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Date: 06/01/23

Event: Managed Long-Term Services and Supports Meeting

>> Good morning. This is David Johnson. Shanrika, can you hear me?
>> Hi, David, we can hear you.
>> Wonderful. Are we ready for us to get started?
>> Yeah. It looks good.
>> Wonderful. Good morning, everyone. This is David Johnson speaking. We are going to call this month's MLTSS subcommittee meeting to order. Before we proceed, I will take subcommittee attendance. As a reminder, this meeting is being recorded and your participation in this meeting is your consent to being recorded.
I want to acknowledge and apologize for any inconvenience. I am calling in remotely. I am under COVID isolation. And Mike Grier is excused for a personal matter. My thanks in advance to the staff and subcommittee members in person to help make sure that our hybrid meeting without an in-person chair goes as smoothly as can be.
I'm going to proceed with subcommittee member attendance.
Ali Kronley?
Anna Warheit.
>> Good morning, I'm here.
>> Good morning.
Cindy Celi.
>> Good morning. This is Cindy.
>> Hi, good morning.
Neil Brady.
Gail Weidman.
German Parodi.
>> Present.
>> Good morning.
>> Heshie Zinman is excused today.
Jay Harner.
Juanita Gray.
Kyle Glozier.
Laura Lyons.
>> Good morning.
>> Good morning. Lloyd Wertz.
Matt Seeley. Monica Vaccaro.
>> Good morning.
>> Good morning.
Patricia Canela-Duckett.
>> Good morning, everyone.
>> Good morning.
Sherry Welsh.

>> Good morning, everyone.
>> Hi.
>> And Tanya Teglo is excused.
Are there other subcommittee members I have missed that would like to announce themselves? All right. We will check again in a few minutes. We will proceed to this month's housekeeping notes.
Again, as a reminder, this meeting is being recorded. Your participation in this meeting is your consent to being recorded. As part of committee rules, please keep your language professional. As a point of order, this meeting is in the department of education building in the honor's suite and a webinar.
The meeting is scheduled until 1:00 a.m. To comply, we will end promptly at that time. All participants except for the committee members and presenters will be in listen only mode during the webinar. While committee members and presenters will be able to speak during the webinar, to help minimize background noise and improve sound quality of the webinar, we ask attendees to self-mute using the mute button or feature on the phone, computer, or laptop. To minimize the noise the the suite, we ask that you turn off your microphones when you are not speaking.
The captionist is documenting the discussion remotely. So it is critical for people to speak directly into the microphone, state their name, and speak slowly and clearly. Please wait for others to finish their comment or question before speaking. This will enable the captionist to identify speakers.
Hold questions and comments until the end of each presentation. Keep them concise, clear, and to the point. We ask attendees to submit your questions and comments into the questions box located in the go to webinar pop up window on the right side of your computer screen.
So enter a question or comment, type into the text box under Questions, include the topic to which your question or comment is referencing, and press send.
Those attending in person who have a question or comment should wait until the end of the presentation to approach one of the microphones located at the two tables opposite the speaker. You will be called upon to have your question responded to.
Before using a microphone in the room, please press the button on the base to turn it on. You should see a red light indicating the microphone is on and ready to use. State your name for the captionist and remember to speak slowly and clearly. When you are done speaking, press the button at the base of the microphone to turn it off. The red light will turn off. It's important to utilize the microphones placed around the room to assist the captionist in transcribing the meeting discussion accurately.
This is time at the end of the meeting for comments. Webinar attendees should enter the questions and comments in the questions box and include the topic to which it is referencing. We want to remind everyone that this meeting is a place for general information and questions about OLTL managed care. Questions or comments of a personal or individualized nature will be redirected to the appropriate people for follow up.
Responses will be sent directly to the individual asking the question.
If you have questions or comments that weren't heard, please send your questions or comments to the account identified at the bottom of the meeting agenda.
Transcripts and meeting documents are posted on the MLTSS meeting minutes list serve within a few days after the meeting. And the remaining 2023MLTSS meeting -- on the department of human services website.
Bear with me here. We will go into emergency evacuation procedures for the honors suite.

In the event of an emergency or evacuation, we will proceed to the assembly area to the left of the Zion church on the corner of fourth and market. If you require assistance to evacuate, go to the safe area located outside of the main doors of the honor's suite. The staff will be in the safe area and stay with you until you are told you may go back to the suite or you are evacuated. Everyone must exit the building. Take your belongings with you. Do not operate cell phones and do not try to use the elevators, as they will be locked down.
We will use stair 1 and stair 2 to exit the building. For stair 1, exit through the main doors on the left side near the elevators. Turn right and go down the hallway by the water fountain. Stair 1 is on the left.
For stair 2, exit in the back doors. Exiting from the side doors, turn left and stair 2 is in front of you. From the back door exits, turn left and left again and stair 2 is directly ahead. Keep to the inside of the stairwell and head out. Turn left and walk down Dewberry alley. And cross fourth street to the train station.
We will now proceed to MLTSS meeting follow ups.
Jermaine or Paula, are you ready?
>> Go ahead.MLTSS subcommittee meeting. Related to training resources, audience member asked through chat for resources or webinars for new home care agencies. Meghan is to provide a response.
>> Meghan's response will be included on the additional documents, which you will be provided on the MLTSS meeting minutes list serve shortly after the June 1st meeting today. It's quite extensive and includes a lot of links.
>> Yes. As a reminder to folks, all meeting follow ups from the previous month's meeting are available on the list serve. And we do not go through all of these in the other meeting information.
Related to service coordinator case loads, audience member asked through chat what is the case load for youth service coordinator? All three MCOs to provide a response? AmeriHealth Caritas responded that their community ratio is 1 to 70. The nursing facility ratio is 1 to 250. PHW responded per the contract, service coordination ratios are as follows. Home and community-based services participants, 1 to 70. And nursing facility residents is 1 to 250. UPMC responded. The target case loads are as follows. HCBS service coordinators is 1 to 65. Nursing
Actual varies based on the geographic region. But overall, the averages are slightly lower than the target for HCBS and higher for nursing facility service coordinators.
>> Related to behavioral health needs of nursing facility residents, audience member Pam asked through chat if service coordinators for nursing facility residents are Are they working with nursing facility residents to see if they have behavioral health needs? And are they helping them to connect to providers or resources? The initiatives seem to focus on home and community-based services.
>> MCOs responded. And again, these responses are quite lengthy. So they will be included on the additional documents provided on the list serve shortly after the June 1st meeting.
>> This is David Johnson. It sounds like someone may be unmuted on the phone that's not currently speaking. As a reminder, if you're not speaking, if you could please mute your phone so we don't have audio interference. Thank you.
Related to CHC-MCO provider contracts, in chat, if there is a plan to open new contracts with the MCOs for new providers? All three provide a response.
>> AmeriHealth Caritas Keystone first responded that at this time, the personal assistance services network is closed for both AHC, CHC, and Keystone first CHC.

AHC Keystone first is interested in contractings with adult day care providers across the state of PA.
PHW responded they continue to accept applications for providers wishing to serve the southwest region of Pennsylvania. They are not accepting applications for the other regions of the state at this time.the provider to schedule a call to discuss and review the letter of interest submitted. UPMC thoroughly reviewses all letters of interest received to deem a need to add to the network.
>> Related to medicaid renewal assistance, Elizabeth asked through chat why are participants instructed to reach out to their service coordinators for assistance with medicaid service renewals when the service coordinators do not know the ins and outs and are not permitted to speak to the county assistance offices? Who can participants go to for assistance with renewals? All three MCOs provided a response.
>> AmeriHealth Caritas responded that their service coordinators received instruction and training on the MA renewal process. Inclusive in the training is information on what is needed and who to contact. In the event that a participant requests assistance, contact the county assistance office, the service coordinator is expected to assist and engage the appropriate staff. Additionally, they have seen an improvement with renewals and information with a more streamlined approach with the participants having the referral dependee.
PHW responded the service coordinators have been trained and can assist in completing the necessary paperwork. The service coordinators provide frequent outreach to participants in advance to ensure that the participants complete an annual in-person assessment, complete the redetermination electronically or by paper, and have assistance to troubleshoot issues that arise. PHW uses the human services site and would recommend the same to participants and providers. They provided the link here. This link will be provided on the list serve, the MLTSS meeting minutes.
PHW recommends that participants speak to their service coordinators and should additional assistance be needed, the service coordinator can connect the participant with the state customer service center. They provide two numbers here. And that will also be included on the list serve.
Service coordinators may also provide information regarding other coverage on penny if they are no longer medicaid eligible.
UMPC outreach regarding medical assistance renewals primarily helps direct participants to contact the county assistance office, providing the DHS as published. However, UPMC does offer the ability to connect with service coordinators or a member of their eligibility team if the participants need assistance in placing the call or completing the application.
>> Thank you, Paula.
And lastly, related to medical and nonmedical guidance, audience member Carla asked for nonmedical and medical agencies what guidance can you give to new agencies who are effective in the programs that are offered. Lori from AmeriHealth Caritas responded she would have to follow up.
>> AmeriHealth Caritas responded the providers should reach out to their account executives for guidance. Additionally, the AmeriHealth Caritas Keystone web night has a host of valuable information.
>> Great. Thank you, Paula. That concludes our follow-ups for the May 12th meeting. As a reminder, these responses, among others, will be posted on the MLTSS meeting minutes list serve shortly after our meeting today.
I know we are a bit ahead of schedule here. Before we proceed to OLTL updates, are there any

