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DATE: January 3, 2020

EVENT: Managed Long-Term Services and Supports Meeting

>> **Kevin:** We'll be starting the meeting in just a second. We had you on mute.

>> **CART Captioner:** I won't be able to ID the speakers if they don't say their names every time they speak. If I can easily tell, I'll do my best.

>> **Speaker:** If you can mute if you're not speaking we would appreciate that very much.

>> **Drew:** Drew.

>> **David:** David Johnson.

>> **Linda:** Linda Litton co-chair and advocate.

>> **Kevin:**

>> **Barbara:** Barbara Polzer liberty community connections. May I have the admit qlee members on the phone identify themselves.

>> **Rich:** Rich Wellins.

>> **Tanya:** Tanya Teglo.

>> Yes, sir. Jesse Wilderman.

>> **Neil:** Neil Brady.

>> **Barbara:** Any other committee members? All right. I'll give us some housekeeping attacking points. Please keep your language professional. Please direct your comments to the chairman and wait until called upon and please keep your comments to two minutes. The transcript from meeting documents are posted on the listserv and posted within a few days of the meeting. Today the captionist is documenting this discussion remotely so please speak clearly and

slowly. Please state your name prior to making your comment. The meeting is also being audio recorded. The meeting is scheduled to end promptly at 1:00. If you have questions or comments that weren't heard, please send them to the resource account and that resource account is listed on your agenda. The exit aisles must remain open. Please do not block them. Please turn off your cell phones. On leaving please throw away your empty cups, bottles or wrappers. Public comments are taken throughout the presentation and not just at the end of the meeting. The 2020 [inaudible] meeting dates are available on the DHS website and I'm going to ask can listen to today to give us the emergency evacuation procedures.

>> **Linda:** In the event of an evacuation or emergency, we will proceed to the assembly area to the left of the Zion church on the corner of fourth and market. Up you require assistance to evacuate go to the safe area located right outside the doors. A member of OLTL will stay with you until you are evacuated or told to go back into. Everybody must exit the building. Take your belongings with you. Do not operate your cell phones and do not try to use the elevators as they will be locked down.

We will use stair one and stair two to exit the bulling. Stair one use the honor suite left side near the elevator. Turn right and go down the hallway by the water fountain. Stair one is on the left. Stair two exit the honor suite through the doors on the right side or the back of the room. For those exiting through the back door make a left and then another left and stairway two is directly in front of you. If you go through the right doors you just make the one left and stairway two is in front of you. Merge to the outside. Stay -- keep to the inside of the stairwell. Merge to the outside. Turn left and walk down Dewberry ally to chestnut street. Turn left to the corner of Fourth Street. Turn left to Blackberry street and cross Fourth Street to the train station. Thank you.

>> **Barbara:** Thank you, Linda. Now I'm going to turn it over to Kevin Hancock for the OLTL update.

>> **Kevin:** I'm going to go through the implementation updates and also go through some requested data reporting relating to complaints and grievances and then turn it over to Randy who is going to talk about critical ups dent reporting and then crystal will give us a quick update on electronic visibility verification. I have to start we have a statewide program -- anybody notice the statewide program which is a big deal. Brendan did. That is good. Anybody else?

It has been an incredible journey. Almost five years now. It will be five years since we started it off in arm of 2015 planning the program and bringing it through and

largely attributed to all the people in this room as well as people who are not able to be here today and many people who are actually working the program in the field right now. This is a success story. I have always been kind of reluctant to say that. I think at this the point we can talk about be a true reform of long-term care reform in Pennsylvania. Those people that contributed to the success I'm grateful for all of the work that you have done to be able to do that and that includes all of our advocate community, our managed organizations, our provided community and provider associations and so many people that were involved in this process to bring it to fruition.

So I think we really do need to take a moment to give ourselves a hand that we now have a statewide program. Thank you all for your work.

[Applause]

What happened to success when it comes to government programming is people stop paying attention to you. That is kind of what is happening right now.

With that I'm going to jump into phase III implementation. Just a note our essential priorities for phase III are the same as they were for phases one and phase II. We're looking to make sure there is no interruption of participant services during this continuity and care period regardless of the types of services they're receiving and also to mock sure there is no interruption in provider payments. This will continue to be something that we monitor very closely. We are having daily hutles with all three managed care organizations when we discuss any reported interruptions participant services. We have had a few that have been reported. One off certainly and largely attributed to be perfectly honest a direct care worker who misses a shift or doesn't show up for a shift. Backup plan in this case are executed or managed care organizations work with providers to make sure there is other coverage that is available.

We do have -- I'm not going to go into too much detail but many people may be aware we have an on-going very large provider issue that affects the southeast, Lee high capital and the northeast. We're monitoring that very closely and managed care organizations are working with their participants to look for potentially other providers to be all the provide certain types of services because a provider in this region is unfortunately having issues with payroll and is not able to make payment. So that is not related to CHC but an issue that we're monitoring closely because of obviously the health and safety risk of participants and we look forward to that being resolved and we appreciate the work of other home care providers and also the managed care organizations working quickly to have these issues addressed.

In addition, we -- when it comes to provider payments, similar to phases I and two, we have a couple of different issues with service authorizations specifically with home care services, some of it related to data integrity again. The numbers are much, much smaller for phase III compared to phase I and certainly phase II but those issues are being quickly addressed by the managed care organizations, by the financial management services vendor PPL and by the office of long term living when we're dealing with particular data integrity issues.

So we are seeing minor issues so far. We're also paying attention to call volumes with participants and providers had in the managed care organizations, but for the most part, we are meeting the objective of limited to no interruption in participant services and that is a little early yet but limited to no interruption in provider payment. We appreciate the willingness of providers, participants and the managed care organizations to talk about issues and to troubleshoot how they can be resolved very quickly. I'm going to have to say that phase III for the last several weeks has moved along knock on wood more smoothly than we saw certainly in phase I and also phase II but that being said, there is still a few hiccups but it is going pretty well. Any questions about that? Okay.

>> **Speaker:** Any surprises that you [away from microphone]

>> **Kevin:** Talking about an issue this morning. For the folks on the phone if you didn't have a chance to hear Blair because he didn't use his microphone. Just picking on Blair. He asked up there were any surprises. One surprise I heard this morning is from one of the managed care organizations who mentioned that they had a significant call volumes and one of the call volume issues that was raised was the people were asking how to change their primary primary care physician if they're non--- they can keep their Medicare primary care and they don't have to make any changes to their Medicare coverage unless they want to make changes to the Medicare coverage. We were loud and clear on that message. We reinforce that with our independent enrollment program. The fact that we're still getting questions like that was a little bit of a surprise. But it is just the reality is unfortunately people are duals not LTSS don't pay as much attention to their Medicaid coverage as they do to the Medicare coverage and still creates confusion. To me that was the biggest thing so far today.

>> **Tanya:** How long will the authorization issues take to fix?

>> **Kevin:** It is my understanding they will be fixed today. But there certainly will be one off issues. Largely attributed to issues with data integrity from the source systems. They'll probably take a couple of weeks to clean up. There should be no

risk of interruption for direct care worker payment. We'll make sure that is something that is covered and managed care associations will do the same.

>> Tanya: I know I reported some of it to you yesterday but the problem actually goes back to the first. It is like the first in whatever happened yesterday. I just wanted to get that clarified. I don't know if like the service coordinators have been given a date or anything yet. I'm just trying to make sure that this -- you know what I mean that everybody knows when it should be worked out by so it doesn't become a problem.

>> Kevin: Understood. So a little -- some of these issues are definitely case-by-case. They may take a little longer than others depending on what has to be rebuilt to have the authorization in the system. Your issue in particular will be -- is going to be fixed today if not already fixed and would be fixed retroactively. All of the issues will be addressed retroactively if they cover from the first on. But as I mentioned some cases the Fulks mute be a little bit more complex and may take longer than just a few days.

>> CART Captioner: The fix might take longer is what he said.

>> Kevin: Either the internal or external coordinator should be able to get the information they need to communicate to the participants on when the services will be -- the service issues would be addressed. That is a good point.

>> Tanya: Okay. Thank you.

>> Speaker: Kevin, quick question. You're mainly talking about interruption of service during transition. Is the issue of providing hours versus those that are authorized if you're not in transition is that a separate issue?

>> Kevin: For people who are already in phases that are parts of the state that have been implemented, that would be a separate issue. If the issue for you, for example, is that the number of hours you're receiving for personal assistance services is not matching the number of hours you're authorized to receive, that is a problem that would start by reaching out to your managed care organization and then just following through the complaints process. But you should be receiving the hours that you're authorized to receive that is for sure.

>> Speaker: Okay.

>> Kevin: But yes to answer your question it is an implementation issue.

>> **Steve:** For the southeast, we wound up wasn't immediately that resolve the issues after the first several weeks. So the continuity of care providers continue to provide the serves didn't really have authorization yet from the [away from microphone] in HHA or wherever. Then when they started billing is when service coordinators had to get much more accurately involved. Certainly there will be some additional things which is natural but just be prepared there is some additional things.

