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Date: 9/2/2020

Event: Managed Long-Term Services and Supports Meeting

- >> **CAPTIONER:** Hello [standing by]

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*.**>> Barb:** I will give it one more minutes. I just saw Blair come on too. At least with him we have a quorum if we need anything to happen. I'm going to start and take a roll call. Good morning, everyone. Happy we. Welcome to our September MLTSS meeting. Everyone please mute your phones. We are going to take roll call. When I call your name acknowledge if you are on the line. Blair?

>> Hi, this is Blair, can you hear me?

>> Barb: Yes, I can good morning Neil.

>> Good morning, happy September.

>> Barb: David?

>> Good morning, Barb, this is David.

>> Denise.

>> Denise is on the call.

>> Barb: Monica sitting in for Drew.

>> I am here.

>> Barg: Gail?

>> Good morning.

>> Barb: Hamon?

>>

>> Good morning, Jessie?

>> Juanitta?

>> Good morning.

>> Barb: Good morning. Linda you are on.

>> Matt?

>> Matt: I'm here.

>> Barb: Mark?

>> Mike?

>> Mike: Good morning, Barb. I'm here.

>> Barb: Rich Farr? Richard? Richard Wellins?

>> Sister Catherine?

>> Steve

>> Steve: I am here.

>> Barb: Good morning. Tanya?

>> Terry?

>> William?

>> William: Yes, good morning, everyone.

>> Barb: Good morning. Thank you. I will quickly go through some housekeeping rules. Please keep --

>> Jesse: This is Jesse: I just joined a minute late. I don't know if you were taking attendance I am here.

>> Barb: Please keep this language professional this is webinar with remote streaming and all for the committee members and presenters will be in listen only mode during the webinar. While committee members and presenters will be able to speak during the webinar we ask that you please mute your phone when not speaking. This helps to minimize the background noise and improve the sound quality of the webinar. We are asking participants to please submit your questions

and comments in the chat box located in the gotowebinar pop up window tonight. Enter a question or comment type into the text box under questions and press send.

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Public comments are taken apt the end of each presentation instead of during the presentation. We always allow an additional 15 minute period at the end for any additional public comments. Our 2020 meet willing days are available on the website with that I will turn it over to Jamie Buchenauer who will present us with the OLTL updates.

>> Jamie: Good morning, lap I Wednesday. I really enjoy the rain m that I don't have to water my flowers and other plants outside. After 3 days of rain I am looking forward to the sun again. Thank you for having me. I will present the OLTL and I will turn it over to Randy who will present information that I know the submac has been looking forward to. Then we will be turning it over to Abby who will give an update and presentation on the OLTL data Dash. We are excited to share that with you. With that we will get started.

I'm going to start with on the agenda with the COVID updates for the group and Abby will give the OLTL data DASH overview which we are excited to present. The COVID-19 updates. Many of you will remember we are talking about the act 24 -- on or around July 1 the Office of Long Term Living send out the fund to go providers who were enrolled in the medical assistance program. Many got their CARES act funding July 1, July 15 or late July at the very latest. The remaining groups of providers, long term living providers who need to receive their CARES act funding contributions are our personal care home and assisted living providers.

The act 24 appropriated $50 million for the personal care home and assisted living providers, $45 million was to be distributed based on the occupancy and $5 million was to be distributed based on the number of SSI residents in these facilities. So because we needed some information from personal care homes and assisted living providers, they had to submit a facility sub deadty payment form to the Office of Long Term Living. Many did submit this to an E-mail box as requested and our office of long term staff are busy processing these forms and inputting the information into our systems in order to make the payment.

I would just ask that for a little patience here. We know that we have over 1300 providers who are trying to get paid in this way. And it is a very manual process for us to input this information and the provide will actually receive a paper check. We have offered over time to staff working in this area and actually sent out a recruitment to others in OLTL and the department of human services to assist us in processing those payments and getting those payments out to providers.

We know how important it is for them. We just wanted to give everybody an update on what is going on with personal care homes and assisted living providers. I will note that this also applies to nursing facilities that are not enrolled in the MA program. They had to go through this process as well sending us information and we are processing their payments as well.

The other update I wanted to give on the act 24CARES act payment the $28 million that was appropriated by this legislation for direct care workers who provide services to participant-directed model. Their payments were finally issued on August 31. So I had seen some feedback that people were receiving the direct care workers were receiving their payments August 29, August 30 and August 31. Some got a direct department, some got paper checks. It depended on how those payments were being sent out. The time period that people received them in. I know I had received feedback that these are going into the pockets of the direct care workers and we're happy that these payments finally went out.

Just so you know many are calling these payments hero pay. If you hear somebody say I got my hero pay, this was the act 24CARES act payment for direct care workers.

So that is actually really good news. The other update we wanted to provide is the personal care homes and assisted living residence the completion of the universal testing requirement. It was way back on June 26 where the Secretary of Health signed an expanded testing order directing personal care homes and assisted living residences and intermediate care facilities to complete universal testing and this

was testing for both staff and residence by August 31. Many may remember the order was based on a similar directive to nursing facilities that was given by the Secretary of Health. The nursing facilities were on different time lines they need today complete their universal testing by July 24. They were successful and had done that. Both secretaries of health and DHS secretary announce nod yesterday that we were able to achieve 100% compliance and test the staff and residents in the 1363 facilities. So that was good news that we were able to complete that baseline testing.

There was a lot of people involved and it was a good group effort by the Department of Health staff and in some cases PEMA was involved. A lot of the credit for achieving this 100% compliance goes to our regional response health collaborative partners. They really reached out to those facilities, called them in some casesarranged for the testing and in some cases went out and did the testing.

They were heavily involved in this testing effort and we thank all who were involved in getting to 100% compliance in order to test these residents and staff.

So I wanted to give everybody an update on that work that was excellent and a really good achievement. We continue to work to protect those staff and residents in our personal care homes and our assisted living residences. This baseline testing was only part of the effort. We know there is more work to do. We continue that work. If you go to the next slide, parts of that work involves our regional response health collaborative program. We had given previous updates to this sub MAC committee about the regional response collaborative program and the work they would do with personal care homes, intermediate and other licensed facilities under the department of human services. They are really in place to to support those facility was any COVID-19 related issues that those facilities have.

So here is just a quick overview of the work that partners have been doing as of August 31. Like we said a lot of their effort requirements. They really have -- they are charged with doing 2 on site facility visits so they have completed 654 of these. They have to go on site and to determine if they need any support. This is a critical function of this program. They are heavily involved in that effort. They deploy rapid response team if there is an outbreak at a facility and the facility needs assistance, one of the fist calls they make is to the regional response in their area to assist them with infection control, PPE or whatever the facility may need in having an outbreak of COVID-19.

So you know we have done 59 rapid redeployment.

>> The call center has 507 calls as of the week of 8/17 I'm sure they have gone up. They can call them and outreach with any clinical consultation questions that they have.

The other thing I want to note one of the things that the rapid response health collaborative program offers is two technical assistance statewide learning network webinars a week. So to state 1800 participants have participated in these webinars to get further education or just clarification on recently issued guidance that the Department of Health or the Department of Human Services has issued. So those have been widely attended as well.

So you can see assignments completed, those are anything from just the on site facility visits, questions or guidance regarding PPE, PPE deployment. Really anything that those different facilities may contact those partners for are considered assignments. You see the completed assignments and assignments that are still in progress that we are working with the various facilities on.

So I wanted to give a quick overview on just the things that the regional response health collaborative program is working on to date.

So next I am going to turn it over to Randy who will walk you through the 1915appendix K transition plan. It promised to provide data to stakeholders regarding the reopening strategy. This is an overview of that data. Randy will walk us through it.

>> Randy: Good morning. This is Randy I'm the bureau director for integrated services. As Jamie said one of the things we wanted to do as we look moving forward to try to men the CHC program is how we were going to do working with the 3MCO to do assessments for individuals to ensure that their plans were appropriate and to start getting back into the cycle of doing them on an annual basis in zone 3 the northwest, northeast and Lehigh area we had them coming out the end of June.

We wanted to put something no place to start processing assessments. So we got a lot of input from stakeholders and from the MCO and internally within the department and put together a reopening plan that we have provided MCOs the end of June. How they were going to train them to train them to handle things

related COVID and infection control and how they were going to provide them PPE and appropriate equipment to do face-to-face assessments and outreach to participant and what their plans were to start this process off.

As part of the reopening process we have also had directed the MCOs to provide us on a weekly basis a number of statistical data that we are requiring things like the number of outreaches they have done, the number of participants who have refused face-to-face assessments the number of participants that have refused face-to-face and telephone assessments.

We also asked them to give us the number of assessments completed face to face and --

>>

male do other people hear him?

>> **FEMALE:** Yes.

>> **Randy:** Some of the other data is the number of reductions they did. We are working on gaining that. I wanted to present some of the information to you today and then if you have questions obviously we have all 3MCOs that can answer some of the questions. This is data as of last week.

A couple of things that you have to understand is that each of the MCOs decided on their processes a little differently P H.W. began working with participants and doing outreach the end of June. UPMC and Amerihealth did training and system training in July and started outreach calls for face-to-face assessments in August so the numbers are a little bit different based on the fact that P H.W. was working through the process before the other two MCOs to see some number differences based on that.

So the first thing is numbers of participants that refused face to face assessment the reason why P H.W. is higher they started outreach before the other MCOs. Normally what we wanted to do is compare this to the number of outreach calls that were being made on assessments. The concern is that the MCOs don't really collect that. They have number of outreach calls they do. They can be out reached for well necessary check and follow up phone calls. They could be for a variety of aspects not just talking about assessments or reassessments. So that's why I'm not providing you the big number of calls. But this is a number of participants that have refused face-to-face.