subcommittee members that have joined on since attendance and would like to announce themselves? I have Gail, Ali, and Jay present as well. All right. We will proceed.
Bear with me a moment here. I'm not sure, is deputy secretary in person in the meeting room?
>> Hi, David. Yes, I am. And just so that you are aware, I believe there is a question on the floor in regards to take that question or not.
>> If it's all right with you, yes, we can. I know we are a bit ahead of schedule.
>> Okay. They are coming up to a microphone.
>> Thank you for the assistance.
>> Hi, this is Pamela from -- central PA. I know I said it many, many times and I will say it again for the record that 65 to 70 cases per service coordinator is absurd. I get calls weekly. People can't get through to their service coordinator. Call after call. I'm sure that's a big reason. I actually have heard odd things that I need to follow up with that service coordinators are telling consumers that they do not help the individual find other home care agencies to fill their hours. So I need to follow up with that one a little more.
And some other odd things that service coordinators should be doing. I'm wondering if they're too busy to do them.
And then I guess my other question is with such a deficit of direct care workers, what are MCOs, and maybe I'm wrong with understanding what the answer was. But why are so many MCOs not taking on new home care agencies if they're coming up and are able to staff some of the people who need the help? Why is there not more? We have been talking month after month after month about how desperate we are for people to fill hours.
So those are my questions.
>> Thank you, Pam. I know the question of service coordination and case loads I think is a worthy topic for us to discuss. I'm not sure if we have any managed care organizations present. Perhaps that's something to revisit during public comment at the end when we have full representation.
Are there any other questions or comments regarding meeting follow ups from May's meeting? Okay. If none, we will proceed to OLTL updates from deputy secretary Juliet Marsala. The floor is yours.
>> This is Juliet, the deputy secretary for the office of long term living.
I have a few quick updates. And I wanted to spend a little bit of time talking about in lieu of services in the MLTSS program.
The first update is the community health choices request for information. The comments have been reviewed. They have been summarized into major themes. And they have been posted to the community health choices website yesterday afternoon. So they are there for folks to review and to kind of address Pam's comment and concern with regards to service coordination, you will see that in one of the themes of comments that we have received. And our team is looking very closely at that. And case load sizes is important to us to address. So more to come on that.
In addition, we had talked about how as I recently joined the department, I have a desire to go out and do a listening tour to meet with participants across the Commonwealth and hear directly from participants, family members, and other community members about all of OLTL programs, not just CHC. But the overprogram, the act 150 program. The bureau of human services and listening, monitoring and oversight of personal care homes, our LIFE programs. So that is kicking off next week on June 5th. I will be in Erie. And we have three wonderful partners who are hosting listening sessions at their sites. And so I will be visiting voices for independence, community resources for independence, and life Northwestern PA in the area on June 5th.
In addition, you should be seeing updates on some virtual listening sessions in June. We have

three in June. We will likely have more in July. And those details will be coming through shortly. And then we are arranging for different visits and those future sessions and dates will be announced hopefully very soon. We're looking at July for those visit dates and all the other regions. So very grateful for the centers for independent living and LIFE centers and triple As and folks willing to help host these listening sessions and meet and greets.
I also wanted to take time to introduce and announce some changes in our OLTL leadership team and give a warm welcome to Teresa Hartman. She's the new bureau director for the bureau of human services and licensing. She is a dedicated professional. She has dedicated her career to working with aging and disabled persons. And also helping them manage chronic and acute conditions. She has been doing this for over 30 years in the Commonwealth. She is a registered nurse and working as a nurse, she has a vast amount of experience doing bedside nursing care, care management, and has served in multiple management and regional positions in the nursing home industry. As well as being chief compliance officer and chief operations officer for community health choices programs and home and community-based services programs.
She is someone who knows the industry from end to end and we're very excited to have her with us as part of our team and supporting ensuring that our personal care homes and assisted living facilities are meeting our quality expectations in how they are serving individuals in Pennsylvania.
Teresa, did you want to come up and introduce yourself and say a few words?
>> Good morning, everyone. I'm very happy to be here to represent. I also have a very soft voice. I'm very happy to be here today to be a part of the OLTL team and to work with our personal care and assisted living and overseeing protective services.
I have only been here a few weeks, but learning a lot. I have been out to shadow one of the inspections.
And to work directly with the providers so that we can have a good collaboration and make sure that we do everything we can to provide as much housing as possible within those homes and support everyone being successful, keeping their licenses, staying compliant, meeting our quality standards.
So I look forward to working with all of you.
>> Great. Thank you. I might be stealing a little bit of Laura's thunder. She's presenting an adult protective services later on. But I wanted to provide an update that on April 22nd, the Department put out for comment an updated regulations. The comment period closed recently on May 22nd. And we did receive 11 comments on that. So just wanted folks to give you that update and those comments will be released with the final form. Or included with the final form.
Any questions on those updates before I move on?
Okay. Hearing none.
So I wanted to talk a little bit today about and give a brief overview of the centers of Medicare and medicaid services in lieu of services for our managed care program. There's great excitement about this tool and additional CMS guidance. I kind of wanted to set what the expectations are for in lieu of services so folks have a greater understanding of it.
So in lieu of services are in place with the goal of being cost effective and with the goal of ensuring that they are medically appropriate services or medically appropriate settings that could be substituted for medicaid coverage services in managed care.
We have listed here where you can find the current in lieu of services federal regulations. A little light reading if you want to get into it.
But just sort of at a high level, states must determine, we have certain responsibilities. One of

those is that we are responsible for determining that in lieu of services is a cost effective and medically appropriate substitute for conference services or alternative settings under the state plan. That's our role and responsibility is to ensure that they meet that criteria and not that the state is developing that. So I just wanted to make that clear.

Another high level thing of importance, and you will hear me repeat it again, is that enrollees cannot be required to use in lieu of services. It's an option. It adds an optional service. This is not a service that anyone can say you must use this service. Okay? So it adds an additional option. It adds additional choice. I wanted to make that clear.

We are part of the approval process. It must be authorized and identified in the managed care plan contract. So that's why you also see it, that option in contracts. And as they get developed, you will see more added to the contracts.

And they must be offered, they're in there to enrollees at the option of managed care plan. Just for additional updates on guidance on the services is still fairly new across the board. On January 7th, 2021, CMS published a state health official letter that kind of describes opportunities under medicaid and CHIP to address social determinants of health. We are seeing more sharing of how states can utilize the in lieu of services tool in different capacities.

And then on January 4th, 2023, CMS issued additional guidance that further clarified for us how we can use the in lieu of services to address health related social needs. And in addition, provided clearer guidance to the state about new requirements for evaluating new and existing in lieu of services and additional reporting requirements and documentation to assure that those in lieu of services are meeting the federal guidelines and regulations.

And in that guidance, they introduce six principles that are critical for us to use to ensure that in lieu of services are appropriate and to ensure that in lieu of services are used efficiently within our adult programs and other managed care programs.

So I'm going to go into the six principles really quickly. And again, at a high level.

So these are the principles that we work with in partnership with managed care organizations, should they choose to develop an in lieu of service. This is where we work collaboratively together to ensure that the in lieu of service is medically appropriate in an appropriate alternative setting and cost effective to services already covered in the state program.

So the first one is that in lieu of services must advance the objective of the medicaid program. They cannot violate any federal rules. You can't use in lieu of services, for example, to circumvent state rules.

And in lieu of services are limited to services that are already approvable through the identified authorities under which our program is implemented. So for community health choices, we're predominantly looking at services under the 1915C waivers. Okay? So it's not sort of a open ended, you can't get super, super creative. We do have guardrails that we have to look at and evaluate.

The second principle is that they do have to be cost effective. They can't cost more than the service that's already in place. We have had folks submit questions about whether or not in lieu of services could be used for a tool for alternative services. But it has to be clear how they're cost effective.

And we do this through looking at projected and final cost percentages, the cost percentages have to be annually certified. They're worked through with actuaries. They are reviewed by CMS as a component of our rate certification review. So every year, we go through rate certification review with CMS for our MLTSS plan. And we have to get that approved by CMS. So in lieu of services will be added to that rate certification process.

And so we have additional details that the cost percentages if they are above, how we have to

handle that and add additional descriptions and processes.
And so as you can see here, for the fiscal year 2024, reading through it, we submit the rate certification with the 2027. So we have to sort of show and approve that we are being regulated and monitored on our ability to effectively use in lieu of services.
Number three is that they have to be medically appropriate. And in order to do that, when in lieu of services are being developed, the managed care organization have to sort of name it, define the in lieu of service, identify the target populations that they're working with. We have to agree to contract language. It has to meet a whole bunch of check marks that would make it qualify for in lieu of services.
And that is to say that it's not sort of immediate or fast. There's a process.
There's a question?
>> Yeah. When you note the 5% maximum, is that 5% per MCO contractor? Or 5% statewide as the maximum that can be dedicated to ILOS?
>> I don't think I said that.
>> Pardon?
>> I don't think I said that.
>> You did not say that. I'm asking that.
>> I will look for that particular detail. Or I can come back to you as a follow up. Because I don't have that in front of me right now.
>> Good morning. Jen Hale. Our understanding is it's 5% aggregate across the program.
>> So in you're successful in one area, it may be 12% or 15%, while still keeping the Commonwealth below the 5% maximum.
>> That's correct.
>> Thank you very much.
>> This is why I really appreciate Jen.
And so number four, you have heard me allude to this at the beginning. Very importantly, the in lieu of services must preserve enrollee rights and protections. It's voluntary and cannot be forced. And enrollees cannot be denied. And they maintain their rights for appeals and grievances as well. So I think that's really, really important. So if someone would otherwise meet the target population and meet the service description for the MCOs in lieu of services and they are denied, they do have appeal and grievances rights. I think that's really important.
Number five, the in lieu of services are subject to monitoring and oversight. They have quality expectations. We will be monitoring them, looking at them, ensuring that they are medically necessary, they are in appropriate settings. They are meeting quality measures as designed as part of the in lieu of services. And that quality and monitoring will be documented and reported on.
And then they are subject to retrospective evaluations. So we can look at it for going back two years, what have you, and really looking at how things are going.
We're excited about it. But again, there is a lot of work that goes into it.
And then on April 27th, CMS released additional notice for proposed rule making for medicaid and CHIP managed care programs on access, finance, and quality. That's looking for a framework for states to offer the services to address the unmet needs and health EK inquiry through the provision of in lieu of services.
Certainly a lot of signals from CMS in support of in lieu of services development. As I said before, this is a tool. It is an option for managed care observations to develop and put forward. But we certainly are in support of using all the tools that we can to improve the home and community-based services service options.

