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DATE: May 31, 2019

EVENT: Managed Long-Term Services and Supports Meeting

>> Good morning, everyone. We'd like to get started. Can you hear me? Good morning, everyone. I'd like to call the meeting to order and begin with introductions. Would you mind starting? >> Hello, everyone. My name is Luba, I'm with the home healthcare.
>> Hi. I'm Ann Marie with the IAPA.
>> I'm Heshi, consumer advocate of GTBL initiative.
>> *(*Away from mic) for ageing. >> Linda whitton, participant, advocate.
>> Kevin Hancock, office for long term living.
>> Barb, community connections.
>> *(*Away from mic) with united healthcare.
>> Jim piper, senior care and away from mic) Pennsylvania.
>> We have a new member today and he'd like to introduce himself and say a few words.
>> Thank you. William (away from mic) and I've worked many, many years as providing care in both as a caregiver and as a supervisor for many years. And now I see myself on the other side of things where I'm the one who actually needs the care. So thank you.
>> Thank you, William. Appreciate you serving. Do we have committee members on the phone who would like to identify themselves?
>> Yes. *(*Away from mic) >> Good morning. This is Terry Brennan.
>> Pennsylvania healthcare association.

>> Good morning.
>> Brenda dare, consumer advocate.
>> Good morning. >> Good morning.
>> Can you guys hear me okay? >> Good morning. Neil Brady. >> Good morning. >> Good morning, Neil. >> [Echoing] >> All right. I'm going to read the housekeeping committee rules. Since we're in a new place the restrooms are located on the plaza level of this building. Take the elevator to the PL button, cross the glass rooms until you see the key store restaurant sign. The restrooms are in the left and right corridors and the signs are posted to direct you to the restrooms. For the audio purposes, please make sure that you speak into a microphone. Please keep your language professional,

direct your comments to the chairmen and wait until called upon and please keep your comments to two minutes. The meeting minutes, the transcript and the documents are all posted on the list serve under the MLTSS meeting minutes and we usually have them posted within a few days of the meeting. The captionist is documenting the discussions from a remote location today so please speak into the microphone and speak clearly and slowly. This meeting is also being audio recorded. The meeting is scheduled until 1:00 to comply with the logistical agreements, we have to end the meeting promptly at that time. If you have any questions or comments that weren't heard please send them to the resource account at RA-PWCHC@PA.GOV. It's listed on the agenda. Exit aisles must remain open so please do not block them. Please turn off your cell phones. Upon leaving please throw aw*ay y*our empty cups, bottles and wrappers. As always, public comments will be taken during the presentation instead of just at the end of the meeting, ho*wev*er, we do reserve 15 minutes at the end for any additional public comments. Our 2019 MLTSS meeting dates are available on the DHS website and I'm now going to turn it over to Linda for the emergency evacuation procedures. >> If there's an emergency or evacuation the assembly area will be located on the north side between the keystone building and the state museum located right outside -- sorr*y.* If you require assistance to evacuate, you must go to the safe area located right outside in hearing room one by the table. OTLC staff will remain with you until you're told to go back into the hearing room or you are evacuated. Everyone must exit the building, take your belongings with you, do not operate cell phones, do not try to use the elevators as they will be locked down*. W*e will use the stairs on either side of hearing room 1 to the ke*y*stone plaza and then take the steps for exit by north street. When you exit the keystone building, turn right on north street, the assembly area will be the plaza area on your right between the keystone building and the state museum. >> Thank you, Linda. Now we′re going to turn it over to Kevin for the OLTL updates.

>> Good morning, everybody. Great to see such a great turn out on a beautiful Friday morning. Especially a little bit worried since we had to change the venue a little bit. So today as an agenda I'll be reviewing MLTSS sub governance which is something we do on a yearly basis, especially when we talk about the ending of terms for some of our committee members. Since this is part of a legislative committee and it's also required as part of our federal partnership, it's actually important -- [background noise on phone] most specifically provide an update on the provider workshop. *W*e've already had two of the three weeks of provider workshops and we'll go through and talk about some of the stuff we have received there and then we'll talk about the southeast end of the continuity care period which will be [background noise on phone] starting with the MLTSS sub mac community governance that I will be reading, the MLTSS sub committee was established in August of 2015 to be a resource to the medical

assistance project committee enabling [background noise on phone] be removed from future servicemanaged care. In other words, the MLTSS was designed specifically for the implementation of community health choices. The mac or the medical assistance advisory committee operating guidelines regarding terms in the standard for appointment and renewals are as follows, standard appointment is a two year with no more than consecutive t*wo*-year terms which means you can have a two-year term and be reupped for t*wo y*ears. An individual may be reappointed following a two year period of non-membership. That means if a person has two years when it comes to membership they can be reupped again. Consideration will be given for a second term of t*wo* years. For members with term dates expiring on August 31st, 2019, who will be eligible to serve a second term, the OLTL deputy secretary in conjunction with the chair and vice chair, that's Linda, will look at attendance and absence records to see if the member had a pattern of unexcusedunexcused absences. If a pattern is identified the deputy secretary of OLTL can terminate a member's appointment. The secretary will consider attendance, absence records and members knowledge and interest to determine whether a member should continue for a second term. That sounds a lot more severe than it is. Usually if a person is not able to attend on the committee they let us know and they usually make the decision that they have to resign. It's usually some sort of professional or personal conflict that addresses their absence and normally they the voluntarily decide. Member attendance is a fundamental aspect of committee business, especially in this session. Since we are implementing a massive program, the -- we do count on committee members to be able to provide feedback and to be part of reviews of relevant documents and other related (a*way* from mic) associated with the implement of community health choices. For members who plan to attend a committee meeting and cannot attend in person, members are expected to attend webinar or dial in, as many people are dialling in via the phone. I'll highlight Tonya lives in Erie and it can be quite a trip and she's been an active participant. If there's an emergency situation where the member cannot participate via webinar, dial in is accessible. The member must notify the committee chair exoffico [background noise on phone] may send an alternate in his or her place which does happen fairly frequently, however an alternate should be a replace. Ment -- replacement over a period of time. That means they can't be replaced for somebody else. If the member determines that he or she cannot continue to fulfill the commitment to the committee the member should consider resigning. Member attendance is important and the member's alternate has no official voting rights and cannot be counted as the quorum. So term expiring, those members recommended to continue for a second term will

be sent an e-mail in June explaining the term is coming to an end and asking if they would like to continue for a second term. So you will be hearing that very soon if you're on that list. If you wish to continue the member must confirm the desire to continue as a committee member and submit an updated resume if needed. Any questions about that? Okay. No questions? Okay. >> I had a question quick. If you can hear me. >> Sure. Sure can. >> Has there ever been a *v*ote on anything? I can't recall the committee ever voting? Maybe I *w*as asleep. >> There's never been a vote. I will have to say that we've had the MLTSS committee members to review documents with us but, no, never been a vote or a motion. You could be the first. >> And then are there any committee members that serve on both committees, the medical committee as well as this one as this committee advises?

>> So, yes. Yes, absolutely. We actually have members who are represented -- Barb, for example, is the designee for the MLTSS sub MAC for the large MAC and then there are representatives from multiple subcommittees that also participate on the MAC as well. >> All right. Thank you. >> And we do have some individuals, not really with this committee but with the long-term care sub MAC that always sometimes participate on the consumer sub MAC as well. Linda, for example, is somebody that's on both subcommittees. Thank you. Any other questions? Thank you for asking that question. Okay. So I'm going to jump into the community health choices updates starting with the phase three provider workshop. If you're a

member in the prior two phases we conducted provider workshops as a way to introduce community health choices to providers where CHC is going to be implemented. We are doing that for phase three as well. Because the zones -- there are three zones for phase three. We are doing provider workshops in each of those zones. We've already completed the workshops in Lee high capital zone that includes this area, Harrisburg, York, Lancaster, Allentown, Bethlehem, Redding, that I are all part of the Lee high capitol zone. They were in the third week of May and the sessions were held in Harrisburg, shipensberg. In addition to these provider associations we are also in each of the zones have been a separate session on a fourth da*y* that's focused specifically on transportation for obvious reasons. We believe -- have learned from the southwest implementation that transportation will be one of the largest challenges in the implementation and we decided to dedicate time and opportunity for transportation brokers, managed care organizations and transportation providers in the area to have a chance to dialogue really to talk about how transportation is provided in the system as it is right now, opportunities for improvement and real problems that are anticipated in the roll out. [Telephone background noise] so we've had two of these sessions. The third session will be next week and that will be in the northwest zone or in the northeast zone. The northwest zone was this past week and it was conducted in lock haven university and university of Bradford. The transportation session in northwest *w*as in

university of Bradford as well. We had 600 people attend in Lee high capitol and 420 people attend in northwest zone. I have to -- I'm going to characterize the sessions as different. Very different compared to the first two implementations. [Background noise on telephone] was introducing community health choices to the world and southwest. In the second phase implementation it was in the Philadelphia area, it was much more focused -- providers were much more focused on what would happen at the end of the southwest continuity care period and talking about problems in the implementation and how we can make them better. In both sessions they were very eye opening and we think that there was a lot of opportunity for all of us to learn about better ways to do this but in this phase, in the first two weeks what we've seen so far is that community health choices to be perfectly frank is no longer a misread. Everybody this those sessions was very much aware of the program. They did have questions on how it's going to be rolling out and how it's going to be effecting them from a billing perspective, what they need to do with provider contracting. The questions were much more tactical and much more focused on how providers can convert to a managed care configuration. The whole dialogue was much more -- much more logistically oriented.

There was no questions about managed care, who the managed care organizations were and why we were doing this. The focus was really about what do we need to do to get ready and how will our current business model change with this new formula for managing long term care. So we adjusted to be much more focused on those questions and the MTOs were much more focused on the questions as well. We've also had a lot of -- I'm very grateful to a lot of providers that have already gone through the implementations and the other phases really talk about their experience, positively and negatively offering some advice to providers as they go through the change themselves on the best way to manage it and the best way to get ready. In my view actually that has been the most important part of this discussion. In my view it's been the most valuable for providers to hear from their peers on what they need to do to be ready for the transition and what the change actually means. And how to -- to be perfectly honest, how to be successful. At this point we are thinking that the provider workshops have been pretty helpful but they have been very different compared to the phase one and phase two implementations. I'm not sure -- do you have anything you want to add? A comment. >>I have a question. This is Shala from north central P.A What type of providers were included in these sessions?