>> **Kevin:** In the southeast to support your statement, Steve, in the southeast we had some authorizations -- to Blair's earlier point that was an issue caught us by surprised. We had significant data issues in the southeast identical to the southwest. We were not able to get ahead of that it was a surprise to us. But it was very -- cleared up by February at the latest but the reality is that we did have more issues. We are not anticipating those same volumes of issues in this final phase. Up it does occur I'll be surprised. A little disappointed. But it is not -- we cannot blame it all on HH exchange and it is resources and everybody in this room certainly complained about those two systems for a long time and sometimes the data transfer from the sources is to the new systems that are operated by the MCO parties -- has not been successful as we would like to say that it has been. Good point. Any other questions about that?

Next slide shows the phase III break down in population by each of the zones. As you see, AmeriHealth for Lehigh capital zone that was made and Pennsylvania health and has 28%.

>> **CART Captioner:** I apologize I was not provided these power pointers ahead of time to prepare.

>> **Kevin:** They have 41%, UMC has 31 and health has 28%. And the northwest zone UPMC has 53% which is the most striking of the market share distributions of the three zones. AmeriHealth has 24% and Pennsylvania health has 23%. So we would say with Lee high capital and none of these numbers were surprising to us at all to be perfectly honest. The physical health choices presence was just certainly a factor in the way that this was distributed. We'll continue to monitor to see if these percentages change. But seriously this is the way we thought it would -- we thought it would sort of evolve from -- from the planned section of the participants.

One thing that we cannot report this month but certainly report it next month is the final percentages for advance plant selection. We have a couple different data always wonderful thing. We have a couple of different numbers from different

sources and we need to do a little bit more validation before we report out the final percentages. We're expecting it to be close to what we saw in November but we want to make sure that the actual calculation of the percentage parties correct. We are working on that now. Okay.

>> Jim: It is Jim Piefer. I can't see the slides I'm driving. Was there any proportional increase in the people that selected the life programs? I know there is not as many. I was just curious.

>> Kevin: That is a great question, Jim. We do not know yet at this point what percentage of people going through the process selected the life program as compared to going into community health choices. They certainly received the communication but that is something we're going to follow up on.

So a couple of different factor that were a little dust for life in the final phase especially in the northwest running a pilot right now for enrollments and curious to see if the pilot had any impact in enrollment as well. We will report back on that percent. We were not able to do that until last year in March. Hopefully we can have it done earlier and we'll definitely report that out.

>> Jim: Thank you, Kevin.

>> Kevin: Thank you. Next slide shows phase III population by population category. Only largest population are the non-LTSS or NFI duals (sp) and going through the modern care duals and people are receiving long term care in nursing facilities. The home community based are also the other two larger populations. Very small populations for non-duals in the fume phase. If you remember 96% of the total population was dually eligible for Medicare and Medicaid. Very few people receiving long term care in nursing facilities are non-dual. We have a few more people who are non-duals receiving long term care in the community. But these populations are proportionately smaller. If you were the southeast population of individuals were much, much higher.

So before I jump into complaints and grievances data, does anybody have any more questions about phase III implementation?

>> Jim: I just think that your leadership and your key team members in this process really need to be recognized. Your multiple to communication and patience in this process was amazing and I think everybody should take note of that. Congratulations to you and your team.

>> Kevin: Thank you, Jim. I really do appreciate that. I have to highlight so in the past year we have begun to move into much more operational role. Randy and his team and folks get a lion's share credit to underwrite this implementation as does crustal working through the EEV issues and helping us with communication for CHC. Joe [NAME] obviously running keeping the ship afloat while I was running all over the state. And [NAME] Gonzalez and her team billing out quality strategy for the program. All that being done so we had our policy folks overseen by Jen's area making sure that we had all of the resources needed to zero actually get paid by our Federal partners in this program which is pretty important. A little bit over $5 billion. And also to Mike hill's area for working through a lot of the service issues as well as the procurement issues as well while we went forward and pushed through implementation. Surely our finance group run by Dan Sharar. Those folks were heavily involved in the monitoring -- the financial monitoring of the program while at the same time still performing all the work that is needed to maintain the fee for service specifically for nursing facility rates. I have incredible team of people and I'm grateful for all the work that they did and I can't say how lucky it has been to be able to have this privilege to work with them on a project this big. Biggest project of my life and also the most successful. Largely attributable to you'll the work the people in long term living who provided tireless effort to make this happen as well as all our stakeholders. Thank you, Jim. That is a long answer to a short comment. Any other questions? Okay.

So jumping into we were asked to give a little more detail on complaints and grievances. A lot of this data has been submitted to the consumer sub mat. The first shows the number of complaints per 10,000 participants in the southwest. We use this 10,000 number because it sort of is a way to normalize the data and it also adjusts for variances in enrollment.

We do have a lot of variances in enrollment for all of the zones and we wanted to make sure that we are able to compare Apple to Apples when it comes to the actual volume because if we looked at volume totals and managed organization with a higher enrollment we'll likely have more complaints. More -- could be more of a reflection of their higher enrollment than it is for the actual number of complaints. That is the reason we sort of standardized in this direction.

So this -- if you look at the total numbers per 10,000, the volumes are comparatively low and I would less AmeriHealth answer their approach for the reason they seem to have the lower number of complaints. They do have a process they use that that looks to address complaints in a little bit of a different way and at least in terms of the number of complaints that actually come to fruition it looks

to be effective. But for the most part, a complaint reporting does have some differences between the three managed care organizations.

Next slide shows the number of complaints in the Southeast for 10,000 participants. And keep autopsy the first one is AmeriHealth Keystone First entity and we're finding them to be largely the same. These are the first two quarters of 2019. Obviously we implemented Southeast in January of 2019. So we're hoping to have more data showing each of these. Stop me if anybody has any questions.

The next slide shows the number of southwest grievances per 10,000 individuals. And the next slide shows the Southeast number of grievances for the first two -- I think that this if I'm not mistaken this should be the first two quarters of 2019 as well. There is a little bit of a problem on the graphic.

The next slide those the LT are SS versus non-LTSS grievances. We're tracking LTSS grievances. This is important in choices because most of the folks in our program are dually eligible. The physical health services are primarily paid by the Medicaid program. So LTSS is important because we're the primary payer. The if you look at the total numbers, LTSS versus non-LTSS, the volumes are -- the volumes are relatively low and I think that we are exploring quarter one, 2019, for Pennsylvania Health and Wellness because it seems to be a bit of an outlier in terms of the report. And the next slide. It shows the Southeast LTSS versus non-LTSS grievances. It would be the first two quarters of 2019 and once again the volumes are very low at this point.

This is not surprising. There is actually with LTSS versus non-LTSS, the first two quarters were part of the continuity period and those receiving home base serves would have had their existing service plan authorized for services as well.

>> **Speaker:** [away from microphone] medical all of that.

>> **Kevin:** Anything under the waiver also nursing facility services as well.

>> **Speaker:** Okay. Just medical would be the non-LTSS.

>> **Kevin:** Physical health services would be the non-LTSS. That is correct. Anything part of the package -- do you want me to repeat?

>> **Speaker:** [away from microphone]

>> Kevin: Matt is saying that Pam wasn't loud enough. So I called Pam Joan. I'm sorry. I'm not sure why. But the question was, what is covered under LTSS serves? Just make clear all 32 of the home community base waiver services in Community Health Choices as well as nursing facility service and physical health services are those services that are secondary to Medicare payments and part of the Medicaid adult benefit package. Okay.

The next slide. Are we on 14 or 15? Fourteen. Next slide shows LTSS grievances. I think this is by service if I'm not mistaken. The next slide shows type of grievances by service. And obviously personal assistant services represent about 87% of all the home community-based services that are received and that is the highest number of grievances we see for LTSS services in the southwest. The next complaints and grievances for the Southeast, also, show for the first two quarters show that pass the most significant amount of grievances as well. With that I'm going to turn it over to Randy know land who is going to provide a review of the Community Health Choices approach to critical incident reporting.

>> Randy: Good morning, everyone. This is Randy Noland. Your Director of Services and before I go over critical incident reporting I want to thank you for all the kudos that we got and acknowledge that Kevin put all that and in writing for all of us. So that is not something he normally does commit to writing. We will make sure we print that and make it go around the office.

>> Kevin: You're not getting any more money Randy.

>> Randy. The other thing I wanted to do before I go into critical reporting there was a couple of things that needed to be adjusted within the bureau as far as staffing. One the division director [inaudible] and licensing and so it needed to zero back her position and needed to backfill my position. I want to introduce the new staff, let you when I go over critical incidence we're rebuilding with new staff.

