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DATE: October 2, 2019

EVENT: Managed Long-Term Services and Supports Meeting

BARBARA POLZER: Good morning everybody. We are going to get started in two minutes.
Good morning everyone. Let's get started with introductions.
NINA DELGRANDE: Good morning. Representing the life providers.
WILLIAM SPOTTS: Consumer.
STEVE GAMBLE: AA As.
MIKE GRIER: Pennsylvania council on independent living.
LUBA SOMITS: Home healthcare.
JESSE WILDERMAN: Healthcare of Pennsylvania.
RICHARD WELLINS: Forth of a consumer.
MATT SEELEY: Statewide independent living council.
GAIL WEIDMAN: Pennsylvania health /HOEGS.
HESHIE ZINMAN: Consumer advocate.
DAVID JOHNSON: Center for advocacy for the elderly.
LINDA LITTON: Participant advocate.
KEVIN HANCOCK: Deputy Secretary for the department of human services Office of Long-Term Living.
BARBARA POLZER: Liberty connection. Can we have the members on the phone please identify themselves. Do we have any Committee members on the phone?
BARBARA POLZER: Thank Tonya. Good morning N-E-I-L. I heard sister but I didn't hear who else chimed in.
GERMAN PARODI:
BARBARA POLZER: Thank you German.
Do we have anyone on the phone representing drew N-A-G-E-L-E.
All right. Well thank you. I will start with the housekeeping talking points. Please keep your language and professional and direct your comments to the Chairman and wait until called upon and please keep your comments limited to two minutes. Our meeting minutes and transcripts are posted on the list serve under the MLTSS meeting minutes and usually posted within a few day of the meeting. The captionist is documenting the discussion please speak clearly and slowly. The meeting is also being auto recorded. The meeting is scheduled to 1:00 And we must end promptly at that time. If you have any questions or comments that weren't heard please send them to the resource account for your reference that resource account is listed on the agenda. The exit aisles must remain

own. Please turn off your cell phone and throw away your cups bottles and wrappers upon leaving. Public comment are taken during the presentation. We still allow a 15 minute period for additional public comments if we have the time. The 2019 and the 2020 MLTSS sub M-A-C meeting dates are available on D H S website and now I'm going to turn it over to Linda for the emergency evacuation procedures.
LINDA LITTON: In the event of an emergency or evacuation, we will proceed to the area to the left of the Zion church on the corner of 4th and market. If you require assistance to evacuate, you must go to the safe area located right outside the main gates of the honor S-U-I-T-E. O-L-T-L staff will be with you in the safe area and stay with you until you are told you may go back into the honor S-U-I-T-E where you were evacuated. Everyone must exit the building. Take your /AOE longings with you. Do not operate phones. Do not try to use the elevators as they will be locked down. We will use stairway 1 and 2 to exit the building . Store stare 1 exit through the main doors to the left side near the elevator and turn right and go down the hallway by the water fountain stairway 1 is to the left. For stare 2, exit the honor S-U-I-T-E through the side doors on the right side of the room or the backdoors. For those exiting from the side doors turn left and stare 2 is directly in front of you. For those exiting from the backdoors turn left and then left again and S-T-A-I-R 2 is directly ahead. Keep to the inside of the stairwell and merge to the outside. Turn left and walk down-D- U-B-E-R-R-Y alley to Chestnut Street and turn left to the corner of the 4th and turn left on BlackBerry street and cross 4th street to the train station. Thank you.
BARBARA POLZER: Thank you Linda. Next up are the O L. T L. Updates with Kevin.
KEVIN HANCOCK: So good morning everybody. Jill and Randy will be providing most of the updates for today. I just wanted to sort of revisit something that was introduced in the last MLTSS update or the last MLTSS sub M-A-C regarding the long term council recommendations for direct care workforce. It was offered by an audience member that this council should take a look at the recommendations that came out of the long-term care council reports and we the Office of Long-Term Living had distributed that report to the membership and at this point, I was going to turn to the Chairman to see if it is something that would want to be discussed further.
BARBARA POLZER: Okay. Are there -- is there any discussion regarding the document. Hopefully you had an opportunity to read it.
JESSE WILDERMAN: Yeah. I guess not surprisingly, I would -- I wanted to really to make a motion that the Committee formally put forth the recommendations of long-term care council. My understanding of the recommendations is that they pass long-term care council unanimously so they have stakeholder across the groups. Part of the reason that I think that this is critical for this Committee is my understanding and we are actually have a number of direct care workers to keep us honest on trying to keep this issue of the direct care worker crisis at the front of all of the discussions we are having and we are clearly -- we call it the care crisis but we are clearly facing a crisis in long-term care

workforce and my understanding is really the whole premises of MLTSS is that we can keep people healthy and happy in their own communities and that that will both give people what they want and will be a cost efficient way to get people to support the independence and dignity that they deserve. We can't do that. I don't believe all the work that this Committee has done and stakeholders have done. We can't do that on a low wage high turn over workforce that turns over at 50 percent or 100 percent of the year. The average direct care worker makes probably less than $20,000 a year and has limited access to any sort of benefits and the report says we are going to need 37 thousand additional -- if nobody leaves direct care work in the next five years, we are going to need an additional 37000 people in Pennsylvania providing this work. I really think it is at a crisis and the blue print recommendations are pretty straightforward which I appreciate about them and are pretty clear. A pack of $15 an hour and increasing the reimbursement rates and career pathways, use of technology, you know, and awareness and direct care workers and so the question and these are also not wildly new recommendations these are things that have been out there for a long time and but the question really is why haven't we already done those things and part of it is a lack of political will to make the changes that are necessary and part of it is, you know, being able to raise the revenue as a state government to be able to actually fund what is going to become a total crisis for everybody around -- it is a crisis for everybody around the table and everybody who is involved in the system.
So I think it is critical -- and we are also not naive that somehow passing these recommendations here means they are going to be implemented tomorrow. But the more we can create settings and forums where broad groups of stakeholders are strongly endorsing and supporting this direction and calling for action by our decisionmakers the more likely we are to get action by the decisionmakers. I wanted to move the Committee take up and vote for support so we can pass onto decisionmakers not only long term council supports but broadly other stakeholders and other forums as well are coming out for the need for action. I know there are a couple of folks who wanted to share why they think it is important as well if that is permissible.
KEVIN HANCOCK: Normal procedure has a motion, a second and then we have discussion. I could be wrong about that.
BARBARA POLZER: I think you are correct. Do I have a second for the motion.
HESHIE ZINMAN: I'll second it.
BARBARA POLZER: Thank you any discussion?
SPEAKER: Hello, my name is Melanie I'm here to tell you why the blue print is important. 15 an hour is so imperative to so many caregivers many of us are so close to homelessness but the wages you are stuck between paying utilities or buying food. I make 11.20 working 40 hours a week providing for an aunt. I cannot provide a life for my children. I had a baby in February and I returned to work four days after I had them so I could continue to support my family. Right now while I'm standing in front of you,

when I get home my lights my very well be shut off. That is why you should definitely approve the blue print. It is not fair we provide for others and can't provide for ourself. Thank you.
BARBARA POLZER: Thank you. I appreciate your story. (Applause.)
SPEAKER: Good morning. My name is Pamela and I would like to speak with the blue print standardized training and career development. The goal for the development is to /AOE equip the direct care workers that everyone will have transferrable skills to meet the daily challenges and also for career development. The system, what we are aiming for is performance with CPR, skills to measure vital signs for the people we care for and also to operate medical equipment. There are people that require lifting and a lot of things of that nature and people don't feel they have the skills to perform these particular duties. A training at at the workshop and implemented by the government beginning December 1 st we request that you would help us to get that in place. My name is -- excuse me I'm a little nervous. Also, I have a degree in health administration and I'm taking care of my /TPHOERPBLG right now. I need the skills to do my daily duties for effectively and transfer onto other people who are providing. Thank you.
BARBARA POLZER: Thank you for sharing your story.
SPEAKER: Hell low my name is Norman I'm from Pittsburgh Pennsylvania area. I'm a retired broadcast engineer. I worked for KD K A and C N N. About six years ago my wife had a stroke and a couple of hours later my whole world changes and because she is partially paralyzed, most meals that she has, you know, when she eats she chokes almost every meal and, you know, so I'm -- I'm sitting here and I'm -- with the skills that I have and the education that I have, I fear every day that I won't be able to help her. So I listened to Jessie earlier saying the turn over rate is high. Although I'm retired my wife requires additional care and so I'm going to be there but, you know, it is not a definite that a caregiver is going to be there. I think it is important that we provide all the help, the training, every benefit that every other employee has to make them -- help them perform better on their jobs.
BARBARA POLZER: Thank you, sir, for sharing your story.
Is there any discussion among the Committee members?
STEVE GAMBLE: Do you know if the secretary has included either last year or this year in their budget asked for this particular line item.
KEVIN HANCOCK: So if you remember last year's budget proposed a progressive increase to the state minimum wage that was associated with the rest of this issue as well. We heard discussion that that is something that is going to be considered as part of the 2020, 2021 budget as well but I can't confirm.
RICHARD WELLINS: What is the minimum wage.
KEVIN HANCOCK: Right now it is 7.25.
RICHARD WELLINS: $7.25.

KEVIN HANCOCK: It is the price of a Starbucks coffee. So I received a message from a nursing facility provider who wanted to add some comment to this discussion that I was hoping to be able to include for the record if that is okay with the Committee.
Okay. So this individual wanted to make sure that it is clear that a change proposal especially with regard to wages would be -- the minimum wage issue in particular, if we move to a $15 minimum wage, it will be not just impacting the direct care workforce but also some individuals in nursing facilities for example that provide other type of services including dietary and housekeeping et cetera etc. And this individual wanted to go on the record by stating that this change without a dramatic increase to the M A reimbursement would force nursing facility providers to either, A, close communities, B, stop caring for a significant portion of low income residents. C, layoff a few hundred workers or D some combination. So he asked that this be put on the record that when we talk about this, he wanted to make sure it is clear that reimbursement rates for these type of services would have to take into consideration and accommodate the increase in wages as well. So just for the record.
BARBARA POLZER: Thank you, Kevin.
MATT SEELEY: Is that an anonymous comment.
KEVIN HANCOCK: He did not give me permission to give his name. But it is actually not really that dramatic but I didn't want to give the name without his permission.
MATT SEELEY: He wanted to comment on the record without --
KEVIN HANCOCK: I will ask him and for the record, I'll make sure that it is clarified. This individual wanted to make this position known himself as well but he wasn't available today.
BARBARA POLZER: Thank you. Anymore discussion among the Committee members.
NINA DELGRANDE: So I could go on the record and stating and agreeing with the same thing and while I agree that our direct care workers need to be paid more, I'm in full support of that. In the home health and life industry we have the same fair if we have to raise the wage then we have to raise for a lot of other people and without further reimbursement for those services that could put us out of business and we would have to hey people off. I agree with that statement that Mr. Anonymous is making.
KEVIN HANCOCK: Let's not call him that.
NINA DELGRANDE: Whatever you want to call him.
KEVIN HANCOCK: The person that has not given me permission to give his name which is my fault more than his.
NINA DELGRANDE: I agree that our direct care workers need to be paid higher. I don't disagree with that but we need some kind of reimbursement to help us do that. Dash dash anyone else.
TELEPHONE: There is a way that direct care workers get paid higher wages already if -- if the participants to use services my way and I don't know why this has not been discussed as they talk to the service coordinators because there already is a way to

make some happen. But the information has to be brought to the for front more and I have been working on that for the past several years. I have a work group meeting once a month with O L. T L., some participants with service any way and service coordinators that I think a lot more has to be done with the education of how an open budget model is run so people can have the opportunity to give their workforce a more stabilizing wage and somehow with everything that is under agency model, it has to also be opened up so that there is a -- there is, like, there just has to be a way that service any way is opened up so more people have that opportunity and have the -- have the ability to stabilize their workforce through better -- better wages and more -- and can see this as a career path and I don't know unlike for people that use participant directed services already that they are not using this option because this is a way to overcome this wage barrier already. Now, is that me saying that the minimum wage and everything shouldn't be raised across the board. Heck no. Because I believe that it should be and it has to be but what I'm saying out there to everyone listening to this and everyone that is part of this Committee already, there is a way to already do this but people have to one take the initiative to be able to do it. Thank you.
BARBARA POLZER: Thank you Tonya.
JESSE WILDERMAN: I just want to respond also to the recommendations contemplate raising the Medicaid reimbursement rate in parallel with the minimum wage increases. It contemplates the idea and understanding that we can't just simply say we have to pay people more but we have to increase the state funding for it. As I understand, the most recent minimum wage proposal that was put before the Legislature last year and didn't succeed, there was a commitment from the administration to reinvest savings that were accrued from having people from minimum wage increases into specific -- specifically into home and community based services -- begin to deal with this crisis. Every other state around Pennsylvania, every single one that touches the State of Pennsylvania has increased the minimum wage. Every single one of them. New Jersey just went to 15 and they all have nursing home and home and community based providers and they all have those services and yet, they have significantly increased the minimum wage from our, you know, 7.5 an hour. So it is possible and it has happened in many other places to get this done and the -- the thing I would just stress to the Committee is that to some degree, it is not really an option anymore that we can do it when it is safe and totally guarantee that it is going to work out. This is a crisis and I know providers and I know people with disabilities and seniors are facing the inability to find and retain workers in a way that is actually putting people's independence dignity and lives at risk. I mean, that is actually happening. And so until we create more demands for this and create the urgency to actually move the ball forward and get a path to 15, I don't think that that crisis will go away. Even under the best circumstances and even if aggressively start attacking it today -- that required -- the last thing I will say is it does require us to

