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DATE: December 3, 2019

EVENT: Managed Long-Term Services and Supports Meeting

BARBARA POLZER: Good morning everybody we are going to get started in a minute.

I'm so impressed the room got silent so quickly. We will start with introductions Nina would you mind.

NINA DELGRANDE: From life providers.

BLAIR BOROCH: United length care.

STEVE GAMBLE: Delaware county agency on aging.

MIKE GRIER: Pennsylvania council on independent living.

LUBA SOMITS: Good morning.

MATT SEELEY: Statewide independent living counsel.

DREW NAGELE: .

HESHIE ZINMAN: L. G B T L.

Consumer advocate.

David Johnson.

LINDA LITTON: Participant advocate co-chair.

BARBARA POLZER: Liberty community connections. Do we have any Committee members on the phone.

TELEPHONE: Denise Curry, Pennsylvania healthcare association.

BARBARA POLZER: Good morning.

TELEPHONE: Jim Peifer.

BARBARA POLZER: Good morning.

TELEPHONE: Rich Farr.

BARBARA POLZER: Good morning Rich.

TELEPHONE: She can hear you but not on the computer. Tonya.

TELEPHONE: Gail.

BARBARA POLZER: Good morning Gail. Any other Committee members? Well, thank you. Some brief talking points. Please keep your language processional. Please direct your comments to the Chairman and wait to be called on and please limit your comments to two minutes. Meeting transcripts and documents are posted on the list serve under MLTSS meeting minutes and they are normally posted within a few days of meeting. The captionist is documenting the discussion so please speak clearly and slowly and the meeting is being audio recorded. This meeting is scheduled until 1:00 And to comply, we need to end promptly at that time. If you have any questions or comments that were not heard or answered, please send them to the resource account for your reference. The resource account address is listed on the agenda. The exit aisles must remain open. Please turn off your cell phones and when living please throw away your empty cups bottles and wrappers. Public comments are taken during the entire presentation instead of just the end of the meeting. However, we do try to reserve 15 minutes at the end. The 2020 MLTSS meeting dates on available on the human services website and at this point I'm going to turn it over to Linda for the emergency evacuation procedures.

LINDA LITTON: Good morning everybody. In the event of an emergency or evacuation, we will proceed to assembly area to the Zion church of 4th and market. If you require assistance to evacuate, you must go to the safe area located right outside the main doors of the honor suit. O L. T L. Staff will be with you in the safe area until you are told you may go back into the Honor Suite or are evacuated. Everyone must exit the building and take your bee longings with you and do not use your cell phones or elevator. We will use stare 1 and stare 2. To go to stare 1 exit the door at the left and go straight ahead, make a right at the water fountain and stare 1 is to your left. S-T-A-I-R 2 exit the right side of the room, make a left and stairway 1 is in front of you. If you exit from the back, make a left, make another left and stairway 2 is in front of you.

Sorry. You want to keep to the inside of the stairwell and merge to the outside. Turn to the left and walk down-D- U-B-E-R-R-Y avenue to Chestnut Street and turn left at the corner of 4th and left on BlackBerry street and cross 4th street to the train station. Thank you.

BARBARA POLZER: Thank you Linda. Now, we are going to turn it over to Kevin for the OLTL Updates.

KEVIN HANCOCK: Good morning everybody and happy holidays. It is not too early for me to say that since we won't be meet be until after. Before I begin with the community health choices standard updates. I wanted to introduce Randy loss. Randy works in our office of mental health and substance abuse services and he is the employment first

contact for the office of mental health and substance abuse services. He is working with people with behavioral health challenges and he is also looking for opportunities to do some outreach with the disability community and I told him that if he wanted an opportunity to meet some of the key -- key individuals who are engaged in working with employment related concerns for the long-term care and disability community, this would be the meeting to do it. I pointed out Mike in the corner because he is the president for the Pennsylvania centers for independent living but there are a lot representing united healthcare workers is also -- if you don't mind raising your hand is also an important contact in this space. There are other people in the room. If you have a few minutes and want to have an opportunity to talk to Randy, about some of the work relating to employment first, you will be here for a little while is that right? And maybe exchange business cards and maybe also have an opportunity to be able to develop a level of contacts. Randy does work with Ed butler from the Office of Long-Term Living who is our employment first contact but Randy, I think, also has a broader portfolio when it comes to people with disabilities that may have a cooccurring diagnosis for some behavioral health diagnoses. I'm going to jump into the updates. We will be covering the traditional phase 3 updates as well as enrollment updates. In the previous meeting, there was a request for some numbers. Starting with the phase 3 implementation updates. So first, update will be about the phase three provider networks. At this point, they are moving along very well, just as a reminder nursing facilities, there are 318 total in phase 3 and A-M-E-R-I health as 256 and PA health has 241 and UPMC has 268. We are happy with these numbers. Nursing facilities, individuals who are receiving services in a Medicaid enrolled nursing facility will not be ever asked to move. Their continuity of care -- they will have to develop and in network or out of network with those nursing facilities but we are expecting that all 318 will be contracted. It may be progressing past the implementation date but regardless people will be covered. Hospitals there are 93 total in the final phase. AmeriHealth has 85. PA health and wellness has 60. And UPMC has 69. One in the northeast in Geisinger health system is the largest in the northeast and it is our understanding that at least two of the three Managed Care Organizations do have a fully executed contract so we are happy about that. All other nursing facilities and hospitals are in process and we will be continuously receive updates on these network changes all the way indefinitely actually and we get those updates on a weekly basis. We will monitoring network advocacy through community health choices it is something we do to be able to continue -- to identify if there are areas of provider concern or weakness as the program goes on. We monitor for the southwest and southeast on a weekly basis as well. So in addition to provider network, we are focusing on continuing education sessions for participants. The individuals who were in -- had gone through plan selection for community health choices were assigned that plan officially in mid-November. But people who wished to still override auto assignments were still wished to make a change to their plan selection can do so until December 20th. We will continue these information sessions so we are continuing to get the word out throughout that time period through December 20th. And we want to make sure we are reinforcing the opportunity for people to make a plan

change at any time in community health choices even after implementation with that effective date being the first of the following month if it is the first half of the month when they are making the change or if they make the change in the second half of the month, it will be the month after that. We want to remind people that they can make a plan change even if they are auto assigned to a plan they are not happy with. Participate sessions did continue. We did have 52 they occurred in 43 different sites and we had more than 3,000 attendees. We were happy about that. Stakeholder participation continues to play a key role. We had 92 individuals who volunteered as meeting facilitators the AA As and the centers for independent living are all part of the sessions. The apprise program was represented in every single one of those 72 sessions to be available to answer questions relating to the Medicare program and in addition the Maximus representative was available to help with enrollment support and be able to talk through enroll C H C.com website. In addition, there were life plan representatives in most of the 72 sessions as well and part of the time for the life program was -- part of the time for the participant sessions was set aside for describing the life program and we saw that that was very effective as well.

And in addition, there will be 11 additional -- there were 11 additional information sessions that were focused on the under 60 disability population and they were primarily managed by the centers for independent living and we have heard very good things about those sessions in particular. It is something that was new to the final phase and it is something that I have to go on the record it is unfortunate that we did these type of under 60 dedicated sessions as well. It is nice to do it for the final phase. Lesson learned.

MATT SEELEY: Do you have a breakdown of the 3,000 and 600.

KEVIN HANCOCK: What kind of breakdown.

MATT SEELEY: How much were providers and actual participants.

KEVIN HANCOCK: I think the 3,000 were participants. Their participants or caregivers. So we -- I don't think we -- providers were well come to some of these sessions but the focus was on participants so we did focus on registration for participants and their families.
Any other questions?

Okay. So in addition to the sessions that have already occurred, we are continuing these participant outreach sessions and we are focusing on some grassroots for special populations. We did this in the southeast and found it to be effective especially for organizations or groups that represented particular cultural or language requirements. We are working with the M-E-N-D- E-Z-A group and they are working with grassroots organization throughout the final phase to see if sessions could be conducted in a language of preference for a particular community and also to look for opportunity today's be able to do outreach to special populations and communities. So Philadelphia area obviously the southeast has a lot of different communities with language special

language requirements and this certainly came up in the southeast but phase 3 has a lot of communities with special language requirements. There were refuge settlements in the Erie area and Lancaster and they are large portions that are Spanish speaking. From the Office of Long-Term Living, she was able to do some of the Spanish speaking sessions with these special groups as well as well as some radio shows and we are looking for suggestions. We still have time to be able to do some of these suggestions. So if you would like to make known any special communities that may need this type of outreach or grassroots outreach, please let us know and outreach to us or reach out to the group and we will make every arrangement to make sure those sessions are occurring.

So these sessions include community outreach events and stakeholders round tables. I was was at the one of the round table in Lancaster and it was a see verse group of participants and learned a lot in special outreach for the special group populations. We are very grateful to the participants to provide -- this not only informs the implementation but informs the way we conduct participate outreach for community health choices. This is an ongoing concern and we look forward to any suggestions from any of our stakeholders to do this type of outreach for the population.

