended. We hope to know that by August 14th. But I can't say at this point whether it will be extended or not.
What was the second part of that question?
>> SPEAKER: How many folks impacted?
>> SPEAKER: Yeah. As for the number of people impacted, that's something I can get back with the group about to make sure we have the most up to date information.
>> SPEAKER: This is David Johnson. And this can be a question directed to the manage care plans and life providers later. With the data provided who to communicate in the near term, are they aware of the communications that went out or are they waiting for the ending of the PHE?
>> SPEAKER: And David, are you asking communications from whom?
>> SPEAKER: The managed care plans and life providers to receive data on who to communicate with in the near term?
>> SPEAKER: I would like to wait for the presenters to get a picture of what's going on.
>> SPEAKER: Thank you.
>> SPEAKER: And a question that came in through chat from Gail Weidman. Is it recommended that nursing facilities sign up to be PHE helpers given they work with residents and families on MA applications and renewals?
>> SPEAKER: Yes. The group working with the PHE unwinding would like as many people as possible to become PHE helpers. We share the information through the list serves, other offices and agencies involved with shared through their networks. The PHE helper portal will provide

information in the areas of other than helps people with the everyday application. So it's beneficial to sign up and receive that information.
If participants and patients are signed up, they may ask a question to someone helping them, they may be referencing materials they received in the helper portal. It may be helpful to know what they're seeing.
>> SPEAKER: I have nothing else in chat.
>> SPEAKER: Great. Thank you.
>> SPEAKER: Hi. This is Cam Howard. I'm not understanding what this is. Is this the health emergency, so the end of the health crisis, the COVID, so it's identifying people who are on MA that shouldn't be on MA anymore? They were denied in the time period? Or I'm not understanding what this is. To break it down to make it a little easier or basic, that would help me.
>> SPEAKER: No problem. So one of the links provided at the end of this is the main medical assistance page. And that page is maintained by DHS that shows exactly how medical assistance is impacted by the public health emergency.
In general, during this public health emergency, states have not been able to close individuals' medical assistance for certain reasons. There are some people who are potentially ineligible for medical assistance, may be found ineligible after the protection of the public health emergency go away.
What DHS is doing is trying to encourage people at this point to update the contact information, complete the renewals, if they haven't, make sure things are up to date so that DHS knows whether they are eligible. Once the PHE ends, there will be what we're calling an unwinding where eligibility will be proffered to determine who should remain on medical assistance and who doesn't.
If someone is not eligible, that's when they can potentially be referred to CHIP, Pennie, to get health coverage.
Does that help?
>> SPEAKER: It looks like another something coming down the pipe that's going to be harder on our community.
If they're found ineligible but still need services, what's the plan? Is that what the helper is, the people that are helpers help them identify other sources because they're found ineligible? Is that what you're calling the helpers?
>> SPEAKER: Information on the helper portal will be around different topics, including what to do if your medical assistance ends after the PHE. There's information on the website that I mentioned. There is frequently asked questions section that can answer questions that you may have.
When a person goes through their eligibility, when it's processed and the information is updated, if they're found ineligible, they can be given information at that point saying about possible eligibility for CHIPS or Pennie.
>> SPEAKER: Is it going to be the FCs telling them that? Or refer them and say have at it? Or I guess I'm trying to understand it. If I'm confused, the consumers are going to be. And what happens all the time is when people lose services, they come to us. And we're trying to help fight it. But we're already overwhelmed in independent living.
So how do we work on making sure that they get the help they need after they are found ineligible? I guess that's -- I don't know. I'm trying to figure this out. It happens every time systems have changed, we have gotten -- and not to say we're not here for our people, because we are. And we will serve them. But we're going to need a little help. Can you talk with

independent living that -- because with the overload, that sets a lot of people trying to figure out where do I go where there's resources? Seniors especially. They have the options program, which is not an option. And the care giver program, which is very limited. And then our people, if they qualify for act 150, if they don't, they have no other options.
So how to work in advance and what stakeholder are you working with to make sure you have the right people at the table to ensure that when they're found ineligible, the resources are out there to be prepared? We need to be prepared. We need to know well in advance to. And anything we can do, whether agencies that serve our communities.
>> SPEAKER: Okay. So what I would like to do is take back your concerns about communications with the triple As and find out what they can do. And if you want to send me your concerns in an email, I can give that to the group and we can look at whether we need more information on the website about that or maybe we can add things to frequently asked questions or portal content.
But I will let you know. Does that help?
>> SPEAKER: I guess just to add to that, when I hear the word unwinding, I think of gradually unwinding. Is this going to to end at a moment in time and the flood gates will open? Or is this going to be done over time.
>> SPEAKER: So for anyone who might not have heard the question. The question was the unwinding, is it a point of time or happening over a certain period?
So what I can say is that the unwinding is not at a point in time. It will be a process, a period of time. And let me go back to the group and give you exact information about that. I don't want to give information that could possibly change at this point. But the unwinding is not one specific point in time. It will be a time period where cases will be processed after the PHE ends.
>> SPEAKER: This is David Johnson. Are you aware of staffing increases in the office level in response to the unwinding and the projected surge in demand?
>> SPEAKER: I would like to bring that one back to you also.
>> SPEAKER: Certainly.
>> SPEAKER: And just to reiterate, if I'm bringing things back, it's because there are partners involved. And I don't want to speak outside of OLTL without getting a consensus from the group.
>> SPEAKER: That is understood and appreciated. Thank you.
>> SPEAKER: Any other questions? Excellent. Thank you. Thank you.
Next we're going to move to pay for performance measures, Abigail Coleman, doctor Larry Appel and Dr. David Kelley, OMAP.
>> SPEAKER: Good morning. I'm Dr. David Kelley, the medical office for OLTL and OMAP.
>> SPEAKER: Good morning. I'm Dr. David Kelley, the chief medical officer for OLTL and OMAP with DHS. Thanks again for the opportunity to come this morning and present our MCO pay for performance program. Next slide.
So what we intend to cover today is actually describe the pay for performance program that we are holding the MCOs accountable to. And we will go through each measure, you have seen before. We presented these measures at this meeting and in other forms. We will be presenting them today over three actual measurement years of 2019, 2020, and 2021. We will have time for questions. And we're going to ask our MCOs to respond to their performance and how they intend to improve their performance. Next slide.
This slide demonstrates a whole host of quality improvement activities that OLTL has in place for the community health choices program. And we're going to talk specifically about one of the pay for performance programs, specifically looking at MCO performance.
We're drawing on other aspects of our quality measurement, including home and community-

based survey results. And they're pictured on the diagram as well. We're using a lot of other components of our quality strategy to put together the MCO pay for performance program.
Next slide.
So the program I'm going to describe is defined in the 2022 community health choices contract, and I have laid out the exhibit and pages and also provided a link if anyone cares to go in there and read the detailed descriptions of what we're going to cover today.
This program really looks at seven priority quality measures that we have internally looked at since 2018 with our managed care plans.
And so we have been measuring these measures since 2018. And we have been going over the results with our managed care plans for several years.
So hopefully, as we go through each of the measures, none of them will be a surprise to you or to our MCOs since we have been looking at this pretty diligently.
It measures, again, selected to drive quality improvements and services and support for our CHR participants. And the measures align with waiver assurances. And recently, there was a released CMS from the HCBS quality measures set announced about ten days ago or two weeks ago. I provided a link to that measure sets.
Next slide.
So again, the pay for performance program is really looking at a set of seven measures. And we're establishing for each of those seven measures benchmarks or goals. And we'll outline what the goals are.
And then each measure, the MCOs are accountable for hitting those goals. But they're also accountable for having we call incremental improvement, looking at improvement from year to year.
For purposes of the actual incentive dollars that MCOs can earn, we will be looking at the goals that will be set for 2022.
And the MCOs will be insented on incremental improvement for results from 2021, which we will share with you today. But we will not have the 2022 results, obviously, probably until next summer.
Again, we will share the results today of these measures for three trended years. And again, the goals for 2022, the final goals will be set by the office of long-term living for 2022.
Next slide.
This actually lists the measures for your reference. And Dr. Appel and Jill are going to go through the measures and the performance of the managed care plans.
I wanted to lay out here are the measures and where they come from. The first four come from the National Committee for Quality Assurance, MCQA. And these are the long-term services and support measures. They were developed by CMS and is modifications and we have been measuring them for multiple years.
This is looking at individuals to see within the waiver programs, see if comprehensive assessments and updates have been done. Whether or not a comprehensive care plan and timely updates have been done.
Whether or not the care plan that has been developed has actually been shared with that participant's primary care provider.
And then we also want to make sure that as individuals come out of, let's say an inpatient hospitalization, we want to make sure they are being reassessed to make sure their service plan is meeting all of their needs.
Next measure looks at what's called consumer assessment of health care providers and systems, or CAHPS. This is a satisfaction survey for all members within the CHC program. This