The second are the number that refused face-to-face and telephonic.

Were going to be working with those individuals to try to determine what the issue was. Obviously the goal is that people have have to be an assessment done on a annual baser to make sure their plan is a appropriate and correct and they are getting the correct services. The department is working to develop an outreach letter to go out to those participants to explain can the need to do a telephonic assessment if they don't want somebody to see them face-to-face we will do some follow up with this population here luckily it is a small number so we will have some outreach on those numbers.

Next slide. This is the number of face-to-face assessments completed. Again, the differences are because UPMC and Amerihealth just start today do their face to face. We expect to see increases in their numbers especially as we start moving forward, amerihealth will address individuals in the southeast. We expect to see some numbers increase.

Percentages here this is the number of face to face out of all of the assessments. So Ameriheathh, 4%. UPMC2%. As Emerihealth and UPMC does their outreach we expect to see the number of percentages increase in the number of face-to face.

Number of telephonic.

Amerihealth, 2164, P H.W., 5944, UPMC, 3057. This is something we will look at in the next couple of weeks of data that comes in to see if these numbers switch a little bit so the number of face-to-face assessments would be higher than the percentage of telephonic assessments. We are looking at that closely.

We should see denses as Amerihealth and UPMC do their outreach. Next slide.

This is one of the things we asked them to look at the number of participants who had a service reduction or denial. Service reduction is any reduction to their current services, a denial would be any request for new or additional services if somebody asked a home mod or requested additional hours this would fall under the denial category.

So out of all of the assessments. Amerihealth, 1855 or 27%. P H.W. is 1560 or 22% of their cases have had a reduction. UPMC has had 134. UPMC has not processed reductions. They have had some imes that they have processed. The expectation is that number will certainly increase as they start doing reassessments and potential reductions of plans.

The expectation was this is kind of normal that we see about 20 to 25% reduction on existing plans when reassessments are done especially the fact that we are going through and doing reassessments on northeast, northwest and Lehigh cap as we look at reassessing people's con nowty of care plan. We have the expectation that we will see reduction or changes in those services.

The next set of data is the number of participants who had a reduction this is the number of the participants in the above chart that had a reduction or denial who filed a grievance or appeal. Those numbers may be off because they have up to 10 days to file a grievance or hearing. So the reconstruction may occur but the request for grievance or hearing may not happen until next week or the week after. We do expect to see these numbers increase. So far Amerhealth, 466, 25%. P H.W., 260, 17% of the cases. UPMC, 94, 70% of their cases. Again this number is high because of their small volume at this point in time plus they have only done denials. We usuallily see a higher rate of appeals when something is completely denied.

One of the things we are going to be asking or working with the MCOs on right now that we should be able to report out in our next session is the number of denials and then -- they are occurring for face-to-face versus telephonic assessment. We are working with the MCO to collect the data so we know if we this did the face-to-face how many of them resulted in reductions or imes. Of the telephonic assesses how many of them resulted in reductions or imes. We want to look at is there a difference between face-to-in home visits when you are looking at their environment and watching them in their environment versus the number it of reduction and denials for individuals that are doing telephonically when you are not seeing the picture around the whole picture. The participant may not be explaining their need completely. We want to look and see if there are any difference in those percentages.

We also know that telephonically it is a way to do the assessment it is not the best way. You may not get a null understanding of the person's need. The person may also exaggerate their needs or upgrade their needs on a telephonic. It is the way they answered the questions and they may not answer the questions.

We will look at that very closely to sew what difference we have in that and we will continue to push face-to-face assessments as we move forward. Next slide.

I don't have a next slide. At this point in time I don't know if there are any questions that come up that the MCs can answer on this information or if you take a look at this as you are going through and you want to send something in chat wise or questions in through the box. We can certainly do that

>> **>> MALE:** I have a question. May I?

>> Randy:

>> MALE: This is peripheral. It sounds like -- collar fee me if I am hearing this correctly they would prefer in person to telephonic for the reasons you just explained there. I am wondering does OLTL or the MCOs if you could talk about your liability plan in the potential situation that a service coordinator potentially infects someone who has been intently quarantining from the beginning this would be the only different factor given that we understand that MCOs are doing procedures. Can you talk a little bit about that?

>> Randy: I mean, the bottom one is we have to give participants choice. If participants refuse to have a face-to-face because they have been quarantined and they are only working with their family members and they don't want outsiders no their home. Some people have direct care workers they have consistent direct care workers that only work with them so they are comfortable with them coming into the home. Our plan moving forward is to see where we are at as far as people requesting face to face versus telephonic hearings whether we mode to adjust anything based on that as we work through the process. Things could also change depending on whether there is an up tick in COVID-related cases as we move no the fall. We may have to change our process again to go telephonically or go back toy a moratorium situation. That is all stuff that will be decided depending on how things go

Our preference is face-to-face where we are honoring the wishes of the participants. Each of the MCOs have trained their FCs to prepare to go into a home visit how to approach the individual and use PPE in that situation. I think to answer part of your question as far as the process the MCOs go through, I am going to turn it over to them if that's okay.

>> Sellers: Sure. I know Jen Rogers is on. Would you like to speak to this?

>> Jnn: Can you hear me? Hi, everybody. That's a great and one that comes up a lot. People in the Commonwealth are being vigilant about quarantining and taking it seriously and we want to honor that. The they are trained as Randy said on the measures and protocols and health screeners to for themselves and participants. We have set up a system for our service coordinators where they are doing a health screening on themselves in advance of doing face-to-face visits and also doing a health screener of participants. So this happens at the outreach call asking questions related to potential COVID-19 exposure also before they enter the home. We are documenting those responses. That doesn't happen out of an abundance of conversation. We don't want to expose our staff or participants to anything potentially harmful related what we know about the disease. Syracuse coordinators have been practicing good hand hygiene. They have been issued safety

kits which include masks for everyone present at the meet being. There are disposable masks if participants don't have masks or anybody in the meeting doesn't have masks. We have access to hand San tires from the service coordinator disposing -- and disposal plastic bag for getting rid of masks that have been used. We will be sending out pens so there isn't any cross con tram nation if signatures are used and not everybody has their own pen and control prep wipes to weep down any screens or surfaces used during the assessment. So if I am reporting myself I apologize. They have a bag to put all of the used supply in and dispose of that before they go to the next meeting or returning home.

So again to summarize, we are encouraging that we be diligent in the process of screening ourselves and screening everybody that would be present at meeting. We are stressing the importance of social distancing trying to get a little creative and talk to our participants ahead of time to see what are the opportunities to social distance at the home and who absolutely needs to be present and use the time in the home as efficiently as possible. I hope that answers that questions.

>> MALE: Maybe it is something we can share later. Also information and maybe later on what are liability plans. [german]

>> Sellers: Jenn, did you want to respond to that or are we going to go to PWH.

>> Jenn: Phw.

>> Sellers: Olivia Martin is going to respond for P H.W.

>> Olivia: So we do a lot of the same similar things. We have a comfort level screening a comfort level assessment when when scheduling s face-to case for

telephonic. If anything is answered yes that they are uncomfortable with the assessment then that assessment did not occur face-to-face. We have the health screenings that we do the day of scheduling the assessment and then the morning of directly before the face-to-face visit. We leave it specifically up to the participant. There is no forcing of a face-to-face visit by any means.

We have trained extensively on PPE use and the protocols we use for our external partners and service coordinators as well. And the documentation and screenings.

So a lot of this stuff I am not going to belabor exactly what we do step by step but it is very similar as Amerihealth and most likely with UPMC. We are following the Department of Aging's recommendations for PPE. As far as liability is concerned I am going to have to get back to you own that one. I apologize for skipping that question. But I don't want to misspoke on that.

>> Sellers: Thank you, Olivia: For UPMC Mike Smith can you speak to this?

>> Mike: Sure, can you hear me?

>> Sellers: Yes.

>> Mike: We are doing a lost the things that the others are doing. The one thing that we are trying to out lies [inaudible]

Disseminate the need foreclose contact. We are going to meet in the next week we will be notification them by mail to get [inaudible] the latest update to state we will be in the field and visit with them and what our expectations are. We did approach the meeting in addition to the screening tools we also talk about [inaudible] in a way to basically make sure that we are -- we are getting some notes that I got feedback. Is that better?

>> Sellers: You were cutting in and out a little bit, Mike.

>> Mike: Let me see if this works better. Hold on.

>> Heshie: Can folks mute.

>> Mike: Muting might help too. So we have a script for -- I am definitely hearing some duplication there. let me try one more thing. Is that better? Perfect.

So we are everything everybody to have face coverings and they social distance. I think that is going to be a huge benefit. We have got obviously the trainings on the hand screening and the face mask utilization. We provide some of that information previously in our mailings to participants. We will send that out again shortly, another mailing to participants about that and a return to the field.

Certainly if they are not comfortable with our visit, we can do this telephonically. They already mentioned the screening questions. I think the other pose that I would mention or talk about, I'm not sure I understand the liability question, German. I think it would be helpful if you expand on that. We can spoke to it at some point. Again just like the rest of everybody else, we're trying to do as much of the visit telephonically in advance of the meeting with the participant so we spend as little time in their home as possible. We can do it effectively and get what we need, you know, in terms of information that we are collecting for the assessment.. German would you expand on what you are looking for in terms of the liability issue?

>> German: In case a participant of any of your MCOs somehow a chief a lawsuit with the argument that they contracted COVID-19 due to one of your employees.

>> If they are developing a plan. If not as a participate want that would be an answer. If yes we would like to know that.