>> That's a very good question. We had five different break out sessions and they were included and heavily involved in the session -- the break out session I managed the service coordination. The community-based provider session as well. Actually the big fill -- independence, for example, they had a presence in a lot of the sessions. >> Fantastic and also medical providers were there? >> So home and community based providers had their own break out session in the afternoon. Service coordinators had their own break out decisions. Behavior health providers had their own break out

session. So physical health providers were there. Jill managed that in some cases with our medical director Dr. Lapel and they came this time compared to the first two phases. It was another difference compared to the first two phases. >> Great. Thank you. >> Sure. Any other questions about the sessions? So as mentioned, we do have another set of sessions next week and they -- they will be in -- the first one is in the Poconos and university of Scranton -- or Scranton university, I'm not actually sure. They are actually going to start on Tuesday next week instead of Monday. It will be Tuesday, Wednesday, Thursday and Friday. So one of the highlights of the transportation summit because transportation we believe will be one of the largest challenges we have faced so far in the implementation of the program, specifically in the southwest, it's going much, much better in the southeast for a lot of reasons. Very educated providers. We know in phase three it's probably going to be even a bigger challenge than it was in the southwest. What we learned, especially from home care provide s is they have been the stopgap in the final -- in all three of the zones in providing transportation for their program participants. What that means is that they do personal assistance service hours to cover transportation for their recipients which is outside of the existing service definition but we have to take it into consideration because it's probably the only way that transportation will be able to work. We know that we're going to have to look at how transportation is being provided in the existing -- in the existing system and not do anything that -- will make things worse for participants as well as for providers. So that was particularly helpful. The managed care organization also learned a lot and spoke a lot about the relationship between transportation providers and brokers and the relationship between the MATE program and coordination with non-emergency medical transportation to non-medical transportation offered through the community healthcare waiver. Also the service coordination is an essential role for people receiving long term care in community and making sure that transportation is coordinated. As we have continued to emphasize we do not want to make things worse by offering an additional benefit for non medical transportation so we're going to work with providers to make sure that the service delivery is not anymore challenging than it is right now. In fact we're hoping to make it a lot better. The transportation was an important discussion and everybody universally agreed that it will probably be one of the biggest challenges we have in the final phase. >> Kevin, this is rich again. Thad a quick question. On transportation, may be a stupid question. You know, I signed up for American cancer society, they have a volunteer program where you take cancer patients to treatments. Is there any like organization with severe disabilities who can't drive special vehicles but there is any organization that exists or that could, it could be something like call 100-ride where someone puts together an active volunteer network of retirees? >> So the area on ageing sometimes volunteers as part of their transportation may be providing to senior centers. So a lot of that does actually exist, shared ride also is an eligible benefit more many people. I think

in some cases they use volunteer and paid transportation providers as well. So it does exist right now, Rich, but just to be clear, most of the transportation we're talking about is scheduled transportation. There's usually some sort of a Medicaid funded payment that's SOESHLTH -- that's associated with it so we don't have to rely on volunteers necessarily. One of the challenges is that it may not be as flexible or as convenient for participants, especially when it comes to their appointment and/or -- >> All right. >> What they want to use. That's what we want to take into consideration. >> Okay. >> This is Pam. Just wanted to ask what are the things that you're looking -- my concern is I talk with one of the transportation providers in our area that covers like 10 counties and he was very adamant that he didn't want to work with brokers. I know that some are working with brokers and there's a lot of concerns around that which I'm sure you heard. What is being done? They got a lot of them. They got -- they control like the big counties, the counties with big cities and the counties that have just them, that's all they have. I'm really concerned. >> Are they public transit? >> I'm sorry? >> Are they a public transit provider? >> Yes. >> So I want to -- I obviously would have to hear from them that concern but I would want to follow up by that they may be confusing the benefits that's offered in community health choices with the medical assistance transportation program.

>> I talked to them about both things. The broker's discussion for either situation, he worked -- dealt with brokers and other situations where he's been in the past and was very firm. Does it have to be brokers? Is there anything else? Are they able to raise rates? Are they able to change -- you know, what is going to happen? What would happen if for 10 counties they didn't do it because of the broker? Is there back up? Is there going to be a plan B? Is there something for people? >> So transportation providers -- I mean, obviously like any provider, they don't have to contract with the managed care organization. The plan B would be to demonstrate (away from mic) the MCOs are going to have to demonstrate to us they can provide an adequate network to be able to meet the transportation needs of the participants. So just as background for you, we did have a public transportation provider in the southwest that I reached out to directly. We talked through some of the concerns and issues and they eventually did develop a contractual relationship with the MCOS. They are likely to do the same thing, find out what the concerns are and how they can be elevated. I want to know what their -- so there are some -- there were some challenges especially with phase one implementation and they are working with brokers but we haven't seen some of the same challenges in the southeast and I would want to know what we could do to have them be part of the program directly so I would engage with them directly to be honest. I will do that. >>I can try and connect you. I'll ask them to meet with you or talk with you or connect, e mail you both together or something. I'm really worried about it. I really am. >> Kevin, is the -- is the issue a lack of providers? In other words, there's too much demand? And it's hard to get the

transportation? Or is the barrier something else? >> The barrier is a lack of providers and the distance associated with transportation and the lack of providers, the demand isn't as much of an issue. Demand is pretty much as it always has been, rich, but it's more about transportation providers not being available and the lack of flexibility in some cases and scheduling transportation in rural areas. Demand is not the variable that's causing the problem. It's geography and the lack of providers available in the area. At least from my perspective. >> Good morning. The association of area agencies on ageing. I just wanted to make a broader transportation comment about all transportation, nonmedical, shared ride, funded, all that and some concerns that we are hearing especially from public transportation providers in this medical assistance broker RFP or whatever you want to call it coming out and the ripple effect if the broker model continues and there is a limitation on those providers who will be providing medical assistance transportation. If there are not the same number of transportation providers who are able -- who contract with the brokers, that there can be and we expect there to be a ripple effect on other areas. So if a smaller transportation provider is able to provide a certain number of rides, a certain frequency of rides because they have committee of scale, because they are providing MATP, if that MATP is called out it will result in fewer rides, it will result in less -- you have to wait much longer to be picked up, the cost will go up. The cost to rent a van for the day is going to be the same whether you have it full. So I just wanted to point out that there's a lot of intermingled pieces to transportation in general and just wanted to raise that.

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>> I agree that transportation is a very inner dependent enterprise. >> Pam with the Pennsylvania health project. I just wanted to -- I was wondering if we could elaborate a little bit on some of the different approaches the MCOs are exploring to meet this need for non-medical transport. You mentioned with the challenges with geography and the time involved. I'm wondering what kind of innovations and career solutions are the MCOs exploring? >> I wouldn't actually just leave it to the MCOS. >> Everyone involved. >> So the MCOs first and foremost are going to look to the existing network of transportation providers to be able to provide the services. I actually think it has to be a responsibility of the department to look at our service definition for non-medical transportation as well as some of our other waiver services. We need to see if we can allow for more flexibility when it comes to the provision of transportation. So we have to look at the way that we designed the services to see if we can create more flexibility which means that other types of people would be involved essentially in proviingng transportation for non-medical transportation. >> When you speak of flexibility you're speaking of other entities to be able to provide the service, flexibility with the enrollment? >> Not necessarily require all non-medical transportation to be billable

service for non-medical transportation. I'll just give you an example. This is very much conceptual. It's not writing policy in the middle oh -- middle of a meeting. Home care providers have let us know that their attendants have given rides to participants as part of their personal assistance service. Something the participants ask more and the participants want. The reason they are asking for it is so much convenience instead of having to schedule a ride with a transportation provider. We have to take that into consideration. We also have to take into consideration the health and safe of the participants but we have to take into consideration the *w*ay the transportation is being provided now in the geographic area where participants live be able to meet the needs. So it's a point of discussion at this point. *Y*ou look like you still have questions? >> No. I was just kind of trying to get a sense of what are some of the other providers you envision being brought into this to fill that needs and it seems like more flexibility for providers to do that. Are there any other potential providers? >> Usually some -- many providers offer transportation as part of their services. That would be an example of another provider type that could be involved in non-medical transportation. >> Thanks. >> Sure. All of the licensed providers have transportation as part of their system as well. Sorry, I was told to pull the mic a little bit closer. Okay. So any other questions or comments? Great comments about transportation. There will be a lot more to come on this. In fact, I think if we can find a way to put it on the agenda for July, the July 1st or the early August meeting to talk about transportation for phase three I think we should do that. Have people -- have the *M*COs talk about their plans. I think the -- and hear your ideas on how *w*e can make it work better obviously. Rich, that could be an *o*pportunity for you to make a motion of some sort. >> I'm assuming if there's changing in transportation that would require an Amendment to the waiver. Are you anticipating any other Amendments to the waiver in the near future?

>> *Y*es. There will be some -- we have to do some tweaking of waiver Amendments. An example -- Jen hail is here, right? She's hiding way in the back. She's hiding way in back. So if we have to get into the specifics I'm going to ask her to talk about it. An example is *w*e're making a change to residential rehabilitation with service hours to accommodate -- to make it a little bit more in line with the office developmental program for definition for residential rehabilitation. There will be other *w*aiver amendments. We have public process when it comes to waiver amendments and we'll make sure the committee is very aware of what the changes will be. That may not apply to you in the future. We'll talk about it later. >> Kind of just not to prolong the discussion on that but the issue with dom care, has that been resolved or is there a point in time when people who are in CHCLTSS could be a resident in a DO*M* care home? >> No, there's not to be perfectly honest. The department of ageing regulates domicile care or receives the AAA oversight of care. The regulations for DOM care has I understand them still prohibits people in the facilities being clinically eligible. They are waived fairly frequently. The regulations are waved fairly frequently but the regulations still have that

prohibition. >> (Away from mic) >> I thought that was an issue with CMS as part of the transition plan to be resolved? >> I'm not sure if I could speak to that. Jen. Would you be able to come up to the table again? I'm sorry. >> We don't need to prolong it. >> Steve had asked whether or not domicile care as an measure as part of the transition plan with CMS.

>> Sure. I don't recall that DOM care was part of our settings for the final role setting transition plan. >> It's an allowable setting in CHC. >> It's an allowable setting. >> The regulations actually at this point are -- >> The DOM care setting was not part of OLTL's transition plan included in the waiver. >> Okay. >> | said we would just recommend that that be considered once again because it really is I think an untapped resource for housing alternative for people in CHC. >> We value DOM care as a setting and we agree, it could be an opportunity. It is a covered location in community health choices. The issue is the regulatory prohibition in domicile care being clinically eligible. >> This is Pam again. I was going to say for the physical disability community that we definitely want discussion because we're going to probably oppose dom care, a lot of us anyway. Concerns that are already happening for some people are expressing in Philadelphia and it's worth mentioning it, they are wondering what types of housing situations people are already going into from nursing homes and if you -- if it's easier to get someone in a DOM care where they already have the furniture and they have all the other stuff and they go there and then they decide, wait, this isn't what I want, I wanted my own apartment, they don't have the supports they would have had in nursing home transition to get the furnishings, all the supports they needed. I would say if you're going to look at this there needs to be a lot of discussion from a lot of resources on whether CHC should support DOM care or any other kind of congregate setting. >> I'm not sure if we define -- I'm not sure if DOM care is designed as congregate setting but I understand what you're saying. About nursing home transition, I understand that point that you don't get the same resources from DOM care to an independent setting in your own apartment as from a nursing center in independent living. I think that's a valid point to raise. >> Do DOM care have their own front doors, all the things that would make it an independent setting? That is important for our community. >> So I think -- a lot of people -- >> There's a lot of questions we would have I think before we would ever --

>> I'd love to have a debate. >> Yeah. >> To be honest I'm actually willing to have advocate for DOM care because a lot of people choose it and there's been really models for shared living in a lot of other states that Pennsylvania has not adopted that met some of the criteria for the independent living movement that at the same time addresses what is truly a crisis when it comes to housing shortages for people with disabilities.