So just as a quick update for phase 3 plan selection, the transition activities occurred as mentioned middle November specifically the weekend of November 16th and what that meant is if people had selected a plan, they were assigned to that plan in the system or if they did not select the plan they were auto assigned as already mentioned, those plan selections can be -- can be over ridden all the way up until December 20th but also note that people can make a plan change at any time. As of November 16th, 39 percent of the participants transitioning to C H C have made an advance plan selection. So realistically, I have to continue to say that I'm surprised about more people in the phase 3 actually actively selected a plan in phase 1 and phase 2. I had mentioned this many times in the past we are on track to beat the national record for how many people are doing advance plan selection. Unfortunately, where most of the population is solely eligible and the majority of the people receive most of their services through the Medicare program. They do not pay much attention to the Medicaid coverage and they often go through auto assignment simply because it is not their primary payer for their services.

Nationally when an M L. TSS program goes live, they have an assignment closer to 80 percent. In Pennsylvania, we are happy with the 60 percent but we would certainly like to see it better. We are on track to meet what we were in the southeast and southwest and we are definitely on track to exceed it so we are very happy about that. These next slides will do the breakdown by the individual zones. The first is the northeast by population. We show that the northeast had selected -- had 38 percent selection rate and that means that at this point, 62 percent of the total population were auto assigned. And if you remember when we described the northeast, it was for people who are receiving long term services and supports. The majority are in nursing

facilities. Even with a larger auto assignment rate, it is likely that those individuals are receiving long-term care in the nursing facility as opposed to the community. Certainly something that we are hoping that we can balance but nursing facilities are the primary long-term care provide sister in the northeast.

The next shows the northwest and we are happy to say that 46.1 percent had an active plan collection. S-H-O-N-A gets credit for that.

Why this is a particular accomplishment is how rural the northwest is. The most rural counties in this zone. Forest county where we have one participant. We are very happy to see the number of people who are selecting. Particular percentages of note are the home and community based duals and nonduals. 63 percent of the people communitying care in the community choose a plan and 55 percent of those in the community were not dually eligible also selected a plan. We are very happy with those numbers as we are happy with the 636.7 in the not dual eligible. So very happy with the -with the northwest. As we are with the Lehigh capital zone which was 44.8 percent. Once again, H CBS dual and nondual have a high plan selection rate. That is something we are happy to see. So far the numbers are look good for the plan selection for the final phase. This is a surprise to me. I'm being honest. It is a very rural area in all three of the zones but mosticly in the northeast and northwest. Congratulations to all of the people that were involved in the community activity. It looks like a lot of it has worked. So thank you for all of that. Any questions about these numbers before we jump into C H C enrollment?

Anybody else happy. I'm really happy about these.

So we wanted to also provide some updates on where we are at with enrollment for the entire program the first is southwest. The total enrollment is 80908. If you remember the original amount that we enrolled in the southwest about 7 $9,000. Growth in the southest is slow but it is growing but it is slow compared to the southeast which is growing like gang busters but the level of populations have not seen any change from January 2018, the actual enrollment date for the southwest. These numbers will be made available to you. I won't go through each one. I will characterize the southwest as slow growing and very little change in the distribution in the population. Although we are seeing some tick up with home and community based duals and nonduals compared to nursing facility. Just to be honest the slope is relatively steady. Changing over to the southeast we are at 134,000 there is not a whole lot of growth since January of 2019 when this zone was implemented but it is growing most specifically in the home and community based dual and nondual. That is both over 60 and under 60. The southeast is growing like crazy. That is where all of the growth is in Pennsylvania. We are paying close attention to it to understand why and make sure we are budgeting for it. This is as of September of 2019. And just to be very clear when you talk about -- so Pennsylvania is seeing some significant increases in home and community based enrollment compared to nursing home enrollment. We are in the 60 to 65 percent range. We would like to be like New Mexico and Arizona to be 80 percent with home and community

based because we want to reflect participant preferences. We are on track to get there quickly to my great surprise. I say a lot of that is attribute today community health choices and the focus on home and community based services but the larger -- the larger reason is that most people who are enrolling in long-term care in Pennsylvania are choosing home and community based services. So the enrollment is where the major credit lies with the movement towards home and community based services in Pennsylvania. But I would also note that when people talk about this, we also talk about how the program with home and community based services may on average cost less compared to nursing facilities but the reality is that our program may be showing orientation towards home and community based services but we are still growing very rapidly in terms of the cost of the program as well. That is largely -- if you remember last year we grew by 800 million dollars. Mostly attributed to long-term care enrollment and cost of care mostly in the community but our program is on track to be growing that much for this area as well. The program is growing like crazy.

(Applause.)

Easy for you to say.

SPEAKER: I thought it was what the consumer wanted, that quality of life.

KEVIN HANCOCK: You sit in those budget hearings. Well, actually, you will be a guest speaker for our budget hearings.

SPEAKER: All right. I can do that.

KEVIN HANCOCK: Last slide shows the resource information that we always have. All of the transcripts for the managed are available at our health choices PA -- as are the transcripts for the third Thursday webinars and we continue to encourage people to go out to -- to this website for updated information about community health choices including the new participant training that we talked in the previous MLTSS and encourage your participants or your residents or their families to learn more about the program through the webinar that has been recorded and is available for people on that website. We also encourage everybody to continue to participate with the list serve and to continue to make sure that you are advertising the independent enrollment broker telephone number. 844, 824, 3655 or the hearing impaired number. 18332540690 or visit enroll C H C.com for information or to go through the enrollment process or to change your enrollment for the community health choices Managed Care Organizations. And that is my update. Does anybody have any questions for me?

This is really good. This is good stuff. What we are -- have been able to accomplish in Pennsylvania. This is the final phase and what we have been able to accomplish in Pennsylvania for incredibly rural region is largely a credit to all of those people and a lot of credit to the C-I-Ls and the AA As and all of the

service coordination entities for getting the word out and doing a great job of crafting a message that is meant for the population. M-E-N-D- E-Z-A group gets a lot of credit by

reaching out to special populations and I'm going to give a hand to everybody who has been involved in the communication. It has been a great success. Congratulations to the C-I-Ls the AA As their partners and the M-E-N-D- E-Z-A group. Congratulations. (Applause.) I will bring it back over to you Barb.

BARBARA POLZER: This is incredible. It is not even 10:30. Well, we are going to move right along and we have a -- drew, I'm sorriment.

DREW NAGELE: I don't see it on the agenda here so I just want to take advantage of Kevin while he is still here. At the last meeting, I understand that there was a report about grievances and complaints and we had asked whether it was possible to have a the types of people who were making grievances and complaints categorized and I was just wondering if there is any progress on that.

KEVIN HANCOCK: There is. We will make sure we present in the January or February sub M-A-C. We talked about the reports and the data collection. One of the challenges we have in these early days of community health choices is standardizes the three Managed Care Organizations. We are working through standard dyeing, we want to make sure we are comparing apples to apples data and also break it down by population. So it will be available in the future months so thank you for the reminder.

DREW NAGELE: Thank you.

KEVIN HANCOCK: Thank you.

JESSE WILDERMAN: This is an exciting report and in the interest of beating a dead horse of the workforce. One of the critical components is we see this dramatic expansion it is a wonderful thing at the same time having a train wreck of not, you know, aging caregivers and not having enough caregivers to provide the services for the increasing need and desire to be in the community and so when we talk about the cost increasing basically being driven by new enrollment makes a lot of sense and I think we have to keep kind of relentlessly focused on understanding that it also costs to be able to have a workforce that can support the growing number of people there and that -- and so it would be good at some point. I know the Managed Care Organizations have been rightly relentlessly focused on phase 3 roll out and making sure that happens right. Once we get phase 3 up and running and it is going to go smoothly and see all of those things happening, I want to make sure that the department and this community and the Managed Care Organizations that we revisit and have repeatedly. I'm not suggesting that we haven't but revisit again what we are doing in the program to try to continue to make sure that the workforce is there to, you know, across in the rural areas, acutely challenged there but everywhere frankly and having a culturally competent workforce that can serve people in the way they want to be served in the language they speak and the food that they eat and the way that provides good facility services because home and community based services are cheaper but we can't make them so cheap in a way that it under cuts what it takes to provide the people the services they want and how

they want them. I know you know that. I'm speaking to the choir. I want to lift that up as part of the excitement of seeing this growth is making sure we return to that challenge over and over again to try to keep pushing on it.

KEVIN HANCOCK: Couldn't agree more. The only point I would add is that we do continue to talk about the direct care workforce and the challenges associated with retention and recruitments largely attribute today benefits wages and training. We have had many conversations with -- with our SCI U partners and other entities on way we can augment those three opportunities for improving recruitment and retention. And I would also add that the direct care workforce is not just about home and community based services it is about facility based services as well and the system across the board is strained with recruitment and retention for the direct care workforce. So when we talk about this is a challenge, it is a holistic challenge and it doesn't affect the long-term care system but it does. We are not alone in this but we recognize that -- that this is a crisis and continue to articulate it as a crisis and just as a reminder, this Committee did endorse a long-term care council blue print on how to address this crisis and look for opportunities and implement something that will improve the goal recruitment and retention.