>>

>> MALE: What we are trying to do is avoid any circumstances where participant or staff would be engaged in something that would be problematic. Nobody will be looking to go to a participant and say you didn't tell us about COVID. We're looking to support the participant not to engage in that type of an activity. On top of it, we're following CDC guidance. And the guidance that's been put out by the state and everybody else. We have developed at our health plan we have clinical resources to help us achieve really good outcomes. So we would expect that anything of that nature unless it was blatantly attempted that somebody was trying to infect somebody with COVID I don't think anybody would there is no reason for us to be concerned about that liability in materials of going into somebody's home and saying you have given us COVID. In fact we are training everybody to avoid even the possibility of that.

We have a nurse line in the event that somebody thinks that the participant may have been exposed or whatever and they would not even be staying in the household beyond the CDC guidance. They would be turningen a and heading out the door almost immediately after all of the screening and all of the work showed any issue they would turn around and say let's do this telephonically.

>> German: This is a little different thank you for the clarity. Take us back. More towards the liability shields that were written in the heros act giving liability shields to employers and nursing entities. Such as insurance. The high built shields. We would like to know what you are developing language around that?

>> Okay.

>> German: Did you mention the 1135 waver?

>> MALE: . Yes, I did. There was a section in the 1135 that allows for verbal approval of your plan that is a relatively new thing.

>> German: We would like to know what options in 1535 if that could be shared. Thank you.

>> Sellers: Did another committee member have a question?

>> Wendy: This is wenty. How are you? Good morning, everyone.

>> Sellers: Good morning.

>> Wendy: I had a question to piggyback off the gentlemen. I was concerned about the exposure and liability as well. There is prove that the COVID lives on more than hands, other surfaces your clothes you can get it in other ways. Your hand bag or pocketbook it. lives more on surfaces as well. It could be transmitted actually on other surfaces besides washing and the other, you know, different ways that you try to combat it. I was concerned about that as well. He did answer the question the speaker before answered that it will not be totally enforced or forcible to put someone's health at risk if afraid. It can make them feel uncomfortable and cause them discomfort. They feel as if they are being forced. That's are what I was concerned about. How did you combat that when there is proof from research that it is France mitted and that it lives on other surfaces just besides it being transmitted even in hospitals or whatever, it doesn't matter

how much precaution you take.

>> Mike: UPMC part of our protocol is to have hand sanitizing prior to entering the home and exiting the home. So you are San toying your hands on both oceans so that you are not -- if you come in contact with any of the surfaces with your hands you are not going to be transmitting that as well as we are providing stools for our staff to be socially distance. They are bringing in their own equipment and laptops for this activity. One of the reasons why we don't want to be printing an doing things in person we don't want to take any bags in the household. We are taking a stool and our laptop an wi-fi connection that they keep in their pocket no the home so they can conduct their assessment completely electronically and limit any surface that's they would have to come in contact with.

They may -- the only time that they would be in contact with anything in the household is if there was any kind of environmental review that needed to be done and again, the entire time that is happening you are remaining socially distant and not handling much of anything. Even if you were, you had sanitized your hands prior to coming into the household.

I hope that answers your question.

>> Wendy: Not really. Somewhat. COVID has been known to live on the clothing. It was told that it has been transmitted even through clothing.

>> Mike: College first degree part of our protocol making sure you are starting out with your clothing in a fully clean environment.

>> Wendy: Thank you. I appreciate that.

>> Barb: Randy can we go back to the slide when you give us facts on the number who had a reduction or foiled a grievance and appeal. I was wondering if we could get more data at a future date on the outcome of those grievances and appeals and the reasons for the filing of the grievance or appeal.

>> Randy: I think the reasons for they foiled the grievance or appeal because of the reduction or ime of services.

>> Barb: Which service.

>> **Randy:** You want to know by service type?

>> **Barb:** Yeah, please.

>> **Sellers:** Randy, while we are on that slide, I presume the reduction were in hours we have an indication of the amount of reduction per plan or the base plan that was reduced.

>> **Randy:** I will try to get grievances by type. The second was percentage of reductions.

>> **Sellers:** Right.

>> **Randy:** The other question was the outcome.

>> **Sellers:** I think Barb wanted the outcome.

>> **Randy:** The outcome of the grievances and a piles. >> **Stephen:** [inaudible]

Adult day cares. If the adult day cares open up the hours.

>> **Randy:** I don't know the number of adult day cares. Across the state I don't know what adult daycare centers are open. The MCOs are working with those providers if they are open that people are still getting services. Even if they do open, obviously they have limitations on their occupancy. They can't reopen 1 o 0% we will have participants even though the adult daycare center is open they may be going one or two days a week versus 5 days a week. They will need to get the services in the home. The MCOs are aware that have and they have been working with the adult daycare providers and participants to make sure they are getting services. We know that some people at this point in time do not want to go back to adult daycare now or again. So we are working with those individuals the MCOs are working with them also.

>> **Jamie:** I think we had the adult daycare certainties submit a survey to show how many were open and how many were still closed. I am trying to find that number. When I do I will let everybody know.

>> **Stephen:** Thank you.

>> **Sellers:** Randy, I'm sorry. .

>> **Randy:** To wrap this up. I will see if I can collect data on the grievances by type, the percentage of reduction in the past and the outcome of the grievances and appeals.

>> **Barb:** Thank you.

>> **Sellers:** Barb, I have a number of questions from participants if you want me to hold those to the end we can to try to stay on time or if you want me to do them now.

>> **Barb:** How about we hold them so we can be respectful of other people's time here. Thank you, Jamie and Randy. Next we are going to move on to the MCO approach to implementing the QI plan from the 2019HCBS CAHPS survey results we have have Brian MacDai can d do this.

>> **Randy:** Don't we have another piece on the --

>> **Jamie:** I'm sorry, Abby.

>> **Barb:** I am so happy. I shut it down.

>> **And eye:** I didn't want Abby to get off the hook.

>> **Abby:** Thanks, Randy, I appreciate it. Good morning I'm Abby program I am with the Office of Long Term Living. Today I am going to present to you a new document that we have started producing on a monthly basis and we are calling it the OLTL data Dash. I will walk through the information that is contained in the data dash first and I will show you where you can find it on the web site on a monthly basis so that you can get some of your basic questions that we get a lot, a lot of questions answered on your own.

So the data Dash is a monthly report that we are going to start publishing. There are a couple of versions out there already for June an July. So the most recent version is the August edition which contains July data. So if you could scroll down a little bit, you will see that there is a table of content that out lines everything that is included in the data Dash and hyper link that you can jump to whatever piece of

information you are interested in looking at quickly. Keep scrolling. There is an acronym guide. Then we get into the first piece of information.

So the first set of charts and information really are outlining the earn rolement data. You can see at a quick chance what the July enrollment numbers were 371,361 participants in July. And that number is up from the June numbers. Then it also gives you the HCBS and nursing facility enrollment numbers. You can see HCBS is up and CHC numbers are down. The first chart is -- the font is small object the screen. We tried to match the MCO color with the logo so even if you can't read the font you can tell that blue is amerihealth. The greenish yellow is P H.W. and purple is UPMC. They are the size. We can scroll down to the next chart. The next chart breaks out the monthly enrollment by zone so you can quickly tell in each zone who has a larger percentage of the population with the maps on the left that you can quickly see what part of the state that covers.

Again, it is broken out by the MCO and by color. So keep scrolling. The last chart provided the actual number of people enrolled. This breaks it out by the percentage of market share for each region. You can see state wide UPMC has approximately 34% of the population P H.W. has 24.15 and amerihealt has 34.3. You see the breakdown who has the larger percentage of the population. Scrolling down the chart on the left is basically showing enrollment changes by region from June to July. So you can see an MCO is gaining or losing market share in each particular region and across the state you can see what is happening with that MCO at a quick glass.

The chart on the right breaks the CHC population down by population group, you can see that the NFI is our largest at 62%. And then we have approximately 25% participants and our nursing facility population is about 12% scrolling down.

The next set of charts really look at Medicare type for our CHC participants. So this first type is breaking out what type of Medicare. The black rules the non-blue. The blue unaligned. Red align aligned. The purple is Medicare advantage. Really on this chart you can see the difference between each of the regions for example if you look at northeast you can see that there is a huge green segment which is fee for service. You can see the difference in the population in terms of duals and non-duals. 3% in the northeast as proposed to 14% of the non-duals in the southeast. It gives you a good breakdown of the different Medicare types and you can see that in the southwest we have a large population of participants who are in [inaudible]

Own the right it gives a summary of the shift we are seeing in the Medicare type really what we are seeing we are seeing align and unaligned growing. We will get to that more as we scroll down some more. So this next chart breaks out the Medicare type by CHC zone and plan. Really I guess something to take note of here is again the reddish pink is aligned. The green you can see in the northeast consistent with above we have a high percentage of fee for service Medicare. And you can see how it is broken down by plan, by region. We can scroll down to the next chart which is looking at D-SNP enrollments by plan. You can see looking at the trends since January we have seen an overall growth in D senior DNP enrollment in the aligned and unaligned. Overall since January we have seen an in8% participants who have a D-SNP as their Medicare type.

Scroll down. This chart is looking at rebalancing and the number of participants who are in the community those are the green bars. You can see that we have a growth it continues to grow, this is looking at a 13 month period. That trend has -- that has continued since at least 2017. We have been on this same upward trend where the number of participants served in the community continues to increase.

The nursing facility participants is on a decline. This is act 150 and Life. When you are looking at the numbers in the chart below and looking at the numbers above, they are a little bit different and that is why those numbers are slightly different there. Scroll down.

Then this chart is to summarize other OLTL program enrollment clouding OBRA act 150 and LIFE so you can get an idea how many participants they are serving. Scroll down.