>> And I know we have a housing crisis but I don't want to see people going into situations because, oh, I can get out of a nursingng home and you're going to get me into somewhere and I'll take whatever you can give me and they get there and go what do I

do now. So I appreciate. >> Don't let the perfect get in the way of the good. >> What? >> Don't let the perfect get in the way of the good. All right. That will be fun. So I'm going to take this opportunity to see the questions to highlight the fact that Steve, who has been a valued partner with the entire long-term care community is going to be retiring next -- in the next month. I wanted to take a moment to thank him for his service for long-term care. He's a subject matter expert in the ageing system, he's always -- he's raised -- he's been -- he's been a pain sometimes for sure but he's usually in many cases the points he's offered to the department he's usually been right and we are really going to miss his voice and he hope he finds in his retirement some way to become active, maybe become an activist of some sort to continue to help us progress the long-term care system in Pennsylvania. I wanted to thank you for your service and give you a hand. >> [Applause] >> So moving onto the southeast continuity of care period, so the continuity care period for this does end on June 30th and what should be happening right now and what has been happening with the managed care organizations is that all participants should have received or be going to a comprehensive needs assessment if they *w*ere part of the implementation that began on January 1st, 2019. That comprehensive needs assessment should be triggering the person centered service planning that will put in place their new person centered service plans that will be effective on July 1st, which means officially on July 1st, 2019, the managed care organizations in the southeast and Philadelphia area will be overseeing the entire service system and the service system will be transitioning from what was part of the service system to the managed care operations. Points that we *w*ould highlight, we did go through this in the southwest. *W*e will -- the departments and our partners will be paying very close attention to the contents of the service plans, the out comes and the assessments and any changes to levels of services. Most specifically any decrease in services. We did pay very close attention to this last year in the southwest and we *w*orked with the managed care organizations very directly when it came to the ways that they articulated the denial or the changes in levels of services. *W*e'*v*e seen some progress with the managed care organizations on the way that they articulated changes with participants. With that being said, it's the area that we will pay the most attention to in the weeks and months to come. So any questions about that? Okay. So highlighting -- continuing to highlight the southeast, we do have some updates both keystone, which is the rest of the state and UPMC have notified us they will not be continuing a relationship with some providers primarily service coordination entities at the end of the continuity care period. UPMC let us know they will be terminating the relationships with 72 providers and those providers have already been notified. Keystone let us know they will be terminating relationships with 67 coordination SSTS. From keystone it affects 5,844 people and the Vijividuals already received their notification. For UPMC effecting individuals but it's primarily service coordination. So the managed care organizations have the requirement to use either internal or external service coordinators to be able to

meet the requirements for the agreement and they have presented evidence an assurances that service coordination would be offered. Any questions about that? >> Is that for southwest, southwest or across the board? -- southwest, southeast or across the board? >> Southeast, Rich. The Philadelphia area. >> Just a little bit of experience you say assurances, again, part of the committee is to provide feedback. In my own case the workload -- my current service coordinator who is, I don't know, sort of a dual employee has increased astronomically. Are there guidelines when you say they have shown their ability to do this, are there guidelines for ratios and number of people a service coordinator has to handle? Because my fear is costs might get in the way of an acceptable workload. >> Sure. That is very important and very good feedback, rich. Thank you for asking the question. So the managed care organizations have to propose to us what their case load will be specifically for service coordinators and all three have done so. Do you know off the top of your head what the three case loads proposals are for MCOs? If not we can get it. Case loads for service coordinators. >> (Away from mic) >> So just to repeat, and we'll verify this as part of the record, ameri health keystone and Pennsylvania home wellness have a coordination ratio of one service coordinator to 60 individuals and UPMC has 1 to 75. So, rich, they would have to demonstrate to us and it's something we do monitor that they are meeting the case load requirements. We would also have to continue to evaluate whether that service coordination case load is too high to meet the needs of participants based on feedback we have, we receive from you and other individuals.

>> Has anyone -- Well, I think it says there's not an issue -- it's not an issue we are going to resolve here but I'm wondering if you were to ask a random sample -- because that's an important role, very important. What they see as their challenges, what their stress levels are, whether they feel they are able to manage 75 people. I know that is going to be a little skewed but I suspect we may see some shocking results. I also have no idea what turn over is in those positions. Yeah. >> It's a great suggestion. We just -- just as a reminder, all three of the managed care organizations are offering a hybrid model for service coordination using internal and external service coordinators. If their internal service coordinators are part of the managed care organization and from the department's perspective because it's an administrative function of the managed care organizations even the external service
coordinators are directly with the managed care organization. So the feedback would have to come from the managed care organizations themselves. Clarification, from Randy, Pennsylvania health wellness is 1 to 75, not 1 to 60. Thanks issue Randy. -- thanks, Randy. >> My question was going to be if UPMC or keystone kept any of the service coordination providers agencies but now that you mentioned they're using a hybrid program can you elaborate. >> Using the southeast as an example, since the southwest is in continuity of care, all three are using a hybrid model. In the southwest the managed care organizations are maintaining a contracted relationship with a

service coordination entity that were in existence prior to the implementation of community health choices in addition to having their own employees manage service care coordination as well. Service coordination is an administrative function of the managed care organizations and the managed care organizations can propose how they are operating it. They did a model where they are using direct staff as well as the contractors to be able to manage the work.

>> Is there a standard on coordinators to attempt to keep the case load so there's some familiarity between consumers and the coordinator? >> Can I repeat your question to make sure I understand it? >> Is there a standard for support coordinators to maintain the same case load so there's a familiarity in consumers and coordinators? >> So you're asking if the service coordinators have a part of service systems are keeping some of their own cases? >> No. You know, UP*MC* is doing the service provision coordinator for people in the southeast. That's broken down by 75 per case load. Do those 75 people know to contact directly if they have any issue? >> Yes, that's federal requirements in the agreement. >> Thank you. That answered my question. >> Thank you for restating your question. >> M*y* comment comes from keystone first participants in the southeast, some of them saw this notice six days before it took effect. I'm not a participant of keystone personally. I know a participant that looked at their mail saying I just saw it and it's happening in a week. I believe that UPMC gave a 30 day notice. >> 45 days, right? >> 45 days. >> Both UPMC and keystone first gave a notice to participants about 90 days to the providers. Keystone first is continuing to work with 32 entities in the southeast to see if they can establish continuing contracts. So they're still evaluating 32 entities. UPMC is still working with the other entities they have terminated. They have all given notice. >> Thank you. >> So I -- >> I'll confer now. >> I appreciate that. I know there's one example of one service coordinator that just closed shop and that would be outside both of the departments as well as the -- as well as the MCOs control for the notice. So that could be the example that you're talking about. >> It could be >> If you let us know we would appreciate that. >> These terminations will not take effect until keystone July 1st and UPMC July 15th.

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They have been notified now. They may be making decisions to change service coordinators over the next month but they have all been given notice. >> Thank you for that. >> Thank you. >> Kevin, just as a follow up. Do we know what -- I'm sure there's varied reasons for why. Do we have a sense of generally of what the why is on why they are terminating so many of these contracts? Part of the question is I assume the managed care organizations like to have control over this function given keystone's role in designing and implementing on the system and part of it also may be that they *w*ant to get more control over how hours are -- you know, how hours are structured, how

hours are used and those kinds of things and -- so this -- what is the rational behind why there's a fair number of termination? >> So I'll give three examples of reasons. The first is the size of the case load it just didn't make sense from a business perspective to maintain a relationship with a service coordinator that had a small case load. The second issue is responsiveness. They couldn't ever get ahold of the service cored -- coordinator to find out what they were doing to manage the service plans. The third is that they had some concerns about the level of quality that is associated with the management. Those are the three examples that were given to me directly. Just to be very honest, some concerns. Case load issue is very obvious. That would be a business decision. Thank you for the question. >> I just want to ask a question for Theo. He's on the call but he is -- he's in listen only mode. His one question goes *way* back to did you say that the committee would be able to see the waiver Amendments before they go out? Is there supposed to be a 30 day? >> There's a public comment period. >> Yeah. So will you make sure a notice has gone to everybody on the committee so that they can comment? They should be on the list I'm sure. >> Sure. Sure. >> Okay. >> Thank you. So before I turn it back o*v*er --

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>> My two cents, Kevin, is that one of the big providers | think a driving force is they feel they can do it more cost efficiently at a better or equal level of quality which I think is sort of what you said. That they're not trying to increase costs, they're trying to reduce costs and might be able to do that by spreading case loads and hiring better people. I don't know. >> I'm sure those are points that the three -- not speaking for the managed care organizations but I'm sure, rich, those are points that the MCOs definitely took into consideration. >> I wonder if -- >> [Multiple speakers] >> Go ahead. >> No, go ahead, rich. I'm sorry. I didn't mean to interrupt you.

>> I *w*onder if there's a possibility at any meeting to have five or six local service coordinators from different organizations visit the committee, whether the committee could interview them in some *way,* maybe with or without the service providers. I think we might learn a lot. I know *w*e can't decide that in two minutes but I think that might be *v*ery enlightening for a lot of people. >> I'm going to be honest, rich, I would resist that because we have defined it as an administrative function of the managed care organization. This is their contractual responsibility. It wouldn't be the same as having a personal assistant service provider provide the same type of testimony. Really service coordination in the CHC realm is a direct *M*CO administrative responsibility. Happy to discuss further however. >> Behavior helicopter -- health advocate. Can you describe the training they have been given or plan to be given to deal with the behavioral health needs of the persons on their case loads?

>> I think that's a TER riffing question. -- I think that's a terrific question and is a terrific

topic for the future presentation. If you allow us to add it as an agenda topic to the future that would be my preference. So it's not just behavioral health, cognitive impairments and training focus that has to be part of the service coordinator training by the managed care organizations and their subcontractors. Cultural competency as we talked about last month with the LGBTQ community, for example, is another area of focus. So *we* would -- I'd love to use your request as an opportunity to be able to have it as an agenda topic where we can truly focus on all of the behavioral health interaction that is are associated with behavioral care organization and the managed care

>> That's good news. Thank you. >> Once again, before I turn it over to Barb, last month if you remember there was a concern raised about some UPMC health system training that was offered in the phase three area. I've asked a represent from UPMC to come to the table and to provide some background about that training, the way the issues were addressed and to also make himself available for questions.