understand that the reimbursement rates have to increase and raise resources in the state.
BARBARA POLZER: Thank you. Anymore discussion?
DENISE: The only thing that I would add, I agree that I think it goes /WOPBD the comments that Kevin made with nursing facilities and it is really in all aspects of healthcare and the -- the only thing to add to the wage piece is technology, expectations cost the data integrations have an impact. The training that is going to be asked of us to improve the situations and the living conditions and home and community based as well as nursing home as well was with home health all have an impact and I think that that has to be put into consideration with the Medicaid as well.
BARBARA POLZER: Thank you. Anymore discussion?
GERMAN PARODI: May I add brief comment.
BARBARA POLZER: Sure. Go ahead.
GERMAN PARODI: As we move forward with this, I know it is -- for me needs to be said as we talk about increasing wages that make sure that that happens that we are not last to compensate for that and secondly, with -- through all of this discussion and the motion, is there space for O-L-T-L or-D- H-S to create guidelines on how the legislation passes and how it is implemented for the M COs to accordingly move that rate to the attendant. Kevin, is there guidelines to be established from the department.
BARBARA POLZER: Unfortunately Kevin had to leave the meeting and we have Jill sitting up here. Can you answer that or do we need to take that back.
SPEAKER: I believe that O L. T L. Is definitely going to have input as we move forward. So it won't be -- it won't be without our input and our opportunity to comment and contribute.
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SPEAKER: I know the wages will require funding but common sense says not doing it is going to be greater cost for the program into the work that has already been done to keep people out of nursing facilities and living in the home, the cost would be greater to not support this.
RICHARD WELLINS: The surrounding states that increase minimum wage, do they get a change in their Medicaid rate or do they handle it in some other way.
JESSE WILDERMAN: I --
RICHARD WELLINS: They all increased wages but would Medicaid -- did Medicaid reimbursement go up.
JESSE WILDERMAN: I actually don't know the answer to that question for every state around us but I know that in many cases is yes, when the provider agencies and/or the nursing facilities or others are facing the wage record that that creates pressure on the flip side which is to say that the Legislature and others have to increase the funding. I think the specific proposal here in Pennsylvania is that they estimated what the cost savings would be to increase minimum wage and I think it was 245 million dollars into

home and community based rates to understand that this is -- to be able to allow providers and to be able to increase the rates to meet the -- so I don't know the exact details but what we have seen in all of the states that the rates have gone up to 15, that that generates the requirement frankly to increase the funding for -- I mean, the places that have the highest wages for the direct care workers have the /RO best reimbursement rates. There is a direct correlation between that. So if you look at places like Washington state and other places you see the Medicaid reimbursement rates are the highest.
SPEAKER: What about benefits, like, basic vacations and healthcare and especially healthcare and -- you know, especially healthcare, that is the basic one. Can they have that?
BARBARA POLZER: We would love to see that.
SPEAKER: The answer is is no. I think the answer is no.
SPEAKER: What do you say about that.
SPEAKER: They would like that.
BARBARA POLZER: As Jill just said, we would love that but we have to start somewhere. Any other discussion?
LUBA SOMITS: I just wanted to comment that I think the document is is a step in the right direction for everyone whether it is a provider or an individual. We need to take a look at the on boarding piece and what we offer and the increase in the rate is very very important but I also think it is very important so that organizations that provide healthcare, home care just like the nursing facility just mentioned that we are lining the process so that nobody is harmed whether it is a facility, provider, so that those rates are comparable. So you have an individual rate but you also have the rate for the provider to be able to do the work they need to do. The example that you are talking about in the southeast, New Jersey may have increased a rate but the provider rate continues to --
SPEAKER: Another thing nursing facilities kill people, like, you know, like nursing homes. They kill people and not help them.
LUBA SOMITS: I was just using them as an example of one of the organizations and I totally understand your position believe me. That is why I'm in home care. So I just wanted to just make sure that in that process that we are -- the timing is correct so that everyone can do the things that they need to for everyone in this process and not just focus on one area. Without everybody being aligned and working -- not working together, it is not going to work even if you have just a flat rate increase and that has been shown in other states.
BARBARA POLZER: Thank you. German?
GERMAN PARODI: Thank you, Barb. I remember in the last meeting Kevin saying that the MCOs.
MATT SEELEY: Can you press the Mike on.

GERMAN PARODI: Their motive and directive in our state is to -- so in the coming year, we do not see that, then I don't see a reason for having managed care passed.
BARBARA POLZER: Thank you. We did get a comment from someone on the phone. Staffing is a serious issue now even paying $12 or more does not address the issue due to high demand on labor force from other nonhedge care companies. We have to find other ways to encourage caregivers to recruit and retain workers. Steve?
STEVE GAMBLE: This is on Medicaid, I do ask that they also consider the option being consequence for the options program for home and community based services. Certainly we support a living wage but if we don't get any additional revenue or resources, it is just fewer units of service that are able to be provided at the same amount of money. We need to be cognizant of that as well.
BARBARA POLZER: Thank you.
LUBA SOMITS: If I can offer an comment in regard to the options. I think it is a very very important element in long-term care services and supports. And when contracts are allowed to be per county and some of those rates in those contracts are extremely low and when you look at those rates, there are providers that turn away because the rates are so low because they can't afford to do that. And some of those rates are lower than the Medicaid rate and so that is a real certain and when those things occur, you have individuals that are seniors in the community that are vulnerable and in need of services and in my opinion, there is a shortage of good providers that are able to provide that service for that reason.
BARBARA POLZER: Thank you. Dan?
SPEAKER: I wanted to address the blue print, the concerns where is the funding comes from. How are we going to pay people living wage, the demand for increase in workforce and the crisis that is looming. So everything that you are concerned about is in the blue print. It is a road map. Most importantly part of the road map that is key is public awareness , funding public awareness , not just the people in this room.
BARBARA POLZER: Thank you. S any other comments?
Would we like to take a vote on this? Committee members who are in favor of this motion raise your hands please. Committee members on the phone who are in favor. Can you please identify yourselves.
TELEPHONE: This is German.
BARBARA POLZER: Thank you.
TELEPHONE: N-E-I-L Brady, yes.
BARBARA POLZER: Thank you.
TELEPHONE: Sister Catherine, yes.
BARBARA POLZER: Thank you. Tonya? Are you still there?
All right. Well, thank you. It appears as this motion has passed. (Applause.)
HESHIE ZINMAN: So I would like to address another issue having to do with person centered care and that is the issue of L. G T B health equity. Pennsylvania greatest

strength lies in our diversity however, L. Gee Bee T Q residents do not have full under state law as the Commonwealth lacks comprehensive nondiscrimination protection.
The -- I'm a member of the long-term care council. The long-term care council recently voted unanimously to support the passage of House Bill 1404, Senate bill 224 and 614 which would amend the Pennsylvania human relations act to band discrimination based on sexual orientation and gender identity and expression.
We would like -- so our idea is to get the department's, committees that work on long-term care, person centered care to also unanimously vote to send a letter to the state assembly urging passage of these three bills in favor of L-G-B-T nondiscrimination. So I would like -- I guess I'm thinking we would like this Committee to vote to have the M-A-C, the larger -- I mean, we are a subcommittee of the M-A-C so we are asking that this Committee vote in favor of the M-A-C taking on this issue and voting unanimously in favor of the passage of these three bills so that there could also be a letter sent from the Office of Long-Term Living to the state alleles sum /PWHREU regarding these three bills.
BARBARA POLZER: Okay. So we need to -- we as the sub A-M-C would make a recommendation to the M-A-C. We would do that.
HESHIE ZINMAN: You don't have to vote on that. We can just say we are going to make a recommendation? Is everybody on board with that.
SPEAKER: Can we get a copy of the bills require to the vote.
HESHIE ZINMAN: Yes.
SPEAKER: I think similar to the motion. It seems like a no brainer but we should just take a look, have the opportunity to take a look at the bills.
BARBARA POLZER: So we will get that office out to the Committee members and have a vote next month.
HESHIE ZINMAN: That is great.
BARBARA POLZER: Thank you. Wow, that was exciting. I'm going to turn it over to Jill for the O L. T L. Updates.
JILL: Good morning everyone. All right. So I'm really excited about this because this is something that I personally have been working on with a lot of people in this room actually to get finalized so I'm really excited to show people the new participant training that we have on line and honestly, you can use this as a tool to educate participants. I already know that some of our nursing facilities are using the nursing facility module so play for folks and discuss the information contained in the presentations. So I'm really excited about it.
So this is difficult to see here. So it is out on our website and I think everybody here is familiar with our website the health choices dot PA dot G-O-V. And we didn't do a live demo here because sometimes our technology isn't reliable in this room. So bear with me. If you go to our health choices website and you go to I need services, so it is the participant side, you know how our website has two different sides one for provider information and one for participant information.

There are three trainings available. They are in the same format as the previous provider training. So they are a presentation style that is narrated and you play through the presentation. There are three of them. One geared for folks that are residing in a nursing facility. One for folks that are receiving home and community based services and one for folks that are nursing facility ineligible or dual eligible participants.
So this is what is looks like when you click on the training. You can play the on line -- the presentation or you can look at the text.
So this presentation on this slide is the one for waiver participants. And it talks about each one has common sections and then some specific depending on whether you are a waiver participant and N F I or residing in a nursing facility. So it does cover what community health choices is, what if I'm dual eligible, if I live in a nursing facility or I'm enrolled in a waiver and then what are my next steps.
So this is what the page looks like for the beginning segment about what is community health choices. It follows through as you can see on the menu and you can also click on the transcripts so you can see the narration, if that is something that folks would prefer to do.
It covers what community health choices is, why the change, how it works, who is included, and, of course, an everyone knows the answer to this question, will C H C affect my Medicare. No. C H C will not affect my Medicare.
The next slide is a -- one of the slides from the dual eligible training and it goes through key questions and we do receive these questions. They are probably one of the most frequently asked questions is can I keep my current providers, what about my current benefits and you know do I get a health screening, what about my care management plan, those types of questions as a dual eligible. So it does cover that information and, of course, our answers are yes, you can keep your Medicare providers and C H C does not impact your Medicare benefits.
The next slide is a slide from the nursing facility training segment. And it reviews the questions that would be pertinent to someone residing in a nursing facility. What about my current facility. What about my current benefits? What about a service coordinator because remember that is something new for our resident /TPH-Z nursing facilities, they will be receiving a service coordinator that will work with them and the nursing facility. So it talks about getting a service coordinator. It talks about comprehensive assessments and developing a person centered plan and it addresses nursing home transition. So it makes sure that folks know that if they want to transition to home and community based living what they would need to do to go through that process and how folks will work with them.
And then the next slide is a slide that is from the waiver module. So folks that are currently receiving waiver services, it talks about what, you know, how it would impact services that they receive now. Again, what about my current provider so it talks about the continuity of care period. It talks about service coordination and also talks about the