The new staff coming in three division directors now. One of them you know who oversees integrated care which is Jonathan Bowman who zero skipped out of today's meeting. The other two division directors I have one is division of participants and torts which was comes [NAME] the division. The division is responsible for the IB enrollment and working with aging well, instant management and EIM system and everything participant facing. We brought him over from the office of maintenance where he was project manager overseeing a lot of policy area over there [away from microphone] and so anything related to the IB, that is where it goes now.

>> CART Captioner: Although it may sound loud in the room, it is bouncing off the walls and coming back to me with an echo. Thank you.

>> Randy. And the whole implementation of the program, where we bring somebody over with experience and work in the Bureau of Managed care overseeing the health choices plan. We were able to bring him over and that is Mike Wilkerson. Some of you may know him from working on physical health side. He'll be overseeing the monitoring compliance unit. That would be overseeing all the programs.

Critical incident reporting, that is a unit that we're rebuilding a lot of staff left. Hope is in the next month or two we'll be able to present a longer preservation on where we're going into management and EIM (sp) system. We're building a staff from there. Mike [NAME] is director and we hired a section chief who should start by the end of the month. Just hired a nurse who should start by the end of the month that will oversee some of the things more challenging and hard to place cases. We hired a number of other staff to run the day-to-day work with instant management and to work with protective services and adult protective services on these cases.

For critical instant reporting, just go through these fairly quickly. The NCOs are responsible to ensure that providers comply with critical incident and adverse reporting requirements and then enter them into the EIM system. Also responsible for investigating those instances that do not elevate up to the protective services level. They will with work with the departments inti prize and management system and ensure that all the providers are entering reports into that system. That is critical. We're doing a lot of training on that. We had done some changes to the system try to make reporting easier within the system. And then there is a number of things that before reporting an incident that the NCOs are responsible for. They need to ensure if it is an incident that could result in protective services that you contact APS or APS for -- if older APS for individuals to investigate the case. If there are issues they need to call law enforcement or someone else has a responsibility to make sure that they do that and then it is their responsibility to ensure that the service coordinator and providers enter the incidences within the EIM system within a 48 hour time period.

One of the things that we're working with, working very closely with as far as aging and older adult protective services which is part of the [NAME] new bureau that is now under the long-term living. We'll have an opportunity to work more closely with the APS program. We're really working through the process of how the NCOs interact with these two entities to resolve and service cases. So APS or -- it is

investigating a case the NCO will not be investigating a case. Not have had two investigations going on and trying to gain information. So the responsibility of NCOs those cases is to coordinate services with APS to ensure that more services are needed in person's home we provide the serves through the NCO. It is also the responsibility for the NCOs and the APS workers to coordinate back and forth so that the reports go back and forth so proper information could be entered into the enterprise and management system and resolve the case. So coordination working them back and forth. We're trying to open up communication as much as possible with understanding that there are different aspects of the protective service laws and that we have to adhere to but this is a collaboration now between the NCO and all protective services and so we're trying to work through creating better communication and NCO is in charge with coming up with a plan of how to be accessible 24 hours a day. So that they can provide the information at the PS worker will need to assist the participant. So that is part of the process of working through to improve this.

Hopefully as we move forward we'll create this collaboration and this communication between the MCO and the protective service workers as you said we're revamping the staffing and take a look at being able to pull some more reports out and the staff's responsibility would be following up on these cases to make sure that they are being processed properly. That participants are getting the services they need and they're safe in their home environment. Yes, Pam. Yes, I do know your name is Pam.

>> **Pam:** The way things put into it and disability rights part of it helping

>> **CART Captioner:** Unable to hear Pam.

>> **Pam:** People new coming in to working around services still being considered. Sometimes it is hard to consider that. We want -- you want to protect somebody allowing that person to have their own decision-making with what type of help and how they want to help and talk about [away from microphone] planning but making sure that those two concepts are still in consideration. Are you understanding what I'm saying?

>> **Randy:** I agree with you. We have to follow through the parameters. Even though we have some new staff coming the entity that handles protective services for us which is through the liberty contract will remain in effect. So that staffing on the protective service side is the same staffing same way with the Department of Aging the same staffing that we have been working with. We will have that ability to have that continuity as we work with them going forward.

>> Pam: I agree still [away from microphone]

>> Randy. He's one of the new persons coming in and we'll be able to now go back and look at the history.

>> Pam: [away from microphone] a lot of people involved to create

>> Kevin: We would want to -- if you have particular feedback from -- on liberty and adult protective services we would love to be able to hear it. Gene as Randy mentioned is the bureau director for the service of human life and we're always looking to improve that as much as possible. Thank you.

>> Speaker: Something that is important is timeliness of authorization especially with the [away from microphone] cases imminent risk is going on. Being able to authority is something immediately is essential.

>> Randy: I agree that is why I charged the NCOs to be available. The call numbers they have they have somebody staff wise set up to do phone trees to make sure that the worker can talk a lot of persons within a 30 minute window to work with them to make sure we get services in the place and make sure that they're safe in the home. A bit more than just

>> Speaker: That person has the authority to authority the service right away. The

>> Randy: That person will have the authority to authority the service. Yes. Is that correct NCOs? A lot of head shaking. Yes, head shaking.

>> Kevin: Do they want to be more specific?

>> Randy: Do you want to elaborate what your plan is on that Brendan or are Jim or Anna? This is part of the fun you get to sit up here and do this.

>> Speaker: I can't walk up there and say no I don't want to elaborate on it. But yes, we have a process we have a phone number that we have given protective services so they can reach out. We know to cut through some of the HIPAA and protective services confidentiality rules. We have a dedicated line they have access to. We have staff within our service coordination department we can authority services when they're needed.

>> Randy: Jen?

>> Speaker: Established process and as everyone knows

>> CART Captioner: I'm sorry, it is hard to hear them if they're not at the main microphone.

>> Speaker:

>> Randy: Is that before or after?

>> Speaker: It is immediately. So institutions articulated where with -- to make sure that their immediate needs are met and provider in place and then to process services and criteria of critical incident which is comprehensive [away from microphone]

>> Randy: Thank you.

>> Jeff: This is Jeff from -- go back to what Pam was saying. Some of us were part of the group disability rights in Pennsylvania back in 2010 helped to get it passed for ages 18 to 59. We're still waiting for regulation. It is going on ten years now. That is one of the challenges that we have. Do we have any idea when the department is actually going to have regulations for this? I can't think of -- this is regulation on any level.

>> Kevin: We have been using the contract with the adult services vendor to frame out how the program is meant to operate. How would you see the -- that is the authority. I mean we have the legislation to be able to do it protective services and we had developed a contract to frame out how the services are going to be -- to be operated. Do you think the contract itself with -- with the vendor is insufficient, Jeff?

>> Jeff: From a general policy standpoint. I think it should be shared with the group. I'm not sure how many people in here are actually aware of what is actually in there. And that -- it is not operated procedure for something like this. You look if anything else not just in Pennsylvania but other states child protective services or other adults. I don't know why it is hesitancy on getting some regulations and we probably help with consistency, too.

>> Kevin: Sometimes the administrative burden of promulgating regulations can be quite arduous. And comparable example so we have a managed care regulation. We do have managed care regulations for -- they cover broadly managed care and Community Health Choices under act 68 but we do not have Community Health Choices regulations. We oversee the program via the agreements with the managed care organizations. It does give us the legal authority to be able to do

that. The legislation itself was specific to the adult protective services it was specific enough to articulate what the program would do. I'm not saying I'm opposed to regulations. I do believe that regulations are often our friend. But I think that is -- that has been consistent thinking about the program. And I'm happy to take the feed back, back that stakeholders believe we should have a body of regulation that covers adult protective services.

>> **CART Captioner:** Still unable to hear this person speaking.

>> **Pam:** When it comes to get somebody out of a tough situation whose responsibility because I don't want to see people going to nursing homes. Somebody needs emergency backup. Those kinds of things. Who is going to be responsible for that? Because I have seen such inconsistency along the way. Some people getting great other people you have to get out of this situation. I'm kind of looking for housing and what do I do? And who is the responsibility who is that and --

>> Randy. That is part of what we're developing the relationship between the MCO and APS and coordination of services between the two. And they work back and forth to resolve the issues.

>> **Pam:** Hoping this is right all the discussions we had about the share care homes over the years will this help in those situations where some care providers appreciate the piece and are called to help get somebody out zero [away from microphone] will this group be able to look at those situations any more and help get people out of the correct situations [away from microphone] I guess you [away from microphone]

>> **CART Captioner:** Unable to clearly hear her. Too far from the microphone. The

>> **Randy:** We will work together to ensure that person's safety. If that means temporary lodging at hotel or means [away from microphone] or whatever means it gets to get the person out of the harmful environment we'll work on doing that.

The other side as far as looking at the three person homes largely discussed -- the discussion that this department is happening how do we monitor and having oversight of these three person homes so the issues do not occur.

