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DATE: July 1, 2019

EVENT: Managed Long-Term Services and Supports Meeting

>> BARB POLZER: Good morning everyone we would like to get started.
We would like to start with introductions William, would you mind beginning?
>> SPEAKER: William Spotts.
>> SPEAKER: Jim Pieffer, leading HPA.
>> SPEAKER: Good morning, Nina Delgrande.
>> BARB POLZER: Barb Polzer.
>> KEVIN HANCOCK: Kevin Hancock, department of long-term services.
>> LINDA LITTON: Linda Litton, participant advocate.
Heshie Zinman, participant advocate.
>> SPEAKER: Drew Nagele from the brain injury association.
>> THEO BRADDY: Theo Braddy.
>> SPEAKER: Luba Somits, Bayada home health care.
>> BARB POLZER: Do we have any members on the phone?
>> SPEAKER: Yes.
Tanya Teglo.
>> BARB POLZER: Good morning.
>> SPEAKER: Estella Hyde.
>> BARB POLZER: Good morning Estella.
>> SPEAKER: Ralph trainer.
>> BARB POLZER: Good morning Ralph.
>> RALPH TRAINER: Good morning everyone.
>> SPEAKER: Neil Brady.
>> BARB POLZER: Good morning Neil.
>> SPEAKER: Rich Wellins consumer.
>> BARB POLZER: Good morning Rich.
>> SPEAKER: Denise Curry.
>> BARB POLZER: Thank you Denise. I'm going read the housekeeping rules please keep your language professional, direct the comments to the chairman and wait until called upon and please limit your comments to two minutes. All of our meeting minutes and transcripts are posted on the Listserv under the MLTSS meeting minutes we normally have them posted within a few days of the meeting.
The captionist is recording -- is documenting the discussion so

please speak clearly and slowly and the meets is also
being audio recorded this meeting is scheduled until 1:00 to comply with
the logistic call agreements we'll end promptly at that time, if you
have any questions or comments that were not heard please send your
questions and comments to the resource account for your reference the
resource accounts is listed on the agenda.
The skill aisles must remain open, please do not block these aisles.
Turn off your cell phones please throw away your empty cups bottles
-- public comments are taken during the presentations and instead of
just being heard at the meeting, electric is always additional 15 minutes
period at the end of the meeting for additional comments.
The 2019MLTSS sub-MAAC meeting dates are available on the Department
of Human Services now I'll turn to over to Linda for the emergency
evacuation procedures.
>> LINDA LITTON: In the event of an emergency or evacuation we will
proceed to the we will proceed to the left of Zion church on the corner
of fourth and market if require assistance to evacuate, you must go to
the safe area located right outside of the main doors ever the honors
suite, both OLTL staff will be in the safe area with you and stay until
you are told you may go back into the honors suite or your evacuated.
Everyone must exit the building take your belongings with you do not
provide your cell phones do not try to use the elevators they will be
locked down. We will use stairway one and two, to exit the building
for stair one, exit the honors suite, the hallway by the water fountain,
stairways 1 is on the left.
For stair two, exit the honors suite through the side door to the
right side of the room or the back door, for those exiting from the side
doors, or back doors, turn left, and stairway two is directly ahead of
you.
Exiting from the back door turn left and left again and stairway two
is ahead of you.
Keep inside to the stairwell, merge to the outside. Turn left and
walk down Dewberry ally to Chestnut street, turn left to Fourth Street
and turn left to Blackberry street, cross Fourth Street to the train
station. Thank you.
>> BARB POLZER: Thank you.
Thank you Linda.
Next we'll have Kevin give the OLTL updates.
>> KEVIN HANCOCK: Thank you Barb good morning everyone I'm going to
start with giving some updates on MLTSS governance and updates on
the community HealthChoices. Starting with MLTSS governance since, as
reminder since the medical assistance advisory committee legislated is
also something that is Federally mandated -- the just as a reminder on
the phone if you could mute your phones if you're not speaking,
appreciate it very much we're getting a lot of feedback.
But we go through a fairly formal process when it comes to the way

the committee membership is designed, since the managed long-term services and supports sub-MAAC is part of the MAAC structure it has to be a fairly formal a process that have to be followed and follows with terminations -- now we have 8 member vacations in the MLTSS sub-MAAC that is resulting from the fact that we have six members, who completed two, this is a four year old committee, will be a four year old committee in August.
We have -- 6 members who have completed two consecutive two year terms, people, six members who have been part of the committee for, for a -- for four years total. Those positions will have to be renominated and we've also had two resignations as well.
And -- that, leaves us with 8. We have two of the positions, nominations for the positions already filled we have 6, six vacancies we're looking to fill, if you have any suggestions or you yourself have an interest, please make sure you reach out to Marilyn or we'll go through the process, we're required to receive your resume or Vita, whatever you would designate your qualifications for the committee, it goes through the approval process as well, ultimately, the Department of Human Services, can finalize the appointment for these positions we will have six additional vacancies we're looking to fill at this point.
Please let us know.
Does anyone have any questions for that or on the phone?
Okay.
Great.
So, we'll jump into the CHC updates as well I have to apologize I am, one --
>> SPEAKER: I didn't get your here in time.
Are there certain categories of positions that are open or are they totally open?
>> KEVIN HANCOCK: So, we will not be looking to duplicate positions on committee, if we already have -- we think is a stakeholder group representative.
>> AUDIENCE MEMBER: Thank you.
>> KEVIN HANCOCK: Sure that's kind of informal.
I'm just, since Rebecca ask the question, use her as an example, one of the resignations came from representative from the area agencies on aging.
We will be looking to fill that position with someone else from another area agency on aging I already received a nomination from the AAAs to be part of the committee. That's just a great example thank you Rebecca for asking the question. Any other questions before I jump into the CHC updates?
Okay.
Great since the last sub-MAAC we did complete all of the provider sessions, what we're calling the spring provider sessions in the phase 3 zones, we completed in May, we had sessions in Lehigh

capital and northwest. And the June we had a session in the northeast. We had a lot of great questions a lot of attendance and, have to say that the transportation sessions, which were all day session were particularly engaging and we learned a lot from providers and individuals who are part of the stakeholder communities and those areas on, what the as is, is, in those areas. How transportation has been managed over a long period of time and, we're looking for opportunities to make sure that we're keeping what works and looking for opportunities to improve what is not working very well. So -- we look forward to, we look forward to continuing those discussions. And also have a lot of provider suggestions as well, largely characterizing what the sessions were like in phase 3. Unlike the two years of implementation, the focus for providers was really to get to know the MCOs to learn a little bit more about, the tack tickettal changes associated with the managed care. So what that means is that, providers all much the providers were familiar with what community HealthChoices was, and when they were attending they working to develop a relationship with the managed care organizations. And there were not really any surprises it was about nuts and bolts change to a managed care platform compared to fee for service less about education for what managed care is and what, community HealthChoices was. And, is -- and why we're doing this and more about what we need to do, to be ready for the change. So that was -- we I have to give a special shout out to a lot of the providers that -- participate in -- had already been through the transition to the community HealthChoices either in the southwest or the southeast. Their willingness to participate and discuss their experience, was incredibly helpful, especially for providers that were getting ready to go through the transition. So -- thank are thanks you.

>> PAM AUER: Quick question.

Are they all north? Are transportation providers, they understand that they -- are they contracting? Are they getting on Board? And -- thinking about our local area the -- I had a lot of questions and concerns about it, have they said they're getting on Board or getting connected.

>> KEVIN HANCOCK: That would be a better question for the MCOs it's my understanding that transportation providers are going through the contracting process.

But I would differ to the MCOs to answer that, I think that's a great question to answer.

Just, since -- the question was asked would someone from one of the 3 MCOs be willing to answer a status for contracting for network providers? I'll start with UPMC.

I'll ask them to come to the table, status for contracting network providers if you don't know at this point we'll take it back and make sure we get the answer.

So -- so okay.

>> SPEAKER: You know the -- as Kevin has indicated the process is ongoing and, you know we can, provide numbers you know I don't have anything with me right now, we will be glad to get that information out to you.
>> KEVIN HANCOCK: Okay.
Do you want to answer for Keystone AmeriHealth.
>> AUDIENCE MEMBER: I -- there we go.
I will say for MCM the contracting efforts, they have over 40 transportation providers currently under contract.
They're working with the rest of the providers I don't have the complete list of the names, where they're located today.
But that is something that we do monitor, especially after those transportation sessions.
>> KEVIN HANCOCK: Thank you Anna or Jenn?
Do you want to give a quick update from Pennsylvania health wellness .
>> AUDIENCE MEMBER: PHW shares a broker with AmeriHealth so -- as Chris said, there's a number of providers they're already signing. We are asking MCM to meet with us regularly we meet at least, monthly but we're upping that to every couple of weeks to get a status report on how they're doing with signing the vendors in all of the 3 regions of the State. We can get more definite numbers.
>> KEVIN HANCOCK: Great that will be something as part of a report next month. So -- great.
Okay.
So -- update, additional updates relating to phase 3 we have some updates relating to the time line, we've -- today is July 1st, so starting in July, we will be sending out the initial touch point flier that is going out -- July 16th?
>> AUDIENCE MEMBER: Fourteenth.
>> KEVIN HANCOCK: July 14th. Okay.
So -- the initial touch point flier which basically gives participants are going through the transition a heads up
they're going to receive mailings in the near future that will be going out on July 14th something will be done in the priority phases effective to give people an idea something is going to be coming their way.
In addition, in July, as part of phase 3, the overlapping requirement, we have -- with Federal government is the implementation of the electronic visit verification it looks as if there's going to be a informational webinar on EVV, July 9, 1 to 3:30 for --
>> AUDIENCE MEMBER: It was the 15th, they're going to start Monday 15th.
>> KEVIN HANCOCK: The touch point flier will be going out July 15th . For August, we will be sending out as we did in prior two implementations information session mailer going out

indicating where the sessions are scheduled to attend and how people would -- go through the process of registering for those sessions.
That will be going out in early August.
And then, the first round of pre-transition notices we don't have an exact date do we yet?
>> AUDIENCE MEMBER: Um, actually, I'll have to look for that, get back to you.
>> KEVIN HANCOCK: I think, Deloit, did send out a deck last week that had the dates.
>> AUDIENCE MEMBER: They did.
But -- you know, they're all still being finalized.
>> KEVIN HANCOCK: Tentative.
The first round of pre-transition notices will be going out mid to late August and, those pre-transition notices are formal notices letting people know they will be moving into community HealthChoices and, will also give instructions for people to go through a process of appeal if they think they're not a population that is appropriate for the transition in the community HealthChoices.
In addition to that, the enrollment packets will be sent out by the independent enrollment broker, immediately after the pre-transition notices go out and, those enrollment packets will provide instructions for what people need to do, to make advanced plan selection prior to the implementation for community HealthChoices. Also give the dates as noted on the next slide for November and December, for when plan selection has to be finalized or when, they would have to do a plan change for all of it to be effective on January 1st.
So July August and even September -- if you can go to the next slide will be very September October will be very intensive as it was in the prior two phases for participant communication and information to make sure participantses have the information they need to be able to do advanced plan selection.
We continue to provide to increase the number of individuals who are selecting their plans on their own. And, in the southwests and southeast we were around 40 percent plan section. We would like to be able to do better for the -- for the phase 3 it's going to be a tough challenge especially with the folks if they're not able or elect not to attend one of the participant information sessions we're hoping to have as many people do attend the participant information sessions.
Sort of an FYI, especially for individuals duly eligible, do not need long-term services and supports it's often the case they don't pay much attention that is happening to their Medicaid coverage that might be a reason why they may elect -- to go through the auto assignment process.
Through in September and October we'll have another session of provider provider meetings. The reason we're going to be having these provider meeting those give providers a more of a chance -- since they

have had communication with MCOs to talk about any challenges or concerns they may have about enrollments, credentialing or billing with the managed care organizations and we're doing that as a lessons learned.
We think having a second set of provider sessions will help providers feel a higher degree of readiness as they move into the final phase for community HealthChoices we think it's going to be particularly helpful since we're implementing 3 zones at the same time. For the providers to be able to be in a position to ask the informed questions after they have had significant lengthy conversations with the managed care organizations.
The pre-transition notices and enrollment packets will continue to go out September through October. As well as reminders to encourage participants to do advanced plan selection and then, we're also asking service coordinators and nursing facilities to have meaningful contacts with participants to make sure they have an opportunity to answer questions of parenthesissants especially, long-term care participants in the nursing facility or in the community, about what the change is going to mean for them, how they will feel about making a plan, selection or a plan change after the November 13th date which is the last day that plan selection will be able to occur before auto assignments. What they need to do for a plan change the last day for plan change, for effects I have to be January 1, is December 20th. So -- any questions on that.
>> SPEAKER: Kevin -- for southwest, parts of the State, this is Rich, have already transitioned, are there orientation sessions for new eligible people? Or is the population size insufficient for orientation session?
>> KEVIN HANCOCK: Good question Rich, what normally occurs is that, participants, if they're new enrollees will receive information from the independent enrollment broker. And then, the communication with new enrollees in the southwest and southeasts is a little bit more one-to-one.
The independent enrollment broker explains network and plan information, about the 3 managed care organizations. And then would walk through participants what they would need to do, to be able to select a managed care organization on their own.
If they're going through the eligible process for long-term services and supports they're given the opportunity to do advanced plan selection so that, they will be -- have contacts with their participants with the managed care -- participants contacts with the managed care organizations pretty much on day one. So, so -- part of that one-to-one communication by the independent enrollment broker would include the opportunity to select a plan in advance so the coordination would be able to take place fairly quickly.
So -- there would not be -- in other words there would not be ongoing participant sessions in the existing zones because the