direct -- the participant directed model where folks are hiring their own workers, it talks about the current benefit package the current benefits and comprehensive assessments and talks about what our expectations are for the planning team and how they can use their planning team and services that may be additionally added for them. Because remember, we have some folks that are receiving waiver services under the attendant care or under the aging waiver that will be receiving additional services under community health choices.
And then finally, this slide is common to all of the presentations, it talks about what is next. So it reviews the enrollment packet. It talks about the C H C health plans. It talks about how to select a plan. So talking -- talking to your providers, selecting the plan and then what you do to work with your Managed Care Organization.
So are there any questions on that? I do encourage everyone please go out and check these out, they are great. For our home care workers that are in the audience, it may be something fun that you guys could pull up and watch with your participants that you serve. In fact, the original idea for this and you have to say that, the original idea for these modules came from folks that are directing their own services and they said, you know, I may not get -- I may not understand all of the mail, I may not be able to get on line all the time but my direct care worker and I could watch something. If you have a video or something like that. So that is kind of how this morphed into these trainings on the web. So it might be something that you can share with folks and say, hey, if we have additional questions, let's check out the training.
NINA DELGRANDE: So is there a module on the life program as well to let them know that that is also an option if they choose not to go into one of these.
JILL: There is a slide that is included about the life program just as there is in the participant outreach sessions that are currently going onto talk about if they are already in the life program, they do not have to change or, you know, information about the life program if that is something that they want to be -- they may be interested in and how to get additional information.
NINA DELGRANDE: But if they are not currently in life but they want to enroll in life versus go into C H C.
JILL: That is correct.
NINA DELGRANDE: Is that information in there.
JILL: There is information in the presentation about the life program. Yes.
NINA DELGRANDE: In each one of those --
JILL: . Yeah. There is a common -- common theme across all of them and then there are specific slides for that individual group.
NINA DELGRANDE: Is there opportunity to make a presentation kind of about life because we are talking at each of the -- like, they community meetings with the providers, we are actually talking about the life program. Like, they hear about all of this but we have been doing presentations. So is there an opportunity for us to have a slide

in there or a couple -- you know a couple slides more than one that would talk about here is what the life program really is.
JILL: I mean, we could talk about future trainings for the life program and I see Jonathan sitting behind you over there. These sessions, this material, is part of the comprehensive C H C communications strategy. So it was something that was added to reach additional folks and that is why it was mirrored off of our other communication materials. So we did include information about life but it is also the purpose of this is to educate people about the materials that they are currently receiving.
NINA DELGRANDE: Okay. Thank you.
RICHARD WELLINS: I had a quick question. If you had a waiver or assessed then as nursing home eligible, managed by an M C O, which module do I look at.
JILL: You could go to the waiver --
RICHARD WELLINS: Dual eligible.
JILL: Then you could do dual eligible as well.
RICHARD WELLINS: Okay.
JILL: Yeah.
RICHARD WELLINS: So both of them.
JILL: And the dual eligible one is specifically for N F I duals so it is folks that have Medicare and Medicaid and may not be currently receiving waiver services. So if you are receiving waiver services then you would want to check out the waiver module.
RICHARD WELLINS: But it is no longer considered a waiver.
JILL: Correct.
RICHARD WELLINS: It is services provided --
JILL: Yes. Yes.
RICHARD WELLINS: Got it. Thank you.
SPEAKER: Was the office of mental health and substance abuse services involved in /-TD creation of the documents. I see a one line reference but I see no further information that could be gleaned by reading that document as to the provision of and receipt of behavioral health services.
JILL: So the modules actually were created in line with our other communications that were sent out about community health choices and they were reviewed by our communications team so we do have representation from all of our program offices on that communications group and then we work very closely with the Pennsylvania health law project and our consumer advocates to review the materials prior to it going to narration.
SPEAKER: End you came up with one line. Thanks.
DAVID JOHNSON: What metrics are being collected regarding who is using it, if they are -- what data can be captured.
JILL: We are not. This is posted on our website. So we haven't developed any matrix if someone is using it. It is like our provider trainings that are posted on the website. And

we don't and haven't developed any kind of data capturing to see how many hits that might be or who might be using it. We are getting feedback from folks that are using it. But other than that, it is just a piece of information that is posted on our website to give another media for folks to access information.
DAVID JOHNSON: Follow-up question. Would O L. T L. Be open to feedback as to where this information is posted on the consumer website. I don't want to say it is buried. But I think helpful for people who are web savvy. I know on the main page you have to click another link to view updates and then choice of module. Is it possible there could be some more prominent featuring on the main page and quickly find it. The main links on the websites the C H C plans --
JILL: Sure. We can take that back to the communication office. And also, just so everyone knows, we did share this link to -- to the trainings with other organizations. So it did go out to our list serve but we also shared it directly with our provider associations and other groups to share or link to. There is also link from our PPL website as well so that folks can know that the training is out there and they can link to it.
DAVID JOHNSON: Okay.
JILL: Yep.
SPEAKER: I think this is a really good supplement to the 72 in person sessions he is especially for the people that aren't able to get out. If you can talk or explore a little bit about when people had questions specifically after reviewing the material, either the 1800 number or R A account that they can go to.
JILL: Each one of the modules does have what is next and if you have questions and it directs folks back to the independent enrollment broker.
Any other questions? Okay. I'm going to turn it over to Randy to talk about our network adequacy.
SPEAKER: Is Kevin coming back.
JILL: I'm not quite sure. He might be back.
SPEAKER: Do you know if one of you can talk to the I-E-D- process the shifted process where they are doing the up front and have more data on that in terms of the lag time in terms of what it is taking to make referrals over the current assessment.
SPEAKER: I wanted to just make the announcement that centers for independent living will be doing an additional 11 education sessions.
MATT SEELEY: Can't hear you.
SPEAKER: I just wanted to let everyone know that centers for independent living have an agreement with the Office of Long-Term Living, we will be doing 11 additional sessions throughout the state.
JILL: Thank you.
MIKE GRIER: Thank you.
SPEAKER: Good morning folks. I'm Randy the Bureau director for coordinated care from the Office of Long-Term Living and talk a little bit about provider networks and answer

any questions that you have at this point in time and move forward the next is discussing about behavioral health.
First line we have up here is a breakdown of the amount of nursing facilities and hospitals that each of the three M COs have. Fully contracted or credentialed. You can see there is 318 total nursing facilities in the three phases and then the breakdown of the numbers below. All nurse fag silts have been contacted and the M COs are working with them and working through contracts. Some of these corporations take a little longer to sign off on things but all of the contracts are out and they have weekly follow-up with each of them on that. Same way with hospitals in regards to that all of the contracts are out with them and working with the hospitals. Once the hospitals sign off on them, then the physician group at the hospital also are then credentialed and fall in line because they are part of the hospital. So there is a lot of stuff in process right now. We have -- we have weekly reports from all three MCOs. We are having biweekly meetings starting with the Department of Health. We met the end of August. We are meeting Friday with the Department of Health and has a responsibility to monitor and certify managed care planning networks so we will be working with them every week throughout the rest of the October November to make sure everything is situated.
As far as working with the providers once they are in network. Each of the M COs will conduct various trainings. The training will be how do you work with the M C O and sign up with us. Billing and invoicing, they doing a lot of testing areas with nursing facility and other providers to make sure that they are billing and invoicing can be done correctly. A lot of training on the person centered service plans. The concepts, the forms. The format that the M COs use and then obviously part of the discussion with about the E V. V. System as to what they are supposed to do. Working with H H H on authorizations and working with H H H on E V. V. So they are working through that process with them.
So a lot of training going on. All three of the M COs are working together to do the inter R A I training in each region and that training is coming up over the next couple of weeks. Into November 22 latest so that they can get everybody trained on the assessment tool that they will be utilizing. So all of that training is going on right now. One of the things that I want to highlight and I'm going to be sending some clarifications out in regards to this. I know there has been a number of questions and concerns that have come in and when people go on the enroll C H C website to look for their providers. That website information is generated based on the -- what we call the operations five report that each of the M COs have to submit on a weekly basis. It is updated on a weekly basis so that the most current information is out there as far as what providers are contracting with which MCOs. The caution I want to put out to you and the clarification I'm going to put out to the independent enrollment broker and I already spoke with all three M COs about this. The fact is not all PC Ps are going to show up. They are not all Medicaid enroll providers a lot of them are Medicare providers

which is allowable. They don't have to enroll in Medicaid. Some of these providers don't want to be listed on our website or the M C O website but they are willing to continue to provide these services through the Medicare program and then accept the co-payments from the M COs as long as their enrollment in M M A. They are allowed to do that. The clarification that I'm going to send out is that their phone operators need to be able to explain that to participants when they call in. The second thing is warm transfer that participant to the M C O is that they want to talk about. The M COs can talk about provider network in phase 3. They can confirm whether they are working with Dr. Jones and their contract is in process with Dr. Jones or whether they will pay Dr. Jones as an out of network provider. The own thing they won't be able to do is if someone says all of the doctors are in the system how do I enroll with you. They can't answer that question. That has to be transferred to the i.e. B to hand /STP-LT actual plan selection and enrollment. They can provide information in regards to providers themselves.
So a lot of times the Medicare provider may not be enrolled or doesn't have to enroll in M A and the M COs are responsible for paying them any co-pays that may occur for the Medicare system. That is one of the requirements that they have. That is why the PC Ps are not showing up and some of the specialists are not going to show up. They don't want to enroll in M A. They are willing to participate with the Medicare payment. The M COs will work with those providers and work with them at out of network providers. So I mean, so I realize there is a lot of panic out here because some of these individuals aren't pro showing up on the provider website. The caution I'm going to put out and the information I'm going to put out is to make sure that they take that next step and they tell them either warm transfer them to the M C O or provide them the information so they can call the M C O and ask them directly. I had the discussions with the M COs they need to be answering these questions.
SPEAKER: Just trying to be real clear on this. Are there two different lists or something, if the person, you are saying if the doctor doesn't want to be listed are they not listed on the website but I-E-B can -- there is one list they are on there or not on there if you still want to know, you call the M C O directly is that what you are saying. I just can't put it together.
SPEAKER: They may not know. If Dr. Jones is only participating in Medicare and doesn't want to have his name on the C H C enroll website, it is not going to be out there. So that is really why you have to talk to the M C O. You have to look at the M C O website and see what they have on the provider web list or call the participant hotline and discuss it with them.
SPEAKER: I know you are learning as you go but that is not what has been -- I know you are telling the trainers now for the participant trainings now but essentially, what has been said at the ones I have been at is if they are there -- if you are looking for your doctor, it has never been pushed to go to the M C O directly that you are looking at and

so there are going to be people going to the participant sessions who are not going to have the same information.
SPEAKER: I apologize if that message wasn't clear. Here is probably the easiest way to do it. Talk to your provider. Your provider should be able to tell you that they are enrolled in M A or not enrolling or enrolling with M C O or not --
SPEAKER: I just asked the doctor yesterday, they don't know anything about it.
SPEAKER: A lot of times asking the doctor, you got to ask the office manager. Sometimes the doctors don't know who their enrolled in and who is paying them or anything like that. It is usually the office staff that can handle it. It is the one that gets all of the information and handles everything.
SPEAKER: Regarding the training for service coordinators to complete the inter I. Is there anything specific in that training how to address cognitive issues their training, they are assessing who may not be able to accurately reflect their functional needs.
SPEAKER: Patti, are you here. Can you come up and answer that for me.
SPEAKER: I'm behind the pole.
SPEAKER: I knew you were there.
SPEAKER: Jen is here. You are asking about the inter I and the training for assessment.
SPEAKER: For the cognitive piece.
SPEAKER: And the training specifically addressing the issue for people with cognitive impairments who may not be able to accurately discuss their function.
SPEAKER: Yes. So the three M COs will continue to do the inter I training together in phase 3 as we did in phase 1 and 2. And I don't want to speak for the other two M COs but AmeriHealth, we do include with that a cognitive assessment tool to help us determine whether or not the individual is really has the cognitive ability to answer that on their own or if we should enlist the help of others but it is discussing during the inter I training that the cognitive challenges can be identified.
SPEAKER: Is it a specific tool or a series of questions built into the inter I.
SPEAKER: We use a specific tool to do a cognitive assessment and it has a scoring and it is evidence based. So if an individual -- because we do have some individuals, even individuals with, you know, with brain injury that when you ask them a question, they are going to tell you that yes, I can answer that but truly they can't answer that. So the tool helps us identify and kind of reinforce the service coordinator when they need to enlist help from someone else.
SPEAKER: Can you tell us what that tool is.
SPEAKER: I can have the doctor join us and review the tool. It may be helpful from all of the M COs because I'm not 100 versed on it to present it here but we would be happy to talk about how we do a cognitive assessment but I think it would be beneficial to hear from all three.
SPEAKER: Speaking of that. Anna, do you want to address the question?
SPEAKER: I will turn to the pole.

