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DATE: August 9, 2019

EVENT: Managed Long-Term Services and Supports Meeting

BARB POLZER: Okay everybody, we would like to get started.
>> BARB POLZER: Good morning I would like to call the meeting to order, can we start off with introductions please.
>> SPEAKER: Luba Somits.
>> SPEAKER: Pam Auer, central independent living PA for Theo.
>> LINDA LITTON: Linda Litton participant and advocate.
>> BARB POLZER: Barb Polzer Liberty Community Connections.
>> SPEAKER: Jim Fitzner,.
>> SPEAKER: About, month, Blair Boroch,
>> BARB POLZER: We have committee members on the upon would you like to introduce yourselves.
Excuse me?
>> SPEAKER: Taya Teglo.
>> SPEAKER: Good morning.
>> SPEAKER: Brenda Dare.
>> BARB POLZER: Good morning.
>> SPEAKER: Denise Curry.
>> SPEAKER: Terry Brennan.
>> BARB POLZER: Good morning, Denise and Terry.
>> SPEAKER: Jim Pieffer.
>> BARB POLZER: Good morning Jim. Do we have someone calling in for Drew Nagele? Okay.
I guess she is not here yet. I'll go into the housekeeping please keep your language professional.
Direct your comments to the chairman and wait until called upon please limit your comments to two minutes. Our meeting minutes, transcripts and the documents, are posted on the Listserv under MLTSS meeting minutes and we normally have them posted within a few days of the meeting.
The captionist is documenting the discussion, so please, speak clearly and slowly and the meeting is also being audio recorded. This meeting is scheduled until 1:00. And to comply with those logistical

agreements we must end at that time promptly. If you have any questions or comments that weren't heard please send those questions and comments to the RA account, that address is listed on the agenda. The exit aisles must remain open please do not block the I'm. Please turn off your cell phones and upon leaving throw away your empty cups, bottles and wrappers. Public comments are taken during the course of the meeting instead of just at the end. We always do reserve an additional 15-minute period at the end for additional comments, 2019 meeting dates are posted on the DHS web site and I'll turn it over to Linda for the emergency evacuation procedures.
>> LINDA LITTON: Hello everyone, in the event of an emergency, we will proceed to the assembly area, to the left of the Zion church on the corner of fourth and market.
If you require assistance to evacuate you must go to the safe area located right outside the main doors of the honors suite. OLTL staff will be with you during that time and they will stay with you until you're told you can go back into the honors suite or you must be evacuated. Everyone must leave the building to take your belongings with you, do not operate cell phones and do not try to use the elevators as they will be locked down.
We will use stair one and stair two to exit the building. For stair one, exit the honors suite through the main doors on the left side near the elevator. Turn right and go down the hallway towards the water fountain. Stair one is on the left.
For stair two, exit the honors suite, through the side door to the right. Or in the back at the back doors.
If you go out the right door, make a left and stairway two is on your left.
If you go out the back doors, make a left and then the other left, then stairway two is right directly in front of you. Keep to the inside of the stairwell, merge to the outside, turn left and walk down the dewberry Alley, to Chestnut Street, turn left to the corner of Fourth Street, turn left on Blackberry street, cross Fourth Street to the train station. Thank you.
>> BARB POLZER: Thank you Linda.
So first up on the agenda are the OLTL updates and, Jill Vovakes will be providing them.
>> JILL VOVAKES: Good morning everyone.
First I within to acknowledge we have six members of the Board that are leaving I think Kevin had talked about that last time.

We have folks that have ended their two-year, round of service and we will be having new members, join us, the next meeting.
So we'll give an introduction of 8 new members. We had two retirees and six folks that are leaving at the end of their two-year periods. So next month we will get to meet our new members have them introduce themselves and tell a little bit about themselves.
So thank you for your service and we appreciate all of your input and contributions over the last two years.
For OLTL updates today, we're going to be splitting this up a little bit. You see on the agenda we have home modifications, Randy Nolen will be briefly talking about home modifications with the MCOs.
Electronic visit verification, Kristen will be reviewing for us, and Jim hail will be speaking to us about CHC waiver renewal. So -- phase 3, here we are.
We just refresher 143,000 participants, in phase 3 across 3 zones in the State.
48 counties. A lot of activity is already conducted a lot is under way.
We have a lot coming over the next few months.
So, July 15th, our initial touch flier went out to all participants.
As well as the LIFE program flier.
August 1, our aging well participant information sessions mailer went out and all of the, um, sessions that have been set up for participants, there's 72 of them, across the 3 zones are currently out there waiting for registrations. So participants can sign up now and register for the session that best meets their needs for location and time.
The first mailing of pre-transition notices is right around the corner. Those will start going out, the 19th and run through the 30th.
And our meaningful contact activities have already begun.
The aging well, group will be -- is currently under way doing training with service coordinators to conduct meaningful contact for their participants.
I think, everyone here is on the Listserv. You've seen the messaging went out from the department just as a reminder to service coordinators that meaningful contact should start occurring they should be doing outreach to their participants to communicate about communities HealthChoices.
The multiple mailing of our pre-transition notices and enrollment

packets are going to be going out all through Septembers and October.
So, remember, we're doing that in phases, the first phase is August.
The end of August. We run through multiple phases to send out notices and enrollment packets for -- to capture any new participants that may have come into those zones, and would be eligible for community HealthChoices.
And we are having additional provider sessions in October for those providers that may not have been able to get to the earlier sessions.
So we'll be having one provider session in each one of the zones in October. Those dates are currently being solidified by our communications office.
It will be the same format as past provider education sessions.
Morning overview session. Then there will be breakout sessions.
The difference for the fall will be that there will be an additional break out session, specifically for transportation if everyone recalls we did a separate transportation summit. Day for the first round of provider educations. So this time we will have breakout sessions for behavioral health and physical health providers, service coordinators, home care nursing facility and transportation on.
Ongoing just as a reminder November 13th is the last day for plan selection before the auto assignment.
And if folks are not able to make a selection, before the 13th they are auto assigned they will still have the ability to change their managed care organization up to December 20th for that to be effective January 1.
Any questions on our updates? Okay.
I'll turn this over to Randy to talk about home modifications.
>> BARB POLZER: You don't want to be front and center.
(laughter)
>> RANDY NOLEN: Okay.
Good morning everyone.
I'm Randy Nolen from the Office of Long-Term Living. It's not on.
Am I on now. Okay.
See you told me to turn it on, see what happened.
Okay.
Sorry about the confusion of seating I was ordered to sit here.
So I follow the chair's order.
(laughter)
We talk thought over the last couple of months about the home mod trying to get data, I have some preliminary data I'm working through

with all 3 of the MCOs I'm trying to get an understanding from them on the numbers and how they're actually counting home modifications. How they're classifying rentals versus purchases.
So there's still some work we're doing with them and I'll have all of 3 of them here today to discuss some issues with the home mods. So we're working through that part of the process. I have some preliminary numbers that I can give you.
I'm hoping to have this all worked through to have some slides for next month's meeting in regard to home mods working through the process itself.
With home mods we're also meeting every other month and a special work group after this meeting, to talk about home mods. That will be next month, we'll have that meeting, the follow-up meeting the day after the NHT meeting we'll follow-up with some of the stuff with home mods. Trying to get the MCOs to get processes into place so we can improve the timeliness of the home mods and the issues that need to be addressed. So we're working through that part of the process.
So, what I've done I've asked the MCOs to provide me a couple of things. One is a number count of how many home mods they have had come in, with some other numbers, filtered out through how many had been completed and how many are still pending. So that's the data I'm trying to work through.
The other thing that I asked them for is a comprehensive list of participants, who have requested what the progress of their home mod is, so that I have an idea how many stair glides are being requested, how many bathroom modifications are being requested, how many ramps are being requested, we're working through all that type of data at this point in time.
Preliminary what I can tell you is that in the southwest, for the period of January 2018 through March 2019 AmeriHealth has received, 102 home mod requests, PHW received 387. And UPMC, 1142.
So I'm working through those numbers to make sure they actually match up with the list of participants that they provided me so I can see if there's a difference in the numbers that's part of the process the next couple of weeks we'll be going through to make sure things match up. In the southeast, AmeriHealth is for the reporting period of January 1, 2019 through June, 2019.
AmeriHealth has received 162.
PHW, 118 and UPMC, 259.
Now I know for AmeriHealth's data this is not included in the

southeast. They have 479 stair glide rentals so they don't include those as part of the home mod numbers they have those additional stair glide rentals. All 3 of them have -- all 3 MCOs have a fairly large number of stair glide rentals in the southeast which we are working with the PMCOs to take a look, they're evaluating the rentals to see if, why they're rentals why they're not permanent purchases so they're working through that part of the process also. Certain is some of these rentals have been out here for years we've renting the stair glide it's probably been paid for six times already. The MCOs are, working through that process to make sure we're more efficient in these types of services.

So I mean those are the preliminary numbers I've got. I'll be able to provide you more information next month, as far as how many have been processed, finalized and denied.

And, how many there are by, breakdown of category. So with that being said, um, and I know these preliminary numbers I gave you some numbers last month at the home mod meeting that raised a concern, a lot of concern about the numbers themselves, which has led to us, going back and forth with the MCOs to try to define and identify, the appropriate population.

So at this point I think I'll call the MCOs up to the table starting with UPMC, to talk about their home mod process.

>> SPEAKER: Do you want an overview or something specific?

>> RANDY NOLEN: Probably just, quick overview, but also, some insight into how you're counting home mods and what your process is, as far as time lines, when these requests come in.

>> SPEAKER: Okay.

So our process for home modifications, we do, you know our service coordinators are the first point of entry to identifying a need. need for the home modifications. They then work with the necessary medical staff whether it be a physical therapist, occupational therapist to identify you know the -- appropriate type of modification.

We also have a specialized home modification department, that, reviews and evaluating the appropriateness of the home modifications they're also as you mentioned looking at the appropriateness for rental equipment versus you know permanent equipment . Because there are a number of them even in the southwest that we have purchased or the state has purchased a couple of times over.

The timeliness, depends on a couple of different factors.

A lot of the back and forth is on getting the medical providers to

identify the need or make the order for -- evaluation for that equipment. We are in the process of evaluating kind of our network of providers who do that, so we can streamline and cut down the time line on that evaluation.
>> RANDY NOLEN: Okay, anyone have any questions.
>> SPEAKER: Can you please remind them to identify themselves?
>> RANDY NOLEN: In case you could not hear Pat, please identify yourselves.
>> SPEAKER: David, senior director for long-term services and supports for UPMC community HealthChoices.
>> BARB POLZER: Pam?
>> SPEAKER: Trying to remember how I wanted to ask the question, what I wanted to ask, is with the -- the -- I'm sorry, come back to me.
>> BARB POLZER: Okay.
Dave, do you have a pool of therapists that you pull from?
>> SPEAKER: That is something we're looking at, at developing. We don't, um, we use the existing providers, we are looking at developing and enhancing that.
>> SPEAKER: Yeah I think is Brendan Harris vice president of, UPMC, health plan we're looking at having the occupational and physical therapists review, those elements there and then working with contractors we can potentially certify to make sure they're able to complete the jobs in an appropriate manner make sure they're -- there's quality work and effective you know, piece there, because again home mods are incredibly important tool to keeping folks in the community we want to look at how we can further enhance that project. You know we've been doing a number of things around that to try to streamline our internal processes but also look externally to make sure we have the right vendors in place to be able to support the construction and then it is meeting the needs of the participant.
>> BARB POLZER: Could you please touch on your process for emergency repairs?
>> SPEAKER: Okay.
So -- a lot of that is -- working with the vendor or the supplier of the equipment. Um, so depending -- we have to check and see -- if the product is under warranty. To make sure that you know, who is responsible for the replacement and upkeep of that equipment.
So our service coordinators and our home modification department works on that, with the participant and the vendor who you know if it's

known who -- completed that modification or rented that
equipment.
>> BARB POLZER: No estimate about how long and probably because it
is different for each situation.
>> SPEAKER: Yeah, um, we can look into specifically how -- roughly
how long it is, get back to you on that, but it does vary based upon the
type of equipment as well as, you know, if it's covered or if we need to
look into having someone else you know, replace it completely.
>> BARB POLZER: Okay I just got a text that, Brenda has a question,
Brenda is on the phone.
>> SPEAKER: Hi -- um, here's -- one of the problems people have,
when they submitted home mod stuff are, does the service coordinator,
provide contact and updates as far as what the progress is or where
things are in the process? Is there a established policy for how often
users can receive the updates or way to be more informed about the
process.
>> SPEAKER: So the, um, that is something we are working on as
well to increase the visibility for our coordinators of the progress of
home modifications.
One of the things that, they get regular updates from the home mod I have department
on the process, we're trying to
expand ways to track and see when things have gone out for bid what the
progress is and they can share the information with the participant.
>> SPEAKER: Thank you.
>> BARB POLZER: Pam?
>> SPEAKER: Okay.
My first question was, back to what you were asking but did the
State change their position or clarify their position on the home
modifications and that it has to be a medical provider for the MCOs? That
was one of the issues for awhile that, there was not clarity who
could do evaluations and the MCOs were under the understanding it had to
be a medical provider or PC, the language was different did that get
changed at all, did that get modified so it can be like sending
the evaluations and follows the process and following the contractor?
>> RANDY NOLEN: I'll ask our policy people to talk about that.
>> SPEAKER: Good morning.
Pam, that -- was not currently included in the proposed changes that
I'm going to go over later but there will be a public comment process
and maybe we can talk about that here, so that we can take that back and
make sure that we evaluate that for inconclusion.