enrollment relations is one-to-one between the applicants and the independent enrollment brokers.
So does anyone have any other questions about phase 3 implementation? Okay.
Then I'm going to jump into -- talking about the monitoring report update.
I think this information for quarter one of the -- 2019, is that correct? Okay.
So, just I'll highlight the first monitoring of the reported, which is Ops4, complaints and grievances.
This slide highlights the top non-long term services and supports complaints and grievances. This is for southwest participants in 2019. Highlighted here you'll see the formacies mentioned fairly frequency as the top non-LTSS complaint or grievance categories which is pretty consistent with the HealthChoices as well.
Complaint categories a Mary care it is gets credit for not having any complaints filed in quarter one and Pennsylvania health wellness had nonemergency medical transportation as well as some issues with customer service and then, UPMC had issues with customer service as well as -- questions about administration.
Once again that's non-LTSS complaints and grievances.
For southeast participants I think this -- takes us to 2019.
AmeriHealth Caritas had no grievances filed in quarter one. For southeast section, that's surprising for a new program, PHW, had grievance filed with pharmacy that's been our experience with HealthChoices and complaints customer service issues on the part of the managed care organizations.
The next report, to show is, Ops8 which is missed services this is starting with the southwest.
And, this shows, missed home health, home health aid and personal assistant services, for southwest participants, if a particular agency was not able to staff a particular as much as, this shows the total percentage still relatively low, considering the population for the southwest.
The this is the percent of hours an agency was unable to staff.
I think, it is -- it is for AmeriHealth for this says quarter 4, 2018 and quarter 1, 2019 they were all under 1%.
The next slide shows the southeasts quarter one, 2019.
Once again missed shifts and once again, below 1%. Actually, AmeriHealth Caritas, some value it was below even .00 -- 001 percent.
So far relatively slow, volumes in the shift reports regardless, missed services are something that have to be taken seriously by the MCOs they do. Most specifically for the long-term services and supports individuals receiving long-term care in the community and for personal assistant services.
They have to work out a backup plan to make sure that's in place

also to address ongoing provider issues if it turns out to not be an issue with providers being able to of is it a a particular service.
The next slide focuses on Ops8 for missed services relating to transportation. This reflects -- this slide here reflects missed trips for the southwest participants.
Including quarter 4, 2018 and quarter 1, 2019. These volumes are a little bit higher.
Reflecting, what we have heard with some of the challenges relating to transportation in the southwest.
And we're definitely looking at this data as a way to improve the program for the southwest. Certainly the southeast and also for the phase 3 implementation as well. It's kind of informing us what we need to do.
The next slide reflects missed transportation southeast participants very low volumes here as well.
We are -- we continue to be perfectly honest the southeast continues to have pretty consistent and reliable transportation, transportation systems so they use SEPTA I couple of weeks ago I lodged a complaint, I'm not where to file it, someone from Philadelphia can help me Nancy I'll ask you a little bit later
(laughter)
But -- we continue to state the reason why transportation, continues to be consistent and reliable in the southeast because of SEPTA we're grateful for their willingness to engage in talks with the community HealthChoices.
The next Ops report is Ops21 person centered service plan changes we're monitoring this very closely in the southwest and now certainly in the southeast at the end of the continuity of care period. This slide reflects, quarters 1, quarter 1, 2018 through quarter 1, 2019 the percentage of changes, we will note that the percentage ever changes continue to be consistently slow especially in the last quarter we've seen very few changes in plans.
And -- the calculation for this is the number of home community based services with service plan increases, versus the total number of HCBS participants. This is also including reason for changes as well.
The next slide shows the southeast there should be, this is quarter 1, it was within the continuity of care period. There should be very few changes as you will see on the slide there were very few changes to the service plan during this time period.
So those are the plans we're highlighting we do have the entire deck of, data for all of our ops reports we're collecting now available as part of the record for the MLTSS portion of the HealthChoices web site.
So we encourage you to go through any of that data, see if there's anymore information you want us to highlight as we continue to go through the updates.
With that -- are there --

>> SPEAKER: Kevin, Rich, did you say when you started off did you say pharmacy grievances were high or low? I forgot -- I could not, you went very fast.
>> KEVIN HANCOCK: Total number of, grievances complaints in community HealthChoices at this point, Rich is low.
Total number was -- total volumes.
Pharmacy, I would say for all 3 of the managed care organizations, is a frequent grievance for the non-LTSS population.
>> SPEAKER: Okay.
>> KEVIN HANCOCK: For physical health services.
>> SPEAKER: We talked on the phone about 3 weeks ago we talked about devoting some time at a meeting on pharmacy, which I don't think would be a bad idea I don't know what it would look like, who we would, it might be worthwhile discussing that.
>> KEVIN HANCOCK: I agree completely I think that we actually, we have had this conversation with a number of people in the room, there's a lot of physical healths services that merits a little bit further discussion with community HealthChoices and I think we're looking for a time at this point I've talked to Marilyn Yocum we're looking for a time to be able to make sure that conversation about pharmacy and other services is on agenda, it will -- we would have -- our pharmacy director we share our pharmacy director with the HealthChoices program Dr. Terry Cathers we would invite her to attend the meeting to be involved in the discussion as well as well the 3 CHC pharmacy directors as well.
>> SPEAKER: Great.
>> KEVIN HANCOCK: Great.
>> SPEAKER: Kevin is there going to be another part of the presentations today that will deal with the FED updates?
>> KEVIN HANCOCK: We didn't have FED updates on the -- on the agenda we can answer any questions you have about it.
>> SPEAKER: Well, I had a question about last month's report, whereas I understand it, um, 1157 FEDs went to medicine sexual review out of, there was a huge number I think, 20,000 or something and, so -- I guess I'm just wondering what was the process that kicks FED to medical review and then, is there any information available about the diagnosis of people in the FED process?
>> KEVIN HANCOCK: On your ladder question we would have to get back to you about that information. It is possible that, that information is available, it is not available on the FED itself, it may be available the physician certification so it is possible, to know that.
So, reasons for the medical review, number one, would be -- if there was a misconnect between the results of the FED, functional eligible determine and the physician certification. Say for example the physician certification came back as nursing facility clinically eligible or non-ing not eligible if the FED had the opposite result,

they would go through the medical review that's a example of a case that would be submitted for review. Another case that would go through medical review the assessors themselves, checked the box stating that they disagree with the outcomes of the FED they would ask for a medical review as well. There's probably a couple more -- do you want to throw out any other examples those are the two main and -- we are also sampling some other -- any of the outcomes as well to go through review. So --
>> SPEAKER: One point, um, it had been talked about, that if medical review needed some expertise that wasn't available in-house it would be called upon.
Is there any way to know if that's happening?
>> KEVIN HANCOCK: So, our medical director is not here today. I think that we've had that discussion with our medical Dr. Appel in the room I think that -- just, using the brain injury population as an example, we might ask brain injury subjected subject matter experts to be engaged in particular cases where the outcome, needs requires review, if they're found in the FCED, if there's suspected traumatic brain injury or any other type of cognitive impairment, that might undermine the outcome of the FED we may seek out subject matter expertise.
>> SPEAKER: That's what we're interested in, of the 20,000 that were done, um, we're not seeing any new people with brain injury being entered into services.
So we're just wondering, are they not applying? Or are they applying and not getting through the FED? And we're looking for a way to understand this because there's at least, 1200 people a year coming out of hospitals with diagnosis of TBI in the State of Pennsylvania.
>> KEVIN HANCOCK: We'll take that back we might reach out to you to talk to you about that a bit further we'll have -- we'll have to see if we've done any type of analysis on that, as well. I'm sure Marilyn is capturing this as a follow-up. Thank you.
>> SPEAKER: Sure.
>> SPEAKER: Just a quick question, do they go to medical review before it goes back to the participant? Or the -- patient who is applying to say they're NFCE.
>> KEVIN HANCOCK: It's possible the participant could know the outcome FED pretty much realtime. But -- if there's a misconnect between the two, so the participant may know or have a heads up of the outcome of the FED if there's a misconnects they would not receive the final determination until the medical review is completed.
>> SPEAKER: We're having difficulty sometimes where it comes back they're NFI, the participant disagrees called the AAA wants to appeal it sits and -- nothing happens they're not hearing back.
So -- that's what -- we're small.
But I've heard that through some of the other LIFE programs as well, just FYI.

>> KEVIN HANCOCK: I would say there was some slowness with the notices.
That may have caused that delay a little bit.
It's my understanding that the backlog for those notices have been addressed.
>> SPEAKER: It may have cleared up but there's been a big complaint that is happening.
>> KEVIN HANCOCK: Probably a current complaint I would also say it was a fair complaint.
(laughter)
There was a backup.
>> SPEAKER: Thanks.
>> KEVIN HANCOCK: Sure.
Okay.
Great questions we have a couple follow-ups from any of that.
Anyone else have anything for me.
>> SPEAKER: In regard to the assessment process are there any aspects of the assessment process that are notes appealable?
>> KEVIN HANCOCK: Interesting question. If they were determined to be NFI adverse action could be appealed by a participant I guess, um, outcome that would -- normally not be appealable is if the person was determined to be nursing facility clinically eligible the physician certification agreed with the determination, they're found to be clinically eligible for the program they would not appeal that.
That's -- a good question, any adverse action on the part of the participants in the services anything anything testify to the participant is appealable.
>> AUDIENCE MEMBER: They can still appeal it if it's NFCE they have a right to appeal any.
>> KEVIN HANCOCK: True.
>> AUDIENCE MEMBER: I don't know why they would, but it has happened.
>> KEVIN HANCOCK: It has happened with the OBRA assessments that's a good point, Randy, people going through OBRA assessments we did have people appeal that discussion so you're right, anything is appealable.
>> SPEAKER: So the collection of data, for example if the participant, wants some information included that information has to be included in the assessment process, during that assessment process?
>> KEVIN HANCOCK: It can be included as part of the assessment process, how it is included might be a specific question we would want to have, sometime in the near future we'll have to go through the FED process with this committee, so we'll have either aging well or -- representatives from the department, to go through the assessment process, to see if the information that they want included would be included.

>> SPEAKER: If the participants were found they were NFCE eligible for before, now found to be NFI.
>> KEVIN HANCOCK: That's happened.
>> SPEAKER: What is the process, and -- is there any number on how many people that has happened to?
>> KEVIN HANCOCK: It could happen, it could happen in the nursing if a sill or the community, it does happen people progress, to no longer requiring nursing facility clinical supports. It is appealable. So they can go through the appeals process if they disagree with the determination.
But --
>> SPEAKER: They will continue to keep their services until there's some decision made.
>> KEVIN HANCOCK: Yes. That's correct.
>> SPEAKER: Okay.
>> KEVIN HANCOCK: Okay.
>> AUDIENCE MEMBER: We plan on going over this process on the next third Thursday, because we did receive multiple requests and questions about this process, so -- we're pulling something together for the next third Thursday.
>> KEVIN HANCOCK: So just to repeat, Jill's comment, there will be -- the next third Thursday is going to be focused on the FED and the FED process, it was also something discussed in the consumer sub-MAAC as well I did notanda. So -- but I understand it went pretty well.
>> BARB POLZER: Pam?
>> PAM MAMARELLA: Sorry, I didn't see on the agenda or anywhere else I'm going to ask, what I've been asking about the -- home mods I thought we would get some data in July based upon the quality reports or something.
Where people are -- I have actually known someone who just recently evaluated for approval for ramp into his house, so -- that was in southwest. So have we gotten that where we are in the -- I know you're having your meeting later I'm not part of that, home modifications people are, but where are we with finding out anything about backlogs or -- because in my mind, access delayed is access denied, people are not getting their denials in the delay process, they're not getting the right to do pro I would really like to know what is happening.
>> KEVIN HANCOCK: Ive with an Ops report specifically dedicated to home modifications imanother not sure where it is in the terms of the data collection process.
>> RANDY NOLEN: That report is not active at this point, we did ad hoc stuff I have do have information on it.
>> KEVIN HANCOCK: Do you want to present it.
>> KEVIN HANCOCK: Why don't we call this tentative data, is that all right. We'll call it tentative data, at this point, if you --
part of the reason we didn't have it on the agenda because we have the

request from representatives from the zone 3 to go through readiness for -- just to be honest that's the reason we bumped it, we'll go through -- what's on the agenda next is to have the MCOs to go through the readiness and lessons learned that -- we want to give as much time for the questions as possible for that.
>> RANDY NOLEN: I'll give you a quick summary this is Randy Nolan, we're working a lot on home mods we have a meeting this afternoon as a department, we are starting to put together, what home mods we have pending internally for phase 3 and, to ensure that we have an appropriate list out to the MCOs to phase 3.
But as far as, phase 2, these are some limb numbers I've got from the MCOs they can discuss a little bit more.
For 2018, AmeriHealth stated they had 22 requests. They have completed all 22 of the requests I don't know if they were completed in 25018 or, since 2019.
And their average time for completion is about 75 days.
For PHW, they had 70 requests, in 2018, they completed 15 of those. They have an additional 176 in 2019.
Their average time frame for completion is about 70 days.
UPMC had 607 requests in 2018 they completed 412 of those. They have an additional 341, in 2019, this is all on the southwest right now.
And their average time frame for completion is about 204 days.
Then in the southeast for the first quarter, AmeriHealth has received 54, requests, PHW, 151 and UPM, 69 and -- AmeriHealth completed 13, PHW, 4UPMC is 4, the rest are in are in the process, they can talk more about that, those are preliminary numbers we have at this point in time.
time.Pam.
>> SPEAKER: Thank you.
Thank you I mean that's a lot of home modes, people waiting I understand, 200 days maybe I guess I should be asking them, I'm surprised that the 70 days and -- um, are they like real quick turn around real quick mods? I mean, those are things that, I would be interested to find out I'll leave that for the home modification, that's a lot of people waiting for home modifications.
Can we continue to find out where they're at. There was the first one, 100 some, 15 were completed.
>> RANDY NOLEN: That's some of the stuff I'm going it follow-up with them on, what are the home mods I'm going to ask for categories of home mods, bathroom modification, handrails stuff like that, whether it's actual physical changing within the house itself, widening the doorways whether it's a ramp, share glide that's the next set of information I'm going to ask for them, now I have this part of the day. Some of the delays is back and forth getting paperwork done to get the bids down, to get the paperwork needed from the service