Questions on that?
>> Tell me about the relationship between the proposed rule making that was issued on April 27th and this ILOS that you referred to the last couple of meetings and now specifically at this one.
>> I'm not sure I'm following exactly what you're asking. So in lieu of services with the new final rule making, the relationship is that in lieu of services still has to meet the final regulations that are developed in the final rule makes. That's sort of the draft at this stage. They can't circumvent any of the final regulations. That's sort of the relationship. You have to design with that in mind.
>> Okay. So you mentioned as part of this presentation. But they're not directly related events. One will be ruled by the issuance of the other.
>> Correct. And in lieu of services will always be ruled by any of the CMS federal regulations that they change and adapt over time. Yep. Great question.
Jeff?
>> This is Jeff from Pennsylvania SILC. Thanks for the update. I will do some of this with the bulletin reading before the next meeting.
In terms of the principles you're mentioning, will they be applied across the board to both home and community-based services and nursing facilities?
>> The principles I talked about are very specific to the use of in lieu of services and how in lieu of services are designed to develop. So there's lots of principles in the regulations that nursing facilities and home and community-based services have to adhere to. The six that I was talking about today are very specific to as we think about developing in lieu of services, we absolutely need to make sure that they're aligned with the six principles today.
So if there was an in lieu of service in a nursing have to adhere to the six principles, in addition to all of the other federal regulations in place. Yep. Great question.
>> Secretary, thank you for the office of long term living update. Are there any other questions from subcommittee members?
>> I think one more --
>> Committee members first. I guess David was asking.
>> Oh.
>> Doesn't sound like any. Any questions from the audience?
>> This is Pam. I guess my question I'm confused about the cost. I think it had to meet -- it couldn't exceed -- I'm not understanding that part of it. For the home and community-based services, the attending care can't exceed the cost of a nursing home stay. I think that's what you were saying. Whatever ISO or whatever that's called. Can they exceed the cost? Or can they not exceed the cost? I'm sorry, I'm just confused.
>> The in lieu of services should not exceed the cost of the service they're substituting for. Yep.
>> Are there any questions in the chat for the office of long term living?
>> Just so you know, Shaun is coming up to the microphone, David.
>> Thank you very much.
>> Sorry. I know I need to do reading. My name is Shauna. I'm trying to understand the in lieu of services provision. Am I thinking of it correctly, is it like mom's meals in lieu of attendant care?
>> No.
>> What is it? Can you give me a concrete example?
>> Sure. For example, and you will see this in the 2023 approved agreement, the example I use is the potential for utilizing assisted living in lieu of a nursing facility admission. So it's an alternative setting. They may be able to supplement beyond assisted living care generally because you're serving a different population or you may target -- have a certain targeted

population. And create an in lieu of service in an assisted living facility versus having someone be served in a nursing facility. It would have to be medically appropriate, have cost savings, be optional, and meet the needs of the individual. And it would have to be a quality service.
So these aren't very quick I'm substituting this for that. They have to be planned. They have to be designed. They have to come up through the office of long term living for approval. And then they also have to be submitted to the CMS for approval as well.
>> I guess as a -- I was sort of thinking that's what you might be thinking. And I guess as a comment to that, I think the disability community might have great concerns about assisted living as an option. And I would like to have a separate conversation about that at some point. Because I think that if assisted living is being used as a housing substitution, we have a housing crisis in Pennsylvania. But assisted living isn't the answer. So I just think that that deserves some conversation as we move forward.
>> Yeah. Happy to talk to you about that.
>> Lloyd again. Having had the pleasure of running an assisted living facility for about a dozen years earlier in my career, I recall that in processing an admission to my facility, I had to get an MA51 saying that the patient qualification for this program, I believe you do have to meet the requirements for being able to be in a skilled nursing facility. How can that balance out in the example you just gave?
>> So what the in lieu of services would allow is identify alternative setting. It's not just a necessarily one for one. And I haven't seen personally in lieu of services descriptions yet. I will be getting into it. I know our team has. It's not necessarily just a we're substituting this for that. There's likely more going into it or more services. They are waivers involved that have to be looked at. Assisted living facilities in other states are already a medicaid service in their waiver programs. If you look at Ohio, Tennessee, Indiana, they're already within the waiver programs as a waiver service.
We're not there yet. But in lieu of services is a way to explore that.
And I think at the last MLTSS meeting, there is a question about whether or not the OLTL is looking to expand assisted living facilities. I wanted to clarify that there's no cap on assisted living facilities or personal care homes. We monitor when someone comes an assisted living facility. But we don't have a say -- it's an able and willing provider. We're not pushing expansion or nonexpansion in any given point.
David, I don't see any additional questions.
>> Another hypothetical.
>> I'm not -- Matt asked me for another hypothetical.
So I believe in California, not for MLTSS, but for their medicaid program generally speaking, they have used in lieu of services for temporary housing for targeted homeless populations in a way to reduce emergency room department and hospitalization. So that's sort of a way that they have used that in California. So that's another example for you.
>> This is Matt. I guess what's throwing me off, it's services and can present it to the state as a way of innovating or being creative with how they serve their members?
[indiscernible] that right? Yep. Yep. So it's checks and balances, right?
[indiscernible]
>> Patty.
>> Two related questions. The timing. You gave an example of in 2024 period is what you consider for implementation July 2027. Does that mean there's a two of three-year lag between the start and the implementation?
>> No. That's the financial reporting submission.

>> Okay. And then another side of what Shauna was asking about. Is any of this process -- to the community? Is all of this happening behind closed doors and then we find out that managed care plan proposed implementation of skilled nursing -- in order to --
[Indiscernible]
Would that be visible to the community at large? Or is this going to happen and we find out it's been implemented?
>> Yeah. I'm going to pull you up on the process in terms of what you're working through. If you think of it in terms of managed care organizations, I would say develop their pilots and their programs in their own contracts. I think it would be dependent on the MCO.. >> Definitely. Great question. As I'm listening to the conversation, I would point to our partners or colleagues in the office of mental health and substance abuse. Within their managed care program, they have several in lieu of services. For additional information or examples, obviously a different structure, but that could be another example that you might want to look at.
When plans develop or propose an in lieu of service, we look to make sure that it is meeting CMS criteria. We But I think in the best practice, if they do come forward, we can share that as part of changes that would be occurring in the agreement for the next contract year. Does that make sense?
>> Yes. This seems to be a number of examples hovered around assisted living. Which seems like there's a process underway. And that's kind of the question that I'm asking. If there is a process underway -- is it because the FTO might be looking at it as a competitive advantage or a way to improve their market position or whatever. But the community at large would not have insight and experience in other states, I happened to work in Florida and Tennessee where assisted living facilities, as an example, started out -- and then became an automatic service. Evidence was the fact that they had used them for two years with a plan. And so it becomes like a done deal by the time sunshine.
>> Okay.
>> So just with the prior request -- as a community, we would like to be involved. And they become closer in reality.
>> Right now, it's something that we support in terms of the agreement, in the 2023 agreement for potential. But we don't have any kind of developed criteria or anything right now to share. I think when we get to that point, we would be happy to share.
>> And then if we were going to put any new services in the waiver, I mean, I think if we were going to put or add a service, there is going to be a very lengthy public comment period as well and public input through that process.
>> But would it come here first?
>> Would it come to MLTSS first? I mean, I think it would come to MLTSS, the public, I can't say for sure.
>> Before the comment period. When it's introduced to OLTL.
>> As it's being developed and we're getting close? Yeah, absolutely.
>> Good morning. This is David Johnson speaking. Apologies, I lost connectivity for a few minutes. Out of respect for other speakers, we will proceed to the next agenda item on adult protective services regulations. And we can reserve additional questions for the office of long term living to the additional public comment period.
Deputy secretary, thank you very much.
Laura Deitz from the bureau of human services license speaking on APS regulations. Laura, are you available?
>> Yes, I am. Good morning. My name is Laura Deitz, the director of the adult protective

services division in the human services licensing office of long term living. I was approached a couple of weeks ago to talk about the adult protective services regulations.
I'm hoping that I kind of touch on maybe what you folks for looking for or answer any questions. Juliet touched a little bit on it. She's trying to cut my time out so I can end at 11:00 and get you guys back on track.
So the adult protective services regulation under the APS act, the act 70 of 2010, says that we have to have regulations put in place. And we have to do that in consultation with adults, families, advocates, and other areas within the Commonwealth that may be affected by these regulations.
And the purpose of these is to strengthen and clarify the statewide system for the protection and protection reduction and elimination of abuse, neglect, exploitation, abandonment of adults living with disabilities between the ages of 18 and 59.
So this has been a very long process prior to my time even coming to this division. So they started with some of these meetings back in January of 2011. And they ran through September of 2015. There was 23 meetings total. And the participants were identified as a group known as the adult protective services coalition. And they were advocates for physical, intellectual and brain injuries. There were provider associations, mental health association, and providers in the Commonwealth that served adults with disabilities. The department incorporated many of the comments into the recommendations in the draft regulations.
So Juliet talked about this a little bit. So the proposed draft regulations were published if the PA bulletin April 22nd and closed for comment. And we should have the regulatory review commission comment back by June 21st of this year.
So when I put this together and sent it out to the team, they thought maybe this is where folks were wanting to have a little bit of information on what do these regulations really do for APS?
We have expanded and added definitions to provide clarification to the act. There is many times we get requests for information and just to ensure that we're either, A, allowed to disclose information, or B, what can't be disclosed, clearly define that. We are looking into what the subject of report is, which we're looking at the subject is anybody identified within the reported need.
We defined what state license and state operation facilities are. Those are a cup of the examples. In total, there were about 16 added terms to help clarify the act.
It elaborates on the screening process. And the interesting part is we have a current contract, and that contract is with liberty health care. And some of the things have been built in into the contract. The categorization priority, we require them to see them within 24 hours. And nonprior to in 72 hours. We already put that into process and added it to the APS regulations.
We have identified requirements for state license facilities. We have kind of an agreement right now with how those cases, whether it's a state center, whether it's a state hospital, and currently, we drafted a process for those cases that has been in play since prior to my time. So I don't want to give an exact date that went in. At least 2017. It clarifies the rights of adults in need of protective services.
And it defines specific qualifications for training for the agency staff and availability of the training. And the enhancements of the last contract is we require the APS vendor to have 40 hours ongoing training.
So I think that is the large bulk of maybe what the group was looking for.
On the next slide, if you want to see the draft regulations if you haven't, if you want to review any of the public comments that we have received, they are published on the IRRC website. And I put the easiest way to get to it is using the number, 3364. Put that in and it pulls up the

page. You will see all of the 11 comments.
And I will say there's 11 commenters. Because some of those that we received have multiple comments on different areas in the regulation.
And in the last slide, if you have any questions about APS, you're more than welcome to reach out to my team and I. And reach out to myself. All times willing to
So I went through that very fast. And I did hit 11:00. So get you back on track.
But are there any questions that I might be able to
>> Laura, thank you very much for making up for lost time. Not your responsibility. But we do appreciate it.
Are there any questions for Laura from the subcommittee?
>> No, David, there's not. There is from the audience, though.
>> Hearing none.
>> Yes. Jeff from Pennsylvania SILC again. I'm glad these are finally out 12 and a half years is a long time and a number of us in the room were also supportive of getting this through the legislature and just part of the work group even before 2010. So it's good.
There are some concerns that we have heard in our network about APS and none of us thought when APS was being developed it was going to be a potential tool to get people into guardianship isn't protecting them. I'm kind of curious if you see anything with APS and that issues come up when you're developing the draft.
>> Questions from the audience?
>> Thank you for that question. Certainly guardianship is a last resort. There should be other alternatives utilized before that. All least restrictive measures should be looked into for every specific case. I certainly, if there are specific concerns for any case that you may become aware of, you can reach out to me. I may not be able to provide specific details of the cases. But we look into the concerns within the division and make sure -- we say don't leave any stone left unturned. There could be an option out there.
I think in the bulk of it, the amount of reports we get, say 18,000, out of those, we investigate about 15,000. Substantiate around 10,000. If liberty has to pursue guardianship -- but again, that's the last measure if there's no other alternative measures for that adult. But again, if there's case specifics, you can reach out to me and I will gladly research those.
>> Can you tell us if they are offering supportive decision making or other alternatives before we get to guardianship? Or is that included in revisions of the draft?
>> Can you repeat the beginning of your question, please?
>> So in terms of putting other alternatives first before we get to guardianship, like supporting decision making and other options, is that something that's been discussed as perhaps first choice before you get to guardianship?
>> Thank you. Yes. And it's actually in the contract that we have with Liberty that all others have to be explored. My background, I came from children and youth. And we did that supportive group decision making. A lot of times with those families. And we have the nonnegotiatable. The person has to be safe. What can the folks at the table put together to keep the adults safe without the child having to go to foster care? If those options with available, absolutely, they would pursue those.
>> And some of this is tied into some of the current discussions about guardianship reform in senator bill 506 by senator Baker and other reforms. We had guardianship hearings too. Those are things to consider. Thank you.
>> You mentioned the 40 hours of training. And is there a consent -- ways of -- I guess I'm concerned about autonomy. And is it consistent? If the person still has the right. If they make