>> SPEAKER: Is that something this committee can say, make a formal recommendation today make sure it goes in, what this group says.
>> SPEAKER: You can make a formal recommendation today.
>> SPEAKER: Or subcommittee that meets on home modification he's think that, it would be -- important for this committee to make that.
>> SPEAKER: Yep, absolutely.
>> SPEAKER: Absolutely.
>> SPEAKER: Jen --
>> BARB POLZER: That was Jen hail.
>> SPEAKER: This is Pam Auer again, I have another question, too.
I know you're getting back to Barb, about time frames but that's critical.
I mean, if you could give us some solid concrete dates people are being stuck in institutions waiting for a decision, am I going to get a home mod, am I not going to get a home mod, how long does it take? We're not even in that process here yet.
I have some people that are, waiting for those kinds of decisions.
Is there any way to create an expedited you know, process for that, emergency for people who are in institutions?
>> SPEAKER: We agree.
I mean I think it's -- it's a critical thing because you know really when you're trying to keep someone at home or being discharged you want to make sure they have the supports in place we want follow-up get you specifics so we don't give you wrong information it is something we work through as fast as we can.
Our -- we have teams dedicated in the southwest and southeast to really work through those as fast as we can. And working through the process with the OT and PT to make sure we're able to do it. As you can see, as Randy presented, we have a significant volume we work through you know, based on what we have seen so far, so -- um you know, we will get those specifics back to you, gut again we agree this is something important we work through as fast as we can.
>> BARB POLZER: Linda?
>> LINDA LITTON: I have I have a question. A couple of months ago we brought up the fact of batteries that people were being bedridden until the batteries came.
I wanted to know what the update of that is, since we talked about that?
>> SPEAKER: I think that for DME and particularly you know, batteries for power chairs things like that, we do work with the vendors who

supply those to insure as quickly as we can, to get that coverage and replacement necessary. We don't you know, it is unfortunate when there's a delay in that, we do, our service coordinators and care managers work with Medicare teams to insure we get those as expedited as possible.
>> LINDA LITTON: I'm wondering how expeditious it is,
are we talking about a number of days or weeks. It does make a big difference.
>> SPEAKER: I think the challenge to giving you a specific time is,
you know, we're working primarily through Medicare first and so you know one of the, one of the potential needs as well as Medicare, so the time frames can vary significantly on this.
But we do have you know, our service coordinators as well as our care managers have regular meetings to talk about this, so they can move them as quickly as we can, to insure someone is not waiting you know, a very long time for that.
>> LINDA LITTON: Okay.
Thank you.
>> BARB POLZER: Nancy?
>> SPEAKER: Nancy from DIA. I have the same question, I think you should be able to tell us today what you know, because it's been awhile, year and a half if you look at two parts of the State. What is the average time for waiting for home mod? I mean we come here every month and then it's always the next month and the next month.
I don't understand. Isn't there supposed to be network advocacy,
if you came into an area you're supposed to have network adequacy, while you're in there. Once again this is only affecting the consumers, not affecting anyone else because you can still go on with your life, so there needs to be answers, what is the average time right now, for a home mod? What is the average time right now, for a battery? I think that's really simple.
>> RANDY NOLEN: The issue of network adequacy, obviously depending upon the home mod there's a problem finding appropriate construction companies or, businesses to do that.
I know that's been, one of the challenges for the MCOs. Some of the stuff that also drives the timing of it is actually getting the paperwork in or the bids in, with all the information necessary. So sometimes it is it does delay the process. But, I'll let you guys address more what you're doing internally, trying to correct that.
>> SPEAKER: I mean, again, I think you know as we kind of laid out

earlier as far as the home mods are concerned we really try to, expedite our are view in managing them internally. But sometimes it does, Randy to your point, finding you know a vendor that will be able to do it, contractors able to do the work having the OT and PT review, there's a number of steps we have to go through to be able to effectively manage that and make sure it is -- then it's good for the consumer too. The participant, because at the end of the day we want to make sure it's safe and solved correctly and appropriately. It does take some time to do that sometimes, it also depends on the extent of the home modification itself as well.
You know because -- you know putting in the stair glide is different than putting in a ramp are or you know, putting in a shower handles things like that, really depends what the actual home modification is, um, to really do that I think that's, one of the other complicating factors you cannot look at a blanket number you have to look at each type of home modification as they are.
>> BARB POLZER: Lou?
>> SPEAKER: Um Lewis from ADAPT, when you change over to one MCO to another one, how long does it take to get your service back?
>> SPEAKER: It should be, seamless. So if you're transitioning from one MCO to another MCO, the information related to your services should transfer with you and there shouldn't be a break in that.
>> SPEAKER: Because we have a lot of issues with a lot of consumers not getting their TRANS passes, go to the MCO they go to the MCO -- they call them, when they left you all -- come get your last pass with you all. And in Philadelphia we have a lot of issues with people like they say with the batteries with this, with that and the Trans pass they loose their doctors, they loose their medicine. Because -- you say right away, it takes more than that. It has been taking more than that. It has been taking a lot, people get sick.
>> SPEAKER: I apologize, um you know for the delays in the process. But you know, the information is -- from the MCO that you're leaving from, continuity of care information, so service plan, care plan information, it is to be transferring to the gaining MCO.
>> SPEAKER: Still takes longer.
>> SPEAKER: It should be you know, if we have a notice -- prior.
>> SPEAKER: Prior to.
>> SPEAKER: Prior to the transition.

>> SPEAKER: Do you have a time limit?
>> SPEAKER: We get a notification, um, if we know, in advance of the transfer if you transferred August 1, we found out between July 15th and August 1st we would, prepare that information prior to the transfer date. Sometimes, we don't necessarily find out until August 1st and that could cause the delay in that transfer.
>> SPEAKER: Because the consumers don't get confuse -- they go to them, where did I get my TRANS pass, everything is on -- uncoordinated, everything.
I don't think they have time for that.
It is too much on their plate.
>> SPEAKER: For, our coordinators when they -- actually our coordinators.
>> SPEAKER: You can't make.
>> SPEAKER: If they're busy they need them today it's an emergency, I can't reach them because she is busy.
It's too much.
>> SPEAKER: Well for UPMC we do have a number that you can call, and there's always someone available, that should be able to assist you even if it's not your specific coordinator.
>> SPEAKER: Right. But -- they have done that and what I heard they have not gotten a call back.
No one reached them.
>> SPEAKER: Okay.
If you can -- um, provide an example we can certainly look into the specifics of that.
And help you.
>> RANDY NOLEN: As far as to answer part of your question the agreement, did state they have five days within five days to transfer all relevant information from the losing to the gaining MCO. That includes the care plan, um, the person-centered planning assessments, everything, the authorizations, everything is to be transitioned within that five-day period so there is, seamless care.
So, if we're running into issues or have participants that you're working with, that that's a problem, let us know we'll certainly work on correcting that.
>> BARB POLZER: Okay.
>> RANDY NOLEN: Okay.
So we'll move observe to PHW.
>> SPEAKER: He has a question.

>> RANDY NOLEN: Okay.
Hold on a second.
We have a question over here.
>> SPEAKER: Hello. My name is Mark Edwards I'm from Harrisburg.
I'm just curious about something that was brought up earlier with the stair lift modifications that some of them are rented and some of them are bought and it was said here that some of them, with the rentals are paid several times over.
Um -- could you explain that for me? And why is that, won't it be easier to buy the unit instead of renting it over and over again.
>> RANDY NOLEN: Yeah. I agree with you.
What has happened a lot of under the fee for service system, a lot of the service coordinators were putting these in as rentals. The reason behind it, I'm not sure whether it was the landlord said he would only allow it in temporarily as a rental or whatever the situation was. Sometimes if stay a stair glide costs $1,000 we're paying a rental of $200 a month after the fifth month, then we paid a $1,000 we're in the program, continuously paying these rentals. That's what I mean by we're paying for them over and over again. The actual cost of the stair glide.
I agree with you 100 percent, that we should be looking at these, if there's a legitimate reason to rent them, because, the landlord of the property, wants to deal with that, through a rental or the participant says I'm only going to be here 3 months and then I'm planning on moving somewhere else, then the rental makes sense. But if it's a long term situation where the person is going to need the stair glide, they're planning on living there long term they should be looking at purchasing them. So I agree with you, we should be looking at purchasing
.
>> AUDIENCE MEMBER: And just, makes sense that, um, that would be a better way to use the resources that are available to you and it would make better sense to have that looked in to, so everything would be clear for everyone involved.
>> RANDY NOLEN: 100 percent agree with you.
>> AUDIENCE MEMBER: I hope that will be done.
>> RANDY NOLEN: I -- we've directed to talk to the MCOs they realize this is an issue they are, reviewing all of these renteddals at this point.
>> AUDIENCE MEMBER: Thank you very much.
>> RANDY NOLEN: Thank you.

>> SPEAKER: Hello. Norris Benz, PA health and wellness.
>> RANDY NOLEN: Hold on second.
>> SPEAKER: It's okay.
Just a comment, to think about for that -- the MCOs some of the landlords I've experienced with doing nursing home transition yes we'll allow a modification or a stair lift, as long as take it back out when you move. So -- is that one of the considerations why they went to rental and is there a way to override that? Like, have a plan of -- you know provider that can remove them give them as donations or something? The equipment, when someone moves?
>> RANDY NOLEN: Yeah. That's certainly something they're looking at.
>> SPEAKER: That's I think a good.
Is egway for PHW, Norris Benz, vice president at PH health and wellness we're actively replacing the rentals, with the units they own. As Randy indicated in the fee for service system, most of the stair glides were rented we're going in and doing our evaluations we're replacing the rentals with unit that is are owned by the participants . With that, I'll go into Jay, who can tell you a little bit about our process for home modifications.
>> SPEAKER: Thanks Norris, much like UPMC, we have a process by which, um, a participant or a provider, participants chosen provider would come to us, work with their service coordinator, request would come in, um, that request, would then be, a discussion would be held, with that participant. Their caregiver, family member, whomever they want at that discussion, about who the home modification or -- durable medical equipment request would be.
With he would then, bring that back there would be a medical evaluation.
And, a decision would then be rendered the work would be done.
Time frame and I know, people have asked about time frames are really dependent upon what kind of request is made, what the extent of the home modification. Would it require, minor construction? Major construction? Those types of things. Do we have a qualified contractor that can do the work? And you know, what is their schedule, too, much like any time you're dealing with a home modification or remodeling your own home your contractor may have other jobs stacked up. Our goal is to get those done as quickly as possible.
If there is an emergency, we're going to try to turn around a review, immediately within a day. If, not within 48 hours, depending upon the

availability of the qualified contractor to come out and look at the repair and what is needed. And we're going to expedite that as quickly as possible.
If we're unable to facilitate an emergency fix, what we can do is then, work with either a PAS worker or the service coordinator, to find out that there are other ways we can support the participant in the meantime while that repair is either being scheduled to be made or being made.
So the goal here is, is to support the individual while they are getting the work done. So if that -- repair can be done within a few days, great. If it is going to take some more time we're going it find an alternative way to support participant, while that work is getting done.
>> BARB POLZER: What about your plans, for OT and PT, do you have a pool the biggest challenge I'm hearing from service coordinators we're being presented with a very huge list, and this is not specific to you, so please don't take it that way. A very huge list of providers they make calls one after another, only to be told we're not doing this we're not doing this. So there's time wasted there. If we could all get to the point where there's a list of OT/PTs who have agreed to provide this service it would cut down on a lot of frustration. That's just the step one.
>> SPEAKER: Um, in a general sense I can tell you that, we do have OT and PTs in network. As a matter of fact, if there is specialized equipment, stair glide or whatever, or -- someone needs assistance or a -- a bit of education on how to use a certain piece of equipment, a tub transfer, grab bars anything like that, if that stuff is -- if education is needed, we are providing, OT/PT visits on site, so that we can have that person educated and their caregivers educated on the use of the equipment.
>> BARB POLZER: And you have designated therapists to do the evaluations for home mods?
>> SPEAKER: Yes we do. And the assessors we utilize are certified in OT and PT. We also engaged with the DME providers for assistance in emergencies if we need a loner until we can get a new stair glide in there, we really try to respond within a day when there's an emergency situation. We have a process and we try to get out there as quickly as possible.
>> BARB POLZER: Thank you.
>> SPEAKER: Thank you.

>> RANDY NOLEN: And any other questions for PHW?
(pausing for questions)
>> RANDY NOLEN: AmeriHealth Keystone?
Okay.
Can you hear me now? Okay.
Great.
Missy, director of long-term services and supports clinical services for AmeriHealth Keystone.
Ien whatted to go over with our home modification process, much like Jay and David outlined with the other two MCOs the identification of the needs start with the service coordinator doing a comprehensive needs assessment in the home with the participant. We get a request at times from participants who may self-identify they have a need for home modification at that time we also go out to do an evaluation to monitor for the safety of that home modification.
We want to increase independence in the home with home modifications when it is safe for the participant to use them. And to that regard we are using the therapist as the other two plans have mentioned to help us with those evaluations to make sure they're safe and we've had successful partnerships with therapists in both southeast and southwest homes, zones, excuse me.
In getting those, evaluations completed for us.
We on the issue of rentals, we are managing large number of rentals right now especially in the southeast region.
I share the concerns that the group has had today regarding the cost of the rentals and if that's really the best way to go, especially for this -- we're in the process of, evaluating all those rentals and transitioning them over to purchased units, at this time so that is a working process that we're working through, um, right now.
>> BARB POLZER: The identified therapists that you have, are those lists, shared with all of the service coordination entities?
>> SPEAKER: Yes.
They would have access to -- um, you know, all of our resources just all of the as much as coordinate nation entities have access to the same resource as internal service coordinators they have access to the lists
.
>> BARB POLZER: Okay.
Thank you.
>> AUDIENCE MEMBER: I have a question.
I have a consumer, that reported to me that -- her

coordinator from Keystone First, I apologize stated she had to pay for therapist to come out, and check her home to see what kind of modification she needs.
>> SPEAKER: Okay.
Um --
>> SPEAKER: My name is Miss Tores, I'm the manager of liberty bell home care services.
>> SPEAKER: Thank oosphere bringing that up, that -- there should be no cost to the participant at all through the home modification process. The evaluation by the therapist is at no charge to the participant.
I encourage you to either you know, get with me after the meeting so we can, get the name of the participant to see if we can get that resolved. Or, you know, you can certainly feel free to call into the service coordinator, or -- you know, to try to get a clarification on that.
>> AUDIENCE MEMBER: Thank you.
>> SPEAKER: Thank you.
>> BARB POLZER: Shirley.
>> SPEAKER: Latoya, I have a question.
Besides the company that is coming in to do the durable medical equipment them coming in to do the measurements and stuff because the last time I had my -- they came in on the weekend will the OT and PT person be able to come in on the weekend I work during the week?
>> SPEAKER: Um, thank you for bringing that up, that is a great question, we strive to be as person center the as possible and if the only time we can enter your home to do those evaluations is on the weekend we will continue to contact providers, until we can find one that can accommodate your request.
>> SPEAKER: Thank you.
>> SPEAKER: No problem.
>> BARB POLZER: Brenda, do you have a question -- I'm sorry?
>> SPEAKER: Yes, I did.
When evaluations by occupational and physical therapists are taking place for home mods it concerns me because if that is the first time they are there, they may not have all of the knowledge and information that they need, to make that evaluation accurately. If a person has a pre-existing relationship an occupational or physical therapist, are they automatically invited to be the ones to do that evaluation? Or can that process being implemented?

