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Date: 11/02/22

Event: Managed Long-Term Services and Supports Meeting

>> DAVID JOHNSON: Good morning everyone, we are going to begin by taking attendance. Is Ali Kronley present?
>> ALI KRONLEY:Good morning.
>> DAVID JOHNSON:Cindy?
>> CINDY CELI:Good morning this is Cindy.
>> DAVID JOHNSON: - -?
>> GAIL WEIDMAN: Good morning.
>> DAVID JOHNSON: Good morning. - - [ROLL CALL FOR ATTENDANCE] Are there any subcommittee members I missed that I did not consult?
>> Heshie Zinman is here.
>> DAVID JOHNSON: Heshie Zinman is present. Thank you, Mike can kick us off.
>> MICHAEL GRIER: Thank you David. The housekeeping talking points, please keep your language professional. This meeting is being conducted in person at the Department of Education's honor suite and - - on it with remote streaming. This is being audiorecorded. The meeting is scheduled until 1:00 PM. To comply with logistical arrangements we will and at this time. All webinar participants except committee members and presenters will be in listen only mode during the webinar. While committee members and presenters will be able to speak during the webinar to help minimize background noise and improve sound quality, of the webinar, we ask that attendees to self using the mute feature on your phone. Please hold comments until the end of each presentation and your question may be answered during the presentation. Please keep your questions and comments concise, clear and to the point. We ask that participants please submit your questions and comments into the chat box located in the go to webinar pop up located on the left-hand side of your computer screen. To answer questions or comments type into the text box questions and press send. Audience members who have a question or comment should wait until the end of the presentation to approach one of the microphones located at the tables opposite of the speaker. The chair or vice chair will then call you. To minimize background noise in the honor suite we ask committee members present audience members in the room please turn off your microphones when you are not speaking. The captioner is documenting this discussion remotely. It is very important for people to speak directly into the microphone, say their name and to speak slowly and clearly otherwise the captioner may not be able to capture the conversation. This will also be in the captioner recording who has asked questions and to whom questions will need to be sent. When submitting a question or comment into the chat box it is important for people to include their name in the chat box. Before using the microphone in the honor suite press the button at the base to turn it on. You should see a red light indicated that the microphone is on ready for use. State your name and the microphone for the captioner and remember to speak slowly and

clearly. When you are done speaking press the button at the base of the microphone to turn it off. The red light will turn off indicating the microphone is off. It is important to utilize the microphones placed around to assist the captioner in transcribing the meeting discussion accurately. Other comments will be taken at the end of each presentation instead of during the presentation. There will be an Additional. And of the meeting - - if you have questions or comments that were not heard please send your questions or comments in the resource account listed on the agenda. Transcript and meeting documents are posted on MLTSS meeting minutes. These documents are normally posted within a few days of receiving the transcript. The 2022 MLTSS meeting dates are available on the Department of human services website, You know the website. Emergency evacuation procedures. In the event of emergency or evacuation we will proceed to the assembly area to the left of the Zion church at fourth and market. If you are required to evacuate you must go to the safe area located outside the main doors of the honor suite. MLTSS staff to be in a safe area until you are told, you can go back into the honor suite when evacuated. Everyone must evacuate. Take your belongings with you. Do not operate cell phones, do not try to use elevators as they will be locked down. We will use stair one and two to exit the building. One, exit the honor suite on the left side of the elevators, turn right and go down the hallway by the water fountain. Stair one is on the left. For stair two, exit honor suite through the side doors on the right side of the room or the back doors. From the side doors, turn left and the stairs are directly in front of you. Doctor exits, turn left and left again and stair two is directly ahead. Keep to the inside of the stairwell - - turn left and walked down through the valley on - - Street, turn to fourth Street and turn left and cross fourth Street to - -. Good morning. We will start our meeting with follow-ups. From our October meeting. I will go ahead and read the question and - - will respond. Related to the dataset, data subcommittee vice chair is David Johnson, what is behind code 99? None of the above. In the MPS 3.0 - -
>> - - Into any previous authority. Some possible options could include - - jail or prison, state or mental hospital and in some instances long-term hospital stays.
>> MICHAEL GRIER: Thanks. In addition to - - audience member - - asked if the MPS allows the individual to identify multiple reasons for admission if there are contributing factors. Randy Nolan from L LPL said he would follow up.
>> Miriam - - responded - - identify reasons for admission based on the diagnosis. The diagnosis listed identifying why an individual is being admitted including any previous diagnosis. Section F, question F0521 asked for the primary reason for admission. One box may be selected in response.
>> MICHAEL GRIER: Related to MPS data, transition of individuals into nursing facilities, audience member Sean asked if there is any way to evaluate the MPS data in order to get the information about level of need whether more consumers, higher needs are making up a percentage. Randy Nolan said he would verify.
>> Miriam from - - responded information related to the level of needs included in sections I and J of the assessment, each resident's case index shows how complex the care needs are. The higher the CMI, the more complex of the resident they are for the facility. Individuals being admitted with a significant change in functional status for deterioration and cognitive status have declined over time. More