is not just limited to the individuals within -- that are NFCE. And this looks at overall service with a particular managed care plan.
The next measure is from our home and community based survey, which is done annually. I believe the results are shared every year with this committee. And again, we are looking at one of the very specific questions that we think is important and pivotal. And that is whether or not person-centered service plan includes all things important to you, to the participants.
Then the last measure is one that is a PA performance measure that has been developed by OLTL in conjunction with our external quality review organization. And this is looking at participants who actually transitioned to community from skilled nursing facilities. And they actually stay there for six months.
So those are the measures. I am next going to turn it over to Dr. Appel. And we will start to actually go through the actual measured results. Next slide.
Doctor Appel?
>> SPEAKER: Great. Good morning. And thank you all very much for allowing us to present this material today.
We are very excited to be discussing these measures as we continually evaluate and look for the improvements and opportunities.
The LTSS measure, as Dr. Kelley mentioned, are relatively new developed by the national committee for quality assurance, or NCQA. These measures are key indicatorsover the work that MCOs do with participants.
And they really help guide the MCOs in areas of strength and areas of improvement.
They measure, as Dr. Kelley mentioned, assessments, are they quality and timely? Service plans, are they quality and timely? Sharing the plans and reassess.
And an overarching goal of these measures is to help drive care coordination, which is one of the five goals of the program.
Looking at the slide, comprehensive assessments and updates, these measures are -- this measures the health -- there are several parts of the assessment that need to be done in order to for this to be counted as a successful assessment. Are the health conditions, acute and chronic, assessed? Are the ABLs assessed? Are the medications assessed? Is there a mental health assessment? Cognitive function? Is there a standardized tool used to assess cognitive function? Home safety risk, is that assessed? Nursing facility, personal care home, home care, is that assessed? Care giver availability? Are there care givers and are they available and paid or unpaid? Family members?
And also, current providers. Who is currently providing care? These are the elements that need to be documented and assessed in order for this to count as a successful assessment.
When we look at the data on the comprehensive assessment and update measure, we see substantial improvement. I draw your attention to the black column at the end of the diagram, which note overall substantial improvement and a steady two-year course of improvement. Note that the statewide goal for 2021, 75%, was met overall in average. And we are at 79.7%.
Next slide.
So the next measurement was comprehensive care plan update. So the measurement here was within 120 days of enrollment, the comprehensive assessment was 90 days of enrollment. Within 120 days of enrollment or annually, was there an updated care plan? And again, there were several criteria required to make this into the measurement category.
Is the individual -- is the individual's health monitored? Does the plan meet the medical needs? Does the plan meet the functional needs? Does the plan meet the cognitive impairment needs? Does the plan meet the member's needs in an emergency, is that planned out? Is there a

family, friend, or care giver involved in the plan development? And is their contact info listed? Does the member have a representative or agreement if the plan has been agreed to or they have a representative to appeal the plan if it's not agreed to?
And again, we see when we look at the results that there's significant improvement overall. And note that the weighted average of 76.9% is above the statewide goal.
Next slide.
So another measure is are these plans that are being developed, hopefully in the 120 days, are they shared with the primary care providers? Again, overall, we do see significant improvement in the sharing process. Part of this relates to the involvement of the MCOs with the HIOs, the health information organizations.
And again, the average weighted average is 63.8% for 2021, with a statewide goal lower than that. So the average has been met.
And then, there's the question of reassessment and care plan updates after an inpatient discharge. And again, here it's within 30 days of discharge, has there been a reassessment indicating the nine core elements we talked about on the initial assessment and also the elements of a care plan done within 30 days of a discharge from an acute hospital?
And you will see this is an improvement opportunity. Next slide. Sorry.
There we go.
You will see that this is an improvement opportunity. I'm sure the MCOs that are going to be discussing their measures after we finish will be discussing this.
From the OLTL perspective, we initiated a performance improvement project under the overall care coordination idea. And this project is specific to ensure timely notification of hospitals and discharges to the health plans.
We're working with all stakeholders involved, including health systems and other organizations to ensure success of this performance improvement project. Including health information exchanges and health information organizations individually with the plans to ensure and establish excellent notification processes.
So those are the measures. And I guess we can wait for questions until the end. And I will now turn it over to Jill to talk about the other performance measures Dr. Kelley mentioned.
>> SPEAKER: Thank you, Larry. So I am new to this role. So bear with me if I can't answer all your questions. I will go back and get you the answers.
So the next set of performance measures are related to CAHPS. And that is for overall plan service. On the slide, you can see that the 2021 statewide goal is 79.5%. And overall, you see statewide that there was an improvement across all plans from 2019 to current.
And currently, all -- a majority of our plans are all meeting that aligned statewide goal.
Next slide.
>> SPEAKER: You want us to hold questions again?
>> SPEAKER: Yeah, until the end, if you don't mind.
Okay. 21 survey results for service coordinator and service choice category. This is if the personal care service person-centered service plan includes the things that are important to the individual. Our statewide goal is set at 70%. And as you can see, MCOs are trying to work up to the statewide goal. Although, overall, everyone did improve in 2021.
Next slide.
This goal is the Pennsylvania specific participants who transitioned to the community from a nursing facility and remained there for six months. As you can see, the '21 statewide goal is 300 cases per MCO. And the MCOs did exceed that. Challenger year 2021, there were a transition of 1,074 individuals. And you can see by month that the MCOs are pretty consistent. There was

a spike in March. But overall, they're pretty consistent with their transitions from nursing facilities and keeping them safe and in the community for six months.
Next slide.
So overall, the pay for performance statewide results, there was an incremental improvement in five of six of the measures. And the seventh NHT measure is on track to improve from '21 to '22. There is an over 7% increase in assessment and care plan measures.
Over 23% increase in sharing care plans with the person-centered plan, but room for improvement there.
And performance remains low in the reassessment after inpatient discharge. I do believe we're working quite a bit on that with the managed care plans and bringing in some coordination with the Medicare managed care plans to try and improve that.
Also, person-centered service plans including all things that are important to you, the measure did increase 2% to 67%.
And it's still significant variation in performance across the MCOs. And our CHC MCOs will present their assessment of performance and discuss interventions for improvement on each measure. So if you want to ask them some specific questions.
And our goals for 2022 will be updated and finalized based on the 2021 performance. So we should have something in the next meeting or two to present on the 2022 measures.
And I think that takes us to questions.
>> SPEAKER: Questions?
>> SPEAKER: I'm curious about, Jill, your measures. Were they categorized by -- let me start over.
They include people both in facilities and home, correct? Are those -- do you have data that is divided, categorized that way? Or is it all just everybody?
>> SPEAKER: You want me to address that?
>> SPEAKER: Sure.
>> SPEAKER: Back up a few slides to the --
>> SPEAKER: Slide 11?
>> SPEAKER: Go to slide 11. That's the overall health plan satisfaction. That includes everyone in CHC. And this specific measure, which we look at there are two measures, the aligned and unaligned. Looking at -- and the reason we chose this particular measure is because the performance here is lower than looking at everybody in each CHC plan. We were specifically looking at those participants who were, let's say, in a DSNIP plan with one of the three MCOs and also in the CHC plan. But it is looking at individuals, not just those that are getting home community-based wavering for nursing facilities. That's that particular answer to that measure.
The next measure, slide 12, this is looking at individuals home and community-based waivers. This is specific. So if you're not an FCE, you are not included in this survey. This is specific to individuals that are getting -- that have individualized plans and living within the community. So this is a narrower subset of those individuals.
These are all nationally obtained measures. They're nationally defined measures. We have a lot of sub analysis. So for instance, every year, I think we bring this survey to you guys. And I think we are able to break it down by regions, by various categories for you. This is really a rollup. And I know in other meetings we delve into this CAHPS survey. There are many questions on the survey, and we delve into the detailed questions and the sub analyses of the questions.
>> SPEAKER: I believe that was presented --
>> SPEAKER: We usually look at -- we make sure there's adequate sampling in all of the community health regions so that we're capturing periods of individuals throughout the state.