>> SPEAKER: Thank you for that question. That's an excellent suggestion. Again we strive to be person centered and, working with participants to build their own person-centered planning team. If they have a therapist they would like invited to that person centered planning team for use we would be happy to accommodate that.
>> RANDY NOLEN: It is -- it is a choice of the participant so if the participant knows someone they want to work with, um, they can certainly let the MCO know you know I like this therapist to do this or this construction company to do this work. Just realize that especially when you get to the bid the way the agreement reads is that, um, if you get two bids that are -- the bids are the same thing and exactly the same process, to do the home mod, they're going to take the lowest bid. So -- you can't always -- have the right company to come in, if they have a PT/OT they're comfortable working with, they should let the service coordinators know that.
>> SPEAKER: Okay.
>> BARB POLZER: Brenda, um, Pat sent me a text do you want me to pass this over to Randy?
>> AUDIENCE MEMBER: This isn't from Brenda it is from someone else.
>> BARB POLZER: Sorry I apologize.
Anything else Brenda.
>> SPEAKER: This is Dan hearted from liberty resources itch a quick question geared towards the department than the MCOs but they can chime in if they want, we're hearing the same concerns that Barb brought up from consumers there's not enough PT/OTs available to do the assessments.
That they're required by the MCOs prior to the home mod provider giving the bid this is a huge concern we think this is creating more delays and why we're seeing, I think at the last sub-MAAC meeting we saw some of the time gaps between, each of the MCOs, how long it was taking for the home mods to be completed. One of the questions I had for the department would the department be open to considering hoax mod providers not necessarily providing OTPT, but referring to OTPT providers that have done this in the past that are willing to do this? We found some of the PTVOT providers listed in network are being provided by the MCOs that do this, want to do this. Again a question for the state, are you open, do you see this as a conflict or are you open for provideers to preserve to OT/PT providers?
>> JILL VOVAKES: Correct me if I'm wrong the question is, is the department open to home modification providers, um, engaging, the PTVOT?

Correct?
>> SPEAKER: Yes.
>> JILL VOVAKES: Our expectation would be that the -- the MCO the service coordinator, the MCO service coordinators would be -- um, the ones who would be making those arrangements.
>> SPEAKER: It's not happening. They're -- some of the delays are because of a result of the PT/OTs being provided the supports coordinators don't do this they don't want to do this.
>> JILL VOVAKES: So, just to confirm my understanding, in the fee for service program, we have PT/OTs doing this, what I'm hearing these PT/OTs may not be utilized now, necessarily with under the CHC is that what you're seeing?
>> AUDIENCE MEMBER: That could be -- one of the reasons we're hearing in some cases the consumers are being given a list of PT/OTs to call up and identify if they can come out and do the assessment I find that ridiculous the consumer is calling the PT/OT to do the assessment that should be the responsibility of the managed care organization to coordinated we're hearing the S, considers the list they're being given, is not accurate, the people on the list do not provide the service, whether they did it prior to CHC today they don't do it, we do know there are some home mods have know, have existing relationships and even with some of the MCOs have, established processes that kind of build that connection so the PT/OT the home mod provider are fully engaged it seems like that is working.
I don't know if all 3 MCOs are up for that, if the State is open to how home mod providers are doing this, have gone this, as long as is not in conflict I don't see why that would not solve some of the PT/OT problems that exist today.
A lack of -- this is all, in light of, if there's any changes that don't come which we hope do in the waiver renewal.
>> RANDY NOLEN: Yeah. I agree with your point.
I mean it is a waste of time if we're calling 20 OTs none of them do the type of work the MCOs should be identifying that. And, as far as the change in the process of working through that, um, that would probably be a really good discussion for the home mod meeting that we'll have, next month, following the MLTSS meeting. So -- I don't know if you're -- would be available to stay for that meeting. That we have -- a great place to have that discussion with all of the 3 MCOs at the same time.
>> SPEAKER: I can do that, what I am looking for from the State, we

know the only MCOs do part of the contract requirements with the State, do you see a conflict with the NHT, home mod provider, not NHT, home mod providers reaching out to a PT/OT who may not be in that current list of the to establish that relationship and connect them with the MCO at the same time, say hey, I have a job, that I need someone to go out and do a PT/OT assessment for this person needs the mod they're waiting and they're waiting.
Is the State hoping for that, do you see that as a conflict.
>> RANDY NOLEN: I think it's something we need to discuss we're dictating the managed care organizations manage this process. So -- um, we would have to certainly look at the perimeters of how you want to do this. So -- um, the MCOs are going to have to do the process.
>> AUDIENCE MEMBER: Would you agree -- would you agree that -- the consumer --
>> BARB POLZER: Brenda hang on one second please.
>> AUDIENCE MEMBER: Would you agree the consumer should not be responsible for reaching out to the PT/OT.
>> SPEAKER: This is Missy from AmeriHealth this is not our policy to have the consumer to reach out to their own PT and OT the service coordinator is managing that process as Randy said.
>> SPEAKER: One session on that -- um, you mentioned they're not in network for that MCO and that might create a payment problem I would think working with the MCO to say -- you know, I have an identified resource that can solve this problem, MCOs might have the ability to reach out to contract with them or do a single indicates agreement with them, if there's -- if it is a shortage, if there's not enough PT/OT they cannot identify someone who does that identify that type of work. That's a good suggestion I think that, while that would be, wonderful, I think that the ways now are in the processes that the MCOs have established not so much there's not being providers that want to do this, home mod providers may know of or other organizations may know of, for the PT/OTs it sounds like there's some process, issues or strain at the MCO level which we all know this is a huge you know, a huge shift from fee for service to CHC to under the managed care, which is to be expected I would hope after rolling out in the southwest and southeast we would have a process in place that's a little more efficient than it is.
>> JILL VOVAKES: I would also piggy back of what Blair said, I mean, if you have specific issues you have specific cases um, up specific PT and OT that you know, can perform the function, I would be

going -- you as the provider, contracted with the MCO, go back to the MCO and share that information with them.
Because ultimately they are, responsible for setting this up, I mean currently the structure, dictates that should be the ones arranging for that evaluation. So -- you as the servicing provider need to go back and work with the MCO.
>> SPEAKER: I understand that, I think that, I guess, Randy to your point the next month home mod meeting might be a better place to talk about this, but again the MCOs, are listening to you for direction on what they're supposed to be doing, per the contract. We make recommendations on how you can make the process more efficient if it goes -- against what your contractor requirements are, they're not going to do it, I think coming from the State, it is more valuable than coming from the provider network, I agree with everything you say in terms of reaching out to them, when we see issues it is a really the State that dictates what happens.
>> RANDY NOLEN: We dictate in accordance with our agreement. So I can't dictate outside of the agreement, at times I may try to, but -- I can get push back on that I think these are things that can be resolved with open discussion I think, if you got a set of providers or known providers out there that would actually provide these services they don't currently contract with one or any of the MCOs I think that would be a starting process, from your side, to get these guys to contact the MC Os to become part of the netted work let them know, here's a resource these people willing to do assessments five or ten a week, whatever to at least get that part of it going when an assessment is needed they have that contact.
>> SPEAKER: I agree I think what I'm looking for is ways to make the system more effective as far as decision and process thinking I know SCs are responsible for everything they should have a logo on the shirt for the super hero they are, because of everything they do. They are get given a huge amount of tasks even more so than in the past,
a home mod provider can fill in the gaps can identify a OT/PT provider by referring them to the MCO I referred an referral from the MCO to do a bid for a job, can you -- look to do the PTOT for it and submit to the MC I think that will be a level of efficiency that doesn't exist today.
>> RANDY NOLEN: I would think you guys can correct me if I'm wrong, all 3 MCOs would being to have that discussion and look at that as a an option.

>> SPEAKER: Yes.
>> SPEAKER: Yes.
>> SPEAKER: I agree.
>> BARB POLZER: Brenda?
>> SPEAKER: Just a question for Randy, really I think for some of our folks here in the southwest that I worked with personally one of the issues is that, this might be a person who is already using this kind of equipment but is in a new environment.
Is there any way we can create a I, um, an opt out process for that PT/OT evaluation to allow the home mod provider to say -- can this equipment is being used I can certify it is there, he knows how to use it.
To sort of eliminate that step from the process?
>> RANDY NOLEN: I think some may depend upon the original situation, is the home mod ten years old or just done in the last year with all evaluations? I think, the MCOs would have to look at that on an individual case by case and make a determination whether they needed a new OT or PT evaluation, that is certainly within the discretion of the MCOs to make those decisions.
>> SPEAKER: So that's -- that's flexibility to opt out the PT/OT evaluation already exists?
>> RANDY NOLEN: We have some processes in place, that if, things were done, within the last few months or -- there's been no alteration I think that's something they can evaluate.
I agree that, if someone had a -- home mod done with a PT/OT evaluation six months ago and they moved, um, for whatever reason, and need the same home mod implemented I think that's something that the MCOs would have to evaluate.
>> JILL VOVAKES: Still need to evaluate the new location.
>> RANDY NOLEN: They would have to evaluate the new location but, um, they may be able to evaluate whether they need to do an actual new OT assessment on the person themselves or PT assessment on the person themselves they may still --
>> SPEAKER: For clarification I'll use my sex as an example. I have a --
(indiscernible)
Itched the lift installed for 22 years, in various places, I know how to use it very well, but it is not something that a lot of people, are familiar with, one provider -- I admit, if I move do I need a new OT/PT assessment for a piece of equipment I've used longer than most of the OT

and PTs in practice?
>> RANDY NOLEN: I think that's the question you would be discussing with your SC about that the MCOs have to make that decision.
>> SPEAKER: That flexibility exists thank you for clarifying that.
>> RANDY NOLEN: Okay.
>> BARB POLZER: Carrie?
>> SPEAKER: Good morning this is Carie Bach from voices for independence, can you please clarify what the actual waiver language says? Because, to my knowledge, it states that an individual, evaluation must be completed for a home modification.
And then the next sentence says that it may be completed by an OT, PT or a speech pathologist.
And so, to me, that actually does, leave some room for others who are -- qualified to do these evaluations I'm not saying that the OTPT evaluation is not important because as a home mod provider we do utilize them.
With the shortage that we're currently facing, is it a requirement to have a home mod with the home OT, PT evaluation?
>> RANDY NOLEN: Miss hail?
Hail.
>> SPEAKER: Good morning Patty Clark with the Office of Long Term Living policy bureau. So -- the community HealthChoices waiver, under home adaptations, you're right. There are -- there is some different language in there when I think read the sentence you'll understand the distinction.
For home adaptations -- this service, does not include, but requires an independent evaluation. Depending upon the type of adaptation, and in accordance with their scopes of practice and expertise, the independent evaluation may be conducted by occupational therapist, a speech hearing and language therapist or a physical therapist meeting all applicable department standards including regulations policies and procedures. Relating to their appropriate qualifications.
I think the first part of that sentence, we say that the, um, the evaluation, is required. The second sentence says, it may be conducted by PT/OT/speech, the may part, the word may in the seconds sentence, refers to the type of therapist that is conducting evaluation.
Well the word -- the word may is, providing the flexibility of those 3 different types of professionals.
Depending upon the adaptation and the person's situation.
>> AUDIENCE MEMBER: I think -- it should be there should be an

either in there, either -- one of these therapists.
>> SPEAKER: Uh-hum yeah. If it is confusing we could add the word either or say that -- it is conducted by it must be conducted by a physical therapist, occupational therapist or speech therapist.
>> AUDIENCE MEMBER: We're talking about this contract, has it been signed by the MCOs.
>> SPEAKER: The language I was readings is from the CHC waiver language. So that's not um, it is -- considered part of the contract that it is a separate document that we, where we describe the program and the services and, we, um, have to submit this to the Federal government for approval.
>> AUDIENCE MEMBER: It is also in the agreement, um, 2019 agreement. And that's the exact language.
That's the exact language there as well.
>> SPEAKER: Okay.
As I said we could, we could clarify that language add a couple of words to make it clear, that it is, it is required.
I think that probably when Jen Hail comes up does her update on the, the waiver changes she will -- she might speak a little more to this.
>> AUDIENCE MEMBER: Okay.
I had a few other questions.
So -- I believe that there's Federal law that landlords cannot prohibit modifications, that would tenants would need to live safely. So I mean, that should be something that the MC Os could keep. The other thing is about -- the time frame that was brought up, awhile ago, um, and was kind of, dismissed because there are complications of spatial logistics and networks and like kind of while I think it is a more -- to them, I think that's kind of what the question is about. We're wondering about those logistics. That, that is kind of at the heart of getting that time frame, getting that average you can bring it down by like stair lift and by specific modification. But I think, like getting an average time frame, um, would be really good to have. But my main, this is Liam from Philly ADAPT, my name question, um, so this is again language from the 2019 agreement, um, there is no expectation that waiver funds will be used to turn return the home to the original state.
>> BARB POLZER: People on the phone please mute yourselves.
>> AUDIENCE MEMBER: -- yes. So, um, there is no expectation that waivers to be used to return the home to the original state in the

case of rental properties, I know, coming from the disability community, a lot of our community is in rental properties.
So, I'm wondering if you could speak to that? Because I think, you know, in the case of stair glides and, many other modifications, it would be some cost on the back end and I'm wondering if that, where that goes in, into the calculation.
>> SPEAKER: I'm not sure.
>> RANDY NOLEN: Yeah I think, I think, you asked two things I'll comment on them. One was the average time and, one -- made me think I'll ask the MCOs to break it down by the actual home mods if it was a stair glide, if it is a construction to widen doorways and, putting in new showers so I'll ask them by type of home mod what their average time is, to break it down a little bit more so we're not just throwing 100 day number at you, it really doesn't mean anything, some should be quicker and some may take longer I'll get that piece of the information for you.
And just to try to clarify your other point. You're saying that, um, is there an issue or is there a payment resource, if a home mod is done, the individual, participant leaves that rental part, moves somewhere else, is there a requirement to make the home whole, prior to making the modification, and is there a mechanism or a financial mechanism to do that? And was that your question?
>> AUDIENCE MEMBER: That's correct. Because I mean, it says waiver funds cannot be used for that.
>> RANDY NOLEN: Right. Right.
I don't know, that's the first each been asked that question, so I don't know the answer to that, so I will have to take that back and research it I don't know -- from the perspective what can be done there.
>> SPEAKER: Yeah. Just to confirm, that is in the waiver under home adaptations, um, specifically, in the a couple of sentences that, talk about having home adaptations for the rental property, the language says that the rented property adaptations must meet the following -- number one, there is a reasonable expectation that the participant will continue to live in the home and number two, written permission is secured from the property owner for the adaptation including that there is no expectation that waiver funds will be used to return the home to its original state.
So, for example, if a doorway was widened or, some type of a similar type of a home adaptation was done the expectation is that if the