significantly in 2020, OLTL numbers increased in 2021 yet they remained lower than pre-COVID.
>> MICHAEL GRIER: Related to the analysis, audience member Catherine Weaver asked if the rate analysis for PAS services when, excuse me, when the last brief analysis for PAS services wives. - - Said she would follow-up.
>> OLTL will provide response to the September - - committee meeting.
>> MICHAEL GRIER: Proprietor search administration, subcommittee member - - asked if they would be provider rating with CHC-MCO providers search pages. - - Said this was a great recommendation and she would take it back to see if there is something that can be added. All three MCO's were asked to respond.
>> PH W responded provider ratings are performed by independent organizations. Member from health plans, services like web MD grade, etc. provide this service. PH W does not believe it is appropriate to establish the rating scale for providers. Investigating a potentially - - links to a variety of services mentioned. So participants can link to them to pursue provider ratings. - - Healthcare responded from a technology standpoint provider ranking are something that can be added. They want to work closely with OLTL and other CHC-MCO's to understand what is being rated and for what provider. Questions that would need to be addressed would be what data points of - - systems, what provider types would a rating be applied to. What is the frequency to the ratings. Will all CHC-MCO choose the same rating system and data points? Will providers be able to appeal their ratings and if so, what process would be put in place? What disadvantage and provider does not have enough experience to support a high rating. The rating system could be based on quality metrics, does the rating test participants - - providers. With - - plan specifically means safe ratings. For example, a providers - - 41 MCO and one for another. - - Responded while the suggestion appears straightforward actual implementation of the suggested is difficult. PPM has been discussing options for years and would be happy to work with other MCO's to execute a plan of action. Understanding the criteria for this type of scoring will also require the support of the healthcare and other provider industries that could be significantly impacted by this type of approach. UPMC suggested high-level reporting based credential information along with the status of accreditation and a possible starting point for the conversation before expanding into a more formal rating system.
>> MICHAEL GRIER: Thank you Paula. Related to the provider enrollment, audience member - - asked can CHC-MCO tell how many participants get 100 percent of the services after their start date? Jamie said OLTL can follow up with MCO's whether they provide and track that data.
>> - - Responded court Nader's follow-up to ensure services are in place and escalate the health plan operations teams if there are any issues. Examining dashboard and reporting options to monitor service delivery. AmeriHealth responded they are able to track - - 2023. Transworld responded this credit best practice and required operational reports UPMC tracks information on a number of levels. - - Delivery services is a critical aspect of the program. One key approach is monitoring authorized services in comparison with electronic visit verification data as well as claims data. This data is tracked internally within UPMC - - through operational reporting and purchasing as well through OLTL reporting. This reporting