BARBARA POLZER: Kevin, we had a question come in over the phone. Do you have the number of selections by plan by zone.

KEVIN HANCOCK: We do. We decided not to present it in this meeting. It is something that we will present in the January meeting just because at this point, there is still a little bit of validation and a lot of shuffling in the final month. So we just didn't think it would be a service to the Committee to present the numbers as is since it is changing. Based on the southeast and southwest experiences we know that that changing sort of beginning to subside after the implementation date. So we promise we will have it by plan by zone my plan after January 1 st.

BARBARA POLZER: Thank you. Any other questions for Kevin. Then we are going to move on. We have the C-I-L central PA going to do a presentation for us on cultural competency specifically for the deaf and blind population. And we have Sharon and Heather.

SHARON: Good morning. Since we are ahead of time, I guess that means I have more time to talk. I'm kidding. We plan to keep it short and sweet. Good morning everybody. My name is Sharon and I work for the center of independent living of central PA which is here in Camp Hill. I wanted to take a minute to recognize our CEO Janetta and I believe Pam is here somewhere. Where is Pam. It is a coworker of ours. Pam is here too and I'll let Heather introduce herself.

HEATHER: Good morning. My name is Heather and I come from the Lehigh Valley area. I'm working with
Sharon at the center for independent living here but I do live in Bethlehem. So I'm working in this area and working remotely.

SHARON: I just want to take a -- I want to say thank you. I believe it was Theo who brought up the topic of talking about persons who are deaf blind and S S P services and brought it to the community and then they asked us to do the presentation today. So again, I don't want to take up too much of your time. I know you have a lot of other things on your plate especially with the roll out starting in January. I wanted to talk a little bit about the program and where we are and then turn it over to Heather to really talk about the nuts an bolts of the services and what we provide and how it assists people who are deaf blind.

So the center for independent living created deaf blind living well services D B L. W S in 2014. And that was through a pilot, a grant that was offered by OVR office of vocational rehabilitation. They have been funding the program ever since until this past year. So starting October 1 st, Matt, with the S-I-L-C they agreed to fund the grant. So without them coming forward, the service would not exist right now. So starting October 1 st, S-I-L-C is funding the program and the grant is for one year and it can be renewed a max of four years so a five year grant.

So this -- we are restructuring the program a little bit. The program is operating like an interpreter referral service, if you know how interpreter referral service operates. We have three positions. They are all part time positions. I'm the supervisor of the program. Heather is the education and outreach coordinator and we are in the process of looking for a scheduler for the service. If anybody is interesting in scheduling and working with people who are deaf blind and happen to affluent in American sign language, let me know. We are looking for someone. That is the last person we need to be part of our team. With deaf blind living well services, what we do before we talk about S S B services, we connect the person who is deaf blind with an S S P and Heather will talk to you about what an S S P does. So what we do is we go around the Commonwealth and we identify persons who are deaf blind who meet the criteria and use our service. Then we train people to become an S S P. I know I keep saying S S P. We will get into that. So then we kind of link the two so they can provide assistance to provide assistance to the person who is deaf blind. With the service because it is funded by a grant, we don't have unlimited fun, unfortunately, I wish we did. Each deaf blind person within our program, can receive 10 hours of service per month and the S S Ps are paid, they are paid $15 an hour for their service and all of our S S Ps have to go through the training program and they are vetted. I'm going to turn it over to Heather to talk more about deaf blindness and what an S S P does and then open it up for questions and go from there.

HEATHER: So my back ground, I came from the education world. I'm a teacher of the deaf and hard of hearing within the Nazareth school district. I was with them for 20 years. I come to this position with the experience of the K 12 system and I always spoke to people within our center for independent living in our area about those transitional ages and their response to educators was, you need to prepare your young people for being independent and advocates for their own selves when they graduate. Now that I'm on the other side and see all of the wonderful work the C-I-L does here and the

Lehigh Valley I know learned how S S Ps can assist deaf blind individuals to become independent and I think that is the wonderful part of this program. I was as we call in other places around the state the original group of S S Ps who were trained four years ago -five? Five years ago and I was trained with that group to provide S S P services and I was kind of -- I'm a proficient signer but have never worked with the deaf blind association until a student of mine starting losing his hearing in 4th grade and now graduated and getting him to understand how to use services in the adult world. When I was trained as an S S P, I thought, you know, what do we do? Where do we go. Basically, it is not my decision. It is empowering deaf blind individuals to make their own choices to determine what they want to do with our assistance. I think that is a different shift from the education world where we are teaching and teaching and now we are empowering the adults. The adults, I have worked with, I have been to Hershey Park. I have been to an audiologist and I have been to places in the community to engage those deaf blind people in providing sighted guide. Some people have never known there is about 30 different T-shirts at chocolate world. So to have that environmental information told by an S S P to that deaf blind individual is amazing. She said I never knew there was so many T-shirts. When I'm here with my family we are hurried through to finish up. We spent 7 hours at chocolate world and that was -again, not my choice. I could get through that in 30 minutes with my husband. A deaf blind person who wants to see every T-shirt was empowered by the S S P to basically lead them through, give environmental information. I said do you want to ride the ride. I described what the ride might be. The different kinds of chocolate.

Let's taste the different chocolates. Those kind of environmentals. I'm not in the pictures. I'm the invisible person behind the scene empowering them to take the I-N-S-T-A gram picture is pairing the right person with the right individual. Deaf blind people like every hearing sighted individual they are all different. We think of the Helen Keller every deaf blind person is going to know sign language and it is going to be great and the instant moment and understand what is going on. That really doesn't happen sometimes. Some people might be losing their hearing, losing their vision. Some might know sign language and some might not. It is pairing the right person with the the right individual to have a great moment of independence and I think that that is what my role as the educational outreach person is to build that information and referral to find the people across the Commonwealth that might be isolated and then pairing them with some great services through the grant and I thank you for that ongoing support.

So currently, the S S Ps support service providers is an S S P. We are trained in how to work with them from pick up at their location where they meet us and give that experience. Some, again, don't know sign language but we will take them to the places they would like to go, grocery shopping is a favorite.

They like to go to certain stores. Again, we pair them where they want to go not where we want to go.

SHARON: So how the service works is it is very similar to an interpreter referral service. So we as Heather said person whose are deaf blind, they are in control of their hours and their services and they are empowered so they decide how they want to use the hours. Like I said, they get ten hours a month. Like, for example, Heather and I were talking on the way over we have a woman who wants to learn to knit. So we paired we are with an S S P, I think, who knits. Who knits and has that experience.

So again, it is pairing that right person so now this -- the deaf blind person wants to use her hours, I think it is once a month for three or four hours. She wants to travel and get her knitting supplies and take a class the S S P is there to help guide her through the class.

HEATHER: As the S S Ps learn the people around the state and their style, they are more excited to be a better S S P. So this S S P might have to travel while to the person who would like to knit but this S S P has to conferences and has knitted with other usher syndrome individuals who have bigger needles and have strategies and know what their interests are and pair them with teaching some other skills that might have some skill sets from other areas of the state. We are not pairing only the people from one area with another. If we are willing to travel and make connections those S S Ps can form connections that the deaf blind person feels they are not as isolated. They can speak through the video phone and then have those relationships that are just as important.

SHARON: I think it is something to keep in mind, for example, we have a lot of persons who are deaf blind who like to go to the grocery store. I remember talking to one of this one woman Z-A-N-O-L-A she lives in the Harrisburg area. She didn't realize there was a whole aisles of salad dressing. It is things that you and I take for granted. Reading your mail. How is a deaf blind person going to read their mail. They can't. They have a lot of -- they use their hours to have someone come over and cyst through their mail and label their clothes so they know what is winter and spring and what color and so they know what goes with what. Things we take for granted that we do by ourselves but persons who are deaf blind can't. We we talk about cultural competency. It is not the deafness or the blindness that is the obstacle that is the challenge, it is the communication. How do they interact with their world. You and I can do that pretty easily. For a person who is deaf blind, they can't. As Heather said every person is different. We work with persons who are deaf blind who are completely deaf and blind and they use braille and American sign language and folks on the other end who is hard of hearing. They use English and they can see like a pinhole and that is all they can see or some have peripheral vision. So it depends on the person. It is all finding that right match to provide that service because that person, that S S P has a lot of personal information if they are helping go to the bank, which we have that, grocery shopping. They are in their house and reading their mail. So it is all our S S Ps are vetted. They have a code of conduct they need to follow. We have a long way to go with S S Ps. It is not a profession yet. Sign language interpreters became a profession officially in 1964. So since then the

profession has growing the models of interpretation and the philosophies inter from theer views have been changing

over those years. So interpreters are here and S S Ps are down here. There are only two states in the country that actually that have a law to provide S S P services. We are working with some Legislators now to create -- let me back up. The deaf blind community is looking to create along with us a comprehensive system in Pennsylvania. Because S S Ps don't follow under the Americans with disabilities act. It is getting people to pay for the service is the issue, concern, obstacle that we will overcome.