participant then mover moved out of the rental
property the waiver would not pay to have it put back to the original state.
So that would be an example of that.
>> AUDIENCE MEMBER: In the case of like, you know if I needed a stair glide put into an apartment that I rented, I feel like my point would still stand I'm wondering about the, making them -- no financial mechanism that I mean even if it had to be, um, talked about like you know, in the front on the front end with the landlord, um, I if I can't pay for that removal of, who can? And because I mean it seems like if I can't, then that would be prohibited.
>> SPEAKER: I agree totally. And -- so -- a stair glide, would not be covered under a home adaptation. That would fall more under the category of specialized medical equipment and supplies. Because it is something that is removable from the home and so, in those cases the waiver would pay to have something removed. So that's -- it's kind of two different categories there.
But I agree. You would want to be able to have those stair glides removed if the participant moved out of the rental property.
>> BARB POLZER: Is that it, Liam.
>> AUDIENCE MEMBER: I think so. Really does seem like a lot of these home adaptations that are more, um, were less easily removable yeah. Thank you. I'll leave it there.
I really wanted to stipulate though, that could be a problem in a lot of cases. And should be addressed.
>> BARB POLZER: Okay.
>> RANDY NOLEN: I think we have to look at it on a case by case basis.
I think we were just briefly talking that for some landlords it may be a benefit to keep that stair glide in there, it might help rent property out again.
So, I mean, we have to look at that on a case by case basis I think.
>> BARB POLZER: In the essence of time I'll take one more question, Shona.
>> AUDIENCE MEMBER: Thank you, I'm Shona Aiken for voices of independence, we've been doing home mods for a very long time, I just want to go back for a second about the OT/PT issue. And say that -- um, the language in the waiver says may, I really feel strongly that I think others, in this room would agree with me that, may is there because, OT/PT is not always necessary.

People with disabilities who have had their disability for a very long time are used to using a home modification or a home adaptation, know better what we need than, than a lot of times the OT/PT coming in off the street, who have never really worked with us and -- I can use myself as a personal example.
If you do a bathroom modification for me the standard OT/PT would recommend an ADA compliant toilet. ADA compliant toilet is 6 inches too high for Shona Aiken I cannot use it. We've had situations in our home, where home modifications were recommended by OT/PTs needed to be removed and one that, that -- needed to comply with function was put in in replace of it. So I would, I would strongly encourage that we leave that word may in there. Because, an OT/PT is expensive.
If there are circumstances where you know, the consumer knows what they need and they have been using the same adaptation for years, there's really no need, to add that additional expense and spend state money in areas where it doesn't need to be spent.
So, so I would caution you to examine that, because yes, they're needed in many cases. Yes, when someone is new to a disability or experience or has a change in condition that is unexpected and they're looking for a different modification, that's very, very needed I agree we use them all the time.
However, it is not the case, in every home modification. Mods wear out things need to be replaced. It is just the same we would be expending state dollars in this way, when those of us who have been doing this for, many, many years know it's not necessary.
>> BARB POLZER: Thank you Shona.
Okay.
>> SPEAKER: I just -- this is Jesse Wilderman I want to make a quick comment this report from the MCOs has been helpful, but -- in my mind not sufficient, so seconding what Nancy and Liam said we really need the numbers here on the duration it takes Randy your idea of breaking it down by you know the type of, home modification and the duration is a really good one I think. We do need to know those I wanted to -- one aspect has not been brought in, the impact on the direct care worker the PAS worker in situations where people are waiting, waiting and waiting the direct care worker and the participant figure out work ands so we have a direct care worker who is carrying someone upstairs because they have not been able to get the home modification in a you know in a reasonable period of time and so, um, and -- that's, dangerous.

And results in, increased levels much injuries for you know, for PAS workers and direct care workers it is really important that we not only know how long it is taking, but that the participant is getting regular updates and the direct care worker along with them on when it is coming. And you know, what is the hold up? And just keeping that line of communication open, but for this group I think, first really understanding those numbers. Um, to me is just essential. So I know it's been said a couple of times that should be pretty straight forward and, easy for us to collect. So we can, then track our ability to improve those time frames. So, bring that perspective in, because everyone knows that the -- you know, the direct care workers are faced with the work arounds because they have to, but it's not great for anyone, we know direct care workers already face some of the highest injury rates of any profession back
injuries, especially. This has a direct impact often them to stay in the work.
>> RANDY NOLEN: I agree with your point. Thanks.
we'll -- over the next month I'll work with the MCOs we'll get some more number break downs, process break outs, we'll have further discussion next month, at this meeting and at the follow-up work group with home mods. Thanks, guys.
>> BARB POLZER: Next we're going to have Cristen present on EVV, uh-oh, Jen?
>> SPEAKER: I think it's me.
Waiver renewals.
>> BARBARA POLZER: EVV next. According to the agenda it is, Kristen, but is there --
>> SPEAKER: PowerPoint is a different order. But --
>> SPEAKER: Conversation flow would it make sense to dot waiver renewal.
>> BARB POLZER: We'll have Jen come up do the CHC waiver renewals, thank you Kristen.
Okay.
>> SPEAKER: Good morning everyone, I am Jen Hail, with OLTL, policy thank you for accommodating the agenda switch I think that, our previous conversation, this would flow in nicely. So -- um, I am going to give an update on the, CHC waiver renewal as well as, the OBRA amendment we're planning to do.
So the current 1915C, waiver expires on June 30, 2020, we will going to align the waiver, aligning with the calendar year. It will

allow us to align the changes that occur within the CHC agreement, which runs on the calendar year as well.
So, our plan is to, renew the waiver with minimal changes, with an effective date of January 1, 2020.
So, we understand that, um there's been a lot of feedback and a lot of stakeholder input into some of the requests for changes for the waiver.
So, we are planning to do a more comprehensive amendment in the spring of 2020 for effective date of January 1, 2021, so we will be, um, putting together some plans to do stakeholder outreach, hopefully starting in the fall to talk about those more substantive changes for the amendment that we'll be drafting in 2020.
So just to walk through of some the main changes that will take place for the waiver for effective date of January 1, 2020, the first is the change to the qualifications for service coordinators.
On the slide here you can see on the left-hand side we have what the current approved languages is.
And on the right-hand side, we have what is being proposed and then, um, what is bolded is the actual change in the language. So, for this particular change for the service coordination qualification the change allows for more flexibility in the SC Quals, specifically the current requirement requires all SCs to have a bachelor's degree. And the proposed language allows for 3 years' experience in place of the bachelor's degree.
Moving onto the service coordinator supervisors we follow kind of the same line of thought when we proposed changes for the SC supervisors and moving from strictly an RN or a licensed social worker, to an RN or an individual with a masters degree and a commitment to obtain their license within a year.
We included some additional clarifying language around the requirement to include emergency backup plan in the person centered service plan. This is something that, has always been a requirement and we just flushed out some of the language in the proposed waiver renewal.
And then also, we are making revisions to our employment service definitions. We are adding language that Office of Vocational Rehabilitation or OVR services are considered to not be available if OVR has not made an eligibility determination within 120 days we're also adding language to the employment service definitions to address the closure of order of selection from OVR. In that, while there's a

closure of the order of selection that individuals can access the employment services in the waiver.
Um, so that, that will be included in the waiver renewal, Barb is smiling that makes me happy.
>> BARB POLZER: Yes.
>> SPEAKER: Um moving on, with the changes to some of the service definitions, um, we are proposing to change the service definition from residential habilitation we're modifying the number of hours are defined as a day unit so we are, modifying that from 12 to 8.
And then, for the comprehensive needs assessment, there is currently language in the CHC waiver that outlines trigger events that would initiate the completion of a comprehensive needs assessment. So in a proposed waiver we are adding a trigger event for when the CHC/MCO must complete the comprehensive needs assessment that is outlined here on the slide. It is when the CHC MCO identifies that a participant has not been receiving services for a five or more days in the suspension of those services are unplanned.
We are requiring the CHC MCOs to do outreach to the participant, within 24 hours of identifying that and then, after talking with the participant, um, if there's a health or a needs change, health status or needs change they must go out and complete the comprehensive needs assessment within 14 business days, within 14 days.
Those are a summary of the major changes that we're including in the proposed waiver renewal.
We anticipate that a public notice will be published in the Pennsylvania bulletin mid August, I think our target date is August 17th, but -- um hopefully that stays true.
And, then -- that will initiate a 30 day official public comment period where we encourage and invite, the public, stakeholders anyone to submit written comments on the waiver changes.
We will send out a Listserv just to make sure that everyone gets notice when that is published in the Pennsylvania bulletin all the materials will be posted to our web site for review.
Then, along with some of the conversations we had earlier, we -- comments in today's presentation if you have any comments to submit to the RA account listed here on the slide.
-- but, also, any feedback that you guys would like to give on some of the changes. Or recommendations for the CHC waiver, I'll pause there before I go onto the OBRA amendment.
(pausing for comments)

Questions? Comments? Feedback?
>> SPEAKER: I just wanted a little more clarity on the five day rules five days if they're not using services and then within the 24 hours of the noticing service coordinator has to call the person is there, like what if they don't get a hold of them, in that time, do they shut it down, does it stop the services if they don't get a hold of them in 24 hours is there some guidelines around that? Within 24 hours you have 3 days to get a hold of the person before you -- I'm just thinking, my mom was in the hospital I would let them know you know -- if I wasn't able to you know, some was really sick I would not be able to get a hold of them I would want someone that's a great thing follow-up with the person, maybe -- you know, have some guidelines around that for how long before you shut it off
or suspend, sorry, suspend services if you can't get it after 24 hours.
>> SPEAKER: That's a great requested we have not flushed it out that much, if you have a recommendation we can certainly go back and take a look at putting some paramaters and some things in place about number of contacts that need to be made things like that.
>> SPEAKER: Okay.
The other question, the language that was read before, about the home modifications who can do them. We talked about experience and expertise all of that then it went into the medical part of it, the PT/OT, there are some people doing the same kind of thing the PTs and OTs doing have the ADA experience they have the life experience the language is right there if you could tweak it a little bit to include others who are already doing the home modification evaluation process have you know, have certification, have ADA certification.
And I'm sure, from our office Jeanetta will send some of that language, there are people that are already doing that, that could easily slipped in there.
Not that I -- I think that, kind of what Shona is saying too you you know, there is reason for PT/OT, it should always have to be -- there needs to be some language that says, if -- if there isn't, when there isn't, or it isn't necessary for a PT/OT evaluation.
>> SPEAKER: Okay.
I think that's great and I think that, historically we use certified specialist, if we can get my recommendation would be to submit like what more specific language or more specifics around what that certified specialist would be, that would be great.
>> BARB POLZER: Amy?

>> SPEAKER: Hi this is Pam silver from the Pennsylvania health law project.
I also wanted to return to the five day rule.
I just want to understand what exactly is the Rationale for this change of adding this new triggering evented. What is the, kind of evil or harm that prompted adding this as a trigger event?
>> SPEAKER: I don't know it is necessarily, um, evil or harm I think it is someone hasn't been receiving services that there's a requirement four the SC to be following up within certain time frames, to make sure that, um, there's almost a safety check to make sure that the participant is okay.
You know, why have they not been receiving services, you know, it is just an added extra level of, insuring health and safety.
>> AUDIENCE MEMBER: Okay.
Thank you.
>> SPEAKER: Uh-hum.
Shona? Yep.
>> SPEAKER: This is Shirley.
>> SPEAKER: Sorry.
>> SPEAKER: It is not a question -- two questions actually we were just wondering if you could clarify, what you mean by the service definition for residential Habilitation I cannot see what the actual change would be.
>> SPEAKER: Sure. So, we are changing the service definition currently, an individual has to be at the residential habilitation residence for 12 hours in order for the residential Habilitation provider to bill we are making the day unit we're changing the definition of the day unit from 12 to 8. So someone is there for 8 hours then the residential habilitation provider will be able to bill for that day.
>> SPEAKER: I don't know if you can answer the next question. The State and -- I wanted to ask, um, right now if you don't have a triggering event, let's say you're a consumer you don't have a triggering event, how often are you to be reassessed by your MCO, the State have any guideline.
>> SPEAKER: We do it's annually, we require individuals to be assessed annually or, um if a participant requests to be assessed.
>> SPEAKER: Okay.
If the parenthesis want does not request to be rea he is ised, does the individual MCO have the discretion to allow for more assessments? As

they choose? If there's no triggering event.
>> SPEAKER: If there's no trigger event it would be annual.
>> SPEAKER: Um, so -- I -- I am a consumer. I had an assessment in March. End of March.
And they redid my service plan and my assessment.
I scheduled to have another one on Monday. There was no triggering evented.
I was just told that it needed to be done. So I'm just curious if it is annual, um, what is the -- I did ask the MCO and they said that there's now this biannual and annual assessments that get done rather not say the MCO is -- here.
But, I just am curious if the State says that it is annual, and you're saying that it is annual, unless there's a triggering event or a request for more services then, am I correct to say you're saying that the MCO does not you know, should not be requiring more assessments on their own, if there's -- nothing to warrant it?
>> SPEAKER: I don't think if there's nothing to warrant it, um, without knowing the -- without knowing the specifics I mean without, if there's nothing to warrant it, yes. The requirement is annually.
>> SPEAKER: Okay.
Well you know --
>> SPEAKER: Annual requirement a minimum or a maximum? I guess it is kind of is it --
>> SPEAKER: It has to be at least annual. That's the minimum.
There's no --
>> SPEAKER: So they have the -- the ability to -- I'm just -- I'm just wondering does each individual MCO, if it is at least annual, have their -- if there is no triggering event is there -- do they have the discretion to say needs to be another assessment if there's no triggering event, if there's no request for more hours -- none of that, am I correct? Is the -- does the MCO have the individual discretion to say there needs to be another one?
>> SPEAKER: Yeah. Okay.
So I guess the -- this is Patty with po Clark with policy. Is it possible that the MCO, service coordinator is coming out for a home visit because they would be required to do a home visit more than once a year I believe it's twice, twice a year they would need to do a home visit. The second home visit would not necessarily involve an assessment, but they would just kind of be making a home visit to check on how things are going.