contains participant level information to ensure the quality, efficiency and effectiveness of the services being delivered from each person. Data is also used to prevent service provider oversight and managing of fraud, waste and abuse. Internal tracking is maintained through a series of dashboards to ensure visibility for - - management, network, fraud, waste and abuse and other internal teams that maintain oversight of delivery systems. All internal teams mentioned will see various reports of this data and OLTL maintains oversight that these reports, through admission, authorization, reports and audits.
>> MICHAEL GRIER: Thank you very much Paula. Let's our responses from the October meeting. we will move to the next point of the agenda which looks like, Jamie, are you ready? OLTL updates?
>> JAMIE BUCHENAUER: Good morning everyone, I cannot believe it's November. Hope everyone had a happy Halloween. I will say early on that we are watching - - I monitor but don't much. Unfortunately. We will get started with our OLTL updates. For this month. Getting into the agenda, we will give everyone an update on the - - payments allocation to long-term service providers. Update on - - community spending plans and requirements. I'm hoping - - will be on the line to answer questions individuals may have about reporting. Then, a quick update on act 61 of 2022. We have been getting questions from providers and want to bring to the committee's attention what this new law requires. Many conversation in follow-up to the conversation with our - - any other questions you may have. I have a couple quick updates that are not part of the presentation. Getting into act 54 updates. Many of you know as part of the 2022, 2023 budget act 54 provided $250 million for long-term care providers. That was allocated as with the budget process. We sent out letters to providers eligible for act 54 payments. We explained that MA enrolled providers look at their payments as a gross adjustment. We are hoping payments go on at September and October but honestly they will be heading providers bank accounts hopefully November 9 and hopefully that information has been conveyed on - - devices. MA enrolled facilities, personal - - facilities and providers should be receiving payments as of November 9. We processed a gross adjustments first thing in our system - - would have seen their payments go out October 26. I did check a couple of these and I did see at least three of them, payments went out. So they should have received those entry payments. Just another update for personal care, facility residences and on MA nursing facilities, we did start processing their payments on October 24. Just a reminder this is a very labor-intensive individualized process. We have to process them, their payments individually. Providers were asked to submit a Microsoft Word form a test and they want the payment and providing their federal tax ID information if they did not do it there was a deadline originally. They did not do it by the deadline they still can do it. They can return that electronic form to us, they can download it, fax it or email it to us as well. And we will process their payment. There is no deadline to actually getting our payment if they did not meet that first. They are refusing to collect information their stability. That's our update on act 54 funding. Hopefully everyone due to receive a payment - - will be payable November 9. The next update is about the coming committee based spending act update. I'm hoping everyone remembers strengthening the workforce, adult service payments be made March through

October 2022, we are continuing to make those strengthening workforce payment systems. Response providers to continuing to submit their - - and we continue to make those adjustments and pay out those funds. Just an update on that. I know we have been asked repeatedly how much money we have left over in those buckets. Because those are sprinkling in we have not reconciled. We do not have a final number available in those actual buckets yet. We continue to make payments. But, for the strengthening the workforce payment, the adult based service payments and acts 24 2021 payments we made which were for nursing facility is providers - - care homes. We did send out a message and ask them to start reporting those reports they received. As the October long-term care systems subcommittee, we walked through the portal giving providers an idea what the reporting portal looks like and taking providers through the process on how to report. The first round of reports are due in the portal November 30, 2022. Providers are being asked to report on the funds they have spent to date. If a provider had not spent their funds they will have to continue to file quarterly reports until they spent all the money and then file a final report. They did send out a reporting portal with a link to the reporting portal. The reporting portal blocks providers through depending on the personal assistance service provider - - acts 24 payments, walks you through how to report health provider uses funds and obviously we did walk people through that at the MLTSS meeting October 11. We are getting questions. The most frequent one I received is honestly about login information. I blocked my login information. Who can I contact to get into the portal to report? We've been answering those questions as well. But I'm opening it up now and other test questions. I believe - - is on the line. I'm hopeful they are. He would be our resource if you have in-depth questions about how to report what to report. Our login questions, we are collecting those providers that need new logins and we have to obviously work with IT to generate new login information. Any questions? In the room or on the line? I see Terry has her hand up. I don't know if you want to go to a microphone so that everyone on the line can hear you.

>> I'm hoping we can get - - I'm hoping we can get clarification on purchases before? I apologize. Providers who may have received a significant amount of funds for one licensed location but almost no funding or other licensed locations and whether that funding has been spent appropriately for COVID related guidelines to be allocated across additional locations.

>> JAMIE BUCHENAUER: Is down on the line? I know I regurgitated the guidelines of frequent asked questions on this issue.

>> Hi Jamie, this is Dan. Can you hear me? Hi everyone. In response to your question the answer is yes. If providers receive payment and they have eligible costs from other locations. They can use that to also - - even if they are at the location that was used to determine allocation - - the criteria for calculating the - - provider and you know, we had to follow that criteria to determine how to reverse funds to each provider and service. If the provider has I location that has not been part of the criteria for calculation they will continue to use funds eligible costs at that other location.

>> thanks, - - we will share the message and appreciate the clarification.

>> You are welcome.