the decisions for themselves. If you say our suggestion is you go to a nursing facility and they say nope, I'm staying home where I am.
The other thing is I'm concerned about consistency in APS in terms of what the choices and options are if you're getting that person out. Because I had a couple of calls recently about individuals who they have said that to me, that there was no option of helping me in a shelter until I get this figured out or helping me identify housing. They said you need to go to a nursing facility.
What is APS being trained on around -- or Liberty, whatever, being trained about autonomy around decision making and choice and option? Because there's a big difference between supporting somebody for a couple of weeks in a hotel versus using their medicaid funds or whatever to stick them in a nursing facility where they don't even want to be? And are you the person we call when that happens? When the person says I was given no choice of any other housing option. They said you need to go to a nursing facility? Are you the person?
>> Sure. Okay. So absolutely. Anyone can reach out to me about a case concern. Again, while I can't provide information back to you, either myself or a member of the division reviews that case and then if we identify concerns, we reach out to Liberty and provide the recommendations and follow up steps to them.
Certainly, every case is unique. And to say that somebody said the only option is a nursing facility, I don't know. But again, if you have a case specific, you can send that back to me. Contractually, we I believe off the top of my head gave about 20 examples of topics of ongoing training. And they could present myself with a training that they located to see if I thought it was appropriate and applicable to the program.
So any training opportunity that comes through my email, I send it off to them. We do a lot through the national adult protective services association. They have enhanced their curriculum. We're looking at getting them trained on the national standards as well. And with Teresa coming on board, we're brainstorming on other ideas we have. Again, I think there's about 20 contractually examples that always open ended if they find something, they can bring that back to me. I certainly understand some of those are the hardest cases where someone may make the choice to stay in the situation placing themselves still at risk. But again, there might be other options that can be presented -- the act says reduce or eliminate the risk. We have to look at where that person --
>> Is part of the trainings right to risk information? You may think is it a terrible situation but the person thinks I will stay in the situation versus going to the next step, a nursing facility, which is much worse. It's a judgment thing. And I hate to say this, but you think about how many people are deciding do I leave or stay in that abusive situation without a disability. And they get to make that. So you need to balance that. We are people and should have the right to make that decision. Right to risk, is that a part of the training too?
>> I would say yes. Right to autonomy. I know it's covered in basic training. It is some of to hardest things. People want to improve quality of life. But what is that to each individual? It may be different. We have the conversations with Liberty when they look at a service plan that they can offer the risk reducing services and if the person is able to make the decision, they can accept, reject all, pick and choose. And they are responsible for educating them if they stay in a situation where they are at risk, what the risks are. So it's an informed decision.
>> Hi, David. This is Paula. It doesn't look like we have additional questions in the room. David, can you hear me?
>> Can I ask a question? This is Matt. I'm looking at your -- I don't know if it's the same slide show or not. It says provide guardianship as needed.

[indiscernible]
I didn't know a lot about Liberty. They're able to do that --
>> I do apologize. I'm having a hard time hearing you. I'm trying to put my better ear toward you.
>> I'm looking on the web about Liberty. And there's a slide show here, what is the APS agency health care corporation required to do, provide guardianship as needed. Are they able to do that unilaterally?
>> If it's the only option -- and it's determined by a professional they're not able to make their own decision, they can look at pursuing guardianship. It's an option that is available to them.
>> So yes.
>> It's not the only option. But each case and each investigation is different. Without knowing all the circumstances, it's -- it doesn't have to be the route that they go.
>> So yes is the answer.
>> It's an option, yes.
>> I don't understand why people at the state can't just say yes or no.
>> Apologies, everyone. This is David Johnson. I need to do some audio troubleshooting. Apologies for my connectivity issues and the impact on the meeting. Paula, are you able to hear me?
>> Yes, I can hear you now.
>> Great. Thank you. If there are no more questions for Laura, thank you again, Laura. We will proceed with the next agenda item regarding the medical assistance update from Carl Feldman and Tyrone Williams.
As a reminder, if you have a question or comment and you're using the microphones or calling in, please make sure to state your name so that can be picked up by the captionist. Thank you. Carl and Tyrone, are you available?
>> There was an extra question.
>> I'm sorry. I did not hear that. Can you repeat that, please?
>> David, this is Shanrika. There is a question on the floor.
>> You mentioned about Liberty health care and guardianship. So is Liberty just do the -- they're the APS provider, I understand, adult protective services. Is Liberty also the guardian? Or do they refer that out? If that's too much for our time frame, if you could provide like that, that might be helpful. I'm getting conflict of interest issues, which is something that's being looked at with some of the largers guardianship reforms. And that fits in with the adult protective services.
>> Liberty health care is not the guardian. They utilize the agencies and other options. The official guardianship is determined by the court.
>> Okay. I will say we have heard from advocates on the ODP side that some of their folks have been forced into guardianships in terms of who the current APS provider. So I haven't personally seen that, but we have heard comments. That's something you may want to take a look at and I think this discussion hopefully -- can you tell us if you're going to some of the other subcommittees? I think there are other disability groups that would be interested in this.
>> I will take the ODP thing, comment back to Kristen Ahrens. Just so you know. Since it's ODP and not MLTSS.
>> Let me ask, is there any way you could direct traffic since David and Mike aren't here?
>> David, Matt Seeley requested if we can direct traffic here in the room if that would be helpful for you with regards to the technical difficulties you're having.
>> Yes. My apologies for the technical difficulties. I am calling in now, which hopefully should resolve my audio. My thanks to the office of long term living staff who are able to identify subcommittee in person and audience members in person asking questions. Yes, we will

continue to utilize that with our unique circumstances this month.
In the interest of time, I am going to have us move forward with the next presentation regarding the medicaid unwinding update. If there are additional questions add any additional questions as follow up for next month's meeting.
>> Just one more --
[indiscernible]
>> David, is there a reason that people who are on the chat are not allowed to ask questions or get their questions put through?
>> Questions in the chat are equally as privileged as audience members in person. I believe previous questions regarding questions in the chat have asked for them. Are there reports of people asking questions in the chat that aren't getting them flagged or asked?
>> I'm getting texts like crazy saying that they're putting questions in the chat and not responded to or allowed to ask.
>> Well, that is a very good question. And my stance, and I'm sure Mike agrees, is that questions in the chat, whether stakeholder is attending in person or by webinar should be equal footing. Paula or OLTL staff, are there questions in the chat?
>> Hi, David. We do have one question in the chat to follow up on. A second question, we asked for further explanation of what they're asking. And then the third question, again, was already answered, but we are asking if there is further explanation required.
>> Appreciate that, Paula.
>> You're welcome.
>> If there are no questions in the chat regarding the APS regulations, we will move on with Carl's presentation on the MA unwinding. And Pam, appreciate the question. We'll go on record participation in person or by webinar or submitting questions via chat should be privileged equally. I appreciate the feedback. And I will follow up and make sure we have a more smooth process moving forward. Thank you for the feedback.
>> Good morning. Can you hear me?
>> Yes, I can hear you, Carl.
>> And folks in the room?
>> Yes, Carl, we can hear you.
>> Great, thank you.
I'm happy to be here with you this morning to talk about the unwinding of the continuous coverage requirement. I think this is the first time -- I intended to join a little earlier in the year, but I wasn't able to do that. It's great that this is available and I can be here on the line now.
I'm going to go through background. I will talk about the outreach activities, I'm going to talk about what's available online to assist with the unwinding. And I will take questions at the end. Thanks.
Next slide.
This is some background on what's taken place over the past three years. You probably know a good bit of this, but states could not disenroll individuals from their medical assistance coverage while the public health emergency was ongoing. So you can think about that like a bucket that just kind of continued to fill up. But people could not -- the bucket could not empty. And there were some minor exceptions to that, but for the most part, that was the rule. The Congress changed that a little bit to say that the continuous coverage requirement ended on April 1. But the general process remained.
And we want to make sure everyone understands throughout the entire period, DHS continued to send renewal paperwork. It's not like we sent a renewal once and if they didn't respond, they

never heard from us. We kept reaching out to people even if they didn't respond to continue to collect the most up to date information on people so the individuals would be in the best position into the period, the unwinding period, in which people are now able to disenroll from coverage again.
As of March 2023, there were 3.6 million people enrolled in medical assistance. That's obviously a very large number, and it works out to be like 26, 27% growth in the program. It's pretty much in line with national trends. And of those 3.6 million, 1.3 million are people who would have lost coverage if not for the continuous coverage requirement.
Next slide.
One more. Thanks.
So as I said, Congress reinstituted normal eligibility rules. And that began on April 1st of 2023. What that means is that anyone who is in that maintained population, the 1.3 million, needs to have a renewal before any action can be taken on their case. And we want to make sure everyone understands that activity will take place over the course of a 12-month period. People will have a renewal date in the 12-month period. And all of those maintained households will have the opportunity to renew their coverage before anything changes in their eligibility. Sometimes we're able to reknew people automatically with information we have on file. But for everyone else, they will receive a renewal packet that occurs throughout the 12-month period.
Next slide.
And for more detail on that, most -- when does the renewal occur within the 12-month period? For most people, it's in the regularly scheduled renewal month. These are the exceptions. So if we can align the person with their SNAP renewal date, we're going to do that. SSI recipients who lost eligibility for SSI, they don't have a renewal date. And the CHIP renewals were aligned to be with the ECIS case renewals. Where we could and could not do that, we redistributed them as evenly as possible throughout the overall case load. Next slide.
So this is a visual on what the unwinding kind of looks like over the full 12-month period to give you a sense of that. Next slide.
Here is another visual for the unwinding that I like. I think it gives clarity on the fact that the renewal process occurs for each cohort over 12 months over time. And as you can see, the way this is structured, we initiate the renewal in the month before the renewal is actually due. We even have activities before that that I will get into in a minute. But we initiate the renewal in the month before the renewal is due. And we just repeat that every month over the full unwinding period.
Next slide.
And this is a cut away of one of those periods. So it gives a clear kind of display of each step in the eligibility process.
Next slide.
So as I said, there are some things we do before that first renewal eligibility activity occurs. So 90 days before the renewal, we're sending out a flyer. But not just a flyer. Basically to ask people to update their contact information. This is how we make sure that people are receiving the renewal timely and responding to it. We need to have good contact information. But as I said, we're not only sending a flyer, we're also sending a text message if we can. An email, a helper call if we can do that. And it's not one or the other. We're doing all those things to try to reach people in anticipation of their renewal.
60 days before the renewal, a letter goes out that indicates what is the unwinding? You have to understand many people, they may have enrolled in medical assistance at some point in the last three years, and they might think they don't have to complete a renewal. And this explains