SPEAKER: I would echo what she said. We can have someone come next month and address that as well. We have the same -- same process. Okay?
SPEAKER: Thank you.
SPEAKER: All right. Who is here from UPMC. David in the corner. You guys can't hide. I don't know why you are trying.
SPEAKER: We have the same process. There are also queues but we do have a similar process to the other MCOs.
SPEAKER: So you would be willing next month to present.
SPEAKER: Somebody from UPMC would, yes. I can if you want. It won't be that good.
SPEAKER: Just so you know Jill was making fun of your bears.
DAVID JOHNSON: This may be a question for the M COs but if someone is -- got a Medicare only provider and they are trying to figure out from the M C O if there are going to be billed as an out of network provider. Can you talk about what that would look like, if they call the hotline, what assurance whether someone would be billed as an out of network provider.
SPEAKER: MCOs.
DAVID JOHNSON: I can follow-up on e-mail. If they are going to I-E-B or going to the website and the provider is not listed and they are instructed whether by O L. T L. Or us to go speak with the M C O directly. These Medicare providers aren't too versed on C H C in the southeast. How would the M C O communicate with the participant that they are going to be billed as an out of network. I'm wondering what the expectation would be.
SPEAKER: The expectation will be able to tell the participant, yes, we sent out information to Dr. Jones. He is reviewing the contract or Dr. Jones is not going to contract with us so we will pay -- we will work with him as an out of network provider. They should be able to address everything that they have done with the attempting to get Dr. Jones in as part of the network.
JILL: Really, that should be seamless to the participant. The participant say they have their Medicare provider, I mean, the participant can keep that dock because we are telling them they can keep their Medicare doctors. By agreement, the M COs are bound to pay cost sharing and deductible to those Medicare providers regardless of whether they are enrolled in M A and regardless of whether they are in the C H CMC O network and I know that that is working today because I received questions from the PA medical society from medical providers wanting to know if they could cash the checks. So it is working and they are receiving their cost sharing and the fee schedule even if they have never -- and the comments that I received from PA medical society is I have providers saying they never bothered with Medicaid before and now they are receiving these checks and they want to know if they can cash them. We did some reeducation to the providers and as much as we like to think that our communication strategy is comprehensive, sometimes folks just don't read it. Sometimes they don't pay attention

and including the provider community. So I -- I know we have sent out -- we have been highlighted in pages in the physician journal for PA medical society. We are in their regular newsletters but still some providers were confused by receiving those checks. It does happen but from a participant perspective and in all of the training materials and communications, we are telling them, you can keep your Medicare providers. And they should not be balance billed either.
DAVID JOHNSON: It is appreciated and with so many stakeholders there can be Medicare providers that aren't picking it up. If someone is instructed to go to the M C O. What you said Randy is helpful, what outreach has been done and reviewing contracts and working as an out of network provider. As long as the consumer would have that --
SPEAKER: Can I ask a follow-up. If I call the M C O and ask about Dr. Jones they will know whether Dr. Jones has agreed to accept out of network payments because Dr. Jones doesn't have to agree to that. Is there an actual official agreement or what --
SPEAKER: M COs if you are paying someone out of network provider, you have an actual one time agreement with them is that what you are calling it or how are you handling that?
SPEAKER: We have a single case agreement for none P-A-R and pay that rate.
SPEAKER: PH W has a single case agreement that they pay for that person.
SPEAKER: I think for general coordination of benefits every single medical provider that might not be in your network, you will coordinate. These plans also educate the Medicare providers that they are not allowed to balance bill the member no matter what. If they don't want to bill the Medicaid plan, if they are not going to work with that Medicaid plan for secondary coverage for that co-pay, I can't force them too. That is the only way to get that payment. It is not allowed in Medicare for a dual eligible Medicaid Medicare balanced bill in most Medicare plan.
SPEAKER: I'm trying to get what people actually learn when they call the hotline. There are providers that we worked with. They refused. They don't care. They are not going to bill -- they are not going to bill the C H C plan. They just want to deal with Medicare and stop seeing patients.
SPEAKER: They have a right not to bill --
SPEAKER: I think it would be nice to find that out beforehand.
SPEAKER: The providers have a choice of what they want to do. The M COs needs to be able to tell the participant or make sure they are dual eligible and that their physician is receiving Medicare payment for them and work with that physician but the person can continue to see the physician whether they are in the C H C network or not. They can still see them as they are now and the physician will be paid by Medicare. That is the message they have to put out.
JILL: There is automatic cross over and each one of our plans can speak to that. They are doing just as the department does for part B or D whether there is an automatic cross over from the carrier. The M COs are doing that for these Medicare PC Ps thus the

questions that I received from PA medical sew society. There was no agreement. They are required by contract to pay the cost sharing and deductible up to the fee schedule and they automatically cross over. They are all set up now with E-C-O-B-A agreements so that these automatic cross over.
SPEAKER: That is really good to know and we asked that before whether it was automated yet. So that is helpful.
JILL: So that is why I started getting the questions because the agreements were finalized with C MS, we had provide approval and each one of the M COs finalized --
SPEAKER: So the provider doesn't have to do anything --
JILL: That is correct.
SPEAKER: I would add that there is my perception or communication about some of the Medicare providers and trying to educate them on that and something, you know that, just as you said, it won't be not to see a patient because they can't be reimbursed. I heard that happen and seen that happen. I have gotten complaints from members that they are balanced bill and we help that Medicare recipient correcting that information. It is an ongoing problem. I don't want to sugar coat that. The main thing is that the participant shouldn't be balanced billed for those kind of services. Unfortunately not all of the Medicare providers fully understand that.
SPEAKER: And if I can, it is Patti, I just want to confirm that it is a follow-up was Pam's question earlier. If you call the participant hotline for AmeriHealth or Keystone and you are asking about the Medicare primary care physician, if they have not agreed to contract with Medicaid as well, they will not be listed on the directory website. So when you call the participant hotline, what you will be told is if you have Medicare primary, that that physician does not change and that between cross over claims, et cetera, we will work with that provider but it does not mean that they will be listed on our website. So I don't want you to think that if you look and let's just say, Dr. Randy is a Medicare primary care physician has said look I'll continue to accept my patients that are now enrolled in C H C understanding that you are responsible for the co-pay deductibles but I don't want to sign with Medicaid, if we are doing the single case agreement or the E-C-O-B-A or the deductible payments they will not be listed in the directory. So our participant call center staff are trained to just reinforce the message that we will honor your Medicare primary care physician and any of the cross cover claims. They will not be able to say to you, yes, they are quote unquote in our network. The script is that we will honor that and you do not have to change your Medicare primary care physician. We will not auto assign you another physician. So your card under PC P will say the word Medicare. So in health choices, if you do not actively choose a PC P, you are auto assigned a PC P under community health choices we do not do that. Therefore, you can maintain your primary care physician. I just wanted to reinforce that.
BARBARA POLZER: Thank you. We have a comment and a question. I think we need to be clear that the Medicare provider who is not Medicaid enrolled has to be willing to bill

the C H C plan. We have had clients with providers not willing to do that and therefore no longer willing to treat the participant.
SPEAKER: Yeah. I think that comes back to some of the stuff Blair is saying. It is an educational thing for providers and we need to keep reinforce that. They can be the provider through the Medicare side and they don't want to become enrollment M A with the C H C to get the co-pay or other benefits. They can get the co-payment as a cross over claim as Jill talked about but it comes back to a provider education thing that we will continue to do. Certainly, some of the things that we talk to provider when we do our provider sessions and it is currently information that we put out on the list serve. We put all of the information out in the world, we can do all of these sessions and everything on the website but we can't make them read them or pay attention to them but we will continue to put information out for them.
BARBARA POLZER: Then we have a question. Can a Medicare provider not contracting with C H C refuse to see a patient who is dual eligible.
SPEAKER: Any provider can refuse to see a patient. I mean, it is a decision -- a provider decision if they want to see somebody. They can't base it on race or ethnicity or payment source or something like that but if a provider has a situation where they don't want to treat the individual because they have been noncompliant in the past or a problem for the office. They can certainly make that decision. It is not based on the fact that they are dual eligible. It is not based on the fact that they are in C H C or they are Medicare only. I mean, I don't know what you have seen from the M C O community about that.
BLAIR BOROCH: I have heard of the prior example that I'm not going to provide services. I don't know why -- they are willing to bill the patient for it and not billing Medicaid for it. I don't know why it -- I hear it but rarely on occasion. The other big misperception if they enroll with the state that they have to accept all Medicaid patients that come to the office. That is not at all true. We see that with chip. I mean, we try to clear that up but as Randy said, a provider doesn't have to accept new patients for a variety of reasons as long as it is not for discrimination reasons.
BARBARA POLZER: All right. Thank you. Thank you Randy and Jill. Next up we are going to have a presentation or behavioral health. We have Patti Clark. Nina and the behavioral health MCOs.
SPEAKER: Good morning everyone. My name is Patti Clark and I'm with the Office of Long-Term Living in the policy Bureau. My role here this morning is just to introduce the topic of behavioral health and then turn it over to the presenters.
So I think it has been about six or eight months since we had any type of presentation at this Committee regarding behavioral health. We thought it would be good to check back in on what is happening. This morning, we are going to hear from two of the behavioral health Managed Care Organizations. They are going to talk about what they have been working on related to serving participants in C H C. Then we are going to

hear from a representative from the life program. So just as a refresher for everyone, under C H C, the C H C, M COs are providing physical health services, doctors, hospital, they are providing long term services and supports, for example, in home services and nursing facility services. And then the behavioral health M COs are responsible to serve the C H C members, to provide their behavioral health services and mental health and drug and alcohol services. So there is two different groups that are working together to provide services to the participants under C H C.
And then as a reminder in the life program, this is is an option for anyone who is 55 years of age or older and who is N FCE nursing facility clinically eligible instead of being enrolled in C H C they could choose to go into a life program where all of the person services are coordinated by that life plan that would include their physical health, behavioral health, their long term services and supports both Medicare and Medicaid, it is all coordinated.
So for this morning, first of all, we are going to hear from Community Behavioral Health representative is Joe, he is the Managed Care Organization serves C H C participants in the Philadelphia area. And I'm just going to -- I'm going to mention who all of the presenters are this morning and then let each of them introduce themselves as they present just to Save little bit of time. So after Joe speaks, then we have two presenters that are going to speak about what is happening in Allegheny County. We have Dr. James S-H-U-S-T-E-R. He is the associate chief medical officer of UPMC insurance division for Community Care Behavioral Health.
And presenting with him is Denise M-O-S-S-A-R-E-L-L-I. I'll let her correct me when she comes up. Denise is the Deputy Director for Allegheny County Department of Human Services and Denise and the doctor are going to speak about what is is happening in Allegheny County in terms of folks enrolled in C H C. And then finally, we will hear from Nina. Nina is with the spirit trust Lutheran life plan and she will talk to you about behavioral health and how it is covered in the life program.
So we will start with Joe.
SPEAKER: Good morning everyone. I want to thank the Committee for inviting me back to speak to you all on behavioral health and community health choices and how it is progressing in the City of Philadelphia.
I want to first talk about who we are. Community Behavioral Health. We are under the auspices of the Department of Behavioral Health in the City of Philadelphia.
C B H has been active since 1997 and our vision is that C B H will meet the behavioral health needs of all Philadelphians assuring access, quality care, financial accountability driven by performance and outcomes and we are -- our mission is we end /SROEUGS C B H as a vie /TKERS, innovative and vibrant organization in which we empower support wellness and recovery for all individuals. That is what we do and what we strife for and what we have been doing since 1997.

So when community health choices first came to the for front and implementation in January of 2019, I came out and I spoke to you all on some of the planning we had. And goals we were working on for the implementation. So now it is ten months in and I want to say that we have had a lot of success in our goals. And I highlighted them here in this slide that we have been able to corroborate with the C H C, MCOs. The Office of Long-Term Living who we never had partnerships maybe before. The Philadelphia Corporation for Aging and advocacy groups such as C-A-R-I. We have really wanted to reach that population that have never had C B H coverage before and that is people on the aging waiver as well as individuals in nursing facilities. So our goals of reaching out to nursing facilities are moving forward and as we speak today, my colleagues back at the office are meeting up with new nursing homes too as we speak. So that has been a success. Our behavioral health providership has stepped up and taken on this population with their services. We have almost 200 providers in our network. We have had really great feedback from the providers on what they are able to do with this population especially around mobile mental health, peer services, mobile psych rehab programs inpatient units outpatient providers. We have had providers really step up and take on some of this challenge which is new to them too for this population. As I say, we have been successful with six nursing facilities in getting our word out to them that services are available now with community health choices in the nursing homes but we also offer for the home and community and home healthcare as well as for the nursing facilities, we offer free mental health first aid certification for all employees. These nursing homes are -- three have already gone through it and three more are up -- coming up seen by the end of the year. They will all be trained. We have had some service coordination department, providers that were trained in mental health first aid especially PCA as well. So this is a free training and a certification and this is really -- it goes well on a résumé as well that they are certified in mental health first aid.