>> SPEAKER: Okay. What I'm trying to get at is it seems like the CAHPS, that survey, does that break it down showing people in facilities versus people in community, their satisfaction with the plan? Do you know what I'm asking? I'm more interested in 11. I'm not so worried -- but my question is getting less to the providers, and more to whether someone in a nursing home facility is satisfied with their plan versus someone in the community satisfied with their plan. Do you get where I'm going?
>> SPEAKER: Yes. So this particular survey, there's random selection. Theoretically individuals in nursing homes could be selected. And also individuals in the home and community-based waivers. It is a broader look. However, because of the sampling size, I don't know if there's really a good sampling size for folks that are living in nursing facilities. That's one of the reasons we work with the medicaid research center and the University of Pittsburgh. We have done specific satisfaction surveys with individuals living within nursing facilities.
>> SPEAKER: So you don't track what I'm asking?
>> SPEAKER: I don't think we have a break down of who these individuals are if they're in a nursing home or if they're in a waiver or if they're in neither. And that's not part of the normal CAHPS survey. And the plans, it's all anonymous so we can't go back and do a lot of slicing and dicing. We want to make sure participants feel comfortable when they're answering the questions that we don't know who they are.
>> SPEAKER: And one final. The slide that you dealt with individuals leaving nursing homes going to the community for at least six months, whatever number that was.
>> SPEAKER: 13.
>> SPEAKER: And I forget you said these are the top seven measures, something like that, because there's other measures?
>> SPEAKER: These are seven measures that we internally looked at. We have a lot of discussion. So these are seven measures. But there are other measures and other data points that we look at around the whole rebalancing issue in general.
So this is just one of many things that we internally look at.
>> SPEAKER: The question is do you track --
[inaudible]
So that leaves home and community-based services go to institutions for more than six months?
>> SPEAKER: I think -- I mean, we can look at that.
>> SPEAKER: It seems that OLTL has been asked a number of times.
>> SPEAKER: I mean, we can certainly look at those individuals that move from home and community-based service and move into a nursing home. And we track and look at that data. I can tell you that as we trend that data, we see that increasingly, there are more folks moving into the community and out of nursing homes.
We probably have data.
>> SPEAKER: We have asked before about the OLTL teams, you can or want to track that, that's what it sounds like. I'm curious about -- I did the trend of people moving out. I'm curious about the trend --
>> SPEAKER: I think it leads to data I have looked at recently. The trend is participants are moving out. And the percent of individuals are moving out into the community or they're staying in the community, which is the purpose of the community -- CHC. And we had that data. We can bring that back.
>> SPEAKER: That would be fantastic.
>> SPEAKER: This is Jermayn. And that is part of what you mentioned. I think what you haven't

been able to get is the reasons why people are going to nursing homes --
>> SPEAKER: That's something we do not capture are the reasons for why they move into a nursing home. I would say we -- I don't want to really speculate, but I would think that many of the individuals land in the hospital with a complex condition or worsening of their current conditions. And then --
>> SPEAKER: And then they're getting shifted.
>> SPEAKER: We understand about the medical things that happen that goes into a hospital and then they transition to a -- we get that. But other reasons that people may be going to nursing homes is what I'm curious about.
>> SPEAKER: I'm not aware of that. The data that we're presenting here is captured on plans and other systems. So that's something -- to my knowledge, I don't think we capture that.
>> SPEAKER: Thank you.
>> SPEAKER: I just wanted to ask is there any other committee members that has questions?
>> SPEAKER: Lloyd here. Just one. Do family members get involved for those who either are unwilling or might not be able to give their responses to these questions on a quality basis?
>> SPEAKER: Yes. They can be participants in participating in the survey.
>> SPEAKER: Thank you.
>> SPEAKER: I would have to go back and look at the detailed ways the surveys are done. Because they're very detailed rules of engagement. I don't know that the difference between -- I understand the question. I don't know the answer. Again, these are set by national organizations. We don't make those rules. We just have to follow them. We will come back with an answer for that. Thanks.
[inaudible]
>> SPEAKER: Any other committee members?
>> SPEAKER: My name is Shauna and I'm from Erie, Pennsylvania. I'm the CEO of voices for independence.
The questions -- one track of questions I have is as my role of CEO after Voices, the other one is as the spouse of someone who used these services. And I say used because on May 2nd, my husband went into a hospital because his direct care worker quit. He had six, he was down to two. And that morning, he was down to one.
And we had been looking for about eight months for care givers, spending almost $1,000 of our own money trying to find care givers. We even did a TV commercial to recruit our own care givers. And he ended up going to the hospital because there was going to be ongoing 12 and a half hour gaps in his care every day and I couldn't care for him.
Three days later, he ended up in a nursing home and he's been there since May 5th.
I bring that up not because I want you to think about my personal situation, but I want you to understand that one of the questions I asked the social worker in his facility not even three weeks ago is how many other people are in this building because they're in the same boat my husband is in? And at that time, I was answered seven. There were seven individuals who used to be community participants that were at that moment in the nursing facility because they couldn't find direct care workers.
It's frustrating for me because we're sitting here talking about statistics that have a lot of national significance. But there are people in Pennsylvania that are in crisis. And we aren't fixing it. We need to fix it. I look at this data, I ask myself is question how was it acquired? How were the answers to the questions acquired? Because I got to tell you, from my -- trying to communicate with the people that could help him, help us, was next to impossible.
And I got to believe that if there were seven people three weeks ago in my husband's nursing

facility that were in his boat, then they're all across Pennsylvania dealing with the same issue. Until we fix the direct care worker crisis, problems -- none of this other stuff matters.
So somehow, you know, I got to say I'm very disheartened that Jamie is not here. As the leader of a PO, I would hope that she would be here presenting this information and hearing what we have to say.
But somehow, we have got to start there. There's a real crisis in this state. And we haven't done enough to fix it. Thank you.
>> SPEAKER: And I would just say just so you know, Jamie will hear about your comments. She just wasn't able to be here today.
And totally agree that the direct care workforce shortage is a problem for everyone, everyone across the state. We'll definitely make sure that she knows about your comments for sure.
>> SPEAKER: May I ask, though, where did this data come from? How did people get consumer input? Because I wonder, like Matt, if you ask family members or care givers, you're going to get a different answer than if you ask the people using the service.
And even me, I have been married to my husband as of today 26 years. And if somebody asks me a question about him, my answer might be slightly different than his.
So I want to know how did we get participant input? And did we truly get participant input? Because if there's one thing this pandemic has taught me, it is that we have -- people be disabilities have been marginalized over the last two and a half years. And I'm glad I'm here today, but I'm very disheartened that I'm one of the few that are here today. And I think somehow we need to get -- we need to get back to this table so that we can work together to fix these problems. Because without people who use the services, the people making the decisions about the services are going to screw up.
And this data is sort of meaningless to me because it seems invalid because I don't know how it was captured.
>> SPEAKER: We can certainly come back and give you more details on how it was captured and how it was done for the health plan survey and CAHPS survey. We can follow up on that. And I want to say we are concerned with what you brought to us, your situation and others. And obviously, during the pandemic, we have seen a shortage of health care workers and service workers across the continuum. So we are certainly -- we're very concerned about that. I know that in the last budget that was passed, I believe there was actually increased funding for direct care workers. So that's not going to solve all the problems.
And I would encourage you to contact your MCO. Because they are the ones that should be accountable to help you get the services that you get. And not just your service coordinator. But others within that managed care organization. And if that's not happening, then we need to figure out why that's not happening.
I'm sorry so hear about your husband's circumstances.
>> SPEAKER: Any other questions from the audience? Pam?
>> SPEAKER: I'm Pam, an advocate. I don't receive services. But I see what happens every day. And I wanted to go back because it relates to this. The questions we asked last month related to this too, because I was asking about tracking the people going into the nursing homes. And we want to know how they're being tracked, we want to know why they're going in. We know the lack of direct care workerers is a major issue. Who is tracking these people? Who is keeping track of them? How do they know?
One guy we got, he needs total care, lives in the middle of nowhere. Got sent to the hospital. The hospital said we can't keep him. He has no health issues. He isn't able to do ADL independently.