why they do need to do that and everything involved in doing that.
And it also includes everything necessary for them to complete their renewal online through compass. And we're also sending the communications referenced earlier in the same manner. And 30 days before the renewal, we send out a renewal packet. And there's text reminders prompting people to return items if needed.
Next slide.
We want to make sure to talk about Pennie a bit here. A big part of why we're emphatic about people returning the renewals even if they know they are no longer eligible, which is something that certainly happens, is that we have a wonderful state-based marketplace, Pennie, that was established. And newly available to us to get people enrolled in subsidized qualified health plans. And the subsidies are pretty good. People can get a pretty cheap plan on the exchange. If we have good information on the person's income, for example, they came in and completed the renewal and sent it back and we found out they're not financial eligible, we hand that information off to Pennie. And they use the information to tell the person up front how much they will receive in subsidies on the exchange. It's a pretty nice set up for people who do in fact work through the process.
Pennie set up a special enrollment period with a period of retroactive coverage, which is pretty unheard of in the insurance world. Even if the person doesn't return the renewal, we're attempting to reach them so that they can be connected with Pennie and they are setting up texting, calling, they have letters they're sending out. We think that's a worth while connection to make for people.
Next slide.
We have traditional mass media advertising. Some of this has been set up by the centers for medicaid and Medicare services, federal government. But Pennsylvania has this as well. We're doing it through all of the modes described here. We are attempting to reach non-English speaking members of our community with stakeholders that they would know and trust. And we're coordinating with Pennie to run ad come pains to make sure that we have the broadest conference throughout the whole unwinding period to ensure that people return their renewal. That's important to us.
And we have a whole separate thread built out on grass roots outreach to try and do on the ground, in-person events throughout the unwinding period.
Next slide.
So on our DHS web page, we have a number of really useful information that can tell you a lot about what's going on during the unwinding. The big one I think for this group that will be very useful is the communications tool kit that we will talk about in a minute. But the new thing we have on there is unwinding data tracker, which shows a lot of details about what's taking place with the COVID maintain population during the unwinding period. We thought this was something people will be interested in. They want to see are individuals moving to other coverage, what are the reasons that they might be disenrolled, are people coming back? You can find a lot of that information there.
And I believe there is also another section, I did this slide before it was put up, with the federal reports. So the data trackers focus narrowly on the maintain population. But the federal reports are included there too. And you can look at that to see what's going on with the entirety of the medicaid population. Next slide.
These are some clips that I pulled out of what's in the stakeholder tool kit. We have got social media graphics for you to steal. We have got foldable print outs that you can use for your offices. We have got text and language that you can use for anything you might think you want

to communicate with people about the unwinding. It's there to be used.
If you go to the stakeholder tool kit and look around and think I work with the population that probably would not be able to engage with the material as is, we would encourage you to reach out to us and we will be happy to work with you to develop something additional. to try and make that connection.
That was the last of my slides. But I know that there's probably a lot of questions about the unwinding period, and I'm happy to take them now.
>> Thank you for your presentation, Carl. Are there questions from subcommittee members?
>> Yes. This is Monica from the brain injury association of Pennsylvania. Thank you for these materials. We will certainly use them to help get the word out.
I do think there are some individuals with brain injury or cognitive impairments that will need individual coaching to do this. And we're happy to help. I see that you have helpers. But we would need to know who they are. I don't know if you're able to identify people with brain injury who did not respond. If you are, we're happy to help.
>> Okay. Thank you for that information.
>> My question is are you able to identify people who didn't respond in terms of which ones of those might be people with brain injury? Is that information you would have?
>> That information is shared with our managed care organizations, and they have the ability to work with their provider network on reenrollment and enrollment support.
>> Okay. I think all of the information that you have, there will still be people who need to be really helped with actually doing it. We have a brain injury resource line that has volunteers that can help if the individuals can be identified to us.
>> Thank you, Monica. Carl, this is David Johnson. Appreciate your presentation. And for the ongoing opportunity to provide stakeholder input and fieldback. I continue to be concerned about the focus on Pennie as a resource for assistance. We know that the majority of enrollees in community health choices are dually eligible for Medicare and medicaid. In the event of MA ineligibility, Pennie won't be a helpful resource for the population. Granted, it's not as potentially impactful as losing primary insurance. But someone losing their medicaid eligibility may want to seriously reconsider their Medicare options.
At present, what is being communicated by DHS about PA med as resource to help with Medicare information counseling?
>> Thanks. That's a good point. I definitely agree that while Pennie has a no wrong door system in which somebody who engages with them can be connected with us or another entity, if necessary, it would be our preference for those individuals not to have to go to Pennie if it's not a service that's available to them or suited to their needs.
We have identified a pool of people, I think it's around 5,000, who are without Medicare coverage who are eligible for Medicare. And for those individuals, we're doing a specific outreach to connect them with PA Medi. Outside of that, I would encourage you to talk with the department of aging about the ways they engage with individuals who are eligible for Medicare.
>> Sure. And I can appreciate there may be difficulty coordinating the department of aging with PA Medi. And certainly no disrespect to colleagues at Pennie and the counseling work they do. The concern I have is while there is a no wrong door policy with Pennie, given that the majority of the population affected are also eligible for Medicare, the concern is that Pennie is fielding a number of calls that essentially are almost immediate referrals to PAMEDI and that being a tax on the system and the work they have to do regardless. Is there data available on how many referrals Pennie is making to PA Medi? Is that tracked?
>> I think that is something you would need to speak with Pennie about.

>> I will follow up. Thank you.

I understand from Paula that Lloyd has a question for Carl.

>> That is the truth. Thank you.

Similar question regarding individuals with mental illness and possible need for increased assistance in completing the applications. In the case of physical health, you don't really necessarily know which MCO to whom the individual might be engaged. However, with mental illness, you do. There is one behavioral health managed care organization assigned to any given county. Are there plans to contact the MCOs to perhaps provide assistance when someone pops up? I know you would have to identify that through the case management system. A number of the case managers would be good at that. I wondered if there's a plan for making that happen.

>> I think we agree they are a really valuable resource in this process. We have our normal process of sharing information with the health plans, all of the health plans about changes in eligibility and why those changes in eligibility occurred. But we also have been providing detailed information on the individuals that are the COVID maintain cohort to all of the health plans. Because we believe they may be the most disconnected from the eligibility system.

And I can just tell you based on what I have seen in the questionnaire that we have done with the health plans that the DHMCOs and CHMCOs are definitely engaging heavily in sending out materials and text messages and calling with their members about ensuring that they are ready to complete their renewals.

So we see them in that role, we're providing them information to fulfill that role. From the feedback we're getting from them, we believe they are fulfilling that role. It's definitely on our mind.

>> Thank you, Carl. Good work.

>> Carl, I know this is a topic of pretty broad interest. And I know that we started your presentation a bit late. I will try to resolve additional questions in the next ten minutes.

Are there any other questions for Carl from subcommittee members?

>> Nobody in the room.

>> Okay. Are there any questions from the audience?

>> I don't see any questions from the audience.

>> Great. And any questions in the chat, Paula?

>> Yeah. There are some questions in the chat.

>> Great, thank you.

>> This question is from Frank. You mentioned that if someone is physically ineligible for MA, the information participants under 60 years old. It would seem the participants under 60 years of age are going to both Pennie and act 150. This might be confusing to participants.

>> Thank you for that. And I should clarify this is a presentation and this is a discussion we have with a lot of groups. And we're not sending Pennie information to people who are -- we're not sending information to Pennie for people who are clearly ineligible for a Pennie plan.

>> I just want to clarify for Frank that Act 150 isn't medical insurance coverage. It is coverage for home care and -- the individual may still need Act 150 and Pennie.

My apologies. This is Juliet.

>> Some more questions in chat regarding --

>> Yes, please go ahead. We will try to answer the questions until 11:45.

>> That was the last question.

>> My apologies. I misheard you.

If no more questions for Carl, thank you for your presentation, Carl. We appreciate it.

>> Thank you.
>> Moving along with the agenda, the next item are prosations on complex care units from each of the managed care organizations. If there is otherwise no preference, if we could have a representative from AmeriHealth Caritas Keystone First begin.
>> We have a second part to the MA unwinding. And Tyrone Williams is ready to present.
>> My apologies. Excuse me, Tyrone. Yes, please continue with your presentation. And thank you, Paula.
>> Thank you. Hopefully everyone can hear me. My name is Tyrone Williams, I work for the office of long term living. I'm the section chief for our assessment unit who is responsible for our assessment entity, aging well, who is responsible for doing assessments for individuals regarding the eligibility for HCBS and also they assess and reassessments of individuals in waiver and support those activities as well.
Today, I'm going to give a brief overview of the reassessment process and answer any questions after that.
Next slide, please.
As part of the -- so annually, the MCOs are responsible for doing a comprehensive needs assessment. At least every 365 days, unless there is a -- that occurs. After submission into our assessment system, Pennsylvania individualized assessment system, any time a level of care is generated by the system, whether that be nursing facility clinically eligible or nursing facility ineligible, aging well does get an alert. And then they review and validate the result.
With part of the unwinding -- as part of continuous coverage, we have individuals who have been determined -- since the pandemic, we have allowed for their continuing coverage in the waiver services. As we currently as with the unwinding, essentially being done, the continuous eligibility period being done at this point, we are now in the process of going back and reviewing those cases again and making determinations on these individuals. Next slide, please.
If validated NFI, if the person is found to be NFI, aging well will notify the MCO and request a new physician certification for that individual.
One of the things that I want to emphasize is that, again, aging well, who is our independent assessment entity, their primary role is essentially is to be a desk review, which essentially compares an individual's level of care from one year to the next or from -- or one assessment to another. If a trigger event occurs during the course of a year.
And essentially, they review both documents and they identify any discrepancies between those documents, especially for individuals who go from NFCE to NFI.
That's primarily their role in that process. The actual level of care is generated by the assessments that the MCO does. So aging well, the independent assessment entity does not -- they do not do a new assessment at all. They do not override an MCO's initial determination of whether that person is eligible or anything like that. They simply verify and validate that result.
Once that result is validated, in this case in NFI, they send a notice, again, as I think I stated, a physician certification request to the MCO, who then is responsible for getting that PC and returning it to aging well for the next steps in the process.
In that case, if we have a difference between the physician certification and the level of care, in this case, NFI, so if the physician certification comes back NFCE and the level of care is NFI, then the office of long term living, our clinical review team will review that information and make a determination.
If OLTL determines NFI, ineligibility notice will be sent to participants with appeal rights.
Next slide, please.
So in terms of the -- we actually broke this out into three different populations based on phases