This map is showing LIFE enrollment by county. Just to point out the different between the gray and the white county the gray are assigned will have their risk as opposed to Elk which at the time of this report being run did not have any current enrollment. Finally we can scroll down to the last map which is showing the number of personal care homes and assisted living facilities by county. And that's pretty much everything within the data Dash. If you scroll down my contact information is there if you have any questions about anything that is contained in the data brief shoot me an E-mail I will be happy to answer that for you. And then just one final thing I will show you where we can be found on the website.

If you are on the DHS web pages up at the top the top right there is that section that says "about". If you click -- there is a section called data-boards. There it is.

Once you are on that page you can scroll down and of course we are the Office of Long Term Living and you will see the last two months are already posted out there. The August brief that I just presented today is fresh off the presses so it is not -- it hasn't been published yet. It should be out there fairly shortly. I don't know if anybody has any questions for me.

>> Sellers: I haven't received any, but you may get a follow up E-mail.

>> Abby: Okay.

>> Barb: I don't a question just a comment. I think it is awesome that we can view this data. Thank you so much.

>> Sellers: I did get one comment, bash that came in. This is very well done but does not address any measure of behavioral health engagement that is problematic and needs higher levels of attention. And then thank you, Lloyd.

>> Abby: The intent was really to answer some basic questions about the program. I do understand that there are a lot of questions that people have about utilization and other things. Those are really a lot more in depth studies and I am not sure that we would be to include that in a monthly report. It was just things that we get tons and tons of questions on a monthly basis in an easily digestible format.

>> Sellers: Okay. Jamie, do you want to give the survey results on the a adult day?

>> Jamie: Sure. I posted a comment. We got the results of a survey by PADSA and they said that they surveyed their members and according to their survey data 68% of the adult day service centers have not reopened as of July 24. It is not just the centers in the Philadelphia area. I think many of the adult day centers are struggling with reopening and reopening safely for the population. So as a result of that I know that our service coordinators are looking at people service plans that had adult day and obviously providing additional services for those who cannot attend adult day.

>> Sellers: Thanks. All right. Thank you, Amy and Jamie. Appreciate it. I hope it is now save to move on to Brian and the MCOs.

>> Brian: Good morning it is Brian MacDaid from the office of long term living. Thank you for joining us. We would like to go over the areas for improvement that were identified in the 2019, HCBS survey which I have presented earlier this past spring I believe in May to this group.

Part of the discussion that came out of this was identification of some areas in which which was identified as need for improvement per the findings the results of the 2019HCBS survey. Next slide.

This is a quick recap of the areas which were identified for improvement such as the choice of services that matter to the participants as well as the assisting participants with their planning their time and activities. Also informing participants when staff cannot come on time or come at all. The coordination of the participant's dental care and follow up. As well as the coordination and transportation to medical appointments and non-medical activities. Also need to help to provide assist answer to help them remain active with their friends and family. And also there is identified need to increase participant's awareness of employment assistance and housing services.

This morning we do have each of the plans are going to address these areas of improvement especially in regards to how their plans are taking steps and measures to address these identified areas and also to hopefully with their efforts that are going to be identified to the group to be able to share how hopefully for the 2020HCBS and definitely for the 2021HCBS surveys they will see improvement in those areas. With that I will hand it over to representative from our PA health and wellness. Thank you once again.

>> Good morning. Just a quick check Brian, are you able to hear me?

Brian yes.

>> I'm Maleak. I am going to take a home tonight talk to you about our strategy as it relates to the home and community based survey. For those that are familiar with the survey it is a satisfaction survey sent out to our participants administered by telephone where it measures the participant' s experience with the Medicare home and community based support services delivered by the providers. In order

to qualify to be a part of the survey you had to be 2 is and older, continuously enrolled for 3 months and receiving at least one qualifying plan.

The goal for Pennsylvania health an wellness was to have 400 completes a cross the zones. We were able to get 397 responses which is great. So now I'm going to talk about the survey and how we performed.

As you know, the goal is to continuously improve year over year. Pennsylvania health and wellness did improve from the previousor overall. As Brian indicated, there are areas of improvement which I will go through today. What we did we broke it up into a 3 prong strategy where we locked at the provider, participant and plan. Starting off with the participant strategy we locked at education, participant feedback and are looking at our community resources from an education perspective we are in the process of developing the importance of completing the assessment with the SC and making sure that you participate in planning your goals so you can be productive in the community.

In addition we are also looking at dental services where we want to -- dental service extension making sure that you are keeping or rescheduling your appointments if you are unable to attend. We look forward for those to come out by the end of this year.

>> From a participant feedback perspective we have our participant advisory committees where we provide the results and give feedback from the committee. Some of the feedback that we received is going to be related to doing things in the community some of the participants are not aware of the things done in the community as well as transportation and the cost of doing things. We heard that feedback and are revising a plan to work out some of those and address some of those concerns raised.

>> The top complaints are related access and availability. Access to a provider. If you drill that down more it comes out to transportation

Lastly as it relates to the community resources we have implemented what is called a community connect aunt Bertha platform. It is listed on the website and allows to you search for community based organizations for food, housing, transportation and jobs.

If you flip to the next slide for me, we will talk about the provider strategy. The provider side service coordinator entity we have increased the accountability by putting service level agreement into the agreement. What I mean by that we hold on them to a certain standard and monitor that to make sure they are following Pennsylvania health and wellness guidelines. We have retrained our staff and audit process. It can always be improved. I oversee the accreditation. One of the areas of expertise is related to LTSS. We have aligned our auditing with our MCQA industry standards that will allow us to make sure we are hitting all of the points based off of industry standards. Lastly accountability. We look at the missed appointments from the providers and if we identify the trends we reach out to those providers to get the action item how they are going to address that.

We get provider feedback from our advisory committee and dental advisory committee. We ask the providers are they seeing the same trend we see in the survey. Specifically with dental. We noticed that there was a low dental rate. So we have been working with our dental partners to make sure they are seeing the same outlation. If it is low we work to try to increase that. As everyone knows dental health is also just as important as physical health.

Lastly from the provider strategy as we indicated we I amen meanted the community connect with the participants we want to make sure the providers are aware of resources that Pennsylvania health and wellness they have access to share that with the provider and share that down with the participant as well as provider-facing training where we had a webex to talk about cultural competent and how to interact with members and things of that nature. That's been a very positive addition to our action plan.

If you go to the last slide we held ourselves accountable as well as educating. One of the things Pennsylvania health and wellness to hold us accountable we make sure everything is aligned. We also respond to the process that I discussed earlier. We look for trends across the board. On a monthly basis I facilitate a work group with leaders of the organization who have an impact on the survey. I ask them to make sure they have action items and make sure they are looking at the data points and present that with the group and action items and areas of concern. Just to let you know our CO is participating. Know that it is coming from the top down. Some of the things are abdomen liesing trends from the dental vendor, our call sender, complaints, the transportation and missed appointments.

>> From a transportation perspective we have biweekly meeting we look at missed appointments and make sure we address that with our transportation vendor.

The last thing I want to talk about is the housing partners We b can where we are locking to have a career navigator. The career navigator will be working to work with participants to work with them to try to get some employment and lastly we have working on a WebEx where we will have a WebEx to talk about the housing program. That is more information to come on that.

So I don't want to take up too much of everyone's time that is the review of all of the action items that Pennsylvania health an well necessary put in place to improve the results from our home an community based services. We hope to see an increase in 2020. Thank you.

>> Brian: Thank you very much we will move to our next presenters. We have represent environments from [inaudible]

>> hello everybody this is Danielle. I am the director for quality management. And as was covered the purpose of this improvement plan and the survey itself. So I am going to go right into the actual improvement areas for each of the items. What you see here is an overview of what we have is as a robust work plan. It is resolving work plan so as we progress throughout the year we meet typically on a monthly basis so that we have our communication tomorrows involved and we have our provider network and care management. We all work together with a common goal to improve our -- the care that our participants are receiving as well as being indicated in the upcoming HCBS which is currently out right now to our participants. New for this year we have the phase 3 region in this survey.

It will be interesting to see the results. We will be able to have eye comparison this year as well as with the Keystone first CHC. Last year was the first time. It will be interesting to see how it trends. So we start with the choice of services that matter to the participant. We have several interventions. We took the HCBS CAHPS results and evaluated the airs where we may have fallen below and had actually put in some of the interventions prior to this meeting as well. So some of those things that we have included were we train our service coordinators in creating goals for the areas that are triggered such as housing or food insecurities and so forth.

We utilize a team of trainers to review the motivational interviewing techniques so they are able to speak with the participate and r have a rapport so that it can be

documented in the PCSP as well. So everything that we do is using the personal-centered approach.

We require that the participant have at least 3 goals that they create interventions for and they are tide to their services. If a goal is triggered and the participant refuses or declines that goal, we don't forget about that goal, we will bring it back during another a assessment to sew if they want to add it to as one of their goals. It is always kept in the plan as well. As we move on to assist them with their time and activities. This is a more robust toll to help the participant and the service coordinator in mapping out the routines and what activity of daily living that the participant needs hands-on assistance with as well as independence as well as personal preferences. When this is completed the tool allows for the planning at a week's worth at a time taking in account the time for the service delivery and if it makes sense to have daily care. They are still able to attend community events, with with their family and go to work et cetera. So as a facilitator

of this meeting the service coordinator is making sure that they have the participant plan their time and activities.

One of the bar injuries is COVID. It will be interesting to see the response to the survey that is out now.