>> **Kevin:** Just follow-up to Jeff's earlier question regarding regulations, there is a draft buddy of regulations that is going to start going through the review process. So we continue to operate under the authority of our contract with our adult

protective services vendor but we will begin going through the process promulgating services for adult protective services as well.

Last part of the update for LTSS is crystal providing an update on electronic verification.

>> Crystal: Good morning. My name is Kristin. I'm the executive assistant with the office of long-term living. A few updates regarding the electronic visit verification implementation. The main update we were granted a good faith exemption through CMS on December 24th of 2019.

Because of this, we will not be experiencing any impact to our Federal match throughout 2020 and it has enabled us to build in some time line with providers for 2020.

From here on out we expect providers to use a EVV (sp) system starting January ca 21st, 2020. Up not using that we expect that use to begin as soon as possible. We are more than happy to work with you on any issues that you have in needing that requirement.

One of the primary reasons we sought the good faith exemption was due to hurdles in integrating alternative EVV (sp) systems that providers have chosen with state aggregator. HHA exchanged PPL as well as providers have chosen to use alternative systems. That is a large source of our data not yet being sent to the states. For that we're allowing a three-month extension for. We expect that those alternate systems complete those integration activities by March 31st of 2020. If it is becoming apparent for providers that is not feasible, we have developed an exemption request form to be completed and sent to the EVV RA (sp) account that is listed on this slide. We want to be aware of exactly what hurdles you are experiencing and make sure that we can work with you individually to solve those issues.

The last main time line deadline that we have for 2020 is July 1st. July 1st is the day that EVV (sp) visits are required for claims submitted to promise and that claim will have to match an EVV (sp) visit in order for that claim to be paid. We really encourage providers from here on out to not only use the system to become comfortable and certified if they have an alternative system but pay very close attention to the service codes that are now in promise that are providing information to providers when EVV (sp) visits are not currently matching those claims. That is meant to be a tool now to learn and become comfortable with the process before claims payment is impacted in July.

Similar claims payment processes will also be implemented by the code on the same time line, and with that, any questions regarding the good faith exemption, what the expectations are here for the next 6 months to a year?

>> Terry: I have two questions and I think you answered one but I want to make sure I heard it correctly. We have gotten a lot of questions about the necessity or appropriateness of providers submitting that extension request by February 1st. I think they're wondering whether if it is only applies or is required where you have actual integration problems or if you're having sort of one off issues because you're not at 100% compliance yet for various reasons or certificate. What is that?

>> Kristin: Providers can use their discretion if they feel they need assistance. We're going to begin monitoring providers who are already either using the Sandata (sp) system, or [NAME] and we're going to look at how often providers are submitting claims and what the proportion of claims that have an EVV (sp) visit. We can start to identify those outliers but if they feel that they need additional assistance and they want to work with us on that, they can feel free to submit that exemption as well.

>> Terry: We have been but erroring on submitting. You talk about [away from microphone] having some additional information do you have a time line for that?

>> Kristin: Not at this time. It is still in the drafting phase and has to complete the entire review process. I would not expect that for at least the next month or two.

>> Terry: Thanks.

>> Kristin: Any other questions? Thank you.

>> Kevin: The last slide we have just redisplays the research information including where you sign up for our listserv and also the community health clinic for the health choices website that has all of the information regarding community health including the transcripts for the MLTSS (sp).

>> Barbara: Next we're going to have the MCO talk about the service coordination process. I'm not -- I'm going to look for a volunteer. I'm not going to say David. Brandon. Thank you. Marcus.

>> Marcus: Is it okay if I brought something up

>> CART Captioner: He's very far away from the microphone. I'm not sure I can hear him clearly.

>> Marcus: A number of people at our membership wanted me to bring up advocacy concern at the MLTSS meeting. It was in reference to the information being provided to our consumers about service coordination.

It is my understanding that people are receiving lists with service coordinators listed and that's it. There isn't -- I could be wrong. I don't know. But there l isn't who they work for to or anything like that. So actually the consumers are asked to make this very important decision as far as I'm concerned about their care without complete in my opinion adequate information. So I was wondering if we could kind of address that and certainly folks that work directly with our folks if you would like provide additional input that would be great.

As a representative I would like to throw that out on the table.

>> Kevin: So -- Barb had to explain. I'm a little slow today. Sorry. So we stepping back again I'm going to reiterate this, service coordination under Community Health Choices is fundamentally different. It is an administrative function of the managed care organizations. So when we talk about service coordination in, we are only talking about the managed care organizations and it doesn't matter how the managed care organizations provide that service. Whether they do subcontracting or whether they do -- whether they do individual hire internally. Service coordination is MCO, holistically MCO.

That being said, we did have -- this was something that was requested by the consumer sub representatives of the consumer sub. We have had requests so that participants when they're selecting an individual service coordinator have an opportunity to actually have -- to vet them a little bit differently. They have such a close relationship with the participants. That we're very, very open to feedback on how we can make that work better with the managed care organizations and their participants. We're very, very willing to be able to provide that feed back to the managed care organizations to make that process work better.

Just giving a list of individual names, for example, is completely unhelpful. People need to know who they are working with, background, how long have they been working with people with physical disabilities, up there is in is type of language requirements that need to require an individual as much detail as possible but -- about the service coordinators so they have an opportunity to really make a choice.

So we are open to feed back. My recommendation would be to the committee would be to maybe make a formal recommendation for how you think that should work. It could be something we could just discuss even changing in the agreement if necessary for how the managed care organizations provide real choice for a service coordinator. So just to be -- just to close up the point we're very open to that and how to make it work better.

>> I'll send feedback on that.

>> Tanya: We have had discussions about this for five years now on all kinds of different committees, so I'll be more than happy to assist you in whatever way I can and whatever way the MLTSS committee can on that. But I think what --

I think what we should do is like if you want feedback I think maybe if you have different demographics from different -- like different types of people that use these services, maybe we should develop something where people call into like -- I don't know categories like you said. If somebody needs a service coordinator that can speak the same language as they do. Maybe what would help is if OLTL and the MCOs or whoever else can like set up like something in categories like that so a committee zero -- a committee, myself, whoever, can give you the best feedback that would fit in those certain categories. Do you -- are you understand inning what I'm thinking?

>> Kevin: I think, Tanya, I think what we want to do is have service coordination choices that is truly a person centered which is what -- which is suggesting what Mike was suggesting. I think where we need help is to -- it is going to be impossible to provide all the details for every single individual service coordinator every single time it is -- a selection is being made. If we can figure out a way to more generally provide as much information as possible to be able to offer real service coordination choice and provide that that suggestion to the managed care organization, I think that that would be the most helpful. So what I'm asking would be within to maybe have a little bit more of a formal recommendation on how you think that should work.

>> Tanya: Okay.

>> Richard: Can an individual consumer hire a caretaker on his or her own and be reimbursed even though they're working with a managed care organization?

>> Kevin: A little bit of deviation I'm going to answer the question and turn it back over to Mike. Rich, if you wanted to be a participant or consumer employer in

Community Health Choices, you can certainly do that. You can be the employer but you -- the payment for the services would still be managed by the financial management serves vendor, PPL. The you wouldn't be reimbursed. The direct care workers or the home care agencies would submit their time to PPL and then PPL would take care by making the payment requirements for those direct care workers.

>> Richard: And PPL stands for what I'm sorry?

>> Kevin: Public partnership limited. They're our financial management services vendor. Your managed care organization if you call your managed care organization, rich, your managed care organization will be able to tell you how to set that up.

>> Richard: Okay. Thank you.

>> Kevin: Thank you. So, Mike, I think --

>> Mike: I was just going to say that PPL is in full support of informed choice for all the folks that are part of CHC. This is an informed choice. This is a list of people. And I understand about the detail on all that. I get that. But I think as a committee we can advocate strongly for folks that are in CHC so they can make informed choice. Informed choice doesn't mean that you need detail description of every single person but it does mean that you have general overview that you're going to be working with. This is pretty consistent.

I don't -- Barb and Kevin, I don't know the process for making a -- what is it considered recommendation or a --

>> Kevin: It is --

>> Mike: Something that this committee can say, yes, this is important enough for us to end pursuing and suggesting to you that something is done to be able to pass along an informed choice.

>> Kevin: You could do-it-yourself personally to us. Just give us what you think your definition is of an inform informed choice for service coordinator and we would look to incorporate that in to something that we would ask the NCOs to use.

>> Steve: One model might be to look at behavioral health NCOs they have it on their provider online. You can go in and look at provider and look what their

experience is and their credentials are and where they're from. Sort of getting a list is not necessarily as helpful. In terms of most -- even if you go through the items [away from microphone]

>> **CART Captioner:** Papers moving around the microphone.

>> **Steve:** The culturally competent and all GBT friendly and speak different languages and there is probably a platform in place that allows for that type of choice. And more than likely has. That may be a model to punch that out.

>> **Kevin:** I think that is a good suggestion. Only thing I would want to think about is but service coordinators are not just providers any more. They're employees of the MCOs or they're subcontracted employees of the MCOs. So

>> **CART Captioner:** Maybe NCO.