He goes to a nursing home. And as an advocate, I keep pushing the service coordinators to do what they can. And I have asked the state to get that person services.
Well, you know where he is right now? He's nowhere near that Perry County apartment. He's in Philadelphia because there's no direct care worker to serve him. The service coordinator did not ensure that the direct care workers had the correct care plan with enough service needs and community needs.
So the day after he went home, he went to a nursing home. And he's just one of the several people that I know right now that are on the verge of going into a nursing home.
I was thinking an Shawna saying seven in one nursing home. So what is it across the state? Seven people. And there's how many nursing homes in the state? 400, 600? If you get even seven in all of those.
But we need to find a way to track these people. It isn't just us wanting data, saying hey, why are they going in? And it's not just a direct care worker concern. It's a crisis right now. And we need to help. We need to find out what's happening, why people are going in and you're finding a big part of it is direct care workers. It was before COVID. I know I come across disrespectful, and I will, because it was before COVID started. It just blew up with COVID. We need help here. We need to know why people are going in and how to correct it?
My questions have been way before this.
And then the other question I have is what were the percentages that they had to meet? I know that we were told they exceeded them, exceeded them, exceeded them. How high were they? One they exceeded was at 68%. What were the numbers then? If we can have that in the data information, that helps us see where you're at too.
>> SPEAKER: Do you mean the goals we set for them? It's probably hard to see. In the little boxes that the goals are in there. If you go to the previous slide, you see up in that corner the goals, the statewide goal was 70%. And in this instance, whether the personal service -- person-centered service plan included all the things that were important to the individuals, none of the MCOs here are meeting this statewide. They're below the 70%.
If they did improve this past year, but they're still below the statewide goal.
If you go to the previous one, you see the statewide goal there is 79.5%. And in this instance, overall plan satisfaction, they're all meeting it. So -- well, I guess some of them are not meeting it for 2021. But they all have improved over that three-year period of time.
So that's where that statewide goal is.
And once we finalize the 2022s, you will see. We keep raising the bar. But in this instance, some of the plans have some work to do.
>> SPEAKER: And can I ask one last question, Jill? Is there a break down by the services? Because we're still hearing that people are not getting their home in a timely better. There's still people waiting or not offered that as an option. Is there a break down by that? Transportation is horrendous as a service. Some people are not getting it. So are they broke down by that too?
>> SPEAKER: There are additional. Just one question, the overview question. And then there's sub categories. I know transportation is one of them.
>> SPEAKER: I have to learn this, Pam. So I will go back and look at all of the individual measures. And we can probably share a list of what those measures are.
I know that we did have, like, a presentation of the entire survey. I don't know if we presented all of the measures. But we'll get the list and send it out.
>> SPEAKER: Do you want us to send ones we think are critical?
>> SPEAKER: You can. Absolutely.
>> SPEAKER: And we can share with you the questions as well that we ask.

>> SPEAKER: The MCOs have to use an independent company to do the CAHPS survey. There's rules around the process.
>> SPEAKER: There are supplement L questions we can do for the health plans and I think for the CAHPS. If you have suggestions on the supplemental questions we can add that are specific to the program, we want to hear what they are. We have added supplemental questions over the years. We want your input on that. And we're hearing you loud and clearly.
If you go back to slide 12, you look at the all things important to you, I mean, we're barely over two-thirds of individuals saying yes, my care plan has everything that I need.
Obviously, there's a lot of room for improvement. And we're hearing you loud and clearly that not having your direct care workers are putting individuals at jeopardy in being able to remain safely in the community. That's something we want to improve upon. We will have more internal discussion about how we can look at what was described as the opposite question, why are people going into nursing homes, as best as we can.
>> SPEAKER: Can you go back to slide 11? So maybe I missed something. And that's very likely. The whole point of your presentation, pay for performance. So in this instance, is UMPC getting a bonus because they're meeting a goal? I'm not trying to single anybody out. AHC, are they not getting the bonus?
>> SPEAKER: Nobody is meeting it, so nobody gets anything.
>> SPEAKER: But OPMC is above the 79%.
>> SPEAKER: I'm sorry. I'm on slide 12 on my computer. I'm sorry.
>> SPEAKER: Is that basically what you're saying? They get a bonus because they have met the goal?
>> SPEAKER: In this example, now, we're going to reset the goals for 2022. So yes, this is an example. They would receive an incentive payment for hitting that goal.
>> SPEAKER: AHC would not, for example.
>> SPEAKER: Correct.
>> SPEAKER: I just wanted --
>> SPEAKER: Sorry. I was on the wrong slide.
>> SPEAKER: Thank you.
>> SPEAKER: Hi. Lloyd Wertz here. And this isn't a question to the presenters. But this is a suggestion to the attendees and participants. It is unconscious to me how the state legislation could have passed a budget that gave token offering toward workforce improvement, but put billions of dollars in a rainy day fund and boost the corporate income tax by 10% in the past year. And any day we spend in our home with our family members and do not contact the legislature to let them know our disapproval of this unKONSable budget is a day we have wasted. We need to recognize our responsibility to make sure the commonwealth and the policy leadership in the legislative levels need to hear our positions and need to know we vote our positions. Just sharing. Thanks.
>> SPEAKER: Well said. Thank you, Lloyd, for bringing that up.
Do we have anything in the chat?
>> SPEAKER: I have nothing in the chat. But three questions in the questions section.
I just wanted to check with you time wise.
>> SPEAKER: Let's go ahead and answer them.
>> SPEAKER: Okay. The first question is from Amy. It's a pay for performance question. Why is the date on AHC and Keystone being evaluated as distinct entities for perpetrates of P4P? Why in the original procurement was for a statewide entity?
>> SPEAKER: So we are looking at these measures for both Keystone and AmeriHealth. So