To help us with this we train them to update the plan of care this is done on an individual basis. We also do audit for our service coordinators just to make sure that all of the components of the assessments are completed if there are times when a particular service coordinator additional audits will be done. This is something that we will do on eye monthly basis based off of the previous results. That is something for we do for the interventions. Next informing participants personal assistance staff when staff cannot come on time or at all. With this the plan built in a mini survey in our person-serviced plan to tell their service coordinator what is working, what is not working regarding shift coverage. That was something that was developed early on this year and has been completed. So we are interested to see the results of that as well.

Again, most of our action items are related to training the service coordinating training of providers. Training of our participants and ensuring that everybody is aware of the services that they have and so forth. So we can go to the next slide. Now we are on to the coordination of participants with our dental care. We have a specific work designated for dental care. We have interventions that are being implemented regarding those that may be in a nursing facility. How we can reach participants. A lot of these will be participating. The participant for the service

coordinators. Right now we have dental information that's captured in the person-centered plan. Our goal is to include the dental program as well as good oral hygiene information for our participants. We are working together with our dental team and sending out informational brochures. We are making sure that our providers are aware.

One of the challenges we have is of course the having Medicare primary. We are trying to also educate along those lines as well.

As we move on to coordination of transportation, one of the things that we know transportation tends to be a concern. We have identified through several communications with the service coordinators between participants that there tends to be confusion as to non-medical versus medical. We have developed deployment in a non-medical transportation questionnaire with the aim to better understand the transportation need of our participants. This is helping us and the service coordinators to determine what transportation needs exist and how to best meet those need through the benefit or through community resources. Along those lines with the community resources we have developed a tool to capture all of the resources that exist in Pennsylvania and by zone and how the participant would be able to access or tap into those resources. Anything new we will actually add it as well. Now we are assisting participants being active in the community. This is similar with the previous one where we are developing the participant services and a sports tool. We are training the service coordinator and staff audit. This toys into the previous as we move into employment and house services, we had 2020 they hired an entry dedicated employment coordinator so this has helped us with our program to be able to get it out there for the education and employment. Develop processes for the service coordinators to make referrals to the employment coordinator. So this process was developed and the staff was trained on this.

OVR this allowed for relationships to be established and the lines of communication open for the staff. So once we developed a mechanism for requesting and accepting the needed information from OVR we keep a spreadsheet for our OCR and OLTL inter agency collaboration on a monthly report. Once the outreach is made for and the information is received from the employment coordinator it gets noted in a progress note and sends an E-mail to our service coordinator advising the service coordinator much the participant's status with OVR and outreach is made within 3 business days to advise of their status with OVR.

So our employment coordinator meets with the staff and the program. There are many different action items that take place. We also have a section to revise the POC adding some more employment questions. They have been added to the plan of care in our system. The service coordinator must ask those questions of the participant. So those questions provide more robust assessment of the current and prospective interest in adding employment to their goal.

As we move on to housing we hired housing staff for PA. When there is housing related issues presented the coordinator is able to assist by providing education and resources or active involvement with a participant. The housing coordinator and the employment coordinator will participate in case rounds when there may be a need identified in any of those areas. They are an active part of those case rounds with the service coordinator and medical director as needed.

So again, we also developed a repository of housing resources that include local housing programs, rental assistance programs and programs to help with utilities. This is available to the service coordinators and the housing coordinators. If you could move onto the next s slide. Right here is a snapshot of the challenges that I mentioned throughout the presentation. We are working with our providers educating the providers on the processes and filling out the documentation needed for the reporting. We are trying to get a more -- more dental data if possible. The claims that may be dental related. Our provider network is attempting to build a network in Blair and Cambria counties. Over all main concern is the COVID and the responses that we will receive due to the nature of some of those improvement areas. However, it is going to be a very interesting result.

We look forward to the 2020 result so we can do a better trend. Like Brian said we may not see the impact of all of the areas of improvement and interventions that we had already placed until 2021. We will actively work on this. This is something that we take to heart because this is what people are saying. We want to make sure we address those deficiencies as best as possible.

>> One more slide. The successes. We did update the plan of care goals. This plan of care loads not planning section for areas that are triggered. The person-centered service plan was updated to include all of the activities that the participant wishes to add as a goal. The clinical trainers are loaders in the motivational interviewing. Again, if there is a denial of service, it is a standard practice that the review tomorrow offers alternative services for the participant to consider. It is not just that it is denied we move on. It is something that they try to think of a plan B.

We developed a robust services toll. We had the one-on-one education provided by the management team if issues are identified. And then the dedicated housing and employment staff has been a benefit to our team. That concludes presentation Amerihealth and Keystone first.

>> Brian: If there are no questions we will move to UPMC's presentation.

>> Mike: Thanks, everybody. This is motorcycle Smith with UPMC. I had help with the presentation from the quality management tomorrow. A lot of the activities that are identified as we move through our action plan obviously center around the service coordination aspect of our plan. We work as a team with our quality management folks and felt like we have a lot of connection to the participant. Really that is a good place for us to learn about the survey results. Next slide, please.

So role quickly this is just a high level overview of the CAHPS survey it was mentioned that it was in the field. Last year we had 393 of 400 of our participants participate. If you get one of these questionnaires or are asked to participate, please do. It is our best way to really other than our regular contact with participants to gather information with our committee.

So we really would appreciate you participating. As others have said, we toy a lot of what we are going to talk about in the next several slides slides to our NTQA accreditation process. We are auditing our files regularly for indication that we may need to do remediation on particular foil reviews that result in areas of improvement, potential improvement. So we regularly meet with the quality team meets with service coordination. As a matter of fact weekly to go over find beings of different audits and different quality review processes associated with the distinction process.

And we are really committed to making sure that we do a good job with this work. Finally, one of the things that was mentioned several times and I think it just goes -- I just want to mention an overview for ours is that our assessment findings and what we do with participants we have vastly improved the system capture and putting what we find in the assessment is triggering us to have discussion around goals and improvements in all of those areas. It is really helping us the system changes are helping us to automate and make sure that we are talking to participants about what we are seeing in the assessment and what is important to them. Next slide, please.

While we showed improvement in understanding services and control of services we still need to do some work in this area. So we are targeting new training and education to r, targeting community integration. As of March everybody's life changed as a result of COVID. And so we sort of took that opportunity to start to fill -- develop the database called our community resource guide which was really designed to hip us with community integration and made a COVID resource guide so that we are collecting information on housing and food and other resources in the community as it relates to COVID and looking for opportunities in our phone calls with staff between participants and service coordinators to identify opportunities if there is anything that's changed and give them some resources based on that community resource guide or CRG so they can remain as active as possible and engage in other actives.

We have locked at and start today use more video chat capabilities. We have gone to virtual meetings with our PAC meetings. One of our action that's we resulted in our effort to improve the community we give a little story or information around that in Each slide of our PAC members. We have seen a pick video confidenting and opportunities that people have to engage. Next slide, please.

Transportation, again, we see some positive areas in transportation and positive for our non-medical appointments. Of course COVID is impacting all of this. Our participants one of the things that we are challenged with is we have in the previous slide deck that D ata dash is incredible it gives you useful information. It is about 93% of our participants are in Medicare. For those that have plans we have developed service grids that show benefits grids for the D-SNIP. Many have transportation benefits. If you are in one of those that is a potential transportation opportunity for you to get to medical appointments so we are educating our staff on those.

If you are in foe for service and you have MATP we are working with them. We have had some issues with medical assistance transportation isn't a benefit. But we help coordinate with them and participants to participant in MATP. So we have seen some significant -- we are identifying significant any issues there and working with our transportation broker in the state and everybody to try to address those issues. We are starting to use a portal to x died and improve our non-medical transportation issues so that the scheduling of our non-medical transportation activities to improve that.

We have transportation providers. We are making every attempt to make sure that the rides are on time and timely. We do as the other plans have indicated rec already meetings with our transportation broker to identify those issues. We

Monday tornado the number of complaints and follow up on every complaint regarding transportation and make sure that we are identifying [monitor]

>> And make sure we address how to address those.

We are come through COVID. We are seeing decreases in our trims. What we are seeing is providers are trying to I can Many you are sure they are doing thorough Doe contamination of their transports. That's maybe causing some delays right now in COVID.

That is improving as we sort of head no our new normal and everybody gets bet we are it. Next slide, please.

Dental services we too have a dental group that has gotten together we saw these less than perfect CAP scores. We want to improve our CAP scores. We know there is significant Downstream impact of poor dental care. We know that participants and beyond participants people like myself are not -- we are not always the most thrilled to go to a dental and have our teeth taken care of. So we are working with our service coordinators to identify any -- providing them with training to identify issues around dental services and helping them understand the need for good dental care.

We have our challenge because there are, again, unaligned and aligned benefits around dental care and make sure our staff are trained on those as well. The number 1 thing that we are staying closely informed by our dental network as the other 2 plans are and leveraging it. Leveraging in our case we have a broader health plan network with our SNIP and Medicare advantage program and other things that we are lever abling to make sure that our network is as full as possible as big as possible as well as informed about what the issues are we have learned at our MAC meeting creating an understanding about dental care is something that we are going to need to work with participants often and obviously train our service coordination staff on. Again, I don't know if in the other presentation a lost the activities often times beyond network and the plan itself the service coordination is critical component of making this all work. Next slide, please.. UPMC provides -- we were down a little bit last year in others. Those include benefit counseling, employment skill development, career development and job searching an coaching. Our take away from this the emergency orty of participants responded that one of the main reasons that's holding them back from getting a

job is their health concerns and how it's going to potentially impact their benefits as well.