I like Pennsylvania to be a model and be a leader so we are going to do what other states aren't doing yet is my goal to create this comprehensive system where a person who is deaf blind can get services from a variety of services. One being a managed -- OVR already has a fee code for their customers. So from person who is deaf blind that is seeking employment, going to college, they will pay for S S P services for their customer. We are working, like I said right now for the Legislature trying to get a bill passed to be another prong of this multi faced approach. That is where we are right now. It is not going to happen overnight.

HEATHER: One final -- one last story from an S S P I think as our pop population grows and the people we serve grow, the family members that interact with the deaf blind individuals on a daily basis appreciate this just as much. I work with a young lady under the Kutztown area. She has usher syndrome. She has five degree vision profoundly deaf and now that she can go to the grocery store and the wine store and the Walmart all in one sweep. She gets texts from her husband that says this is amazing. Thank you for taking care of these errands so I can cut the grass when I get home. When he gets home, he would have to go to the wine store and the grocery and she feels part of the family that she is contributing back to those errands as we complain about errands and all of the things we have to do. Some deaf blind people would like to go on errands and feel a part of their family that they can contribute. So the amount of impact is not only on the deaf blind person but improving family life all together that when those groceries come home and the daughter says mommy got your favorite M-U-F-F-I-N-S and she did. For many years she couldn't do that and wait for dad to come home with all of the groceries after a long day of work. And now she is feeling empowered that she can get those things done with the S S P.

SHARON: Does anybody have any questions for us. Again, it is one size does not fit all. It is hard for us to say, so when you encounter a person who is deaf blind do this because one size does not fit all. Every person is unique. So we are available if anybody has any question today's contact us after the presentation. We are happy to work with any of your organizations and provide you with more information or if you happen to have a participant who is deaf blind if we can provide any services, consulting services to you, we are available. But is there any questions at this point? Matt?

MATT SEELEY: Can you go through what the process is becoming an SSP.

SHARON: Sure. What we have done is to -- here in Pennsylvania try to create a consistency like I said, there is no national certification out there. There is no national guidelines. We are trying to create something in house. What we do since the beginning, we actually contract with a trainer who is in Virginia, West Virginia? In Virginia. She is the only -- I'm going to forget the three. She is the only person in the country that has the three certifications. She is a certified
sign language interpreter. Her first language is English and A S L.. She is a certified orientation and mobility specialist and also a certified vocational rehab teacher, I believe.

HEATHER: And she is a teacher of the deaf and a teacher of the blind visually impaired.
SHARON: We are luckily to have found Shannon. Anybody that is interested fills out an application. You have to remember people are deaf blind and we have some that sign and some do not and our program is statewide. So right now, the course usually occurs on a weekend, two days it is a total of 19 hour course. It is very intense. It is a lot of -- you have been through the course.

HEATHER: It is a very hands on, simulations, working with deaf blind people will come to the course to practice with. We network with each other. Really learning what it is like to be a deaf blind person and having a lunch where you can't see or hear and putting people in those shoes and to see what they go through on a daily basis to become a better S S P. With the training after that, they are all vetted with background checks and can provide the services and be paid. As I said, there is no continuing education units out there. There is no professional development. A part of this grant and has been the goal of the program is to provide ongoing professional development. So now that we have two, hopefully seen a third person on board, we are going to start having regular meetings with the S S Ps you have to remember a lot of the S S Ps are starting off, they have a friend who is deaf blind so they don't have a professional business background. They are more like the helper model. They have a friend I'm going to help you out but they don't know how to run a business. We are starting with square one with some of the S S Ps and say how do you create an invoice and how do you fill out an invoice and how do you pay your quarterly taxes now that you are self-employed. We are helping to grow the profession. My goal is that we have S S Ps that are -- become business savvy and their code of conduct. So M COs and other entities start calling them for services which they can do that or call us because they are independent contractors, they know how to appropriately run their business. So it is not just coordinating the services. We are teaching people who are deaf blind to request the services properly and do it in a timely fashion but we are helping the profession grow at the same time. So it is a lot but we are really -- we are excited about it. Moving from the helper model and feel sorry for you model -- I just want to help this lady from my church. It is helping her but that is not our point. It is empowering her to understand how she can do it herself with your assistance, not just making sure self feel that you are in this oh, I feel so sorry for them,

they are alone, yes, but we got to get out of the helper bee model and empower them to make their own choices that is what we are moving this program towards.

SHARON: I think there is another question.

HESHIE ZINMAN: So I'm thinking about deaf blind people who are also members of sexually minority communities. Is there an opportunity to train your S S Ps around L. Gee Bee T cultural competence. Because I would imagine -- I mean, it could be uncomfortable going into an environment and not having any sense of the culture of the person that you are working with.

SHARON: I would say definitely. So as we create our team and start to move forward, we are going to start doing trainings for our S S Ps. We have an informal, I should say, sessions with them that we can talk about one of the business practices but the same time also training such as that. We still have to work on orientation abilities. We are going to work on training facilities so we would be in touch with you to see if you can give us some guidance on that but yes, definitely.

BARBARA POLZER: One came in over the phone. Have you provided SSP to any individuals in CHC yet?

SHARON: That -- clarification? Meaning that a managed care company contacts us to provide that service. No.

SPEAKER: I think that is what they mean.

SHARON: No.

SPEAKER: A supplement to the CHC or waiver services.

SHARON: No we have not.

LINDA LITTON: Do you offer services in southeastern Pennsylvania or southwestern or just central.

SHARON: Statewide.

LINDA LITTON: Statewide.

SHARON: You look confused Matt.

MATT SEELEY: It is possible that some of the deaf blind are in CHC. You are saying the Managed Care Organizations haven't contacted you.

SHARON: So yes. There are persons -- for previous meetings I know and I know there were surveys done trying to identify the number of people that have different disabilities and I remember deaf blind seeing on the screen. I know the numbers are low probably under ten in different MCOs. There is not a large number of people who are deaf blind in CHC but there are some. We have not been contacted by a Managed Care Organization to provide the service. A person who is deaf blind may have contacted

us and said I'm going to a doctor's appointment and I need an SSP to go with me. I would never know if they are C H C participant because the hours are being covered through the grant. So that I would not know.
Any other questions? Anything else on the phone? Just checking.

Thank you for your time. Appreciate it.

Thank you.

BARBARA POLZER: Thank you ladies we appreciate you taking the time to come here today.

This is unprecedented you know that, right? It is now time for CHC-MCO questions. Do we have any questions for the Managed Care Organizations?

LINDA LITTON: When are they going to start using the SSPs?

BARBARA POLZER: Linda wants to know from the Managed Care Organizations when will you begin using SSP services?

LINDA LITTON: By how many people do you run across, you know, within the community that needs that service, I guess, that is pretty much how it would go I'm answering my own question.

SPEAKER: My name is Karen I'm from Philadelphia adapt. This past summer, I was in a major accident. I broke my right femur bone and I have been in the hospital and a three hour operation and I ended up with three days and in rehab. I was in tremendous pain and I know we have opioid addiction concerns and all of that but only certain medications work with me. I'm using myself as an example, it could be with anybody. But I can only use myself as an example.

Pain meds. Usually, regular stuff doesn't work with me, meaning regular Tylenol, Advil, I would be taking them like candy. It does not work. So the ones that do work nobody wants to -nobody wants to provide even though I -even though you say, well, I will take it as prescribed, which is Percocets and Tylenol with codeine. At rehab only 5 M Gs, which did not work. I got my stitches out, I had to have my doctor, the surgeon, can you please up the MGs so she gave me 10. 10 M Gs which was two pills every -- whatever hours. It still didn't work. So I just have to deal with the pain. I mean, that was -- so right now, I'm out. Right now, I'm not taking anything. And the doctor that I was seeing, he wanted to give me some pain patches when I took the script -- when I took the script to my pharmacy -- no. They wouldn't -- they -- insurance -- they can pay for it. So they gave some cream for something that is when -- I hadn't started using but the thing is, certain things that certain people need that are not being paid for. Right now, I have -- I wear boots. Right now, when I stand up to do my transfers to the bathroom, my feet slip. And that could be dangerous because I -- there are times I'm not going to be home. I'm going to be in a public bathroom with no help trying to do this by myself and that was harder since I have accidents. And I just found out I called the vendor and they say,

well, they did it two years after I got my first ones done, they -- the ones I have on now. I need these redone. I got to wait five years. That is not right. And then I do need done is the soles on the bottom -the soles redone so that I won't slip. And vendors are telling me you're going to have to pay for out of your pocket. I ain't got that kind of money. I got bills to pay. So it is just stuff after stuff. This could be done with anybody. I was losing -- thank you.

BARBARA POLZER: Thank you Karen for sharing that information. We have a couple of questions that came in over the phone.

Tonya wants to know when will the plans be sending out ID cards? And I have a member of each plan come to the table and respond to this please?

SPEAKER: PA Health and Wellness. I'm Anna. We will be sending out ID cards after we receive our final 834 and then we have a very short window to get our packets out to folks so that will be the 20th -- after the 20th.

BARBARA POLZER: Thank you Anna.

SPEAKER: I'm with AmeriHealth we will be sending out the ID cards and packets beginning five days prior to January 1 st. So December 26th. That will start the period of mailing out the ID cards.