coordinators some of that time frame is back and forth the hope is as they start getting this process moving forward and -- kind of worked out that, those time frames will go down once they complete that part of the process that's the biggest gap getting the paperwork done. Some of it is getting the contractors scheduled to come out do the work.
>> AUDIENCE MEMBER: Can you, maybe you have discussed this in the meeting later, the whole idea of just getting them in and doing the other part later. Having a policy around when they will do it, all before -- NHT3406 moves in, they should not be arguing back and forth if people know the individual are saying it's not person for safe for the person to go in until all the mods are done, you should have a policy to get someone through the system I don't know if I'm being clear enough here there needs to be something, that helps service coordinators know, how to get someone through the home mods process and, if it is urgent and, yeah some people can go with a ramp, go home with a ramp get the modification the rest done when they're in the home there needs to be a better process when someone needs everything done before they move in, that's just a --
>> RANDY NOLEN: That is something we can talk about at this afternoon's meeting NHT is a particular issue because of the time frames to be able to identify people and ensure they're both still eligible for, CHC in the community. So -- I mean that's, we put that process in place to address some of that. But it is still not a long enough time frame that will allow some of the major home mods to be done, that's ongoing thing we need to discuss.
>> KEVIN HANCOCK: Okay.
Any other questions for me.
>> BARB POLZER: Thank you Kevin, Nancy has one.
>> AUDIENCE MEMBER: CHC participant help line.
Um, is that supposed to take complaints? That number because, someone tried on Friday and they said they didn't, it was a different number. The number had changed.
>> KEVIN HANCOCK: The long term living CHC participant.
>> AUDIENCE MEMBER: Yes.
>> KEVIN HANCOCK: Yes, it is designed to take complaints.
>> AUDIENCE MEMBER: They said no, it was the wrong number. It changed to a different number.
>> KEVIN HANCOCK: Our participant complaint line did not change.
>> AUDIENCE MEMBER: That's the information we had 18007574416, they would not --
>> KEVIN HANCOCK: Come up to the table.
>> SPEAKER: That's -- so it sounds like that's the in Spiritech, CHC line that was put into place to ask, to answer questions. Prior to notices going out for phase 3.
They should be referring any complaints back to the department so if you have specifics about that, that I can take back and provide feedback

we can --
>> AUDIENCE MEMBER: Just the -- 833 number and they would not --
>> SPEAKER: Okay.
>> KEVIN HANCOCK: I mean.
>> AUDIENCE MEMBER: So I just wonder if it's going to be updated.
>> KEVIN HANCOCK: We've been pretty consistent with the help line, long term living manages we have it there to -- to take those complaints.
>> AUDIENCE MEMBER: That number has not changed.
>> SPEAKER: OLTL has not.
>> AUDIENCE MEMBER: This is not the line we're for taking complaints.
>> KEVIN HANCOCK: We need to complain.
>> SPEAKER: We'll make sure they understand they need to be providing the OLTL participant line.
>> KEVIN HANCOCK: That's what they should have done, give that other agency.
>> AUDIENCE MEMBER: They didn't, so the person didn't know what to do.
>> SPEAKER: Yeah.
>> KEVIN HANCOCK: All right.
All right thank you.
Thank you Kevin.
We're going to turn it over to Randy and the CHC MCOs to talk about phase 3 implementation and the lessons learned from phase one and two.
>> RANDY NOLEN: All right I'm going to briefly go over some of the lessons we learned from first implementations I'll have the MCOs come up most of the conversation should be with them today.
Some of the biggest things we learned was, communication.
Earlier more often, clearer, concise communication with participant s providers and advocates everybody involved with the program.
That includes, how to enroll, work with the IEB includes the fact that Medicare will not change.
Every aspect of the program, we need to communicate better so we have done some stuff in phase 3 with earlier provider meetings with additional provider meetings coming up.
We're going to do well over 70 or 80 participant related meetings.
To do education out there, that's probably the biggest thing to look at in regards to, lessons learned from implementation.
One ever the over big lessons obviously centers around transportation. We did not do a real good job in the southwest with transportation initially.
There was a lot of hiccups and bubbles with if.
As we worked with the MCOs and the brokers got them used to what they were supposed to be doing it corrected some of the issues that had occurred out there. Lumping transportation in the southeast, it was a

little bit better with the large partner SEPTA it helped out with some of the issues in the southeast we do recognize this is a major issue in phase 3 and all 3 of the zones as we move forwards implementation. So that's some of the biggest lessons we learned.
Some of the other stuff is just you know, responsiveness of the department and the MCOs to providers and participants, things need to move a little bit quicker.
I think we've learned we need to come clean up the home mod process a little bit more. We certainly need to clean up the nursing home transition process a little more. So we're trying to work through some of that stuff, so that we can do that. Like we said one of the big things we put in place is the allowance of the certifying that people in the nursing facilities will be eligible for CHC in the community. So we can start some of the transitional services. So that came out of one of the lessons we learned to try to assist with transition. So I think as we move forward that's kind of the stuff that we have seen, um and that we want to address in phase 3.
Probably the biggest concern besides transportation in phase 3 is network accuracy, network accuracy in the first 2 zones were well, all the nursing home facilities signed on and host of the hospitals did, a couple systems did not. In the southeast I think, network advocacy was -- we had a couple of hospitals did not sign with the plan, we continued to work through network adequacy, ensuring that people had access to the services they need.
Moving in to phase 3, that's -- my biggest concern.
I see transportation as part of the network concern. My biggest concern is having a enough providers enough specialty providers in the 3 zones in the phase 3, that's my biggest concern as we do readiness review and we work on netted work adequacy with the 3 MCOs to identify not only the nursing facilities and the PC Ps cardiology I was and others that the counties do not it is going to be the issue with the services, dental eye glasses that's unwith of the biggest concerns we have moving into phase 3.
So, hopefully, some of the lessons we learned early on, is to get the MCOs to get out and contract early and quickly.
With these providers to educate the providers, um, not only on CHC but on the builting systems on the processes, that they have to go through with the MCOs it's a lot of education going on with that.
So based on that, unless anyone has any questions I'll call up the 3 MCOs we'll have some follow-up discussion with them.
All right.
I don't have to escort you up here you guys can walk.
>> BARB POLZER: While they are approaching the table I'm going to read a question that came in over the phone that's going to relate to all 3.
Does either OLTL or the CHC MCOs have any comment about the recently

announced decision by the corporate owners of Hanneman hospital to wind down the operations at that center city facility.
How many CHC participants if any are in-patient at at the hospital, how many are duly eligible?
How many are Medicaid only what are the CHC MCOs plans if any to transfer the members that still need in-patient support.
>> KEVIN HANCOCK: So I -- I appreciate the question and it is valid question I don't think the MCOs are able to answer that question today, we could certainly have that reported back.
There's a department wide communication.
>> AUDIENCE MEMBER: Can you speak up.
>> KEVIN HANCOCK: I apologize.
So -- for likely the MCOs are able to answer specific questions today we'll make sure it is reported back there's a department wide communication strategy when it comes to addressing the issues related to the hospital.
So we're going to have get back to you on that.
>> SPEAKER: I can say broadly I know that -- UM departments are in discussion all the MCOs with the Hannehman team, they have yet to formally, notify us of the closure.
So, it is in the newspaper.
They say they're doing that the -- at least for Keystone we have not formally received a notice but UM teams are working together, with the hospital in the event we might need potential discharges. There hasn't been a formal notification.
>> SPEAKER: Similar on the health choices side for physical HealthChoices there's kind of a broad request for the MCO toss gather information through the department, very short term and transition plans.
>> RANDY NOLEN: Who wants to go first?
Go ahead Brandon since you're sitting next to me.
>> SPEAKER: When you called me up, good morning my name is Brandon Harris vice president. Government programs of the UPMC health plan I'll talk a little bit about some of what we've seen as far as lessons learned from the first two phases as well as where we're going from here, David is going to chime in here, keep me honest. You know I think a lot of our lessons earn learned are following suit with Randy indicated the first one is really you know, communication.
You know, early and often is, really the key I think you know we stress that at all the provider sessions it's more than just that as we look to find means of communication not only with, um, the providers, um, participants but also, you know various stakeholders engaged with us as we go forward that's a big lesson learned. You know something we're looking to do, provider communication, and training is another key element.
There were a lot of challenges in the first year as the new program coming forward and it is a lot of, interesting things there but -- you

know really stressing the importance of the training and working with our network teams to make sure the contracts are in place people understand how to bill that is something that is really big there.
I think, you know, two of the other big ones, eligible verification is another really big element that you know we really want to stress.
I think you know that's been one of the challenges especially given Medicare is the primary payor for the physical health as much ass that is going to get complicated as EVV comes along the line finally the last one is something we've really, been working hard to make sure we're able to do that is relationship building we continue to expand the footprint and work with folks we want to make sure we're really able to understand you know some of the needs that they have, build a level of trust you know have a relationship as we look to serve participants in the best manner possible. We look to phase 3 I think you know we all get a little bit concerned, you know we have a lot of challenges as we go forward there I think you know, there's a lot of things working against us the geography is one of the big ones you know the lack of population, density as we go forward you know.
Significant nursing facility population we're hoping to really kind of look at opportunities to rebalance there.
Access gaps Randy indicated as well is another big thing really limited transportation you know, I actually do have numbers for everybody.
You know we actually have 92 transportation providers that we're actually focusing on.
35 are fully contracted and we have 57 that are actually in process with us you know this is something we're trying to do early.
To make sure that we have all of the pieces in place so you know we have, mechanisms to be able to serve our participants going forward.
As we continue to go forward in phase 3 you know, engaging with communities I think we're actually, doing some things a little differently than we did in the first two phases which is, having more of a presence locally.
Engaging with various stakeholders at all levels of the system, to make sure they understand what the CHC is coming, what it means and how we can do the best thing to serve the participant when is if does go live in January. Network development is a big thing you know we actually have about half of the home and community based service locations contracted. Through the prior zones.
You know with the southwest and southeast folks serving greater geography there you know I think as we look forward we're really trying to ramp this up and do the best we can, to make sure that everyone is contracted earlier we actually, you know increase our communication and our education and trainings as we go forward as well. So -- you know we have, additional trainings and in person you know, education sessions for providers that we're going to be doing as well as looking at, how we

can do additional webinars we're looking at some additional opportunities above and beyond this is where we are at this point.
You know and -- we're really kind of looking to really make sure that we have all of the access I mean one of the things is we've been building our network throughout all of phase 3. And the 3 zones. So, we've actually, had significant progress there have our networks up and running but you know, again Medicare is the primary payor we'll work with that to serve the participants as we go forward. Additional education and trainings are coming forward. Finally on the transportation note I think again this is really one of the big elements we have there, we've made significant progress on this, we've had a long way to go, obviously. There's a lot more there and -- you know we're looking at a lot of different opportunities as we continue to go forward on how we can better serve and provide transportation in different means as opposed to some of the traditional methods down in the southwest and southeast. We're very excited about you know some of the new opportunities we're going to do, we know they're significant challenges we can go forward.
>> SPEAKER: Sorry, that was much louder than I anticipated.
We are also looking at -- encouraging every opportunity we get when we meet with providers to pay attention to publications and the materials that we're putting out there, to take advantage of the training opportunities we provide.
You know, also, pointing them to item that's can help prepare them whether it would be, cleaning up data, within their you know the current systems SAMs and, HIXUS, helping them navigate the -- electronic -- eligibility verification system, number of providers when we talk to, that they don't necessarily know how to identify which MCO they're in, so helping them understand how to pull that information from the EDS system to help them know who to work with encouraging them to get signed up with the enterprise incident management early in the process, so they can create those accounts just helping them take steps to prepare for the implementation in January.
>> RANDY NOLEN: All right anyone have any questions for UPMC before we move onto PHW.
>> AUDIENCE MEMBER: Mary Ann Colessa, originally from the great northwest.
Interested in knowing after the Attorney Generals came out, if there was any -- conclusions, guidance or -- suggestions that maybe are you're taking into.
>> RANDY NOLEN: Which report was that?
>> AUDIENCE MEMBER: Attorney General's report on possible discrimination for rural poverty and inability for service and access.
>> RANDY NOLEN: I'm not familiar with the turn.
>> KEVIN HANCOCK: Federal Attorney General. So the question was, if I understand correctly, is there any comment from the MCOs about the

Attorney General's report for discrimination for rural related services is that correct?
So we're not familiar with the report is it a Federal Attorney General's or the -- state Attorney General?
>> AUDIENCE MEMBER: Josh Shapiro's report. That's state.
>> RANDY NOLEN: I've not seen it.
>> AUDIENCE MEMBER:
(inaudible comment)
>> AUDIENCE MEMBER: She is talking about UPMC and Highmark in Pittsburgh.
>> KEVIN HANCOCK: Are you talking about the -- the what was announced by the Attorney General's Office as well as UPMC and Highmark about the ten-year relationship is that what you mean?
I think UPMC can certainly answer -- something about that.
>> SPEAKER: We absolutely can.
Yeah I mean there was an announcement last week, you know I think it -- it definitely opens up access it's not related to CHC it's broader when it gets into Medicare and some of those things.
That Highmark is going to have access to UPMC hospitals and facilities for ten years going in the future.
And -- that was assigned. So there's no loss of services as we look to transition there was originally thought to be, for July 1, with the end of the consent decree we have a contract electric there will be access there should not be any challenges.
>> KEVIN HANCOCK: Just a point of clarification, there's no Highmark insurance product that is directly associated with community HealthChoices al with you there's a affiliated Medicare advantage plan Brandon stated that will have an positive impact on services.
>> AUDIENCE MEMBER: Given your connectedness to my opinion, an excellent behavioral health managed care -- it really is, I wondered if you would be able to Eti (&f) y me on the preparation you're given to service coordinators in dealing with and understanding the needs of the behavioral health population within the CHC, thank you.
>> SPEAKER: We would agree that -- I'm not just saying this there's a representative in the back of the room we have a good relationship with an excellent behavioral health managed care organization, community behavioral health in preparation for implementation we've been meeting with they were involved in the southwestern phase as well at southeast we've continued to meet with them, to talk about opportunities with training we have worked with them to -- develop training for our service coordinators so we can make available to them.
About -- interpreting the tools that we use to help identify, individuals who may be appropriate for behavioral health and that's both on the nursing facility side and home and community-based side we have specific training on identifying characteristics of a participant that may warrant a further discussion for behavioral health.