>> Mike.. Their names could be listed again they're providers of that particular MCO.

>> **Kevin:** We just have to figure out how to frame it. Keeping in mind some privacy concerns for the individual in place as well. The but it is all doable. That is the reason we think it through. This is the time so we have a program that is implemented. This is when we start focusing on program improvement. I think that is a real program improvement. I completely agree with you. Providing a list of names is not helpful. Not person centered not an informed choice.

>> **Speaker:** I would like to make a recommendation then that we as a committee support the department and the MCO's effort to -- to bring more of an informed choice to the participants in CHC so that they can make an informed choice. Because it can't happen now but and the processes I leave up to you guys to do that.

>> **Kevin:** We'll take it back and figure out a venue that we could use to be able to parse out the recommendation and then ask other committee members who are willing to participate to provide feedback as well.

>> **Pam:** [away from microphone] my colleagues also hear from participants who are interested in possibly changing service coordinators, but they have no knowledge to make an informed decision. Such a thought if the MCOs are able to generate a list of names and maybe contact information, is there any reason why they couldn't as part of their onboarding process to do a bio sheet with the facts

and it may be a short blurb and whenever participant requests a change of service coordinator they could -- I don't know but they should look like pull those bios or the service coordinators 'who are available and present participants. It could -- there may be ways to make this simpler.

>> **Kevin:** I actually think that is what we're talking about. What would included in the bio sheet is what we would want to get recommendations on. I think that is exactly what we're talking about and I think that is a great idea.

>> **Speaker:** Do the MCOs currently have some process though in place to honor if a consumer says I cultural competency. Are you just taking names or do you know -- do you have any process at all currently?

>> **Speaker:** Any outreach we complete with our participants they should discuss that choice and [away from microphone] of the service coordinator that the participant wants to choose.

>> **Speaker:** Thank you. Do the other two have any they would like to add?

>> **Speaker:** [away from microphone]

>> **Kevin:** I'm sorry, David, we cannot hear you.

>> **David:** We're in the same process. Discuss at the initial [away from microphone]

>> **Speaker:** How many names go on that list that are given to consumers?

>> **CART Captioner:** Unable to hear David clearly.

>> **David:** That can vary significantly depending on what the purpose might be as well as geography. Hopefully not necessarily going to give individuals a choice of providers two hours away from them. The depending on where the individual is located that could be a number of options that they have to meet their specific needs.

>> **Jennifer:** [away from microphone] Community Health Choices. Our system is similar to David. We can also have [away from microphone] but I think by Barb your initial question from cultural competence and one of the things we train all our service coordinators on is in a person centered way ask them specific questions [away from microphone] in service plan and a way to author situations that they're

happy with the person that they have now. That is great. And we have important better offer more of choice in the future if that comes to be.

Speaking in terms of what Mike said and Pam is saying, [away from microphone] Kevin fully implemented all three.

>> Kevin: Just going to say this is actually a pretty important point that is being raised here about service coordination. We did define service coordination as administrative function of the MCOs. But it could be argued at this point since we are fully implemented that we could do a better job of defining how choices are for service coordination for -- for program participants. So it sounds like all three managed care organizations have a process that they have taken into consideration, cultural competency but all three of you would be open to opportunities for improvement how that choice could be made to participants. They're all nodding their heads.

>> Jennifer: As we move more into [away from microphone] training and retraining our employees move further away from the provider function of service coordination and administrative what that truly means if MCO's opportunity to have a really well-trained workforce [away from microphone] specific needs of participant community.

>> Speaker: I just realized I skipped an agenda item here but we'll finish up with the managed care organizations and then we'll go back to what I missed. You guys are all here and you want to talk about your service coordination process.

>> Speaker: Whenever we get our state file in we end up assigning [away from microphone] to one of the service coordinators in Pennsylvania health and wellness. Make outreach to that participant what we call the welcome call to kind of set up the visit, get an idea of participant, kind of get an understanding of what they're looking for. At that point they set initial service levels, get items set up for the participant. Get wraparound service in place as needed.

Once we have those services authorized, we -- I guess I skipped over the part about a choice. Part of the conversation giving them a choice of the type of service coordinator that they're going to be working with after we have done the initial visit. At that point we take those characteristics into account. And we pass them over to one of our providers in the community who is service coordination entity. Once service coordination entity makes their initial outreach to the participant, they also make sure that everything is okay and make sure that the choice is offered and

make sure that the characteristic of the service coordinator going out is appropriate for what the participant is requesting.

And from that time on our service coordination would just offer monitoring the cases and manage it from them and any outreach visits quarterly visits say anything of that nature.

>> **Barbara:** Is there anything in your process or I think in our last meeting Matt you were talking about the SSP services based on the presentation we had and do the MCOs provide that service because we were talking about possibly making a recommendation to the department for inclusion of that service.

>> **Matt:** Sorry, SSP?

>> **Barbara:** Support services providers for the Deaf blind population?

>> **Matt:** That is part of our assessment any kind of specialized services. We do offer training to our service coordinators and that includes those with traumatic brain injury. [away from microphone] so that is actually embedded in our assessment and we work with them to make sure that they're offering appropriate for those.

>> **Barbara:** Do you have any idea of the five populations who are deaf and blind that you're serving?

>> **Matt:** I wouldn't have that. I'm sure we can pull some sort of ad-hoc authority. Yes, Anna.

>> **Anna:** [away from microphone] 50 individuals accessing that service statewide. Internally when we discuss that PA health we have around five individuals that would access that service and be eligible. Identify that a past service if a person needed additional supports out in the community to do shopping and have that unique service provider, we wouldn't see that as anything on [away from microphone] with that. Specialized service that [away from microphone] for allowing it to be provided. It would be very similar to in-service.

>> **Kevin:** The way we have characterized SSP services in the Community Health Choices waiver is under the umbrella of the existing service definition. That is consistent with the way that the department is framed out. The service as well.

We have also talked consistency -- consistently about some of the challenges of offering support services to the deaf blind population and whether or not the services are adequate and we're more than willing to continue to have those conversations. But Pennsylvania health first described is consistent with the way that we framed out the service definition. I'm assuming the other 2 MCOs are approaching it the same way. I think we should get it on the record. I couldn't agree more, Matt.

>> **Barbara:** Anything else?

>> **Kevin:** I think Matt wanted UPMC and --

>> Matt. Both of you have [away from microphone] they were going back to their workshop and mull it over. For UPMC we did about 59 individuals who [away from microphone] similar to monitoring [away from microphone] how we start looking at the numbers and definition of personal services. We are looking continue to looking into that and want to [away from microphone]

>> **CART Captioner:** Unable to clearly hear this person.

>> **Speaker:** To better support those 59 individuals that need that eligibility.

>> **Speaker:** So Matt [away from microphone] we want to have the opportunity to speak with [NAME] and her team. We have a call for that on January 22nd to talk specifics and glean more information from the pilot and complete independent living thus far and [away from microphone] wait until that meeting happens before we can comment further.

>> **Speaker:** I want to say [away from microphone] I'm happy to [away from microphone] I think

>> **Barbara:** Matt, speak into the microphone please.

>> **Matt:** The Center for Independent Living has different level of access to

>> **CART Captioner:** It did not change if he's speaking into the microphone. Thank you. Still cannot clearly hear him.

>> **Matt:** The center for independent living if you can correct me they're going around trying to find individuals [away from microphone] I don't know how they're

doing it. But you guys have access to everybody's health records. Probably have easier access to [away from microphone]

>> Pam: The [away from microphone] other 45 people know they even need the services and

>> CART Captioner: I can hear you Kevin and Pam. But the others are very far away.

>> Pam: Benefit of SSP and people isolated and getting service from you may not even know they think oh other people might not even be aware that that is the reason truly will improve their life and that is [away from microphone]

>> Matt: The absolutely. I think the majority of Deaf blind individuals I would share with Jeanette over here don't know what SSP is. [away from microphone] new plan that kind of stuff. They're isolated. Relatively [away from microphone]

>> CART Captioner: Unable to hear Pam and Matt.

>> Pam: [away from microphone]

>> Speaker: So I think that that to your point, Matt and Pam, that training and education would be really good. The plan that we lean on themselves to really articulate out what is available to people. And how do you get that information to our teams, the service coordinators, so that those options and general discussion when service planning.

>> David: This is David Johnson from carry. You mention the initial visit coordinator is internal and talks about choice. I understand that there should be no difference between whether someone with internal to the MCO or subcontracted with PHW, my understanding is they'll honor any request that they can for an external service coordination entity. What extent does that come up in a conversation about choice if that is someone sp preferred choice working preexisting FCE to have a contracted PHW?

>> Speaker: The conversation can be had but we just try to focus it on care delivery of the service coordinator to make sure we're picking up entity that has service coordinator whatever those are.