BARBARA POLZER: Thank you Chris.

SPEAKER: I'm just going to sit on Anna's lap. For community health choices we will be sending them out in the same time period.

BARBARA POLZER: Thank you David.

When can and will the CHC plans pay for SSP for their participants?

SPEAKER: I think -- we can look into connecting with the CILs of Central Pennsylvania for the process of getting that started. It will be depending on the memberships and the needs also looking at how we would work with the grant program to make sure we are not --

SPEAKER: We visited the program and actually transferred coordinators on the program. There are 80 individuals who are actively using that program. So it would just really depend on what David said identifying that we are not duplicating services or funding services.

SPEAKER: And for AmeriHealth it will be the same. Taking it back and looking at it and evaluating it from a payment structure and paying where we are not supposed to.

BARBARA POLZER: Thank you.

MATT SEELEY: Can I ask a follow-up to that. So you are all saying that you will pay for SSP services?

SPEAKER: Well, we have to go back -- I have to go back and take a look at that.

MATT SEELEY: They didn't seem to say that. They seemed to say sure as long as there is no duplication of services.

SPEAKER: We are going to have to look if we can fund that service but we have been looking at those alternative services for services for individuals. It is very similar to PAS services in some cases.

SPEAKER: We would be in the same group to look at it and see if we can work with the individual.

BARBARA POLZER: So now, when will you complete that research and will you get back to us at the next meeting.

SPEAKER: I would say that next meeting is probably difficult since we may not necessarily have a good understanding of what exactly our member needs are and what that looks like but it is something once we start seeing our members and visiting with members we can look into how we can incorporate that into that program.

SPEAKER: Same. I can't commit to anything from our health plan if we haven't ahead that decision but we are looking at it.

SPEAKER: You are going to get the same answer for AmeriHealth.

BARBARA POLZER: But why did Jen join us.

SPEAKER: I joined because I think there are two opportunities. One, CHC waiver definitions how does the service fit into the approved 37 LTSS benefits that we have today and if there is an opportunity to change language, I think OLTL is open to that possibility.

Secondly, I think it is about training. So I think what we heard today needs to be incorporated into the curriculum so when services are planning with participants, that light bulb goes off will they understand that this is an available support of service so they can make that recommendation.

BARBARA POLZER: Thank you. There is another question coming in over the phone. The ellipse is going. Please bear with me.

MATT SEELEY: In the meantime, can Kevin address that?

KEVIN HANCOCK: I'll do it. So I'm trying to encourage some of the newer people to be much more forthright when it comes to answering these questions. I will answer the question. So we do broadly cover language requirements both in the waiver and the CHC agreement but we are not specific to S M.D. and we -- we -- we include broadly but we don't include the S and D specific requirements. A lot of other states have talked about having a waiver service –

MATT SEELEY: Do you mean SSP.

KEVIN HANCOCK: Sorry.

MATT SEELEY: That was a new one.

KEVIN HANCOCK: That is another acronym. SSP -- SSP is covered broadly in both the CHC agreement and the waiver but some of other states approach it as a separate waiver service. We have looked at it in the past. There was a lot of communication about SSP services prior to the implementation of Community HealthChoices and we looked at it and we thought the way we covered it in a waiver is appropriate but as Jen had stated, we are open to suggestions from programs if it is needed and that would be something that would be actually if the Committee wants to make a specific recommendation that won't cost us anymore money, then we -- the more specific the better to be perfectly honest.

BARBARA POLZER: So providing this is participant specific, what is the time line for decisions on the policy of covering the service?

KEVIN HANCOCK: I'm not sure I understand the question. So I'm not sure I understand the question. I'm not sure the MCO participants understand the question. Let's answer the question how we want to answer it. So we don't -since we had just opened up the idea of recommendations from the Committee, it would be largely dependent when we receive the recommendations and how they would have to be accommodated in the waiver or agreement. The agreement is already in flight through the signature process for 2020 so we would be talking the earliest we can make a waiver or agreement change would be 2021. But first quarter of 2020 would be one we would be willing to accommodate any significant changes to the agreement or the waiver language. So if the Committee wants to make a recommendation a time line for the recommendation would be -- to be able to meet the rate setting requirements as well as the CMS approval for both the agreement and the waiver would be the first quarter of 2020. Does that make sense? So I answered the question the way I thought they meant.

BARBARA POLZER: Into ellipse yet.

SPEAKER: Can I ask as a follow-up. If there is a decision point that would be coming to add this as a covered service there would need to be a cost evaluation associated with that and does the information already available in terms of the number of people in need of the service and what the rate is to provide and how many hours would be generally needed? Is there a study that needs to take place in order to get to a point where we can evaluate this decision.

KEVIN HANCOCK: So a study would be -- from a budgetary perspective a study would be mandated and we don't have a clear picture of the population at this point. That is a very good point Blair.

SPEAKER: That is the first step how do we get that clearer picture of the population.

KEVIN HANCOCK: I would argue the first step would be once again what the recommendation would be and then we would use that as the focus of the study.

BARBARA POLZER: Is there anyone only the Committee who wants to make the recommendation or do you want to think about this for next meeting?

KEVIN HANCOCK: So my request would be to think about it taken to make it as specific as possible.

BARBARA POLZER: Okay.

KEVIN HANCOCK: Thank you.

BARBARA POLZER: Luba.

LUBA SOMITS: I have a question while all three M COs are here. If we could address the question that the lady had in regard to her adaptive boot. It seems unreasonable that it would be five years before an adaptive boot could be modified due to wear. Is there an avenue that she can take in order to get that addressed since it would occur that she would be a risk of falling if those things were not done. While you are here, if you could just address the need that she has apparently for those shoes to be modified more than just the five -- the typical five year cycle. So we have something to assess the boot etc. If you could comment on that. I would hate for her to walk away without some response for us.

SPEAKER: It is these boots right here. When I stand on them, I slip. I slip and slide.

SPEAKER: I'm able to go to the bathroom on my own but depending on where I am, I -- I slip and slide and -- slip on the floor. If I slip on the floor, my leg is going to be hurting again and I think -I will be back in the hospital.
SPEAKER: So if I can just break this down. I think that five year comes from the original payer. It could have been Medicare, right? It could be whatever. So I think from a take away from your experience where you shared with us what your boots do for you for your independence, that -- your service coordinator needs to help you navigate through. I know there are providers in the room. If I look around here that have been very innovative with coming up with solutions for people and we just need for adaptive equipment and for boots, that you clearly use and you clearly need to maintain your independence. We don't need to get caught in the red tape. Your service coordinator would help you through that. You identify the need and then it is on them to work with everyone that is at the Managed Care Organization to help you get the that you need to get the boots fixed. You need to vocalize that to your service coordinator. It is important to you that you need this to do your daily activities. So, of course, we want to promote that as your Managed Care Organization. So I think L-U-B-A for pointing that out. That is where it starts is having that conversation and making sure that they work through to get the equipment that you need.

SPEAKER: So just to add to that, if you have Medicare, you want to make sure your service coordinator to stop the red tape as Jen said and any delays if you have Medicare, it will likely pay first. SPEAKER: All I have is Keystone First health choices that is all I have.

SPEAKER: Okay.

BARBARA POLZER: Any other questions for the Managed Care Organizations? SPEAKER: Good morning it is Liam from adapt. I was hearing Kevin's numbers about increased -- for our population. Really, the holy grail at this point in terms of data is PAS utilization numbers, I think that would be really interesting thing to see especially, you know, now that in the whole state will be enrolled. Just to see a per capita breakdown of average of PAS utilization. I think it is one thing to see really great, you know, HCBS increases but if it -- the other side of that is decreases in, you know, PA S utilization. It is a victory but it is less of a victory and so that might be more of a Kevin question. But I mean, if any of the MCOs have anything to say about that and the other thing I want to ask about is increases in services like meal delivery and things that MCOs could brand as replacing P S A utilization. I think it would be interesting to see if meal delivery utilization is increasing while PA S is decreasing. And now -- that would obviously not be good for our community because they are not -- it is not a one to one replacement. I would love to see data about that.

KEVIN HANCOCK: So we can provide that data. I would actually want to provide that data in context. So when we show PAS utilization we would want to show the real picture of PAS utilization like this. PAS utilization has gone -- it has increased for fee for service in the southwest and the southeast by anywhere from -- from 12 to 30 percent per person. So you can -when we want to paint the picture for past utilization and you want to raise a concern about decrease in the managed care environment, we would have to make a clear point about the fact that utilization for PA S has increased astronomically in the fee for service system prior to implementation for C H C. We don't know at this point how appropriate those increases were compared but we can evaluate pretty closely how inappropriate or appropriate any changes to utilization occurred after the managed care system. It is a point that I have been making pretty often over the last four and a half years. Utilization for PA S has been increasing pretty dramatically and we would want to make sure we are showing the entire slope positively or negatively in fee for service managed care. I would also add that we did create a pretty much management, 33 different services and we wanted the Managed Care Organizations to create an appropriate -- taking into consideration all of the different type of services. I think your ask is a good ask for showing in addition to PAS what other services are being offered since C H C or for -- for participants in the community. It is certain the PAS and undelivered meals are not the same service but if people are able to have the service plan under written by an array of services to meet the needs and specific to their needs and preferences, that is a picture we would definitely want to see.