And in employment, we look at employment as a key social determinant of health. There is opportunity for improved health with having some ability to work or volunteer. It is part of a community engagement in and of itself in some ways. We have multiple initiatives going on around employment. We have our new care coordination system as I mentioned earlier has employment assessment which you previously was a separate employment assessment now we have integrate that had into our care planning process is that if there are employment activities that you want to pursue that a participant wants to pursue they can see that show up in questions and respond as part of the PCSP process.

Make sure that there is a fluid approach to those discussions. We have got a partnership with a nonprofit called Achieva whose sole goal is to help us improve employment throughout UPMC as well as for our participants in general in helping us to establish strategy and collaborative effort across multiple departments and throughout the state to help us identify job opportunities for people with disabilities and people as part of this program.

And then finally really targeted employment concierge program just started up. We have always had people that are engaged in helping us us with our employment efforts. The service coordinator can work with this employment concierge program to help increase competitive employment outcomes for participants that express interest in wanting to be provide.

They can actually increase the frequency of communication support and connection for folks that are looking for employment. So as we are looking at an OVR application, we are looking at follow up on a particular employment opportunity, we have this concierge program that works with the participant if they want to participate in it. They will get more freakent contact and follow up from the concierge program, more support if it is necessary. On this Concierge program gives them more resources and programs to do that. We have a newsletter for job development and career assessment that I wanted to mention. Next slide, please.

So in terms of housing our scores have increased in that area. Our housing strategy team is working hard to basically increase the demand. We are looking at that housing tomorrow for not only nursing home transition although it is a critical component for helping us with our nursing home transition piece as you will see at the end. One of our improvement actions is housing that we located through that

program that helps our nursing home transition partners and ourselves get somebody transitioned home.

We want to serve and use that housing information that comes out of the environmental assessment and otherwise to help us engage to make sure folks are in stable and affordable housing.

I just want to mention on this call that we are -- since COVID started, we had daily updates that went out to our service coordination network. Those were paired back to weekly updates that go out now. Part of those updates are -- one of the things we will alert them on this Friday is the evictions, the moratorium on evictions has run out. Make sure that you are talking to participants about that. So our housing team is well aware of this and monitoring it. That's how we know about these things as they come up. Itis part of what they do with us and making sure we are a I remember with a of those things.

So we are addressing -- we are also addressing housing rights and accessing information regarding evictions and foreclosures that loads no what I was just talking about. And our strategy team -- our housing team is frequently throughout the year providing education to our service coordination team. In September we have an upcoming prepare renters education program senior ease. We are calling it PREP finding and obtaining and maintaining housing, addressing housing crises and navigating in home and income-based housing options.

This is all training that our service coordinators can get so they can be more effective at accessing it. We also use our GRE which I mentioned which has COVID-related housing activities that might be identified by service coordinators. They can update that resource guide in role time.

Lots of good things happening in the housing space still often times one of the more difficult areas in terms of supporting folks. But we are hoping we are making an impact here. We think that our scores indicate that. We certainly can do more as we know nationally.

Next slide, please.

So informing when staff is not coming. We have provider education component to this as was mentioned in the previous presentation. Reeducation of providers to make sure they are completing their missed visit, shift visit reporting. We are

monitoring our monthly reporting on no shows and addressing them regularly. We also are looking at missed shifts which is a new area that we're seeking to get to know that data so we can really help not only move it forward but make soar that we are addressing those shifts that are being missed and that type of thing.

Making sure that we are training our FCs to empower. One of the things that we want to do is empower participants to say, it is okay to say when somebody doesn't come on eye regular basis or to talk to your provider about being timely, about making sure that they let you know when they are not coming so the participant can be an active participant in the process of engaging the providers as well.

That some of the main activities we are doing around this. One of the things we did at the onset of COVID we worked hard to make sure that we contacted every single one and made sure they had back up plans and they were in place so if somebody did miss a shift we made sure they had something in place and could activate that back up plan and contact us.

Then finally, next slide, please. Choice of services. Again just wanted to make sure that we're addressing -- training our service coordinators to en gauge in them understanding how to help participants develop their personal-centered plan and chose services that are important to them. Make soar that they have the ability to get into the community once COVID is over obviously. And make sure that we're activity engaged in emphasizing some of our work here too is making sure that we are getting back to people and implementing improvements to our ability to communicate with participants around these type of things so if they have a question about a particular service, that we give them the options that are available in our waiver we have a number of service options. Some of them have some over lapping inter play.

Person-directives workers can do things that maybe our community engagement folks can do and vice versa. You want to make sure you are working through the options with folks and communicating choice with them. I know we have g obbled up a ton of time here so I will stop talking.

>>

>> Thank you very much it is prone M acDaid. Thanks to each of the plans for addressing those efforts and continuing efforts to improve and develop new ways to explore and provide services, good quality services to our participants. At some time do we have any individuals that may have any questions? If there is non-feel

free to relay those an we will share those questions with the appropriate members of each of the plans.

Does anyone have any questions at this time?

>> Dave: Barb, I have a question if I could ask one.

>> Barb: Sure.

>> David: If each could expand on the improvements on dental care that are duly eligible for Medicare and Medicaid whether or not they are receiving waiver service or not. Coordination of benefits particularly surrounding dental care continues to be a thorny issue. We know there is a coordination of benefits that being said I was wondering if each of the plan could expand what their care managers and service cord organizers and other MCO staff are doing to help those duly eligible coordinate their dental services.

>> Danielle: I can spoke briefly to this. With the dental care. One of the things we are doing we are drilling down the data that we do receive. We do run an annual dental visit report on anybody that is not noncompliant we share this with the management team as well as the care management tomorrow so it is a gap that is known so when the service coordinator does a telephonic assessment or face-to-face assessment it is something that is addressed.

They mention whatever the primary may be and if there is any assistance needed in coordinating that assistance with at that visit that is something that they would do as well.

Then our care managers as well if they have anybody involved in the care management tomorrow this is another gap they would address as well. Any time they do outreach to the providers, the education is provided on the provider side of thing to make sure that they are looking at the primary carrier for this dental visit to help with that coordination.

>> Mike:. This is Mike from UPMC. We have meetings with the D-SNAPs. We have a benefit grid for them. And we have our service coordinators make sure they are attempting and working with -- attempting to get to and meet with -- have a conversation with folks on the D-SNIPS to help them engage in whatever dental benefit is available to them.

The communication and setting up of the D-SNIP relationship is a critical component for the integration of this care. It is part of the agreement that we all work together and we are trying to take advantage of that for our own aligned members we have regular conversations with our care management team from our SNIP -- excuse the back background noise. As well as the Medicare only members helped by the care management folks from our SNIP as well.. Then with the folks more broadly we have care manager telephonic care managers that might not need help with that.

>> David: Thank you, Mike. I had a quick follow up. You mentioned partnering with the D-SNIP. I'm not sure if you meant MCO or unaffiliated. Is similar type of outreach with other advantage plans that have dental benefits? If you could expand on that.

>> Mike: If we know they have a Medicare advantage plan we will help the participate engage in those discussions as well. Most of the time they will be the SNIP plan. We have 10 of them. 9 or so. And on top of that what you are asking about is the mode care advantage benefits that come no play. We actually have participants at UPMC that you have the UPMC Medicare plan versus the SNIP plan. So there is a lot -- if they have -- we actually, believe it or not a bunch a few folks that have commercial coverage.

Yes, we are looking at all opportunities around dental services. That's why it is a heavy training that we want to be looking at on the service coordination side to help our staff as much as possible. A lot of these sides hit that side of the ledger. Thanks for the question.

>> David: Thank you.

>> Would the organizer be able to enable Olivia Martin. She would be able to answer this on our be half.

>> Olivia: This is Olivia, can you hear me?

>> Sellers: Yep.

>> Olivia: Thanks. I would like to be the last person to answer in these forums it is the shortest and sweetest. We use the service coordinator to identify these gaps through a couple of different assessments. Whether they are aligned or unaligned

we pull in the care manager to address any gaps and we have regular inter disciplinary care team meetings to address any gaps we are finding including dental.

>> David: Thank you.

>> Blair: This is Blair from united healthcare. I have a follow up care before getting no that I just wanted to say that I am he have impressed with the action plans around CAPS and HCBS survey results. They are very expensive. Just wanted to commend the MCOs for taking those results seriously and creating really specific action plans around them. I think it's great for improvement of the program.

My follow up question on dental, separate from the coordination with D-SNIP plans is there the ability to identify those that have dental gaps or dental concerns, those that have traditional Medicare instead of a Medicare advantage plan and use that opportunity to educate members on their more extensive dental benefits available to them by choose being an aligned D-SNIP plan in Pennsylvania? That question could be answered by any of the MCOs.

>> I would say there is opportunity for to us do that. Thanks for that information. We can take that back and start looking to see how we can identify that and putting tonight education that is a good idea. Thank you.

>>

>> We have heard about the limited Medicaid. I was always wondered they are dual eligible. No dental benefit on traditional Medicare.

>> That is a really good point. Certainly we have folks -- a pretty significant portion ifyou look at data that was presented earlier that still have traditional fee for service Medicare. We make it a point to make sure we emphasize those benefits. I'm sure all of the plans do. It is a good point we have worked focused on service coordination that is the area to make sure people get the dental care. The idea if they have fee for service we will lock for the next step to determine how we get that need met. Of all of the SNIPS the D-SNIPS. We have the agreement for folks on the call that is an agreement that says all of the D-SNIPS need to work with Medicaid any other committee members have questions.

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>> David: I would hope that the MCO and service coordinators do encounter a consumer regardless of their Medicare coverage has questions about it have them contact their counties local Apprise through the Department of Aging to get free and unbuy answered counseling. It provider choice an freedom. Making a plug for any consumer with Medicare questions they will be glad to speak with them. They are all familiar with health choices.

