>> just a reminder for folks that are unmuted, if you can self-mute. We started the broadcast, and I think we'll start in 3 or 4 minutes.
thanks.
>> Good morning. We're just about ready to get started. Linda, I think we have the bulk of the committee members. We still have a few we're going to flip over, but if you want to go ahead and get started.
>> CHAIR: Good morning, everyone.
>> Good morning. We can go ahead and get started. I know we have a few new members today.
If they would like to introduce themselvesthemselves.
>> I'm a new member. Lloyd Wuertz. Did a lot of work in behavioral health and been an administrator for a long term health facility in my career.
You might recall seeing me at meetings in the past. I'm the guy that was --
>> Ah, yeah.
>> And talks about behavioral health issues which is what I'll continue to be. So thank you for having me. I hope whoever nominated me will not be embarrassed and I look forward to serving.
>> Okay. Welcome, Lloyd.
>> Hi. I'm a new member as well. I'm Monica Vaccaro. I'm filling the see that drew Nagel previously held. I've been to some of these meetings before either filling in for Drew or as an interested member of the public. I'm representing the brain injury committee.
>> Welcome, Monica.
>> Hi. I'm a new member. My name is Ali Kronley. I'm with

united healthcare workers and SDIU health care PA. I'm filling the seat for by deputy wilderman and I've been at several of these meetings either as an observer or filling in for him and really excited to serve and really here representing the 20,000 direct care workers across the state of Pennsylvania that our organization represents. We're the largest organization of home care workers in the state and really excited to be here.
>> CHAIR: Welcome.
>> Hi. My name is Cindy Celi.
I'm a new member too. I've been in health care for the past 20-odd years and currently in the world of home delivered meals working with the food insecure and moms meals. I look forward to help participating in this committee and have been involved in LTSS since the launch of community HealthChoices. I'm interested in providing whatever support and assistance I can. Thank you very much and appreciate the opportunity.
>> CHAIR: Okay. Welcome, Cindy.
Well, I guess I'll just The House keeping committee rules. Keep your language professional.
This meeting will be from 10:00 a.m. to 1:00 p.m. And we will end on time. And take any cups, whatever, you may have with you when you go. And that's about it. And Jamie will give us the updates for OLTL.
>> Morning, everybody. Happy 2021. I'm looking forward to the new year. I hope you are as well. Welcome to our new members, Lloyd, Monica, Ali, Cindy, and thank you, Luba, for being a new cochair of the MLTSS. This is Jamie BUKen awer with the office of long-term living and I'm giving the OLTL updates this morning. We'll get started. The agenda is providing some COVID-19 updates that we've been giving obviously since back in the spring and some additional information about our monitoring report update on our person-centered service plans. This information is really coming after some of the information that we shared on changes being made to people's plans based on the CHC MCOs doing a lot of reassessments that are required under the CHC agreement, and making -- we had a lot of questions about decreases to service plans. So we pulled some information from our monitoring reports, and we have it to share with you today.
With that, we'll get into the COVID-19 update. So the first

update -- and I think at the December meeting although it seems like so, so long ago since we had the holiday in there, we gave the update we had submitted an appendix K waiver to CMS, and we were going to be updating our transition plan guidance. So we did receive approval from CMS on our appendix K waive amendment.
The purpose was to extend the waiver appendix K until at least March 5, 2021. They were due to expire December 31. With that, we took the opportunity to make which changes to the appendix K.
We did that and the updated guidance went out this morning.
I saw the list serve announcement go out. I hope you did as well. I'm sorry you didn't get more chance to actually review it and see it before the guidance -- or before the meeting today, but we can definitely field any questions that the group has about that appendix K guidance that just went out. The real significant revision we did to the appendix K guidance is providing flexibility for our adult daily living providers to provide remote services. So actually, that guidance for adult daily living roadway providers went out yesterday. How they could provide those services remotely to populations. So those are the upon U. Dates that -- on the big updates we have. More things that we sent out was that there was a couple of services which we allowed to be provided remotely that the appendix K guidance was updated and now that those services can be provided to new participants, the previous appendix K guidance only allowed those services to be provided to existing waiver recipients. So that was another, I wanna say, significant revision to that guidance. So I can pause there.
Did anybody have any specific questions that they had about the appendix K guidance we had just sent out?
>> Jamie. This is [not audible]. How are you?
>> Good. How are you?
>> I'm doing great. I was just wondering if there's been any consideration for doing an extension to the amendment for the appendix K beyond -- you said March 31, right?
>> It's actually March 5 of 2021.
>> Okay.
>> I think that will be upon us pretty quickly. I was wondering if there's been any thought process to extending it maybe till, I don't know, the beginning of the year or the

beginning of 2022 or something like that. I don't know how that process works, but my thought was, you know, March 5 is not too far away.
>> Mike. You're exactly right.
CMS recently -- I want to say mid to late December issued some guidance that basically said for the appendix K waivers, they can be extended by submitting a letter to CMS or a request to CMS that they can be extended to six months after the end of the federal public health emergency time period. So we do plan on actually submitting a request to CMS to extend our appendix K flexibilities for six months post the end of the federal public health emergency. CMS's intent is to give states time to transition off the appendix K flexibilities. So we're looking -- I think the current federal public health emergency ends -- and somebody can correct me here. With the holiday, I feel like my memory is fuzzy. I believe it was set to end sometime in mid-January. So six months would take us into late June or very early July. That is if the Federal Government does not extend the public health emergency again.
>> Thank you.
>> And Jamie, I received one question if no committee members have a question.
>> Sure.
>> So misty said thank you for sharing emergency relocations are currently included for appendix K through March 2021.
Will this be included in the amendment into the 2022 waiver amendment?
>> So I would say to misty's question that we have not contemplated that yet. We were actually working on wrapping up our changes to the 2021CHC waiver amendment they believe Patty is going to give a presentation on today. So we have not contemplated any changes for 2022.
>> Jeff Yzerman also had a question. Jamie, did you say that additional consumers can serve in the latest appendix K amendment? Can you repeat what you stated earlier as to which populations are impacted by OLTL's proposed change beyond consumers. Thanks.
>> So I hope I didn't say that additional consumers can be served. I'm trying to remember my exact language and maybe, Pat, you can help me out. I didn't mean to say that

additional people would be served. I meant that our appendix K -- our current appendix K can be extended for six months post the end of the federal public health emergency.
So whatever provisions are in place at the end of the federal public health emergency time period, we can extend for an additional six months. That doesn't mean that additional people can be served, but the services or the flexibilities we have in place with the current appendix K can continue.
>> Yeah, Jamie, this is Patty.
I could add to that. I think you did provide an update on -- there were a couple of services involving --
>> Oh.
>> Can you hear me?
>> Yeah, absolutely.
>> Okay. Rehab and counseling services. The way we had previously presented the flexibilities for delivering these remotely was that somebody would have had to have been receiving this service prior to COVID, face-to-face, in order to get the service remotely. We changed that with the most recent appendix K where now we're saying for those three services, even if a participant didn't receive it face-to-face prior to COVID, they can start receiving the service now and receive it remotely.
>> Thanks so much, Patty.
>> Okay. Thanks, Patty and Jamie. Jeff said thank you as well.
>> Okay. If there's no other questions on the appendix K, we can move on to the next slide which is the vaccine strategy. So many of you may have seen the Department of Health did issue an interim vaccination plan on December 11, and they -- I'll just note this is a pretty fluid document. The Department of Health is working with other state agencies continues to look at the interim vaccination plan and make updates if needed or necessary accordingly. So there is the website that the plan and other vaccine resources can be found. It's on the Department of Health website. They're coordinating with DOH to develop a vaccination strategy for participants in home and community-based services. Right now, the vaccination strategy is focused, obviously, on hospital and health system workers, those people whose job it is to, obviously, take care of populations where they may encounter COVID-19 patients directly. So in those

COVID units, working at the front desk processing, you know, and doing intake for those COVID patients.
They focused the vaccination on vaccinating those hospital and health system personnel. The other population that's currently the priority is individuals in nursing facilities and, obviously, the staff that work in those nursing facilities. So through the federal farmrmacy partnership working with CVS and Walgreens, nursing facilities are currently being, you know, people in nursing facilities and the staff are currently receiving the vaccination. And I know the Department of Health those hurts nursing facilities that are going to be receiving the vaccination. I believe that's updated weekly. The secretary of health last Wednesday issued an order that set that -- told those hospitals, health systems, FQHCs and other entities receiving the vaccine to set aside 10% of it for an unaffiliated health-care professionals. These would be people that are providing health care services not affiliated with those hospitals and health systems. They should set aside 10% of their supply for those individuals to receive the vaccination. So information about how unaffiliated health-care professionals with receive the vaccination should start to be published, I would say tomorrow. It was on the Department of Health's website that those health systems and hospitals and FQHCs should start to publish that information to how those people with get a vaccine tomorrow. That's good news for our home and community-based providers. They are included in probably those unaffiliated health-care professionals that are still providing health care services. They could be interacting with people that have COVID-19. They should start to look at health system, hospital, and FQHC websites starting tomorrow about how they can obtain a vaccine.
That's really good news. First of all, it's really good news that we have a vaccine and people are starting to receive it. It's really good news that our long-term care facility population is starting to receive a vaccine. And very shortly, those health-care professionals who are serving our home and community-based populations would be able to receive a vaccine as well. I do -- I think it's been posted a couple of places, but I do stress that patients, you know, I know we still have a limited supply. So there will be some, you know, I don't think everybody's going to be able to get vaccinated

this week, but with patients, we will get there, and we will be able to vaccinate the populations. So I think the only other thing I would add is after the nursing facility population is vaccinated, the federal pharmacy partnership program, meaning CVS and Walgreens will start to vaccinate the populations in the personal care homes and nursing facilities as well as other licensed care facilities, licensed by the Department of Human Services as well. So the priority is the nursing facility population. But they will, as soon as they get to the nursing facility population start moving to those other long-term care facilities.

>> Jamie, this is Rich. How are you?

>> Good. How are you?

>> I had a quick question. What about people who are not in a facility who are receiving care and of course independent living is one of the goals at CHC. So they may not be in a home or in a residence. Where are they on the list? Who can we expect to hear from? What role will like [not audible] be playing?

>> Rich, that's a great question, and thank you for it.

So our home and community-based population under the Office of Long Term Living is in the -- I want to say the 1B population to receive the vaccine. Right now, those that I mentioned are in the 1A population. So hopefully 1B will be making plans to vaccinate that population very soon, hopefully within the next couple of months. We've already started to talk to our CHC MCOs about how they can plan and work with the participant to ensure that when the 1B population is ready to get vaccinated, they have a plan for the [not audible]. It's very likely, Rich that the participants receiving home and community-based services will need to be transported somewhere. Either they'll have to go to their doctor's office once they receive the vaccination supply, a pharmacy, a mass vaccination clinic, a hospital location. So it's really going to be determined by where the vaccine is available for our participants to receive it.