>> SPEAKER: I was told, they were going to be redoing my individualized plan so it would be -- an assessment.
>> SPEAKER: Okay.
And as far as the MCO having the ability or the discretion to, um, do an assessment, um, I --
>> SPEAKER: Before they --
>> SPEAKER: There's nothing, there's nothing written as far as a requirement or, um, saying they can't do it.
I would not understand why they would be doing another assessment, if they weren't -- if they weren't aware of maybe a change in your situation or something that happened.
>> SPEAKER: That's what I was going to say.
>> SPEAKER: I think, I don't know if we want to -- like talk after the meeting so we can maybe have some resolution one-to-one.
>> SPEAKER: That's fine I was just curious in general.
>> SPEAKER: Sure.
>> SPEAKER: It was my understanding.
>> SPEAKER: Sure.
>> SPEAKER: Usually annual unless there's a triggering event or request for more hours or something.
>> SPEAKER: Yep.
>> SPEAKER: Just curious, if there were -- you know, that the MCOs had a certain discretions to do certain things a little differently I was just curious about that.
>> SPEAKER: Okay.
>> SPEAKER: Thank you.
>> SPEAKER: Sure.
>> SPEAKER: I have a question.
My name is Miss Torres I'm from liberty health care in southeasts area I have a few consumers that have a few concerns because they were doing some assessments, they said it was a mandatory for them to go on assessments every 3 months.
>> SPEAKER: Can you repeat that again?
>> SPEAKER: Talking about reviewing the person-centered care plan? Compared to doing the full interRAI?
Probably what --
>> BARB POLZER: I'm sorry who is speaking.
>> AUDIENCE MEMBER: Assessment has taking 2-4 hours.
>> SPEAKER: So -- I'm not sure I mean the requirement as it is written in the waiver and the agreement it must be completed at least

annually or, when there's a trigger evented. So I'm not sure if there's a change in since that is, initiating the assessment or not. I'm not sure, without the specifics or -- situation.
>> AUDIENCE MEMBER: We had a situation where we needed units for the following month and -- they gave us authorization for 3 months and, they said well we have to do an assessment, every 3 months in order to update the units and, we were kind of confused because we've been operating for six years and it is done annually.
>> SPEAKER: If there's -- if there's a change that would indicated that someone needs an increase level of support.
>> AUDIENCE MEMBER: No, everything is normal, same hours same units every 3 months, a couple of consumers we have in our company, wanted to be aware of that, it is -- um, I do provide services for almost -- for the a he is isment to be -- done and we can't bill for any of that any services, because of the authorizations are not in on time.
>> SPEAKER: Okay.
>> RANDY NOLEN: One particular MCO or all 3 of them? Speak.
>> AUDIENCE MEMBER: Keystone First.
>> SPEAKER: Yes.
>> RANDY NOLEN: Keystone First can you address why this may be happening?
>> SPEAKER: Hi Missy Weekland, with AmeriHealth Keystone First thank you for bringing this to our attention we'll certainly look into that further InterRAI is not neon the intervals however we do review the person centered care plan, which can take some time because we really want to make sure it's still meeting the participants needs, I'm into the saying that could be done in a 15-20 minute visit it should not necessitate a entire assessment unless there's a change with the participant, that the service coordinator feels it is necessary to reevaluate need, again if you have specific examples I would like to talk afterwards to look into it more, we do the care plan updates, on a quarterly basis.
>> AUDIENCE MEMBER: Okay.
>> SPEAKER: Okay.
>> RANDY NOLEN: Thank you.
>> BARB POLZER: Okay.
Matt then that's the -- unfortunately the last question we're going to take right now we can in fairness to the other presenters we would like to get them in.
>> SPEAKER: Just 2 or 3 questions actually.

Is I'm on the same page this is your agreement with CMS?
>> SPEAKER: Correct. This is our 1915C which is our agreement with CMS.
>> SPEAKER: So then you have separate contracts with the MCOs?
>> SPEAKER: Yes we have the CHC agreement that is between, the department and the CHC MCOs.
>> SPEAKER: So, does this do -- do the MCOs have to conform with that?
>> SPEAKER: Yes they do I didn't mean to cut you off, in the agreement, we require them to follow the waiver and the changes that are contained in within the waiver.
>> SPEAKER: My thinking is some of these things are going to, demosteratively change and the way things that the MCOs do, they're going to eat that, that's a maybe a rhetorical question, can you go back 3 pages to the employment screen or -- actually -- my few questions, does this mirror the ODP?
>> SPEAKER: It does, we worked with ODP and, flushed out some of the language this does mirror their process.
>> SPEAKER: Okay.
All right. That was -- I was curious about the dates. So this I would think is going to change what the MCOs are going to have to do, to a -- a financial extent I would think, they're going to have to just have to accept this?
>> SPEAKER: These are things that we have -- we will be talking to them about I believe beings, they received some of the changes but I know we'll be able to review the changes.
>> SPEAKER: You said awhile ago they all have to do it.
>> SPEAKER: Yeah. It will be part of the agreement.
They will have an opportunity to review and comment on the agreement.
>> SPEAKER: Bullet eventually they have to --
>> SPEAKER: Yes.
>> SPEAKER: Okay.
Good. Thank you.
>> BARB POLZER: Okay.
Okay.
>> SPEAKER: Last slide.
Okay lastly just briefly we'll be completing OBRA waiver amendment.
The waiver for the waiver amendment will be effective January 1, 2020 most of the changes we're making for the CHC waiver will be also applied to the OBRA waiver a public notice will be published in the Pennsylvania

bulletin I think, August 24th is the target date for the publication.
That will begin the 30 day public comment period. Pam?
>> SPEAKER: Just one question. Actually been dealing with an individual who has OBRA under 21, is there any way, in the -- amendment to help some of these kids who are really having a difficult time using the, um, the services of UPSDT, to actually, exempt them at all in certain circumstances from going the route UPSDT. The limited providers under it -- um, it is a long drawn out process. It is just really, difficult for the kids, it is delaying them moving forward in their life trying to get services where if they were offer the OBRA waiver they get the home care they need, they don't have to deal with the nursing as much, and it is just a more smooth process. There's no way, to exempt UPSDT, except for the services that -- um, it doesn't cover. >> SPEAKER: Unfortunately I don't think there's a way to exempt I mean this is something that we've, had, like struggled with, but CMS won't approve something that, that doesn't go through EPSDT, prior to waiver, if you have a comment or a recommendation, please make sure that you submit that during the comment period.
>> SPEAKER: Okay.
>> SPEAKER: Okay.
>> BARB POLZER: Thanks Jen.
Next up we have Kristen for EVV.
>> SPEAKER: Good morning, Kristen, Wireman, Office of Long Term Living, I'll give a brief EVV update we can walk through any questions that you have and -- make sure we have time for other presenters.
So just as a very brief reminder for anyone not familiar with the requirement, we are required to implement EVV as part of the 21st century cares act, it does have to collect the 6 pieces of information listed here. So that is the service provided, the individual receiving the service, the individual providing the service, the date, location and time of the service.
As we mentioned before, the Commonwealth is approaching this as an open vendor model. To allow providers who already have their own EVV system to continue to use the systems as long as they meet the technical specification requirements that we have outlined on the web site and their systems can interface with the DHS aggregator or the MCO system.
And on the next slide I have a chart to better clarify what we mean, because there are -- multiple components in an open vendor model. In the center you can see the DHS aggregator that we talk about, that is

going to be the central hub of all of the data, that we have coming from EVV systems.
On the left side in the orange is the interaction on our fee for service side.
So, fee for service providers, can chooses to use an alternate EVV system, that will have to interface with the aggregator and send the data to the aggregator. They can also, choose to use the free system being provided by the DHS, which is, provided through DXE and SAN data, and PPL, through the participant direction has chosen to use their own system, PPL's information will directly feed into the aggregator.
Now the -- the change is really on the CHC side on the blue side you can see there's a little bit of different of an interaction going on here. So, the MCO, is going to be the initial hub for all of the providers using EVV.
So, all providers will need to send their EVV data, to the MCO, either from their alternate EVV system and they will to build the interface with them or they will need to use, the HHA system offered by the MCOs to satisfy the EVV requirements it's been important, there's been confusion whether people can use the DHS satisfies Sandata system in CHC, it is not built interacting like that, so the Sandata system being offered by free by DHS, will not interact and send information to the MCOs that's why they are offering it as a cost free option. The last one is the PPL system again, any participants in CHC that are participant directed model that EVV data, will go from PPL to the MCO. Ultimately the MCO, will aggregate all of this data and send to the DHS aggregator as well as use it for their -- quality and compliance monitoring.
So then on the next slide we have just an updated time line of the things that are currently in motion.
So, as I mentioned before, the technical specifications for anyone using the alternate EVV system, have it posted on the web site so it is crucial that you begin working with the vendor that you currently have, to make sure that you can meet those technical specifications either to interface with the Sandata or HHA or both.
PPL has also been sending out information, they sent out information packets for both direct care workers and Commonwealth employers in the past week they have started web ex trainings if you're enrolled in a participant directed program or you know someone who is, both Commonwealth employers and vendors can take advantage of the training and they can use the PPL system that will go live on

September 1st. PPL is able to implement a little bit faster, than we had originally anticipated and we want to be able to use that time to allow more flexibility in the easier transition for individuals in it the participant directed community. For the rest ever providers they are expected to start using EVV in October. If they are not already.
We will have additional training announcements coming out later this month for any providers interested in using the Santanda system for free for the fee for service model.
And they will research announcements on how to attend either classroom trainings that will take place across the State instructor led webinars, or, self-paced webinars.
And anyone who is using the San data system, the training in order to use the san data system the training is mandatory to gain access to the system yes?
>> SPEAKER: That map, how does Act 150 effect that?
>> SPEAKER: So -- Act 150 will be in the orange side. Act 150 is still under fee for service providers who, have their own EVV system, will need to integrated with Sandata origin using the Sandata system.
>> SPEAKER: Makes sense the way it is pictured up there, it doesn't make it show as it was --
>> SPEAKER: For clarify, if you're use the Sandata system, can you have the ability to do EDI to create the 837 for the MCOs or not?
>> SPEAKER: Not for the MCOs 6789.
>> AUDIENCE MEMBER: Essentially if you're -- if you're on the managed care side, if you're billing to the MCO you need to use HHA or, your alternates that you've already set up with them.
>> SPEAKER: So the, the Sandata system does have a billing section for the 837, that under the State free system is built for fee for service.
If, a provider, likes the Sandata system they want to expand it, beyond the scope that we have included as having no cost, providers can reach out to Sandata talk to them about whether or not they can expand the system to meet their managed care needs but that is outside of what we're offering.
>> AUDIENCE MEMBER: So, essentially, if a provider who needs to bill to the MCOs, doesn't need -- cannot use the Sandata system without incurring additional costs.
>> SPEAKER: Correct.
>> AUDIENCE MEMBER: Okay.
>> SPEAKER: Yes.

>> SPEAKER: This is actually -- Latoya from Philly adapt. I have -- agency models from our home care services and I was speaking to the agency and they said, they're not going to start the EVV stuff until January, however I know, soft implementation is supposed to start for PPL in September. But the agency they have a lot of consumers I think, if they, wait until January it is going to be overload the system the system may shut down or something I think that the State or managed care organizations should step into different agency models, consumers and the agencies that they have to try out, before January first.
>> SPEAKER: So, that is our expectation that agencies should start to use EVV in October. Our goal for the soft implementation was we wanted them to start using it, so if there were difficulties we could provide technical assistance before that January 1st, mandate. If they're choosing to ignore that direction the mandate does not start until January 1st we are encouraging them to start in October.
>> SPEAKER: I mean I'll continue to have conversations with them, what happens if they choose not to do it?
>> SPEAKER: If we notice through the October to December time frame that a provider is just absolutely not using EVV that's going to trigger us to directly outreach to them because we want to know why. Is it that you're having trouble with the system itself? Or are you unaware of the requirements somehow miss you in the communication? So we will do direct outreach. But, if you're in conversations with them you can let them know we have public meetings, our next public meeting is next week. We're going to have them monthly.
So, that might be a good forum for them to hear the actual expectations for this fall.
>> SPEAKER: Thank you.
>> SPEAKER: Yep.
>> BARB POLZER: We have one more.
>> AUDIENCE MEMBER: This is Pam again from Pennsylvania health law project.
I just, I'm having a little trouble understanding how this might effect folks who are using services through PPL in phase 3.
So are they going to have to learn one system for EVV in October and then turn around and learn a whole another one for EVV in January?
>> SPEAKER: No.
So, that's one of the benefits of PPL electing to use their own internal system is the same system will be used regardless whether or not that participant is in, currently in the aging waiver or as in the