We also have offered R F Q for independent practitioners this is for a population to come into our network and they were out of network before. This was an opportunity to come into our network and ask for some psychologists and psychiatrists and other therapists that work in the field that go into nursing homes and also in the community. We continue to collect data. We are trying to gather all of the data from January to now on the number of community health choices members that have been hospitalized or using some of the providers in our network and we also developed an operations team. One of my team members is with me here. That is Bob. Bob has been excellent in helping us with community integration and community engagement which we have been doing all across the city. We have -- we have engaged in older adult centers and senior centers and went out to talk about behavioral health and community health choices throughout.

So home and community based services, everything beginning as C B H through a call at members services. We have identified people that are receiving phone calls for

members with community health choices and making appointments for them, sharing info with the M COs as well as even with Medicare, even though C H C Medicare primary but our Member Services department will always try to find the appointment for somebody even with a Medicare primary.
As I said with home and community, our mobile mental health therapy service providers have been going out and seeing individuals. We are actually building that providership now. So we have three more providers that are awaiting approval through -- becoming eligible to do this wore the community health choices population.
So there are some barriers, of course, Medicare providership, eligibility was an issue in the past. Hopefully that is going to be changing and still some miscommunication that we are still getting the word out. We are still educating providers and still educating the community, nursing facilities, so we are still educating people on how C B H can provide behavioral health services to you all.
Nursing home -- nursing facilities and behavioral health. As I said earlier, we have providers going into the nursing facility mobile mental health and our peer services that go into the nursing facility. This is an excellent service that has been -- the three nursing homes that we have been working with feel that this service has really helped them with individuals who didn't want to see a psychiatrist. They just wanted someone to talk to. So peer services have been very helpful. As I said earlier, training are available to nursing home staff as well as -- as I sedimental health first aid. We are also initiating our acute services team to go into the nursing facilities to do some crisis training, how to work with an individual in an acute psychiatric crisis, how to utilize the 302 system and the CRCs in the city and they are also offering an M A T medicated assisted treatment on line for nursing facilities to understand M A T. And this is an on line training through the D B H ID S which is another free training. So we have been collaborating with the C H CMC Os. We meet with them biweekly and I want to thank the M COs, the C H CMC Os for hiring behavioral health coordinators who understand Philadelphia as well. Working with them, they have worked in the field in Philadelphia even one of them worked for us in the past. So they are understanding of the city, how we operate, the population and that has been very very helpful when we meet.
So C B H, we have invited the M COs to, like, meetings with different organizations in our department, like, our housing department our tip unit which is for long term residential programs. So we have been partnering throughout.
So we are still working on our data filing sharing which is still actually still working through that. So we will be sharing data across systems very soon. And basically, our next slide is our website. So anything you need to know about C B H the Department of Behavioral Health, all of our initiatives, all of the providers that are in our network is on our Community Behavioral Health website and the two numbers at the bottom are very important. That is the Member Services line and our, of course, our crisis number. So I

want to thank you all for listening. And that we are striving and we are, you know, making a lot of headway with community health choices. So thank you Patti.
SPEAKER: Thank you Joe. Any questions at all for Joe? Yes, sir?
SPEAKER: Is our ultimate goal to change to enroll into their own lives and their own -- their own apartments or houses, you know, so they won't need a nursing home.
SPEAKER: Did you hear the question.
SPEAKER: So an individual would not need a nursing home, is that your question. With behavioral health services, we do have services that help individuals in the community. Right. We have individuals to help people who live in their community in their own home. So we have three services as I mentioned. There is a mobile psychiatric rehabilitation service which helps people with daily living, paying bills or getting out in the community using transportation that have -- that are held back because of their behavioral health challenge.
SPEAKER: But not in a facility.
SPEAKER: That is in the home. In the community. As I said earlier, nursing home community that receive behavioral health is a new population for C B H.
SPEAKER: Nursing homes kill people.
SPEAKER: Thank you. Jeff, did you have a question.
SPEAKER: This is Jeff from Pennsylvania S-I-L-C. If you can elaborate what you are doing under 60 population working with liberty or JEVS. Do you cover just Philadelphia or the other five counties.
SPEAKER: Just Philadelphia. We have worked with JEVS and some of the other agencies in our network because some of these providers are in our network doing behavioral healthcare as well because remember, we have had a huge population of dual eligible under 65 that were already covered by C B H. So their service is -- were already handled, were already taken care of. They were in behavioral health. That didn't change with community health choices. So those individuals were being seen if they were in Medicare. The new population that we really focused on is the aging waiver and people in nursing facilities. The other services were always available for that population with C B H.
SPEAKER: So do you see much as far as mental health, drug and alcohol, for under 60.
SPEAKER: As the crisis continues in the city and the nation, we have task forces, we have people out in the community to get treatment and services and even if they are community health choices or if they are just Medicare Medicaid.
MATT SEELEY: Did you answer the question.
SPEAKER: Well, as I said, we already have providers in our network who have worked with this population in the past.
MATT SEELEY: Was that your question.

SPEAKER: Liberty Resources, we reached out to them. I see Dan back there. We worked with them and try -- we even offered if they want to develop their own provider, mental health program. So we are available to hear and listen.
BARBARA POLZER: Question came in from the audience. How many peers are working in nursing facilities?
SPEAKER: We have three providers right now working in the nursing facilities. The number of -- actually, the nursing facilities have reached out for this service is only three so far. We have three more coming. Our providers are -- we are also bringing in a new provider very soon. We don't know the numbers of peers but they are all certified in older adult peer specialist. There is also peers that are being trained for physical disabilities as well as mental health. So there are three providers right now working in nursing facilities with a new one coming.
SPEAKER: Thank you, Joe. I think we are ready for doctor and Denise.
DR. SCHUSTER: .
DENISE: Is this on? When it is red. Thank you. Good morning. I'm Denise. Patti was pretty close. It is a hard one. I'm the Deputy Director for the Office of Behavioral Health in Allegheny County Department of Human Services. So I think it might be helpful to just say for my part that the county system in Allegheny County is a little bit different. We have been working in an integrated human services department for 20 years under mark who is our director and so all of our offices, mine, aging, child welfare, community services, which is a lot of our housing supports and services, our forensic services, our I-D- services, services for people with intellectual disabilities have been under one umbrella. We had some experience and whole person understanding of social service needs. In my office, I'm responsible for mental health, drug and alcohol, early intervention, Medical Assistance transportation, emergency and crisis services and then my other obligation is to work with the other program offices the other Deputies to ensure that services we are developing in behavioral health are meeting the needs of the special population that they are serving.
DR. SCHUSTER: I'm the associate chief medical officer for UPMC insurance division. I work for a number of years for Community Care Behavioral Health which the M C O that partners with 41 counties around the sat including Allegheny to help their efforts to manage in collaboration with the other services that the counties are managing and I work with the UPMC health choices program as well. So try to speak to some of the issues from both the behavioral health M C O and the C H C perspective.
DENISE: So Allegheny County has a population of about 1.2 million. We serve probably approximately every 5th resident with some sort of humor social service which is pretty significant and many of those folks receive more than one service. So they may get mental health or drug and alcohol but they may get housing support services, aging services, support through child Welfare whatever the case may be.

So in Allegheny County, again, we have integrated because the county is responsible for not only funding things on the block grant side, we are also responsible for governing our health choices program. So we worked very hard with community care from the beginning of time, actually, we are pretty proud that we helped birth community care to really have the relationship that pays attention to the needs of our community and over the 20 years have been pretty innovative and really enjoy the wonderful relationship with a lot of stakeholder involvement and a lot of person serve and other stakeholders in the community. Sometimes we get banged up pretty bad but that is okay. We listen and made adjustments over the years. So maybe you will want to have us back when you hear about this and how it is going and talk a little bit about that.
Okay. So we didn't get to practice. We did a lot of this on e-mail but it is never the same when you are on stage it is different.
So Allegheny County community care as a number of goals related to the C H C. When the C H Cs were developed in the way that they are with the responsibility for behavioral health remaining with community care, we wanted to make sure that we stayed in tandem and in sink with the services and supports both from the health choices side and from the county base side. So one of our primary goals was, of course, to educate educate educate because as you talked about this morning, there are many people who still don't understand what this is and what it can provide and if they are in it or not and I'm speaking about the provider side and I know it has been very confusing, we hear a lot from individuals who are enrolled who don't really understand the benefits that they have available to them. We are very sensitive to that and try throughout to educate educate educate. Our other primary goal is to really work with the collaboration between the providers to create synergies between them because they each provide different thing. They don't all provide the same thing and to create sort of a smoother collaboration so the individuals being served don't have to worry about all of the detailing in the background. It is our job to figure that out. Figure out how to get it paid for and what it covers and how to facilitate the collaboration when it seems to be missing. So there are some key behavioral health services that not available under Medicare. You talked about peer supports and services. We have a robust peer support program in Allegheny County. Again, we were one of the first. We have certified peer specialists on the mental health side. We have also greatly expanded our recovery specialist certification in the past two years. Part of that in response to the opioid crisis but we realize people suffer with other forms of addiction. It is not just opioid. So they want to make sure we don't forget about those folks too.
Mobile mental health services, we have a tremendous amount of mobile mental health being provided across the community. We have been serving people who are Medicare and Medicaid enrolled and a lot of our mobile programs are designed to serve those folks who cannot use the traditional delivery system. They can't go into an office either

because it is difficult physically transportation wise or it is intimidating to go into an office.
We have several types of substance treatments. All of the things, we have a range of services on the mental health side and the drug and alcohol treatment side all the way from outpatient and what we might think of as the least intensive services to inpatient rehab, inpatient psychiatric care and the range in between.
DR. SCHUSTER: I think the substance abuse is important because the Medicare are relatively limited adding the Medicaid around substance abuse has helped to expand the range of services available to them.
In terms of work that has occurred from a behavioral health M C O view to really expand and support the members in C H C, there has been a wide variety of activities. You heard a list in terms of what has occurred in the Philadelphia region and we really have done very similar activities with nursing homes, community health choices programs, behavioral and physical health providers. We actually now have weekly meetings with C H CMC Os to talk about individuals who may be struggling or having difficulty getting the services that they need to talk about how to best do that.
We have actually facilitated and started meetings of all of the C H C and behavioral health M COs in the southeast an southwest regions and the efforts /-PB /TKER way to start those off in the central region as well and there have been a number of community organizations that attend, counties, advocacy groups and other interested parties. So there has been a lot of people from the community that attend. So that has been a helpful way to approach, try to approach some of the challenges.
We have also started with support from O L. T L. And D H S on the -- with the behavioral health M COs have really started sharing daily information between the M COs about things like hospital admissions so if someone is admitted to the hospital both plans and the providers can better coordinate services. There are opportunities for additional data sharing both going forward which I'm going to touch on which I think will enhance our ability to work together.
I'm going to present just a little data about the services that people have used because there has been a lot of appropriate worries at times that C H C members are having difficulty accessing behavioral health services and there are certainly always challenges as you know even if you have commercial or Medicaid or any insurance, there are challenges accessing. We want to make sure those get addressed. But there are some at least kind of positive trends in terms of people accessing services so I wanted to share that information with you. I will try to make it as clear as I can. Some of the information is physical health Medicaid data. Some is community health choices and some is behavioral health. I have some Medicare data as well. That really just reflects the range of, you know, organizations working to support the individuals in C H C, so I try to make it as clear as I can and answer as many questions as I can. If you have questions let me know. I will send additional information or come back a later time. A few of the key