>> Speaker: If someone articulates a preference for particular but service coordination entity that has a contract with PHW are those generally honored?

>> Speaker: Those are honored.

>> Speaker: Great. Thank you.

>> Barbara: Okay, David, do you want to pick up on the service coordination process?

>> Speaker: Sure. Correct me if I'm wrong but I think the question is for phase III moving into -- we're going to implement what participants can expect. Is that an accurate statement?

>> Barbara: I think it is an open field, Jen.

>> Jen: Let's talk about that from a participant’s perspective. We know that for the under60 folks they had -- their services and support for house and [away from microphone] over 60. For AmeriHealth Keystone, service coordinator whether they're internal or external to the plan is trained [away from microphone] LTSS and legacy participants who have been receiving services and support through the program for years z first and foremost need to be educated on what is new. What is changing and what am I now potentially eligible to receive? So our training and our focus is really to educate participants. No, [away from microphone] for iteration of service that you're receiving today but the CAC program has a very large service offering, services available to support individuals in the community. Many

So that would be where we start. How we get there is through comprehensive needs assessment. So every participant that is entered into CHC file base needs to have a comprehensive needs assessment completed. That consists of an [away from microphone] health care assessment and service plan. So the service plan that -- would house the [away from microphone] that is changing depending on what plan you're with and that process is developed using a team approach. The planning team. Establishing who those participants are and documenting their information and what level of engagement they want to have in the person-centered planning service process is part of this assessment.

Developing the service plan looking at the whole person in a person-centered way and documenting what is important to and for the participant is part of the process.

Making sure that they understand their rights and responsibilities and receive the handbook and know how to engage a backup plan, test their back up plan. Again, identifying who the members of their team are and formal support, there is

physicians, their specialists, and that you are therapist what have you developing that in the person-centered service plan.

Also have coordinators entering authorization and again during the cognitive care plan and those don't change. Unless the participant request that they do. And we have service coordinator document in our LTSS system so our team, supervisory team has [away from microphone] site lines into that participant service and they can support them when they call into our contact center.

So I think that gives the picture of it is really a bundle for the service coordinator to educate with the participant on this. This is why I'm here. I think changing you're doing well but I want to educate you on what is available under CHC and orient you to the program and create that person centered service plan so that [away from microphone] okay.

We also educate participants on trigger events how to notify their service providers on a changing caption and change of health status and hospitalization. Change in support and environment. So that that information is responded to effectively to ensure that there is no gap in service and that the right of services supports it and responds to that changing condition. I think that's it.

So like my colleague about the agreement is it it -- [away from microphone] ownership and the annual [away from microphone] completed which includes the [away from microphone]

>> Barbara: Thank you, Jen.

>> Kevin: Any questions related to service coordination and we can save this for later if it is more appropriate. This is questions for preference by recognition that service coordination is an administrative function and managed care provider networks will continual to evolve. I wonder if you could share any kind of feedback or if you have any data on Keystone First contract terminations can service coordination entities, the participants impacted and what the response rate was on the questionnaire that was sent out if there was any lessons learned from communicating this change to participants? It is anecdotally we heard from a number of consumers who were not impacted by this change, were confused by it. They felt like there was no way to gender trust and that managed care provider network change and administrative function. I'm not sure if you have specific data and can share some initial feedback or if we could follow up on response rates on the survey, contact opponents made, that sort of thing.

>> Speaker: [away from microphone] we don't have the specific -- only generates [away from microphone] but I appreciate that and we learned through the process that we would be happy to [away from microphone] provide in detail later. As a whole, we have been monitoring our call volumes and responses and since notices went out [away from microphone] difficult to [away from microphone] change of -- change on any level is hard. I do think that we have applied lessons learned from early launch and our contact center team and personal care teach was staffed appropriately and able to respond to in with your with your and support participants that wanted to change on receipt of the letter and also wanted to change as of Tuesday. So proud of that. We have managed a large volume of participants well and engage stakeholders in the process and very transparent with what is happening.

But ultimately, but [away from microphone] take a look back.

>> Kevin: Thank you. I appreciate that. I can follow up with specific requests see if they can be honored.

>> Barbara: David wants the mic.

>> David: I figured it was my turn. So similar to what yes, sir said for phase III I think it is important [yes, sir]

Care fix on the process and overall process internal. But anybody who is existing as a service coordination prior to January 1st will continue to have that as their primary service coordination. After January 1st with the exception of the agencies that have data providing it and we have what seems to be a growing list of those that are coming in. But those external service coordination entities are the ones that are doing the internal RAI, setting up or making [away from microphone] to the service plan and getting through for review and revision in our system. So the service coordination entities are doing the quarterly visits and monthly phone calls as well as following up on any triggering events and when we are notified we send it out to the entities and follow up and send them pre-populated RAIs for them to complete for the individuals during the continuity care period.

If individuals want to choose or change service coordination entities during the continuity care period we have preexisting relationship with an entity we'll work with them. But they do not generally they're looking for just a change in service coordinator and we give them choice of [away from microphone] so that is during the continuity care period.

But overall, for on-going it all starts with that initial contact for participants when they conduct that assessment we have a checklist which is very have focused on the person's goals, their interests and really focusing on how we can best meet their needs within that visit you get choices and we do walk with different choices and remind them that providers, change providers or coordinators at any time in addition to the RAI we do many mini assessments that put cognition or impression screening and have a backup plan and build out their individual care plan as well as their long term services plan.

Our internal coordinators are also responsible for monthly phone calls. Following up with the triggering event. At minimum we're in contact on a monthly basis and on-going basis but generally we're in contact with them much more frequently.

>> **Barbara:** Does anyone -- Matt, do you have a question?

>> **Matt:** The [away from microphone]

>> **Speaker:** For phase III, yes. There are a number of agencies within a number of participants that have -- stopped providing services on December 31st. And so they came over without a service coordination entity attached to them. And so we have taken over primary service cord nation [away from microphone]

>> **Barbara:** Any other questions for the MCO regarding service coordination? Pam.

>> **Pam:** Last month we trigger but events [away from microphone] about MCO that had language in them [away from microphone] so consumers had the ability to be educated on where they're going to have to be reassessed and a normal regular plan. It has been developed and what that -- does that look like? Anything that you actually [away from microphone]

>> **Speaker:** That is a different question but I also want to be sensitive to the language. You guys are going to change plans on that. That is not the process. That is not how we approach persons centered care now and yes, the service coordinator is responsible for at least our plan to educate the participant on what is a trigger event. But let me back up even further. I think there is still an education piece that needs to happen. What is the role of the service coordinator? What are my rights and responsibilities in the program? What can the program do opposed to going on -- to do that field. All of that is on the table during that person-centered service planning process. The benefits of CHC and the plan veteran's affairs or community resources. So it is really all in the role of the service to form

the plan that supports independence. And with triggering event yes it is an education because previously under the secret service waivers we did not have a formalized approach when X happens it requires another assessment to ensure that serves should continue as they are or they need to change in response to participating so a long winded way answering your questions it all goes back to the trigger event outlined in this agreement. They're in black and white and then [away from microphone] and it is -- the MCO's responsibility to have our service planners when they're informed trigger events has occurred and respond to it and I think that is a key piece, too, to your point. Participants need to know when they're experiencing a trigger event to call their service coordinator to call into the health plan and they know this warrants a look at what is going on in my service. Are they -- are they appropriate for meeting my needs now that I experienced a change.

>> Speaker: [away from microphone] they have to know their rights and responsibilities like you said but somebody else has a trigger event they don't. All of a sudden [away from microphone] last time we had somebody say hey you got a sense in the middle of something and I have no idea why. To have that information up front to be able to say you need a right to do that. I'm looking at it from both sides. My mother [away from microphone] I have to make all those decisions. I get that. Also looking at it I have a job to do but [away from microphone] and if you don't have those [away from microphone] listed out for them, that is not [away from microphone] whatever you're doing now. But that is why I'm asking for it. Just for you guys the thing that [away from microphone] we're not -- this is what is the triggering event. You need to try to do that part. That is why we [away from microphone] give us our information. What do you feel the triggering event and if not [away from microphone]

>> Speaker: But I will say this and I appreciate that. I think there is a shared responsibility towards stakeholders in the room. Trigger event are in the agreement. I think from a standpoint there is an opportunity there as well to make sure that folks that attend programs that you're aware of in your network know that under CHC these are the seven pages that warrant a trigger event.

>> Speaker: Two things [away from microphone]

>> CART Captioner: Not able to hear them clearly.

>> Speaker: There is shared responsibility. I mean I can tell you, too, from a standpoint for mid shift reporting it meets the level of a trigger event that is drafted and trended by the CHS and LPL. I see as shared responsibility. Black in white. Out there in the agreement [away from microphone] and we're all -- if we're

putting the participant we all should be aware of what they are in the definitions and I think from where you stand is there is a participant unclear there is an education opportunity as you say to empower them to know this is a trigger event. These are your responsibilities to give you the services available on the program. That is all that is saying.