CHC waiver. So when they transition over January 1, 2020 there should be no notice of that transition to the participant it should be seamless on the participant and directed care worker side. The only thing that changes is where PPL is sending the data. They will start sending to the MCO.
>> AUDIENCE MEMBER: Okay thank you.
>> SPEAKER: Yep.
>> SPEAKER: The last slide I have is, just a list of -- resources.
So we have a DHS web site specifically dedicated to EVV.
It has a frequently asked questions document. And that is in the process being updated I'm not sure how many people participated in the last public meeting we received over 250 questions we're still working through those as we finish those they will be updated and included on the FAQ page. We have a technical specifications link on that web site for providers.
And we have the schedule of our up coming public meetings the next one is Tuesday August 13th from 1 to 3:30, you can register at the L link on the web site, by the schedule and then if you would like to subscribe to our Listserv, you can contact the RA email box we have listed here.
So any other questions.
>> SPEAKER: Jack Ryan from Philadelphia, how are you, I have a question with regard to EVV we currently use HHA there have been glitch es it is not functioning as readily we expected it to.
Knowing that is happening, coming and January 1, not that far away, what expectation is there from the State from the MCOs to be corrected so, we are knottinged going forward?
>> SPEAKER: So, we have no intention of penalizing you -- just because, there are issues with the system.
We are still working on, what flexibility, we have with the CMS, regarding when we will have to implement penalties, at this point we are trying to admit as much flexibility as possible, even come January 1st you have time to adapt this is a major change, we'll have to provide additional clarification when we get approval from CMS, that will come in the form of a bulletin.
>> AUDIENCE MEMBER: How that will impact the billing and our ability to bill MCOs knowing the services have been provided we also have old system we're using we're running parallel so we know, what is being done it is not syncing with HHA.
>> SPEAKER: That's a process you'll want to develop internally and

with the MCOs if you're having difficulty with making sure that the -- the EVV system is matching your claims and demonstrating what know should have been provided, you should have a back up plan on your end, as far as how you can manually correct those visits in the EVV system and then, a back up plan as well with the MCOs what they expect to make sure those corrections are made appropriately.
>> AUDIENCE MEMBER: We painings taking go through the claims and we do a manual process for that, confirm time sheet date is what they call it on the system I expend an extraordinary amount of FTE to get this done, so we can billion a regular basis.
So we're talking upwards of 9Census that exceeds 850 some odd people, what we have on the waiver side which is part of the MCO we have about 650 to almost 700 people that we have to go through and -- manually verify those that did not make it through the EVV system. So we're talking -- that's labor intensive for my staff.
>> SPEAKER: Absolutely. And, so -- I think, as we move forward part of this is going to be are you seeing the difficulty with the direct care workers not properly using the system or seeing the system glitches itself, where it's not allowing them to use it properly.
>> AUDIENCE MEMBER: Yes to both.
>> SPEAKER: Okay.
>> AUDIENCE MEMBER: Majority of the users that use it, there's a glitch in the system we have to go in and correct it, it is not syncing up properly.
>> SPEAKER: That would be a conversation with the MCOs to deal with the HHA vendor because this is we have some people already implemented like yourself that scale is going be to become much larger that those should be addressed with the HHA vendor.
>> AUDIENCE MEMBER: Okay.
>> SPEAKER: Yes.
>> SPEAKER: Just -- I mean, one of the -- the concerns that -- I didn't know we have a -- I don't know if we have a clear answer we want to keep thinking through is, the question of -- in the, home care space, wage and hour issues are a major complication and, there are significant number of violations around wage and hour compliance on the one hand, EVV could be helpful with that, in terms of verifying people's hours worked and so on and so forth, on the other hand if there's a -- if -- agencies are able to make, manual adjustments to EVV hours I understand why it is useful, if a direct care worker does not log in cite or forgets to log out, things will happen.
On the other hand if an employer manually adjusts, someone's hours

worked without notifying them then a person could end up in a situation where they don't know why they have not gotten paid for certain hours or if someone, a direct care worker you know, doesn't log in or log out correctly as they're getting used to the system and the agency, said we'll not pay you you did not do it right you're not getting the hours, wage and hour violation, how do we, um, design the system in a transparent way that direct care workers can understand when manual adjustments are made and the impact it has on them and also we can, use it as a way to make sure that people are -- I mean I understand why a provider would say, if I don't have the EVV verification I cannot bill for it, I can't get the money for it I can't pay you. But -- the way, the law works is that regardless of whether -- you know, if you work the hours you have to be paid for them.

And so, there's just tension there, trying to make sure the direct care worker is kept in the loop of about annual adjustments.

>> SPEAKER: Can I comment on that, when we have to manually put in, the care givers forget to clock in, um, they have to call the office immediately. Either one or two hours the same day, because normally in consumers home for like six hours say at noon they will clock in at noon they forgot at noon they remembered they call it immediately we confirm they're there, we manually put it in, sometimes they will call us the next day and there's no -- assurance they were there.

And so prevent fraud we have mandatory you must call the office and we accept time sheets but meanwhile if they call us and they say we won't bill for that, because we had issues where, caregivers do not show up at consumers homes.

>> SPEAKER: So, a lot of this does have to be led up to a process developed between the agency and the workers as far as their expectations, if that work was provided and the work proved it was provided you are still required to pay them. The complication here comes when as you said before, it was adjusted manually, say after they, say a worker, billed 8 hours through the EVV visit and it was accurate.

But that agency went back and adjusted it to six, um, maybe to meet their authorization requirements although that worker may have been authorized to work six hours based upon the service plan but for some reason they needed to work that extra time, or -- the agency is not properly allocating those authorization hours the worker worked as they should have been the entire time, no matter

what the EVV visit says that agency still has to pay that worker.
So I think there's -- couple of things here as far as transparency, when that visit is entered, the worker, can always go back and review it . At least, through the Sandata system and the PPL system I cannot speak to every system. But I do know the system we have been working with the worker always has the ability to go back and review, at minimum the last two weeks of shifts so they would be able to identify the change had been made. There is no way we can notify them that the adjustment was made it would be in their best interest to review that time as the next paycheck is coming up. But I do think that there are issues where time could be adjusted specifically, to match a claim to be submitted for authorized hours they should still be due to the worker to be paid regardless of the authorization through the OLTL waiver.
It is a good point.
>> AUDIENCE MEMBER: What happens if the -- the consumer cannot tell you exact time they arrived -- they just don't remember we have cases like that. Workers we ask the consumer was she there? Um, I don't know maybe she came at noon, but the employee is saying I've been here since 8:00 in the morning that's an issue where, we -- have to go with what the consumer says.
>> SPEAKER: You don't have to go with the consumer said if they're not available to verify you could develop other processes where, your workers might complete paper time sheets, log into some web portal provide that, but -- that worker should have other options how to record that time to prop that they worked the time, not relying on the participant who may not be able to necessarily verify that.
>> AUDIENCE MEMBER: If they're lying -- because the reason why we're doing the EVV is to prevent fraud making sure the services are provided if they're lying we continue to submit paperwork once we see a Pat happening with the consumer we can launch an investigation.
>> SPEAKER: You can take the action and correct inappropriate behavior, they're still your employee, I'm not saying because your worker says they worked you have to pay them, if you think they're lying you have to have a process where they can -- rightfully be paid you can rightfully correct the time. It is goings to have to -- be up to the agency on how you're going to do that you do still have to abide by the labor laws.
>> AUDIENCE MEMBER: Perfect. Thank you.
>> SPEAKER: Yes.
>> AUDIENCE MEMBER: Dan from liberty quick question, will ADL IDLs

will be required as part of the EVV record?
>> SPEAKER: Are you referring to --
>> SPEAKER: Duties performed.
>> SPEAKER: We're not expecting that the tasks that, was people often refer to them as tasks be recorded. There's the option to enter those tasks, some EVV systems do have a program they -- have tasks, but that is up to the agency as to whether or not they are requiring tasks to be collected in EVV we do not.
>> SPEAKER: Thank you.
>> BARB POLZER: All right. Thank you Kristen we have more from Tyrone he came back to talk to us more about the FED process.
>> SPEAKER: If you don't mind I'll do it right here so I can see the screen.
Good afternoon everyone. My name is Tyrone Williams I'm the chief of the assessment unit for OLTL I'm here to discuss the waiver enrollment process to CHC and also the fee for service program works.
Before I start I wanted to give some key definitions -- that you will see we've developed a couple of work flows to help us clarify the process. And these are some of the key items that you'll see described in the work flow most of these I'm sure not all, you're familiar with.
But -- again we just wanted to give a reminder.
Also, we provided a little legend for the flow shapes that is part of the work flows, again this is pretty standard stuff.
As, work flows, typically go.
We have the stop start process, as well as action step and then also indicator for when a decision needs to be made.
Over all, what we have here is just a -- a brief explanation of just the, the assessment process in general.
Talked about this in the past, how Pennsylvania individualized assessments system. Or PIA. And PIA is essentially the system we use to request and complete functional eligibility determination assessments. The primary users of the system, would be our independent enrollment broker MAXIMUS and also our independent assessment entity, aging well.
They basically share and exchange information it will go through in the next couple of slides and -- so -- both the IEB as well as, aging well can do FE requests they also -- IEB generates FED results even though they both have access to the system, they can create profiles records as individuals apply.
apply.

Apply for waivers only the IAE or aging well that can actually do a FED.
Just going through again, work flow typically what happens is, individual will contact the IEB and make their wishes known they would like to apply for the waiver.
As soon as that is indicated, IEB application starts especially if they're already on MA. The application will start. If they don't have MA at the time they contact the IEB, then IEB will assist the individual to start the application process for MA.
And once they get receipt, that an individual filled out the PA600L or application the application process will start. During that IEB will concurrently request both FED assessment from aging well, IA, independent assessment entity and they will also request a physician certification from the applicant's doctor. Once that request to aging well is done, the FED assessor under contract with the aging well, will begin to schedule an appointment with that individual.
And conduct a FED. They're required to do this within ten business days of the request. And as they're there, doing the assessment, just a couple of things they go through -- essentially evaluate sources of information,
they use methods to evaluate an individual, this includes interview and observation of the person. Can also include discussion with the individual's family and of the caregivers and even the person's doctor as available they also look at any clinical records or any other administrative documents that will assist them in making, in coding and evaluating individual's functionality.
Once that is done, the information goes through what we call a translator and the translator provides a FED result to be sent back to the IEB.
Via our Pennsylvania individualized assessments system.
And the IEB, receives that, also receives the physician's certification.
So over all just, because we get a lot of questions in terms of time frames.
Essentially the over all time frame for enrollment in a waiver is 90 days. That's the target time frame. Please keep in mind though that time frame is fluid based on variety of different factors. Some within, not in control of the entities who are responsible for administering this process. So, for example, if PC if a doctor is slow in say providing an PC for an individual that could effect the time

frame, 90 days, depending upon when they get that in. The target time frame is 90 days.
Once a FED result is determined, that information, again, goes to the IEB.
And we are going to do this from the standpoint of the individual is, NFCE nursing facility clinically eligible. And the IEB will then retrieve that result, and then, look that result, look at that individual's physician certification to see if they match.
And, depending upon the question or the answers, there is a two different processes. One is if the NFCE, FED result does not match the individual's physician certification, then that will go to our medical director and his clinical team for review.
As part of that review, I met medical clinical team looks at the PC and FED and additional information that is provided and also, again as -- it is available, also, look at medical history as well as the doctor's recommendation to determine the appropriate level of care.
care for NFCE.
If, say the, if by chance the medical director, agrees, with that NFCE result we go back to the IEB and we see both yeses, if the information matches or if the medical director agrees with the NFCE result, the next step is the IEB goes out and conducts a in-home visit, that visit includes variety of different information, they provide MCO's choice information, they -- try to do the match up, the appropriated program for that individual, answer any questions related to the individual's next steps on or care. The IEB does include several different items . Once that is conducted they have, 14-15 days to schedule that in-home visit.
If by chance, the medical director says no, this individual does not agree with the NFCE, OLTL will send a written notice to the participant informing them of their ineligibility and with their right to appeal.
If the individual goes onto the next step, and the answer is yes, then, again the IEB issues approval to the CAO, and at that point the CAO does a financial review because the individual, in order to be eligible for the waiver, they have to be both clinically and financially eligible to participate.
And that's where you get to the next question -- is the individual financially eligible?
>> SPEAKER: I have a question -- in regard to that process.
>> SPEAKER: Sure.

>> SPEAKER: Does the medical director look at all FED and approves all FEDs this is Luba Somits.
>> SPEAKER: They look at medical director looks at FEDs, that don't match the PC. So, if there's a situation where again the person's physician certification and the FED result does not match, medical director and his team will be meet to make a determination on whether the person is NFCE or NFI.
>> SPEAKER: So if it does match the FED assessor is the one that identifies the person is NFCE?
>> SPEAKER: The -- well, initially yes. Depending upon the evaluation at the time of the assessment. Whatever the result is, so, if the result comes back NFCE, and then it actually matches the individual's physician certification,
it goes to the automatically to the home visit, and go through the process of financial evaluation as well.
>> SPEAKER: My other question, in regard to that process, if an individual has already gone through Medicaid application through another system, like the ODP consolidated waiver, how does this change for that individual when that consolidated waiver is that -- now they're being asked to do a waiver application for Community HealthChoices?
>> SPEAKER: I'm not sure.
>> SPEAKER: Within that 90 daytime frame.
>> JILL VOVAKES: We can take that back.
>> SPEAKER: Those are the type of consumers easement to be approached about, in those scenarios where, the ODP system is saying, consolidated waiver is -- is not even they don't even talk about waiting list,
they're talking about at capacity so that's a real concern, now the same individuals those participants and families that are,
strained right now, because they're coming up on a birth date, where services are going to be affected, and now they're being asked to reapply all over again for community HealthChoices how do we assist that, that participant from not being harmed in any way, as far as the time frame for that process?
>> JILL VOVAKES: So in situations like that, um, we do special handle cases. But, we'll have to take that question back I'm not sure what the process is for those situations where someone has already applied and then has been directed, um, to go through the CHC process. >> SPEAKER: That's happening frequently in the ODP system the
supports coordinators that's what they're telling families, to do.
>> JILL VOVAKES: Yes.