points is one it certainly looks like -- we tried to looks at rates abuse behavioral health services for everybody in C H C and we looked at people who were in nursing facilities and people who were receiving home and community based services. And we have some data that is -- some of the data is limited and not all of the plans and I will talk about that as we look at the individual ones. There are also, I talked just a minute ago that the C H C and the behavioral health M COs are starting some routine data exchanges. As you know many of the C H C members are also enrolled in special needs plan, special Medicare advantage plans for dual enrollees and their efforts under way to start data sharing between the behavioral health M COs and Medicare special needs plans as well. There will be more data available going forward. Just to give you a sense of the activity to date. So about -- so of everyone who is enrolled in community health choices, about 14 percent of those -- in Allegheny County. So this is all Allegheny County focused. About 14 percent of those individuals are receiving Medicaid funded mental health or substance use services. As you will see in a minute some individuals are seeing Medicare funded services. 14 percent are receiving Medicaid funded services.
If you go to the next slide, and this just gives you a sense of all of the individuals in the community health choices in Allegheny County about 4300 individual receive mental health or substance. You can see the buck of those are mental health. One of the areas we want to continue to work on is trying to increase people's accessible and awareness of substance abuse services that are available to them.
If you look specifically at individuals in nursing facilities, about 5 percent of those individuals received mental health or substance abuse services that are Medicaid fund it had in April. The data is always a few months behind because you have to wait for people to submit claims in order to actually be able to know what services they received. The data is always three or four months /PWE behind. About 5 percent of those individuals are receiving Medicaid services. You will see some of those are receiving Medicare funded services button doubted we want to get the goal up higher than it is. In terms of what is the right number, what is the right number for services for people to be getting all together, you know, there is no /SKHABGT number that anyone knows but if you look at the -- the total number of -- if you look at the Medicaid enrollment generally, about 25 percent of everyone in Medicaid receives in Allegheny County receives a behavioral health service in a year. Our goal would be to try to make sure 25 percent of individuals who are receiving Medicare or Medicare funded services. In a home and community based services, you can see about 10 percent of those individuals are receiving a Medicaid funded service in any particular month.
And then this is, you know, I said we were trying to combine some data sets. So we looked at everyone who is in the UPMC special needs plan in Allegheny County. And looked to see how many of them were receiving either a Medicare or a Medicaid funded behavioral service. You can see that -- maybe you can't see. I'm happy to share this afterwards with folks. The column on the left that is services paid for by Medicare. 2300

individuals receive a behavioral health service funded by Medicare. About 2400 received a service funded by Medicaid. In the third bar. 1800 had services provided by Medicare and Medicaid both and about 3,000 individuals received a Medicare or Medicaid funded service or both. And this was over a six-month period. The first six months of 2019. About 3,000 individuals who were enrolled in the UPMC special needs program and the first six months of the year received funded by Medicare or Medicaid. The enrollment 10,000 individuals. About 30 percent of the individuals in the UPMC special needs plan in Allegheny County all who are in A C H C. They may not be in the UPMC which is is one of the things that makes the data analysis more trickier about 30 percent received a behavioral health service. So, again, the columns down in blue and orange at the bottom are those individuals who are either receiving home -- that we know of receiving home and community based services or nursing facility services. Those numbers really are probably a little bit higher because not everybody who is in the UPMC special needs plan is also in the community health choices plan. We don't know everybody who is UPMC, didn't know in an H CBS or nursing facility. So there is a little bit more work to do. But I think the general message we wanted to deliver was there is -- there is definitely more work to do and you are going to hear about a new program that Allegheny County is putting in place to increase access especially in nursing facilities because that is the most challenging setting for people to get behavioral health services in. It does look like there is progress being made in terms of people getting access. I will turn this back over to you.

DENISE: So because we have had this general sort of approach to care about working in communities, serving in community including natural supports and serving in the natural environment, it just was a good opportunity for us to look at what is happening with folks that are C H C enrolled particularly those in nursing homes where we make some assumptions that there is not necessarily the amount of care being given that is needed. It doesn't mean that nursing homes aren't trying hard to do what they can but the psychiatric or DNA treatment needs of individuals in those facilities exceed the ability of that facility to have that expertise. We have talked earlier about the funding and staff resources and so nursing homes do what they can with what they have got. We also have seen some trends with folks whose need exceed the nursing home prior to C H C winding up in a hospital or an emergency room and then the challenges of that disruption for those individuals and then getting them back to the facility that they need was also challenging. So our goal was really to do two things with this project, which, you know, we just have started. We were asked to speak about If it today. We don't have any outcome to show you but we are hoping for the best to serve people in communities. So we created with reinvestment money which is available to us as a result of our health choices program to take a portion of our investment and ask the state for permission nursing home transition diversion team not just to serve people in a nursing home with a specialized sort of a compliment of a treatment team that can go in and

work with the individual in the nursing home but also a team that could go into individual's homes where they may be receiving home health or some other health relates supports and work with those teams to avoid the necessity of admission to a nursing home and/or to a psychiatric facility with more intensity.
We also wanted to be able to -- so help folks who wound up in a nursing home because they needed to be in a nursing home by whatever definition to transition smoothly. So the goal was either -- the ultimate goal is to avoid it whenever possible. When not possible to serve people who are admitted to nursing home to work with them there and to come back out into community with them to work with them and work with their families to provide peer support psychiatric care, nursing care, clinical, social work, therapist kind of compliment of a team.
We also had to write a service description to the state and say this is what we want to do. We haven't done it before. Again, we have had mobile mental health services. We had a treatment but those people don't go into the nursing homes. They haven't been able to do it. We felt like this was a population either due to disabling condition or because of being older and eligible for Medicare and Medicaid needed a different kind of an approach. The goal is to build a specialized team to be able to serve a particular population and hopefully with the kind of skill and compassion and understanding that they need to have in order to make this successful.
MATT SEELEY: I have a question just going back to what you were saying I was moved by the disabling condition thing but you were saying that the nursing home diversion -- not diversion avoidance, whatever you called it, where are you going besides people's homes to avoid nursing homes.
DENISE: So these teams would be able to go to wherever that person is that may be living with family. They may be in their own home. They may be in permanent supported housing so the goal is we serve individuals who are in the community and defined broadly as anyone not in the nursing home facility.
MATT SEELEY: Anywhere outside of the nursing home.
DENISE: Um-hum.
DR. SCHUSTER: We have one more slide but I think maybe you already covered everything. In the interest of time, we will take questions.
BARBARA POLZER: A question came in over the phone. Why do you think a high participants of UPMC D S N P are accessing behavior health services.
DR. SCHUSTER: Well, there are basically two kind of eligibility streams in order for people to become eligible for-D- S-N-P in addition to meeting the income requirements for Medicaid. One is age and the other is disability. So roughly about 25 percent -- 20 to 25 percent of the individuals in the UPMC special needs plans are eligible for special needs plan because of a mental health disability. So we would expect a number to be in that range and as I mentioned, over all, Medicaid, the over all percentage of the general Medicaid population so includes everybody people without any health problems the

average -- 25 percent of those individuals in Allegheny County use a behavioral health service each year. So the special needs plan would be higher than the general Medicaid population.
SPEAKER: Other questions?
MIKE GRIER: Denise, how big do you expect this to get?
DENISE: We don't know. We -- we really don't know. We don't know how big it is going to get. Our proposal was for two teams. We also don't know what the transition is going to look like. So how long, if someone is in a nursing facility and comes you don't with their team, so the goal is their team comes with them, we don't know how long that team stays in place. I mean, the goal ultimately is to reengage the individual into existing community supports and so our -- our nonspecialized mobile mental health treatment or sort of the community treatment whatever it may be, and I think that is something of the challenge of this. I mean, it is exciting and it is kind of like unsettling because we don't know what the volume will be or how big it will get. We think -- we anticipate a relatively manageable ramp up as we do the outreach to the nursing homes. On the other hand it is possible that nursing homes knowing this is available because they are mobile, they won't be attached to one facility, they will be able to serve multiple nursing homes could become overwhelming. So when we come back, if you have us back, maybe we will be able to tell you a little bit about lessons learned and how this went.
DENISE: Yes for you on the teams. When you say the team stays intact, is that following the person.
DENISE: Following the person. Not the facility.
DENISE: And then secondly, is this also -- is part of the plan to help address maybe the special needs within the homeless population in Allegheny County.
DENISE: Absolutely. We have a homeless problem as many of your communities do. We have, again, a number of initiatives in place. We have been the beneficiary of a Federal grant which was really focused on behavioral health outreach to the homeless population. Those outcomes have been absolutely amazing. Now, we are trying to work with O-H-M-A-S-S to figure out how we sustain this great work. We have seen reduction in incarceration because that is the other component here. Many folks wind up because of the nature of their live involved in the forensic system either because there is something that got them there or something related to their illness but it was more about survival. In any case jail is jail. So what we found is reduced incarceration. Reduced inpatient admission, reduce emergency room admission and reduced crisis call and increased in stable housing for those who want to be housed and that project has been for providers which is going to teach us a lot for this project one of whom is providing the physical healthcare, how we have a physical health, operation safety net through one of our providers mercy -- Pittsburgh mercy. Community mental health center that does behavioral health outreach. Community human services which is

providing housing, temporary housing until we can get folks where they need to go and another provider that works on the longer term housing arrangements and it was unprecedented these four providers came together and they have never worked together before. They have had to bang out their referral and make it smooth for the person served and wrap around the individual. They have taught us a lot which I hope -- we don't see anyone eligible as exempt from the service. And that really was our philosophy going into this working with O L. T L. And working with O-H-M-A-S-S. People have been supported and excited despite the uncertainty of how this would really come out. As you know, you start things with the best of intention with this much data and understanding as you can garner and you got to change it because it is not quite right. The plan is to have a tremendous amount of stakeholder involvement as we go through this because we realize this has not been done before. When we get to the bottom of this last slide, it is talking about we don't want to know just have we taken care of the clinical needs whether they are physical or behavioral health but what has been the experience of the individual being served and what has been the experience of the family or the natural supports that the person defines as family around them. It is not just what we do. We have to pay attention how we are doing it. We can bring the pest of evidence based but if people feel we haven't respected them and they don't feel like their dignity has been respected then we haven't done a good job. The RFP, the Request for Proposal is out. We are looking for the provider now. All of these perimeters have been made clear. It is inclusion not exclusion. So we want providers to tell us if they are coming in on this that their goal is to serve everyone who is eligible and accepts service. So it is a really different approach. I know.

DR. SCHUSTER: Just one of the points I wanted to make is all of the teams will include peers as part of the team.

SPEAKER: Just one question generally, how do you work with the dementia and Alzheimer's individuals and specifically behavioral issues, even at home and in the nursing home.

DR. SCHUSTER: I think that is clearly an area for probably enhanced capacity in the provider system. But there certainly are significant trainings and significant work has been done with the provider around best practices and around addressing cognitive impair /PHEPT and dementia. Some of the peer staff has been trained and working with older adults and we have actually done some specific trainings for providers as well with addressing dementia. So I'm not the -- I can't address you directly in terms of exactly what, you know, clinical interventions people are using. I would be happy to get that for you. But one of the -- one of the ideas behind the formation of this team was that if you really connect a team with a facility that in addition to serving the individuals in the nursing facility, that the team will also be able to do some adjunct formal training of the staff and work with the facility around what it is for members generally in the facility. So we are hoping that this will be another route in to really enhance the -- provide some

resources to the facilities that they didn't have available and didn't readily have available before. You saw a lot of the individuals in C H C are getting behavioral services but certainly significant art of them are probably one to one or primarily one to one in nature rather than team focused in terms of how they are delivered or what the intervention looks like. We think this is a new opportunity.
LINDA LITTON: When you mention peer, you are talking about certified peer specialist.
DR. SCHUSTER: Yes, I am. Thank you.
DENISE: I wanted to add to the doctor that when we started this we talked about the integrated Department of Human Services at Allegheny County. One of the things we work closely with the office on aging and the Deputy and I meet regularly. There are often a lot of supports and services that are available through that system that families aren't aware of. So the goal is also to tie that bridge. They have been part of this planning so that we can tap those resources for families and individuals as well. And, of course, the stakeholder involvement across the broader community. Allegheny County does have a -- I don't know the technical term but the goal of the Committee, it is a countywide Committee, it is a coalition for people working with disabilities. There are resources and supports on the physical health side that we need to make sure they are coordinating all the way around. We have been able to provide some respite. We have been able to provide rental assistance. We have gone not with this team but serving folks and find that the family is struggling financially because the housing they are in is costing them way too much. We can go to the Office of Aging and find how to help that family and get to where they need and find an affordable and safe way. We expect to be doing a lot more of that.
SPEAKER: Can you talk about how you interface. Your service has become part of the care plan. How does that all work.
DR. SCHUSTER: So the -- the behavioral health M C O staff routinely contact the service coordinators on the -- who are working for the community health choices. And the service -- so the service coordinators should be aware of the behavioral health services that individuals are receiving.
You know the plan is not updated. It is updated periodically but obviously it is not daily or weekly so they wouldn't necessarily immediately become part of the plan. They should be part of the plan in terms of the other services that the individuals are receiving for sure.
SPEAKER: All right. Thank you very much. Our final presentation. Wherever you are most comfortable.
NINA DELGRANDE: I'm going to stay here. So thank you for allowing me the opportunity to talked to. So I am from representing all of the life providers as they said I'm from spiritual Lutheran life. I have two centers and we cover Cumberland Perry and Franklin County. I'm very local here and I think where we probably differ from the two presenters we just had or all of the presenters that we are funded through Medicare and