We've also, just recently last week, recorded a webinar on making reservals and identification for behavioral health services we've made available to our service coordinators, so that they can,
they can have that on a recorded fashion to be using that for training on an ongoing basis.
>> KEVIN HANCOCK: Just to make a clarifying comment to ditched's point, we're assuming UPMC has a good relationship with all of the behavioral health organizations.
>> SPEAKER: We do.
>> KEVIN HANCOCK: Not only because it's a good thing to have, in place of the -- it's a requirement with the CHC complements as well as the.
>> SPEAKER: We do meet with all five behavior health managed care organizations on an ongoing basis we have developed similar training and also, participated in similar forums with each of them as well.
>> RANDY NOLEN: Any other questions for UPMC okay, Anna.
>> SPEAKER: Good morning everyone.
I'm Anna Keith vice president of the community relations for PA health and wellness, Jen Burnett is our senior director for operations for LTSS.
She is going to back me up when I miss something. So lit me see here.
I would be echoing everything that Randy said as a lesson learned but specific to PHW, being we were the new kid on the block, when we came into the State, a couple of years ago, we had a lot of learning to do, just about the State of Pennsylvania, its network the strong advocacy, support that the State has it is not common in all states, so -- aligning ourselves with messaging and how we supported listening sessions for advocates and associations to share with us what we needed to be aware of how we can be responsive was a real lesson learned. So we would, be able to address needs of the folks that were represented by each of those entities. So that was a good lesson learned. We continue to do that through sometimes over communicating but, better that than not.
So we tried to be transparent we meet with associations monthly. We meet with advocacy groups monthly.
And then, we have open lines of communication for folks to call us if at any point they have a concern that they can, they reach out to Jen or me, they -- and they reach out to our participant and provider line as well.
Then we triage it through our internal process. Communication has been significant in the way of doctors. A lot of doctors we found as a lesson learned didn't believe that they had anything to do with CHC had no impact on them.
So we have done a stronger outreach effort through our provider relations team to educate our doctors. We have a great

behavioral health coordinator who works with all of the behavioral health entities in coordinating services for individuals that she participates in the meetings as well monthly with the behavioral health providers.
Lesson learn has been our DME and moment mod processes. We begun over the last several of months working closely with SAMs so we can understand the challenges the DME providers were having try to at least come to a common ground even if we could not agree we could, we could at least listen to one another that's been a real positive move.
Transportation is different in all of the regions we recognize that.
And in a recent call we had with the ADAPT it was very clear we needed to be, hyper sensitive to the rural needs of individuals with transportation. So where the southeast we saw a lot of success in transportation, um, we did get our feet wet in the southwest with some rural areas. But even as recently as our last PAC meeting with the southwest group, they praised us on how much better transportation has gotten and how few complaints there are relative to the number of rides that are being given. That was a real Kudo coming from the consumers that they have seen a drastic improvement in transportation in the southwest.
So we hope we see that in the T zone we're able to get in front of those needs of folks address them. One of those has been a better understanding of the shared ride network how we can educate consumers about accessing it, and how we can participate with shared ride providers about third-party payments and ways we get innovative on how that is done.
And that came about as part of the provider sessions when we were able to get in the room with the transportation providers and everyone just sort of brain stormed and talked about the solving the problems.
SCE education, by far away has been our biggest lesson learned.
Service coordination providers across the State, through service coordination, 100 different ways, and understand PCSBs a 100 different ways bringing folks together for a single understanding of what our expectations are on PCSPs and providing that person to the table who is that person, has been a key to getting better plans built.
I can't say we're there yet.
This is a work in progress. But -- I think we're getting closer than we were, 1/1/18 by far. PCSP planning and training is a work in progress as well.
Just getting folks to understand including consumers to understand how PCSP works is a lesson learned we have to do an ongoing, effort to keep folks in the loop and listen to individuals and train, train, train . We can't tranche on good person-centered plan.
Working closely with housing authorities. Housing is different depending upon the region that a personallies in. So in order to be successful with nursing home transition we need to have solid

relationships with housing authorities and understand their waiting lists and get innovative with housing providers that are out there. Matt Jennigs , uses that word Coopiti cooperation, it takes all 3 MCO toss find housing solutions that's been a good lesson learn how important this is to coordinating efforts with one another.
And then pressing back up plans that's something we're still working hard to get done. So that, individuals have a backup plan especially if they're participant directed services. Where -- they have something to fall back if the provider does not show up.
Je next what else?
>> SPEAKER: I want to follow-up observe your question about mental health coordination, behavioral health coordination.
We have -- as Anna was talking about, person center service planning and our work with service coordination entities the existing legacy service coordinators that are out there and have been working in the fee for service for many years, what we're finding is that, there are many of them that don't coordinate with NM care and behavioral health that's what we're doing, we're doing a lot of work to train them and then, showing -- having expectations in our service level agreements with them and -- in our contracts with the service coordination entities, really under scoring the critical importance of coordinated Medicare and coordinating with behavioral health.
>> RANDY NOLEN: All right any questions PHW?
All right so we'll move onto AmeriHealth Keystone First.
>> SPEAKER: This is Patty Wright first thing I would like to do is introduce Missy Weakland, RN in the Commonwealth community for over 20 years, home and community based for minimum of 13 has just recently last week, so she is back is this is her third week has joined the AmeriHealth Keystone leadership team as our clinical director for LTSS as much ass.
We're thrilled to have Missy here on our team I wanted to take the opportunity to introduce her to everyone.
You're lessons learned are very similar to everyone else to kind of expand a little bit on the behavioral health as David and Jen mentioned there are team meetings I think it's important for everyone to understand it is not just limited to the MCOs, CHC and BH, there are -- there's a full team that is represented, so there are representatives from the counties, from nursing facilities, association, T triple AAs from the DSNPS which emphasizes as Jen mentioned really starting to build the care coordination with the DSNPs around the DSNP benefit as well as Medicare as well as OLTL and OHMSAS, that's a really robust team that meets. It is -- meetings are held in the southwest as well as the southeast.
I think that's one thing to continue to stress that as we move from phase to phase, it is not as if all efforts were put in phase 1 and then they moved to phase 2 and phase one is left behind.

So all of those meetings continue to occur, in all of the phases as we move forward.
Anything to everything that has been mentioner they seem to be common themes for all of us the one thing I would really like to stress is that, what we have really been taking a look at and based upon a lot of feedback from our participant advisory committee and our providers. Are things such as the major question that continues to be asked is, why does everyone have to go out, legacy participants and have a new service plan comprehensive assessment completed within the first six months? We're getting feedback from the legacy participants and some entities, saying that's a little bit of a struggle why does it have to happen? So we're spending time with the entities and participants in phase one and two and now in phase 3.
To help them understand the value to having us all all go out with the assessment with the new InterRAI tool and
the comprehensive plan, some of it, are you coming out because you want to look to decrease did he decrease services. That's not intervention. We're trying to -- there are a lot of new benefits the CHC benefit is a very robust comprehensive benefit packet. The previous benefit packets under the individual waivers varied.
So now, everyone has an opportunity to have a benefit of meals, potential pest eradication. So the message is we're trying to include the delivery to participants to be more response itch on the entities calling them saying I really need to get back out there, because within six months I want to build this plan but this is why I want to come out. This is the value to you as a participant.
So that's really kind of one of the lessons learned is -- helping the participant understand why the changes are of value to them. The other thing that we have received feedback and we're trying to improve the communication is around the trigger events.
The six trigger event in the contract indicates that if a parenthesis want makes a request, for a service, trigger eventses require the service coordinator to go out within 14 days, and complete a and complete a brand new comprehensive assessment that's everything the assessment the InterRAI tool, update the service plan and we're finding that there's a little bit of a different interpretation in that bullet 6 bullet. If there's a change in the participants doctor's a point. Everything was set up to occur on Wednesday the physician has changed that appointment and it is now going to occur the following week there has to be adjustments in the hours in their service plan for the following week to be able to accommodate the additional time. That's kind of an intermediate need. So that doesn't require the service coordinator to go out and complete a whole new assessment. We're finding that it is causing a delay inest gooding these intermediates to -- they have to schedule a full day or half a day, to see the participant look at it as a trigger event, complete everything all over again, where it's a physician, doctor's

appointment you can go ahead and enter that in as additional four units.
So part of that is the communication. We also learned that,
when something like that occurs and we become more knowledgeable about
the interpretation, that we have to share it with the home health
agencies.
We've been trying to educate the service coordination entities. Help
the participants understand why it is not a 14 day, it's not the
trigger event.
But we've learned in our recently participant advisory committee
that the direct care workers are receiving the calls, first.
So that participant is calling their direct care worker, to say -- I
can't have you come out to my doctor's appointment, because all
of this has to happen.
We're learning that if we better communicate those kind as we become,
have a better understanding of their interpretation of some of the
needs, a lot of these calls are going to these agencies first. The
direct care workers. So we're going to improve the communication to
the direct care worker agencies so that they understand, that when the
participant calls they can kind of a leaf some of the anxiety, no, let
me reach out to the service coordinator I can help you with that, that
does not need a whole new assessment so that's just some of the areas
that we're looking at to improve an overall communication. The last
is, we're beginning to receive more and more requests for power of
attorney from individuals that are also their direct care worker.
They completed it and then they become upset when they realize that
they cannot be both the power of attorney and their direct care
worker.
So we're going to start looking at how we can improve the
communication to our participants and direct care workers especially
those that are family members so they can understand that they may want
to appoint someone else as the power of attorney just again -- to reduce
the potential negative impact.
So -- this is --
>> BARB POLZER: People on the phone could you please mute yourself?
>> SPEAKER: Hello my name is Chris -- in addition to the items
you've already heard earlier about the education and communication
earlier with providers -- one of the areas, that -- especially as
we roll into the third phase is, understanding the service coordination
entities that are working together with vendors and that are providing
other services such as, transportation, such as meals, home
modifications, who those entities are working with. Because not all of
those vendors are enrolled as MA providers we may not know who they are.
It will be crucial as we move towards the implementation of the third
phase that we understand who those vendors are and start to have that
dialogue earlier with those vendors opposed to after January 1st. So
that is, one ever the areas from as we lead up to the implementation,

that -- we will ask all of those service coordination entity that's are performing those services, or -- billing for those services, um, and using extra other vendors to please let them the MCOs know it's not just Keystone First AmeriHealth Caritas, it is all 3 MCOs need to have that information as we move forward.
I agree with pretty much everything else that's been said about the training for providers I will not go through all that again.
Thanks.
>> BARB POLZER: I have a question commove the phone.
This is for all 3 of the plans what have the MCOs learned about how to improve coordination between internal and external SCs and ultimately improve the timeliness of issuing authorizations, begin services make payments. Have they made or are they making any system or operational procedures.
>> SPEAKER: This is Patty for Keystone First -- under our model the service coordination, the service coordinators whether they're internal or entities, they all have the same scope of work responsibilities and full access into our system.
So the service coordinators, internal and external have the ability to go in once they have developed the service plan and put in the auths themselves.
We continue to do education around the Auths as they relate to PPL that's a change.
And entities are -- and direct hires, that came from entities are kind of still struggling with you have to put it according to the days of the month, versus a wide range with you know, with one core number.
And the other thing that we have begun to do, we have case rounds that are led by a doctor McCallister and CFO and Dr. Murphy the director of pharmacy, those case rounds are extended to the as much as coordination entities.
And we think it is very helpful because we kind of help them identify cases that can come to case rounds.
And begin to help them understand how to view the physical health services that are being rendered, the pharmacy the role of the medication, role of the pharmacist and we think that has -- the feedback has been it's been very helpful from the entities to help them have a greater understanding of the physical health as well as the pharmacy as they look at the whole person under the plan of care.
>> AUDIENCE MEMBER: I have a question.
My name is Louis, physical a adapt, my question is that -- all 3 of you all, when you change over to your -- we don't get no letter saying they're going to change your model, it is going to be different.
It does.
I go to the pharmacy, I get Huminal and Lantis -- first, it was my high blood pressure.
I went over there -- called you can't get that no more it's changed.

And this is has been a problem because, if my doctor tells me I understand.
When my pharmacy tells me that the -- insurance people changed it, that's a problem.
Because now, I got some medicine I don't know.
I don't have -- Humidal, Lantis, my other pill all that changed.
That's when PH wellness first then Keystone.
Why did you change the medicine that's what I want to know.
I've been taking it for so long --
>> SPEAKER: We're certainly I think it might be better one-to-one the service coordinator doesn't change the medication.
>> AUDIENCE MEMBER: I'm not saying the service coordinator they said the insurance people did.
>> SPEAKER: If there's Medicare primary, Medicare first under part D has a certain formulary I don't know if that changes.
>> AUDIENCE MEMBER: That should have been in our paperwork when we changed over to this, to that person -- they said, you get eye glasses you get your teeth done you can get -- this, they never said we're going to change your medicine.
>> SPEAKER: Okay.
I can -- I'm certainly, happy to help you look into that, because -- again the service coordinator would not change that, your physician may change it, or the pharmacist may change it, based upon a certain formulary I know that's one of the discussions --
>> AUDIENCE MEMBER: Pharmacy told me because -- you all had too many people you can't afford to get that medication they gave me that I'm -- I'm tell you, the truth I'm not going say a lie but what contusioned me is, how do you know my health how do you know that I can take that medicine it will help me. The issue is you changed it.
>> KEVIN HANCOCK: One clarifying question do you have Medicare or as your primary --
>> AUDIENCE MEMBER: I have Keystone now.
>> KEVIN HANCOCK: Keystone for community HealthChoices.
>> AUDIENCE MEMBER: Keystone First.
>> KEVIN HANCOCK: Are you Medicare recipient as well.
>> AUDIENCE MEMBER: When everything changed I don't know what I had to -- I found I just got Keystone that's it.
I used to have both parts.
>> KEVIN HANCOCK: Patty, would you --
>> AUDIENCE MEMBER: There was nothing if you want to educate someone -- educate the consumers.
These -- we are all the -- the ones you'll take care of.
>> KEVIN HANCOCK: --
>> AUDIENCE MEMBER: You can sit on the Board and talk about everything, everything is improving everything is good, everything is that. When it comes to us it's like what happened?