>> So likely, then, and if the 1B population is defined, they will hear likely from their provider. Is that correct?

>> They could hear from their provider, their service coordinator, or there may be outreach, just general community outreach they might hear.

>> All right. Thank you.

>> Yep. So great question.

Thank you.
>> Hi, Jamie, this is David Johnson. Follow-up on the vaccine strategy Rich had with the managed care plans. What expectation or requirements is OLTL having with the managed care plans with residents of long term care facilities regarding receiving the vaccine or being communicated about its availability and questions about the vaccine, any follow-up, any encouragement? Does OLTL have the expectations for the managed care programs for the service coordinators serving residents in long term care facilities?
>> So, that's a really great question. We haven't had that conversation with our CHC MCOs yet, because working with the federal pharmacy partnership programs CVS and Walgreens are going into the long term care facilities, and obviously, doing the education about the vaccine, providing the support to those populations and talking to them about being vaccinated, as well as administering the vaccine.
So the real responsibility of our CHC MCOs is to pay any associated administration costs that aren't picked up by -- if it's a dual eligible Medicare, if that administration falls to Medicaid meaning the CHC MCOs.
And I'll say that there's no --
that I have heard to date --
there's no requirement that those living in a long-term care facility must be vaccinated. I think we're encouraging all of the individuals to be vaccinated if they wish. There's no requirement. But, obviously, encouraging them as much as we can.
>> It's good to hear there's some type of outreach in structure with the pharmacy partnership given the service coordinator with beneficiaries managed-care plan is some advocate or trusted source of information. I would like to ask that the MCOs are prepared to, you know, join that effort in educating residents about the vaccine and potentially, as you mentioned, it's not required but can be encouraged to see what type of encouragement managed-care plans especially the service coordinators can be prepared to offer. As a follow-up, I wonder if you have. Ination about with the pharmacy partnership, what resources or materials or support will there be for residents who do not speak English as their primary language regarding the vaccine and its availability and other

questions that a beneficiary may have.
>> Yeah. Let me -- David, let me see if I can get ahold of those. I know they have a number of materials and have posted them publicly. So, obviously, facilities that they're getting ready to go out and visit to provide the vaccination to have them prior to actually CVS and Walgreens being on-site. I don't know off the top of my head how many different languages or that they're translated into, but definitely can take that back and find out.
>> That would be appreciated.
Thank you.
>> Jamie, hi. Have you thought about the transportation component? Especially if for instance they have drive-thru clinics and the availability of a provider of transportation to wait for someone while they're getting the shot?
>> Yes. Thank you for that question. Absolutely. That's been one of the conversations that we have started with our CHC MCOs. Obviously, we didn't have hard and fast answers since the vaccine isn't available to the population yet. But we do recognize that if there is a mass vaccination clinic, it is probably going to overwhelm MATP, so what is our backup strategy here?
>> Jamie, hi, David Johnson again from Carrie. Follow-up question, I'm thinking about a circumstance if a residence of a long-term care facility receives the first dose of available vaccinations but then is discharged before receiving the second dose, does the CHC managed care plan play some role in coordinating that follow-up dose? What responsibility would you say OLTL would have to ensure that someone who legitimately got the first dose and was discharged before receiving the second dose, what their responsibility would be?
>> David, that's an intNT question and where we're advocating right now for our CHC MCOs. One of the issues is the person a dual eligible? Would any kind of claim information go to Medicare, Medicaid? Would they have a record of that? If it is a dual eligible, the CHC MCO may not have paid that administration fee, so they may have no kind of record that the individual received the first dose of the vaccine or which one. That's the big point. You cannot cross -- if you receive a Pfizer vaccine, you have to get the second dose of the Pfizer vaccine. So we are looking to advocate that our CHC MCOs have access to the vaccine database

where all this information is going to be kept so they know even if they don't get a claim, who received what vaccine and how many doses so they can do that work. Right now, they do not have access. So that's going to hinder them in their work to ensure the pol --
populations in their plan get the closes and the right doses.
>> Thank you for that clarity.
And just as a brief follow-up, should the MCOs have access to that database of vaccine information F they came across a beneficiary who may have received a first dose in a long -term care facility and now they're discharged and living in the community, what could be expected of them to ensure that a second needed dose would be administered?
>> So we started having conversations with the CHC MCOs. If they have that information, the service coordinator could follow up with the participant to ensure that when the vaccine is available they can get that person into their health care provider or some other form at QHC where they can get that second dose of the right vaccine. They need to, obviously, they need to make sure that the person gets the right vaccination.
>> Of course. Thank you.
>> This is Pat. I did find on a DOH website, they're going to translate the COVID-19 vaccine information into Spanish, German and Taiwanese and the Department of Health also has optioned to view its website in other languages.
>> Thank you, Pat. I know they were having conversations about translating those materials.
>> Sure. And then I think Luba, you also had a question?
>> LUBA: Yes. Are the life program participants part of 1b?
>> Yes, they are.
>> LUBA: Thank you.
>> Wait. Let me just caveat that. Some life participants may be in nursing facilities, so those populations would be in the 1A category. If they're the community-based populations, they would be in 1B.
>> LUBA: Thank you very much.
>> Jamie, it's Ali Kronley. And we're really excited to hear the DOH announcement that they set aside 10% for the nonaffiliated health-care providers. I'm wondering if you could speak about how you see that work out?
I'm kind of particularly interested in the participant-directed direct care workers. How will they know, for instance, what

websites to look at or whether or not health systems in their area has the vaccine and are the service coordinators alerting consumers -- could you talk a little bit more about how the direct care workers themselves who should be getting vaccinated will know that kind of this program is rolling out and that they should look for information about it and try to figure out where to access the vaccine?

>> Yeah, that's a great question, and we're waiting to see that information be published as well. We know that health systems, hospitals, FQHCs have been receiving the vaccine. Heretofore it's been reserved, obviously, for their own staff who have been interacting with COVID-19 patients. So now we're waiting to see, you know, when they may get available to that 10% of unaffiliated health care personnel, how they're going to do that. So you know, I want to say we're waiting to see also what is published and how those health systems will kind of queue up those unaffiliated health-care professionals. The plan didn't have much or the order didn't have much detail saying exactly how the health system or a QHC had to do it.

They have some flexibility. I would encourage those unaffiliated healthcare workers to obviously check websites for their support -- hospitals, their FQHCs in their areas they are receiving the vaccine. The Department of Health has published who is receiving the vaccine. Those same entities should start to [not audible] unaffiliated health-care professionals can get the vaccine. Ali, I think they're going to have to sign up for an appointment. So you know, check early and often would be my suggestion. Does that make sense?

>> That makes sense, Jamie. You know, I imagine there will be challenges with that. I think we should keep digging into it.

>> You're right. There probably will be much more demand than there is supply initially which is why -- it sounds like most of those entities are going to have to make a certain amount of appointmentappointments available. And then I don't know -- we haven't given them -- meaning the Department of Health hasn't given any ranking priority. I'm not sure if the health systems or FQHCs will or if they'll make appointments available and it will be first come first serve.

>> Do you know if there's any sort of verification or sort of

proof of employment for the participant direct-care workers that CHS will be providing that the health care systems know they're eligible?
>> Yeah, thanks, Ali. We've had that question internally, meaning we've started to think about that. It's not been posted what any FQHC or hospital or healthcare system is going to require for their unaffiliated health-care providers. We've almost waiting to see what they're going to be requiring to show what we can arm our direct care workers with or provide to them as proof that they are an unaffiliated health care worker.
>> Thanks.
>> Jamie, if no other committee members, I wanted to do a time check. I have a number of questions I came in from the audience. We can handle those as part of the additional public comments if you have additional slides you want to go through or if you want to take them now.
>> I do have additional slides.
Maybe we'll go through the additional slides and then take the questions at the end as we have time, Pat.
>> Sounds good. Thank you.
>> Yep. Sorry about that. This is an interesting -- the vaccine strategy is really interesting and will continue to evolve. I know we're going to have more information to the committee.
Next slide. We just wanted to give everybody an update on the regional response how collaboratee program we call the Rick P program. It was funded through the CARES Act.
It expired on December 31, 2020.
The Department of Human Services working with the Department of Health and PEMA had to think about what was going to take the place of this critical program that was providing support to our long term care facilities with outreach. So we were able to, meaning the wolf administration was able to come up with limited funds to continue providing facility support. It's really --
facilities with outbreaks that are going to get this needed support. So the state-funded effort will leverage the expertise of the health systems that did participate in the regional response health collaborative program, and they have transitioned to the RCATS.
It started December 31 because the federal funding or the previous funding ended December 30 through December

28, 2021. -- February 28, 2021.
They're providing COVID outbreak support to facilities. It's focused so that [not audible]
obviously they're going to be continuing a call center function for those facilities who need to call and get any kind of support that they need, outbreak support. GPE will be provided with existing and new vendors, the Department of Health has some vendors that can provide PPE support. All the PPE support will not be coming through what was previously known as the RIC program. It will be provided but through a different venue. Staffing assistance will continue to be provided through existing and new and contracted agencies as well as the PA national guard, but it will be more limited.
Through the RIC program, we had expansive ability to provide staffing to those long-term health facility who is had know an outbreak and lost say half their staff were COVID positive so they were not available. We had resources through the RIC program to bring in staffing.
Staffing assistance will continue to be provided but a little more limited. We just don't have the federal funding available. Testing assistance will be available as resources permit through the Department of Health's new vendor. So they've been rolling out their new vendor, and educating facilities about how they can get testing support. So the testing assistance is not being provided through the RIC program anymore but through the Department of Health's new vendor. The tomorrows health care portal will still be vEBL but webinars will not be scheduled twice a week anymore but as needed.
It's a slimmed down RIC program known as the RCAAT program.
It's to provide assistance to facilities that have COVID-19 outbreaks. So moving on. So just quickly, we wanted to provide some information from the monitoring reports. We got a lot of questions when we were sharing information last month, but really since we started sharing the information about all of the service plan changes that were happening. So we were reporting on the number of assessments that were happening, the number of assessments that were being conducted telephonically, in person, and then the number of assessments that resulted in a denial or a service reduction. Then we were reporting

on the number of grievances and appeals and so that generated a lot of questions. One of the questions that was really generated was so we were only reporting on services denials or reductions.
We weren't reporting on any other changes to a service plan.
So we went back and took a look at the data we had available.
So for this month, we wanted to show some information from our ops 21 report that the Office of Long Term Living receives. For our three CHC MCOs, we wanted to provide the number of active person-centered service plans in total across the different zones, and you can see the three quarters' worth of data here.
And then through the first quarter of 20tWNT and2020 and the second center the number with an increase or decrease are included. During quarter 1 of 2020 and quarter 2 of 2020, there weren't a lot of decreases occurring. This is because of the moratorium that was put on service plan decreases during the COVID-19 public health emergency. So the quarter 3 of 2020. The decreases you see there, I would note sometimes those decreases were put in place prior to the moratorium, but the changes took effect in the quarter 1 of 2020. And then in quarter 3 of 2020, we had, with the release of the appendix K transition plan, that I believe we rolled out on June 26, 2020, the plans were starting to reassess and assess their populations, making changes to the service accordingly. Quarter three is when that started to happen. We wanted to show both the increase and decrease in service plans that were taking place during 2020. Now, we, obviously, do not have quarter 4 of 2020 data yet. But you can see, you know, across many of the plans, you know, just as many service plan increases as decreases are in place. Just as Amerihealth, Caritas that most population is in the southeast. That's where most of the changes to the service plans were occurring.
The next slide, just shows graphically the percent of person-centered service plans with an increase and with a decrease across the different areas and different quarters.
And so the next slide is Pennsylvania Health and Wellness. Very similar numbers in terms of increases and decreases across the different quarters. But we thought this information was helpful to get a grasp on kind of what was

occurring across all service plans. The one thing I would note is that the information that we shared with the committee on, obviously, the number of denials or reductions in service plans, we were counting that cumulatively, so it was since July 1 or when the plan started making -- doing their reassessments and making changes to service plans, basically, to date or to that week that we counted or collected that data. So, obviously, that information is really not going to match quarter 3 of 2020 just because we were, obviously, counting into quarter 4 of 2020. So I just wanted to note that for everybody's information. And so the next slide just shows the person-centered service being for Pennsylvania health and wellness, percent increase and decrease through the different quarters. And then the last slide is -- the last two slides are the information for UPMC.