>> MICHAEL GRIER: Any other questions from committee members or audience members?
>> JAMIE BUCHENAUER: Are there any questions in the chat? Great, sorry this is Paula. A question came in from Dana. Calculations were particular payments do not include billing there - - is there any plan to include the is in the future?
>> JAMIE BUCHENAUER: Dan I don't know if you heard the question you can answer. We did not include we did not include that, I don't think we have plans to in the future.
>> No I don't believe it's included. - - Criteria that we obtain. To do the calculations. I don't believe it was included but at this point the calculations have been completed. And payments are going out. I would not expect changes to any of those payment amounts.
>> JAMIE BUCHENAUER: I have another question that has come in from Patty - - this would be a follow-up from December meeting. Maybe we should, not really, okay. We
will wait. Paula doesn't have any other questions in the chat or questions for those on the line. It does not look like there are any other questions in the audience here in the room so we will move on. If anyone has questions feel free to put them in the chat and we can address them later on in the meeting. Moving on I want to give everyone an update where we are with the quality improvement funding. You may recall the office of long-term living release this opportunity for community-based providers to apply for quality improvement funding. We would begin taking applications July 1, 2022. The information is posted on our long-term care provider's website. The opportunity is still out there. We have funding available. To date, we have 717 applications which is great. We have allocated over $23.3 million. We do get weekly updates to see where we are on track. You may recall we have about $38 billion available and every week we get 50 or 60 more applications. Providers continue to apply for these funds which is great. And we continue to review them. I believe every two or three weeks we do a gross adjustment trust providers who have been approved for payments and we make those payments periodically. The deadline for these applications is December 31. If you are a provider and have not looked at the opportunity yet or are still on the fence on applying - - to do so, the deadline is December 31 for when we have allocated all of those funds. Moving on, if there's no questions about our American rescue plan act or arc funding, moving on to act 61 of 2022, this will explain - - past July as part of those pieces of legislation passed with the budget. So act 61 of 2022 as a subsection two, I am blanking. Title 18, I'm sorry. I'm thinking of the title but it's on the slide. Institutional - - indicates a caretaker engaging in sexual intercourse, - - intercourse or indecent context with a codependent person is committing a felony of the third degree. The department was obviously - - must legislation and we were supportive of adding this additional provision. There are exceptions to the new subsection. The exception for a care dependent person and a caretaker obviously they are living in - - for current partners whose relationship creates caretaker relationship. One of the very important things that the new - - consent of the dependent care person is another exception to the law nor a defense to the crime. We have asked providers about information about how we would message these new, I want to say subsection and requirements. So we did send out an

announcement on October 24 about the provisions of act 61. Just making sure providers and anybody who is obviously working as a caretaker understands the new requirements of the law and understands the ramifications. It's more an informational - - so all are aware. I believe that providers, especially personal service agencies, health agencies, introduce messaging about the new law. Not sure if anyone has any questions but it's a good FYI.
>> MICHAEL GRIER: Any questions from committee members, audience? For Jamie on this?
>> JAMIE BUCHENAUER: The one thing I will say is we have been asked what providers need to do about it and we would obviously consult but we honestly encourage anybody, any providers with questions to consult their legal counsel about the new law and anything that they may need to do as employers or providers. Go ahead.
>> Question of clarity given that agency choice, we all understand, agency situation combination between - - employer and agency employer. If a consumer and attendant start off as a - - attendant, through the years become intimate partners. This makes that illegal?
>> JAMIE BUCHENAUER: I'm not an attorney but it could potentially make it a felony of the - - degree.
>> Even if it is consensual? Means to competent adults.
>> JAMIE BUCHENAUER: That's why I would encourageany employer or direct care worker who is contemplating this to seek legal advice.
>> I'm hoping I'm not the only one with concerns about this. The potential difficulties with the best. And I'm hoping I'm not the only one who will advocate against it. I know, but we can do something to change it if we need to. I don't know, I just know it's common. Among the living disability community for those kinds of relationships to develop. Even on a national level. I see, in certain circumstances where that could be abuse but in other circumstances where it is to consensual, Competent adults. I want to go on record - - I don't know, the question was to consensual adults, who's going to report it. Depends on the agency. Some Agencies would and May.
>> MICHAEL GRIER: Any other comments?
>> JAMIE BUCHENAUER: I will say questions were raised to us and we thought it was our duty as the office of long-term living to inform about the new law. May be more.
>> I am - - and direct Pennsylvania health comments and want to respond to - - observation. And share her concern that is not on the books. That's whether the office of long-term living, is it possible just to be aware of prosecution ahead that may come up, is it that hopefully there, if there are prosecutions. Should they come up that supports will recognize the consent of the parties and maybe not engaged in further prosecution for diverting. But it is, there are exceptions, it looks like. There is liability as well for the agency. That they get involved in this as well. I would just ask the office, OLTL, to be aware of it and another thing to ponder. Maybe that's working with the office of the Attorney General to say is there some way you could make us aware of prosecutions or arrests in this area. Thank you.
>> JAMIE BUCHENAUER: Okay I think we are moving on to direct care workforce