SPEAKER: And so you are saying that appropriateness was that the word that you were seeing.

KEVIN HANCOCK: Person centered appropriateness is the way I would describe it.

SPEAKER: Would that be judged by complaints or grievances.

KEVIN HANCOCK: So complaints and -- well, more grievances for any changes to service plans. So that is one consideration. Other considerations are just the M C O monitoring and just general census to how these changes are being perceived. So they -- the Managed Care Organizations are required to go through a pretty comprehensive assessment of participant needs as part of the -- you know, the person centered planning process. And if there is not a direct correlation between that assessment and the service plan that is developed that is a problem and that would be something that we would measure as a part of appropriateness. That is a good question.

SPEAKER: Thank you. In any of the M COs have anything to say about that?

DREW NAGELE: Actually, I have a related question. Since Kevin mentioned service utilization is it possible to look at all thirty-some services and look at their utilization pre-waiver and pre-managed care and current? Just so that we have a bigger picture of what is actually changing as managed care moves into this service provision?

KEVIN HANCOCK: The answer would be question and just a largely characterize it and the MCOs will probably agree with this. There hasn't been that many changes in fee for service and managed care. It is something that we are looking at closely. We want the services to be -- to be formed to meet participants needs and preferences. So we are expecting some services. Because we do believe based on hard evidence that the service plans that were developed in many of the cases in the fee for service had nothing to do with participant needs. They had a lot more to do with opportunities for employment to be perfectly honest. We know that that was occurring. So the evaluation is something that we have been taking a look at and we did -- we are encouraging the Managed Care Organization to take the person centered planning process and the tools that they are using to develop a service plan that has met the needs. You wouldn't be seeing -- the expectation is you won't be seeing that much changes just based on the number of grievances and we do get reports on plan changes as well. The numbers are relatively slow or small. The only other thing I would add is a number of the services that are in community health choices weren't in the fee for service system. So obviously the utilization would be in community health choices and in some cases the utilization for services has been relatively slow like P-E-S-C-A certification and we don't have that many providers at this point. Employment related services are also -they were part of the fee for service waivers with low utilization and we have not seen that much of an increase in community health choices. Setting expectations not that many changes and also, low utilization for some types of services.

DREW NAGELE: I anticipate the same thing but if we saw some patterns there, that might suggest some areas for further education and training of service coordinators.

KEVIN HANCOCK: Sure.

DREW NAGELE: Or participants even in terms of the employment services for example.

KEVIN HANCOCK: We are spending a lot -- Randy who was here earlier, that is part of the reason why we are trying to promote this employment first initiative within the department. We want those services to be used and the waiver will be making a fundamental change starting January 1 st assume it go that all is approved by CMS that will allow us a way to -- to work with OVR so that some of -- like ODP some of the OLTL. Employment services can be fast tracked for access if there is a capacity issue with OVR to be able to support them. We are taking steps to encourage but setting expectations that slow utilization at this point. That is a good example. It is something we are asking from the Committee. As we shift to full implementation community health choices, program improvement will begin to be the focus a lot more focus on quality, quality that Marie has presented over the last couple of years will become the focus of the program and the Committee will be able to provide feedback on ways we can improve this program. Thank you. David

SPEAKER: Follow-up question for the MCOs and Kevin. Kevin, you mentioned some are under utilized because of --

KEVIN HANCOCK: I didn't say under utilized but low utilization.

SPEAKER: Walking through from a consumer perspective. This has come up if a consumer is from their home or LTSS eligible and if there is a lack providers how does the service coordinator interface with the consumer, is the MCO actively trying to get providers in their networks for the consumers perspective, if you can speak on a benefit what that might be for them.

SPEAKER: So for Keystone First and AmeriHealth, we haven't had any issues authorizing P-E-S-K-R-A -- we want to make sure the waiver is last resort. We go through with the participant do you live in public housing is your landlord responsible for this. What other opportunities are there to have this covered before we top into the LTSS benefit. That is the first thing but we haven't had any denials for pest eradication in either plan. We work with the participant and their family to get it remediated and hopefully so it is not a recurring problem for folks. We know that is in no one's best interest. From a provider -- I will hand this over to Chris.

SPEAKER: If there are any area that's we identify that we don't have a provider for that specialty, we outreach and do searches and we encourage those individual vendors or providers to become an M A enrolled provider especially under O L. T L. So we can contract with them on an ongoing basis. We have several providers that are statewide

so we don't have any areas that we can't cover and get somebody out there but if there are other vendors that wish to become participating, we will work with them and work with the provider services and M A to help and guide them through that process and have them enrolled as we move forward.

SPEAKER: Thanks, Chris. I'm not sure our response would be much different. I'm not aware of any pest eradication that has been denied but we have had to go through the process to make sure the individual that we are the payer of last resort and the landlord has done theirs and so on.

SPEAKER: And for UPMC, it would be similar. You know, we would go through the same process of ensure that go a landlord or municipality is taking care of that prior to the waiver taking.

KEVIN HANCOCK: Point of clarification. We are not talking about denials we are talking about lower than expected utilization.

SPEAKER: Correct.

BARBARA POLZER: Amy.

SPEAKER: Sorry. Speaking to the prevalence of bedbugs in Philadelphia.

SPEAKER: This is Amy from the Pennsylvania health law on the pest eradication question, I will see that one of the plans has issued a denial because we have seen it and it was on the basis of a landlord's responsibility. What is your -- and this landlord had put in writing that they were refusing to provide it. What are each of your plan's positions when a landlord refuses pest eradication. What research have you done to determine a landlord's responsibility. It is not consistent across the state. Philadelphia has different rules than other cities. What is your position on that?

KEVIN HANCOCK: This is all you guys.

SPEAKER: I will speak to the second point first which is our service coordinators do work with landlords and the participant to identify if there is a tenant agreement or also, more to identify that information for a municipality to see what the responsibility is. As it relates to the provision of that service.

As far as if a landlord refuses, I honestly have to say I will have to go back in and check with our folks to see what actions we would take in that instance. I think it becomes problematic for us if the landlord isn't willing to do their role in that to become problematic for us to move forward in funding.

SPEAKER: Amy, I wouldn't want to misspeak. I would have to look at our policy and we can get you that feedback but I'm not exactly sure what happens when a landlord refuse it's to do their piece.

SPEAKER: Same here. I think at the end of the day though we want to remediate the problem. So we would work with whoever we can to get that done. I would have to check on the specifics. I think you are right that the language is not clear from a code perspective but that is not what we would want to look into. It depends on the unit size and how many residents as to the responsibility of the property owner.

SPEAKER: Yeah. I think it would help to understand what you would do in a case where you determine the landlord responsible and they refuse. It is not the same as a home modification. A home modification if a landlord refuses to allow it, then the only -- then it is really something that can't be done and becomes a disability discrimination issue. But with bedbugs, this is the only way to in many circumstances to get a landlord to comply would be to bring legal action forcing compliance which the Medicaid program doesn't require somebody to sue who injures them in order to get the car insurance company for automobile to be the first payer. So I'm just hoping that you will consider not forcing people to have to go through those extra steps of bringing a lawsuit and I don't think necessarily moving is a good option because we all established that finding new housing can be challenging. Recognizing that we don't want to landlords to think the C H C will pay for it. I think it needs to be looked at closely because you can look at a situation where you are leaving people in a tenable situation.

SPEAKER: We can go back and explore it and if you have information that there are different kind of legal issues or direction by county, if you have any information, you can share it with us, I think we would all be open to receiving the information. I think it is very challenging when it is a landlord owned property and if the pest eradication would require furniture or certain things to be moved or something changed in the environment and they are not willing to do that. Then it is difficult for a managed care company to force them to do that and in the end, while housing is challenging, of course, the participant still kind of has the right to continue to stay there or not but as we said, we can all, you know, go back and look at it but it is payer of last resort and it is not a property that we own or the participant. But any information you have that you are willing to share we would be happy to review that.

SPEAKER: So on December 5th, in Philadelphia, at City Council, you could show up and force the city to actually have a policy where the landlord would pay for it. So they are trying to make it so the landlords and the tenant -obviously the tenant can't afford it. So a little bit of pressure would help.

SPEAKER: If you want to send me the information, I can pass it on.

SPEAKER: We are trying to identify, it is hard. Same challenges you have. There are how many different counties and different municipalities with rules, some have regulations, some don't but I do think that this warrants further discussion and also, is there any progress on a related topic of getting a broker to do the pest eradication since it is difficult to get providers who is Medicaid enrolled.

SPEAKER: We do have a statewide contract with AmeriHealth Keystone. So we may not be running into as many issues.

SPEAKER: Amy, we haven't had the plethora of pest companies but we have not run into a situation where we can't identify one that can get the work done and we have subcontracted to get that done as well. We have resolved the issue. It is just not this long list of providers to choose from.

SPEAKER: Same for us.

SPEAKER: Thank you.