You can see the active person-centered service plans and increases for the first 3/4 of 2020. The last slide is a graphical representation again.

I think with that, that is last slide. Pat, dimy best -- you can take -- I'll pause to take any questions from the members or members of the audience, if we have time.

>> I think you had some -- I think, did a committee member have a question?

>> This is Rich. This is a comment as a consumer UPMC, MCO, our service plan update went flawlessly. We had a phone visit and then a brief in-person visit. But there was it was handled well and on time. I wanted to make that comment.

>> Hi. This is Monica from the brain injury association. This is my first time looking at these data.

I apologize if this was already said. The increases in the service plan does, that include new people or from an existing plan. ?

>> So I'm going to see if anybody can help me out here.

I'm assuming that increases meaning increases in an existing plan. They're not new people coming o obviously, new people coming on would be all increases. But somebody can correct me if I am wrong.

>> This is Randy. You're correct. These are changes in the current person-centered services. Some of the increases might be because with COVID shutting down the adult center, there's increases services to make sure people are

safe out there. These are to existing plans.
>> Thank you.
>> Thanks, Randy.
>> Okay. Diget a few questions specific data but I did want to do a time check, because I know Abby was supposed to start at 10:45.
>> So Pat, I can be available.
If they want to move on to Abby's presentation, I can remain in the meeting. I'll be here anyway, and so I can answer questions later on when we have some additional time.
>> Okay. Sounds good. Thank you.
>> Hi. Good morning, everyone.
You can hear me?
>> Yes, we can, Abby.
>> Thank you very much for having me today. I. Name is Abigail Coleman the director for the division of program analytics in the office of long-term living. Today we are going to be talking about the performance improvement project that the MCOs are working on.
Next slide, please. Before we get started, I did want to put the goal of CHC up on the slide for you. I'm sure you're all very familiar with them. I wanted to highlight that the first two goals are enhanced opportunities for community living and strengthening coordination of LTS and other types of health care including all Medicare and Medicaid services for all dual eligibles.
I wanted to highlight this.
You'll see these are two the themes of our core improvement project as we start to go through some of the slides. So next slide, please. And again a little bit of background here to show you all the different components of the CHC quality strategy, which includes all types of different things, including the MCO operations report, performance measures, our surveys, as well as the 7-year independent evaluation which is being conducted by the Medicaid research center. In addition to that, we have two items that, again, we're going to be talking about today which are our external quality review organization and our performance improvement projects. Next slide, please. So today we will be talking about the performance improvement projects and going through a little of background including why we're doing performance improvement projects, how that fits together with that and

talking about some of the selecting our mentions across all 3MCOs and of the measures being used to track improvements. And then we'll wrap it up today with some next steps. Next slide, please. So again to back it up and give some background on why we're doing performance improvement projects the purpose of a performance improvement projects or PIP as you will hear me refer to them through today's presentation is to assess and improve the process that comes with health care provided by the MCO. And there are federal regulations that require PIP. State must require that the MCOs conductconductconduct performance improvement projects including any PIPs that focus on both clinical and nonclinical areas and there are certain components each of the performance improvement projects must contain. And basically, they must be designed to achieve significant improvement that is sustained over time and health outcomes and participant satisfaction. And they have to include measurement of performance using objective quality indicators, and we're going to talk about what some of those objectives indicators are the that MCOs are using in their PIPs today and they also must include implementation of interventions to achieve an improvement. We'll talk about some of the select interventions that are, again, the MCOs are using. We're going to go into MCO-specific interventions because a lot of the themes are the same across all MCOs, just variations of how they're doing certain things and PIP based on their performance measures and then they need to plan activities for sustaining that improvement over the long term.
So the CHC agreement is really in alignment with what the federal regulations require in that the agreement requires one clinical and one nonclinical PIP. And we'll talk about what we're requiring today in terms of the PIPs. Next slide, please. All right. So a little more background on the PIPs and the EPRs fit together. Federal regulations require the state to contract with an external quality review company to provide measures of certain quality components. And there are four mandatory activities that the external quality review organization must.
If. If you jump down to item number three, on this slide, you'll see validation of performance improvement project is one of the things the EQR must perform. The two components of this protocol which is the guidelines that

PMS lays out of activities that must be performed within each one of these topics for the PIPs are to assess the PIPs's methodology and it includes reviewing the topics, the statement, identifying the population, reviewing informance measures and data collection, et cetera and ultimately, reviewing the data and results. The second item that the EQR must perform is performing an overall validation and reporting the PIP results. OTL has been working with each of these items since 2008 and we worked closely with them in the early stages to develop what our clinical and nonclinical PIP would be, and if we go to the next slide. You will see that we landed on a clinical PIP of strengthening care coordination and a nonclinical PIP of transitioning participants from a nursing facility to the community which again, aligns with two of the main goals of CHC. So since CHC was rolled out in phases, so was the PIPs. That's what the bottom half of this slide is showing, is that each MCO was required to submit a proposal to IPRO for each individual region where they provided all those programs that I just talked about that IPRO did review within their proposal. You can see in the southwest, they submitted that proposal in 2018 with their intervention starting January 1, 2019, and then as the phases rolled out, so did what the baseline period would be and when their interventions would start. These projects are 3-year projects with an option of continuation at the end of the three years, if required.

We will be assessing that as the projects continue on and whether it's appropriate to continue them on beyond the three years or not. So now, if we go to the next slide, we will get into the specifics of each of the performance improvement projects. And we will start with transitioning participants from the nursing facility to the community. Next slide, please.

So the first slide is really show something of the interventions across the different MCOs. Like I said before, there are really are some common themes that were across all 3MCOs. And the first two really reflect that. And deal with the fact that 92% of CHC participants are dual eligible, and so each MCO put into place status-sharing agreements with the behavioral health MCOs and the nine other S-SNPs. The other items that's really related to this is participating with the health information organization to get admissions,

discharges and transfers for their participants. Then there are a few other interventions that may be specific to MCOs, such as having behavioral health coordinator to connect the participant with available behavioral resources once that participant is living in the community and also having the service coordinator assist with appointment scheduling on discharge from the nursing facility is another one that most of the MCOs had some variation on within their PIP.

Next slide, please. And then a couple of other items included educating the nursing facilities on notifying the MCO within one business day of when the participant wanted to transfer out or was assessed for a lower level of care to ensure service coordination, had time to meet with the participant face-to-face or telephonecally due to COVID-19 within one business day and the other one was notification of discharge from the facility. The service coordinator would visit the participant within 48 hours, and then of course, because of COVID-19, some of these interventions had to change a little bit from being in person to telephoncally and alsoed be included within the measures.

So next slide, please. So across-the-board, the way that the PIPs were set up is there were certain measures that were require for each of the MCOs to include as overall indicaters of the PIP's success. What you're look at here are the ones that are across all MCOs, and then after we talk about these, we will get into the MCO-specific intervention tracking measures which are really specific to the MCO and the MCO came up with based on whatever their intervention was. They came up with a measure that would somehow track their progress within specific interventions to see if those interventions were being specific. Again, these are at the statewide level that are being required across all 3MCOs. The first one is transitions of care which have threethree subcomponents. It actually has four, and we'll see that in the stRINTH strengthening care coordination PIP. With this PIP, we required three of the four components of the transition care measure that included receipt of discharge and medication reconciliation after a discharge and patient engagement after discharge. We also required a second performance indicator on this one, and on this one, we're looking at the percentage of participants who are discharged from a nursing facility and remain in the

community greater than six months. There have been some challenges specifically with the transitions of care measure as we have noted and I'm sure I don't need to remind this group that 92% of our population is dual eligible. With Medicaid being the payer of last resorts, they may not be seeing that person was having medications day because Medicare is paying for that care. There have been issues with that measure and we're working with the MCOs to see if there's a better way to perhaps measure the success of this PIP overall and also strengthening our care coordination PIP as well. Next slide, please. So here are some of the key intervention tracking measures for the nursing facility PIP. Again these are MCO specific. A lot of them are very similar across MCOs. It really depended on how their specific intervention was worded. So a lot of these items include timely notification from the nursing facility of when the participant told them they'd like to be discharged from the nursing facility or assessed at a lower level of care. Again educating the nursing facility on the importance of notifying the MCO within 24 hours of participant admission and/or discharge and the percentage of participants discharged from a nursing facility that received assistance with appointment scheduling. And the one above it is also related to most of the MCOs have a tracking measure that track when the participant was contacted after discharge in some form or another. So next slide, please. So now we can move into the strengthening care coordination PIP and next slide, please. Again, these interventions, we've pretty much covered with the nursing facility. There's really a lot of overlap in the two in the sense that, you know, they needed to get these data sharing agreements in place with the D-SNPs to be acare of -- aware of in-patient and each MCO has some sort of intervention that required engagement with the participant after discharge, whether that was outreach calls, reviewing discharge summaries with the participant or assisting with follow-up appointments. Next slide, please. So again, here we see the transition of care performance indicator. There is one additional fourth component which I noted before which is the notification of in-patient admission. And then our second performance measure performance indicator for care coordination is looking at follow-up after hospitalization for mental health and it's a see a mental health practitioner within seven days of that

discharge. And this performance indicator also has the same issue where, again, 92% are dual eligible. Medicare may be paying for that visit.
It's hard to get an accurate sense of how many participants are actually receiving that follow-up within that 7-day period. Next slide, please.
And then finally here are some of the MCO-specific intervention tracking measures for care coordination, which, again, include the percentage of admission notifications received by the MCO within one business day, contact by the service coordinator within a certain number of days of discharge, and again, those data-sharing agreements which are for care coordination. Next slide, please. So the next steps are really we are going to start looking at the baseline and initial southwest intervention tracking measures. That's really what we have data for so far, and working with IPRO and the MCOs to reassess if there are other issues that may be more appropriate to track the performance of the projects through the 3-year period. The other thing is phase three interventions began on 1/1/21 so we're starting that 3-year period for the remaining three regions of CHC starting this month. So I think that is all I have. Next slide. Are there any questions?
>> This is Lloyd. I'm very pleased to see your focus on the assurance of data sharing agreements with the behavioral health managed care organizations. I noticed early on in your presentation, you talked about assuring that individuals who are transitioning to the community are made aware of behavioral health services that could be available to them. I would suggest that assuring the information about those services are shared before the individual is transitions or while the individual is still living in the nursing facility as those services tend to be very few and far between inside those walls.
Are there ways you might be able to impact that sharing of information and that provision of services in those facilities with people with numbers on their doors?
>> Yeah. That's a good question. So that was one of the MCO-specific interventions, and it was really to help the participant with behavioral health issues after they transitioned to the community.
I'm not sure if the behavioral health coordinator is working with the participant while they are actually in the facility.