they are a statewide plan. We are presenting the data here because there are some regional subtle differences. So that's why in slides -- if you go back, it's slide 9. Any of the previous slides. Again, you can see that we're just presenting the data here because, for instance, there is some variation between AmeriHealth and Keystone. Again, we're trying to hold them accountable within the regions in which they came into the program.
>> SPEAKER: Right. And Keystone being that it's in the southeast wasn't implemented in 2018. So we're tracking them separately.
>> SPEAKER: Second question. Can you explain what do you mean by statewide aligned goal presented in the CAHPA result graph?
>> SPEAKER: So again, if that is looking at slide 11, the CAHPS plan, overall plan satisfaction. The goal there, the statewide goal of 79.5%. Again, we set these goals looking across the programs, looking across the MCOs. So that's what that means. For 2021, that was the goal that we set, as I previously stated. We are going to -- now that we have the 2021 data, we are going to reset goals for 2022.
And this particular measure, this is looking just at aligned members. So this would be participants in CHC plan and the aligned. And we also have data that we can certainly present on the entire population. We chose this measure because the performance was actually slightly lower last year this the aligned population.
>> SPEAKER: And one more question. How is the PCSP measure being measured?
>> SPEAKER: Again, this is based on the home and community-based CA H PS survey. And again, we can give you more detail on the sampling. We make sure that there's adequate samples by MCO for each region. Again, these are responses that are gathered this interviews with participants.
And because of COVID, mostly, I believe, these are by phone, I believe. I know that in other years, we maybe pushing that request that they could be done in person. But I believe these results --
>> SPEAKER: These were all by phone. That's correct.
>> SPEAKER: I have nothing else, Mike.
>> SPEAKER: Thank you, Paula.
Any other questions from the committee members or the audience? Thank you all for the presentation. Very much appreciated.
Now we're going to move to the pay for performance programming. First up on the docket is Pennsylvania Health and Wellness.
>> SPEAKER: Good morning, everyone. Can you hear me okay?
>> SPEAKER: We can.
>> SPEAKER: Okay. Apologies for the Raspy voice and not being in person. I'm a little bit under the weather. Please bear with me. Next slide.
Okay. So thanks for having me today. I want to briefly go through our performance measures. They have been pretty detailed out by OLTL. I will go over --
>> SPEAKER: Olivia?
>> SPEAKER: Yes.
>> SPEAKER: Can you introduce yourself? I'm sorry I didn't do that at the beginning. But if you could introduce yourself so the captionist can have that.
>> SPEAKER: Absolutely. I'm Olivia Martin, is senior director of long-term care and coordination at PA Health and Wellness. Thanks for having me. Please let me know if you can't hear me. I'm losing my voice a little bit. Hot tea is my friend.
We're going to talk about our performance measures and some of our goals and some of the

work we have done over the past year to improve upon some of our performance measures.
Next slide, please.
Okay. So looking at some of the measures, we had the measures we walked through. This is the comprehensive assessment, care plan, reassessment and care planning after inpatient discharge, our sharing of our person-centered care plans with our PCP. And then looking at our health plans satisfaction with our CAPHS survey. And looking at our PCSP, including all things important to you. And then our nursing home transition.
Next slide, please. Okay.
So we have actually done a lot of work here with our measures. These are the quality and timeliness measures that Dr. Appel was detailing out.
So we have done multiple changes to our documentation just to really capture the HEDIS elements. We have added multiple training series and refreshers for the service coordination team. We have started a large volume HEDIS audits for trainings to correct issues on the spot.
So you can see the internal audits, this is what they look like. They're trending up. And we end in May. And we are exceeding our state goals.
And these are just a brief look at what the internal audits look like for May.
Next slide.
Okay. This is the CAHPS results. These were detailed out on the previous set. Looking at the results, our health plan service, we landed at 61.8%. In 2022, our results are not validated yet.
And then choosing the services that matter to you. 2020, we were at 63. And we did improve for 2021 at 68%. But like discussed, we are not meeting that goal yet.
So there's lots of work happening on the back end.
Next slide, please.
Okay. This brings us to nursing home transitions. NHT, we actually ended June 2022 year to date. We ended June at 196 transitions. And our goal for 2022, PHW's goal is 400. We're looking to hit the goal of 400 transitions for 2022.
We did exceed, I know it was discussed earlier in the meet that we fell short of 300. But we exceeded 300 for 2021. It was an issue we discovered we were underreporting off NHT for 2021. We did exceed 300. Working with the team to correct that.
Is there another slide? I believe that's it. Are we saving questions until the end?
>> SPEAKER: Let's ask questions right now for PHMU. Any questions for committee members on PHW and the presentation on -- I'm sorry, on the pay for performance.
Questions from the audience?
>> SPEAKER: I guess as a committee member, we ought to ask the question are you receiving reports of shortages of shift coverage due to the lack of direct service workers in your MCO contractors?
>> SPEAKER: I think, you know, statewide, we're sort of all feeling the pinch. You know, with the direct care worker shortage. I don't think anyone isn't receiving reports. We're actively trying to recruit. I know all agencies are trying to recruit and bolster their workforce. It's just a struggle trying to retain quality workers right now.
Really hoping by increasing the rates, you know, that's going to improve the workforce and the retention of those workers.
>> SPEAKER: So what happens when there's a loss of a DSW in a couple of given cases, are there reserves to be pulled from? Or what happens to the work and support that the individual needed from the workers?
>> SPEAKER: Generally, there's always a backup plan identified within the service plan. If someone was in the agency can cover that shift, we would have to put the backup plan in place.

Whether it's a family member, a neighbor, whoever that participant has identified as their backup plan.
>> SPEAKER: Thank you.
>> SPEAKER: Olivia, can you ask you a follow-up on what you said like a minute ago? You said increase in the rate will help with that. Are you talking about the increase that already happened? Or are you talking about an additional increase?
>> SPEAKER: The increase that already happened.
>> SPEAKER: Thank you.
>> SPEAKER: Any other questions from committee members? Great. Thank you very much. Enjoy that hot tea.
>> SPEAKER: Thank you.
>> SPEAKER: AmeriHealth Caritas/Keystone First.
>> SPEAKER: This is Debbie Sweeney, are you able to hear me?
>> SPEAKER: Yes.
>> SPEAKER: I am the interim quality director for Keystone and aMER health Pennsylvania. If we can go to the next slide, please.
What we're displaying here are the 2021 performance rates for both of our plans. You can see them segmented by region. Keystone First operates in the southeast region. And the AmeriHealth Caritas plan operates in the rest of the state. And comparing it against the statewide goal.
We wanted to focus our comments today on the actions that we're taking and things that we have but in place in order to drive improvement in rates for 2022.
So if we look at the nursing home transitions, we have established a new cadence of face to face meetings between the participant, service coordinator, and our nursing home transition coordinator following an individual's transition to the community in an effort to prevent unnecessary readmissions to a hospital or a -- facility.
In addition, we're conducting weekly case plans that are specific to nursing home transitions with the -- being to use an interdisciplinary care team approach to address any barriers to an individual transitioning from the nursing home facility into the community.
As Dr. Appel had spoken earlier, we have a significant opportunity to improve the reassessment and care planning after inpatient discharge, which is one of the HEDIS, LTSS measures.
So we had an alert created within our case management platform that identifies participants who have been admitted to the hospital. Our Triage are available admission, transfer, and discharge data that we receive from the health information organizations, as well as the transfer files for the participants for which AmeriHealth Keystone First are providing both Medicare and Medicaid coverage in order to identify additional participants who have been admitted to the hospital.
>> SPEAKER: We're having some problems hearing you.
>> SPEAKER: Okay.
>> SPEAKER: We can hear you, but sometimes, you fade in and out. Your rate of distance to the mic would be helpful.
>> SPEAKER: Sure. I'm sorry about that.
>> SPEAKER: No problem.
>> SPEAKER: The Triage care managers are alerting the service coordinators of hospitalizations so that the service coordinator can schedule that trigger event assessment following discharge.
When we look at the weighting of health plans that comes from the CAHPS survey, our goals