>> SPEAKER: So -- as you're aware, that is part of what came
across during the listening sessions that I've attended in the community.
>> JILL VOVAKES: Yes.
>> SPEAKER: That was a major concern.
>> JILL VOVAKES: I can tell you out of those listening sessions and
are and after receiving that feedback I know that, question is closely,
working with the deputy of ODP and they are actually looking at that
process right now. I'm sure that, we could bring that back to the
nexts meeting and have that speak to that process.
>> SPEAKER: And, um, if anyone can provide me information about how
to expedite that process for the families that are approaching me about
their deadlines coming up and they're applying twice.
>> JILL VOVAKES: Okay.
Will do.
>> SPEAKER: Greatly appreciated thank.
>> JILL VOVAKES: Yes.
>> SPEAKER: Just to finish up on the process, again, just going
back -- another question?
>> SPEAKER: When can -- we reduce the 90 days so that we start
doing diversion from hospital, not going into nursing homes when do you
think that 90 days could be reduced? To do the enrollment?
>> SPEAKER: I think, it really depends on the individual's
individual's circumstance.
I mean, the -- the we're doing the work as quickly as
possible in terms of getting individuals assessed and processed.
I can't necessarily pinpoint again, depending upon where
information is provided the availability of individuals to do the
assessments. That will, more than anything, determine if say someone
is able to get into a waiver, say, sooner than 90 days.
But I think at this point, um, and obviously we're always looking at
opportunities to see where we could, um, maybe be, more efficient in
certain areas of the process.
, it is that something that we're looking at currently, um, with our
IEB, trying to get those types of considerations and inputs from the
general public and individuals impacted by the process, so again, that
-- that effort by OLTL will address of some those issues as well.
>> SPEAKER: I think they need to start actually creating diversion
plan because that's not happening so you go into a hospital you'll go
into a nursing home, you became permanently disabled
there needs to be a process to reduce that 30 days, they're not going to

go to in to the nursing home.
>> SPEAKER: Okay.
>> BARB POLZER: Okay.
Tyrone we have a question on the phone from Monica.
>> SPEAKER: Sure.
>> BARB POLZER: High, thank you is Monica, from the brain injury association I'm sitting in for drew, the question about the IEB home visit on the chart it is -- the MCO choice counseling, but I heard you talking about other things that happened at that meeting I wonder if you don't mind reviewing the whole purpose of that in-home visited and the next, item on the flow chart which says, there's an approval issued to the CAO is there a decision made by the IEB at that meeting or after that meeting?
>> SPEAKER: If I'm understanding your question correctly, I'll start with the last half of your question.
Once an approval is sent by the CAO that means that individual is again both clinically eligibility as well as financially eligible to be in the system and the CAO will send a notification to all of the individuals and entities involved in that process. That will include the applicant, as well as, the -- the IEBs as well as the MCO are notified so the next system in terms of enrollment will occur.
In terms of the home visit, um, again, the home visit includes not only giving information that's pertaining to any choices of MCO and explaining the program as well, but it also goes into questions, related to identifying say the appropriate program that an individual say may be a benefit for that individual so for example, um, typically in our, in our counties we have other waiver programs that may again be more beneficial for an individual besides say you know -- we have Act 150 enrollment, we have independence waiver, attendant care waiver, these types of things are discussed with the waiver, so their choice of waiver will meet their needs and it is an appropriated fit for that individual. It is essentially, again, is a general meeting to explore those items and, also, to again provide information to that individual, so they're comfortable, with any next steps related to the program.
>> SPEAKER: So is the IEB making some decisions about the appropriate waiver at that meeting?
>> SPEAKER: In conjunction I would not say they're necessarily making a decision. They are working with the individual to identify

program that best meets their needs.
>> SPEAKER: Okay.
Thank you.
>> SPEAKER: I'm willy from family training advocacy in the
liedership council, there seems to be agreement, between OMHSAS and OLTL
about the minimal up take of the choices in the community HealthChoices
program, can you identify to me, the training offered to the assessors
in completing the FED in -- calling out and understanding and
then using the presence of behavioral health disorder to affected
eligibility determination and eventually hopefully the service
determination.
>> SPEAKER: So first of all, all assessors, they are required to
have, to be credentialed, so let me back up a little
bit. The contract contracts with the aging well our independent
assessment entity they are essentially responsible for insuring
assessments are done, as well as done correctly they subcontract
currently, with the AAAs in most of our counties, 52 subcontractors who,
again are responsible for doing the assessments.
As it pertains to training they are required, to have several types
of trainings as it pertains to the actual FED. These trainings are
conducted through a, learning management system they use and that all
assessors have to take and also pass with at least a 95 percent
score.
And it is not just -- the trainings are not focused obviously on the
FED, the tool, how to apply the tool and doing the evaluations but we
also, they also venture into specific areas in terms of medical and
clinical inquiry that may impact a person ability to help them to
determine whether a person is NFCE or NFI, for example, behavioral
health would be a component upon which, um, a certain --
trainings will be centered around in determining the driving
factors in evaluate what the individual who, say, has --
intellectual disability, of some sort.
Which makes sense. Because -- again our FED in terms -- is a
cognition, mood behavior is one of the major components of the FED, it
does help us to determine again, as parts of the over all evaluation of
whether someone is NFCE or NFI.
So, um, there are trainings, um, around you know those types of
issues, again to help individuals to identify you know what makes
an individual NFCE and therefore may need additional assistance typically
if we're trying to keep them at home, also keep in mind that the -- the

assessors are all credentialed social workers many of whom have been involved in level care assessments over a period of time. So -- and I think, one of the beauties much having this particular type of system it is not like we had to train all the individuals over all in terms of what we're trying to accomplish here so --
>> SPEAKER: I just got to say, the back door, that services for -- behavioral health services are not being sought out or provided to the individuals that are participate understanding this program. So either there's an issue at the front door where it's not being recognized how does the existence of a substance use or thought disorder impact the way the FED is completed and eventually, then -- the way the service plan is collected.
I don't know if you studied that but it is not, at the back door happening that's a grave concern of those of us who work with folks both live at home and have numbers live on their doors living in nursing homes are now available to get behavioral health services at a much, higher level but are not.
>> SPEAKER: Noted.
>> SPEAKER: Thank you.
>> SPEAKER: Okay.
I think I went through everything.
Are there any other additional questions?
(pausings for questions)
>> SPEAKER: Yes.
So -- you mentioned that the IEB discusses the different types of waivers so I'm assuming that applies at this point in time mostly to the region 3. So, is the IEB acting on behalf of the department as far as selection in the waiver?
>> SPEAKER: I would not say that, again, they helped facilitate choice, with the recipient but I would not say that the IEB, you know, makes that choice or makes those identifications directly, but they do help facilitate that on behalf of OLTL with the input of the recipient. Or applicant.
>> BARB POLZER: All right thank you Tyrone I appreciate it.
Okay.
And next up we have Howard Degenholz, giving us a CHC evaluation update.
>> HOWARD DEGENHOLTZ: Okay.
Hi, I'm Howard Degenholtz from the Medicaid research center I'll try to move quickly, because --

>> SPEAKER: We're fine for you taking a half an hour.
>> BARB POLZER: Go to 1.
>> SPEAKER: I can go 45 minutes two hours.
(laughter)
>> BARB POLZER: Until 1.
>> SPEAKER: I drank my coffee I'm still good to go, can I have the next slide. So -- what I want to do is I -- I apologize I'm going to have to look at the screen to stay on track I'll cover four things, one is, recent focus groups we conducted. In the southeast, with the early implementation of the phase 2. I'll talk about interviews we've been conducting with key informants and stakeholders I'll reported on a survey that we just conducted nursing if a facility operators and nursing facility administrators just as a reminder you've probably seen this before I've presented in the past the evaluation that we're conducting, behalf of the office of long term living has five major data collection efforts built into it, focus groups of participants which I'm going to talk about today.
A cohort of, interviews with the participants and caregivers I'll not talk about that, key interviews with stakeholders I'm going to touch on that surveys of LTSS providers we have surveyed HCBS and nursing home facility providers I'll focus on the nursing home facility providers and administration analysis I'll touch on a couple of findings on our recently findings.
Next slide. So we recently conducted 18 focus group sessions, from January to May of 2019.
And, these were consumers in the southeast and we asked them about the early experience with transitioning onto community HealthChoices.
One of the common findings we found was there was confusion around physician networks, that the enrollment information they received indicated that they could keep their PCP but many people reported when they talked to their providers, that providers were not accepting any CHC plans. So there was general confusion whether doctors will accept Medicare but not Medicaid.
There were some positive findings people at the time we talked to them, did not record any service interruptions again this was prior to the end of continuity of care. There were some, and some reported no changes in out-of-pocket costs that is kind of sporadic, there were some concerns however, with people -- reporting higher out-of-pocket costs for some prescription medications.
Some people reported they were paying for transportation

out-of-pocket that coverage was not in place for some of their transportation needs and there was confusion over who to call with questions. There was a full alphabet soup as people are aware of, of different sources of potential information and, some people felt they were getting the run around between the different health lines IEB line, county offices and so forth. Next.

We conducted interviews with service coordination entities and with other providers, some reported briefly on some observations we have from interviews with service coordination entities, adult day and several other categories of, um, providers primarily HCBS providers. One thing that we noted in is not a surprise that a lot of service coordination entity and agencies have been experiencing attrition in both the directed work force and the supervisor roles, a lot of those individuals are goings being hired directly by managed care organizations and I think that's basically verifying other things we've heard about what is going on in terms of service coordination in-house by several of the MCOs.

In fairly large numbers. In terms of the assessment process, service coordinators, reported that, there's a fairly high burden on consumers, from the in terms much the initial assessments, FED interRAI, interactions with the IEB, there's some redundancy and that, that these -- encounters with the consumers can take quite a lot of time and, create a bit of a burden for individuals. Also, significant change assessments that people are required to have conducted, also, take a significant amount of time because the service coordinators are required to repeat entire assessment, can't just focus on the, domain area that has changed.

When we talked to a adult day providers there there was one common thing we heard is some of them had anticipated, that there would be increased volume and that has not materialized in fact, some are reporting kind of drop offs in enrollment in adult day.

One common theme was that, providers, HCBS providers, reported kind of getting the run around between problems they might be experiencing with HHA exchange and the MCOs. So they will call HHA exchange. The HHA will tell them to call the MCO, they call the MCO they will say that's a HHA problem, they get the run around in terms of getting the problem solved. There's a -- 40 percent the providers interviewed reported that lack of access to non-medical transportation remains a concern. Impacting people's quality of life. So that continues to be a concern for people.

There was one general observation that there was some service interruptions in the southeast, at the end of the continuity of care period and, service coordinators are reporting, that and providers were reporting that, when the services were interrupted the authorizations were not in place immediately at the end of the continuity of care, that they were they had a lack of confidence in the MCOs. So there was some concern there, from the provider community.
On the other hand, providers report that they are getting payments, faster and, some providers are experiencing increases in volume of referrals.
So, some -- so there was some concerns from service coordination entities that, if they only were working with one of the 3MCOs that they're concerned about their future viability as a business.
And then, this was one particular troubling observation that, some providers are reluctant to call the provider hot line to complain about conflicts with the MCO, in terms of payment or authorization or whatever the underlying issue is, out of concern they might loose their MCO contract.
Next slide.
The next activity I want to report on is a statewide survey that we conducted of nursing facility providers. What we did was we sent out an online survey to all administrators nursing facilities in presence that accepted Medicaid.
Topics included their preparation for community HealthChoices, communication, experience with the MCOs, interactions in service coordination, range of clinician areitions this is companion to an annual survey we've been conducting on the home and community based providers we've done twice I reported on some of those data here previously.
This was conducted during the month of May, 2019. Next.
Real briefly we identified, 629 nursing facilities and in the data file provided by OLTL, 2 of them reported they didn't accept Medicaid. Response rate of 32.4 percent. You can see this is a distributed across the State most of them were from phase 3.
Next.
So -- when we asked nursing facilities how prepared do you feel or did you feel for community HealthChoices, we asked them this question, with regard to several different task areas where they might be interacting with the community HealthChoices program. And also the question was asked, differently for the phase 3 providers, we asked them,

a prospective question, how prepared do you feel for community HealthChoices whereas for phase 1 and phase 2 provider questions asked them the past tense.
So, um, not surprisingly the orange bars represent phase 2 providers and at the time we surveyed them, they, that was in May so they were very actively involved in community HealthChoices and they were getting paid for the first time.
So, it was very salient for them, they would reported the highest rates of having felt prepared for community HealthChoices. With regard to domain areas of contracting with the MCOs, submitting claims, delivering services, the blue bars are phase 1, this is kind of retrospective, where -- providers are -- thinking back to 18 months ago, how prepared did they feel? And, the reporting lower levels of preparation, and compared to the phase two providers not entirely surprising because they're leaning back over time, because we know OLTL took extensive effortness 2018 to make sure that the 2019 phase two, roll out would go smoother. It sort of reflects some of the -- enhanced communication and provider summits so on, that took place during the 2018.
However, if you see the red bars for phase 3, this is providers who are, anticipating going live on January 1, 2020 you can see the level of preparation is the lowest. There's no firm proof in regard to phase 3 nursing facility providers. The final topic is -- go back please. Reporting quality metrics.
This is something that represents the lowest level of preparation go on.
Okay.
So we asked nursing facility administrators about their interactions with service coordination from managed care organizations and this is on a 0-10 scale, where 10 is most satisfied, and 0 was least satisfied or -- yes.
We asked them about this, with regard to four different task areas, so the fest was working with charts you can see, reviewing chart this is is only as in phase 1 and phase 2, you can see that in with regard to, review of charts there's a high level of session in terms of interactions with the service coordination.
But when you turn to nursing home transitions, transitions back to the community drops off. Substantially.
The interactions around long stay transitions that's about 50 percent are highly satisfied in phase 1 and about 40 percent in phase