>>

>> B arb: Thank you.

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>> FEMALE: I heard we were listening to Medicare. What about those that have Medicaid which doesn't cover and they have limited benefits for participants. It doesn't they can afford to pay for things like if need dentures and they don't pay for it and it impacts their health.

Hello? Can you hear me?

Hello?

>> Blair. . I was able to hear you. This is Blair from the committee.

>> FEMALE: I'm trying to figure out if anyone has been trying to on be half of all of the participants in need and are Medicaid serve is anyone fighting for them to get bet for improve them? The improvement will be health an welfare of those individuals.

>> Barb: The MCO or would we need to get back to her?

>> Brian: This is Brian from MLTL. That is a good question to take back to DHS. Just to potentially address. Jamie and others on the line that could potentially address.

Barb: Thank you Brian.

>> The adult dental is limited. If there is benefit limit exception processes for -- if it's going to create a significant medical list took a member to cover certain adult services. But I think the problem is unless it is a serious medical issue, the services

are very limited and not always maybe optimal dental care. That's been on Medicaid benefits for a long time. I am always looking for resources and options to help people with getting services. The structure of the benefit is limited.

>> **FEMALE:** How do we get that improved with all of the changes that are happening? Who is going to speak object be half of us to bring it to the forefront for it to get changed? There is a need. I believe that it is -- it shouldn't be optional for dental care, for certain care. The majority of participants like myself as well that is receiving services have significant dental issues. It is all of it that is important. Fundamentally for our health. I just wanted to know. I am speaking on be half of me along with the other participants that receive Medicaid. I just feel that something should be done about that.

>> **Barb:** Thank you. We will see if we can get answers what steps need to be taken.

>> **FEMALE:** Thank you, thank you so much.

>> **Barb:** Any other questions from committee members?

>> **Mike:** This is Mike Grier speaking. I want to thank the plans for developing some data for us to take a look at. Is this going to be updated on a quarterly basis or maybe biannually to so you can give feedback to the members so they can see the progress? Thank you.

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>> **MALE:** Great question. We track it on a quarterly basis. If you guys were come back to another meeting maybe beginning of next year to see how things are progressing I'm happy to do that.

>> **Danielle:** That is the same for AmeriHealth. We have active work groups and we have tools to measure our success and the annual response from the HCBS would be the response that we would look at the results that we look for for. We have this information available typically on a monthly basis depending on the intervention that is in place.

>> **Mike:** UPMC, this is motorcycle. Would be happy to present on it. With the CAP survey that is coming out now, we are going to be obviously updating and looking at performance issues and opportunities coming out of that data as well.

We are going to have even a broader data set. So it is definitely something we could come back an talk about at some point.

>> Brian: This is Brian MacDaid from OLTL. The survey one of the positive things we have with the survey we are retaining questions from year to year. We are just now starting to establish some of those baselines as far as how we did compared to 20. The to 19 will go to 2020 and 2021 and so forth. Just to let everyone know regarding as far as dental, housing, employment and the other areas that we addressed this morning they will be part of the survey for 2020 and future surveys as well. So just to let you know that as DHC, we are continuing to have that consistency within the SUR say with the national questions as well as the state supplemental questions to make sure that we continue to address these issues.

>> Barb: Thank you, Brian. For committee members we can add this topic on the list for agenda items to be determined for forthcoming meetings.

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>> MALE: . I would follow up on the question about dental, Barb. This is motorcycle Smith again from UPMC. There are dental benefits in Medicare. They are limited but available. Our RFCs should be providing information for people that just have Medicaid. Dentures are covered. There are coverages there. Maybe it would be good to educate this group on what is available on Medicaid and talk further about what the opportunities are to improve those if it is needed. I think there is that overlap the gentleman from united healthcare and Aprize that Medicare covers this too. A vast majority of participants in this program are covered by 2 things. So making sure that we build a strong Medicaid benefit is important and there is one already and then how to coordinate those 2 pieces is important.

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>> Brian: For their list of potentialen to ics for future meetings in regards to following up on each of those individual measures and plans they have opinion developed and presented this morning, but also taking into consideration the topic regarding [inaudible] as well as the services to be a topic. Just a suggestion. It is something for the committee to take into consideration.

>> Barb: Thank you, Brian. Are there any questions through the chat?

>> Sellers: Yes, we do have a few questions that have come in. I can start. A couple of different people are asking about the MCO participant advisory group is it still possible to get involved and how can people get involved in those.

>> Anna: This is Anna. The advisory groups we are always looking for interested participants to be involved and happy to get that information to anyone that would like to participate in any of the zoned chat meetings.

>> Danielle: I agree with Anna. We are welcoming anybody that would like to participate in any of the zones if you send us -- we could send you the information I don't know how OLTL may want to present this. We can send the information over to share.

>> Mike: This is motorcycle from UPMC. We are always looking for participant input as well. They can call our member services number and they can advise them and make sure the information gets to our team that works with our advisory committee.

>> Sellers: Great. So the next question I have also is for the MCO is from janice. She says the presentation of the 3 plans cloud training and responsibility for SD. What is the current case road and what are the responsibility. We hear from participants get having a hard time getting a return phone call from their SC.

>> Mike: This is motorcycle from UPMC. Our service coordinators have 75 participants that they serve on their case loads at any given time. It is a balancing act there are a lot of activities necessary. One of the things that we often do as is part of our education is having frequent commonnation about the items that we are training on. As I said I have weekly updates that we send out to make sure they are aware of the latest and greatest information. Then obviously we have part of our training curriculum is how to manage all of the work issues and we have service cord nation b and member services staff that augment. That's really a big way that they can meet the demand of the job too. We have other resources that can help with issues that might require resolution right away. And I know the other plans have something similar. We are always looking for those streamlining opportunities. One of the things we did as you heard us say in the presentation on the CAPS is

trying to make sure that folks don't have to go book to the assessment. As they develop the plan the information from the assessment is helping them ask the questions to make sure the participants gets to the right place. Those things stream

line the process and make it easier for everybody. That in conjunction with take and member services and telephonic staff augment that whole process.

>> Olivia: Our system is similar to what Mike is speaking on for UPMC. Our ratios are lower. We are 1 to 60 to 1 to 65 depending on the area of the state. We offer a ton of support. A ton of education. Weekly we have an hour to two hour long meetings and training session was our SC. If you are having a specific issue, I invite to you bring it to our attention. We would be happy to address that.

>> Jenn: This is Jenn. Similar to the other two plans structured to have one service coordinator to 75 community-based participants that.

Does vary depending on where we are in the state. In our model of care we have our personal care connectors that have access to answer quick questions that participants might have about their care or services. They have access to see participant goals and their authorized providers and how many hours a week of a particular service we had. We did this so the questions can be answered quickly knowing that our service coordinators are spending about 70% of their time in the field under normal circumstances conducting face to face visits or conducting what are lengthy assessments.

So we are upon toring this. We have tracking systems in place for inquiries that come in or complaints that come in where someone is not able to reach their service coordinator and what they feel is appropriate time. Those concerns are taken seriously and addressed with our supervisors and our management team. I hope this helps answer the question for the person who asked it.

>> Sellers: We are supposed to be able to download them from the portals earlier this year still haven't been granted access. What is being done to ensure reliable and timely communication of updates to providers?

>> Anna: This is anna. I can address what we are doing. 2 fold. One we are looking with the service coordination leadership to ensure that they begin providing PCSPs to consumers and requesting that the consumer has any issue with the home care provider as well. That is an active solution we are doing. There should be some revolution soon. The other side is we are working with Terry and the PA home healthcare association to start talking about how we can improve what used to be the SAF process and is there something we could do similar to what it was but the feedback we received was that the SAF didn't always cover the details that would provide better home care to the consumer and meet the goals and outcomes that are defined. So we are having those conversations to see if we

can get something in the hands of home care providers that would be an improvement in addition to the PCSP.

>> Jenn: This is Jenn. I want to be clear for our plan we never committed to sharing person-centered plans on our portal. There is a lot of sensitive information documented on the PCSP. The person-centered program we need to be careful that we are following the load of the participant who they want their actual person-centered plan shared with. I appreciate as a direct care provider you need to know information about the participant similar to what Anna said that used to be housed on service authorization form what we called it in the fee for service waivers. Terry Henning was taking on the charge of getting a work group together. Then we heard that that information wasn't actually necessary. So our commitment is to continue to work and gather what can be helpful to providers. We do provide authorization updates in HHA and through other systems so the providers have access to the providers that they serve.

>> Mike: This is motorcycle from UPMC. I would echo Jenn' he is comments and say service detail is available in HHA as well. So it is not just authorization but also information about what should be done from our plan. Abouten

>> Sellers: Thanks. So next question how is the budget for services my way deviced. My understanding is that you take the number of direct care workers and multiply them by the pay rate to determine the budget. In this scenario I could use 10 out of 15 hours per week and have 5 hours for goods and services that qualify under services my way. If the allowable rate was $15 an hour I would accumulate $75 per week. I was informed that I cannot reduce hours to budget for additional services such as housecleaning or snow removal. You use the difference between the DCW rate and the pay rate allowed by the program. If that was $2 an hour I would accumulate $30 a week to be used towards goods and services. Which is correct?

>> Olivia: It is olivia: I don't want to spoke out of turn and say the wrong thing I would need that question in writing then I can get back to you on that exactly. Services my way isn't used as much as it once was. So I really don't want to misspeak.

>> Sellers: We can provide that in writing. Do any of the others have comments?