Why are we not educated.
>> KEVIN HANCOCK: Keystone is going to talk to you about your particular service.
>> AUDIENCE MEMBER: How about other people that can't speak for themselves and people that are scared and the people that are going through the problems they ain't getting their medicine they have to wait until the insurance people covered it I had to wait a while for my stuff to come because they changed it.
>> SPEAKER: So let me speak with you, because -- once I understand that situation, then, it can help me understand that situation -- and then, that way we can see if it is impacting anyone else.
And then, that way we can go back -- take a look at that.
>> AUDIENCE MEMBER: I appreciate that, I appreciate that, it is that point that -- before anything, anything that -- all this occurred we should have studied it more and have more education of it, instead of messing it up, because -- when I had health partners I nerve had a problem with nothing.
I never had -- I'm telling you I've been -- I've been here yall, when you go to court you come with everything.
We didn't have this today I don't have that for you today, but I have it for you the next time this is this and that. You all are confused.
Because I'm confused.
That's all I'm going to say.
>> AUDIENCE MEMBER: Check on your appeal rights.
>> SPEAKER: Kevin do you require member notice of formulary changes.
>> KEVIN HANCOCK: Yes we do same as HealthChoices.
>> SPEAKER: This is Shaylin, north central PA ADAPT, what Luie is getting is the lack of -- easy to understand information that is being distributed this is something that we brought up with the past two roll outs.
Is that all of the information that is sent out is very difficult to understand is not -- in an easy format and we're talking about a vast range of people with different intellectual disabilities, reading abilities we've asked several times if we can create different documents to go along with those documents, because we understand they are necessary or mandated what have you.
>> KEVIN HANCOCK: We get sued a lot.
>> AUDIENCE MEMBER: We're not saying to toss those out send something else in, we're asking in addition to these very confusing documents, having one behind it, that says hey this is something that is a bit easier to understand and this is what it really means, explaining some of these things, that people are now experiencing afterwards. Because they did not understand beforehand.
>> KEVIN HANCOCK: I agree about the point about sometimes the readability of the materials we send out, most of the language that is

part of the notices for example, including the changes in formulary notices is driven we a past legal action we try have
readability requirements that try to make the information as accessible as possible the reality is we're challenged by operating in a context where a lot of what we have to communicate has been driven by past legal challenges to the process.
So I agree with you, we have tried to also send clarifying information as well.
But as we continue to try that, the alternative complaint we receive is people are receiving too much information he in their information in their packets we're trying to find alternative feedback.
>> AUDIENCE MEMBER: Is there any way for the MCOs to provide the extra information to folks that is easier to understand?
>> KEVIN HANCOCK: Lot of the information they send of the participants like the changes to the formality Larry has to be approved or reviewed by the department.
>> AUDIENCE MEMBER: Even stuff like -- the enrollment, like this is coming for you these are the possible thing that can happen, when you change to PA health wellness your medicine might change your you know, whatever it is, those types of things your doctor, you might need to change your doctor.
Those types of easy, okay, I understand this, I know I need to get on this.
And, fully understand it. With the -- all that other lovely professionalism stuff.
>> KEVIN HANCOCK: I'm just -- I'm just being as transparent about this as possible. We're doing our best. But, we are constantly constrained in the communication in anything we try to send out that is driven by challenges. But we are very open to feedback on specific items, seriously we will take any type of feedback we can't guarantee we'll be able to make the change we'll definitely try.
>> AUDIENCE MEMBER: If we give specific feedback on these documents you can't change them you said that.
>> KEVIN HANCOCK: It's quite possible we may not be able to change it, we may not be able to change.
>> AUDIENCE MEMBER: This is the feedback.
>> KEVIN HANCOCK: I'm just going to have ask you to be more specific.
>> AUDIENCE MEMBER: Okay.
Itch another question. Um -- I know over arhing theme I've been hearing from the all 3 MCO this is is direct the to all, we need to do education sooner and earlier and, more.
Each heard some steps towards that. But, just wondering if you know I hear that the first flier is going out next week or a couple of weeks but if provide -- if the MCOs are going to providers, I've noticed, living in Williams port that is sometimes we don't have the

pleasure of associations for physical therapists all those lovely networks that exist in some of these more urban areas. And I've noticed primarily, as working out at the Center of Independent Living in north central PA you have to go knock on these doors to get people's attention, to sit at their tables and learn and, just communicate and, I'm just wondering if that's a tactic MCOs are considering for education purposes you know physically going to these places calling them and saying hey this is what is happening instead of hoping that they come to these information sessions?
>> SPEAKER: I can start.
So Shaylin, we are actively on the ground in Williamsport and other communities Scranton, Allentown, York all over the place.
Personally I've been out to Williamsport several times met with Misty listened to feedback we've gotten where we need to make sure we talk to folks at least with PA health wellness we're not sending materials out saying we hope you read this and understand it. We do have a provider relations team out, we have our community outreach team out doing a lot of face time with folks throughout the team.
>> THEO BRADDY: I have a question.
Follow-up --
>> SPEAKER: Kevin, this is -- I had a quick question.
>> THEO BRADDY: What Kevin was saying -- if -- any user friendly -- document, you created on the web site?
>> KEVIN HANCOCK: Theo, Rich I think you had a question, Theo,.
>> SPEAKER: It's hard to hear. Yes, did you say you approved all formulary changes? Your department approves all formulary change are changes.
>> KEVIN HANCOCK: Department looks notices that the MCOs sends out when it comes to formulary changes we may not be engaged in every single change of the formularize.
>> SPEAKER: Who makes the changes the -- the MCOs?
>> KEVIN HANCOCK: MCOs.
>> SPEAKER: Or Medicare.
>> KEVIN HANCOCK: Depends. It is both actually.
The Medicare or Medicare advantage plans may have their own formulary and if person has Medicare part D as their primary pharmacy payor that would be -- that would be something that would be directly relevant to the prescriptions that people are receiving.
>> SPEAKER: Okay.
Thank you.
>> KEVIN HANCOCK: Sure.
>> THEO BRADDY: Okay.
No problem. My question is, is there any user-friendly thing that can be created on the web site we can promote to get to some of these scenarios things that occur that consumers would need to know? For example, a change in medication?

You know, again, what is the direction that person should go you know should they call the MCO directly or talking about some user friendly things that people need to know.
>> KEVIN HANCOCK: So the answer would be yes, I think we're close to developing a participant training webinar that could include some of the suggestions that both Shaqlin you and had for what could be included in you know, making sure participants know what they need to pay attention to.
>> THEO BRADDY: Plain English.
>> KEVIN HANCOCK: Like I think the participant training webinar I think, participant informational webinar might be be able to help as well. Another area is the participant sessions is part of the roll out for community HealthChoices this is, something that is always ongoing. Just with pharmacy there will always be formulary changes. There are notices that go out to the participants the formulary changes having participants know they have to pay attention to that ask their doctors what this means for them is -- what we would like to be able to see. And if we can figure out a strategy, that goes within our legal framework to be able to appropriately communicate to people meeting the requirements of many past legal decisions that may have occurred in addition to making sure it's accessible for participants is the balance we're trying to achieve when it comes to all of this information so --
>> RANDY NOLEN: I want to comment really quickly about the MCOs answer the question.
>> SPEAKER: As a consumer for UPMC, I'm on the UPMC, my son is, I have a pharmacy card.
So -- I call the pharmacy number, on any formulary changes just to double check they go back to the doctor. Because sometimes when there's a formulary change the doctor has to be contacted to prescribe the new script. But -- other than some things that are not covered, one or two, where you have alternatives, it has been pretty smooth process.
So I don't know if the other MCOs have a pharmacy department number but -- as a consumer that's what I do. That's very helpful.
>> KEVIN HANCOCK: Thanks Rich.
>> SPEAKER: To your question on you know engaging participants I think you know we're absolutely starting to be out with meeting with communities and engaging what we talked about is round tables things like that, you know beige for not only for as we ramp up with phase 3 and the other two zones to get feedback we have the participant advisory committees that are available there one of the challenges we have though, unfortunately we don't have members in phase 3, until January 1, a lot of what we do is we're piggy backing what the departments is doing around -- participant engagement we're getting out there we're looking to actually do more to really educate folks so they're prepared for when the change comes.

>> KEVIN HANCOCK: That's -- are you talking about providers education providers.
>> AUDIENCE MEMBER: I was.
>> SPEAKER: Providers -- yeah. So provider education, I'll -- I'm a little confused this morning. Sorry. Yes, absolutely we've started webinars we started doing round tables we started engaging with folks you know the first thing is getting contracts signed and as soon as we have that we have that relationship we can take it from there we are looking to get feedback and do more of those education sessions that's what we talked about, which was really communicating early and often there's webinars in person trainings we're doing a whole variety of different forums we want to bring it local to to be able to support folks within the communities and -- we have a vested interest in Williamsport as you know we're -- really looking forward to -- to expanding that and really engaging with provider as we move forward.
>> SPEAKER: For us it's the same, we have an accounts team that is, very provider specific so they are in and out of the offices, the other thing we're doing kind of ties into the lessons learn is, we're trying to help the physical health community understand those participants that will be transferring from HealthChoices to CHC.
So that their Medicare does not change so if they have Medicare, their primary physician does not change. However, it could be that they, if we're talking about phase 3 let's just say they have Geisinger or someone up there, that this individual may still have Medicare but they may now have a new CHC MCO, so we're trying to help educate them so come January they're starting to look and ask about a different ID card, but again helping them understand the transfer, the CHC program and then the fact that this does not impact their Medicare. Now, Randy if I could I know she has been trying to ask a question, may I hand the mico over.
>> AUDIENCE MEMBER: I had a question earlier about the authorization issue with PPL.
I was just wondering because I know it's an ongoing issue I know everybody has addressed it, but for the, 3 MCOs, do you guys have any insight as to because it's an ongoing issue what participants can do? Like rather than just say oh you have to call your service coordinator or you have to call your service coordinator, if the service coordinator is not getting these things addressed quickly enough or, there's still some kind of other hold up, there's -- directed care workers that are not being paid because of the authorizations, are not being you know dealt with, so -- you know, in the sense you do have service interruption because you may have family members so they don't have agencies so, they're still maybe receiving care the direct care workers are not being paid I'm wondering if the -- MCOs particularly have a -- specific department or, a specific phone number because I have a lot of friends and colleagues who have all 3 of the

different MCOs and a lot of times get the run around about oh your coordinator has to call, the coordinator has to call. Now for myself, my particular MCO, I was able to call for myself and, they were able to get me to someone in their specific department.
That was able to fix my issue. But for the other two, I have allots of friends who are getting the back and forth it might be fixed one month and then there's a whole other 3 weeks before their attendant is getting paid or they're still as a lapse in service, I'm wondering if there are any numbers or -- departments, specifically that they can call on the MCO hot line number or what they should be specifically be saying when they call to get help with this answer? Because having your service coordinator just do -- just saying your service coordinator must do it is, is not answering when people are not getting paid. You still need the services.
>> RANDY NOLEN: I'll let you answer that Patty.
>> SPEAKER: Yes so -- for Keystone AmeriHealth that we do have the contacts and our line which is the 24-hour line and our personal care connectors, so if you were to call into there and, they -- we have what we call an expedited communication process, so they would be working with our personal care connectors, that are there to support all of the service coordinators, and they have the ability to go in and correct those flaws. It is a challenge, because of the monthly day and I don't know if there's any way for PPL to change that but -- um, it is a challenge.
I personally, I can't remember how many days or in each month. Other than February is 28 that's all I can tell you.
So -- so that it is a challenge, but we have an expedited process that the contact center is 24/7 and we do have that process to help.
It is, it does continue to be one of the challenges that we all keep working on and trying to help understand how to calculates those units, based upon the number of months, days within each month.
>> RANDY NOLEN: Let me put it on your radar there will be 29 days on in February,.
(laughter)
>> SPEAKER: Leap year?
>> SPEAKER: Reelection year.
(laughter)
>> SPEAKER: Our process is very similar to that.
Which Patty described we have (866)626-6813 number you get our participant provider services line.
And -- they can pull up an authorization they can take a look at it, talk to you about it.
You don't have to go through your service coordinator to get to that line. Call us a participate as a participant and ask
service, if you feel like you're not getting responded to quickly enough then you can ask for to be escalated to a supervisor then they can move

forward a little bit more. We've got to really -- we have a really strong team we have got a lot of stuff to address those questions so you should get a response timely.
>> SPEAKER: I would suggest that you ask if you should say something or tell the person who you're working with, to say something, -- say you have a PPL issue, if there's a PPL issue we have specialists that are just dealing with, P PL pretty much all they do, they will get right to that specialist opposed to a general program coordinator.
>> SPEAKER: Sorry we have a similar process, you know -- and I'm getting hungry sorry if you hear the Gurgling on the phone.
(laughter)
We have a process where you can call into our service coordinat ation line if you indicate it is a PPL issue they can help address that for you.
And you know, we have special unit that works on PPL cases that, can resolve them fairly quickly
>> SPEAKER: Thank you.
>> SPEAKER: Just wanted to add one other thing. Individuals that -- participants have access into the PPL's portal to see the authorized units if there's a challenge that you see up front you don't have to wait until the back end, you would be able to start that outreach a little bit sooner, prior to pay roll period ending trying to get that resolved up -- the they have the access to be view that.
>> KEVIN HANCOCK: Before you move on I would like to jump back to pharmacy for a second. So points of clarification, first of all our pharmacy director does approve all MCO formulary changes.
So, tear the doctor does approve the formulary changes.
So, we do have a letter that does go out I had mentioned, but that is something that is approved by the departments and -- the department is also moving towards statewide preserved drug list or PDL as well.
So, in addition to our existing approvals, a future change will be that the department is actually standardizing the drugs that will be available through the even the managed care organization plans, that does not include, that does not include, none of this effects a person's Medicare part D coverage which is their primary coverage for pharmacy services if they're on Medicare and have Medicare part D. So sorry.
Noel Noel I think we have a number of questions around the table we'll start down here.
>> AUDIENCE MEMBER: This is Dan from liberty resources Philadelphia center for independent living.
Um, and I have a question that is more for the department and a comment first about the MCOs are welcome to given put too.
Especially with the consumers here and advocates talking today about issues they have experienced, it kind of has raised a concern that we've seen that has to do with providers. Specifically home care providers in the Philadelphia region, specifically.