2 you can see, also, if you look in the lower left corner, we broke that out by plan you can see that the phase one satisfaction ratings are higher than in phase two, not entirely surprising they had over a year's experience with service coordination in those nursing facilities or phase 2 facilities as of May, their interactions were fairly limited.
Next slide.
We asked nursing home administrators, about their over all ratings of the managed care organizations performance. One was the worst, five was the best.
These are just average scores across those same task areas. It is broken out by plan and phase. You can see there really is not a lot of variation here across the different plans and phases.
And in general, the 1 seems to be it also pretty much is a wash. But it is all right around the 7 they're not getting the best score it's average across the Board in terms of all these categories. Next will we asked nursing facility operators about their outlook for community HealthChoices whether they expect to benefit financially, continue to providing care, internal organizational changes and upgrade the technology and overall satisfaction with the implementation. This is the percentage of nursing facility administrators who rated these items as, strongly, agree or somewhat agree in terms in terms of their satisfaction you can see there's a pretty, there's a lot of variability here where the phase one facility operators are rating community HealthChoices more favorability in terms of their outlook.
It drops off in terms of phase two in some of these topic areas.
The highest rating is regard to continuing to provide care, um, but in terms of benefiting financial outlook is not -- is, um, they don't agree with that.
They don't agree with that statement.
And in terms of the overall implementation, again the rates of nursing facility operators rating this highly is relatively low.
Next slide.
Okay.
Just to sum up the section.
Respondents in phase 2 reported that they felt more prepared than those from phase 1. Information has been available for longer however it raises some concerns about the phase 3. The information has been out, in the field for -- with the phase 3 providers they had the most exposure to information and they're the least -- reporting the least

prepared.
One observation that we have is that, facilities are reporting limiting Medicaid beds this might be a continuation of prior trends. And, also, actually I think is out of place can we go to the next slide.
Okay.
I want -- I'll come back to those bullet points.
After we conducted the survey, we started what we call a faux focused study of nursing facilities this is to get a deep dive into 15 nursing facilities from across the State. Five in each of the phases. And in this we're conducting confidential interviews with nursing facility administrators, directors of nursing social workers and other leadership.
We stratified them by size by profit size and by some county run facilities. The topics that we're covering have to do with transportation, behavioral health payment, preparation for community HealthChoices.
We're also interviewing a sample of residences at each facility, those interviews include cover, the selection of their community HealthChoices plan and, opportunities for transition back to the community, we'll also be conducting brief interviews with the family caregivers of each of the 15 facilities as well. Next slide.
So, some observations, from qualitative interviews with the nursing home management we're hearing different things about traps some nursing facilities managers are being told that they're responsible for the cost of transportation. Others are being told that medical transportation is a covered benefit under communities HealthChoices, but non-medical transportation is not covered. Some are told that, one managed care organization requires the facility to provide transportation, there's a lot of variability and confusion in terms who should be paying for what, in transportation. Coordination between communities HealthChoices MCOs and behavioral health, nursing home says it is minimal, so far 2 of the 5, we've interviewed at the time of this report, had a really coordinated effectively with the behavioral health managed care organizations, most facilities are paying directly for mental health services and billing managed care organizations.
We've had some different experiences regarding nursing home transitions some reported that, community HealthChoices, service coordinators are not helpful in the transition process and others are reporting that it is helpful. This is this is an important topic to

keep track of.
And, some nursing facilities are reporting that the guidance they're getting from MCOs is mainly inconsistent.
One place that we interviewed they indicated that, they were told to try and resolve everything on their own before reaching out to the MCO for help, for example, of getting it for their residents, others reported very low interaction. Others are reporting they rarely see the MCO service coordinators not on this slide, we are hearing in the places that we've interviewed and done si te visits high levels of turnover in terms of the service coordinators, assigned to the nursing facilities.
Next slide.
Okay.
I think that covers all of those things. Okay.
Some highlights from recent analysis much data.
of data. What I'm going to report on now is going to seem a little old we've been conducting extensive analysis of administrative data, from the time period prior to the implementation of the community HealthChoices.
As outside evaluator we will have access to the data from 2018 and 2019, however, that data is on a delayed basis what I'm going to do is report on some trends primarily trends prior to community HealthChoices and our approach here is we want to track these trends and then, as we start to analyze data from 2018 to 2019, very important to distinguish pre-existing trends from program affects. So -- just as a highlight, this, um, updates the slide we presented previously showing the distribution of chronic conditions top ten chronic conditions in the community HealthChoices population this includes both nursing home, HCBS and the community dual population.
The most common is hypertension followed by hyper thelemia, nearly 40 percent have depression. High rates, about a third reported anemia.
30 percent, diabetes.
25 percent, arthritis. Chronic kidney knees, around 25 percent.
Heart disease, around 25 percent, COPD, just under 20 percent and about 18 percent Alzheimers early dementia.
Okay.
Next.
In terms of rebalancing tracking this back to 2013, I just want to point to the blue line this is for the younger population age 21-59 you can see a high increasing trend towards home and community based

services for that population.
Next? Now, I know it's a little bit hard to read this is the same trend among people who are over 60. We know baseline this population is much lower rates of HCBS than the younger disabled population. But it has been on an upward trajectory over the four years from 2013 to 2017 covered by this slide.
Next I'll show you, preliminary analysis from the 2018 data.
Presented differently this is going to compare 2017 to 2018. And this is very promising if we look at the orange bars this is showing just in phase 1, it the percentage of people who are NFCE or receiving HCBS as opposed to nursing home increasing. Now the difference is small but it is an increase.
If we look at phase two and phase 3 populations, at the same time, that's increasing but it is slightly smaller rate.
If we look at the overall trend for the entire state, you can see it is also increasing. So the interesting thing here is, if we look at that box in the uprighted corner the orange, difference is -- larger than the gray difference that means that the rate of rebalancing in phase 1, appears to be going a little bit faster than the trend in phases 2 and 3.
So, that's poses I have.
Next.
Okay.
One of the things we're tracking um, just to under pre-existing trends of utilization of HCBS in the population is a non-medical transportation. This is a very complicated issue to measure because transportation is provided very differently across the stated. As we know some people are -- have an allowance they can pay per ride, other people are given a monthly bus pass it's very difficult to compare head to head.
It is also difficult to track the number of rides that people are actually using. So what we've done in our analysis is we're tracking the actual spending per person, per month you can see that has been trending upward from 2013 to 2017.
So we'll be watching that trend, in 2018.
Next?
We're also tracking a number of personal care hours, so, this combines both consumer directed and agency model. And you can see it's been trending upward in terms of hours per person, per day from about 4.6, in 2013 to 6.5 in 2017.

So, again, we'll be tracking this and reporting it as 2018 data, when it becomes available.
Okay.
Next steps for evaluation -- next.
So we completed focus groups in the phase 2 area.
We will be conducting focus groups in the phase 3 areas and the winter of the spring of 2020 as those populations and those people are enrolled into the community HealthChoices. Again, get their early experiences.
We have been conducting interviews with participants and caregivers, so we just recently completed a round of baseline interviews with consumers in the phase 2 region and we will be starting a new baseline for consumers in the phase 3 region, this fall.
We're also conducting an annual, which is approximately 18 month follow-up interviews, with -- participants from phase 1, so that's ongoing right now. And then, obviously we'll start doing a phase 2 annual as they reach that 18 month pointer point. We'll be launching wave 3 of the HCBS provider survey.
And, we're continuing to do secondary data analysis administrative data, we are currently analyzing data through 2017, we're just getting access to -- we have access to 2018 data and our team is loading and analyzing that data right now as we speak.
Um, we'll continue to be conducting key informant interviews across the State. We have the task of monitoring several activities so we monitor, consumer meetings that are starting to take place this fall for the phase 3. There are -- we're also monitoring provider summits and listening sessions taking place in the southeast we're in the process of preparing a public reported that is more comprehensive than the quick presentations that I give to you.
So -- I'll stop there and take questions.
>> BARB POLZER: Liam?
>> AUDIENCE MEMBER: Thank you Liam from ADAPT.
And two questions.
To the first one I would love to see the comparison so phase one, over time, phase 2, a time I think that will be a really interesting thing to see, you know, continuity of care and you know the transition will be helpful to not only compare the areas but compare the phase -- different periods of time. Does that make sense?
>> HOWARD DEGENHOLTZ: Yes thank you very much, that's exactly what we are planning to do. And, um, to provide a little bit more detail

into how that will work we interviewed people in phase one, in basically December/January before they really rolled onto the program we interviewed them again in July, just as continuity of care was ending and I reported some of those data, um, to -- this committee, back in October.
I will look back in the archives for that.
Then we're interviewing those people again, right now, so that is about 12 months after the end of continuity of care.
And that is a much longer, um, comprehensive interview with those individuals.
So, that will give us, information about -- um, more information about their changes in their underlying functional status, access to care quality of life and well being.
And then we also have comparison interviews, from the phase 3 region so we can compare any changes we see in phase 1 people to people, who are in the phase 3 region over the same time period we're right now collecting that data as we speak, so it will be several months before we can report on that.
>> AUDIENCE MEMBER: Great. Yeah. I really not only qualitative but KWAPBTD Tate I have.
>> HOWARD DEGENHOLTZ: Yes.
>> AUDIENCE MEMBER: Ear thing you work in the University of Pittsburgh.
>> HOWARD DEGENHOLTZ: Correct.
>> AUDIENCE MEMBER: Could you speak a little bit to about the possible conflicts? There with UPMC?
>> HOWARD DEGENHOLTZ: I do not work for UPMC if I did I would be paid a lot more.
(laughter)
Complete separate entity
>> AUDIENCE MEMBER: There's no no relation.
>> HOWARD DEGENHOLTZ: We have a fire wall between both institutional level and also at the level of my own individual for my individual involve and my team. Thank you.
>> AUDIENCE MEMBER: Okay.
Bolt poll any other questions for Howard.
>> SPEAKER: I have a question -- regarding the referrals and I notice that -- it said it was higher, but this year, um, you started with the MCOs January 1, 2019. And I received 10 referrals but those ten referrals were done by our agency, by people coming into

our office, asking for help I have not received even one including I've been in business for 6 years, soon to be 7 all of my consumers have been because people coming into my office, I have never done advertisement only thing I have is a -- a large sign outside my door that says home cares and everyone stops by, where we are located there's a lot of traffic for everyone to stop in and ask questions, that's only way I got my consumers I've not received one referral from the State or none of the MCOs.
I have -- met up with other agencies they have over 4,000 consumers, within the 6 years. So -- I wanted to know, is there a favorite from someone.
I haven't received one keg doing I can't comment -- what you're saying in talking to different providers from across the State it's consistent, some providers report very few referrals some providers reported -- high volume I cannot give further information why that is would be it certainly I can validate what you're saying.
>> AUDIENCE MEMBER: In Philadelphia -- where I'm located -- I know a couple of because they have sisters bothers agencies one of them got busted because much the whole situation of service coordinator being a family member, referring people -- I mean -- I don't know because they said there's a cycle where, rotates every month or two and we should be on the list, but -- this is a concern because I have to work hard to -- you know, to maintain by business and make sure I get referrals coming in because consumers do pass away.
>> HOWARD DEGENHOLTZ: So, our role as the external evaluator is to -- report, these patterns we hear to Office of Long Term Living and that's what we've done. So we have provided the evidence we've collected that, um, referrals are inconsistent across the provider netted work. And -- um, that's -- about as far as we can take it, in terms of -- both what we learn from interviewing providers and -- conducting surveys report that to OLTL and then, they need to build that into their policy and quality processes.
>> JILL VOVAKES: I would encourage you to speak to the representatives of the managed care organizations that are in the room today. While you're here.
And have those conversations with them.
>> AUDIENCE MEMBER: I also wanted to point out, last meeting young.
Talked about some fraud and issues going on with agencies, and someone doing paperworks how agency refers, the consumer as family

member.
Um, when he pointed out about the family member, I wanted to speak it was not enough time, so I wanted to point -- that, in my agency, we do reserve our patients -- consumers as -- family members, half of them don't have family members, there's no one that can show up, we do show up and say happy birthday when they get hospitalized we don't get paid we do show up with from ours let them know they're not alone. So I don't want the MCOs to stop, from the agencies not seeing our customers as family members my consumers have -- remained and stayed with us because -- we treated them like family members make sure we send out, a birthday card, they receive a phone call we care they're not alone, so I don't want them to put that as a conflict of interest when it comes to that because our consumers especially the ones are older than 60 are alone just wanted to point that out.
>> BARB POLZER: Okay.
Thank you.
Any other questions for Howard, we have to wrap this up?
>> AUDIENCE MEMBER: Just one, so while -- I guess, for both, what is the State going to do with the information that they're getting from you.
>> HOWARD DEGENHOLTZ: Well, I -- can I, hand that back to, Wilmarie ?
(laughter)
What I would say, Wilmarie can address, the things they have done in response to the various reports.
>> AUDIENCE MEMBER: Good afternoon, good afternoon everyone. QAfternoon.
It is only 1:05.
Happy to be here this is Wilmarie KPWOPB do lez, at Office of Long Term Living also responsible for the over all,CHC evaluation plan I work very closely with Howard I think we talk almost every day. Depending upon the findings and all the information that he has collected, via the surveys or -- just interactions that he is having, both of consumers and providers -- um, a lot of the information, that I think, Howard has shared with OLTL has really helped us, um, as Howard mentioned before last year, when he -- shared with us that, consumers and providers were having issues with, communication, understanding about communities HealthChoices, processes, how CHC going to work for in their programs especially that they have been doing it for a number of years, a lot of that information really helped us to really look at how

we've been approaching implementation Community HealthChoices.
As Howard mentioned before, last year we did listening sessions with providers and consumers.
His data validated we didn't do enough so we knew we had to do a better job for phase 2.
Which is why in phase 2 in the southeast we did a lot more listening sessions, we spent more time with providers. We, um looked at the trainings that were available. We looked at our web site. Added more information and we educated our networks across the states.
We worked with making sure that all of our stakeholders beyond the providers and consumers advocates across the State and other organizations make sure we are on the right track a lot of the other information that I think Howard has really been helpful to the MRC team has been helping us develop a key quality measures we have reported to the subcommittees with regards to how do we make sure that good quality of care is being -- provided to our consumers how do we make sure that we have our managed care organizations be accountable for what we're expecting them to do under the CHC agreement so a lot of, again a lot of the information I think Howard has been collecting for the past few years so this is -- for those of you who are hearing or seeing Howard today for the first time, he has been reporting for over two years on this stuff.
And he has been building every single time with all of the stuff that's happening in the CAC evaluation.
There's a very comprehensive plan on our web site, that details what that plan looks like for the next 7 years.
And, so -- our goal is to, once or twice a year, we come here at the subcommittee to really give you update what is happening, and what kind of information we're actually gathering through the work that I think the MRC team has been conducting for us and so I think it is helpful it is, good that he has access to our historical data. The fact that he is the independent evaliator for CHC, he is he is -- to be independent he Samiate for, to sit here and talk
about, um, real live conferences, and sometimes good things, but not always good thing as you heard today. Is it really just talks about how we're trying to make sure that we're doing the right thing here for Pennsylvania. So -- I think a lot of the information that you heard today was helpful um, some information for I'm sure for the MCOs you know, sort of kind of shake their boots a little bit. This information is also shared with all of the MCOs, before we come here as well.

We give them a heads up, if there are grave concerns impacting consumers at the end of the day, faux community HealthChoices the people we care about are the consumers I said it before I will always say it again our qualitied appropriate for community HealthChoices is consumers need to receive services and providers need to get paid we'll continue to do that.
So hopefully I answered that question?
>> BARB POLZER: Thank you.
>> SPEAKER: I only had five minutes.
>> BARB POLZER: Thank you Howard and Wilmarie.
That's it for today.
Thank you everyone for -- attending and participating. Our next meeting is September 5, same place, have a great summer.
(meeting concluded)