>> MALE: I know there was discussion about services my way in the last MAC meeting or the one before that. This is a complex question and I would like to take it back to our tomorrow and take a look at it as well. A lot of figures and numbers thrown out there. I appreciate the complexity of it. I encourage you if it is UPMC person and you are having questions with your service coordinator because it is a pretty unique program feel free to say can we get on a call with maybe your subject matter expert at UPMC on this kind of question too and we can huddle up and figure it out. Thanks.

>> Sellers: Okay. So the next question I have here is from Pam Allen. In terms of transportation I don't believe participants know they have the right to it. Are SC talking to participants on the services they have access to?

>> Mike: This is Mike -- go ahead.

>> Jenn: We have a habit of doing that, motorcycle. I apologize. That is a great question. That is something that we can continually improve on. It really is on expand being the service coordinator's tool kit to know how to explain services and what is available under the benefits to people. This happens at the initial visit obviously when someone is new to CHC. I think it needs -- our team is encouraged and trained to always have the discussion about what is available to you so it is not just the go-to with personal assistant services, meals and things that are the smaller care plans in the past. Really explaining alternative services to help people in normal circumstances get out no their communities, engage in community integration and en gauge in adult services and also explaining the differences between to your point non-medical transportation and non-emergent medical transportation available tonight. Spoke on that point specifically we have

taken a lock and realized that our own team our service coordinator definitely could benefit from more training tools, resources to understand the different options for transportation, how they vary geographically across Pennsylvania and how to have an informed and confident conversation with somebody to talk about this is when you would check with your D-SNIP. This is when we would call MATP together. These are the kind of things adult day attendants and church bingo, bridge games, what have you, that would be something your benefit would be used for. There is always a need to have a refresher on the benefits available under the LTSS services but also to remind service coordinators to really differentiate and

make sure they are really trained on the variances in transportation available to people and the different sources that should be tapped into. Thank you for the question. We acknowledge it is a continuous effort.

>> MALE: There is a reason we ran into each other. This is motorcycle from UPMC. As part of this improvement plan we have been spending a lot of time just trying to make sure that we have got the MATP benefits, the SNIP benefits, the advantage plan benefits everything we can find out there the non-medical transportation benefits that are aligned and getting that in the hands of our staff.

Obviously transportation discussion is triggered as part of our personal-centered planning process as standardized tools. I'm sure Jenn's team has that as well. Sections of the plan that address transportation, how are you getting to go appointments? How are you getting to go social events and that type of thing? I would bet a dollar to a dime that it's being covered in all service plan discussions amongst the plans for sure. It is a good point. It is complicated.

>> Anna: This is Anna. Jenn's your answer was a some. We a degree with what Jenn is saying. I think it is really important and Olivia called out education a lot with service coordinators. It is critical that service coordinators understand the CHC program and how important it is to have that conversation during a planning around the needs of the individual and what they may or may not be considering is included in the CHC program. So as those conversations are happening and they get more comfortable with each other they can explore how the non-medical transportation services can be utilized.

In addition to the benefits coordination looking at what other community resources are out there that might be a solution as well and it should be considered last rang are than first. Often if they have a really good conversation about needs, choices, preferences you know the things the person likes to do they can develop a pretty good transportation plan or modify it whenever the consumer wants to. That's all I have got.

>> Sellers: Thanks. So I have another question from Kayla about PPE. So we have received questions from our PA PCA members [interference]

>> Sellers: I can getting feedback. Could everybody please mute. Thanks. So we received questions from our PA PCA members as some have received addendums

to not hold them reliable that the MCO may or may not continue to supply PPE. Can you please clarify.

>> Anna: I would not have abdomen answer to that one. We have not had any discussions around that. We have ten community providers contracted with PA health and wellness to offer service coordination and I can tell you that is not it come up in any conversations I have had with the leadership of those organizations at all.

>> Sellers: Any additional comments from UPMC or UHC?

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>> MALE: . I have to agree with Anna. I haven't heard this one coming up. It is something we can take back and look into.

>> Sellers: Okay.

>> Jenn: This is Jenn Rogers. The appropriate forum is the meeting that is scheduled for tomorrow. So perhaps the question can be vetted and understood tomorrow so we give accurate answers regarding supply kits.

>> Sellers: We can send that one for follow up. Another question from Theresa Hartman. Do the MCOs want SCs to report SC exposures or positive cases to them?

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>> MALE: Could you repeat the question?

>> Sellers: Absolutely. Do the MCOs want SC to report SC exposures or positive cases to them?

>> Jenn: I can answer that. Hi, Theresa. For SC exposures their employer would handle that. In the beginning phases still with the on going pandemic and reporting positive cases we've been tracking that by word of mouth and self reporting. Yes, please make sure that information is fillerred to AmeriHealth Keystone. It would need to follow the same sports critical incidence and unplanned hospitalization. In regards to a plan participant, make sure you are covering your bases to report that out even if on a self reporting means.

Plans have another data sources substantiating the COVID positive cases. Thank you.

>> olivia: What Jenn said P H.W. do want to know about positive cases. Also for our community partners you would have to follow your own internal business process. Please work through for external SCs work through your account managers in getting those reported and just like Jenn says if it qualifies as a critical incident it needs to be reported.

En is

>> MALE: UPMC, same answer.

>> Sellers: The next from jab is. The assessment could result in a decrease of service when's giving them a choice between an in home assessment or by phone assessment?

>> Jenn: I can jump in. Sorry, olivia.

>> Olivia: Go ahead.

>> Jenn: I did that to motorcycle so you go ahead.

>> Oliva: Our service coordinators wouldn't know it would result in a reduction. They should have the a conversation when they are doing the comprehensive needs assessment and if anyone has changed that is made from our internal review process. So that would have to go through the medical director and a few stages of approval before a determination would be made. So we wouldn't want the SC giving a specific number of hours at the visit for the reason it might not be accurate.

>> Jenn: I interpreted the different a little differently, janic. I want to be clear how we trained our service coordinators when we are out reaching to participants. OLTL has permitted the plan to allow for choice between a telephonic assessment and face-to case face assessment. Do we let them know at the scheduling that the services can d -- the assessment may result in a change to services reduction or an increase or services stay the same. We want to be very, very clear that can happen

regardless whether or not it is done telephonically and in person. Like olivia said service coordinators don't make that service decision it goes through the review process. We want to be trans apartment when participants are making decisions based on what type of assessment they want that those things can in serve circumstances happen. I hope that's clear.

>> Mike: I would echo what Jenn said. If there were to be a reduction that would also be relayed to the participant through our process, utilization management team as a result of that telephonic assessment that is the requirement that we have been asked to relay. We would also give the opportunity to allow that participant to ask for a face-to-face.

>> Sellers: Thank you. So the next question for the MCO is from juliette relating to hearings and appeals. Would the MCO be able to discuss changes for hearings and appeals given the barriers to mail and receiving notification.

>> Mike: I don't think we have anybody from our CNG group complaint and grievances on the phone. I don't think that we're hearing of -- experiencing any issue was that right now. Of course I don't particularly ask that question every day. I don't have a solid answer. I haven't heard that that's been an issue.

>> Sellers: Amerihealth.

>> MALE: I haven't heard about anything at this point.

>> Chris: This is Chris. We'll take that back as well to our grievance team and have that discussion with them we are not hearing anything.

>> Sellers: Thanks.

How are the MCOs helping consumers to vote?

>> Anna: That is a great question. I am going to take it back and find out how our service coordinators are educating consumers and if we are able to do anything in addition to that to promote consumers to get access to options to their voting. Great question to remind us we need to be sensitive to the changes folks may have right now in getting that done. We can respond to that next time.

>> Jenn: I agree with what Anna. In knife the centers for independent living have ideas we would be open to hearing creative ideas or resources that perhaps as it comes up when we are resuming face to face visits and talking about it as we get closer to the election day and folks have concerns about getting to their poling places I know our service coordinators would be happy to take any information or resources for people with disabilities have that available for when they are having discussions with participants.

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>> MALE: You just scored a spot on our weekly update to our staff that will go out FFriday. I think our community resource guide will be updated as well with the information for regional access, county-based access for voter education it is a really good point. Something that years ago was an emphasis of the labor programs that I think is important to make sure we educate participants on and get them the resources to help them with anything about balloting or transportation if necessary to participate in the election for sure.

>> Sellers: Thanks. So next question I have for the MCO is from Pam Auer. How are each MCO working to improve the delays in processing NHT needs especially home modification and a tentant services.

>> Olivia: I can answer that we are till working diligently to get quiz through our internal processes when it comes to delays I think I need a little more specific than what you are referring to. Is it maybe the contractor? Maybe lack of finding of a provider? I think I just need more specifics to be able to answer that one.

>> Sellers: You are unmuted. Thanks. Any other comments on that one.

>> MALE: I don't know if the question to Pam is regarding anything that has to do with COVID specifically. Or is it just in general. We certainly investigate delays and try to removed ate those on any given situation we are constantly looking for ways to improve our access to home modifications in a more timely manner including helping with evaluations and providing realistic expectations around time frames for different types of home modifications so some are going to take longer than others. So any additional information would be helpful.

>> Sellers: Pam provided people are having difficulty get ago approximates in the actual service to transition.

>> Jenn: I recognize this might be a limbtation but are we talking about approvals at at county assistance level or approvals in goods and services level for transition services? I am unclear. I can speak from Amerihealth Keystone we haven't seen any delays. Non-have been brought to our attention. I need clarification if it is approval for community based LTSS or at the county assistance level or something else.

>> Sellers: We are coming to the end of our time. I can forward that one along.

>> Barb: That is probably the best.

>> Barb: We are at 12:59. So we are going to wrap this meeting up. I thank everybody for participating and our next meeting will be October 7. It will be a webinar remote streaming. Again, thank you everyone and means safe.