in terms of the individuals who have been affected by continuous conference period that we had. The first phase, first population was individuals who were determined to NFI between November of 2022 and January of 2023. What we have instructed our MCOs to do was to go back and do a new assessment on those NFI participants for that period in question.
The second phase is individuals who are determined NFI between February of 2023 and April of 2023. These individuals did not have -- were instructed not to do a new assessment for this particular population. And as a result, our aging well independent assessment entity just forwarded a request for a new PC on these individuals.
And then the last group, again, would be individuals who would not need or do not need a new assessment and they would basically be our operations moving forward. So as individuals become eligible annually or if they have a trigger event, they will have a new comprehensive needs assessment. And then based on the results of that assessment, that will trigger, if you will, the process that we have been talking about.
Next slide.
So essentially, the next two slides provide kind of a work flow of the total process. So it just basically reflects the summary that I provided previously a few seconds ago. The one main thing, at least in terms of the -- and actually for both slides, I want to emphasize is that individuals will have a chance to continue their benefits, particularly if they're determined NFI, if they appeal the decision within ten business days. So everyone determined NFI will have an opportunity to have a fair hearing if they so choose.
So that would be true for both this particular slide, as well as the next slide, which pretty much outlines the appeal process related to these particular populations as well.
OLTL is in no rush to remove people from the waiver. We're taking our time in terms of reviewing each individual, making sure that we are making the right decision. And even if they still remain NFI, those individuals will have an opportunity to appeal that decision, to continue their benefits, and hopefully, you will have minimal disruption in their care while they're going through this process.
That's pretty much it. Any questions?
>> Thank you, Tyrone. Are there any questions from the subcommittee?
>> I see none in the room.
>> And does that include audience members as well, Paula?
>> Yes.
>> Do we have any questions for Tyrone in the chat?
>> Yes, we did have a question just come through. This is from Amy. Does aging well review every assessment that an MCO does, for example, if someone has an FED in April and is found -- it has a trigger assessment in October, does aging well review that in October even though it hasn't been a year? What about if there is an FED in April that shows an FCE and in May, there is an initial assessment, does aging well look at the May assessment and if it is NFI, will that trigger the process of potential disenrollment even though there's only been a month?
>> Yes, that's an area that does exist. To answer the first part of the question, yes, aging well reviews every FED comprehensive needs assessment that an MCO would upload into our system.
If an individual, whether it's as a result of an annual review or during the course of the year due to a -- event, if the individual comes back NFI, that would, if you will, trigger the process.
Now again, as we review those, we do try to take a very, very deliberate approach in terms of looking at the reasons why that individual may have been determined to identify even after a month. And we're asking questions around that. So again, we're not looking to immediately

remove anyone from the program without doing our due diligence in that particular area.
But we do look at every NFI, we do question every NFI. Every NFI that we do see will go through the process. But not without significant review.
>> Thank you, Tyrone. There is an additional question from Kimberly Sharp. What will happen in the process if a person should be -- until we get care facility or other related conditions, will they be assisted to get on --
[indiscernible]
What about brain injury participants? Or not NFCA?
>> That's a little bit out of my wheel house in terms of how those services would be implemented. But I would say that this process is primarily for those individuals who are enrolled in the waiver. And also enrolled in addition to that in an MCO in particular in terms of our reassessment process.
Typically, it is my understanding for those individuals who may have a traumatic brain injury or may be eligible for OBRA, we catch the majority of those individuals when we're doing the initial eligibility review screening for individuals who may be applying for the waiver. And in instances where they may be NFI or they may be eligible for OBRA. So they would normally be identified by our clinical review team based off the PC that we receive for that individual. And when they're caught by our clinical review team, then we start the next phase or we look at OBRA through our independent enrollment broker, Maximus, to see the options in enrolling them in OBRA or other types of programs.
>> Thank you, Tyrone. Amy has an additional question.
Are individuals informed the outreach to their primary care provider is conducted? How does aging well determine the provide and get consent to communicate with the provider. Please elaborate on the due diligence done to determine why the NFI determination happened.
>> The organization is actually the entity to contact the primary care provider. Now, we don't have a uniform method from the three MCOs in terms of how they do that. They may contact them directly. They may have the coordinating entity contact the PCP on their client's behalf. So that's how that aspect of it works. All aging well does is just send out a notification that the person in question will be determined NFI and that as part of that notification, they're requesting the MCO to obtain a physician certification on behalf of that individual.
Second part of the question, in terms of the due diligence, again, we have started, I'm assuming, thinking you're talking about the individuals who say maybe have been determined NFI early on in their enrollment with an MCO very early. We have flagged those individuals in our system in addition, we have MCOs who have identified some of those individuals for us. And we're taking a second look at those individuals in conjunction with our clinical review team, our medical director, again, to ask questions as to why that person may have become NFI for a sort period of time.
I would say that, of course, that would definitely be problematic for us. We understand the disruptions to the families around that. So yes, we're taking -- before we take the next steps in the process, we're taking a hard look at that to make sure that the right decision related to the eligibility is being made.
>> Thanks, Tyrone. Can we have someone from the CHC MCOs respond to how they communicate with the primary care physicians?
>> I'm sorry, have someone from where? MCO, you said?
>> Yes.
>> Okay. Yeah. I assume so. I don't know if there's any in the room. Feel free to elaborate on that if they choose.

>> Tyrone, I will call them up for you. Unless David wants to take over this part. Do we have a representative from AmeriHealth Caritas that can answer this question? Missy is coming up. I have got this part, Tyrone.
>> Okay.
>> Hi, I'm miss SI with AmeriHealth Caritas. The service coordinators are contacting the PCP offices to request an updated MA570 for the redetermination process. Whenever we are notified by aging well that we have a participant who has been assessed as nursing facility ineligible.
>> Great. UPMC?
>> Hello. This is David Garrett from UPMC. CHC. The service coordinators, similar to AmeriHealth Caritas, our service coordinators are doing the initial outreach to individual as a primary care physician to request the MA570 form. We provided them with talking points and then some information to help if submissions have some questions. But the service coordinators are doing the initial follow up with the primary care physician.
>> And PA health and wellness.
>> This is Angela. We do very much the same thing. The representatives at the plan are also reaching out to aging well and following up with the -- following up when we get a request to request physician certification form.
And then we also check in on it. So we include kind of a check and balance so that if we're not hearing back within a couple of weeks, that we are reaching out to them to make sure we're getting the information back timely and getting it submitted to aging well.
>> Thank you. I understand there is a question from the audience. I will take this as a final question on this topic. Seeing we're a bit behind on the agenda, the remaining questions regarding the unwinding updates, we'll reserve them for public comments at the close of the meeting.
Sadi, if you have a question, the floor is yours.
>> Thank you. The slide said this is an appeals process. So I'm presuming that if a person is determined to be NFI, as providers, we're required to continue providing services. So if it's reinstated, determined to be NFCE at a later point, then we're continuing to provide services. Does the eligibility go retroactively to when the original process started?
Loss of eligibility, essentially. And there is an appeal process. As providers, we're required to continue to provide --
>> Correct. If the person elects to pursue the appeal and hearing grievance process, yes.
>> This is Jermaine from OLTL. Patty, I believe this was covered as a follow up at last month's meeting. There was a question should we continue to provide services in case they come back on. And we advised that if a provider checks EDS and it doesn't show eligibility, the provider risks nonpayment. In a situation where someone appeals timely, within ten minutes, the benefits can continue. And then -- I'm sorry, ten days. That would -- the benefits would continue. So they should show it as eligible. But if the person is actually ineligible and not receiving services, the provider risks nonpayment if they provide services during the period of ineligibility.
>> So an appeals process is not an automatic appeal.
>> Correct.
>> Okay. Thank you.
>> Thank you, everyone, for your questions and to Carl and Tyrone for the MA unwinding update.
If there are additional questions on this topic, I respectfully ask to reserve them for public comment.
Now let us proceed to our presentations on complex care units with representatives from each

of the MCOs.
On the slide here, AmeriHealth Caritas Keystone First CHC, you are going to lead us off.
>> Okay. Can you hear me?
>> We can.
>> No? Yes?
>> Yes.
>> Okay. All right.
I'm Shaun Johnson, the manager for the care management. You can go to the next slide.
So our clinical case management team is made up of the complex case management team and the Triage managers. The RNs and licensed clinical social workers. We wanted to build clinical teams of various experiences so they could work collaboratively. So our RNs and social workers have background in emergency medicine, pediatric, geriatric experience, home care, managed care, surgical care, and even neonatology. And we did that so the team could work cohesively and collaboratively and lean on each other when they had questions that weren't to their background.
Next slide, please.
So the goal of the program is we want to identify at risk participants that we can reach out to to complete case management services with them. One of the ways that we identify those participants is through our PICS list. That's the predetective scoring model that comes out monthly. And based off of that, we make our case to participants.
Another thing we use is the in patient hospitalization list and various other reporting sources. Those are the main two sources we use to really identify the population.
Another program goal is to decrease potentially preventable emergency room and hospitalization admissions and readmissions. That is cleated through the ER diversion survey. And the referrals are related to increased use and frequency, when I will talk on another slide about that.
Another goal is to improve transition of care for participants to make sure that medically necessary services are coordinated. We coordinate with various managered care organizations and make sure the right services are utilized at the right time.
We want to continue to meet the NCQA standards for accreditation.
Next slide, please.
Referrals. So the referral process for case management is multifaceted. Our referrals can come in through multiple ways, such as through a discharge planner in a facility where they feel like they need -- participants would need additional continued oversight. Treating providers can identify participants who would benefit. Service coordinators when they're out interacting with their participants, they also can make a referral to our case management department for assistance with basically anything that they have.
And then participants themselves, they can actually call into participant services and refer themselves, refer a family member, care givers can call in, that kind of thing.
And the major way that we do this is once a referral is submitted, it's sent to the email address below. And our complex case management team will review and follow up and send out for potential engagement in the case management program.
Next slide, please.
Medically complex issues. These are the types of things that we typically would identify with our participants who are engaged in our case management program. Pregnancy, clinically complex medical history and medication use. Life planning activities. Cultural needs. Vision and hearing needs. Available care giver resources and available community resources.