However, I do know that a lot of the interventions did include trying to get in and, you know, be a part of that discharge planning process in the actual nursing facility while the participant is in there so that they have services ready to go when they do transition to the community.
>> That's a good question, Lloyd. And I like the MCOs to share from their perspective what other kinds ever things they're doing to make sure that's happening for our consumers. UKMC, are you on the line?
>> Yes, I guess Mike XHITH, do you want to speak to that one?
>> This is Marcy from Pennsylvania Health and Wellness. I can give you a little perspective of BHA our nursing home transition team does to prepare our participants for moving into the community for not only behavioral health but all other needs. As soon as we know that there's a potential discharge or an interest in the participant transitioning into the community, we come in and they work with the participant and/or his family to make sure they have all the services they need when they move into the community. As the gentleman said, in the nursing home, they don't have many of the services they may need when they move into the community. So we have a checklist, and our service coordinators, at this point, they're doing telephonic discharge planning. But the discharge planning plays a huge part of what they do to ensure when our participants move into the community they have all the services they need listed in their person-centered service plan otherwise known as the PCSP. Does that answer your question?
>> It sort of does. But and thank you for calling me a gentleman. I'm concerned about the behavioral health services and awareness of those services whether they're in transition or not, especially those who live in nursing facilities. Having worked in long-term care for a dozen years, those services are scarce, and they should not be especially with a person who now has the expanded ability for services under the programs. I keep focusing how are we stressing that with folks in facilities as well as outside?
>> Just a little response back.
So what we're looking at now is continued service coordinator education in regards to provision of services within the nursing facility. That's not one of the interventions that CHW has on our list but that's a piece of

the education we're doing with our service coordinators now.
>> Thank you.
>> I know we had partnerships between behavioral health MCOs and the CHC MCOs to provide information specifically to nursing facilities and [not audible] how to tap in to those services. Just to suggest a future presentation, but I think it would be valuable for the MCOs to talk about those relationships and how they're growing in [not audible] with the nursing facilities and the SooFRS coordinators to tap into those behavioral services for those that need it?
>> Do we have Jen Rogers from Amerihealth? I thought I saw her at one point.
>> Hi. Good morning. Can you hear me?
>> Yes, thanks, Jen. Good morning, happy new year. To that point, it's important to point out a couple of things.
The partners' meeting is critical in connecting all the players if you will. So CHC MCOs, the nursing facility association and the nursing facilities providers to the plans and understanding the process and connecting participants to those services.
It's also important to note that many people residing in nursing facilities are told. Just knowing that fact and knowing where to pursue therapy is an important accord we train our SooFRS coordinators on.
>> For UPMC, we have mike XHITH and Jamie.
>> We wanted to mention what we find very helpful at UMPC is weekly meetings we have with behavioral health MCOs and the PIPs so if we have individual cases that we need to discuss to assist with transitioning out or the human resources are concerned with filling a gap in those areas we use those weekly calls where they can identify the person or we can identify a person to discuss. We have also been using the quarterly collaborative meeting with the nursing facility associations to better resolve some of these issues that get identified whether it's a facility issue or an individual issue to try to give a solution there and try to problem solve together. I'm not sure if Mike wants to add to that?
>> I think I'm unmuted now. You can hear me?
>> Yes.
>> I think everybody has covered the bases on this one. I'll reiterate the challenges of Medicare dual eligibility at times.

Certainly for nursing home transition, we are very concerned with regard to behavioral health needs and substance disorder needs and that is something that's definitely discussed as part of the nursing home transition, and we see that there is, you know, in the MDS data, there's also information that we receive on a regular basis that we can review to be prepared for that in the transition process in advance of that. So that's a good point.
>> Okay. Any other questions from committee members for Abby?
I had a few come in from the audience. The first is for Pam walls. How do MCOs receive notification of hospitalizations for fee for service? And I guess since PHW went first the last time, why don't we go back to Mike and/or Jamie for UPMC.
>> For fee for service, it is a challenge at times, depending on whether or not the hospital participating, we'll call it an admission discharge information on participants when they leave a facility, if they're in the health information exchange. That's sort of -- if you think of health information as a backbone, like the backbone of a person, sort of neurocenter to get information out, there's 5 or 6 of those in the state that feed in to that system, and it lets us know when people are leaving the facility through ADTPs. Also we get information from these steps that is just now starting to get processed on a regular basis from all the different D-SNP programs and we get information directly from facilities and participants and families. There are multiple waysways of getting it. There still are gaps in the system, but those are the traditional ways, and they're getting more and more effective.
>> And kind of a related question to that, Mike, is what role are the service coordinators then playing in discharge planning for the short-term SNP, the rehab state.
They come out of the hospital.
They go into a nursing home for the therapy.
>> Right.
>> And trying to coordinate that discharge to avoid a long-term setting.
>> That's a really good question and something that we're really working hard on in the program and in one of the biggest opportunities. Right? So they're sort of channelling their inner UMC here. When a participant is discharged through a short-term stay, we working with the receiving

facilities and the nursing home to make sure that the unity service coordinator is aware of the discharge and actively make sure that everybody knows that this person has a community oriented opportunity to go back to the community after a skilled stay, and you know, again, this is a process that we're working on. It's not perfected at this point, but it generally is that the receiving facility works with the SC, nursing facility SC and that's regarding the admission or vice versa. The SC knows from a discharge transfer admission they'll work with internal SC and the facility to coordinate the return to the community. Lots of good results here, although I have to say it's not always -- because we've done an excellent job at coordinating it all. But we are seeing that people come in for shorter-term stays and are getting back out and we're very excited about that. A lot of it is because of coordinating. I think there's still room for improvement there. We're trying to figure out ways where the nursing facilities themselves can make sure they're notifying us for all UPMC where we might be the secondary payer because of Medicare. That's where the challenge comes in and the coordination with other D-SNPs and the HIE and it all comes into play in making sure people knows they're moving through these transitions of care. That's an excellent question and something that we are definitely doing, but like I said, there's still opportunities for improvement.
>> Okay. Sounds like a great program. Okay. So Jen, for Amerihealth, can you talk about how you're getting notified, what data you might be receiving related to hospital discharge planning and then how the service coordinators are working in trying to assist with the managing the short-term nursing facility's mission?
>> Jen, are you there? Maybe we lost Jen. Marcy, can you speak to this for CHW, or is there someone else we should --
>> Certainly yes. I can and then I'll ask Marcus Hicks if he has anything else to join in.
We rely on our health information exchange for the AET data which is admissions, discharge and transfer data.
We get a feed at least twice daily. We have an internal team that focuses strictly on transitions of care. As soon as they're notified of an admission, they start work with the member and/or cave giver for that person. At the time of discharge, our transition of care nurse ensures that the

participant is connected with his or her service coordinator to follow the transition through the short-term stay in the nursing facility. That's our main process for the admission discharge and short-term figurement. Marcus, did you have anything to add to that?

>> Not much more to add. They work hand in hand with internal service coordinators and PIPs to make sure the transition of care goes smoothly for those transitions. We use those ADT reports to get the information and act on that information.

Give me one second to circle back for Amerihealth.

>> This is Jen. You can hear me?

>> Yes.

>> Okay. Sorry about that.

Yes. I was talk and you couldn't hear me. So the other plans, we are looking at submissions and transfers and discharges. And importantly, I think the coordination between the nursing facility, especially now in the time of COVID with nursing facility, social work teams being our point of contact to get in touch with folks that are either in long-term stay or short-term stay is critical as we're reaching days of discharge to work closely with the care team and person-centered team to get folks back into the community. I can think of case we're doing an exceptional job to this in difficult circumstances with COVID.

Communication is the key, knowing that we're all in the same team, who knows what action item is critical. That's the basic. Right? It's especially important now so we don't convert long-term stays to be as as possible that is the responsibility of the service coordinator to get them from their short-term stay and back home and resuming and in some cases adding services to stabilizestabilize them back to community living.

>> Okay. Great. Thank you. So I think there are additional questions, but I know we're running behind schedule, and I know Patty wants to talk about the 2021 amendment, if you want to do that, and then we can try to cover additional questions at the end.

>> That's okay with me. This is Jamie, if it's okay with Linda and Luba.

>> CHAIR: Yes. That would be fine. Thank you.

>> Okay. Good morning, everyone. Is Patty Clark, and I'm going to switch over. Okay.