MATT SEELEY: Just a question for Kevin about the low utilization of the employment service. I'm curious, given the hoops that someone would have to jump through to use that service why you are surprised about the low utilization and secondly, if CMS approves the waiver and all of that or the amendment, is there a chance that Ed butler could come and talk about what that would look like.

KEVIN HANCOCK: So I'm not surprised I'm disappointed. There is a difference.

MATT SEELEY: I'm pretty sure you said surprised.

KEVIN HANCOCK: Well, no.

MATT SEELEY: You can ask Hillary to read it back.

KEVIN HANCOCK: So I will clarify that I'm disappointed. I agree there are a lot of hoops that have to be gone through to access the services which we are trying to access through the waiver language to allow the alternatives. If there are capacity issues with OVR we can work around them. We are expecting that to improve the utilization and that is a great idea to have Ed and Jen Hale report on what those changes would be if the department thinks it is a good idea.

BARBARA POLZER: Sure.

KEVIN HANCOCK: Barb and Linda, I should say.

LUBA SOMITS: Question for Kevin. In regard to your PAS data that you will be collecting is it possible to break out the population of those that are 60 years of age or older and if there is an increase in services for that particular population and here is the reason why I'm asking for it: There was some suspicion that historically, the area agencies on aging may have been using the options model in providing the same number of hours of service for those in waiver. So if we have an independent assessment done by a Managed Care Organization, there may have been an additional need and therefore an increase in the number of P-A-S hours that would have been used. And so if you kind of look at it as aging being the largest number of individuals who are on the aging waiver, to me, it makes sense that you may have had an increase in those hours and, again, it is just thought and discussion that I have heard that there may have been some modeling of options as well as waiver and I think

it would be very interesting for the group to see whether or not there has been a need and maybe an increase in those hours and also people are aging in place, they are going to need more hours. Sometimes it makes sense that that group would need more services having an independent service by the MCOs.

KEVIN HANCOCK: So I think you are going to find that we would have to go pretty far back. So if it is true there was a pattern of management in the aging waiver that would have reflected a constraint in hours, it probably -- it is probably going to be very difficult to identify prior to -- or after 2012. Because of the opening up of service coordination for the aging waiver. So you would have a lot more of the delivery of the aging waiver from 20 -- for the agency model from 2012 all the way up to the implementation of community health choices. So we would have to go prior to 2012 to be able to see if there was really a change in pattern to be able to prove what you are suggesting.

And I would agree with you, it is very possible as people age, the acuity in the community continues to increase. It is very likely that they may need more hours but there might be other ideas why they have been granted other hours as well that may be a little more complicated just based on need. We do think that the approach forepersons centered service planning is a lot more specific to the needs of the individuals. So we are hoping that we will be able to demonstrate more clearly the direct relationship between what is assessed or delivered for an individual person. But we can certainly breakdown by age. If we were going to focus on the aging waiver data, that would be covering the population that you are talking about, but we do have people over the age of 60 who are in the waivers as well. We would have to look at that N community health choices it would be one waiver. It will be over 60 and under 60. We will ask for that data sliced and diced that way.

BARBARA POLZER: We have a request for the plans to provide at the next meeting the number of participants who are deaf and blind the number receiving LTSS.

SPEAKER: This may be for Kevin. I'm curious if you are looking at authorizations versus actual service utilization and then trying to understand possibly why services aren't actually being utilized in terms of, you know, a care plan that might be 40 hours and the person is utilizing PA S hours, they are only utilizing 20 of those hours. It could be because they may need 40 hours but there aren't home care agencies that are able to provide that or they don't have a personal attendant service or it might be that there is no home delivered meal provider that that area. So is that something that the plans are looking at or OLTL Is looking at.

SPEAKER: It is Patti. We certainly do look at that information to number one identify is there a gap in service? Is there a provider gap and if there is, then we work with our network team but we also look at it because there are some individuals that we may authorize certain number of hours per week but then they find that their daughter is coming say every Saturday very consistently and they find that they would rather have their daughter than an attendant come in because they are spending the day with the

daughter. So we kind of evaluate if that is going to become something that is consistently delivered then we would adjust the hours or is it that they thought that they needed more hours when we did the assessment. They kind of had, you know, their input into the assessment, they felt that they really needed more service but they find that they are having the aid leave early which we do find instances. So we do look at it to look at trends for various different issues.

SPEAKER: It is something we look at regularly as far as the service utilization as she mentioned to make sure there is service gaps or coverage gaps for the participant and to see if the participant's needs changed or if the circumstances have changed where a family member or somebody else is more involved from an informal standpoint where they would not necessarily need those waiver hours specifically.

SPEAKER: The other thing we he found is as we have talked to service coordinators is they bill -- individuals prefer to have what if hours built in and then they don't utilize them or there an increase in a change of condition and then the person got better and they don't need the hours as much. There has been something change in the positive and then it needs to be assessed with the level of support. As we continue to navigate the system and how it all works with individuals and it is individualized, we hope we can get the hours in a place where they are more reflective of what the person really knees and they trust the M COs so that they don't need the what if hours, right? Because we will address it and get what they need when they need it timely.

BARBARA POLZER: Question came from Tonya maybe this is more for Kevin. Is there a way there can be an agreement with HUD and the state when it comes to pest eradication.

KEVIN HANCOCK: I think that is what Nancy was proposing with housing related entities for a little bit more of a standard for pest and access. And is it possible? Anything is possible. Is it easy? That is a different question. So I think that the idea of looking for opportunities to communicate what we -what we are trying to achieve with community health choices or where housing is discussed is something we are going to continue to try to do. So or the of a round about answer is it possible? Sure. Anything is possible but how easy is it to achieve. The housing system is very complex.
Housing, so --

LINDA LITTON: We never did get an answer to the deaf blind --

BARBARA POLZER: They have to bring that.

KEVIN HANCOCK: Actually, Linda, thank you for that point. I'm going to say that the Managed Care Organizations should be able to provide that data. They would be able to assess this part of the person centered planning process in the communication requirement and hopefully have some sort of a way or repository the deaf blind population. The department, we may have some communication requirements as part of

their eligibility record but I think the M COs would have a better way to be able to capture that than the department. So that is a good reminder Linda.

BARBARA POLZER: Steve?

SPEAKER: At one of the future meetings would we be able to get an update on how the incident management system is working and the strengths and some of the area where's it may not be working so well in terms of reports and accountability?

KEVIN HANCOCK: Sure I think that would be a good topic actually. The department would present what the expectation are for incident management and the system that is used and the MCOs could describe how they are approaching it and I think it will be good to have a frank discussion on opportunities and challenges when it comes to incident management the relationship between adult and older adult reporting requirements and generally some of the data that we are seeing for incident management.

SPEAKER: I'm with the center for independent living out of Central Pennsylvania. Just a suggestion with the M COs with S S Ps is maybe look at the equal access policy that companies have, that your company has to make sure it includes how to -- that equal access for people who are deaf blind but also if you have a communications policy, it might be a place that you can put in S S Ps for that but I would also include it down to your vendors as well is what are they doing to provide equal access to people who are deaf blind.

BARBARA POLZER: Anymore questions for the MCOs? Any other questions for anybody?

TELEPHONE: It is not a question so much it is more like a comment. You guys are talking about OVR a little bit ago and the issues. The one thing that I think needs to be brought um is most of the time when you go to OVR, and I have -- they only have to place you in, like, a 9:00 to 5:00 job and they are not really looking at sometimes what the individual's skills is. And I think that we could do a lot better with employment situations if they would look at the individual's skill set a little bit more and give them some other pointers on how to use the talents the individual has and also, stop thinking about going to a 9:00 to 5:00 thing. If people could work a few hours from home, like, the ways to get employment, but the big piece that people are missing a lot of the time is how will it affect their benefits to work. The hardest part about this is you go to OVR, they will send you to a different organization that is supposed to know. The other organization doesn't know. There is how many layers. You can really never get a clarified answer on how it works. If we want the employment specifics to go up we need to take the bars off the windows so to speak and let people know truly how it will affect them and how they can -- how they can keep what they need and still work. Does that make sense?

BARBARA POLZER: Absolutely Tonya. Shona?

SPEAKER: It is very difficult thing for people to be able to do and that is why your employment is so low.

BARBARA POLZER: And I agree. We have experienced that with a lot of consumers who are afraid of losing their benefits so they say they are not interested in employment.

SPEAKER: The only thing that makes it hard, is if you have health issues that occur and you need to get them fixed, if you cannot do it on your own time schedule, like, if it had to be at a 9:00 to 5:00 place, you know what I mean, in an office somewhere, that is not going to work for that individual but if there was a different way of doing it, maybe it still could. I mean, I just think we need to think more out of the box sometimes when we think of -- and it is not done.

BARBARA POLZER: Thank you Tonya. Shona.

SPEAKER: I don't know if this is already -- and I apologize if this has already been discussed but recently, I was in Clarion for the state plan for independent living forum and one of the district administrators of OVR brought up in that session that knowing that the Managed Care Organizations are one of the -- one of the services in the list of 32 is employment services and supports. He asked a question that -- that what do we do about coordination of those benefits because Medicaid is the payer of last resort. OVR is supposed to be the payer of last resort and he felt that there needed to be a discussion between Department of Labor and Industry, Office of Long-Term Living and the Managed Care Organizations to figure this out because as it roll out statewide, that has to be a question that is answered.