Next slide continues more.
In addition to direct patient contact, information is gathered and collaboration occurs with relevant sources. So basically, the participants are contacted and working with a participant and we will contact the service coordinator, care givers, both professional and nonprofessional, a spouse, significant other, a power of attorney. Maybe the DSNP MCO. And the nursing facility if there is one involved. We will coordinate and speak with the individuals to build the most appropriate plan of care for the participant.
Next slide, please.
Another program that we have is our maternity program. So if you remember the first slide, it said that we have nurses who have a background in neonatology and pediatrics. They do the bright star program. Once a participant is identified as high risk, that participant is referred to the bright star program. And they are engaged in a program for the entire pregnancy and up to 60 days after the pregnancy -- after she gives birth just to make sure everything is good.
Another thing that we do is that case manager also does our complex case management program. So that participant has additional needs outside of the maternity realm, we will continue to manage that participant in our complex case management program, and she follows them. So she will be able to have a holistic view and rapport and built in relationship with the participant as well. That's one of the unique benefits with the bright star program.
Next slide, please.
So our Triage care management team, they do not contact participants if they have a complex care manager. It's similar work. What they will do is they will follow up with participants that have multiple ER in patient presentation within 30, 60, 90 days. And basically, their work flow. And the goal is to have a decreased ER and decreased inpatient presentation. The work flow would be they would contact a participant, develop a simplified care plan. And when they have the follow up, they're really doing telephonic education about medications, they're going to help schedule transportation to appointments. They're going to do disease management to make sure the participant understands symptoms of exacerbation and when to seek the appropriate level of care, maybe urgent care versus ER versus going to the contact for advice.
This program, they are engaged in the program for four weeks. If the participant concepts and want engagement longer, more intensive care management, they are then transitioned to our complex care management area as well.
Next slide, please.
One of the other things that the Triage team does is monitor daily reporting. The care managers and our nonclinical team, the personal care connectors, they review daily reporting about emergency room visits. They will inform the service coordinator of the inpatient or the emergency room visit. And they do this by sending in an email.
And the reasons for this is to make sure that there's accurate and timely information gathered and critical incident and assessment work flows can be initiated.
Next slide, please.
This special needs unit. So our special needs unit is staffed by RNs and social workers, as well as the nonclinical staff, the personal care connect TORs. They take the lead for the complex needs and collaborates with other departments in the plan and provide additional resources to participants. They will utilize experienced -- excuse me. They will utilize expertise in handling of a particular condition or circumstance to provide coordination to the special needs unit. I can't say the words. Special needs unit as needed.
They assist NFI and NSG participants with issue or concerns with benefits covered under the medicaid fee for service. And they will also refer NFI participants to express a desire to be

evaluated for LTSS services to contact the independent enrollment broker.
And they're really episodic group of clinical team. So if there's something where a participant needs immediate help or help related to not a complex -- well, a complex need, but not a long term need, that's the team that will handle that.
Next slide, please.
And then lastly, they coordinate with DSNPs and other MCOs jointly serving CHC participants to effectively manage care by gathering information and communicating care goals to the service coordinator and other MCOs. It appropriate care and resources and there's no duplication of services as well.
I believe that might be the last slide. Yes.
And that's it.
>> Thank you for the presentation. Before we proceed to the next, do we have specific questions for AmeriHealth Caritas Keystone First CHC from subcommittee members?
>> Nothing in the room.
>> Any questions from the audience?
>> Nothing in the room.
>> Do we have any from the chat?
>> No.
>> Great. Thank you, Paula. And Shaun, thank you for your presentation.
>> No problem. Thank you.
>> Up next, we have a presentation from PA health and wellness.
>> Good afternoon, everybody. This is Heather Clark. And I am going to start off our presentation on our complex care unit.
Our complex care unit is really developed to ensure participants with complex care concerns such as traumatic brain injuries, participants who are on ventilators, and who have complex behavioral health concerns, or health and welfare issues can receive the additional support that they need.
Also, these members may require escalation to adult protective services or older adult services. And we want to be able to ensure that they're getting their support in a timely manner.
The PHW complex care unit is within our care management department. Our chief medical officer is over the CCU. And the CCU unit is comprised of registered nurses, licensed clinical social workers, licensed practical nurses. And we do have some nonlicensed support staff.
We do get referrals for the CCU from a variety of agencies for methods. Regulatory agencies, such as OLTL, APS may refer members to this CCU unit.
Facilities is one of our -- referring entities. We do receive a lot of referrals from facilities. Inpatient facilities requesting assistance with difficult to place participants. We do get a lot of referrals from service coordination, primary care physicians, utilization management. Some specialists -- refer participants over to the CCU unit as well. Home care agencies. And another large referral source is the behavior --
Some of the activities that are completed by our CCU include coordination of benefits among providers and payers. Identification of specialty providers. Helping with transportation and ensuring that transportation needs are being met. Facilitating complex discharges. One of the core components of our CCU linking to PCPs and community resources.
We also complete medication reviews on all CCU participants to ensure that there's no pharmacy issues and a member is aware of the medications that they are taking.
We do complete specialty assessments, behavioral health, maybe depression screenings, diabetes, fall risk screenings.

We also do an assessment of social determinants of health and linkage to the -- supports or services that can provide assistance to bridging any of those gaps in SDOH needs identified.
We also facilitate ICT meetings to ensure all of the key stakeholders that are involved in the member's care are coordinating across the providers.
We do create a care plan and share the care plan with the PCP and members of the ICT.
And then we also coordinate the durable medical equipment. So that's just not an inclusive list of all of the activities that are completed in the CCU unit. It gives some bullets of the most common.
Next I want to turn the presentation over to my partner, Olivia Martin, who has oversight of long term support services.
>> Hi there. Good afternoon. Can you hear me okay?
>> Yes.
>> We can hear you.
>> Thank you. Okay. So I want to briefly touch on some of the collaboration activities between the service coordinator and the CCU. So an integrated approach ensures that individuals with LTSS needs and complex medical needs have access to the services they need to live healthier lives in the community. The focus is person centered, attempting to surround the individual with wrap around supports. For the CHC members, often, the coordination begins with the service coordinator. If complex care needs are identified or barriers are identified that could be dressed with an integrated care team approach, the referral is made to begin bringing together the interdisciplinary care team. Providers are included along with the participant and any identified supports they may have, such as informal supports or POA representatives, DSNP managers, to plan and address any barriers the individual may be experiencing to their care. Some of the barriers could be but aren't limited to discharge for hard to place participants, as Heather highlighted. Traumatic injuries requiring more complex care. Ventilator dependent individuals. Those are complex behavioral health needs. Those lacking a strong back up plan. And reentry to the community for incarcerated individuals.
More frequent touch points are required with a participant and care team for a more proactive approach planning. This ensures needs are addressed and additional risks are identified before problems may arise.
Next slide.
So we strive to bring together a team that addresses an effective combination of care, services, and supports while taking our participants' preferences and goals into account. The approach is person centered and person led, if able. The goal is to address what is important to the individual and what is posing as a barrier to meeting those priorities. This approach considers the individual's age, gender, culture, heritage, language, identity, beliefs. It may require more flexible services and supports tailored to suit the person's wishes and priorities. The approach is strength based where the individual is acknowledged as the experts in their life with the focus on what they can do first. And then the support they need to do that successfully.
This person-centered process brings all the pieces together to enable a person to build and maintain a sense of control over their life.
Next slide.
So I wanted to briefly highlight a recent story that's a good example of the coordination and collaboration of the CCU, service coordinator, and the entire care team. So we were contacted by the department of corrections to assist in securing a plan for reentry into the community for an incarcerated participant. This gentleman was incarcerated for long term and was being released in four days without any further correctional obligation from him. In the short time

frame, we were able to pull together a plan for his day of release that addressed his needs and goals.
So basically, he was wheelchair bound and could ambulate sort distances, but he could not maneuver stairs. He wanted to remain as independent as possible in his home setting.
Also, he did have diabetes and cognitive impairments made medication reminders a priority. This would enable him to remain compliant with the med schedule and maintain a stable blood sugar.
Next slide.
Okay. So we refer to do the CCU and multiple planning sessions were quickly scheduled to plan for a successful reentry into the community. The residential setting posed a barrier due to stairs when the individual could not maneuver. Stretcher transport was arranged. And enabled him access to the second floor. And later that week, the exterior entrance of the home was addressed to permit him safe entry and exit. Personal assistance and skill care was scheduled to begin on the evening of release. The diabetic friendly home delivered meals were set up to begin as well. He's on a regular schedule for meals and his blood sugars has been stable. This gentleman providers reported he's adjusting very well to his return to the community.
Next slide.
Any questions?
>> Thank you for the presentation. Are there any questions for Pennsylvania health and wellness from subcommittee members?
>> There are none in the room.
>> Okay. Any questions from the audience?
>> There aren't any in the room.
>> Appreciate it. Lastly, are there any questions in the chat for PHW?
>> No.
>> Great. We will move along to the final presentation from UPMC.
>> Good afternoon, everybody. My name is many RIS SA ables Dawson, one of the senior directors here. I know we're running a little short of time, so we will be brief today.
Next slide, please.
Thank you. Our complex care unit with UPMC focuses on helping to transition complex cases into our program from other waiver programs and community programs. We spend a lot of time working with our early periodic screening diagnosis and treatment, also known as EPSDT program into CHC. These individuals are aging out of their youth programs, and a lot of times are needing assistance in finding providers that work with adults as they have been with pediatric providers up until that point.
We make sure we're working with individuals who are discharging from the forensic system. Many of them have been in long-term settings with our corrections departments and are being reintegrated back into the community. Helping them find housing, making sure long-term services are in place to help them successfully transition into those communities. Working with individuals coming from other long term programs, like act 150, options, the living independent for elderly or LIFI program, ODP waivers. And those that are coming in to CHC that haven't had it earlier.
We focus on having all of those individuals assessed very quickly getting services into place for continuity of care period. If they have services in place, we make sure to honor the services and work to continue to keep those providers in place.
If individuals don't have services, we help them identify service providers that can be in the home with them where ever it is they meet across the state.