Can everyone see my screen and hear me all right?
>> Yes. Patty, you may want to go into -- it looks like you're doing the notes version. Do you want go into presentation?
>> I'm not sure where I change.
>> If you go down to the three circles.
>> Right here?
>> Yeah. Hide presenter view.
And then go back up and start from the beginning. On the left-hand side. There you go.
Okay.
>> Did that do it?
>> No. Can you go down to display settings? That's not it. Whoops. I'm not sure.
>> Tell you what. Do you want Meredith to just project it?
>> Yeah. Let's do that. That would be quicker, I think.
>> Okay. Sorry to make you dance so fast, Meredith. Okay. I think we're good. Good morning, everyone. This is Patty Clark. I'm with the division of policy development and analysis at OLTL. Work there on the policy bureau. I'm going to give an update on the 2021CHC waiver amendment. This is the home and community-based waiver amendment. The amendment is effective January 1, 2021.
It was approved by CMS just before the holidays on December 22. A couple of reasons for doing the amendment.
We revised service definitions, some of the limitations, and provider qualifications for several of the services. Added clarifying language to the waiver based on the feedback from stakeholders. Amended the responsibilities of the fiscal employer agent, updated EVV information, and we revised some of the waiver performance measures. Next slide. We published a notice in the Pennsylvania bulletin on July 25. This included posting all of the proposed waiver change documents on our DHS website. We received public comments until August 24. And we received nearly 200 comments on the proposed amendments. So thank you to everyone who provided comments. We received them from providers, participants, advocates, the MCOs provided comments. So it was really good public comment period, and we appreciate all of the time you took and the thought you put into your comments. The waiver documents are published on the department's website, and the labor document contains a summary of all public comments with

OLTL's responses. Within this presentation, which I believe the -- everyone will have access to, we do have a link here for getting to the waiver documents on the DHS website. We also will be sending out a Listserv on the LTS to give everybody a link to the new waiver document. Next slide. So now I'm going to go through some of the service definitions and the changes. A lot of this information is going to be exactly the same as what was presented to the MLTSS advisory group back in August when we went through the proposed changes and talked about everything that was put out for public comment. So a lot of this information will be repeat, but some of it will be new. Next slide. So the way we have this information structured, as we go through each service, we list items under headings if they are proposed and final. It means the final version of the waiver that was approved by CMS is exactly the same as what was proposed and public comment back in July. There won't be any changes to what you've seen before. We also have headings that say proposed but modified.
This means that after we put out our proposed changes, we reviewed stakeholder comments.
We also got input from OLTL staff. In some cases CMS came back to us and asked us to make some changes. They were not going to approve what we were proposing. We'll go through some changes that were modified from what was put out for public comment. So starting with assistive technology, some things that were both proposed and in the final version.
Adding language to support the use of smart home technology.
We added language to exclude items that were primarily for a recreational or diversionary nature. We also added certified assistive technology professional as someone who could conduct the independent evaluation and there's a new provider type of equipment technology and modifications agency that can supply the assistive technology. A few things that were proposed but we did modify them for the final versionversion. We removed language that said assistive technology is for the participant's specific therapeutic purpose and replaced that saying assistive technology is used to ensure the health, welfare, independence or safety of the participant. S in -- next slide. For cognitive resharehabilitation, we did modify

the service description for clarity and what was put out for public comment is public what was in the final version. Some things that were modified. We did remove the requirement for an independent neuropsychological or neurobehavioral cement --
assessment that was proposed and replaced it if someone is seeking cog rehab services they need a treatment plan developed by the provider that has to include the goals, frequency and duration of the service. The plan has to be submitted to the MCO and then the provider would review the participant's goals and submit progress on goals to the MCO at least quarterly. And then finally, there was something that we proposed, but it was not adopted after we looked at the stakeholder comments that came in. We proposed that licensed certification occupational therapy assistants could provide a service. But we removed this from the waiver language. Next slide. For community transition services, we removed that the service coordinator as a provider type, service coordination is now an administrative function of the MCO. We expanded the provider type of independent vendors to include landlords, utility companies and retail establishments. We also went forward with saying the service is intended for individuals moving from an institution or other provider-operated arrangement to a private residence where they are responsible for their own living expenses. So the language you see there in bold is new language. We had some language that was proposed but it was not approved, because CMS indicated we could not include it. We were proposing that if the security deposit also requires payment of the first month's rent, that that would be allowable as an expense under community transition services.
However, we had to remove that language as a request of CMS.
Next slide. Also for community transition services, we listed here side by side the proposed and final approved language, and I think for the purposes of today, I'll just have you focus on the final approved section of this, and I'll summarize what changed. For the description of the service, we substituted the words "CHC MCO case individual providers such as landlords, et cetera," we changed that to the CHC MCO pays individual vendors.
This next change is significant.

It was something that CMS required us to change. We added language to say that the service includes only those nonreoccurring setup expenses incurred during the 180 consecutive days prior to discharge from a facility or hospital or another provider-operated living arrangement to an apartment or home in a private residence where the person is directly responsible for his or her own living expenses. The final approved language, the major difference you'll see here as far as operationally, previously, we had allowed, after somebody had already moved into the community, expenses could continue to be billed to community transition services, but now CMS is saying it's only while somebody is still in the facility before they have moved.
Those are the only time the expenses can be incurred and charged to this service. That is a change that CMS is asking for. Next slide. Okay. Some other changes that were also requested by CMS. And again, I'm going to -- we're showing here on the slide the original language on the left and the right is the approved language.
I'll focus on the right-hand side. What is in bold issa what is actually changing. CMS asked us to state the following are allowable expenses that may be incurred. Instead of saying they're categories of expenses, we need to say the following are allowable expenses, and so only those things that are listed can be included in the service. And then I'll move down to the bullet point that talks about security deposits. This is changing. We are stating that security deposits that are required to obtain or retain a lease on an apartment or home are included. We previously had some language saying security deposits or other such one-time payments and they included: CMS wanted us to remove other such one-time payments. And then the last bullet under the final approved language column, services necessary for the participant's health and safety such as one-time cleaning and allerallergen control are included.
This is slightly different from our original language in the waiver. Next slide. For home adaptations, most of what was proposed in July is what was approved in the final version. The independent evaluation may be supplemented with an assessment by individuals holding certain certifications and two years experience. The certifications are certified environmental access consultant, certified living in place

professional, or someone holding an executive certificate in home modifications. We also removed speech, hearing, and language therapist to conduct the independent evaluation . The contractor must ensure the structure is structurally sound.
Contractors must be conflict free and cannot have a vested interest in the property being modified. We also added some other contractor requirements to ensure compliance with the Americans with Disabilities Act and to ensure that the contractors have experience with accessibility modifications.
Next slide. Okay. Continuing on, there's the both proposed and final. Adaptations will not be approved if the home is in foreclosure, de de delinkuent.
Before going to the waiver.
Wheelchair lifts, star slides and ramps. This is pending CMS approval of the state plan amendment. We proposed to not allow duplicate adaptations for Elevator installation repair or maintenance. This can continue to be covered under the waiver, but it will be considered on a case-by-case basis by the MCOs as they are reviewing these requests. Next slide. Okay.
Again, we're showing proposed compared to the final approved language. In this case, we basically just removed some of the references to community resources such as local fire departments, churches, and civic organizations. The community resources would be considered by the service coordinator or participant depending on what's available in that immediate community. Next slide. For nutritional consultation of the service definition was modified to remove duplicate language.
Also individuals working for a home health agency must be a registered dietician or certified nutrition specialist.
For employment services, vocational rehabilitation counselors may provide career assessment, job coaching and job finding services. For both nutritional consultation and employment, what was proposed was approved in the final version. Next slide. Personal assistance services. Proposed and final. We clarified that PAS workers living in the same residence as the participant cannot be paid to perform household chores unless completed solely to benefit the participant. The intent here was not to have a PAS worker be paid to clean their own living areas or do

their own laundry or those types of tasks for themselves. It should be for the participant not the worker.
Also for PAS, proposed but we modified. We proposed to clarify how and when transportation may be provided by the PAS worker and how the costs associated with transportation are covered. So in the final version, we did remove language that intended to clarify that the rate for agency PAS already includes reimbursement for transportation costs. We realized under CHC, the rates are really appreciated between the MCO and the agency providers, so we decided to remove that language. Next slide. So here again we have a side by side of what was proposed and final approved.
And I will focus on the final approved column. So we stay that PAS may include assistance with the following activities. Necessary to complete activities of daily living. We actually in the final version of the waiver, we flipped these two bullets.
We're starting off and it's really for readability. We're starting off by talking about accompanying the participant into the community for purposes related to PAS. This paragraph did not change as far as the language. We just flipped it to be the first paragraph for readability. And then if you look at that second bullet under final approved. We are clarifying that homemaker tasks that are incidental to delivery of PAS such as changing linens, doing dishes, laundering towels, may be provided and must not be comprised the majority of the service. Previously, instead of using homemaker tasks, we described these as activities that of incidental to the delivery of PAS and realized this was cause something confusion for some of the MCOs and for providers and participantparticipants. So we're clarifying this is for homemaker tasks. Next slide. Some additional changes. And again, I'm going to focus on the final approved language. Again we talk about homemaker tasks are provided only for the participant and not for other household members and only when neither the participant nor anyone else in The House hold, relative, or informal caregiver is available, willing, and able to perform such activities for the participant, and where no other community/volunteer agency or third-party payer is capable or responsible for their provision. This change came as a result of comments from stakeholders and from the MCOs

on a need to clarify this section of the PAS service definition. Next slide. Okay.
So for participant-directed services, community supports, we did align the service definition with the personal assistance services definitions, since the services are similar, and so the language that we just reviewed previously on the PAS slides will also be applied to participateparticipant-directed goods and services. The provider type is expanded to include individual vendors, businesses, and independent contractors. Next slide. For personal emergency response system services, the proposed and final were exactly the same.
We updated the service description to include newer technology. We defined what constitutes a UNT unit of sift which is a one-time installation fee or monthly monitoring fee.
We also clarified allowable costs under this service. To include the cost of training participants, the maximum units per calendar year shall be one installation fee or 12 months of service. Also that the provider may not charge any additional costs over and above installation and monitor. Next slide. For therapies and counseling services, again, proposed and final were exactly the same. The following services are provided at a 1 to 1 ratio. Behavior therapy, cog rehab, occupational therapy, physical therapy, and speech and language therapy. Also counseling services do not include group counseling for more than one participant. For specialized medical equipment and supplies, we added that a certified assistive technology official may complete an assessment as necessary. For vehicle modifications, we added they must be obtained in the least expensive, most cost-effective manner. Also the breakdown of the purchase price of a vehicle versus the cost of the adaptation is provided by a vehicle modifications contractor. Okay. A couple of other changes that were made.
In appendix E, we amended the responsibilities of the fiscal employer agent by removing the requirement for support broker.
This is because the support broker duties are performed by either the FEA, currently PPL, or the service coordinator. So there was not a need to include this service in the waiver any longer. For performance measures, we did remove the UT reach and education vendor performance measures

because CHC is now fully implemented and it was only for the implementation phases. We also added a performance measure for participant preventive care visits.
Finally, we had a suggestion to add support service providers to the waiver. However, after reviewing discussion, we decided not to adopt the suggestion.
That's because under the CHC agreement, the MCOs are already required to provide supportive services to everyone at CHC or anyone who is Deaf-blind regardless of whether or not the person is enrolled in the waiver. Also in further discussions with the MCOs, we have learned that they do in fact contract for these services either through a PAS provider or another individual or agency to obtain the services. So this is already occurring, and there was no need to add it to the waiver.
Next slide. Okay. So just a final comment before I take any questions. Obviously, this was -- the waiver was just approved and we're kind of at the first step of implementing some of these changes. We're presenting the information today. We have a plan to --
OLTL has a plan to set up a technical assistance program with the MCOs to go more in-depth through these changes, and then from there, the MCOs would be sharing the changes with the service coordinators and communicating any needed changes to providers in order for all of this to be implemented. So although everything is technically approved as of January 1, it will take some time to actually implement these changes before you see them play out within service plans. So do we have any questions on what was just presented?
>> Any questions from the committee members for Patty? I received a few that I can ask.
Okay. I will go ahead. So from Janelle Gleason related to the changes in participant-directed goods and services to include individual vendors, businesses and independent contractors, will this allow room for companies other PPL to serve as the fiscal agent for participant-directed care workers?
>> No. That's a good question.
But no, it would not. It does not apply specifically for the functions that PPL does in terms of enrolling workers, doing the background checks, processing payroll for participant employers. None of that is impacted by this change. This

refers to the purchase of goods and services where the actual item is being purchased. And so this allows say an actual store like a Walmart or actual store where an item is being purchased for those items to be purchased directly from those regular retailers. So that's the change that was made.