>> Speaker: [away from microphone]

>> Barbara: Any other questions around service coordinators -- sorry.

>> Megan: We want to be aligned with MCO mission and trainings. Do you have a goal in mind when they'll be completed with the external entities to ensure that we're appropriate in our presentation to consumers and participants?

>> Speaker: I can see on [away from microphone] we offer training through -- by WebEx throughout December and I believe the last two were in November. If you missed those ands are assigned to your service coordination entity, has the material and happy to conduct the trainings on-going. We appreciate that there might have been a turnover of staff or whatever and [away from microphone] you feel needs to be trained by the plan we can -- it is baseline. And then we move into our VH process [away from microphone] and close out critical incident management offered monthly. So as to not overwhelm service coordinators, we do have that on the shelf ready to go and [away from microphone] they have outreach already and happy to accommodate the training where necessary.

>> Speaker: Yes, they have. I think more of the training was aligned with completion [away from microphone] best practices, in person type. We have done webinars everything that is offered just nothing -- going back to what you're talking about earlier I think that we could benefit from that.

>> Speaker: Absolutely. Give me feedback and that is something or diedence as we go [away from microphone] and I think that working directly with your service coordinator and as necessary planned leadership. We can certainly provide that.

>> Speaker: As far as training is concerned, our next bar training community partners in the -- will be work trainings which organization probably got the information we'll be doing six of those statement of work trainings this month. In addition to that we'll be hosting calls with all of our partners to give an update on training and any accommodation that you need going forward. You'll have [away from microphone] account manager for your --

>> Speaker: Hosting those trainings.

>> Speaker: If there are specific trainings that you're looking for you can reach out to your [away from microphone] those that are submitted from them as well on an on-going basis.

>> Speaker: There is overwhelming consensus [away from microphone] and when to complete them and you know just where to start. I think that will work.

>> Barbara: Any more service coordination questions? Okay. Then we're going to backtrack. Can you speak to the 2% rate increase for the direct care workforce?

>> Kevin: Just to clarify, a little bit, I think what is being asked is if people remember the 2020 went through the development of the community health choice capitative rates and the department human services matched the consumer directed model for increase as well. That is effective on January the 1st of 2020. I think the question for the administrative organizing is how are -- it is part of the capitation so the managed care organizations are controlling how that is going to be paid to providers. So how is that going to be but paid to providers or included as part of the consumer direct.

>> Speaker: Thanks, Kevin. [away from microphone] health and wellness. Back in July started to notify our providers of our intent to pass along the 2% increase. We have actually communicated through a variety of channels including written as well as provided our call center folks with some language just in case provider called in of hey, what is going on with this 2% increase? We've also worked with the home care association, notified them. December we notified our past provider of our intent to pass that along and that was obviously be used moving forward from January 1.

>> Chris. For our agreements with the personal attendant services agencies and providers, our zero [away from microphone] speak to the fee schedule that is published upon -- online. Once that was updated we woo made those updates within our system to accommodate for those increased rates for the personal attendant for the codes, 1792, 1793 with the appropriate modifiers that were with that that as well as the residential habilitation codes that were updated with their rates so we made those adjustments within our system and any claims that come in with dates of service January 1st forward would have those increased rates.

>> Speaker: Brendan. From UMPC health choices. Similar to AmeriHealth, thank you to the department for publishing the fee schedule. Once published we sent it over to our network and [away from microphone] and implemented. I'm not going to quote the specific codes like Chris could. But we are passing them along as well as central habilitation as well.

>> Barbara: Anyone have any questions? Regarding the 2% increase?

>> Speaker: [away from microphone] the full rate on the fee schedule so just so that everybody is clear, our agreement is on the agency model are with the actual agencies. We are paying those agencies that increase rate. How that is being addressed between the agency and their employers and employee parties between the workers that are hired by the agencies and that agency as their employer on their pay scale. That is not something that we [away from microphone]

>> Kevin: Just as important it would have been the same as secret service Matt. If we increase the two model rates the payment would be to the agency and it would be between the agencies and their workers on how that -- that increase would be conveyed to the actual cost and labor rate.

>> Speaker: You can't do anything to ensure a substantial portion of that is paid to workers. [away from microphone]

>> Kevin: We couldn't either Matt.

>> Matt: I know you couldn't.

>> Kevin: We couldn't even fee for service.

>> Speaker: I appreciate the question, Matt. The 2% is [away from microphone] when we depreciate the 2% increase it is invested in the workforce and we had turnover and we know it is critical to providing quality of care. Certainly, we understand that the partner's perspective I think I expect that a large number of agencies in this room will pass that 2% along to their workers. Expect some that won't. The question for all of us to address is how do we know? What responsibilities do we track, like do you track it ask the provider to report it? Then say you have regulations and administrative cost versus workforce. Can you speak a little bit to that at that?

>> Kevin: I'm going to speak -- Pennsylvania does not have that that body of populations. So --

>> Speaker: It is a shame. The

>> Kevin: And an example they have that type of regulation are Minnesota and Washington State. Pennsylvania does not have the requirements. We bill a rate in the fee for service system based on the process services which includes the labor cost. This agency rate increase was for agency -- personal assistant services and it was intended to be able to support the direct care workforce, but it was mandated direct care workforce and no authority to do that type of a mandate. Just setting realistic expectations, the NCO -- MCOs don't have any more ability to mandate. I agree with you. Just -- Terry may want to speak to be honest. Most agencies will take into consideration the reality that we're in direct workforce crisis and they want to continue to attract quality employees and support the quality employee they want to take into consideration the opportunity to see this money to be able to augment their -- other type of training or benefits or however it is spent. But the intention isn't a mandate. That is what we're just trying to make clear. Turn it over to Terry to provide an opportunity.

>> Terry: Much but we shared the intent of this and benefit the direct care workforce. [away from microphone] been consistent with what you just said, Kevin. Whether it is all an hourly increase versus training or benefit or something else, I can't speak to it. But certainly I can understand the workforce and try to talk about solutions all the time. People understand.

>> Speaker: The intent is great happy with the intent. But is there -- can you track it? Can you come back in a month or whatever and say, receiving 1.7% to the worker. Whether you mandate give it all or not. How much you give.

>> Kevin: Just going to repeat the question to the managed care organizations or even to home care association. Is it possible to ask your network providers whether or not how they use the 2% increase?

>> Speaker: That is something [away from microphone] that is something that we could potentially, you know, survey the past agencies to understand what their intent is. But again, that is something that we talk about beyond survey and understand what they're doing can't necessarily [away from microphone] pass that along.

>> Kevin: Just to broaden the point a little bit, the managed care organizations, three of you, like all of us, are faced with the reality of access when it come z to personal assistant services. And one of the intentions of the change in fiscal code was to be able to maintain that access and service and make sure that the direct

care workforce there is an adequate high-quality workforce that can be able to support the service. So how -- so the opportunity or the impetus for this type of research with your provider networks would be really making sure -- you do have this responsibility -- would be making sure that access is being made maintained. Mandated -- fiscal code is not mandated and I don't think you can mandate it either but knowing how they're using it is actually a way to determine whether are or not it is supporting access to the most frequently used telecommunication service.

>> **Speaker:** Just to tag on to that at least all three of you [away from microphone] letting consumers know how much the worker is getting eligible to the increase I would think would be [away from microphone] if the consumer is interested.

>> **Speaker:** We talked a lot about how to make an important choice and choose between that and the provider if I was making the choice I would want to know how much are providers -- agencies spending on administrative costs versus their direct care force. We ask them a whole host of information. Some of it is -- just I think that we're investing and have the ability to make an informed choice is a critical element.

>> **Speaker:** I'm just thinking because there is a mandate the best we can hope for is voluntary survey of providers. I think we could call upon providers at CHC and people that you're contracted with but that is what we're -- that is what we have available.

>> **Kevin:** I grew withdrew actually. I think this is going to be tough to -- I think this -- everybody who is making raising good points about the idea of informed choice and access but the mandate part is the part that is tricky here. So voluntary -- voluntary survey with provider networks work in the provider association may help to support what the committee is requesting. So the MCOs will take that back and we'll discuss how we can sort of operationalize the request as well. We'll also reach out to the organization and talk about how it could be operationalized from that perspective as well. Maybe just doing a quick call and talking about how something like this could be accommodated.

>> **Speaker:** Actually I don't understand the whole financial part of it at all. The 2% is it like -- is this going to be every year the 2% goes to direct care workers or the agencies and that is why I'm afraid that direct care workers don't get the money. In the past it has been assigned home care agencies and I'm like this is a one-time thing. How do we increase wages to our attendance and we're going to

do other creative things with it and not necessarily all the time to the direct care workers. This is just -- is this 2% going to happen all the time? Is it across the board? And do [away from microphone] tenants will they see the rates with PPL increase for the 2%?