>> So good morning, every*o*ne. And, you know, I want to say thank you to everyone who raised the concerns with the meeting that occurred at UPMC up in Williams port. It actually raised to light a lot of some of the challenges that we have at UPMC with making sure that people understand the intent of the program. Sorry. Normally I don't need a microphone. You know, we appreciate everybody raises the concerns about how the meeting was approached and in the time since that has happened we spent a lot of time and I've spent a lot of times in Williams port working with the system team as well as the system team here in Harrisburg because they are new to the UPMC family of services. Really the intent of the meeting itself was to talk about Alzheimer's and dementia patients. The staff who organized it and ran the meeting didn't understand the sensitivities and the real challenges that are out there. It was a failure. And they really didn't. So since that time, you know*, we*'ve had a lot of conversations and a lot of you know true , you know -- you know, a lot of conversations to really lay out, you know, the intent of CHC and how we need to look at things very differently from a systems side as well as from a health plan side because *w*e are truly committed to the goals that CHC brings to the table with rebalancing and serving people where they need to be and the person centered service plan. So we'*v*e actually -- I think there is a conversation that will be scheduled with the system folks as well as the north central center for independent living, I think that might be scheduled or it's being scheduled. Okay. It's being scheduled. You know, the hope is that we can
actually talk a little bit about some of the challenges and the sensitivities with that and make sure that we're partnering going forward so things like this don't happen again. >> Thank you for that. This is Shalan from north central PA, have partnered with the north central PA. I'm a little bit confused when you mention Alzheimer's and dementia patient. It's my understanding that the staff that organized that meeting are some of the staff that's supposed to be implementing CHC and educating so I don't understand that and I don't kno*w w*hy we're letting people know that with Alzheimer's and dementia can give

at their homes with attendant care services? >> The folks who organize the meetings are not responsible for implementing health choices. *W*e're a large company and we have decisions to keep conflict free. So the system folks are different and have different focuses than the health plan running CHC. They organized this on their own. Some of it was really around emergency diversion. *W*e're trying to keep folks from coming from a nursing facility to an emergency room because nursing facilities have challenging with behavioral health needs which gets into one of the conversations we want to have at one of the future meetings. We really tried to spend a lot of time educating our team about what CHC is, the intent of CHC and where those opportunities lie. That's why *we* want to have the conversation. We're looking for something in June to sit down and get your perspective on what really we need to do better because I think, you know, you raised to light a lot of issues and we'*v*e really been working hard to try and address those.

>> Could you elaborate on how you are remaining conflict free by owning nursing hopes and being an MCO provider? >> So UPMC is made up of four divisions. I'm not an attorney. My attorneys may yell at me for chiming in here. We have four separate decisions, health services that's in charge of the bricks and MORTAR, the insurance division so we're in charge of the insurance products, Medicare, Medicaid and CHC. You know, the health services division is very separate from us. They operate independently from us and are not fully alignaligned. You know, *w*e try to work together where we can, we're an INLD -- integrated delivery and finance system. UPMC does own some nursing facilities but also home care and home health agencies as well. We have a significant presence on all aspects of the market. I think the health services division and I can't really speak for them, they have a -- you know, a significant footprint to be able to provide care for individuals. >> Just before you go on, the department has a responsibility to monitor network adequacy for all MCOS. >> The who? >> The department has a possibility to monitor network adequacy for all MCOS. So we have to look at how they contract with providers and offering choice to participants when they talk about provider type. If they are not doing that they will be out of compliance with their agreement and we would put them on a corrective action plan. They are offering UPMC as well as the other two *M*COs are offering an array of providers as part of their network and We would -- if we saw evidence of a conflict in the way that referrals were actually taking place we would have to raise it because that would put us in violation of our federal partnership with CMS on maintaining conflict free network adequacy. >> Thanks for that. >> Sure. >> I asked all this because at lo of people in our community are very concerned about UPMC coming into the area. You're already there, we know that, right. That's the point that UPMC is the biggest option in our area right now and it almost comes across as it's the only option for people. People are concerned because they are already having issues without MCO being in place with UPMC and the opt and -- and the hospital and the ER and being people referred. We

are concerned because we know that UPMC has not contracted with the seal and there's not been much talks about this. It's starting this year for this region. Our community is very concerned that UPMC is just going to take over this region and especially in that Williams port and surrounding area. >> And I completely get that. You know, the contract is a long one. That's one of the things we want to you can -- *W*e want to talk about, talk through when there's opportunities there. We appreciate the concern and we want to be receptive to that. I appreciate actually -- I appreciate you raising the issues last time because it really raised some flags and I was able to cut through some of the issues on our end to really try and get our team focused on how we can do a better job here and really work together. >> And if we can make sure that your team and our team are working together to inform these medical providers that are referring and discharging and all these things we tried in the past and it has not worked so we intend and have good faith of working together and making that habit. >> That's the intent from our end as well so we look forward to the conversation and speaking with you. >> Thank you for the comment. >> I just had a question related to your four different parts. Are there firewalls protections because when we *w*ere in that meeting they were talking about how great their UPMC nursing homes are. What are the protections from the insurance part and the nursing home part and talking to each other saying you can't do that and what are -- for all the different aspects of it, how are they talking to each other to make sure that -- because in that meeting the woman actually said they were rolling it in 10 days. So obviously they were moving along. How do you talk to each other to see that it doesn't happen again to put us in a nursing home from the doctor's office? >>I think actually CHC provides that opportunity. When we talk about the person centered service plans and kind of the nature of CHC to look at the individual needs and -- and *o*pportunities for individuals I think that gives us the opportunity to really change that and then work with our system partners and the providers to try and make sure that participants are being served in the manner they want to be. I think that gives us the opportunity and, again, I'd love to talk a little bit further in more detail about this to be able to talk through that but I can't speak to what the system folks are doing because they are doing individual cases on a day-to-day basis and we do have separation and the department does manage that for us as Kevin indicated. >> I was actually looking at UPMC's website this morning and it had a blurb about how skilled nursing home placement is the best option for people who cannot care for themselves independently. We know that's not cheer. Home based is the best and cheapest and best quality option for people. Thank you for this. I hope that you can help keep moving this along and also schedule those meetings. >> Absolutely and we look forward to it. >> Just to give the department's perspective, we designed this program. If their proposal they had a significant commitment to offering long-term care in the community. That's the goal number one because that reflects participant purposes, that's what our program is designed to do and we're going to hold them to it.

>> They have that conflict of interest and none of the other MCOs do. >> The point is about the system in general. UPMC isn't the only integrated in Pa. There's one in Philadelphia and one in -- you know, there's an integrated delivery system. We have to monitor it to make sure that there's real participant choice and that's -- | consider that to be the department's responsibility and we have to hold our managed care organizations to be able to offer that real choice. We're with you, in other words. >> I want to share the concern. UPMC has a -- we look at what is happening in Pittsburgh has a unique approach to this compared to other entities in terms of their interests in using their insurance product and their system controls to steer people in one direction or another. We have as people know a huge explosion happening in western Pennsylvania where hundreds of thousands of people are going to lose access to UPMC facilities in an effort to drive people into UPMC's health plan and capture parts of the market. So I would just say that -- that's my characterization of it. And maybe the attorney general's. But there's a history of using the health systems and the insurance components of -- and there aren't -- when you look at Ameri health or PA health and wellness, they don't have that conflict as far as I can tell. So it is something the department I would say is going to have to be particularly vigilant on because it's not like there's a history here for what it's worth. >> We agree. It's our responsibility to monitor that. >> Quick comment. (Away from mic) having heard the word rebalancing, I believe that's one of CHC --

>> I would characterize rule number one of offering long term care in the community. >> Rebalancing and hopefully the numbers will show. >> Great comment actually. >> You're done, Brendan. Thank you. >> I just want to clarify that a lot of the problem is not with UPMC. I understand that UPMC does y to get -- I think that there is that monetary incentive. >> I'm going to repeat goal number one for community health choices offering long-term care in the community. It's the department's -- it's in the contract which means the MCOs have to be able to meet that requirement, the other consideration though is participant preferences. And participants have stated affirmatively that they want to receive long-term care in the community and aggregate but there are some individuals that may want to receive their long-term care in nursing facilities. We believe that nursing facilities will always be a part of the system and the system to be perfectly honest is changing and nursing facilities are a valued partner in the long-term care system. The program is designed to address participant preferences. So the -- when you talk about cost effectiveness of the program itself, from our perspective that doesn't matter. The first component is participant preferences and we will monitor for that and that's part of the agreement as well. >> I think just like Shana was saying, the MOC (away from mic) so I think that's something to think about.

>> So we've had the responsibility to monitor that and as advocates we're hoping that our community partners will continue to raise these issues if you see them. I actually think that last month concern raised and the provider training sessions was incredibly helpful

and it was certainly eye opening for me on how the health systems communicate the relationships between the physical health system and the long-term care system and it will -- those types of concerns raised to this committee and to the department will make us do a better job in making sure that the agreement requirements are met for community-based services. >> That's sort of scary for us to see that the regulating body is not aware of these things. *We* as activists had to bring that to the committee. Thanks.

>> Sure. We need your -- I mean, I'm never going to say that *we* don't need your help.

>> You said that you've been -- you had been monitoring some of this with the MCOS, south *w*estern Pennsylvania has been, you know, the long -- has there been any evidence of south western Pennsylvania of higher levels of --

>> No, just the opposite. Literally community health choices already moved in the direction in the southwest alone where it was -- it's actually increased by I think two full percentage points. We measure rebalancing. It's increased two full percentage points towards the gauge of community-based long-term care which is exactly what we want to see. The state has shifted 10% in three years which means -- it's different by Philadelphia and long-term care in the if community in Philadelphia is growing exponentially. So we're actually now 60/40 community based services as of 2019. But that's largely driven by Philadelphia growth in community-based services. But in the southwest we're seeing it grow for community based as well. The fact that it's had that one year and five months of impact in that direction is exactly what we *w*ant to see in the program. *We've* presented that data already. >> That's what I thought. I will check it out. >> That's one measure but also making sure that the community -- I agree with the point that you can skew a position for one type of care verses another type of care so *we* do need to make sure that that's something that's addressed and monitored by the department as well as our community partners.

>> Just when are *we* going to see the data on where people are going, what types of housing and the data on that home modifications and where people are at in the pipeline? *W*hen are we going to see the data to see where people are transitioning to? What type of housing. >> I'm not sure how to answer. >> I'm asking when are we going to see data to show where people are going housing wise under CHC transition, also with home modifications, when people are getting the home modifications. Are we going to get some data? >> We have presented and will continue to present data on home modifications. One of the question that's outstanding on home modification length of time for approval and how home modifications is being delivered. When you say housing type what do you mean?

>> Are they going to DOM care, personal care homes? Where are people going under CHC? Where are they living? What are our consumers living and receiving services? >> You mean community -- >> I'm sorry? >> *We* can show the data on community verses facility based care. As part of our eligibility in enrollment we capture people's addresses but it doesn't necessarily talk about the type of living

arrangementarrangement. >> Finding out where people are going and what types of housing. We've asked that stuff before, where are they going, what housing are they going to?

There's a lot of concerns when people are transitioning it's an easy transition to get them into maybe someplace that's an assisted living but when they are there, again, when they are there and it's not what they expected it to be they thought maybe they would get their own apartment. I'm wanting to know where are people going into. Not only for transitions but where are people and receiving services, in their own home, are they living them -- we've been asking for it. Where people are receiving.

>> Are you specific to NHT. >> The types of housing and the home modifications. >> (Away from mic) >> We would like to know for housing but for everybody, all of CHC what is happening where the home modifications where they are at, where are they in the pipeline, how long have they been in there, are they getting the right to appeal, getting decisions? >> How will we get that data? >> We've been asked for that. We've been waiting and waiting and we asked --

>> NTH -- you have to often -- home modifications are part of the process for NTH and you have to know what type of arrangement they are in. How would we get that for everybody?

>> Wouldn't service coordinators know? >> They capture information about the individual's living arrangements but may not capture the type of dwelling it is. >> Is it in the evaluation form? Letting people know where

they are living, what type. >> Just speaking -- >> What's the new program, the new -- what's the new evaluation that I can't -- >> NRI. >> Are they happy where they are at? What type of living situation. >> Let me ask. Are the MPOs able to answer whether or not they capture, the type of dwelling that people live in.