here are to improve the awareness among all of our associates about the way that they play in the participant's perception of our health plan. We're also working to develop a short survey that participants can complete after the customer service theme.
And we're ensuring that the customer service team is aware of any process or procedure changes or even any communications that are being sent to participants. For example, in the next month and a half, two months, we'll be sending reminders out regarding flu shots. We want to make sure that our customer service team is aware of that so that in case participants call with questions, they know what has been sent out and in the case of a process or procedure change, what that change was.
For the participant-centered service plan, including all things that are important to the participant, we are producing new participant materials. Our service coordinators are assessing participant preferences and incorporating those into the overall goals within the service plan. And the service coordinators are continuing to use findhelp.org to locate any community resources or services that may be able to assist with addressing participant needs.
Questions for us?
>> SPEAKER: Any questions from the committee members on AmeriHealth?
>> SPEAKER: Lloyd Wertz here once again.
It occurs to me that the reassessments might be more beneficial if they were to occur leading up to a discharge from an inpatient facility, not waiting until the discharge had occurred. Is there a reason you sequenced it that way?
>> SPEAKER: So this is a standardized measure that is produced by the National Committee for Quality Assurance. So we need to align with the specifications prescribed by NCQA so the data is comparable across all organizations reporting on this measure.
>> SPEAKER: Okay. Doesn't it really make sense to try to figure that out before discharge, so you have services in place before discharge, not after?
>> SPEAKER: Absolutely. And we might also unmute Jen Rogers and you can step in. Jen is more close to the service coordination side than I. But the service coordinators are also in communication with participants during hospitalization in an effort to plan that discharge. One particular measure is assessing whether or not that one assessment and update with the care plan occurred within 30 days of the discharge. Absolutely, it's important to have those discharge planning conversations at the point of admission. And throughout the stay.
>> SPEAKER: Thank you. That's helpful.
>> SPEAKER: Thank you.
>> SPEAKER: Good afternoon. This is David Johnson. The data shared here on overall plan service separated align and unalign the interesting. Forgive me if it's repetitive. For the unaligned individuals are you separate identifying the people as fee for service in another DSNIP or a Medicare advantage plan? What data do you have available?
>> SPEAKER: Well, we are not able Stratafy it by the coverage they have. The survey is anonymous. I don't know who the respondents were, and therefore cannot identify which segment they would fall into. But I agree that the information is very interesting, and that's why we look at it both ways.
>> SPEAKER: So just to make sure I understand, when you have someone that's unaligned, all you know is they are not in the aligned DSNIP, correct?
>> SPEAKER: They are not in the aligned DSNIP and do not have early Medicaid plan for coverage. The aligned number includes those that only have our CHC plan for coverage, as well as those that have our CHR plan and our DSNIP for their coverage.
>> SPEAKER: Understood. Thank you.

>> SPEAKER: Thank you.
>> SPEAKER: Any other questions from the committee members or the audience? Paula, do we have any questions?
>> SPEAKER: No, not for this session.
>> SPEAKER: Thank you. All right. Thank you very much for the presentation, Debbie.
Up next is UPMC.
>> SPEAKER: Good afternoon. Can you hear me okay?
>> SPEAKER: Yep. We can hear you fine.
>> SPEAKER: Thank you. We can go to the next slide. This is Mike Smith. I'm the LTSS AVP for the operations. That's a fancy way of saying I work with the service coordinators and care managers here at UPMC. I will do the presentation today. The quality director is off. So I will take us through the slides.
As you can see here on the slides for our work with the HEDIS measures, we're doing pretty good with this. We do have areas that we can certainly improve. But if you look here in the far right column, you will see the state goal for 2022. In the middle column there, you will see our change year over year on this and how we're doing as we move into 2023. And then our measurement for 2021.
So we are moving the needle in the right direction on these measures. We have broken ours down into numerator one and numerator two. And I will briefly touch on this. I am not the expert at it.
Basically, you can cannot -- the way these measures are completed, you cannot move -- you're scoring on numerator one are nine quality metrics, you cannot move on to numerator two unless you hit the first nine in numerator one in some of these measures. That's why they're broken out this way. It helps us focus on improving how we're doing and meeting certain quality metrics associated with these measures.
On the first numerator, the first nine of these areas of quality.
So you will see great improvements in the comprehensive assessments and updates measure. We have 18% for a percentage point increase in both of the areas and both of the numerators. You will see the same growth, although we're not at the measure for the state just yet. We're hoping to get there in a comprehensive care plan updates.
On the reassessments and care plan update, I think this is one there was conversation on in the last presentation. I think it's important to sort of understand that we're inching closer to the 38% goal. But we receive a lot of refusal from participants for reassessments after discharge. What we're doing, and we will go over this on the next slide, is trying to work with participants and explore ways to get them to understand, you know, that we need to update the assessment and look for possible changes in the plan of care post discharge.
And I think it's worth saying that we do have an initiative underway under a different quality measure to try and improve our contact with participants in facilities. But I think folks on the call would probably appreciate the difficulty of outreaching people when they're -- to people when they're in acute care stays or when they have come back from a hospitalization and all they want to do is get back to getting their services and not have another person asking them a bunch of questions.
So I think the big challenge for us is really using motivational interviewing and working with our staff to encourage people to work with us post discharge.
The other area that we have seen some increases and it was discussed in the last presentation as well is in the unaligned and aligned numbers. We have a very high percentage of overall satisfaction in our aligned population. To a certain extent, that carries over even into our

unaligned population, to the earlier discussion. Some of the folks in the unaligned population are fee service individuals as well. You might not have a DSNIP involved with them. And we don't know who those folks are.
I think the most pressing issue we have that we want to work on is the person-centered service plan, including the things important to you. I will say that our composite score on this is almost at the 80% range. But this particular question, which is part of our overall goal to get to 70, is one that is reflected here. We really want to work toward that particular goal.
I think it also is important to mention, you know, that we continually train on these things. We will go to the next slide. And we will talk about some of the things we're doing to really try and improve upon some of these metrics.
Next slide, please.
So, you know, first with participant engagement, you know, we have relaunched and worked with members and participants on the participant experience committees at the health plan in June on all lines of business. We have, as mentioned earlier, the special needs plans, the Medicare plans, we're working to sort of incorporate and leverage the resources associated with our Medicare beneficiaries and those plans as part of our overall member satisfaction in trying to improve upon that.
And we developed enhanced strategies to engage participants in new ideas about health plans and supports and benefit, such as the apps and telehealth options. We're training and educating folks on that.
We also review annually this summer our CAHPS response course with our -- to go over participants' experience to try and help us with participant engagement around, you know, our service coordination, really understanding the importance of the participant responses to these questions and how we can inform them to help engage participants more effectively.
And I think also to an earlier discussion mentioned here, a vast majority of the participants that complete this are the participants themselves. It's not a proxy. But, you know, it's important to understand that we're trying to mike SHAUR that our staff know -- make sure our staff know that this is what they're thinking and this is why it's important to move the needle on some of the initiatives.
We have done provider training around this as well to improve, you know, our on boarding, our work with providers in moving the needle and understanding what's in plans and how to improve communications between us and the MCOs. Between us and the providers. We had a learning collaborative where we did a project that was designed by the providers to help improve outreach and improve performance around medical visits and things of that nature. It was very well received by the members of the collaborative. We have talked about it on these calls before.
We have regular service coordination trainings every other Friday with our teams, as well as quarterly trainings. We socialize results of our -- these surveys with our PAC and HEAC members as well to try and drive improvements based on what they're seeing in the results. So we get some feedback from them.
We have trained our service coordinators on the actual process. And we have put in place a quality action plan that we use to really drive our performance through a plan study act approach.
And finally, in the last slide there, data analytics can't underestimate or can't overstate, I should say, the importance of data analytics. We have available, you know, made available and worked on in our case management system improvements that have created much more transparency for staff and built out dashboards so that they can see their performance at an individual level

and know when they're not meeting metrics before we even have to ask them about that.
And so we're very excited about that. And some of the significant improvements that you saw in our metrics are directly related to how we improved our system. A big one that you saw that we had 100% increase in our primary care plans with our primary care practitioners is really around making some systems improvements and data improvements that help us share those plans more effectively. With not only the primary care physicians, but also with the service providers when the participant says that it's okay for us to share that.
And I'm going to go to the next slide. I will introduce Ashley Mancini, who works with the nursing home transition team. Ashley is a great asset to UPMC and works closely with the partner organizations. She will speak to some of the terrific work happening in nursing home transition. Ashley, are you able come off mute?
>> SPEAKER: Hi. Can you hear me? And thank you for the into duction. I'm Ashley, one of the managers of the housing strategy team. I'm so excited to be here today and have the opportunity to talk about some of the strategic initiatives the team is working on around NHT.
I would like to note that this slide was created prior to our amazing team members Christina and Sarah completing the NHT report. I would like to give you the most current numbers, slightly different than what's on the slide.
Year to date, we have had 204 transitions from January to June of this year. And approximately 2% of the participants have re-entered the nursing facility within six months of transitions to the community.
And this is a real testament to all the amazing work and support that's done prior to the transition and well after.
And I would now like to move over and highlight some of the other efforts that we're focused on this year. Starting with the initiatives that focus on the participant, including education and feedback.
We do have an NHT brochure given to any participant interested in the NHT process. The document outlines the steps of the NHT process and is a document that can be shared with obviously the participant, informal supports. And we often share it with nursing facilities staff to educate them as well on the process.
We truly value our participants' insight and feedback on this process and want to hear what's working and any ideas that they might have to help improve the experience. So we have implemented the NHT participant post-transition satisfaction survey. This is completed with any participant that has recently transitioned into the community. And we take a close look at those and evaluate those. We can adjust as needed.
We have a new pre-transition assessment that reviews potential risks and possible needs that should be discussed with a participant and the care team prior to the transition. That's new to our process.
In order to ensure a successful long-term transition, we also have NHT post transition follow-ups, which is in addition to the follow-ups that our community-based service coordinators are already offering participants.
I am so excited to just briefly mention that we have a new pilot program called NHT plus, which we have partnered with the NHT providers on to expand transition services to other setting options, including assisting participants that are in the community and need to remain in the community.
Now let's move on and talk about the additional work that we have done to assist our NHT providers.
Our NHT providers have access to the online care management system to ensure the