>> Kevin: The 2% increase was 2% increase to the existing rates. So that 2% is in place with those rates.

>> Speaker: [away from microphone]

>> Kevin: They will stay at 2%. There is not an increase every year of an additional 2% unless Terry is much more successful in bargaining during the budget season for that to happen. The 2% was increase of one time for 2% but it continues on as part of the design of rates and also the 2% was baked into the CHC decapitation in which as well.

>> Speaker: [away from microphone] for PPL as well if they're with CHC, the ones that are not with CHC, the act 50 not see any of the increase?

>> Kevin: So the department made the decision to augment the consumer directed funding and that was passed through to the managed care organizations. They can answer how they coordinated that with public partnerships or PPLs for consumer directed but the implication is much more directly that the consumer directed rates would be increased for the wages of the health care workers. The range changed.

>> The expectation for [NAME] was to pass that along consumer driven [away from microphone]

>> PPL will have the same ability to use it administratively as home care agency or just whatever is given to PPL -- okay. Awesome. The

>> Speaker: I want to speak a little bit to the caveat of PPL and how that rate is pass placed. I do tend to digress. I'll try not to.

When a common law employer hires a worker they have a max bill rate. That is the max rate they can pay their worker. They take into consideration recalculated annually which is this year January 1st unemployment compensation and workers compensation insurance. So that impacts the max bill rate. What PPL is doing is calculating how much they can increase that rate based on all of those factors and the 2% and common law employer is being informed of how their rate is changing

and that they have the option either to use that as an incentive down the line for a rate. Pass it on immediately or based on other factors they may not be eligible to raise the rate.

That is happening now. The that took affect January 1st along with the recalculations of the owner employment and workers' comp. and that communication has gone up through participants through the male mail and available on the portal and they can look it up directly.

>> Speaker: Can I just -- you're saying the max rate [away from microphone]

>> Speaker: Yes. For many of the participants that max rate will go up. There is the chance based on the other factors it may not [away from microphone] based on unemployment and workers' compensation. .

>> Barbara: Thank you, Kristin, for the clarification. Anyone else have any questions regarding the 2% increase? Anyone have any other questions at all? Pam. First one.

>> Pam: Yes. This is Pam and I had one related to the direct care workers rate. So the MCOs, when you're going through the credentialing or contracting process with these PAS agencies, are the workers' rages or percentage of the budget that is going towards the work -- worker wages, is any of that a factor into the contract? We have been contracting with -- you factor in how much of their budget or how much -- like how much they're paying their workers or is that something like [away from microphone]

>> Speaker: There is a couple of points. I'll just chime in. I don't believe that we're taking into account those factors when we do credentialing. I think a lot of the network coming forward is just being people service network that came with the care period for the first implementation that we're doing that this. Any additional providers at this point we're not going to necessarily take that into consideration. A

>> Kevin: Maybe a future opportunity for when we start a purchasing our different incentives that could be built into the program moving into steady state we could look at opportunities for direct care workforce is something that the department is very serious about supporting. Agency model work and consumer directed model. It doesn't matter. Still looking for opportunities to do different types of incentives with managed care and different networks to support the direct care workforce and consider it as part of the future design of the program.

>> Speaker: Recognize that the MCOs would want to be -- for that money as they're allocating to these agencies it is like being used as much as possible for the work forces because that --

>> Kevin: I would agree with the point and it is one of the things that we have focused on before supporting the director workforce.

>> Speaker: I want to point out to people that 2% on an 11-dollar wage is 22-cent increase. $13 it is 26 cents. This is a step in the right direction but it is nothing like what the Department of Aging report was recommending that we need for direct care workers in the state. Their recommendation was to start 11 to 13 immediately and eventually getting to 13. And I don't see how -- you know, that is not going to happen with this voluntary plan that if we don't know what is being passed along so I think we're not done on this issue. And --

>> Speaker: I agree. We're kind of splitting hairs on the 2%. [away from microphone]

>> Speaker: I just want to split hairs on the map. Not a 2% on it that the workers are getting increase on it and so actually about a 40% an hour increase but agencies are passing 100% along with the workforce,

>> Speaker: Can I ask voluntary survey that they're willing to do. So the department does it have connections [away from microphone] with the direct care car workers that they could can follow the survey directly then?

>> Kevin: In a consumer directed model we have much more holistic list of workers and didn't that we can access the PPL. Basically it is a pass through for consumer directed services. It wouldn't be that helpful. We do have contact information with provider agencies that offer personal assistant services and they have to be medicated and enrolled. We consider department survey agencies or home care association could survey the agencies. But it wouldn't -- we don't have as much of a -- of a transparency for who the director workers actually are. So the answer to that is z very broadly probably not.

>> Barbara: I just want to share a comment that came in over the phone from Rebecca shepherd from ABC seniors. Agencies have already passed the law more than 2% pay increase over the last two years. Otherwise we wouldn't have a direct care workforce. Our offices have had to increase pay rates more than 10%. Thank you, Rebecca.

>> Kevin: Thank you, Rebecca, for the comment. I think that is quality care agencies also take that into consideration. Not because they have to hire people but -- and in a tough market. So with that being said, the point was made it may not be consistent. Many will with -- many want to hire people and will but some won't. I think that is the question. And having some understanding from -- between the MCO and provider networks on how to -- how the plans they used from voluntary any we're expectative might be helpful in answering this question.

>> Barbara: Any more comments or questions? Hearing none, we're going to adjourn this meeting. And hopefully see you next month. February the 5th. Thank you, everyone.

>> Kevin: As an announcement there is a [away from microphone] immediately after this. It will begin at 1:00. So people have a little bit of time for breaks.

>> CART Captioner: Thank you. Take care.

>> Kevin: Before people leave --

>> Speaker: Transportation update from the CHC. Many MCO providers.

>> Kevin: Page 3.

>> Speaker: This is Chris again. You'll probably hear similar update from Pennsylvania Health and Wellness. We utilize them as our broker through the continuity care period through phase III. Similar to all other services. We are not expecting individuals to have to switch their providers. They're already services and transportation from a specific vendor. That is expected to continue. That being said there is one organization that has said they will not that continue to do continuity of care. Our service coordination team is engaged to outreach to those individuals. There was ten individuals impacted and scheduling updated transportation to it to make sure that they're continued through as we move forward, we will with -- any vendors that still want to participate within community he choices that have not executed the agreement with our broker will be working with contract potential with them. Currently today we have providers that will service every county in phase III. There are no gaps where we do not have any providers to be able to perform transportation services.

>> Barbara: Chris did a nice job of that report. Mine would be I agree with everything he said. I don't have anything in addition to ask.

>> Speaker: I wouldn't change much either. I think that Chris summed it up best for all of us. We continue to have service in every county in phase III and look for additional options [away from microphone] to [away from microphone]

>> Kevin: The only thing I will add from department perspective, we did receive a recommendation. Personal services in more rural areas often involve the director workers providing some of that transportation. We did receive a recommendation from the long-term care council to improve something [away from microphone] more service definition something that we're taking into consideration as well. Definitely more to come on this issue. The big objective that we have is not to make anything worse. Anything to do or allow working what is working while at the same time look for opportunities for improvement. This is the kind of suggestionsing that we think are helpful to move transportation forward. Long term care council may have add as a component of personal care services. So we had to look at it and obviously we have a [away from microphone] and it could end up being very expensive.

>> Speaker: The [away from microphone] workers on website somewhere what providers are providing for what county is there any way to know which providers they're contracting with? What with -- and only one person in that county but who is providing that service to them would be PA, who do you have that is serving some of those counties and I actually think about 'the far end of [away from microphone] and sometimes it is one day a week. And how do we know? It is on the website.

>> Speaker: I'm not sure [away from microphone]

>> Speaker: All three are using MPM.

>> Speaker: No. We're using a separate vendor. CTS is our vendor. I'll go verify that information. I thought it was on the website but I'll make sure of that.

>> Barbara: Anything else?

>> Speaker: Do we have a follow-up on the amendment to CMS on employment?

>> Kevin: Specifically talking about the waiver amendment that would sort of replicate what the offices involved in the program has where if they -- the office with vocational rehabilitation we would be able to waive that requirement and go directly to our waiver services. Is that correct? At this point do you know it is still --

so we're not sure yet. We're still waiting Christina's approval for an agreement and waiver. So we're hoping for the best. But we have not heard yet.

>> **Speaker:** [away from microphone] running high together talk about how this might work. Are you waiting?

>> **Speaker:** We have already talked to them how it would work. We're planning to work closely -- okay. So you want them to come in here -- you would want the process to be outlined. So the committee auto is asking for the process to be at length for when the waiver is approved.

>> **Kevin:** The end of February.

>> **Barbara:** Okay. Anyone else? Going once. Going twice. All right. I think that we are fully ended now. Thank you everyone.

>> **CART Captioner:** Thank you for your patience. I did not have adequate audio for all the speakers. Happy New Year.