We have noticed a trend concerning that's been happention over I say since the beginning of CHC starting I know these issues have occurred prior to COC they're welcoming more relevant to us, witnessing it.
Where you know a population both the disabled and/or aging who is already vulnerable at this point as you're hearing some of the issues they're facing, or seeing them being targeted I would say, by these home care agencies and some cases where home care agencies are placing ads in newspapers that state they're giving gifts to consumers which we know is a clear violation of Medicaid, Medicare. We have seen other cases where the home care agency will promote themselves as family to the concerned. We have seen other cases where the home care agency will promote ads that say as an -- a potential attendant if you have a family member who may be eligible if we can get them enrolled and, have you start working for them.
We witnessed this. We've heard about these before, but now we're seeing it with our own eyes. We had a case last week at the CIL we share a space with a large SC agency who is handing out non-medical transportation passes to their consumers.
Where we had an agency out the front door soliciting handing out pamphlets and business cards to consumers as they were getting their trnans pass, which is something we nerve do, because we believe in choice we welcome providers to comes to the CIL with permission beforehand. Or -- the SC agency getting permission beforehand, in this case they did not have that.
And this is not the first. So we are seeing a trend.
And another trend that I would like to point out too, there are businesses that operate the promise that anyone become a home care agency with as little as 15 hours of training and 3-4 weeks to get enrolled.
We call them mushrooms in Philadelphia they pop up everywhere, there's not a street you can go down you won't see an ad or billboard or a bus that is offer covered with a home care agency, some of these home care agencies are legitimate have integrity a lot of them do not.
We're also starting to see some of these practices spread to the SC side, but we cannot say for certain it's fraudulent or deceptive we have heard of a situation where an SCE started the transfer process or requested the transfer process of the -- of the consumer from one agency to theirs. Thankfully the current SC agency was able to capture it, before it happened, before it was completed and stopped it.
But again, it really feels like the wild west right now in Philadelphia with some of these providers. So I guess the question for the department is -- are there any processes or discussions being had that talk about handling this prior to what it was before CHC, and -- what's plan? Can we make this a priority? This really as we've heard today from consumers that are having issues with other issues, they can easily be targeted by some of these companies, with these promises.

>> KEVIN HANCOCK: So, thank you Dan.
We have heard about these issues longs before CHC and to be perfectly honest it's mostly in the Philadelphia area.
And we agree it is -- very much the wild west. Prior to the implementation of community HealthChoices and the fee for service system we had to go through a process we would have to have a credible complaint and, we would have to go through a pretty significant investigation process that would take into consideration due process for having someone removed from the Medicaid fee for service system. It is very lengthy, it is sometimes can involve auditor general, Attorney General's office, inspector general's office, bureau of program integrity it can take a very long time.
So one of the -- advantages of the managed care to be perfectly honest is that, we have Federal authority in communities HealthChoices to wave the provider requirement that is in place for any -- for fee for service. So the managed care organizations have the opportunity in community HealthChoices to get rid of these providers, without having to go through a Medicaid disenrollment process H is lengthy and can sometimes take years. With that I'll turn it over to the MCOs to talk about how they themselves, are evaluating provider qualifications as part of their credentialing process and, how they, are addressing these providers, where you know they're engaging in the nephareous practices we'll start with Pennsylvania health wellness, you know we'll start with UPMC
(laughter)
>> SPEAKER: We have a standardized credentialing process for all providers that our contracting department follows. But, I mean I know where you're going with this Dan. So I can tell you the -- what we've seen in the last 18 months and how we proceeded with that.
When we identified a provider, for example, with the ghost address. We -- we start our investigation on that as to whether or not they actually exist we found providers with --
(inaudible)
As their address we turned that over we worked with the -- we work with OLTL Kevin's department we work with -- the office of business integrity we have submitted, concerns and complaints over to the State for investigation in the Attorney General's Office, we have also recently added our own internal investigations group to look at complaints that have come through we have a weekly progress abuse work group we're looking at certain things that come through and decide how they are getting investigated based upon our contract and requirements that we follow.
We recently made the decision based on quality metrics that we put in place and communicated as much as coordination entities for several months as to what we expected from them, in order to maintain a relationship with us and then we'll be exercising our rights as Kevin

described to terminate the contracts with service coordination entities have been nonresponsive, have been unwillingly to meet qualities standards and over all just having unwillingness to partner with us as we reach outcomes
>> SPEAKER: Can you speak more to home care agencies we understand SC agencies and stricter requirements as far as what the
State put in as far as credentialing any credentialing is the Department of Health and MA enrollinged with one other business insurance requirements there's no real true credentialing outside of this one company that promises 15 hours of training.
>> SPEAKER: In the spirit of transparency we have focused so much understand on getting service coordination right that will be our next big mountain that we climb but -- at present, when provider relationships teams go out to home care providers they find the entity doesn't exist or they can't validate their credentials we don't proceed with them.
Give us a little time I'm sure by there time next year it will be a different message it hasn't been our primary focus as far as service coordination.
>> SPEAKER: So, yeah. I mean I think you know, from UPMC side of things we take the credentialing process very strong, post continuity of care is obviously a big question as we basically take everyone during that continuity of care period. Once we get through that, I think that's where, if you know of some of these agencies you've heard please let us know we eventual will a provider moon toring team in each of the zones that is going out there and actually monitoring providers we started in southeast actually and going in we're looking and doing audits along those lines. So the extent that you have some of these things please let us know we will be glad to look at how we can potentially aggression that, because that is not acceptable behavior from our perspective.
>> SPEAKER: I would say similar to some of the items that Anna mention we have a account executive team as we receive any, you know, information that, provider may not be there or -- you know, soliciting and should not be they will do that outreach initially.
We do also have our specialty investigations unit we work together with, so they will actually, conduct the internal investigations.
In conjunction with various departments such as quality network, legal as appropriate, you know we have we've gone to offices where we sent someone out with pictures where the mail is piling up because that's the address that is, listed maybe they vacated the premises there's nothing there, and again, it is -- it is not a short turn around time there's a process to take place.
Where you will make the referrals to the program integrity that will follow through the process as well. So it is not a -- that is going to take some time -- again --
>> BARB POLZER: People on the phone please pollute your lines.

>> SPEAKER: We're notes waiting unwilling the end of COC, as we received these we have started that process now, it is -- it didn't have to waited until end of continuity of care part of -- any willing and qualified, is your following the rules you're doing what you're supposed to do throughout the process, we don't have to wait for July 1st.
>> SPEAKER: Thanks Chrissy would like to go on record strongly encourage the department to consider, pausing or limiting provider enrollment, until the MCOs can figure out what the process is for the regions that CHCs already roled out, again -- it is -- it is almost as if, what we call mushrooms they're popping up and -- when you have a company that promises that you can be enrollinged, both in MA and into the -- MCOs and they will handle the process for you, as well as 15 hours of training we find that hard to believe that's -- enough, to running a home care agency I can provide who that company is.
>> SPEAKER: Please do.
>> JESSE WILDERMAN: Just a follow-up on this, I mean -- part of the challenge, frankly is that the, agency holds the relationship with the participant.
So, it seems to be hard -- the idea that the managed care organization can intervene and say, behave differently, or else -- when at the same time, you may loose participants because the -- the agency will simply say well I will just switch to someone else.
They hold the relationship, so there's a structural problem here on the idea that managed care organizations can be the enforcer of you know, this problem, which is a huge problem and, it is a problem in the southeast, we also have heard similar you know maybe not on the scale of the southeast but in the southwest and other places as well.
And so I think we need to think about how to -- to ship that in away that allows you know the intents of the managed care which is that, providers that are high quality and that, invest in their work force and that you know, provide consistent high quality services rise to the top and get pay for performance and providers that don't, don't. Providers engaging in illegal or fraudulent practices disappear.
That's I think part of the theory of the -- the case we're trying to build here but there's -- I don't know if the MCOs want to speak to that, there's a structural problem, I go to you, behave differently you take your relationship with your assistants, they're not supposed to.
>> RANDY NOLEN: We have a question over here, she has been waiting for awhile.
>> SPEAKER: I'm Susan Tachau, from Pennsylvania assistive technology foundation I want to go back a little bit -- oh I want to go become -- Susan Tachau, Pennsylvania assistive technology foundation I want to go back a few minutes ago to talking about lessons learn and communicating with participants in English.
We received arrogant from the health spark foundation to try to put

together Ann infographic on some of the services that are provided, by community HealthChoices we, Kevin I sent it to you, make sure it was okay.
And -- we worked with the health law project and I can put copies out on the table, but the main thing is, people are hearing that their health care comes through community HealthChoices they don't realize all the other as much ass.
And there is a lot of writing that's being sent.
As the parent of someone who is receiving a lot of this writing I can tell you, it is not been read or understood.
And that was the reason for the info graphic. So -- any way we can send it to you, MCOs, electronically. We can, it's fully accessible. It -- we made it 508 complaint it's in English and Spainish. So thank you.
>> KEVIN HANCOCK: You can send the department will communicate with the MCOs with the info graphic. What we could do is -- send to the committee members here for feedback too, if that's okay.
>> AUDIENCE MEMBER: I'll send to you -- you will send it out. Great . Where is the best place for me to put this? On the front table then? Sign in table, if people want to see a copy it's really I mean we would be delighted for providers to have this.
It is -- designed for waiver participants.
>> KEVIN HANCOCK: You're welcome to make it available on the table outside.
We just, have to have the caveat that right now it's not a product of the Department of Human Services or the managed care organizations.
>> AUDIENCE MEMBER: Not to worry I put my branding on it.
>> KEVIN HANCOCK: Good.
(laughter)
>> KEVIN HANCOCK: Thank you.
>> BARB POLZER: I'll ask that we hold questions and comments so we can do the -- the presentation on direct care work force.
And all fair unless to the presenter.
Sorry it is Charles Quinnan and the MCOs.
I don't think you have to leave, you're part of this.
>> SPEAKER: Whole different team.
(laughter)
>> KEVIN HANCOCK: Can I introduce Chuck?
>> BARB POLZER: Sure.
>> KEVIN HANCOCK: I want to take a minute to introduce chuck, he is with the Pennsylvania Department of Aging he the is executive director of long-term care council, is that right.
(laughter)
He -- coordinates with the pretty robust committee of stakeholders on key issues effecting the long-term care system the past year they

have spent a great deal of time talking about the direct care work force and opportunities to built out a robust care work force which is very clear which is part of the financial HealthChoices as well I've asked Chuck to plenty today's in today's meeting on a report that was developed by the long-term care council on suggestions and ways to be able to address this, what we can be a looming crisis, we have been very clear the entire long-term care system, is -- build on the work that is performed by the direct care workers and -- we want to do everything we can to be able to make it as attracted I have -- position and the best type of work as possible thank you for your willing to participate in the committee.
>> CHARLES QUINNAN: Thank you Kevin.
Thank you Kevin.
I'll just note I did do a presentation to this group I think about a year or so ago oblong term care council I will not get into the background we have the privilege of having Kevin serve as secretary Miller designee to the council along with five other cabinet secretaries . In addition I want to recognize we have long term council member with us as part of this committee, Heshie Zinman, in addition to the audience I see a few care counsel Rebecca from P4A, Daniel Kleinmann from PA health wellness as well.
Moving along, I'll kind of go through the slides briefly everything I'm presenting to you today is in the long-term care council's blue print, strengthening Pennsylvania's direct care work force at the end of the presentation is a link if anyone would like a hard cope, I'll be happy to get them to you as well.
The blue print -- is structured, in terms of the structure, of the blue print, um, in my presentation, it will follow the structure, we'll talk about the worsening crisis, Pennsylvania's direct care work force, Pennsylvania's work force from a demographic perspective. The work force shortage, wages, economic insecurity, which wages flow into, the approach the council took and finally the recommendations.
The report was culmination by a year and a half long term work with the ability to have recommendations to address the Commonwealth's escalating work force crisis in many ways the contents much the blue print are not new, as we go through the recommendations these are recommendations that are largely based on previous reports as well.
The work force crisis we know that, volatility with the direct care work force impacts participants and consumers access to long term as much ass and supports. As well as the quality of those services.
As well as multitude of factors that lead to the shortage and high turn over wages, of course, training, it as we know emotionally physically challenging work and lack of advancement opportunities lack of respects for an occupation that provides physical services and support to those individuals we're trying to help and maintain independence in the community.