documentation is completed throughout the process. This is the work Mike Smith was talking about as well is that system process change.
We have also recently updated our value-based NHT case rate structure for our providers. We truly value our partnership with our NHT providers and appreciate their dedication, perspective, and expertise to ensure we have successful programs. We're excited to be able to do that this year.
We have updated our NHT documentation and our provider work flow. And I want to mention, we're really proud of our provider work flow. We have received a lot of positive feedback from our providers saying that the work flow is extremely helpful tool as it outlines the roles, responsibilities, process, procedures, goals, and expectations of our program.
We have enhanced our efforts around education and training for the NHT providers as well. Any time we find any webinars that are somehow related to NHT, we share that information with our providers and encourage them to participant.
In addition, this year, we have a medical legal partnership pilot program. And they are also offering webinars for service coordinator team and NHT providers.
Some of the efforts we have focussed on to assist the nursing facility service coordinator around NHT first starts with right sizing the case load to allow them to have time with the participants.
We have advanced our NHT on boarding training to help better target transition candidates. We have definitely had new staff join our team this year, and really want to make sure they have a clear understanding of the NHT process.
Part of the training that we offer on the on boarding really focuses on identifying participants for an NHT referral.
The nursing facility service coordinator where we view the nursing facility MDS to see if the participant indicated if they would like to return to the community. Also, they discuss the NHT program with the participant at their initial visit. And really discuss the options with the participant if they're interested in going back to the community or if they would like to remain in the nursing facility.
Throughout the NHT process, the nursing facility service coordinator works closely with the NHT coordinator to work on barriers the participant may have to return back to the community. They are constantly updating each other throughout the process. And when necessary, they will schedule ICT meetings to include the participant, family members, members of the service coordination team, the house and strategy teams, the NHT provider team. Just to put all of our heads together and figure out the best next steps to move forward.
So I know I have covered a lot of information today, but I hope that you have a better idea now on some of the efforts we have been working on around NHT. Everyone involved in this process is truly passionate about assisting interested participants that have the entire to move out of the nursing facility and get back to the community successfully.
Thank you so much for your time. I really appreciate it.
>> SPEAKER: Thank you for the presentation. Committee members, are there any questions for UPMC?
>> SPEAKER: I have a question. I don't know if it's for UPMC or Randy. You have talked about the Ops reports before. Is there a way to get those, look at those? The Ops 32 reports? Are they on the web or something?
>> SPEAKER: They're not available on the web at this point in time. But, I mean, we present data off of them. But you're looking to have access to the whole report.
>> SPEAKER: The specifics up there are interesting to me. I would like to see what they are ongoing.

>> SPEAKER: Okay. We will talk about that internally.
>> SPEAKER: Thank you.
>> SPEAKER: Other questions for the committee members?
>> SPEAKER: Matt was asking, I thought when they were announcing the Ops reports, that they would be reported out over time, like the full reports. Maybe I'm wrong. When we were first discussing the different types of Ops reports, that they would come back, the full reports. Because --
>> SPEAKER: Yeah, we did talk about releasing all of the reports because they come into it in an Excel format. What we were talking about is what we do now. We take that data and we put it into graphs and put it into slides and present it. So the information that you do see when we're doing the statistics and everything is what we do receive. It's just made prettier for you. Yeah.
>> SPEAKER: But you're going to look into -- this is Matt again, you will look into possibly releasing that or allowing us to see those? I don't really -- I don't want to -- I'm not trying to insinuate, but I would like to see the raw data, if possible.
>> SPEAKER: We will have that discussion.
>> SPEAKER: Thank you.
>> SPEAKER: Thank you. Any other questions for UPMC or any of the MCOs that presented on the pay for performance program?
Pam, did you have something? Or no?
>> SPEAKER: Do I go? Can we do public comment questions?
>> SPEAKER: Just a second.
>> SPEAKER: Real quickly, the question about sharing the care plans with the -- why is that so low? Is it people don't want to share it, the participants? I mean, it's not necessarily for UPMC. The state goal is pretty low there too. It's like one out of two people -- or one out of two cases is shared. Why is that so low?
>> SPEAKER: I will let UPMC answer as well.
>> SPEAKER: I think all three were low.
>> SPEAKER: Right. In general, a couple of pieces of this. And it's being worked on. And a lot of this had to do with information exchange and sharing through the health information organization. And one aspect of that that is improving substantially is the new platform that the HIE, which is the overall exchange between one area and the -- one organization and the other are now offering. For example, if somebody is in Philadelphia, and they're assessed and they have a care plan. And it so happens that, you know, their information needs to be transferred to another part of the state, that process is going to be much easier.
>> SPEAKER: I can't imagine that --
>> SPEAKER: I think the overall -- not that particular situation, but I think the overall transmission with the HIOs, even locally, so even within one particular area, has been an issue. And that's a practice that is being developed. I know a couple of the MCOs have developed best practices around that. And I think that process has really only recently been taken public.
>> SPEAKER: Certainly, if UPMC has more of an answer.
>> SPEAKER: I have a quick follow-up question regarding that. Regarding the shared care plan with the PCP, is that by aligned and unaligned population?
>> SPEAKER: So I believe that we only tracked the aligned.
>> SPEAKER: Okay.
>> SPEAKER: All right. Paula, do we have any questions in the chat?
>> SPEAKER: I have questions that go back to Dr. Appel and Dr. Kelley's presentation. I have three if we want to hit those.

>> SPEAKER: Let's hit those.
>> SPEAKER: Okay. So regarding the AHC, if you are tracking them separately, are they receiving P awards separately? Is P4P done on a regional basis for all MCOs or just AHC pay out?
>> SPEAKER: So I think we need to get the exact numbers on that. And then we will get you the exact answer.
>> SPEAKER: Next question is when the 2021c AHPS survey results were shared at the February MLTSS meeting, there was dissatisfaction with a low response rate of 6.7%. Especially as compared to the year before. Let me flip my screen down here. Are there concerns about using CAHPS survey data for P4P considering the low response rates?
>> SPEAKER: And thanks for that question. So there still are minimal thresholds that are required for statistical validity. And while we would have liked a higher response rate, the response rate this year still was well within the bounds of the statistical validity. So it's still perfectly acceptable to use this for P4P.
However, again, you know, the point about increasing the overall response rate to ensure, you know, as much participation as possible is certainly a good one.
>> SPEAKER: What is the threshold?
>> SPEAKER: And so I don't recall off the top of my head. But I know it was well below 6.7.
>> SPEAKER: I'm done. I have no other questions.
>> SPEAKER: Thank you.
With that, we will move into the additional public comment section of our agenda. Any public comments from the audience and/or the committee members? Go ahead, Shawna.
>> SPEAKER: I know is subject wasn't brought up and I will be general in my comments. But I am concerned about what has happened with the new agency with choice proposal. The fact that it appears -- I have been working in the arena for well over 25 years, and the public -- the comment period for this particular agency with choice RFI was the shortest I have ever seen. And the fact that when the RFP came out there was no public comment period for that is also concerning.
And so I want to go on record as putting those concerns forward. Just because I think that it's a symptom of a bigger problem. We have so many irons burning in this fire right now. And we're fragmenting the system to such a great degree that the people at the end of the continuum, the participants, are the ones that are going to get hurt.
And, you know, I put forth my comments about the lack of direct care workers earlier. But I don't see how we're going to implement a system for agency with choice. Which by the way, Pennsylvania has had agency with choice for many, many years. It was just never recognized by the office of long-term living. Many of us call it consumer delegated services.
I don't see how we're going to make this system work, again, because we don't have the workers to do the services that currently exist.
And we have seen issues cause great turmoil in people's lives. And we're just repeating the same crisis over and over and over again.
So I felt like I needed to put that on record. I don't understand why these things are being done without proper input from the people who use the service and administer the services. Thank you.
>> SPEAKER: Thank you, Shawna.
Jill, also, if you could please let Jamie know that I have been contacted by a number of people about the RFA now for agency with choice. And they were just expressing some concerns about the time frame. Excuse me, I'm sorry. The time frame and the fact that there was such quick --