KEVIN HANCOCK: So first, there are five employment services of the 32. Five of them are employment. We do have conversations with OVR all the time. This employment first initiative is not just to the Department of Human Services. It involves the Department of Labor and Industry, Department of Health and Department of Education and other partners to be able to improve opportunities for people in the system to be able to obtain employment. That being said, it is still complex. The current process requires that OVR services be utilized before the Medicaid funded services are utilized. That is a Federal requirement. That is what we trying to outweigh of going through the process with CMS right now. If there is ever a situation with capacity issues OVR, we would be able to -- we would be able to go directly to the Medicaid funded services. Other states have done this and it is the way that it is managed with the office of developmental programs and we are try to replicate that to make it easier to access. Medicaid is the payer of last resort, but we are looking for more flex ability. Those services that are available in the Medicaid program take into consideration individual skill sets. They are meant to be more person centered. So hopefully, once those services are more easily accessed, then we will see more utilization. Those services will be more centered to be able to address the employment preferences in the employment that does reflect the individual skill sets.

SPEAKER: Just in response to that, two questions then or two comments. One given the order of selection process that OVR and Pennsylvania is going through then that would mean that Medicaid services could be utilized currently and in addition to that, I'm glad to hear that those conversations are happening but they are not trickling down to the district administrators. Jack Hewitt is the one who brought it to my attention asking me to clarify how we are going to handle it. Somehow when we talk about communication through this process, we need to get messages to the people that can impact them.

KEVIN HANCOCK: I agree. And we will share the feedback with the Department of Labor and Industry.

Thank you.

BARBARA POLZER: Pam?

SPEAKER: I wasn't here at the last meeting and so I'm wondering if at the last meeting you all had information on the transportation and the breakdown? I know you have a brokers and the brokers have so many transportation providers contracted but is there a breakdown by county. How do we know that forest county, as an example has transportation. Was that at the last meeting that I missed or do you have any information on that. I just recall two meetings ago when I was here, we had asked about that.

SPEAKER: Pam, we to my knowledge, we are covered in all of the counties now as we get into the T zone M T M has assured us of that. We did have that information. I can get an updated report of that information and venture to the next meeting if you would like that. But we are feeling pretty comfortable with the transportation network at this point.

SPEAKER: Yes we use MTM and one of the additional items that we are using as we have -- we are extracting any providers that are on that file have that have that transportation authorized to do a comparison of what M T M has in their network to see if there is anybody who may not be contracting or in the credentialing process to see if they want to continue within community health choices and be a provider beyond the care period. There are additional steps even though we are covered, we still look at enhancing that number.

SPEAKER: For UPMC, we did provide that at the last meeting and can provide an update for the next meeting. Our transportation broker continues to do outreach. We do have coverage in all of the counties but continuing work to help support in the program.

SPEAKER: I had another question but I'm sorry.

BARBARA POLZER: Drew?

DREW NAGELE: Kevin had --

KEVIN HANCOCK: I was going to ask Pam where she was at the last meeting.

SPEAKER: I was in Spain.

DREW NAGELE: This is just a follow-up to Tonya's question about the employment services. There is a nuance here that I think doesn't always get fully understood and that is because the waiver, you know, has to defer to OVR first, what OVR asks is is this person close to competitive employment. They won't accept them for services unless they are near ready and so then they send the person out for evaluation and that is where the whole thing gets really, you know, complicated because that can take forever to get someone evaluated and so the only way we were able to shortcut this for those who were appropriate for waiver employment services was by actually, you know, making an agreement with the district administrator of OVR that they would accept the provider's assessment of how ready the person was for employment. And I'm sure that that is not happening statewide. So I was able to do that in Montgomery County and Bucks County but it didn't -- I'm sure it doesn't pervade the whole state. So I'm really pleased to hear that you are trying to work on a different way to approach this and I hope C MS approves it but there still could be a subtle at the if they are required to be rejected by OVR first.

KEVIN HANCOCK: So it is -- the approach that you are describing is a nonstandard approach. I'm glad it is working. It is not necessarily the way that OVR might want to -- I think that they would want to be able to control their own assessment. I think it is great that you are in a position where you would -- able to develop that type of relationship but the communications that I have been engaged in OVR has wanted to be much more directly in line with managing those kind of assessments. Your characterization is correct. Ready for employment for readiness for employment is the first step. The biggest challenge we had in this system is OVR capacity to be able to do those assessments which is a lengthy and very involved process. We are hoping this new approach that we are taking like O D P and if OVR is in a position to be able to -- to agree that they had capacity challenges to let us go directly to the waiver employment services we are hoping that that will help. To your point, it is great that you are able to develop that type of relationship that I would -- it has been my experience, at least when I'm in a room that OVR has always wanted to sort of be in a little bit more in control of that assessment.

DREW NAGELE: Right. If they do that, then it could take the person a year to go through that process because of wait list and order of selection and everything else that OVR is going through. I guess if you are working on a different deal, it should be clear, you know, when -- when is OVR saying they can't do it? Because they may think they can do it but they really can't do it.

KEVIN HANCOCK: We agree.

DREW NAGELE: I actually have a pest comment. One of our participants is having difficulty getting that service. They are being told by the MCO that there is only one provider and that there is a three month backlog. So I don't know if M COs can respond to that?

KEVIN HANCOCK: I think they would need to know the individual case. So my recommendation would be to -- do you know which MCO.

DREW NAGELE: Bridgette?

SPEAKER: Keystone.

DREW NAGELE: Can you come to the table and give more details.

BARBARA POLZER: Take it off line.

KEVIN HANCOCK: Because it is case specific. I think you would want to talk to the MCO specifically. Okay.

Thanks.

BARBARA POLZER: Matt?

MATT SEELEY: I thought I missed something here. Just about -- back to the OVR thing. I was in a rehab council meeting maybe a year ago. I don't know Julia would know better. Ryan Hyde was there and he said that Managed Care Organizations, I don't know if these four individuals specifically but said brought up OVR 100 times and Ryan Hyde said OVR is brought up all this many times and nobody has really asked me anything. I'm kind of curious, we have been talking about OVR here a lot. OVR is never in the room.

KEVIN HANCOCK: So we have had OVR present here before and they are in the room. They are invited to everyone of the meetings. They know that we often discuss employment with this Committee. We meet with them on a pretty frequent basis as part of this employment first and Ed butler and my team has pretty close contacts with OVR as well. So I would argue -- I would –

MATT SEELEY: Don't argue.

KEVIN HANCOCK: I wouldn't argue to Ryan because I like Ryan. I would say to Ryan that I'm present when that -- those communications are taking place. Those points of communication are taking place and I think that the issues however they have been expressed has not really changed and he has been very much engaged in those discussions.

MATT SEELEY: I would just like to ask, if Ed butler comes in January or February, maybe somebody from OVR be invited too so they can talk about how the relationship works.

KEVIN HANCOCK: Couldn't agree more.

SPEAKER: Matt brought up my name. Since we are talking about OVR. I would like to invite anyone to the OVR state board meeting that is happening this Friday and it is open to the public and public commentary for folks here to share your thoughts and experiences.

KEVIN HANCOCK: Follow-up question to that? Is there a member -- is there board member for the centers for independent living or the area agencies on aging.

SPEAKER: On the state board? KEVIN HANCOCK: Yeah.

MATT SEELEY: That is on Thursday by the way, isn't it?

SPEAKER: December 6th.

BARBARA POLZER: That is Friday.

KEVIN HANCOCK: This Sunday is the 8th.

SPEAKER: I don't know if there is members on the area on aging on that particular board. I mean, we do have representation from the Pennsylvania rehab council.

THE COURT: Okay.

SPEAKER: On that board and there is a lot of representation from the disability community on the Pennsylvania rehab council.

KEVIN HANCOCK: Okay. Thank you.

BARBARA POLZER: Linda you had a question.

LINDA LITTON: I guess it is more of a comment than a question. I can only say from a wheelchair user's perspective, every single person is different and if we are talking about person first care, why can't OVR be a little more flexible now that we are going into person first because I'm sure every person whether they are just Medicare or Medicare and a waiver, you know what I'm saying. So how does that get evaluated? I know I consider myself pretty high functioning. I do need a lot of care but I know I couldn't work an eight hour day. So I agree with Tonya on the timing factor.

Thank you.

KEVIN HANCOCK: I'm not in a position to be able to answer that for OVR but I agree with Matt's point. We will look for an opportunity to talk about employment again in January and February and we will ask OVR to be here. So my recommendation Linda would be for you to ask that question to them directly.

LINDA LITTON: Yes.

MATT SEELEY: I will ask it.

BARBARA POLZER: Any other questions or comments? That being said --

KEVIN HANCOCK: What is going on today.

BARBARA POLZER: What reality am I in today?

LINDA LITTON: Did we have two --

BARBARA POLZER: Well, if there is nothing else. We are going to close. Thank you everyone for your participation and input. Happy holidays and hope to see you January 3rd.