The CCU does not carry cases long term. They focus on making sure we have successful transitions into the program. And it's not something that we have external referrals to. And we obviously get referrals for hard to place cases from OLTL and DHS. But for our service coordination teams, we make sure that all of our referrals and requests for assistance continue to go through our service coordination hub or member services. Both of those numbers are on the bottom of our slide.
Next slide, please.
So our CCU is a team of specialized service coordinators who work with establishing and transitioning care into appropriate network providers, as we had discussed. They do an initial assessment that is completed over the phone initially so that we can make sure we're getting a good baseline of some services while we're working to get a regional service coordinator who serves the area the participant lives in out into the home.
We make a transit care plan to make sure we're addressing gaps in care in a timely manner, which many times includes working with community partners, other waiver groups, the IEB and CAO are helpful to make sure we have the services in place and that we're not having individuals with those gaps in care.
Lastly, our service coordinators in this unit do a warm hand off with the permanent regional service coordinator. They do that on the phone. If appropriate, they do a three-way call to introduce the service to the participant. They work with the families and many members of the person planning team for the individuals. Often times, that includes providers, their long-term care givers, both formal and informal, powers of attorney, guardians, and anyone that an individual would like us to work with.
Our complex care unit is comprised of some specialized service coordinators. They work very closely with other specialized coordinators across the state in the home to manage the complex conditions long term with all of our individuals on the plan.
Next slide, please.
Our CCU also supports individuals who are already with the plan, so not just transitioning individuals. We focus on those who have vent or trachea needs, individuals that have a TBI. We're starting to look at how to best support individuals that have cognitive or behavioral concerns. So really, they're working as a support with those service coordinators to help provide resources, guidance, make some phone calls if needed. Because we truly believe that the service coordinator is the person who knows that participant best. We're making sure to support them.
Lastly, we make sure to follow a person-centered approach. All of our services and recommendations are definitely participant choice. And we want to make sure that our individuals have a say in what care that they are getting and who they are getting it from.
We really work to make sure that it is a collaborative process with all of our participants and our greater CHR staff.
And that is all for us. Any questions?
>> There are none in the room.
Hi, David, can you hear us?
>> This is Jermaine glover. Looks like we might have lost David. We don't have questions in the room. Not sure if any of the subcommittee members on the phone have any questions?
So at this time, I think we can move on to additional public comment. Any subcommittee members have questions, comments about anything covering the meeting today? Anyone in the room?
Anything in the chat?

>> We do have one question in chat that can be addressed today. This question is from Kimberly Sharp, and it's for Juliet.
Recently, we ran into a person with a brain injury being denied CHC. This person would have previously been under COM care and had a special rehab classification rather than ICS or been --
[Indiscernible]
What is the recommendation for those what would have be covered under COM care? Should they be supported under OBRA?
>> What I would say, Kimberly, if you can send that individual's information to me who would have been classified as a special rehab facility level of care, my email is Jmarsala @PA.gov. I can look into that one specifically.
But individuals with brain injury who would meet the level of care required for CHC should be served in CHC. The level of care for OBRA is ICF, ORC, they would need to meet that criteria. If you're seeing individuals who would formerly be in COM care, they should be served for the most part in community health choices. I believe COM care was folded into community health choices or ended as community health choices was coming online in 2016. So if there are individuals who have a brain injury diagnosis or traumatic brain injury diagnosis that you feel is not being correctly served, absolutely, please forward them to our attention.
>> Thank you, Juliet.
This question is from Amy Lowstein. Sorry, Amy.
Can each MCO talk about their outreach plan to connect with people who lose coverage during the unwinding period?
>> Let me call folks up. UPMC.
>> Hello again. This was David. We are doing a multipronged approach in outreaching to participants who are potentially losing conference from the continuous eligibility. We are sending written notification, as well as making multiple phone calls to those individuals and engaging our providers and service coordinators as well to reach out to the participants to remind them about the importance of renewing their medicaid applications, as well as offering assistance from our service coordination team, as well as our eligibility specialists if they need assistance in filling out those applications.
>> PA health and wellness?
>> Thanks, Juliet. This is Angela from PA health and wellness. We have a robust communication plan and outreach plan that's tailored to each eligibility group. And it begins with documented outreach like letters that are being sent, and a combination of different communication styles. So for example, we do letters, texts, and all of this begins 60 days prior to the participant's eligibility due date. So there's three different texts sent at days 60, 45, and 30. And then we also do emails at 60, 45, 30 days. And the fourth one within 10 days. We do automated calls, direct mail 45 days to 60 days. Outbound calls that are rolling from 30 to 60 days before the redetermination due date. We have special IVR messaging on our phone for inbound calls so that participants who have a question on redetermination can get immediately to a dedicated call team to support them with their redetermination process.
We have a public facing website that has information. We do mass marketing and provider outreach and materials for providers. We also are active on social media. And then we have a communications team and community health workers that are in the field supporting people with their redetermination packets.
Apologies. Okay. Sorry about that.
In addition to that, our service coordination team is also doing outreach, handing on assistance

to support with packets. And make sure assessments with completed timely. And we do inbound call support. And as we discussed earlier, we have a team that's helping folks with their notification forms as well.
So every staff that might hear about someone who has had an address change or some change in their contact information, they're trained on CAO notification forms so that we can help a lot of people quickly by making sure that the addresses and contact information is current. This helps to ensure they're receiving all of the materials that OLTL is sending to them.
>> Great. Thank you. AmeriHealth Caritas Keystone First.
>> Hi, this is Frank from AmeriHealth Caritas. Can you hear me okay?
>> We can.
>> Thank you. Thank you for the opportunity to reply to Amy's question.
Just like UPMC and PHW, we have robust outreach activities going on. Certainly service coordinators are reaching out to participants whose eligibility is coming due in the next 45 days. We also have text campaigns and letters that will be going out to participants whose medicaid renewal will be coming up in the next 45 days.
Additionally, we are working and we receive what are called 042 transportations. I believe it's 042. Where a participant has submitted their renewal and for some county assistance office. And our service coordinators are conducting outreach to those participants so they respond to that additional outreach so that their medicaid
>> Thank you for the responses. This is David Johnson. My apologies for experiencing connectivity issues and thanks to moving on to additional public comments. Do we have any additional questions or comments?
>> We do have several questions in the chat. But they are for Laura Deitz. And I wanted to let everyone know who did have questions for Laura regarding adult protective services, that's Jay, Tom, and Misty, we will forward the questions to Laura and she will reach out to you guys directly.
>> Thank you. Are there any additional questions or comments?
>> We have an additional question from Amy Lowenstein.
I appreciate the information effort on what is being done to reach current members. However, the question was about people who lose conference. DHS grants a time limited permission from the MCOs to contact former participants, particularly those who were terminated for paperwork problems to help reenroll in MA.
So I will re-read her original question.
Can the MC ordinary cares talk about their outreach plans to connect with people who lost MA conference during the unwinding period?
>> Thank you. Could a representative from each managed care plan respond to Amy's point of clarification?
>> This is Frank again. As I had mentioned as far as the 042 transportations, we're trying to get in front of it, Amy, where the participants submitted renewal paperwork and it appears that additional information is being requested and we are conducting outreach to those participants to assist them or ask them to respond to the CAO.
Additionally, if a person does lose coverage, we are referring that to Pennie or to Act 150, as requested.
>> Thank you. Angela, are you able to respond on behalf of PHW?
>> I am. Thank you. Similarly, PHW is supporting participants if they were to lose eligibility, there is that 90-day redetermination or reconsideration period. And so we do have routine dashboards, we have daily dashboards that show participants losing eligibility and service

coordinators or other team members are reaching out to participants to make sure that they can still do anything procedurely that they need to do in order to get reconsideration.
If they have lost eligibility for a nonprocedural reason, say they're just no longer eligible from a financial standpoint or a level of care standpoint, then our staff are helping folks by providing a bit of options counseling so that they know what other services are available to support them so they have connections to Pennie and Act 150 program. Also so they're aware of different community and social supports that could be available to assist them.
And that happens for people of all eligible types as well.
>> Thank you, Angela. And David, are you able respond on behalf of UPMC?
>> Yes. So similar to Pennsylvania health and wellness and AmeriHealth Caritas, we're focusing on helping supporting people initially to retain that eligibility. But if individuals do lose eligibility, we do offer them information about the appeals process, as well as other alternative options and assist them in making referrals to the program.
>> Thank you. Do we have any additional public comments or questions?
>> We do. Tom and Misty are requesting that their questions are ready for the subcommittee members.
Regarding guardianship -- in PA area -- provide an APS and Ombuds men -- how do the state requires the less restrictive settings before guardianship and placing individuals in institutions?
>> This is David. Are you able to hear me?
>> My apologies. My audio cut out again. I heard part of the question. For my sake, I appreciate everyone's -- will you please repeat the question?
>> Yes.
>> Thank you.
>> In PA10 area ALTH agency offices provide services as well as provide guardianship. How does the state ensure these restrictive alternatives and settings -- before placing individuals in guardianships and institutions.
>> Thank you. And Laura left the meeting, correct?
>> Yes.
>> So this is Juliet. And I can step in here. The triple A is from the guardianship -- they do fall under the department of aging. So while we do coordinate very, very closely with the department of aging and their adult protective services program, if the committee would like, I would be happy to extend an invitation to the department of aging for them to come and provide additional depth on this question or to provide a follow up response.
>> Thank you, Juliet. Yes, at the very least, we can get a follow up response from a representative from the department of aging. We can certainly discuss perhaps the future agenda item.
The next question from Tom, who takes reports on guardianship abuse?
>> So guardianship abuses can also be reported through as you would any other reports of abuse, neglect, or exploitation.
>> Thank you, Juliet.
This question is from Misty Dion. Can you get clarification on the area agency of aging roles and guardianship on budsman and guardianship roles and services?
>> This is Juliet. We will ensure the department of aging includes that in their response.
>> We don't have any additional questions in chat.
>> Thank you. I believe I see a question or comment from German. If you are on the call and able to unmute yourself, you're welcome to pose it yourself, if you would like.
>> This is German. Thank you. Regarding the in lieu of services, Pennsylvania for decades has

acted under the precedent of not having a -- pay one entity for housing with direct services. I propose this committee go on that has and may pay for combined housing and LTSS.
>> Can you repeat that? The captioner didn't get the middle of it. You said -- Pennsylvania has a precedent of something.
>> Has for decades -- and this is in the chat. For decades has acted under the precedent of not having MA pay one entity for housing with direct services. I propose this committee go on record and not recommend assisted living or other title that has MA pay -- and LTSS.
>> Thank you, German. What I would propose regarding recommendations made by this committee is if we can or you can draft this in writing outside of the chat, circulate amongst subcommittee members, and this could be an order of business at next month's meeting.
>> Be happy to. Thank you.
>> Thank you. Additional public comments or questions?
>> There's no questions in the room. And there are no questions in chat.
>> Great. Before I make a motion for adjournment, I want to sincerely thank everyone for the patience and understanding with this virtual chairing today. I have their support and understanding.
Is there a motion for adjournment?
>> I motion to adjourn.
>> Great. Thank you. Next meeting will be July 6th hosted in person at the PA department of education honor suite and online via webinar. I thank everyone for your participation. Hope you have a great rest of your day.