>> Okay. And the next question is from Ann. Is the first month's rent still allowable?

She's not seeing it.

>> So the guidance that CMS gave us when we sent in our proposed changes was that only the security deposit is allowable under community transition services. So that's the only thing, just the security deposit that's allowed.

>> Okay. And then from Kate, does it mean that PAS caregivers who live the at same residence will need additional education on plan of care?

>> It would -- yes, it may --

that may occur depending on what the current PAS workers are doing in the scope of the service plan. So likely, what would happen is as service coordinators are educated about the changes, and they review a participant's service plan, they might look at what activities a PAS worker is doing within the home and then would include in the service plan only the activities that the homemaker tasks that are being performed on the part of the participant.

It would all occur through the approval of the service plan.

>> Okay. And then I think there's several variations on this, Patty, and then we probably are going it need to move on. But I think folks wanted to understand a little bit more about SSP and that the CHC MCO should already be providinglyprovidingly this.

>> Uh-huh. Yes. I mean, the CHC agreement requires the MCOs to provide not only any type of communication or supportive service that the participant requires. So someone who is Deaf-blind and what the SSP serviceservices. It actually allows the person to interact, the participants to interact with their environment, and this is something that the MCOs would be required to provide as part of the CHC agreement already.

>> Okay. Great. Well, there are some additional questions, but I know we also have a presentation from MCO. Jamie, Linda, we want to go ahead and move through those presentations.

>> I think that's a good idea.

>> Yep. Sounds good.

>> Okay. So Jen, I guess you are up first.

>> Okay, great. Thank you, Pat.

Can you hear me?

>> Yes.

>> Okay. So we want to advance the slide, should I just say next slide, please? Does that work?

>> Works for me.

>> That would be great.

>> Okay.

[Laughter]

This is the limits of Zoom.

Okay. Today I'm going to talk to you about our approach and way of managing telephonic assessments in light of COVID.

So prepandemic, comprehensive needs assessments were completed face-to-face with participants and the members of their person-centered planning team, usually in their home or a place in the community. Generally, as I said, the assessments were completed in their home that allowed the coordinator to observe the participants and their environment. So post pandemic or in pandemic times when we are working telephonically as a measure of safety, it's important to note that the assessing tools which are person-centered plan plan development and engagement with the person-centered planning team can be successfully completed telephonically because we have trained them to ask questions that prompt discussion to gain a full color picture of what the participants wants and needs are. Next slide please.

The service coordinator process for following and conducting outreach is as follows: So our telephonic outreach to the participants or their legal guardian is schedule the assessment include offering a face-to-face visit, but if we're deferring face-to-face visits until a later date, nothing happens at this time. Services remain as authorized. If the participant chooses to have a telephonic assessment, one is scheduled at a time and date convenient for the clients and the members of the person-centered planning team.

It takes a considerable amount of time when in person or conducting it telephonically.

Service to that end, service coordinators inform the participants of the assessment process, how long it takes, who can be involved and if using Zoom is a possibility for the participant. Next slide. So the goal of the telephonic assessment is for the service coordinator to understand the whole color picture of what is needed for the participants' independence. SooFRS coordinators are conducting telephonic assessments successfully by using motivational interviewing techniques such as asking open-ended questions, using affirmations, using reflective listening skills and summarizing what they're hearing so we're not losing folks along the process. We are also differentiating needs versus wants and goal planning accordingly. So service coordinators are discussing met and unmet needs with the participants and the folks of theirs Chooing who are also present on the call or on the conference. We're asking questions about the participant's daily routine.

We're explaining community HealthChoices and the benefits and discussing and exploring community resources that are available and applicable, we're coordinating with the DSNP and behavior at health providers to make sure we're looking at whole-person care. Next slide.

So the telephonic coordinator, the service coordinator is the assessment meeting facilitator.

They're in charge of making sure that the assessment is thorough, the questions are answered, and that they're not losing a participant or anyone else on the call along the way. So we encourage folks, if it's okay with the participant to use speaker phone on Zoom conference line so everyone who wants to be included is at the meeting. The service coordinator sets the meeting agenda, completes the inter-RAI comprehensive needs assessment. They're asking the questions over the phone and explaining the LTSS benefits available in CHC. So service coordinators also responsible for developing or updating a person-centered service plan, which is inclusive of goal setting of and having discussions about goal progress.

Coordinators complete the personal services and supports tool to help them understand the daily routines and needs for hands-on help with activities for daily living. They're responsible for updating authorizations and providing choice of service providers. We want service coordinators to answer all questions and we have a tool that has a visit

checklist to make sure all talktalking checkpoints have been covered and all next steps are explained and our LTSS review process. Next slide, please.
So post assessment. The service coordinators are also responsible for monitoring and managing. What is working and what is not working. Nothing is set in stone. We're looking at trigger events and reminding participants what the definition of a trigger event is, we're looking at service utilization, missed shifts information, care gap information, and I spoke to it earlier, administration from discharge and the agency, and what the data tells us about the participant and then prompts them to another assessment to try to make sure there aren't any unmet needs. I think that's it. Next slide. So I don't know if you want to handle questions now or at the end, Pat. But hoping that of the clear and concise for the audience. Thank you.
>> Thanks. I don't have any questions. So at this point I don't know if any committee members have any questions for Jen.
>> Jen, thank you for your complete description. Can you identify for me what a trigger event means. They have certain meaning in behavior ag --
behavioral health.
>> Sure. You're testing me. Is that Lloyd speaking?
>> I'm sorry. That is Lloyd.
>> No. It's okay. We take that straight from the CHC agreement.
So changing condition, unplanned hospitalization, change in environment or caregiver, or at a participant's request or a cave giver -- caregiver missed five days or longer. That's off the top of my head. I think I covered everything. There are six elements that make up the trigger event definition. I don't know, Pat, did I get them all?
>> Yeah. I think you have them, Jen.
>> Okay. I hope that's helpful.
>> It is. Thank you. They're pretty major events. Thank you.
>> Okay. Any other questions for Jen? Okay. Then I believe we are for PHW, I believe we were going to have Marcus, were you going to be covering this?
>> Yes. That will be me.
>> Okay.
>> All right. Thank you. So thanks, everybody, happy new year. I appreciate you letting me come speak for a little bit.

I know we're running behind, so in the interest of time, I will try to just hit some of the key points that highlight that Jen may not have covered. I know we have a lot of similarities in our process. We can jump into the slides. All right. So at this point, all participants receiving any type of HCBS, LTS services have to go through a comprehensive needs assessment is and have a person-centered service plan. In accordance with the CHC agreement, all the service coordinators required to performa that comprehensive needs assessment with each participant at least once a year and identify any trigger event.
During the pandemic, we shifted our works and assessments towards telephonic assessment.
It's due in part to ensure the safety of all of over members and the entire population and service coordinators that are regularly in the field interacting. So we can go to the next slide. So our service coordinate has been trained on motivational interviews on techniques. This helps you more effectively gather during the
assessment. We work to gather the participant from all of our assessments and any other members of the person-centered team and we're able to relay some of the information from some of the alternative services like path provider notes that may come through on the HHH exchange and even some of the items on the home delivery of meals to the residents. That point, we definitely encourage a participant to have a person-centered to participate in the assessment process. That can help serve as Yves of placement and sort of a mouthpiece for the participant as needed to help get different points across and discuss things that may have been missed during the assessment process. So if that helps us to make our decisions. A I also wanted to pause the point of the circumstances that service coordinators working with PAS relationships that predate the pandemic and the predate the assessment of the telephonic assessment. This made the transition to telephonic assessments are slightly smoother because they lot of the SCs had already met face-to-face with the participant and had been able to serve prior to.
Next slide. So essentially our service coordinators contact the participants and we ask if they would refer to do the assessment in person or telephonically. We treat everybody

on a case-by-case basis. The person-centered plan means they are participating and as identified by the participant, it should and can be available for the participants regardless of what the assessment is conducted in person or on the telephone. So I think one of the great things about having a person-centered team in place to support the participant during the process is that additional set of eyes and ears in the home that can provide feedback regarding the environment. As you know, our PCSB is a tech niche and has a lot of.
Anything for preferences and goals and needs and more importantly, a backup plan, an emergency plan. That's been important during the pandemic.
Sometimes a PAS workers may not be able to make it out or a situation occurs that someone experiencesexperiences an exposure to COVID. That's important that a backup plan is in place if at all possible. So go to the next one. So inter.
Are -- RAI is a point in time assessment that doesn't require any physical contact. You assess for cognitive function, communication, behavioral issue, psychosocial issues, it captures a lot of the social determinants of health involved with mental health like depression, loneliness and takes into account in conjunction with the PCSP language and culture. They arrive at of PCSP. That helps with the provision. It helps and you capture more details so you can make the best decisions possible for what participants actually need. All right. And that would be the end of over slide show. I appreciate the time.
>> Okay. And then that leaves us with UPMC. Mike are you covering this?
>> Yes, I am and happy new year to everybody. Can you hear me?
>> Yes, we can.
>> Terrific. So next slide, please. So we're covering a lot of the same ground as the other 2MCOs covered here. The person-centered process includes a comprehensive assessment in the person-centered plan. And so we want to make sure that we're covering all the needed areas, get to know somebody and get that complete picture of their needs and their circumstances when we're conducting the assessments.
Next slide, please. So I think that we want to just emphasize here that, you know, we have some standardized training in

place, when it comes to the person-centered planning process, and part of that training is really emphasizing the need for person-centered planning team participation if at all possible, and we're placing a lot of emphasis on that through correspondence and team meetings and supervisory meetings with staff to try to get as much person -- many folks from the PCPT team, person-centered planning team involved in the discussions. So that we have their input in the information as part of the overall team. Obviously, the person themselves is the focus, but when we're doing a telephonic assessment, we try to make sure that we're including them. We really want to do a lot of work in our training. In strengths base, assessment, and care plan and service planning.
We want to get their hobbies and interests, what their behavioral, you know F they have behavioral health needs and that type of thing. We really focus a lot on that. Regardless of whether it's telephonic or face-to-face. Next slide, please. So the other two plans, we're using motivational interviewing and wanted to highlight our training here in the secondary one, you know, besides having a balance in motivational interviewing is a guided style of communication.
We want a balance between listening and providing information and advice so you can get an informed discussion with the participant which is critical. You can do that by phone or in person. All of our staff had mental health first aid training and in this time of COVID we want to identify and understand the needs of participants from the standpoint of some may be experiencing social isolation and that type of thing and make sure that we're addressing their behavioral health needs as we discussed earlier for participant but more so in this environment, we want to make sure we emphasize we do have this training and it's important to us and part of the assessment process but also just getting to know someone. Next slide, please. By the way of review, you know, typically, an assessment is conducted face-to-face. In this COVID period, pandemic period, we need to have some way to prioritize participant and coordinator safety, so telephonic assessments are a good opportunity to do that. We basically -- I also want to mention as Marcus said, we know a lot of these folks. We've been in their homes. We've met them prior to the

pandemic. But there are new participants that are coming in, and so we certainly take that into consideration and you know, we're looking at assessments, we want to look at change over time. That's one of the beauties of the inter-RAI assessment to see what's happening based on the assessment. We're looking for those changes in our documentation and making sure that we consider feedback from the participant. Again, whether it's telephonic or in person.