>> So I think -- to say I think this is part of our meeting for directly following this because there's so many caveats to the what if situations that it's really hard to capture the category. If you're transitioning to -- >> If you can speak into the microphone. >> Transitioning to a home with others, transitioning to their previous location. I think it would be helpful and why we think the opportunity is the meeting after the sub MAC to really define the criteria so that we can have uniform meeting data across the three.

>> I'll wait to talk about it at the next one. We've been asking for this data not only for fit wasn't -- it just didn't work as well in the southeast. There were clearly communication issue with the MPOs and the entities that provided the emergency repairs that create a problem. >> Mainly to the providers in the southeast that it was tied to theto the supply services needed. >> I think it was more about communication. You know more about it.

>>I think the struggle that we have is the length of time it's been taking for an emergency repair to take place. Working with the MCOs, trying to come up with a process for an expedited review or whatever instead of having something as an emergency repair

take 30 to 45 days to the point where consumers missing chemo treatments or something like that. So it's just working with them to see if we can arrive at some kind of solution. >> From your perspective has it gotten better? >> I don't know. >> It was more compared to the southwest. Part of our examination on lessons learned would be to question the different -- why it has been different. >> Now that I think about it more, on the providers what have been a well known issue and what we've seen before

the challenges of roll out of community health choices.

>> Okay. >> Thank you, Kevin. We're going to move on and the next item on the agenda is functional eligibility determination data and Tyrone Williams is going to be presenting. I goes Mike hill.

>> I'm Tyrone Williams in the office for long-term living. I'm here to report to different sets of data as it determines to our functional eligibility determination tool. So a little bit of background. This information does speak to our completed feds if you will. That includes for all programs, not just for the HCBS waiver but other types of programs that with do assessments. In addition the time frame that we're looking at is April 1, 2019, through May 28th, 2019. With that being said in terms of the number of completed slides between April and May we had 20,597 completed bed but our bed assessments at the triple A. In terms of further break down, 7,934 of those were assessment referrals done by IED and 16,412 were initiated by the AAA who are contracts with our assessment. The completion rate is 85%. 76% of those were completed within the 10 daytime frame. That's what we require. The number by recommendation break down is 15,613 came out to be nursing facility clinically eligible and 4,495 were non-facility ineligible. Percentage wise, 77% and 23% in a (away from mic) the last bit of information that was requested was the number of requested medical reviews. That number is 1,057 assessments were referred to OLTL for a medical review to determine clinical eligibility. Any questions?

>> There's one thing we will be making to the fed document itself to the FED. We're adding some -- as a request of disabled veterans, the disabled veteran's association we're adding some questions regarding -- around veteran status and disability. That will be added and we'll be keeping track of that for the DAB.

>> Your last question before you retire. >> You looked at year to year data, so looking at the data through April of May of 2018 and comparing that to 2019. We looked internally and we saw an increase from NFI to NFCE from year to year. In 2018 that 84% of the people who were assessed were determined NFCE and 16% NFI and in April of '19 those numbers shifted to 64% NFCE and 35% NFI. So really significant increase in the number of people being determined NFL over NFCE. I was wondering if you were seeing the same trends across the state?

>> We see the same trends but we want to break it out so we're actually looking at apples to apples when we look at the assessment types that we're looking at. To do

the comparisons. So we're looking at it. We have seen the same gross percentages like you're talking about. We *w*ant to break it out further to make sure that we're -- what we're looking at is accurate. The thing that I think we're seeing is a more accurate determination or a more accurate recommendation by the fed than in the past because it's applied more consistently. So we *w*ant to look at that. *W*e want to look at the numbers a little bit more. *W*e've only been into it for about a month and a half to look at anything. *W*e want to be more consistent with what we're looking at to make sure what we're looking at is accurate, work with some of the physicians on the medical director reviews to make sure that what we're looking at there is coming through as accurate as well because *w*e're adding those into the mix and the number. Since we've only been doing it now for about a month and a half we *w*ant to make sure that what we're looking at is good.

>> I think it was remarkable. The data testing on this is there was much greater comparable from the LCD and the fed. >> I know that the recommendation -- the NFCE recommendation through validation process was running at about 75 to 77% which is right about where we are right now. *W*ith the NFCE determination that we're seeing. So the numbers -- the percentages are comparable to what the testing showed. So I think we're comfortable with that but as you said, there is a discrepency with if NFI so I want to look at that before we make any recommendation. >> *W*e're seeing an increase of people refer today the option program as a result of that large number of folks determined NFCE. >> And other programs as well

>> The medical reviews, 1157 are they the cases that came from the IED or cases that are AAA. >> They include both. >> There's a pretty fair backlog of those cases at this point. >> There's a slight backlog but we are diligently working through those. We have committed additional resources to look at those more timely that we have at least four nurses reviewing those and it made significant progress in terms of reviewing those. >> Thank you. >> *(*A*w*ay from mic) >> Yeah, they're making dramatic progress. Over the past three weeks there's been dramatic increase in the o*v*er all backlog. In some areas related to the backlog we're essentially caught up. In some areas we're close to caught up. So it -- the additional resources have been a dramatic assistant.

>> Just a comment in regards to the data. I would assume that usually this time of year what you're seeing on the ageing side would be that they're reevaluating their budget and possibly taking people off the wait list for the options program. You have to be determined as not being NFC in order to qualify for options. So you would just by the nature of that program and what you do in the options program in order to qualify them for those dollars you will see a higher number of NFL individuals. I'm just referencing that data and the timeline that you used that you may be impacted by the fact that in my opinion agencies on ageing are probably taking individuals off the wait list as well so you would have -- >> That's a good -- >> Assessing them for -- >> Those are the things

we have to look at. Since we've only been doing it a month and a half we want to make sure that we're taking into account those types of things. There's also a lot of times we see seasonally too you're applications increase at certain types of the year. We want to look at that as well. So, you know, we should have more data available next month, during the next couple of months. We'll keep you posted. Tyrone is doing a great job tracking it. I will work with Dr.

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Helen and Kelly and bring those number to you. >> This is just a request. I see with the slight backlog it's not possible but it would be interested in the future to see what the results of the medical reviews are. >> Yeah. That's one of the things -- Dr. Cula and Dr. Kelly have talked about bringing that data forward too. I think antitotally -- antidotely that it's been in if agreement with the physician results. Am I misstating that? >> (Away from mic) >> To a large percent that's correct. Again, we haven't quantified it exactly. That's correct. >> So it would be interesting to see. >> We definitely will be bringing that forward. Because of the backlog we didn't have good accurate numbers this time around but we will have down the road. >> Thank you. >> Hi. I'd like to know what information does the physician actually get on the FED review other than the FED and the M851. >> Hi. Larry. So we first have access to the M851 or the 507 physician certification form. That form is actually more in depth and does have a lot of different diagnosis that the physician lists on it. We also have the FED and then there's a comment box at the end of the FED that we have that the assessor often writes some other notes in and other summaries in. So if there is a difference we have all that information. >> [Multiple speakers] >> On these cases especially when dealing with the complex issues. You have no clinical records coming in and I would challenge the veracity of that review process. Not your decision on the information you have but I would challenge the fact that on some of these cases you do not have enough information to sort out whether there are skilled services being delivered on a regular basis whether it's a skilled service plan or not. >> We do in the assessor comments frequently that kind of information. >> You know, whether or not it gets there or not I've been to seven counties and in seven counties the assessor said they're not allowed to even check the block that they disagree with the NFI. >> That's not true.

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>> That's not true. >> That's not true. >> I'm telling you what we're hearing in the process. The point being if you have a physician review process and you can't send to the physician, you doing the reviews pertinent clinical information, we've had three A-FIB cases, COPD and 02. We had the last A-fib COPD with a chest denied. I would

suggest if you don't have any of that information that that review process needs to be relooked at.

>> There's also the ability to upload documents which can also -- >> But it's not in the process. It's not in the process. The whole physician review process in what the applicant can request needs to be put in writing that you have a right to request the physician review, the right to send in information. That whole process is not accurately outlined. You get conflicting information. We got information that said the senior program requesting you can't get the FED. You can't get the FED until you appeal. *We* were even told that you can't appeal the FED decision. This process really needs to be looked at and some clarification from an applicant side on how these things -- how this process flows and how it works and how to we get a physician, you, some meaningful information on these casings. The only thing you're doing is validating the FED. I would argue that the MA51 doesn't have the type of information that you need to look at clinically complex cases where they might be able to perform some functionality.

You get some of these cases that you have bevel diabetics that might not even wake up from sleeping that night. You know, you have cases out there that need to be looked at from a clinical standpoint of you. When you looked at the university of Pittsburgh sorting of the data you had people -- you had a very high percentage of people that had two partials in the four domains. About 40-some percent, I can't recall the exact number *w*ere NFCDE determined and that's because of the over riding clinical information on these

cases. >> This is good feedback that we will take back. I will tell you that we do have as Mike mentioned some assessments where *w*e do receive additional documentation as well. But *w*e will take this back and look more thoroughly at the

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entire process. You mentioned some things that, you know, with -- we do want to ensure that assessors do indicate that participants have appeal rights and that the assessors do feel that they can give us all the information and that there's no prohibition of any kind.

>> *Y*eah. Again, some of these records need to get to you and there is no outline process on how to do that. >> We appreciate this. >> Thanks. >> We'll take a look. >> Thanks. >> This is Rich just listening to this. Hearing a little bit of a different perception of what is actually happening from two person's points of view. It sounds like a serious issue. I would like to see personally at the next meeting with half of what the gentleman speaking said is true. Are people able to appeal? Are they able to check that box that allows an appeal? So I'm a little bit concerned. It's like listening to C NBC and fox at the same time a little bit. So I don't know. How big of an issue is it? Do we need to hear

back? Is there a closed loop on this? Kevin?

>> We're going to go back and take a look at the process. Part of it is training of the assessors as well. From what Jim is saying it sounds like the assessors are passing on that information as well. We have to go back and talk with them. >> Can we circle back at the next meeting ohher the -- or the meeting after that? How do we close the issue?

>> We haven't really seen that to be the case but -- >> Okay. You haven't seen it to be the case, someone else has.

>> Rich, we committed to certainly evaluate how information is part of the medical review process and we'll certainly do that. If there's better ways that information could be shared with medical review team that's looking at the conflicts between these assessments and certifications or if there's information that needs to be brought to bear to do a much more thorough evaluation of the assessments *w*e will do that. I have to go on record saying that there's a big difference between medically complex and clinically eligible. This program is not -- it's -- there are -- there are certainly medically complex people that will be nursing NFI. A very large portion of the dual eligible population in community health choices and in general are very medically complex. That does not mean that their nursing facility clinically eligible. A lot of the medical records that could be brought to bear in that type of review that relates to medical complexity may not necessarily indicate that a person is nursing facility clinically eligible just to be very clear and also to set expectations. >> I've asked it before and I'm going to ask it again. Can we get some people, part of the review committee as well, this is a non-medical program that are involved in determines whether they are NSI -- or what is it called a review -- part of the re*v*iew committee? You're right, not everybody who has medical conditions might have activities of daily living where they need attendant care but times they do and it might not be seen the same way as someone who might understand it who is living it. >> Just to be clear the FED is part of the eligibility process. We use a subcontractor, a contracted subcontractor to perform the assessments. The determination has to be made by the department.