Recently saw benchmarking study in terms of home care agencies that said, turn over for Pennsylvania is little over 88 percent which up, from 50% several years back, so -- turn over, by in large is not improving it is in fact increasing as well as the shortage I'll get into, in a little bit.
In terms of Pennsylvania's direct care workers, um, there you go thank you.
We know they provide vast majority of the hands on services and supports to participants.
Pennsylvania, there's over 219,000 direct care workers, the vast majority are employed in long-term services and supports including home care, all the way to the skilled nursing facilities.
The U.S. Department of Labor defines 3 standard occupations, when we say directed care workers I want to be clear what we mean. So -- Federal government defines the occupation as personal care aids, so those that would be folks providing services in the home care industry they may be providing services in personal care homes assisted living residences or adult day centers as well as home health aides and of course, nursing assistants, often referred to nurse aids or CNAs in Pennsylvania.
And lastly direct care workers for our pushes also include special participant directed workers.
In addition the blue print provides additional demographic information on the work force, such as education, race, citizenship and the like. As we know personal care aids make the largest segment of this industry, followed by nursing assistant and home health aides.
He terms much the work force shortage, 37,000 more workers will be needed by 2026.
It is important to know that, this is not including vacancies due to turn over. So, that number does not include workers who either leave the occupation entirely or, those who go from you know, jump to another provider perhaps for a few cents or a few dollars more.
And adding to the shortage we know the demographics in terms of our aging population in terms of the disability population very high percentage in Pennsylvania, has in terms of the nation.
Managing folks with a variety of complex medical conditions, we know that over 50 percent of the seniors who are part of the long-term services support system have multiple chronic conditions and approximately 70 percent of those who are turning to age 675 will not access to these services at some point.
And in addition the Pennsylvania's age dependency ratios the population with the baby boomers continues to explode, the number of working age adults are -- 0-59 are either, decreasing or increasing very slightly the number of works is not keeping pace with that trend.
In addition to the turn over in vacancies. As I mentioned.
Moving along to wages I will not go through all this as we knee

this is -- tends to be a very low paying occupation, in terms of the state's median wage for occupation is 18.05 which is far above the median wage for home health care aides which follow between 150 to 200 percent of poverty level.
Again the large segment of the direct care work force I know, this group knows this is employed in home care, lowest paying in the industry . Direct care worker, recruitment retention remains a critical issue across all segments of the long-term services and supports continuum. This struggle for workers, um, we know is continuing to intensify as these providers, and -- participants can compete with employers in other service sectors other retail sectors they need to pay comparable pages wages or higher wages we're seeing this more and more employer such as Amazon and target even Sheetz, are moving towards or at $15 an hour minimum wage.
Wages of course ties into economic insecurity over half of the direct care workers employment in home care, 40 percent in nursing homes and 36 percent in residential care which would encompass care homes assisted living are -- below the 2000 percent of the Federal poverty level.
In terms of public assistance, the workers rely on public assistance from Medicaid to assistance with purchasing food, food stamps cash, assistance as well.
So briefly the approach, the council took, the council in looking at this issue wanted to make sure it considered all the various perspectives in terms of the direct care work force, certainly the consumer perspective as well as the provider perspective and understanding the challenges providers face as well as the workers themselves.
Again as I mentioned briefly before, the council, looked at previous reporteds and studies going back nearly two decade in not surprisingly a lot of the recommendations on these reports were not implemented. So they're -- to this point, has not been a systemic reform that's needed to lift up and enhance the direct care work force. We heard with the community HealthChoices managed care organizations with this process to get a better understanding what their thoughts were and what direction they were heading in as Kevin mentioned, work force innovation is part of the agreement with the MCOs.
We also brought in the work force development system to get a better understanding. We all know there's a local work force development Board and there's training dollars available unfortunately one of the criteria is wages that are moving towards a family sustaining wage which is a big hurdle with the direct care work force.
In addition to more formal training so those are things that our report addresses to hopefully in the future leverage more of the work force development system to provide support to providers and workers and again in training.
The recommendations result of dialogue with direct care workers

consumers, provider MCOs and work force experts again the -- there's a report 2007 under Governor Rendell, it is called addressing pensees direct care work force capacity, primary recommendation for quality jobs and quality care and several of these recommendations, are in align with recommendations in that report. Which is kind of interesting we look at that report, 12 years ago, they're calling, they were starting with a minimum wage of $12 an hour and, here we are in 2019, calls to getting up to $15 by 2025 indexing to the cost of
living.
In terms of the recommendations -- the first recommendation pertains to awareness and outreach. So given the crisis that the Commonwealth is faced, members felt there's a need for a more organized public awareness outreach. Both in terms of reaching out to the potential workers, informing educating the public in terms of why they should care about the need to enhance and lift up this work force.
As most of us we know require services and supports of some kind as we age.
So the first recommendation is creating that statewide public awareness campaign as well as emif a vicing the need to recruit, retain more workers and value these provisions. There's recommendations to form a consortium, this is one of the recommendations the council really thought were the providers really have the ability to get some skin in the game in terms of joining together to collectively talk about the challenges they all face with direct care workers, because as we know this is not unique to any one type of the provider in the continuum.
And in addition to -- recommendations around informing public officials, trying to get providers to join together to educated public officials in terms of, having them go and shadow direct care worker for you know more than a few hours but throughout their day to get a real sense what their challenges are as well as other outreach efforts.
And the next recommendation has to do with standardized training and career pathways.
So this is aimed at better equipping workers we have heard from works as well as other providers the challenges that workers feel ill prepared when they go into the job.
As well as not having the opportunity to progress and provide direct care, if they're a personal care aid or attendant,
being able to build off that training become a home health or nurse Hades without having to go through the entire nurse aid training program . Recognition that -- there would be some sort of foundation of skills that are common among all direct care workers which then could be built upon and, the main strategy for this, would be the formulation of a work group which, of course, includes stakeholders to look at developing a model training curriculum and credentialing system in the State. There's a few models that were developed in the past. Part of the 2007 report -- as well as the better care better jobs initiative.

Um, so -- the intent there is to look at the current training system as we know and, in terms of direct care workers, a lot of the training tends to be provider specific and driven there's core competencies, workers have to meet in home care.
There's not that standardized training exam component and then going on, there's a registry components for nurse aids for example.
So there would be a work group established. There's a strategy, that the partner with the CHC MCO toss pilot test a monitor training curriculum they felt very strongly that is the Commonwealth looks at standardized training it needs to be uniformly across the Commonwealth.
There are direct care workers that provide services and supports to consumers throughout their dare you know that are members of all 3 health plans so workers are not just providing services for one of the MCOs but for, many cases multiple MCOs continuity and standardization is important.
And then, pie let testing the program, making adjustments.
And, also looking at how we can best support workers and, providers in terms of, possible funding for training.
Again there's other -- I'll not go through all the strategies how can we leverage for instance the Pennsylvania higher education association to maybe loan, or grant programs for existing students who may want to dedicate a few years of their life to entering the field and -- exchange for tuition assistance.
The next recommendation is liveable wages. This recommendation falls in line with the stepped increase in time line of the Governor's minimum wage proposal, recognizing the need to help workers not only having the ability to enter this profession, but to stay in the proposition, to be able to sports themselves and their families. Recommending going to $12 an hour and the current budget here. Increasing by 50 cents per year, until getting $15 by 2025 and insyste indexing to inflation, in addition to that, if the Commonwealth was increasing the minimum wage for all workers across the State, still to the large extent the issue of workers being able to choose jobs at the same pay level with less responsibilities and less stress, better hours, et cetera, so then, members are interested in through the managed care program, how additional insent tips could be leveraged, whether it's value purchased pay for performance that has a compone and of work force advancement, looking at quality indicators to pay to workers to lift them above the pink mum wage.
The next recommendation is data collection.
One of the in terms of, I think one of the key missing aspectses in terms much statewide data is the system to collect statewide data in terms of different provider systems Medicaid for one.
There's a lot of data on turn over we know it's a growing problem.
A lot of that data tends to be driven by providers and associations through surveys but beginning to collect data through the

managed care system, in terms what turn overlooks like through the providers they're contracted with and the workers, um, as well as other work force quality indicators, in terms of hours, um, benefits, um, and looking at quality indicators as it results to consumers and participants.
And again, that would be another component for pie let testing consumer input, provider inputted to make sure the data as we collects it is -- is actual data, that is valuable and not only looking at, trends with the direct care work force, but are enhancements initiatives implemented to help strengthen the work force are they working starting to measure those initiatives?
Care team integration members felt strongly all direct care workers should be part of, care teams as we know they spend the most time with participants. They're the best position to notice those subtle nuance changes to avoid more serious health care events, hospitalizations, readmissions or being placed in a more restrictive setting. So the strategies aligned with care team integration.
And in addition, um, technology utilization, both recognizing greater support for technology assistance, assistive technology not only for direct care workers themselves to enable and empower participants to live more independently fully, by accessing the assistive technology and the strategies around that with the managed care organizations, strategies around enhancing the assistive technology line items I saw that Susan from Pennsylvania assistive technology foundation is here. We had discussions with Susan as well as with the lending library had made recommendations increasing their appropriations.
I see that in this budget there's a slight increase for the foundation as well as the assistive tech -- excuse me, assistive technology lending library library. That foundation as well.
And --
>> SPEAKER: Can I offer a comment?
>> SPEAKER: Sure.
Hi, Mary Ann Collessa I did work for 25-30 years -- excuse me.
A lot of advocacy for rural and low income and disabled. And, one of the things that I crosswords with CILs I don't know if you're able to break this is the Rosetta stone on the wages there a grid or map they have -- where a certain portion is allowed to receive this much as a direct care worker, and another portion is allowed I mean you get my jis t. The issue became for me although the rural community seems to be blessed with I say this star it isically, heck of a lot. Fracking we don't seem too get our gas prices down I would hope at this point, that we look at the fact that our direct care workers are probably making less than the wage offered simply because they have to go further for employment.
I don't buy I know this will get tomates thrown at me from the Philadelphia area, it is the cost of living that's why the -- the

southeast area, needs a bigger wage for their direct care workers.
And I really hope that we look at that as well. Because that
becomes a real problem for people who are going to accept employment at,
a reduced wage in northwest and southwest.
And, then have to drive further so basically you're asking them to
work for five or six dollars an hour, no one is going to step out on
that.
It is just, it is impossible.
When you look -- even if they are receiving like the Walmart plan in
my opinion well here's your sheet you need to go sign up for health care
we'll make sure you get your EBT we'll keep you low enough, child care
we'll keep you at that 20 hours -- it just seems so immoral to me I
think just think there's a different and better way -- especially that
the State could be doing considering our aging population the crisis we
now recognize when it comes to direct care workers I just want to offer
that if I could, I don't think a rural direct care workers are being
seen as earning much less than their counterparts.
And I'm available if you want a big mouth on the committee, I'll be
happy to try to offer I just joined the 65 year olds I'm done after this
I will not get any older -- I just -- I did your White House conference
for the aging years ago AAAs, when I was -- 20 years ago, so I think, I
do have some values to observe and I will be willing to -- but I hope
you look at that piece.
>> CHARLES QUINNAN: Sure thank you for that, that certainly was an
issue, transportation was an issue that came up -- ultimately where the
members landed, certainly you look at the report, this is not, inclusive
of all the issues that direct care workers face what they want to do
was, come up with core recommendations, to the begin the conversation,
core recommendations they believe from a systemic standpoint need to
start to be addressed.
With the recognition of those other issues.
The only -- before I forget the last point I want to mention about
assistive technology this goes to rural Pennsylvania, was -- recognition
that we need to invest in state broadband, assistive technology is only
helpful if folks have access to appropriate access to it as well.
I appreciate that I love to follow-up with you and -- talk to you
about being involved.
>> AUDIENCE MEMBER: Thank you.
>> THEO BRADDY: I have a quick question.
I read it had been disseminated a quite bit it's a well done
document I want to say congratulations on that.
I NOAA lot went into it, my question is, what are you going to do
with it? Because -- it ain't something that we don't know and talked
about -- and planned about especially, a lot of people with disabilities
attend want care direct care workers in this room we know this stuff.
So -- what is going to happen? And how will it become a priority.

How do we, how do we implement this thing? Because I think we talked about it I know nothing happened without a study without a plan all that.
But -- come on.
We got to do this.
>> CHARLES QUINNAN: That is a major theme of, of the discussions with the council.
When it first decided to look at this priority. As I mentioned there's been, um, more reports and studies I can recall, rights now over the last 20 years at least.
And -- they wanted this report, to not be another report that sits idl e on a shelf they want to be an active working document. So one ever the first charges was -- responsive Heshie can speak to this, the responsibility fell to the council members going back to their organizations to to put forth this document.
I was happy too once when we released the document the Governor, came out issued the press release talking about how the recommendations line up with his initiatives, restore PA minimum wage.
And in addition too he was looking to his new work force command center to look at the other recommendations to explore and see how they can go forth but again, it is, um, I think, a key aspect too is the providers, across the continuum not only -- speaking in silos but you know, recognizing the benefit for everyone to speak collectively.
Because there is an issue regardless of where you fall in terms of the continuum providing care.
But keeping that -- keeping that message out there, that's why public awareness is a first recommendation you'll see folks are not aware of it, they know everyone in this room is aware of it. But why those on the outside need to be aware of it, need to care, need to be vested and supporting the types of recommendations that are needed to begin that up lichtin lifting so to speak. There's other groups I went to speak to council on aging is under the departments of aging I spoke to them about the blueprinted. They endorsed it. They reached out to everybody member of the General Assembly. Noting their support AARP came out after it was released.
I know Pennsylvania I believe provider coalition came out, in support.
So -- members we're trying to do everything we can to get the word out keep that focus, public outreach is a major components that is something that will be developed, and in addition to there's a -- the work force development Board under Labor and Industry they formed health care ad hoc committee during our process, to look at direct care work force.
I sit on that for the Department of Aging. So what they're looking at doing rather than replicate the work the council already did, how do we take this further and they're looking at, costing out some of the

recommendations, and -- figuring outweighs to keep the conversation going as you know, that is absolutely key.
>> JESSE WILDERMAN: So -- I want to -- second with Theo said because when you look at this -- I think the report is really really well done I appreciate all the work that the council has done on it, it also looks -- has some of the similar recommendation that's were plead in made in 2007, 12 years later -- we took direct care workers we work with, took the report when it was done and wents and visited every elected official on the council as representation of the council and said really appreciate this, this is wonderful what do we do to implement this.
I think, that's obviously critical.
There is also my understanding is, in this -- in this budget there is a, some resources for increasing reimbursement rates for home care providers and one of the questions I have sort of recommendations is, with the MCOs here the first question is do we have a standard for what percentage ever the reimbursement rate makes it down to the direct care work force? How do we measure that? How do we make sure that the resources we are putting in, are being used as efficiently as possible? And we talked earlier about the wild west of in some cases, the wild west of the home care agencies many of them do incredible job put every penny they can, in the direct care work force to make sure the services are you know good and that the person can continue to stay in their job not turn over then there are some that don't.
What's the work that we're doing to make sure that there is a, requirement the money make it down to the direct care work force to get increases and generally speaking, that is the first question. The second question is, um, it is really for the managed care organizations, how do we reward providers who are, who are doing that and justify, you know, providing higher reimbursement rates for providers who are investing in the work force who are taking this crisis seriously who are actually reducing turn over and, how do we measure the impact of those higher reimbursement rates. Because at the end of the day, it -- we have to grow the pot of money that we have to invest in the work force to get to $15 an hour to support the Governor's proposal on minimum wage we have to make sure the money we do have is making down to the direct care work force not getting put in other places as I say there are many, many providers who are really aggressive about that and there are some who are less and so how do we -- you know, do both of those things at the same time.
>> CHARLES QUINNAN: Sure thanks for the comment thank you for reaching out again you know, that's an excellent point I think it's also paramount everyone in this room, not only individually but collectively, in the organizations and the provider networks reach out to you know to discuss the report. To keep focus on the report, to reach out, you know to be your elected officials I think Heshie will probably second