Medicaid. We have Federal dollars and state dollars we get a lump sum of money and do with it what we can to keep people safely in their home out of a nurse fag silt. At times we do have to put someone in a nursing home. We are a fully integrated program meaning that behavioral health is just covered as part of the life program. So it is not a carve out where we have to, you know, send them somewhere else. I mean, we send them and contract with providers but if a participant in the life program needs behavioral health, they are identified two ways. One upon entrance or, you know, admission into our program. We typically know when we get that referral that there is mental health or behavioral health issues. We would coordinate in a service with whatever provider they have. If we don't contract with them, we would contract with them because we want to see whoever they are currently seeing we don't want to see an interruption in the service. We would continue doing that so they can continue that service If they are in the program for six months, a year, whatever and then we discover that, you know, something arises and they need behavioral health services, then it comes to the I-D- team and they meet every single morning. So approvals get done at I-D- T every day. So authorization would happen and the authorization is really to say that yes we agree that they need the service and then we put an authorization in that says that behavioral health, whenever we are going to send them can send us a bill so we can pay whoever we contracted with. In essence the life program is the payer and the provider that is the fully integrated thing. So some programs if they are very large may have their own behavioral health specialist on-site. We are a smaller program so we don't. What we do do is because we have, I think right now we have 54 percent of our participants need some type of behavioral health services. So it is a lot. , you know, it is a problem. We actually have the behavioral health specialist come on site. We do provide transportation. So a couple of years ago, we were actually, you know, loading the bus for one person to go to a visit and then bringing them back and taking another one and bringing them back. We said how about you come here. So we do have in both of my centers and two different counties, two different providers they come on site and see the people. If somebody needs -- we have people with psychotic breaks and had to go to inpatient psych. We cover that and pay for that. I wrote some notes down here to kind of answer all of the questions that have been asked. So we do -- also I said we have some participants who do need to go to a nursing home and when that happened we continue to provide that mental health coverage and they go for various reasons they go for short term rehab after a hospitalization or a fall but we don't break that, you know, behavioral health component. It is very important. So we keep that going. I know there was a question about dementia and Alzheimer and that is a huge part of our population. In life, it is a huge part of training that we do with our staff. We are well equipped to kind of handle that and a lot of times is it dementia or is it behavioral health problem or a little bit of both. And one thing that is probably a little different from other providers is that almost all of the physicians and providers in the life

programs are certified in geriatrics. So they have specialized training in handling all of that. Sometimes we are not sure. Let's get a behavioral health consult and see what they say. Our providers will work with that person and with the I-D- T. It is on their care plan. We look at their recommendations and kind of go from there.
So that is what the life program does but it is all included and happens pretty quickly. I'm dead.
SPEAKER: The system is down.
NINA DELGRANDE: I got to be loud. Questions? I was done.
SPEAKER: Any questions for Nina?
BARBARA POLZER: Is there a question? All right. Well, thank you. Next up we are going to have a session on transportation. T-A-M-A-R-A Carter, Nina and the three MCOs.
SPEAKER: I'm with the Bureau of policy and O L. T L. And before we get some information from any of the representatives M COs and life, I'm just going to go over a few slides to give a high level of how different entities work together to provide transportation.
So this first slide here is for population of nursing facility residents. You can see it separates emergency medical, nonemergency medical and nonmedical transportation which is all provided through C H C. Because nursing facility recipients are L. TSS, they are eligible for a nonmedical. Under emergency medical, you can see the C H CMC O provides payment for transportation, the coordination that is handled with a nursing facility and the M C O. So they will work together to figure out how they are going to provide coordination for transportation. Under nonemergency medical transportation, the costs and amounts paid between facility and M C O are part of the contracting process. lt is coordination between the nursing facilities and the M COs and under nonmedical transportation the M C O is responsible for payment and discussion is made about handling coordination.
For the A CBS population, M C O is responsible for payment of emergency medical. The M C O and the participant will figure out a coordination. It is covered in their participant handbooks what should be done when there is an emergency. So it is all laid out for a participant.
There are more parties involved when it comes to nonemergency medical. This is where M A T P gets involved. If it is not specialized transportation like ambulance or stretcher then it is referred to M A T P for any unexceptional non-ambulance transportation. If it is determined acceptable by M A T P then the county assistance office can look at providing transportation for exceptional services. Coordination with is with the M C O and participant. For nonmedical for this population. M C O is responsible for payment and M C O and participant work on coordination. And for the population, things would be laid out in the person centered care plan. The person is involved letting the M C O what transportation is needed. And the M C O and the participant discuss coordination for emergency medical. Again because they are in the community like the H CBS

population, it is the same process with nonemergency medical, if it is not the M C.O.'s responsibility they will refer to M A T P. If M A T P can't provide it, they will look at county assistance office for help.
MATT SEELEY: Can I ask you what you mean by exceptional.
SPEAKER: Exceptional will be exceptional distance or out of the time frame that M A T P can provide transportation. Anything that is not included in M A T P transportation services.
And nonmedical transportation, they are not eligible because they are not part of the L. TSS population. M COs have flexibility with what they provide for nonmedical but at this point they are providing nonmedical for this population. Before we get into the specific areas does anyone have any questions about this information? I think we will hear from M A T P first and who do we have representing M A T P.
SPEAKER: I'm here. Good afternoon my name is T-A-M-A-R-A Carter. I'm the director of M A T P and I guess I'm here to provide an update on the study. Just to provide a little context for those who are not aware, June of last year, legislation required D H S to issue an R F A for statewide or regional broker to administer the M A T P. So D H S posted the R F A in December of 2018 and then June of 2019 legislation, again, required D H S to in coordination with PennDOT and aging to commission an analysis of the impact that a broker M A T P model before entering into a contract for a full risk broker model.
So the study is under way. I cannot provide any content information at this time because the preliminary report was just submitted for Executive review. So the report is in draft form and it has not yet been submitted to the pertinent parties. The initial due date was September 28th because we were granted an extension. So the due date is now October 28th. I can just basically tell you, maybe give you an outline of what the preliminary report will look like. It will list the background, like what led up to the study. It will, of course, have an introduction, basically how the requirements will be met through literature review, financial data, surveys and things of that nature. And the activities to date which are work group was formed back in July. The work group choose Mercer as the entity to conduct the analysis. So the work group meets on a weekly basis and it is basically information sharing at this point. We provide Mercer with information and they, you know, do what they are supposed to do as far as meeting the requirement.
It will have a section in thereof Mercer's independent research. It will have a section of stakeholder engagement which we have initiated. We are scheduled actually to meet with the County Commissioners tomorrow and transit agencies next week. And, of course, the analysis will take a look at M A T P in its current state and it will take a look at a broker model. So that is -- that is basically all I can share at this point. I know you probably wanted to hear more information but that is all I'm able to provide at this point. Are there any questions.
MATT SEELEY: I don't know a lot about this but can you just -- who is Mercer.

SPEAKER: Mercer is a government entity who has worked with the Commonwealth for many years in different capacities and D H S, along with aging and PennDOT thought they would be best suited to conduct the analysis.
KEVIN HANCOCK: Mercer is an actual yearly consultant. They are not a governmental entity but they do a lot of work for the Medicare and office of long-term living. They are involved in setting the sound grades for community health choices.
SPEAKER: Thank you for that clarification.
SPEAKER: Who authorized the extension?
SPEAKER: I believe Legislators. I am really not sure about that. Yeah.
SPEAKER: Do they have a stakeholder group for riders. Will they are have input from actual riders.
SPEAKER: At this point, I know we are trying to schedule a meeting with Pennsylvania health law project. And that is all we have scheduled at this point. Any other questions?
SPEAKER: Just on behalf of what he was saying asking about the rider's input. It is great to have health law project but if you can get stakeholder riders not just the voice from people who represent or represent. You know what I mean? I have nothing but respect for health law but if you want to hear, Mike with P-I-C-L can help you or the centers for independent living connect because we have a lot of concerns about this. We really do and a lot of those centers for independent living have connection with local providers too and hear from all around.
SPEAKER: As I said, we are meeting with the County Commissioners tomorrow and we would have hoped that they would have reached out to their county, county constituents and the human services agency we would have hoped that they would have gotten feedback from them. So in a way, they hopefully will be on -- speaking on the consumer as behalf. Any other questions? Okay. Well, thank you very much. And the report will be publicized at D H S dot PA dot go publication slash statistical reports. Thank you very much.
SPEAKER: We will move onto Nina. Hear from you again.
NINA DELGRANDE: Thank you. So with the life program, again, fully integrated. So the way transportation works in the life program is that it is all included with a program. So it is not carved out. We all have our own buses that we run. So we provide all of our own transportation. So we transport our participants to and from the life center to and from any outside medical appointments that can't be done at the life center. To and from any dialysis appointments that they need to go to. And that would even include, you know, hours that the center is not open. So if it is something that we can't do, if it is a holiday weekend, you know, something super early in the morning or late in the evening when the buses aren't running then we have contracted providers that we use to do those, you know, transports for us or somebody would need a stretcher, something like that. We also cover emergencies. So if somebody would have to call 911. That would be reimbursed. That would be covered through the life program. As well as any

nonemergent transport. So say a participant needs to be transported nonemergent somewhere, we would cover that as well. So we do not use M A T P at all. Everything is covered through the life program. Somebody needs to go out and get groceries that is part of their care plan, all of this is included in their care plan. We talk care of that. Our aids help them do that or the aids do it for them /THOER take them. We do outings so people can go to the store together. Do you have a question.
SPEAKER: I don't mean to interrupt you but I do.
NINA DELGRANDE: Go ahead.
SPEAKER: I just wanted to know more about the nonmedical transportation done through life. Like if somebody wants to go to the movies or they want a nonmedical transportation is really like a social opportunity for people at least on the -- it will be the C A C waivers but on the waivers do people have the opportunity to say I want to go to the movies, I want to go to the mall, you know, I want to go two counties over to see a play?
NINA DELGRANDE: So we do not cover nonmedical.
SPEAKER: So how is --
NINA DELGRANDE: So we do not cover nonmedical. They would rely on their family to do that. However, to do social things and activities. We have outings all the time. So the life program all do town hall once a month. It is run by participants and they take poles and votes and activities that they would like to do. If they want to go to a movie or go bowling, if they want to ride the pride of Susquehanna down on the river, they have done all kinds of thing go to zoo America.
SPEAKER: Everything they do is going to be a group. The person doesn't have the ability to do things --
NINA DELGRANDE: Not independently.
SPEAKER: Okay.
NINA DELGRANDE: Are there any other questions? It is pretty short and sweet.
MATT SEELEY: Anything they want to do would have to have their attendant bring them.
NINA DELGRANDE: We cover everything that is medically necessary. We don't provide transportation for activities.
MATT SEELEY: Groceries and testifying like that the attendant would drive them. And if they can't.
NINA DELGRANDE: With would provide that transportation. We would not take the bus an entire bus for within participant. Probably their aid would take them to the store and most of the time our participants are all 55 or older and nursing facility clinically eligible. Meaning they need a little assistance. Most of our participants can't make it through the grocery store. They want the aid to go with them through the store. They usually request that. Our aids will do that or they will say here is my list or my credit card or whatever. That is up to a participant whatever way they want it. A lot of it is driven by what the participant wants. Does that make sense?

MATT SEELEY: No. I'm lost. That is all right.
RICHARD WELLINS: I think his question was, is transportation for nonmedical provided to those who serve and I think your response was no. But if a person needs to go grocery shopping, that their aid could take them, if the aid wants to take them.
NINA DELGRANDE: Right.
RICHARD WELLINS: Regularly, they can't call you and say I need to go to the grocery store or a play or a movie.
NINA DELGRANDE: That is correct. So to clarify, we will do things to help them with their activities of daily living. So you need groceries so you would help them get their groceries and part of the care plan and scheduled. Whether it is once a week they need to go to the grocery store or every Wednesday, you are going to have an aid and help you go to the store. And if they need an extra day added on, they would come into the center and say can I have an extra hour next week, I need to do extra grocery shopping and go to Walmart and here is why. The team would approve that. But to go to the movies to go out to dinner and those sort of things that is handled through our activity center and that would be in a group setting it would not be a one on one.
LINDA LITTON: I have a question for you. How many wheelchairs can fit on your bus at one time.
NINA DELGRANDE: It depends on the size of the bus. Most of our buses can fit six or seven wheelchairs.
LINDA LITTON: Thank you.
BARBARA POLZER: In the essence of time, I'm going to ask that we hold questions so the M COs can give their presentations. Don't all jump at once.
SPEAKER: Okay. PA health and wellness as we enter into the T zone nonmedical transportation looks a whole lot like the southwest and the southeast. It is driven by the person center service plan and when an individual identifies what they would like for their nonmedical transportation and it fits their goals, it all has to connect and then should have no problem being authorized and be built into our M T M plan. We also have friends and family. So the T zone if an individual does identify someone they would like to have drive them, we would reimburse that mileage at 50 cents per mile. The individual would need to plan for that in so much as getting the individual that will drive them registered with M T M so that we have their license and proof of insurance and then M T M does reimburse that driver. We do have the added advantage of L-Y-F-T as we go into the T recognizing that not all of the counties will have that type of availability for L-Y-F-T but it is an enhancement to the T that we did not have require in the southwest and the southeast and then as far as our network build in the T for nonmedical, I brought Peggy with me. She is our business owner for the M T M relationship and I can let her speak as to how that build is coming.
SPEAKER: We have been meeting with M T M weekly every Tuesday afternoon to update the provider network. We have coverage in all of the counties with the exception of 18.