>> But there's not allo*w*ed to be anybod*y* on the outside to have a volunteer, like this group, that would be part of this review committee to help look at it and that knows disability and knows activities of daily living and that could comment. >> We'll certainly have a conversation about the composition of that revie*w* but that review has to be done by the department.

>> Thank you. >> It's just -- I mean, that's just eligibility determination for Medicaid.

>> Mike, another question. You've just gone back to the data. It looks like about 38.5% of all of the FEDs that were completed came through were requests from the IEB and I'm I assume -- I'm assuming that's the system. >>I don't have that number. I can check on it. >> It's just interesting that such a large number is come through the AAA. So the percentage of the requests for FEDs from being requested from the IED is about 38.5% of the total. I was just wondering if that was comparable to

what it was prior to the introduction of PIA and the FED? >> I don't have that number. I can go back again. >> One other issue I don't have any specific data on but know has come up at least at PICS is there's been a number of people who have in DOM care that are undergoing their annual redetermination who are coming up as an FCE under the FED. Similarly I think also for people in personal care boarding homes. Interestingly enough a number of people who are admitted to nursing homes and are looking for a retroactive eligibility are coming up NFI. So I don't know if you're looking at those three particular sort of -- you know, populations within the o*v*er all but certainly that's problematic for folks, particularly in DOM care and personal care boarding homes. >> We definitely are seeing that as well, Steve and we are -- we will be addressing that as we need to down the road. I think Kevin mentioned this morning about services being DOM care facility and that department of ageing has a right to waive that requirement if they come up to NFCE to remain there. So there's some things that we have to work out. We are seeing some of that as well. >> Well, this is just speaking to their annual -- >> Right. No, I understand. I understand that. >> Just a question in regard to the DOM participants. So if they are NFCE and if the program requires them to be NFI what is happen being those consumers as far as them remaining in the program? Do they have to leave?

>> Those are the ones that can request that requirement be *w*aived. I know Kevin has worked with them.

>> Your question was if their clinical eligibility or functional eligibility changes and it's no longer appropriate for eligibility for a particular type of service, what happens to the people; is that correct? >> Yeah. Who are in DOM. So now they are NFCE or identified as NFCE when they should be NFI. As far as the program requirements right now. Is that right? >> So it's my understanding that the DOM care cases --|| know that Dr. Lapel has looked at some of the DOM care cases and confirmed that I are NFCE in some cases and he can certainly speak to that. The process for DOM care is that the regulations prohibit them from being able to be NFCE and receive DOM care as a setting but those regulations can

be waived and that's normally -- >> That's not happening. I think it Haas more to do -- I think that it has more to do with the waiting of domains in the FED.. >> So a couple of things on this. We have looked at -- when we did revise the FED we did take cognition and mental status over all into account. Some of the participants in the DOM care facility have come up. When we look at the physician certification as well as at the FED as well as at the comments that the assessor has put, there have been a few participants that have been clearly designated as NFCE and having had experience both as a clinician practicing for 22 years in internal medicine and also looking at the LCD there *w*ere a few -- are a few participants that are NFCE and regardless of their current residential status. As Kevin indicated, you know, *w*hat happens after that designation, you know, occurs, you know, but there are -- there are a few that are

NFCE. >> I guess I was just kind of reacting to also was, you know, my impression of the DOM program was you're NFI and it's a home-like setting. Where *y*ou are three people or less live in that home-like setting. It also provides an opportunity for some people to age in place who need some additional support. So where has that gone? Where is it in this process? >> Not everybody that comes up as NFCE goes to a nursing home, correct?

>> Correct. >> Now the ma JO -- majority of people that are NFCE can receive care in the community. We love and support the DOM care model. *W*e believe it presents opportunities for a housing that's desirable for people. I'm not going to speak to the department of ageing be you -- ageing be you the current perspective is designed to have that regulatory prohibition for NFCE. We believe there's a model that allows people who have NFCE to have DOM care.

>> I would like to add we have allowed for safety nets within the process. As stated earlier, we have a way for assessors to disagree or agree with the FED result which will be looked at by a medical director based on the reason*. W*e've also working very closely with the department of ageing. They also assist us with those reviews as well for individuals of DOM care and so we discussed those and we make determinations based on a variety of different feedback from different people that are involve in the process. So with the ability for an accesser to agree or disagree we have more than enough of a safety net to ensure that the -- a

person is in the appropriate setting. So just to add -- if by chance it is determined that they're NFCE that individual will be properly transitioned to a setting that most -- that is most appropriate for them. I mean, at least that's our vision and that's our desire in those instances. >> *(*Away from mic) >> Speaking for ageing well, we want to make it known that *we* are *very* committed to quality improvement and the best *w*ay that we can do that is if we're told about concerns that are happening, you know, if you hear that there is something that was said, you know, there was just a comment about potential misinformation being shared about the ability to appeal a FED decision and those kind of things. Any specific information that we can be provided including the name and when and any of that, please provide it to us because *we* can't make improvements if we don't know what is happening. *W*e may hear stories but if we don't have those specifics we can't drill down and find out what is happening. The other thing I wanted to say, this is something that I may be nitpicking but to me meeting the requirement of the 95% of the FEDs being done on time and the report here showed that it was I think 76%, I would just ask that there be a look at there are certain situations where there are kind of excused you know, reasons why it can legitimately be longer, the person may decide they no longer want to have the FED, maybe the person moved or maybe the person requested to have it delayed until their family member could be there or something like that as well as there's some issue around if a with draw happening and the timeliness of when the with draw hits the system. So I would just ask that that be

considered. I know as far as I'm concerned I don't want it to be appearing that we're not meeting our obligations and I want to know if we're not.

Thank you. >> Sure. Just to add to that, just to be clear, given that this is a new tool that just started April 1st, and a 10-day turn around being a new requirement, I think 76% is a very good percentage given that we've only been operating now about two months and we expect to see improvements as assessors get more comfortable with the tool moving for*w*ard.

>> Thank you. >> Sure.

>> A few questions that came in over the phone. Thoughts on the FED look back? An applicant had a stroke a week before the FED and was deemed NEI. Three day look out is performing an injustice to our seniors.

>> So a couple of things with that. Again, it's a few factors. Number one, that could -- that stroke could be listed in two places. One is the assessors comments. The second is the physician certification but if some second comment, is you know, it depends on the kind of stroke, there's a large varieties of strokes, the bottom line is there's small strokes and big strokes, there's strokes that effect people substantially and stokes that are essentially people not effected, the third piece is as Kevin mentioned, it really does depend on what kind of effects over all and complexities and comorbidities the participant had and how those affect, translate into that person's over all mental status and if function because people can be medically complex and still be NFI. So in and of itself it's hard to assess what that means.

>> Thank you. Can you repeat the NFCE to NFI break down prior to the April 1st FED roll out?

>> The question just asked that we repeat the NFCE to NFL break down prior to the April 1st FED roll out.

>> Well this is just –

>> *(*A*w*ay from mic) >> Right. This is our data. So for April 2018 it was 84%, NFCE16%, NEI. In April of '19, 64% and 35% NFI. So April to April.

>> And then we have a request that we have a break down, a county break down of NÉCE to NFI provided to us. >> Just for the record, since we spoke so much about DOM care, it's not a service in CHC. >> *(*Aw*a*y from mic) >> Right. Is it -- if someone who received some care can receive services from CHC? >> So if somebody -- if somebody has -- I'm going to give
you the long answer.

>> Thank you.

>> SO DOM care is an allowable setting for home and community based services in CHC. It's not a CHC service. The way that would have to happen is the person is in a DOM care setting, they have aged in place using the term, the regulations were waived, they were determined to be nursing facility clinically eligible and eligible for home and community-based services, they would be able to receive -- they would be

able to receive home and community based service ins a DOM care setting. So it's not an easy translation but can be. Still from a CHC perspective a community-based setting.

>> Could perhaps the data that you're starting to collect *(a*way from mic) could there be some meta data on who is CHC participant in DOM care also? >> I think we can get that because I think that's one of the things we do capture. To Pam's earlier point there's a lot of settings that we do not have but I think we can probably do a match between DOM care and CHC. I believe the number is probably pretty small.

>> Thank you. >> I'd just like to, you know, seems like DOM care day today but I would like to recommend that you know maybe a work group, an interdepartmental work group could come together and discuss this. I think there's an understanding on the AAA side that individuals who are eligible for LTSS under CHC are not able to be placed in a DOM care. The original waiver application excluded DOM care residents to participate in CHC LTSS. In the final application asse -- application as I recall it was still an item that was under consideration and revie*w.* So that's my recollection. I think the -- >> *(*Away from mic) that was under consideration and review. So that's my recollection. I think the -- >> *(*A*w*ay from mic)

>> But also for new residents to, you know, have a commune-based setting. >> So if an exclusion did exist it related more to the qualification for being able to be eligible for DOM care which actually do prohibit NFCE but the way the program is structured. *W*e do expressly allow choices for home and community-based services.

>> For people receiving LTSS? >> If people are NFCE and receiving LTSS they can receive it from a CHC perspective in a DOM care setting just to be care. We did that because we knew people were. We had people in the ageing waiver who were receiving -- or had DOM care. >> Right. Again, if there's an opportunity for the department to come together and provide some clarify on that, I think that would really be helpful. >> Sure. >> Thank you. >>I think it will probabl*y* -- *w*e would look to our department of ageing to -- obviously it's a program they oversee so we would want to them to take the lead on how they want the service to be delivered. And everything that we've done with CHC and DOM care has been something -- >> We support this idea but we're hoping for steak -- stakeholders. >> Thank you, Tyrone and Mike. Now w*e*'re going to have will Marie talk about the CAP survey update. >> Thank you. Happy Friday, everybody*. Yo*u guys can do better than that. Happy Friday. *Y*ou guys should be v*ery,* very excited. You know why? It's been a year and a half and we've had a couple of hiccups but we have a very good program in Pennsylvania. For those of you who don't know I'm Marie Gonzalez. I work very closely with the clinicians in the area of quality. I also work very closely with all of the bureau areas that make up office of long-term living. So I've also done a lot of work with some of the other DHS program offices to really learn about helping quality really impact what we're doing with community health choices. So a lot of the conversations that we have had in these sub

committee meetings really has impacted quality because at the end of the day community health cases is about providing better quality care for consumers so that consumers can have better outcomes and thus avoiding them from landing in a hospital or going into a nursing home if that's not where they want to go and so you have probably have heard me talk a lot about the quality strategy that we've had for community health choices probably for two or three years now. I've walked a lot of people through the various quality components. You heard a lot of measures that we've talked about. We've shared a lot of struggles. Together we've talked about the challenges we've seen with implementing community health choice. So quality has been at the forefront for CHC. So today I'm really going to talk about something that we've been talking about for quite some time, it's information that we shared I guess probably in January of this year. You've heard Kevin talk a lot about the fact that with community health choices we are in a much very different position than we were when we were managing fee for service system. We've got more data than we could ever possibly imagine or dream of. So it's figuring out what we do with that data so that it's meaningful, so that it can help us sort of -- help us along the way to better improve community health choices as we continue to implement. So today I was asked to just really kind of give a high level of some of the information that we've been gathering from the ACBS CAP survey that's been implemented last year in the southwest. The CAP survey was really designed person centered so consumers really measuring experience of care by our consumers. It's really one small component of how our consumers can tell us 40 - - how they are receiving the care by they planning, coordinating service entities and the workers. So the tool is really designed for consumers. So the consumers are the ones that are providing the responses. We've asked the MCOs to gaugeexperience of care last year in the southwest because it was a very brand new tool for Pennsylvania. We identified a very small sample for them to do. This is, again, information that we've already shared with all of you. We just want to give you some highlights. A lot of the stuff that you will see right now just confirms everything that we've been talking about for the past year. I don't have a clicker. Where is the clicker? Next. All right. So I'm not going to look up so I have the slides here. I'm going to put my reading glasses on because I am ageing. I am investing in my future. I want community health choices to work because I'm a baby boomer and I'm very, very close to that age 60 so I want to make sure community choice is effective.