Those are some of the considerings we have made during the assessment. I want to spend a little bit of time on this slide. It really, we -- there's a lot of prep work. If you've ever painted a room or anything like that, some of the most important things that you do are sort of sanding and spackling and getting the room ready for the paint. So you know, preparing for assessments is really critical. You want to be looking at all those information services that Jen already mentioned. Prior assessments and that type of thing. But in this environment, we also want to emphasize and have been trying to, we have -- in the last month, we conducted over 220 video visits through our health information system. I'm going to get into more detail on that going forward. When you're doing -- scheduling these assessments, we want to make sure that you have the opportunity to the PCP team, and available, whether they have to be conferenced in through a conference call, if they really want an in-person assessment and we're in a high-COVID area, you might have a deferred telephonic assessment and until you can get into the home and do that.

Specifically, whenever you do a telephonic visit or particularly a video visit, you want to ask permission of the participant and make sure that you're just -- the participant understands what is going on in terms of how to use the technology and highlight potential considerations around, you know, whether they're using a computer or a tablet, and you know, sharing video or just sound. So sort of like these calls, you have -- we want to make sure that everybody can engage and be part of the discussion. It's always good to have, you know, the numbers of the team -- members of the team visiting as well. If they can't, we sometimes work with a participant and their team to get things ready too, prior to the actual call. If we're scheduling

a visit are their medications? Can you have them available with us? Medicare benefits but it's fee for service or something like that we want to know those things and discuss them when we get together. And you know, so this slide, you know, really the prep for the meeting is very important. We're going to talk a little bit about video visits, but in-person visits, you know, we have the ability to take a look at the environment they're in and do some observations this are a little bit more difficult when you're conducting these telephonically. But you have descriptors and individuals describe their environment and their experiencing and their visual verbal picture, and then, obviously, you're going to work with them on the PCSP developmental we covered earlier. Next slide, please.
That will be interesting for us to get some general telephonic visit notes in here. What we see is assessments, you know, it gives us an opportunity to do assessments without an increased risk for anybody. That's an opportunity that these visits get. Visits will take a little longer. We were surprised by this. I guess we shouldn't have been. But sometimes folks cannot stay on the phone for the entire time and you need to have a secondary call to follow up.
And these calls, scheduling them sometimes can take time. Some folks pick up the phone and want to do it right then that can create scheduling issues on the other side of the equation. And as I said, they're conducted over several calls, and you know, individual information is self-reported and not quite as easy to verify things. We work with them to listen closely to the descriptors and what's going on. Next slide, please. So we wanted to talk about in-person visits and virtual visits. In COVID-19, during COVID-19, we use -- we try to conduct most of our visits telephonically. This is really the discussion of the telephonic assessment but we're doing that anyways. When we're in the home, we're focusing on things we want to verify visually and we're going to do that through conversation, if we're not able to do that, but we just thought it would be helpful for to you see how they conduct their visits when they do it. We provide social distancing and platform. We provide the equipment and keep on our contact very limited in the home. We wear masks obviously and distance. In a virtual visit, visits allows us a similar factors to be SFSH observed, things we're

looking at when going in person. We always emphasize and review with a participant that the information, the video is not being captured. We want to make sure that people feel comfortable talking to us with using this technology, and you know, so that's a big part of making sure that the virtual visits goes smoothly. Next slide, please. As I mentioned earlier, we have been piloting for the past month the use of video visits. We attempted 266 visits this past December, and we conducted 226 visits. We have gotten some feedback that we'll share with you and allows us to have a visual cue with the person we're learning. There's unspoken communications and cues and facial expressions that obviously can be more difficult to discern. So there's more communication again, longer telephone calls with participantparticipants as a result of that. Next slide, please. So using -- Helios and virtual visits, we can always conduct those and what's really nice about our virtual visits is we don't have to worry about unexpected things coming up. We don't have to travel distance.
There's scheduling constraints that occur when you're doing a face-to-face visit, and rescheduling can be more difficult. There are a lot of benefits to learning more about how we do better virtual visits.
Just to be clear, while this was a pilot, we have other means of doing virtual visits through our teams program. But what's really nice about the virtual visits within our system are that they can be conducted through just sending a next --
text link to somebody or through an e-mail and they click on the link. They don't have to have any software on their end of the discussion to interact with us.
So next slide, please. So this is some of the feedback from our own staff and from the participants that we work with. And you know, it's nice to see facial expressions. They feel more engaged when we have the virtual visits through our system so you know, in one case, I was able to see that we had, by using the virtual visit they had a standard stool in the shower or if there was a shower chair. Things like that and you have to explore more time in the phone without the video capability. So that's the end of our presentation as well.
Thanks for letting us share.
>> Okay. Thanks, Mike. Are there any questions from

committee members? No? And I don't have any questions on this topic from the audience. But I have a lunch of MCO questions and follow-up questions.
>> Okay. That sounds good.
>> I will start with -- IEMin' I'm going to do some specific to the MCO and there's some COVID questions and also some that are related to specifically to the MCOs and the COVID arena.
So we'll skip those. I think the first one is from Donnell Simon. I'm from Vermont with wellness health services agency, and this will be specific to UPMC and PA health and wellness.
The will they accept new providers in 2021? I guess an alet's start with PHW first.
>> At this time PA health and wellness closed its network for PAS providers. In order to assess our network and with, I believe, at this point, we're seeing around 1,100 providers in the network. We will be examining our network in the coming months, but today if someone were to call, we would be told by our call centers that our network is closed for home care providers. Okay. Thank you. Then for UPMC, I don't see Andrea who would normally answer that. Mike or is there someone else from UPMC?
>> I don't know if Andrea is on here. She said she's muted.
>> Yeah. She may be one of the -- like about --
>> Now we can hear you, Andrea.
>> I'm sorry recollect you guys.
I was muted on your end. You know, I'll follow along with what was just said. We do review every request for new providers. It's not automatic.
No, and you know, we don't necessarily use the term that our network is closed. However, at this point, we do feel we have an adequate and sufficient network. But if requests are received, we do review them on various levels where they are located, who are they covering, things like that line. So I do agree at this point we're not really bringing in new home care providers until we work through the review of our current providers and determine our adequacy, our quality programs and things along that line.
>> Okay. Thank you. Jen, this next one is for you. Service coordinators do not work directly with Amerihealth make updates on optimizations. We generally hear from them and this is not. This is from Janice minor.

>> Hi, Janice. Thanks for the question. Absolutely. Whether employed by Amerihealth, your role is the same as a service coordinator and you can and should service responsibility make up these two authorizations. If that's something you're hearing that's not aligning with what you just shared, Pat, I'll put my e-mail in the chat and I need to know what's going on. That's not our current model. All service coordinators, whether internal or external should be making updates to participants. The participant has to be on the caseload assigned to the service coordinator. So if I were --
let's say, and you were on my caseload last month but you aren't today, that's a correct statement. The service coordinator who is no longer assigned to the participant cannot make preauthorizations.
It would have to be done by the currently assigned service coordinator. I'd like to trouble shoot this with you. If you can, please e-mail me.
>> Okay. Thanks, Jen. And then the next question, I think, we talk about this at the last couple of meetings where the providers have expressed concerns that they're facing and challenges they're facing with authorizations, and this is from Alexandra Kostinich. Providers are still having huge problems with authorizations. The units are not calculated correctly.
Often are not updated on time, et cetera. Sometimes it's taking 6 to 9 months to receive Ops for services. I know when we talked about this at the last meeting, I believe, the plan mentioned that you were trying to work through some of those types of corrections. If you can give updates on how things are progressing with HHA, to improve the accuracy of the authorizations and Mike, we'll start with you this time.
>> Start with just saying if you have specific information on -
-
we never want to see an authorization sit out there for even a day or two. So having something out there 6 to 9 months is very troubling. So if you have those kind of activities or that kind of issue, you should definitely be talking to, you know, our team, and I can -- again, give you my direct e-mail so that SmithMRS if we're not getting the assistance you need through other approaches. But no. We did have a short time, we had some issues with total number of units

calculating in some of our plans. So we did some retraining of our staff. So you should not be seeing those issues -- I think it was particularly happening in the COC area, and we addressed that through retraining of our staff on how to build the authorizations in the system.
We have a relatively new system.
And you know, again, if you have authorizations that are delayed, you can work through our member services line and/or through our service coordination offices and service coordinators to get those updated. You really shouldn't have that occurring too much from the UPMCed is.
You alms have a proceeder network, and Andrea, correct me if I'm wrong, you have a network Representative that can also backchannel the SC side of things and talk to us on your behalf and work with us to get those things straightened out.
You have a lot of different methods to go through either HHA, talk to your Representative there, work with our service coordinators and offices so there's some avenues there. So that's it for me.
>> Okay. Thanks. Anna, how about for PHW?
>> Yeah. I would agree with what Mike said. There really shouldn't be a lot of issues, but if there are, I would encourage the provider to contact their provider relations rep that they have through PA health and wellness. If they don't know who that is, they can call our correct direct service number, and I can put that in the chat. And they can track down the call center team. It's pretty skilled in tracking down what might be occurring with that authorization. So we're not seeing a lot of escalations in that area. Granted, everyone is human, so please make the call, and I'll put my e-mail in the chat as well if you want to reach out to me.
>> Okay. Great. And Jen.
>> Thanks, Pat. My answer doesn't vary very much from What Mike and Anna have already shared. We know the impact of this. And things are never perfect. I believe we have established and have the installation line. I can share that again in the chat. We have the service coordinator's information available and the exchange that was a provider request and recommendation and enhance put into the cyst them 2020. For us, the service coordinator is the person that needs to be contacted to answer any authorization questions.