that all the council members were here they would all say that.
I was going to mention the increase that you said as well.
So there's a 2 percent increase in the recently enacted budget.
For personal assistant services for home care providers, and -- the language reads intent of the increase of that the 2% is to provide wage increase for direct care workers providing personal assistant services. In terms of what structure looks like that's a question for the Department of Human Services.
But, I know the members, we're happy to see that, at the same time you know, it's a step in the right direction as you mentioned you know, a lot more work has to be done that's why they, called for increasing minimum wage for direct care workers for the $15 and building off that.
So --
>> KEVIN HANCOCK: So it's my understanding, I haven't not really looked at the language to be perfectly honest it's my understanding the 2% is going to be effects I have January 1, 2020 was directed towards the agency model, is that also -- correct. Win win that's my understanding.
>> KEVIN HANCOCK: We need to explore how -- the requirements will be elemented, with CHC, that 2 percent is going to be built into -- will have to be built into the CHC MCO rates. And that will defer to the MCOs I'll actually defer now to the MCOs to answer how to -- a lot of Jessie's questions how -- the MCOs will be managing the relationship with the providers to make sure that -- that the -- the money is used as intended.
The department's in the managed care environment request not direct the payments, we were actually we have a regulatory prohibition on that is happening we would love to have the MCOs speak to how they plan to work with the providers and -- address with additional resources for the crisis of direct care workers especially with low wages
(laughter)
>> SPEAKER: All right.
I'm going to have to take that one back to get you a better answer.
>> KEVIN HANCOCK: It's new, that's -- I think that's fair.
This -- there new requirement I think that brought up a question that Jesse asked, correct me if I'm wrong Jesse how are the manage the care organizations working with providers to address the issue? Really? I mean -- developing, performance incentives et cetera, et cetera.
>> SPEAKER: I can tell you we started last year, PA health wellness developed an sequence itch quality indicators project worked with SEIU on that, for example. We socialized it to nursing facilities the home care association triples, as well.
To get feedback as to whether or not we were on the right track to -- have expectations or quality within, um, personal attend want

services or personal care services. We got really positive feedback they said yes, we agree with this, go ahead with this. So the next step is, finding a partner that is willing to work with us on something that could look like a value based incentive program where by they meet those outcome questions track the data. And we're rewarding them via some type of savings model we're not that far along what that will look like, we're on the right track we do want to reward quality performance.
>> KEVIN HANCOCK: Keystone want to jump in?
>> SPEAKER: So for Keystone, right now we are still approaching CHC as an implementation.
And, we're trying to use this time to do track and trends of utilization we have begun discussions with some agencies, about value based purchasing model, what would it look like? How would we track it? How would we communicating.
We do have, um, one agency that we're exploring partnerships with, that is kind of helping out outline what a model component could look like such as if they have a tool that can help alert us to falls or other potential concerns with participant how would that information be relayed to us? How go we incorporate it into our care plan?
Because that agency with that tool may be developing a separate care plan so how do we lend those? And then, how can we use that information to establish quality measures to be able to then trend value based. We're using the time right now, in the southwest because our membership is lower, we have not had enough core number of participants with any one agency to be able to have enough information to do that. We're in a better position in the southeast because of our membership to kind of, use those months to evaluate that.
The other thing we are doing is, um, in response to feedback first off we're very happy to go on any work group our media and marketing team to help build awareness. So we would be happy to participate that and see how we can, um, use any of our tools to be able to communicate the value of direct care workers and the respect for direct care workers.
We are also in the process of developing funding for men toreship program for direct care workers. One thing if anyone here or on the phone out there in phone land, has a copy, we understand there at one time was a mentoring scholarship I know, we had talked about this a long time ago Luba, there was a mentoring program that had funding associated with it.
And it had an established criteria, um, if anyone has a copy of that and -- could share it with say I guess in this chair if they could chair with BarbPolzer, we understand there was a lot of value in the program we would like to mirror that in ways we can. Butter we're hoping that provides some sort is able to reinforce that direct care worker through recognizing individuals that are mentoring that can then mentor direct care workers. The other thing we're in discussions right now with a vendor there was feedback in

this kind of a attaches or hooks onto the previous subcommittee meeting about LGBTQ that a lot of direct care workers would like better information how to address those issues.
When they're in individual's homes directed care workers have raised concerns about individuals that are transgendered if maybe something that is new to them.
They're helping them with very personal issues. Personal care.
And -- for them to have a better understanding of that, so we are in discussions now with a vendor to help us to develop a training program, Heshie met with us about some issues and education about training employees. But -- for this discussion here, um, how can we better equip direct care workers with education and knowledge and skill set, around LGBTQ issues most recently, autism has really kind of just been raised with us, that a lot of direct care workers with adults, are really struggling with the behaviors and not understanding that.
So we're trying to invest some efforts into that area.
Begin are.
>> CHARLES QUINNAN: I would add the standardized training component I spoke about earlier, does include peer mentoring, which was, something that we, gleaned from our discussion with the organization.
>> KEVIN HANCOCK: And who is speaking for UPMC.
>> SPEAKER: So I'm Joe Angelleli I'm the senior adviser with Geritologist have been part of previous work groups addressing direct care work force in the state. We're very pleased to work with others, other payors other providers, state officials in terms of designing the next generation of direct care work force training credentialing system that addresses those work force issues, last fall after the continuity of care period was in the southwest we did a survey of 190 agencies, PAS agencies there, got 69 responses specific to the direct care work force we had a wide range of training it was recorded they were doing between 2 arranged 75 hours, mean was about 24 hours, high rates of turn over reported low wages, average wage was 10. 68 and -- really sort of lots of interest in working with the MCOs and others in a consortium manner to design this next generation of a training system.
What that will include is, we've brought together, based upon the results of the survey we brought together some of the providers in the southwest to -- review a proposed articulation of a expanded PCA training and they would articulate into both the home health aid training or potentially a community health worker training. Because we see if you review the competencies that are part of the ticket care work force there's a lot of the competencies that community health care workers are being asked to address we think there's a possible career trajectory with direct care work he's who want to work with the home care agencies as -- as community health workers we see that as a real phutted year in health care in terms of their role. So -- we did a

crosswalk of, from the national direct service work force competency recommendations from 2013 which was a CMS funded through the Medicaid office at CMS they did a full report multi-stakeholder process on what are the competencies of this work? We cross walked that with really these, community health worker competencies got some feedback and the report was issued, so we've been reviewing that and -- really want to commit to working with other, the other MCOs in terms of a system that makes sense for the employer for the worker for obviously for the participant first.
And, what that looks like. So we think there's all sorts of opportunities with the direct care work force and the IT, sort of the -- eyes in the home to have a structured way of communicating about that. Agencies, potentially using something called the stop and watch tool which has been used in other settings to sort of a structured communication way of, communicating in the structured manner about sort of late changes observed the behavior. The question then becomes how does that get report the to both our care team management and our service coordinators and our -- the agencies themselves and, how will that work we think, working together, we can, get alignment about what that core curriculum needs to look like and think how we resource that together with value based payment models that, work for everyone and don't drive the agencies crazy with 3 different versions.
>> AUDIENCE MEMBER: This is Nancy I'm getting old as we stay here -- so, um, attend want you know, direct care workers are 30 years behind getting paid. They're only 2 people that really counted that is the consumer attend want the two most important people they're not getting paid, stop with all of the training all of this, it needs to happen now.
We're working with managed care organizations, there is money, you can force this, it is something -- something needs to happen we keep talking about all this other stuff, they're going to die before they ever get a pay raise because the of way they have to live there needs to be a real push behind this
(applause
)
>> SPEAKER: If I could make a quick comment I am in support of what she said there are things to be -- things that cross purposes.
Postcards went out for the EVV and we have a hand with a black pond -- it goes to the direct care worker and it is an 8-ball, Mr. and Mrs. You're behind the 8-ball.
We don't want you anymore, what's the cross purposes?
>> KEVIN HANCOCK: I'm not sure I understand the question.
>> AUDIENCE MEMBER: They say a picture is worth a thousand words. So we're introducing EVV, to the T section and we're saying okay, here it is you're the pawn, what goes first in the chess game? The pawn. So that's the participant.

Okay.
Then we have it going to the direct care worker, it's a postcard about EVV, download the app. However, what the picture is an 8-ball -- where is the dignity invested for these people? Why at this depreciated population, are we having double speak?
>> KEVIN HANCOCK: EVV is a Federal requirement. And -- are you raising a concern about the communication went out to the direct care workers?
>> AUDIENCE MEMBER: Correct.
>> KEVIN HANCOCK: Okay.
I haven't seen it. But -- we'll be happy to talk about it with you if you have any suggestions we want to make sure the direct care workers are ready for the -- the requirement implementation requirement to make sure there's no risk of interpretation of payment.
If there's any better way to communicate that with direct care workers we can take any suggestions.
>> AUDIENCE MEMBER: The postcard had a big 8-ball on it, that's what he is talking about. There's a lot of is he plan ticks around that.
These folks already feel down trotten what's been going on the postcard with a big 8-ball on it.
Is just --
>> AUDIENCE MEMBER: I'm a direct care worker I've not received this postcard with an 8 bought -- um, just to highlight the issues that have been made at the end of the day when you write all these flowery strategies recommendations, increases need to happen for attend wants we're not getting paid the real livable wage as Nancy said, we have the power to do that, now we have our fancy corporations to take care of us.
I would like to ask all 3 MCOs one last question, actually I want to ask Kevin one question, um, if the minimum wage bill does not get passed are we still planning with going forward with the $15 increase?
>> KEVIN HANCOCK: So the minimum wage was not included in the signed budget.
>> AUDIENCE MEMBER: Oh.
>> KEVIN HANCOCK: I have a comment. Um so there was -- minimum wage ralley occurred while I was away and -- there was a lot of stakeholders that were represented in that -- in that ralley, that was planned to sort of, elevate the type of passion and the need for the minimum wage to be part of the budget. But there was some key representatives who were not part of that rally, I'll talk to you about that sometime.
>> AUDIENCE MEMBER: Sure, minimum wage doesn't fix the issue now, we're talking about six years from now.
>> KEVIN HANCOCK: I think you know what I mean, we could have had some of the advocacy could have been welcome in that.
>> AUDIENCE MEMBER: We've been doing this advocacy, for 30 years I

mean, everyone -- since longer you've been alive for sure.
But -- rasheds to attend want care wages we've nothing but advocating for higher wages we don't believe the minimum wage bill is going to fix the problem when it comes to PPL provide -- PPL attendants
(applause)
We are not even talking about that here we're just talking about the agencies and -- we are missing a whole group of people that are not -- we're not even talking about how they're going to get their wage increase how do we make sure PPL gives that wage increase minimum wage does notes fix the problem, we're mentioned at the very bot, with two lines two paragraphs whatever, it doesn't show increase going directly to the attendants. It is showing it goes to the providers, as Dan said providers are -- you know, not in it for us, they're in it for the money whatever else.
And -- we're not getting that increase. So -- I -- I just would like to see, more real action, rather than the same words that we've been seeing for 11 years as Jesse told us.
>> KEVIN HANCOCK:
(applause)
>> AUDIENCE MEMBER: I think -- Liam from Philly Adapt I want to echo a lot of what has been said.
Two things, but -- you know, all the recommendations I do think, like -- money is the life blood of this whole thing I think, as you outlined all these people are living so close to poverty. Um, I think, you know, I mean any other recommendation in terms of making the job easier, would be important but it's all moot if they're being paid nothing.
I think, the other thing I wanted to point out is you said like everyone in this room knows that the increase has to happen I mean it feels like, there's some like hype of courseacy there right you know, the MCOs I think -- I do understand it's more complicated than that.
I totally, I can't believe that there's no more sway there, like what Kevin said. With the relationship between MCO and providers I think there's some -- there's a market relationship there like -- I -- can't imagine that MCOs don't have some ability influence direct care wagers I don't think we can
rely on Pennsylvania's government in this way.
To make this, especially when, it is, everyone in this room knows what we need to do.
>> KEVIN HANCOCK: I think Jesse presented a pathway to what you're describing where the MCOs can create incentives for the providers to be able to -- to address the wage needs of the direct care workers and also, um, work with the department can work with PPL, the funding has to be there though just to be clear.
I think Jesse outlined an opportunity for the way the MCOs can be engaged with the providers to make sure that the work of the direct care

workers is rewarded appropriately and they get the fair wages.
>> CHARLES QUINNAN: Can I add something Kevin I just want to make it crystal clear when I went over the report the recommendations, um, participant directed workers, are as much apart of these recommendations as agency workers as other provider types as well.
The issue came up with increase that was in the budgets that is tied to the home care providers agency model so that's why that was talked about.
But the intent is participant directed as much as it is agency based.
In terms the other recommendations, members first and foremost would agree 100 percent that wages need to be increased wages need to be increased a long time ago. If we don't start that is -- you know we'll never get there.
With that said the passion in this room is what the members, you know -- want to emphasize, um, we need to maintain and communicate that out side of this building.
You know, it is like every legislative session you're up against a wall I work for the legislature for over 13 years you have a whole new group of legislators come in whole new education process.
So unfortunately you know you cannot let's up in terms of talking about the crisis you can't legality up in terms of talking about how impacts people and their real every day lives. Just like recognized Kathleen

End of Transcript