So with your help we will make sure we have this program. Right? All right. You guys kill me. So we're going to go through this quickly. I already kind of mentioned that this is a requirement under the CHC agreement. Again, this is just one of many tools that we're using to ensure that consumers have a voice to tell us how they are experiencing their care by the MCOs and their service coordinating entities and the workers. Last year we asked the MCOs and identified a very small sample for each of them to do. They were required to have an independent vendor implementation this survey. We

included having them to add the supplemental employment survey. I mentioned before that this survey was designed as a person centered survey and so a lot of the things that we have talked about that we know are important to us in Pennsylvania are part of the survey. For instance, employment, transportation and housing and so. So we're going to share just a little bit of a snapshot of what some of the consumers in the southwest have been able to say. Last year there was a month of August through September was when the survey was implemented and done via telephone. Now the tool was designed on two different modes. It was designed to either do telephonic or face-to-face because it's the first time we adopted it in Pennsylvania we choose to just only do telephonic. Later on we'll talk a little bit about what our strategy is going to be for this year in 2019. But for the most part the sample that the plans or the vendors used range between 13% to 29% of a response rate by the MCOs and also we selected about 400 samples check -- collectively. They were able to survey over 700 individuals in the southwest. So I think that's really important. Pennsylvania health and wellness 305, Amerihealth, and UPMC about 143 folks were interinterviewed. This is high level the folks that responded to the survey. The age group 35 and 64 there was a sample of 39%. I'm not going to go through each slide in too much detail. When you look at too many numbers you look at how we're interpreting data. So I want to highlight the things that I know that would be important to all of you and those that are on the phone. I think the important thing for this particular slide is that with regards to education, which I think is key, there is a lot of people still interested in employment and want this support, is that 67% of the folks that responded and this is still a small sample, many of them had a high school and a GED which means some of the folks that we are serving in community health choices have an educational background and could be interested also in working. So we'll talk a little bit about that in another slide. The next slide. Additional responding characteristics for the most part respondents that participated in the survey had a good and fair health. About 68%. Also with regards to mental and emotional health, about 50% good and fair. Again, these responses were from the consumers. This is information that the interviewers gathered by talking to our CHC par TIS pants. -- participants. Really important on this slide is the residential independence. 52% of the folks that participated share that they do live alone. So that's going to be important to acknowledge because there will be another slide that talks a little bit about community support. Next slide. Assistance receiving during the survey. Most of the consumers responded individually. A very small amount of folks needed some assistance which makes sense, right, for the folks that we are serving within the community health choices. And then about 16% of the folks who participated needed someone else present. That was probably a caregiver or family member or somebody that provided past services. The next slide. Other results. These are just the responses of options that people had in responding to the various questions, you

know, yes or no, obviously and always so they have the ability to re respond how they feel, again W regards to the various questions that they are asking. Next slide. So we now get into a lot of the data and I think what is important on this slide is that 75% of the folks that participated on the survey choose the services that matter most to them. I think that's really important. It really supports the design of the survey because we want to make sure that consumers feel that they have the ability to choose and decide what they need and how they -- and how they are getting it in the setting they are living in so that's important. Next slide. Service coordination and service choice. It's important. The one highlight that I would say on this slide is that 57% or so, close to 58% of the person centered | want -- included all things important to consumers. That to me is a red flag because the number should be higher. The folks who participated on this survey only 57, 58% said that things that were more important to them were part of their person centered planning. So this supports a lot of the conversations that we have had in the sub committee meetings that talks about consumers want to make sure that the person centered planning they want to be a part of it, they want to make sure that what is in it is important to them. So we need to do more work in this area with the managed care organization. Next slide. This one is on paths and other communication. I would highlight that on this slide consumers share that listen carefully to you is important to them yet the number here from the respondents close to 80%. So this should be 100%. We should always -- consumers should always feel that they are being heard 100% and not 80%. Next slide. This one is something that you all have -- we've talked a lot about making sure that our consumers have the ability to access dental services. So with this I said what we would highlight in this slide is consumers share that better benefit information is important to consumers and we should be able to to a better job at educating our consumers that, one, they have access to dental services and two, how do we -- or the MCOs, how can they provide better services to our consumers to get better access.

The other thing I would highlight on this slide is consumers felt that they needed assistance in finding a dentist and that -- although 12% seem like a small number, it's still a big deal because it is impacting consumer services. Next slide. If I'm going too fast let me know. You guys look like you're very interested from here. Yeah? Okay. Awesome. Transportation. I can't say more on transportation. I've been on the road trip with the team. I've sat down through the transportation summit and I will tell you going down the T of the state there's a lot of challenges. I saw a lot of tree and deers and not a light and that's a big challenge. Transportation is huge . It might be easier in Philadelphia. In Philly the transportation is not so bad. If the T the service coordinating entities and the director workers are challenged. So this is a big one. On this slide I will tell you that right to medical appointment is a big deal for our consumers. So that's still a low number and that's important for us to recognize. Next slide. This one was a real big one for me. A lot of these numbers are a little bit concerning regarding

planning your time and activities. Many of the consumers felt that not having the ability to get together with near by friends and, again, this is what I talkedtalked earlier about, just having community support for consumers is so huge. That's why community health department -- health choices was designed, to live in the community if they *w*ant to and enrich their lives so they can live a long life and live a healthy life. So able to do things in the community was also a big one. Our respondents say the same thing as well. National weather service slide. --next slide. This one is the safety and respect. This is the -- the thing for this slide is that I think it's important to recognize that our consumers understand if they want to report abuse they now how to. That's key and important. In Pennsylvania we have a 1-800 number where people can call and report abuse. They know that and their families know that.

This validatingng work that we in the commonwealth have been done. This one is on employment. Out of the 700 folks that participated on this survey and provided response, only 15 confirmed. 15 individuals confirmed they were working. So, wow. V*ery, v*ery, *v*ery tiny number. And so for those folks that do not work some said they *w*ere interested in working about 60 individuals said I would really, really like to work. About -- you look in the red box, about 116 individuals did not ask for help in getting a job but part of it -- we think is that about 85 did not know that they could get help to find a job for pay. So in this area I'm thinking that what we need to do together with the managed care organization is making sure that our participants know if they are interested if -- in working that there's support systems to be able to do this.

This is a great opportunity to work and provide more support for our CHC participants. So definitely an opportunity for us to work on. The next couple of slides is just really highlights on some summaries. Obviously some areas of concerns or opportunities for improvement because we can always build on what we know is educating our service coordination workforce. Making sure that they have the proper training, making sure that if there are issues and challenges that we are together both the department and the MCOs are working with the service coordinating entities to help them with that. Do we have a question?

>> Oh, I thought you were finished. >> Oh, thank you very much. The other thing on the service coordination includes dressing, bathing, meal preparation. This supports a lot of the stuff that I think we've talked a lot about. Our consumers, again, this tool is really gauging experience of care. So for them they want to make sure that they are -- many consumers are addadvocateg for the people providing that service. So they have relationship with service coordinating entities, have relationships with direct workers. So if they have the ability to talk and share it would be great to have more training for the people that are providing my needs or servicing my needs. I'd like them to have those resources some that kind of feedback I think is really important and I think it's an opportunity for our MCOs. In the area of the past, participants have felt -- for the folks who participated felt they have not been noted when staff are not on time or can't come

at all. Another way to make sure that if our consumers are aware if somebody is not coming to provide those services they are being contacted or there's a back up to make sure that someone is going in to provide services for them. The big one we talked about today is transportation. We know that's an issue that will continue. I'm between me and the MCOs coming up here up here, I encourage all of you to ask questions to the MCOs. Kind of that's why I'm going through it really quick. I know you guys are all chompy wants to talk to the MCOS. You have lots of questions, right? How many people have questions for the MCOs? Nobody has questions for the MCOs. I know you do. I know you do. Next slide. Again, these are other lists of other quality opportunities for the MCOS. A lot of this information we have shared with the MCOs so this is not a surprise to them.

They are a*w*are of these results. So a lot of it, again, is just impacting a lot of the things that are important to the consumers we're servng in community health choices. With that the next slide. Our plans for this year. Obviously w*e* want to plan to increase the sampling and we're combining both the southwest and the southeast. The time frames will continue to remain the same this year being the ACPS CAP sur*v*ey will be implemented during the August 1st through October 31st time frame. The goal will be for the vendor to submit their information to us by November the 15th and so we hope that either by the end of the year or early part of next year we'll come back and share with you some more interesting data in combination between the southwest and the southeast. We're targeting about 1,200 people so we're going from a sampling of 400 from the southwest or 700 to almost double that for this year. So, again, our hope is to continue to build what we'*v*e been doing knowing that these forms that we have, all the provider summits that we are doing is really identifying other things that we need to work on and so, again, with that this is not the only surve*y* as you probably already know. *We*'ve shared a lot of information with you all throughout the months. The Medicaid research center is interviewing various providers. They did it in 2017. They are continuing to do it throughout the state. You all know that there's a nursing home resident survey that's happening now so nursing home residents are being interviewed. That's going to go on until August the 31st. Nursing home administrators have been asked to

>> [Background noise] >> Been doing a lot of interviews. A lot of information that we're gathering and what we are doing to ensure that information and put it in a way that we can all kind of make sure that we understand what is happening and how can we continue to improve what we're doing with community health choices. I think with that --

>> [Background noise] >> Just a comment and a couple to have -- and a couple of questions on employment. We know that OVR is going to accept new consumers if you will and provide services and stuff like that. So that needs to be known as far as looking for our community to be more employed.

Thope there's some way to capture if anybody is -- >> [Background noise]

>> Can I ask you a question before you move on? >> Sure. >> Has [background noise] been in contact with the department of labor?

>>[Background noise] >> Then lastly I noticed that 99% of the applicants were nonSpanish, white. My question with the lens of cultural competency was the survey sent out in consumers first preferred language? Or was it only in English? >> English and in Spanish. >> English and Spanish. I know this is the southwest but as you roll the survey out in the southeast -- >> Absolutely. >> We hope that cultural competency is put into place. >> Absolutely. Thank you for your feedback. >> Mike Greer. Kevin, we have responded to the OVR and will be submitting questions and comments.

>> We have a couple that came in over the phone. >> Oh. >> How is the bureau monitoring the vendors who distribute the surveys? >> Did they say it's interesting? >> Well, it's interesting that UPMC has the least number of responses which could be a concern if if UPMC supports the majority of CHC southwest recipients.