And I think Mike also shared that the provider network team worked closely with the service coordination team and relight any issues that might be provided by the community. Opening the lines ever communication and using them, and providing us with feedback is helpful. So I know that we have talked about this at many meetings and probably will continue to. The provider community providing us with feedback and working with provider network for any kind of misunderstandings on how authorizations work or the process that this plans, we can make some progress on reducing the amount of issues in the 2021.
>> Okay. Great. So to make sure that we have time, because we have a number of COVID questions related to the vaccine strategy and other interests, so I think I know David Johnson had a question. That's also one we had a couple of audience members asked. David, do you want to go ahead and ask the MCOs?
>> Sure. Thank you. This is a follow-up to the answers Jamie had provided earlier. I'm wondering how -- and I recognize that OLTL and the managed care plans are speaking about, this but how are the CHC MCOs preparing service coordinators that are better serving residents and long of had term centers on things like vaccination education and availability and encouragement and any type of follow-up? And do the managed care plans have any requirements for these service coordinators regarding the vaccine?
>> Great, thanks, David. I'm going to make it broader ask and ask them to cover it in the three populations. What's your education plan for nursing facility residents? What's your education plan for home and community-based participants?
And then also for the NFI dual.
Jen, I think you're up first this time.
>> Thanks, Pat. It's a great question and one we are discussing. The best thing I can tell you right now is there are many people at the plan working closely with OLTL, and understanding the vaccine distribution and education that comes along with it. Of course, we train and educate our service coordinators based on CDC guidance and the guidance coming out of the Department of Health.
We want them updated with an FAQ so they feel confident asking questions whether they're from nursing home based participants or we have lots of ways of reaches of

memberships to communicate with them vaccine information and comes down to the logistics of getting to and from an appointment. If those are brass tacks that Habs we get closer to rolling out the vaccine to nonhealthcare workers, it's important information for all of them to be outfitted with to disseminate that information to participant to get in line for the vaccine and also talking about tracking and data collection and access to the data that the state is keeping on vaccine recipients and that's important for health plans to have as well. So it's critical priority right now, but for us, at Amerihealth and keystone, we're working closely to make sure we're a good relay, reliable, resource for participants to have their questions answered about vaccination. So thank you.
>> Thanks, Jen. Anna, how about for PHW?
>> I think Jen did a beautiful job with that explanation. We're doing very much the same thing.
We have a team that is monitoring CDC guidelines and what Pennsylvania is doing and looking for guidance from OLTL and looking at all products and all populations we support and how we'll be coordinating that with our nursing team. It's a huge undertaking to monitoring this and how we're doing this with our transportation team and the call center staff, educating our service coordinators, just as pieces will allow, Jamie said it earlier. It's fluid. Things are fluid. We're gETZing more and more information every day.
As soon as we get closer to wider distribution, we'll be able to share more information.
Okay. Mike, how about for UPMC?
>> Yeah. Similar to the other two, but a few points, I think, that Jamie mentioned that CDS are managing. We're just working with the service departments there and we're working with them in terms of understanding who is getting the vaccinations and that type of thing. We certainly are with the home and community-based side of the equation. We provided FAQs to our staff. And with nursing facilities as well.
FAQs to be discussed about what we're seeing in terms of the vaccination, our understanding of its impact and that type of thing. Also we have taken the opportunity to sort of create questions, FAQ development, questions and answers forum.
UPMC. So we're gathering questions from participants.

Questions we'll share with UMPC and OLTL and the example is can I require my staff to have a vaccination.
That's a good question. I don't have a perfect answer for that right now. Personal, if you're in PPO, you might be able to do that. It's interesting to be --
going to be an interesting decision tree that goes there, and we'll need guidance from other parties besides our own self. In terms of the clinical aspect of it, we have a lot of resources at UPMC we're focusing on making sure our website is completely up-to-date. We use that as a resource for our service coordinators in communicating with participants and facilities and others. So that's generally what we're doing.
>> Okay. Thanks, Mike. I think some of the next group may be a combination of the MTOs and Jamie. So from Pam, how will Walgreens, CVS explain [not audible] and others who don't speak one of the languages that is written, info that has been translated?
>> So Pat, this is Jamie. We can reach out to the Department of Health and, you know, I haven't been involved in the conversations with the federal pharmacy partnership program, but I know the Department of Health has, and staff from our Department of Human Services.
I'm sure they have asked this question and gotten this response. Let me see if I can reach out to them and get a response about how they're handling that.
>> Okay. Great. And then from Jeff Yzerman, ideaing those receiving COVID-19 vaccines, do those in the settings including consumers in non-Medicaid waiver program including act 150, nonwaiver attendant care and options that would include aging, what about consumers and care give evidence that receive or do PRIEFTZ home care and then just a comment that some of those populations are more at risk of going into a nursing home and providing the vaccine option up front may improve overall public health and costs for everyone in the mall. I think it's a broader question of where do the non -- which I think goes back to a little bit of the individuals who would be considered goals are not in CHC and where they gIT into the vaccination strategy.
[Fit]
>> I was just reading the vaccination strategy again. The population that is mentioned in the group 1B that has high

risk conditions is the Office of Long Term Living home and community-based services. So that would include the act 150 population. That would be for the participants themselves. I think that was part of Jeff's question. It's not saying that the 1B group is only the CHC participants. It's saying Office of Long Term Living and home and community-based services.
>> Okay.
>> I think she was also talking about the informal health-care providers? And so what I would stress to people is they should read the definitions that are in the interim vaccination plan for that health care personnel for phase 1A, and you know, make a determination if they fall under that definition. It's hard to know more about what they're providing if they are a health care personnel or not.
>> Okay. And Jamie, is that actually in the interim vaccination plan?
>> Yes. The definition of health care personnel that would be vac vaccinated in phase one is on page 11.
>> Okay. Great. So I just sent that link out to everyone, because I know we did have a couple of people asking where some of these things could be found. I think that answers that. The next question is from misty deon. What efforts have OCL and the and the OLTL protect people [not audible] and.
[Reading the question]
How is the department working to the home modification process to keep people in their own homes?
It's two questions. One is have the MCOs and has OTLT increased efforts to do nursing home diversion number one and the second question is what's being done to improve the timeliness of home modifications. Jamie, I don't know if you want to speak to it first or have the MCOs speak to it first.
>> So you know, I will just say they know we've had a lot of conversations regarding nursing home diversion at this point in time. And you know, we have actually talked to a lot of HPTZs where hospitals where normally they would discharge patients and the person doesn't want to go to a nursing facility at this point in time because of COVID. So we have worked to try and put services in place along with the CHC MCOs to serve that person in their home, because it is a person's choice as to whether where they want to be

served and receiving their services. Part of that deals with getting people eligible for waiver services quickly, and so you know, we continue, obviously, to work on and improve our enrollment times for enrolling people into waiver services or CHC home and community-based services. I just looked at the most recent statistics that we have for the time period it's taking for a person to be enrolled in, you know, in the waiver services, and it continues to improve, which I'm really happy to see.
I know that on a case-by-case basis, we are called upon to expedite those. And so, the office of long-term living works to do that in case where is we know about those.
>> Okay. And I guess we'll turn to the MCOs. I know Mike Grier also posted a question about is there nursing home transition outreach education occurring during the pandemic. So the MCOs, if you can speak to --
have you enhanced any of your efforts around diversion as a result of COVID and nursing and outreach program. An aa, you are up first.
>> I can add something regarding nursing home transition and outreach and education? So it is the Office of Long Term Living did submit a proposal for a nursing home education and outreach program, and we submit aid proposal to CMS so it would be funded 100% by the money follows the person program. I think it's currently beingested.
-- being evaluated. We recognize the need to do this.
We'll probably start doing this once vaccinations are done in long term care facilities.
Obviously, we want this outreach and education program to be in person, and so you know, having additional people go into nursing facilities, we want to be able to do it at a safe time.
I wanted to add that is one of the things that the Office of Long Term Living is working on.
>> Okay. Thank you. So Anna.
>> Thank you, Pat. I would say that our momentum on helping individuals who are wanting to move out of nursing facilities hasn't changed at all during the pandemic. If not, it's probably escalated. I'm seeing regular reports of individuals coming out long lists of names of folks that are being transitioned, and although I can't really provide a lot of detail. That would be Jennifer and I think she could probably provide that in the nursing facility subcommittee

that's held after MLTS meetings.
From what we're seeing, there's no stoppage of folks that want to move out of the facilities.
Our teams are working with them, and we're doing everything we can for those who want to move to get them out as soon as possible as well as risks that might be in place and we monitor that to make sure they are safe so when coming out, they don't go back to the nursing facility.
To misty's question, we continue to move as quickly as we can, and then the education around nursing facility transitions continues to be something that service coordinators discuss with participants as much as they can, given our current time is a little more difficult to have those conversations since they can't get into the facilities.
We're doing a lot of work there and not seeing our numbers declining. We have hit some really good numbers this PAFTZ year on transitions despite the pandemic.
>> Thanks, Anna. Mike for UPMC.
>> Yeah. I think Anna covered a lot of the same ground. I would go back to the earlier question about hospital and nursing facility, you know, that hand-off, I think, we also saw during this time period that we continue to see a lot of folks are flowing through or going directly home from hospitalizations. And a higher level than maybe in the past. And I think that's, you know, it could be the result of some of that additional coordination.
But we're also using heavily the -- we finally sort of cracked the code on using the MDS data that the state provides us. We started using that really heavily over the summer and analyzing it and looking for opportunities to transition. More folks, just as a by waff I I -- way of background, the money follows the person, you have a wide net and talking to everybody about transition, but also understanding the needs are when they go to their community.
Talking to more folks is the way you get more folks through the process. And certainly we're trying to do that effectively even despite the fact we have limited access to telephone calls and technology-based visits that type of thing are all used to the best effect possible. It doesn't seem to have slowed things down. We actually have, like an awe have transitioned more people this year than ever. I think we also saw people just sort of going through the from the hospital to the home and hospital to the skilled nursing and back

home at a higher level. So they didn't necessarily hit the transition process. One other thing I mentioned is we want to see the transition to care team, you know, when they're in the hospital engaging in sort of nursing home transition at that level, and we work to expedite that kind of approach as well.
We're learning more and more about how we're going -- we can do that more effectively in this environment. Thanks.
>> Okay. Thanks, Mike. And Jen.
>> So Pat, in the interest of time, I don't have much to add beyond what's already been discussed by Anna and Mike.
>> Okay. Great. So we are at 1:01, so Linda and Luba, I'll turn it back over to you. I guess before I do that, shisay we do have a number of unanswered questions that will go to OLTL for follow-up. So we apologize for not getting through all of them.
>> Thank you for mentioning that. That was going to be my next question to make sure that everyone that submitted a question had the opportunity to get an answer. So at this point, we will consider the meeting adjourned. Thank you, everyone. And really appreciate all the new participants that we had on the line and also new members on the committee.
Really wanted to provide you a warm welcome and thank you for joining us.
>> Thank you.