not quick turn around time, but to complete the application on such an expansive procurement that they were asking me questions like why is this? I don't know.
So if you could pass that along to make sure that -- and Shawna, thank you for your comments on agency with choice.
Go ahead, Pam.
>> SPEAKER: I want to support everything Shawna said. It's very rare when you get the two subcommittees that made recommendations around it, and obviously, their recommendations was disregarded and totally ignored. That has people that hardly ever come together and agree on things, and they were disregarded. I just think it's -- I'm really concerned about with all the things piling up and changes piling up what's going to happen to the program if it will exist in the long run if we don't have the direct care workers. And creating more rifts in the program.
I was asked by a consumer about a couple of things he's concerned about. And with his MCO. One of them is for his nonmedical transportation, he's having to battle to try to get -- for the nonmedical transportation. He's supposed to for certain distances or procedures use a lift or a gurney transfer to where he needs to go. And he's having difficulty getting that through his MCO. And I just wonder about where we're at still with transportation and the managed care system and their ability to maintain the providers for the areas, especially the rural areas.
And I know that transportation alliance is working, trying to work on that as well.
And then the other thing is the fiscal manager stuff, the new tempest. There are people having trouble getting a payroll summary and long waits trying to get through to tempest. They ask that be brought up.
And then one last thing. I will bring it up again in the nursing home transition meeting. But I think everybody should know there's difficulty getting people they need before they come home. It doesn't make sense to just put a ramp in if there's more modifications needed. It's more cost effective and I know that people want to get in. But people are told get the ramp, get in, and we will work on the rest of the home when you get home. It doesn't make sense you have somebody you're transitioning from an institution to a prison to another prison. You're going from one institution to another. You might be able to get it up, but you can't function in our own home if you don't get the modifications done before you're getting home. And there's the delay when you have to do the planning once you get into the home. Something needs to be done about that.
And there was something else. I will leave it at that. I'm just really, really concerned for our people in the long run with all the different things that are adding up. And when I heard today about the Medicaid after the emergency, repeal eligibility, is that another layer to the barriers people are experiencing trying to get their home and community-based services and live successfully in the community?
>> SPEAKER: Thank you, Pam.
>> SPEAKER: Pam, if you can send me the information about the gentleman with the transportation office, I will work with the MCO on that. We will talk more about the next meeting about the home modification stuff.
>> SPEAKER: And also, Pam, we have talked about transportation being a topic at one of the future MLTSS meetings. We have talked about that. And it's in the process. We're trying to get -- as we're going on. I will let you know when it's going to be on the agenda.
>> SPEAKER: That's good for people to hear you saying that on the call, not being able to respond and feeling left out and not knowing we're working on that. It's good for people to hear that.
>> SPEAKER: Thank you. Thanks.

>> SPEAKER: Hi. My name is CJ Weber. And I am with angel on call. We service pretty much all of Pennsylvania. I have a lot of concerns about agency with choice and the fact that it got little attention during the meeting. The RFA was a quick turn around. And there's a lot of questions within the question period. But we're not going to have a lot of time between the time the answers come out and completing the bid.
Not to mention, and I appreciate and I think everyone should be independence and that's what we're striving for, but we have an FMS model and 3,000-plus agencies in Pennsylvania. And technically, according to the RFS, we're con FLIKTDed out. Why are we bringing a confusing mechanism into the mix? So maybe we focus on the tempest situation and getting that fixed before we add to the continuum that will make more confusion for the participants.
And really, we need to make sure that we are getting enough funding so that we can provide the benefits, which I think is one of the things agency with choice is supposed to be accomplishing was making the direct care worker more of a career than just the stop on the resume that they keep talking about. If we have the proper funding, and I will say most agencies do provide benefits and other ancillary things that we don't have to do, you know, the ACR gives us some regulations. Most of us are trying to give the benefits to be competitive. And we're not getting the additional funding.
In my opinion, and I know that doesn't count for much, but many of us agencies are aligned in this. If we have the adequate funds, we would be able to better serve the population. And there's plenty of choices for independence.
>> SPEAKER: Thank you for your comments.
Other comments?
>> SPEAKER: I will shut up after this, I promise. But what CJ said is absolutely true. And you have 2200 agencies out there. And I would venture to guess that all of us have implemented an agency with choice-like strategy to survive this crisis.
We're hiring friends, we're hiring neighbors, we're hiring family members because the direct care worker shortage is so -- it's beyond crisis. We had a crisis before COVID. COVID just put a light and lost all the buttons fly on the original crisis and magnified it.
We can't continue to ignore the crisis we're in. And I agree with CJ, if we add another model to the system right now, it's going to collapse. There are not enough supports in place. And if the model even works under the promises that are contained within the RFI, RFA, RFP, whatever initials you want to use, if the model even works, you're going to have people who won't get served because there's no possible way to keep those promises.
If the agencies out there who have been working in this industry, like Voices, 20-plus years, we have health insurance. We have PTO. We have all those things. We know that the system doesn't support us making it affordable.
And so to create another system and maybe give them an administrative fee that will allow them to be able to afford it, that just tears apart the entire system you already have.
Good providers who have been putting blood, sweat, and tears in this for years have gotten no support. You're not only hurting consumers, but you're hurting the system overall.
>> SPEAKER: Thank you, Shawna.
Other questions? Committee members?
>> SPEAKER: I will make one more comment, I promise. Because it's so important. We could talk about this all day. But honestly, we need to prop up the agencies who want to do quality things. We just talked for what, two hours about pay for performance. Okay. I know we're getting there and it's been prolonged because the study date was pushed down the road because of COVID. I appreciate that. If the state wants to have a smaller number of agencies to monitor,

because that's a huge issue. That's the growth every day. That's impossible to watch.
And the family and friends create the very unique challenge because you have a lot of oversight that you need to provide to ensure that we're providing for fraud and abuse. You have partner agencies in the state that will self-report when that happens, that will train these people properly. And that will give the MCOs the reports they need and the states the reports they need to make the programs successful and sustainable to the long term. We want to be a partner. I feel like this is sort of dumped on us. And we had no time to provide comment.
Back in March, we had, what, two weeks to submit comments? And I think there were only a handful of agencies that did. But they all feel the same way. The reason the handful of agencies did is because nobody has time. We're too busy trying to operate our business with very small margins.
I love what I do. I have been in the business seven years, which is not as long as these ladies, but there's easier industries to work in. We do it because we care. We love our participants and we want to program to be successful. But the state needs to work with us on this. And I feel like this was a slap in the face. You guys haven't been doing a good enough job and here is another program that's going to basically just hurt your business.
>> SPEAKER: Thank you for the comments and putting that on the record.
Anything else from the committee members or the audience?
I will take a motion for adjournment.
>> SPEAKER: Sure. I can second that.
>> SPEAKER: You can. All right. Our next meeting will be September 7th. Same time. Same place.
And thank all of you for participating. I appreciate it. And all our presenters, thank you very much. Great job today. Thank you. Bye.