For some sort of service agreement. So we are well on our way to having all 67 counties covered hopefully by mid-November.
SPEAKER: And then just to close that out, as with shared ride providers, we have been reaching out with a lot of the shared riders to create relationships with them to provide good information to consumers that are looking for transportation options should they run into any challenges there. In the communities that have bus passes we will continue to do that and through continuity of care, they would continue to use the same process they were using prior to C H C.
SPEAKER: So AmeriHealth is also using M T M to just kind of expand on what they have already indicated, in addition to that M T M is really doing a thorough overview of public transportation as Anna had mentioned and I know Barb with liberty has also brought to our attention which we have passed onto M T M that in some areas instead of passes there are bus tokens that are being used so M T M is evaluating the tokens versus the pass process and what we would need to ensure that. In addition to that, we have both M COs provided M T M with a list of all of the service coordination entities that have been sharing with us what they have been using for transportation over the past several years. So M T M is reaching out to each of those entities to get a better understanding of who they have been using, how they have been using them and then how we can contract with them because we understand there has been a heavy reliance on those entities and their transportation partners. And, again, the friends and family is there. We will actually be developing an education piece to help the participants understand how that will work and just to reiterate what Anna had stated, it can be approved. It will be put in the service plan but the driver does need to have an active license and proof of insurance for liability reasons for both their safety and that of the participant. And we just recently had our readiness review and have presented that and transportation is included in our network updates. UPMC.
SPEAKER: Yes. Thank you. I am provider account Executive with UPMC health plan and literally I echo what my colleagues have shared with regard to transportation for nonmedical starts with the service plan. The service coordinator will coordinate the nonmedical transportation with our transportation broker, coordinate transportation solutions and we offer every mode of transportation that we would need. We have taxi -- we have wheelchair van and a stretcher van. We L-Y-F-T in any market and we use bus passes and friends and family /-FLT as far as coverage, we have coverage in every single county as of today. We have a total of 143 statewide provider 66 in region one. 36 in region 2 and 41 signed in zone 3 with 46 perspective transportation providers. It is open to any willing participant we can credential who meets the criteria for state and Federal requirements to operate a transportation service. We will -- UPMC health plan is in constant communication with CT S. We don't just hand off the transportation to the broker and consider it finished. If our broker is unable to coordinate transportation then UPMC health plan will get involved. With our relationship most of our network providers

for our physical health benefit are in the CP S network and will reach out and try to assist and find a willing and able provider regardless of the location. If we are talking rural areas we have taken providers from one county and taken them two or three counties over to get the transportation. We will go to whatever length we have to to get the member taken care of. Beyond that, I think we all three meet each other in terms of the way we function. I'm open to any questions.
MATT SEELEY: You had all of that data. Do you have any breakdown by county.
SPEAKER: Not with me I don't. You want specific data with how many providers in each county.
MATT SEELEY: With more --
SPEAKER: Our concern as well. Like I said, to deal with that, we have relationships with providers who are willing to cross county lines and go to those more rural areas. We partner with some vendors who are willing to look at certain markets where we lack coverage and do a start up essentially. The numbers have to work for them but they are willing to consider a start up in areas where we don't have coverage. Like I said, we have 41 signed in the T zone. 46 more in the pipeline. A high confidence level that we will get coverage in any county.
SPEAKER: The only thing I would caution when you ask for a report, we can simply provide that as well. When you see the number and it may indicate four or five, that does not necessarily reflect that -- that could be the number of vendors but they could have a fleet of 12, 15, 22. So I just want to be cautious. I don't want someone to look at a number and see Fulton County see two. That doesn't mean there are only two cars available. That means there is two vendors but there could be multiple fleets available to each number. I want to caution the way you look at the numbers.
SPEAKER: I agree. And we can give you the breakdown if you want to see total ambulance or wheelchair vans we can give you those numbers.
MATT SEELEY: My other question you brought up the friends and family thing. They need to be registered with M P M and give you license and whatever. You brought up the liability thing. How does liability work in that situation.
SPEAKER: That just means for the participant. If the friend or family, and again, I'm not the lawyer, so this is just a broad, we want to ensure that the driver has active insurance because if -- if that participant is saying I want my neighbor to drive me, they understand that they are assuming whatever risk that driver incurs. So if there is an accident, it is with that driver. I mean, it is just as if you asked your neighbor to take you somewhere. It is not the managed care. We are reimbursing for the mileage, you know, because we understand that they are performing a service to the individual. So that is why we feel it is important for us to at least know that the driver has an active license and insurance. It is not for us to go in and research into that, that is really the participant's responsibility because they are asking someone other than the vendor that has been credentialed to provide them with transportation.

MATT SEELEY: My concern, she left, Nina, the attendants driving people around. I don't -- is that made clear up front.
SPEAKER: I mean, the attendant and it has been shared with us at many provider forums that the attendants are doing that. We are not reimbursing the home health agency as a transportation vendor. So, again, that is a participant's individual choice to accept that attendant as a driver. I don't want to speak for the other two.
SPEAKER: Yeah. I agree. I can tell you that from UPMC health plan standpoint, you know, transportation solutions using an attestation so they will go to the friend or family and have a signed attestation that verifies they have a driver's license and valid insurance and a couple other criteria. I want to say it is six months but they have to renew that. Without that having been renewed they are not eligible for reimbursement and reimbursement will go directly to the friend or family member, not the participant. As far as the legal aspect, I think that was the basis of your question. I'm not an attorney either. In the event that something happens everybody is in the pool when it comes to litigation. So, we coordinate transportation as the broker, they will handle all of the paperwork in terms of the attestation and from a legal standpoint and it ends up, I can't really speak to that.
SPEAKER: Hi I'm Pam silver from the Pennsylvania health law project. One area where there was a lot of confusion and concern during the phase 2 roll out was in the hand off or the interaction between medical and nonmedical transportation. There was a lot of confusion as to who do I call if I need a ride to my doctor as opposed to who do I call to set up nonmedical transportation. I was wondering if the M COs could share what lessons they have learned since the phase 2 roll out and what efforts do you have to going to ensure there is a seamless hand off between those services so the participant isn't having to make a bunch of different phone calls just to get a ride set up. What are you guys doing to make that as smooth as possible on the participant side /SPHAOEBG speak I will start there and my colleagues can jump in. It is really important that individuals in the program read their participant handbook because it is very clear about what is covered and what is not covered. But if they do have questions, they can call the health plan and we have all of our call center teams are educated on the process. Sometimes in the early part of the go live, there was confusion but in our health plan thought we covered medical and we do if the person requires emergency or stretcher ambulance and that is where folks with get use but covered through your doctor is covered through M A T P and not the health plan unless there is special circumstances if the individual needs that stretcher or ambulance to get them there. A lot of time with the service coordinator that should be identified when they are doing their person centered plan and also discussed with the service coordinator so all of those options can be explained to the individual if there is confusion but the handbook does spell out transportation and what is and isn't covered. If there is confusion, call the health plan, they will explain and they do warm transfer to the other transportation resources.

SPEAKER: How does that warm transfer work.
SPEAKER: Sure our call center has those numbers and will keep the individuals on the line and then make the call to the other entity and make sure that the person is passed over with their needs met. And that is documented then that they have done it.
SPEAKER: So for UPMC health plan same process. So on the intake side there is one number to call. There is one number that the participant uses the call for any transportation. Coordinated transportation solutions for UPMC community health choices will over the phone credential the call o determine is this -- what path does this go. Is this medical? Has there been a denial by the M A T P provider because this is an exceptional case and need ambulance or stretcher and cross the county lines. CT S will take care of that on the front end. If there is no barrier or denial, they will shift the member to M A T P, warm transfer and refer them to M A T P if there is still a question, they can warm transfer to our provider relations team and they will assist the member over the phone. So it is really kind of seamless, one number, CT S will do the credentialing over the phone. If it is social, they follow a process. If it is medical, they follow a process and I don't think there is any really grey area to that unless you get the exceptional transportation issue and then we have to figure that out.
SPEAKER: Ours is the same.
GERMAN PARODI: I have a question about the medical and nonmedical transportation and about that.
BARBARA POLZER: Go ahead.
GERMAN PARODI: Thank you. I received a letter with my trans pass a couple of days ago but the letter came along with it and surely my managed care folks are there but the other ones, M C M medical transportation management and the letter comes from St. Louis but it talks about that I need to use for medical appointments only. It says in your bus tickets, which is incorrect, these tickets are only to be used for transportation to the medical listed below. Listed for October 1 st. I don't have a medical appointment there. Transport for the month, yes. It even has for trip info to contact SEPTA their general phone number I know that this is fully incorrect. How many thousands of people received this letter. I don't know if this is only with my -- you know, M C O but this is really incorrect. What is going on and there has got to be -- do you all know about this.
SPEAKER: You are absolutely correct. It was wrong. So actually, Barb brought it to our attention. They shared the letter with us. The letter had been generated by M T M without review from either M C O. They thought they were being proactive. And the letter was incorrect that you are correct the bus trans passes are not to be used for medical. So that letter has been reviewed and has been corrected. So both M COs that are using M T M and the date when it indicated October, that is really just to say that your bus pass for the month of October, doesn't mean you have to ride all day long and use it on October 1 only. Trust me. Nobody wants to do that all day. So that was an error. It did not mean that your medical appointment was only on October 1 st. So

again, we appreciate any time that you find anything like that please feel free to bring it to your service coordinator to the center for independent living and they will get it to us and we appreciated that because it -- it just had not gone through us but it has been corrected.
GERMAN PARODI: Thank you I'm concerned about my fellow members with learning differences and again, intellectual disabilities and surely that the infrastructure is ready to answer the query about this mistake. Thank you.
SPEAKER: I'm going to speak to that too. This is Anna. I think we are going to have Peggy morning star and send a letter with an apology with an error and that should cover all of the individuals that may have received it accidentally.
BARBARA POLZER: We have a minute and a half. That is it.
SPEAKER: Oh. I'm going to talk so fast. So I think alleles her /STPAOEU health being brought up and commending the merits of tokens, trans passes. I'm wondering if there is any investigation about, you know, limiting trans passes for people who have only a couple nonmedical transportation events in their person centered service plan. I think -- does that make sense yeah. Yeah. Because now, consumers can get monthly trans passes and if in the person centered service plan there is only, like, five events that a consumer has to go to, is there any -- yeah. Yeah. -- in that case, when the M COs -- is that an issue.
SPEAKER: For PA health and wellness when we have had individuals that ask for a monthly pass and I got Peggy here who is part of the team, what we found is is those passes can often be much more cost effective than just other types of transportation and provides the individual with a lot of flexibility. An individual who is utilizing their community and involved in it will probably have use of it more than five times a month. But employment is important they need to get to jobs and volunteer activities and individuals use it for adult day services if they want to get to those programs. It really just depends on your plan and how to plan to access your community.
SPEAKER: I guess I'm wondering, you know people say it is not going to be cost effective if -- if -- I mean, does the consumer have justify the cost effectiveness part of it?
SPEAKER: No. I mean, we are not asking them to justify the cost effectiveness . It is the same as Anna had indicated by the time we buy five or six and get them to you, you determine what day you want to use them, we don't want them to become invalid. So as of right now and unless there's a large change for SEPTA at least for southeast, it is really most cost effective to give you the bus pass for the month.
SPEAKER: I agree with that same statement from UPMC health plan standpoint. There has been discussion that I'm aware of that we would limit that to the consumer.
BARBARA POLZER: All right. Everyone thank you. Meeting is closed and hope to see you next month. November 6th. Have a great one.