>> Okay. So when I said that collectively we asked every plan to survey 400 individuals, that's 400 individuals total. So we had roughly around the same numbers for each plan. One plan just met what we wanted them to do, the others went beyond. I don't know what reasons but they did go beyond. I think that that was fine. It was the first time that we did it. So the fact that they went over 700 collectively as a system I think is helpful. With regards to the vendor's [background noise on phone] doesn't require to have a vendor. There is an independent vendor that [background noise on phone] and work with the vendors directly and we also had conversations. [Background noise on phone] and the deadline that we wanted to [background noise on phone]

>> I'm sure a number will pop up. [Background noise on phone]

>> Yes. Yep. I mean, yes. >> Can they bring up slide 16 again? >> Slide 16. You guys were paying attention. Okay. Slide 16. Slide 16 is an opportunity identified for the MCOs or by the MCO. So here's a list of things that I think the MCOs shared with [background noise on phone] with stake holders to go down and further analyze. This would be a good question for the MCOs to talk about when they come up whether they used the survey sample with their advisory council. That could be a very good question. It's something -- again, it's a lot of the results is giving opportunities for us to improve what we're doing with community health choices. There's -- the next one was [background noise on phone] less than favorable survey scores. So I think another opportunity for the MCOs. They talked about here on the third bullet about care member complaints and grievances with survey. I think this one is sort of like -- I kind of mentioned it already. We're getting a lot of information which is the first time ever because we really didn't have a survey [background noise on phone] the only way we knew there were issues was if they called the hotline number or they filed a grievance or filed a complaint. Now they have the ability to talk and share whatever issues they have ahead of time. This is only one data source. There's multiple areas where people have a

platform to be able to share their experiences and they can share their issues. They also have the MCOs they can report on [background noise on phone] but we also know [background noise on phone] have the ability to have that dental service once a year. We want to make sure that's happening. There's things we touched on from past providers to be able to provide information on that. We shared one of the slides that talked about consumers really want to make sure that they can participate in community events. They have access to friends and family, that issue is going to be important as we solve the transportation issue as Welch
as well. Yes, Mr. Blare. Is it an easy question? >> It's not a question at all. Just a recommendation to be considered. It talks about retraining oh -- of the service coordinators to readdress the issues, the person centered plan not containing everything. In addition to retraining, looking at the training itself and having participants and advocates to look at the training to make sure that it addresses those needs rather than just retrain with a training program that's already been in place. >> Thank you. Very good feedback. I'm glad you didn't have a question. >> Now I have one. >> Uh-oh. >> Were participants asked if they roved an in person assessment by their service coordinator? We are finding that many have only ever talked about the SC on the phone. >>I think the tool does ask whether or not they participated in their assessment and they do collect the feedback but I can follow up on that one to make sure. >> Any other questions? >>I don't have a question I have a comment. I thought Marie did a very fine job articulating which can be a dry subject and she obviously knows the facts so I just want to say very well done. >> Thank you. >> Thank you. >> Thank you very much. >> I'll come back. >> There's one more text. Thank you for the day response. Is there someone I can reach out to for data specifically? >> This or other data? Yes, you can contact me (wigonzalez@pa.gov). Do I give them my information. Is it on the -- is it on your slide at all?

>> No. You can contact Kevin Hancock. There you go. We will send that information. You know, again, these are all very, very high level. We hope that at a future date we can share a little bit more data on what has happened on the interviews that are occurring both in nursing homes and other interviews happening now across the state. So you have folks that are being interviewed in community health choices, both providers and con -- consumers. So we'll be able to share information as we gather it. Thank you for being kind to me and not asking too many complicated questions.

>> Thank you. Next up is an open session for questions with the MCOs. We have a few minutes. Do we have any? Jessie? >> So I just wanted to -- I just wanted to lift up -- I know we talked about in the past and it recently came out that people may have seen the governor's long term care council's recommendations on the direct care workforce. It's actually a pretty compelling report and set of recommendations if people haven't looked at it suggesting we need 37,000 additional director worker in the next five or six years to be able to meet the need. It's one of the key out comes we're hoping for in

CHC is to expand people to live in the community and we can't do that if we don't meet the need of the workforce. I hope I didn't prompt that. So if people haven't taken a look at the recommendations, some of the stuff I lift up is the idea of livable wages, standardized training, expanding the labor pool. My understanding is the recommendations were made actually unanimously that there was consensus across all the stakeholders that these *w*ere the key recommendations we needed to move forward on if we were going to meet the needs of the workforce. Staggeringly something like 46% of workers are on public assistance because their wages are so low. I think it's an Acute crisis that people here know a lot about. Actually today we have about 25 direct care workers from around the state who have joined us in the audience and who are --

>> [Applause] >> They spent the morning meeting with legislators and advocates and others to talk about the recommendations and try to move forward because we think they can be transformative if we were providing better services to people, lowering costs ultimately and making community living possible and to expand in the direct care workforce. So I guess what I wanted to really ask as a question is, what is the commonwealth doing to try to figure out, what is the department doing to figure out to begin how we implement these recommendations? One of the things we set out is each managed care organization would have a focus on workforce and improving innovating and expanding the workforce. So I wanted to put that question I guess maybe to the department and also to the managed care organization. >> So thank you, Jese. So as you know, in community health itself we have four areas of focus for program innovation, the gel -- the goal of the program. One is robust direct care workforce*. W*e believe that one of the tools the department has in addressing the crisis that we agree exists for the direct -- having a *w*orkforce that supports our program parparticipants is by having the managed care organizations work with providers and with direct care workers to be able to make the work -- tin credibly important the direct care *w*orkers do more attractive. Yearly focus for the CHC has been training. They have presented to the long-term care council as you know about their approached training and they have also been very, *v*ery open to feedback on the approached training. I think that if it's -- if I'm not mistaken the direct care representative used some of that kind of information for the proposal that you are developing for much more standard curriculum for direct care *w*orker training. He can answer whether that's true or not. Just from what I saw in the proposal there looked to be some over laps what the MCOs were proposing and what was part of the proposal that will be offered later today to the director of human secretary. Recognizing the training is one of three areas that happen to be the focus, we also believe that wages and benefits are a consideration as well. As part of the governor's proposed budget he has proposed an increase in the minimum wage and to be able to accommodate that increase this the minimum wage there's been a proposal to increase personal service rates to be able to meet the

proposed threshold and the governor has also proposed to have that wage increase be incrementally increased over a number of years. And the service rates would be modified either within or outside of CHC. So two of the three areas that we think are the focus of building out a robust workforce we have the frame work of a direction I think and we are working with direct care representatives and many direct care workers in the room for discussions how *we* can address the benefit question as well. >> So, Kevin, just to clarify, the -- >> If you can let me finish. >> I'm sorry. Go ahead.

>> Just we do have a meeting later on today. We have a meet and confer discussion with direct care workforce representatives to discuss these ideas and I think we'll be focusing on training later today if I'm not mistaken. Sorry for interrupting.

>> That's okay. So the state government can actually set the minimum wage for personal attendant care specifically?

>> That proposal is across the state. So it's not just -- >> Right. >> Potentially benefit the direct care workforce, especially if they have wage -- >> Okay. >> -- what is currently being proposed but it's a statewide minimum wage proposal.

>> Okay. >> I think we *w*anted to turn it over to the MCOs I think to chime in on Jesse's question as well for activities supporting the direct care workforce. I think that was part of the ask. >> Don't be shy. >> So we have three MCOs in the room and we are going to ask them to come to the table.

>> As you know*, we* have been working with the long-term care council. We actually presented a plan last year that looks at a training pilot program if you will. That will work with I believe approximately 200 direct care workers and *we*'re looking at basic CPR training all the way up to dealing with death and dying, complex healthcare needs, et cetera. And everything in between. With the goal that the training pro*v*ides the direct care worker with the tools and skills so that should they choose to further their career with a different type of care provider, either public or private, that they have that skill set and that frame work that they can then take to the next level and say to folks, hey, I have this -- you know, this 80 hour training program provided and this has given me skills above and beyond just the regular skills that I may have accrued throughout and hopefully that will set them apart from other direct care workers and offer them other employment opportunities that do have things like benefits and consistent hours, et cetera. >> So I worked on that sub committee. >> Yes. >> The direct care workers. Could you and the other MCOs address training direct care workers around issues of LGBTQ cultural competence? One of the big issues is having folks come into our hopes that are uncomfortable with orientation and identity and the role that, you know, cultural competence plays in receiving competent care. >> Dave, will jump into that. Will it be possible for the other two MCOs to answer their approach and then come back to the question. >> Sure. >> Hello. Senior director for long term services and support. In addition to training that we've been looking at implementing for the direct care workers, we're also exploring value-based purchasing models in our

contracting with providers with incentives that those would go directly towards the direct care workforce for higher payment incentives for quality work that would be driven down to the *w*orkers directly. So those are areas that we're looking at to incentivize and put that money back in and make that investment for them. >> Hi. This is Jen from Amerihealth care. I don't kno*w* where the question came from. Oh, hi. So I think that -- to give you a very broad answer, very similar to the initiatives it's learning what the needs are of the caregivers, the caregiver train and train service coordinators to be attune to that. That's a caveat to understanding where *w*e can direct support and reinforce

And then as we move into zone three learning what the different challenges are there, I think that's a fair statement that the challenge is on the caregiver and direct care workers vary based on geography. Maybe if they have several participants that they are supporting or working for. I think we're in a learning phase in trying to figure out the best way to plug in and impact change. >> So first of all, we can help with the learning phase to maybe help speed that up if that's useful. The second thing is I think UPMC addressed it but others didn't which is the question of enhanced rate for providers that are investing in the work -- in theory there's a return on investment for you all if you do this. Right. Which is that people say healthy in the communities longer because they have a direct care worker who is both well trained and sticks around because they don't go to another job because it provides benefits or a higher wage. So it's worth putting the money into the rate to end up with direct care workers who stick around longer and provide higher quality because it meets your goal of keeping people out of institutions and ultimately there's a return on investment. The commonwealth is tackle this and tackle that by increasing minimum wage in a *w*ay that then creates more resources to be able to put into the home and community based system but I think I just want to urge if the *M*COS think about that as part of your plan in how you lift up providers with enhanced rates in a way that will in theory lead to better care and keeping people in the community --|| mean, training is a critical, critical piece and I'm excited that people are thinking about implementing it and doing projects. As Kevin listed up, it feels like it's one of several piece that is has to be addressed as we move the ball down the field. >> Would you mind if we table your question in the next meeting because we've run out of time?

>> Yeah. >> *W*e can that as the first question for the *M*COS. >> I have a quick -- we have been meeting with the Pennsylvania health and wellness regularly as part of their advisory board stakeholder meetings and with UPMC and keystone, we need to hear from them.

>> *(*Awa*y* from mic) >>I have one additional question just to ask Kevin maybe. It's a little lopsided. I'll hold it down*. W*e'*v*e been asking for the past several meetings about the MCos on phase three and an action plan for phrase three and deep dive for phase

three and just wondering the that's on the agenda for the next meeting?

>> Can be. >> Thank you. >> Actually would you be willing to e-mail some of the things you would want to have hit on? >> Sure. >> We've talked about lessons learned already but maybe more useful discussion if we focus on the area that you *w*ant to hear about.

>> The main thing is these advisory boards that we hear from health and wellness and not the other two and be involved as stakeholders.

>> Thank you, everyone for coming and for participating and our next meeting is July 1st and we're back in the honor suite building.