shortage. Great. Next slide. I know at this meeting obviously we've have a conversation that came up in November. I think it even came up in October. Question about why the office of long-term living was doing to monitor potential direct care workforce shortage. Questions were around when an individual has services put on their renewed service plan. How long does it take those services to start. Are you monitoring individuals to not get services or their waiting for services. Without forcing individuals into nursing facilities. We had a conversation and I think it is helpful to share with this group the things going on to monitor as much as we can, obviously, individuals who are not receiving services because they are not able to find a worker or potentially an agency. One of the things brought up at the last MLTSS meeting is the new operations report, ops 23. On the slide you can see the area that are tracked for the 23 reports. Assessment states, I'm sorry. It should say date of the current team meeting. The effective date of the service plan, the date that first services provided, if delay is due to service - - it allows comments to be reported and a number of businesses from a planning - - we are tracking the data elements to try and see obviously if - - for services provided indicates something is going on there. Unfortunately it's going to be really hard to look at this report and say there is definite issues going on, especially if the delay is due to a participant which isn't necessarily a date field, it's a common field that gives reason. Example, a participant selects an agency to start providing their services and that agency has no workers available. Obviously the next move would be to provide participants, have them choose another agency. If the participant is not open to selection of another agency there is going to be some delay obviously while that first agency recruits a direct care worker because a participant is not open to working with another agency. This does happen. There's going to be some obviously reasons for delay due to a participant. Obviously if a participant has a specific provider they want to work with maybe through participant directed model, that worker is being onboard and by either the - - agency, not the new one. I'm sorry. As the worker works through that process there could be delay as well. Many reasons why that delay could be due to participant which could impact when that first services provided. Just wanted to bring this committee up on the ops 23 report. I'm not sure if we have questions or looking at - - if there's anything we want to add around the ops 23 report. Sorry, a little on the spot. For those of you not in the room, and the audience has not - - so it's not like he can immediately comment. I put him on the spot, I will just call that out.

>> Good morning folks, I'm used to being on the spot, this is - - from long-term living. We have reported, taking a look at other data working back and forth with a business partner for business reports to make sure we are capturing everything. We are hoping report data on this within the next couple of months as we continue to collect and verify data. This report will give us a snapshot for people coming into the program when first assigned, when first assessed and services start. The number of comment fields, a lot harder to put out there but all of that will have knowledge of why. Some of the delay and services. Look forward to reporting on this more in the future.

>> Report asked if we could see the raw data? Did somebody ask about that?

>> I think that was a - - report but this one - - [Mulitple speakers] We cannot use raw data because there's information on it.
>> Can we redact it?
>> - - Report we have redacted all of thatinformation.
>> - - From PHS, - - due to a participant because of a particular agency, it is still reflective of a workforce challenge or deficiency I think. Second, is there a second report or effort of data collection where you are collecting and comparing authorized - - against total number deceived ours?
>> We do have a report of total number of - -
>> So you collect that? Is that something you have reported on recently?
>> Not sure we have.
>> Okay, will make that request.
>> - - Next meeting.
>> I think it was last meeting we asked all CHC-MCO to talk about because they are monitoring closely, the number of authorized hours and the number of billed hours or claims. They talked about how each of them is seeing an uptick. Usually I think, I'm going to do this from memory. I can stand corrected by any CHC-MCO's. Enter 85 percent of authorized hours are used over multiple and they are saying that will pick up into the 90s in terms of the number of - - participants. Not saying that right. Using 90 percent of their authorized hours. - - I've also listened in on the. Remotely. I may not have heard it as clearly. It seems they were tracking in different manners based on their description - - if we are definitely reviewing it based on total authorized, the schedule is in there. That's a different issue. It's really getting authorized and the actually provided, I would appreciate that.
>> Getting those numbers, 90 percent, that's great. Does anyone have a hard time? Jay has been helpful. I don't know if he's on the line. He's been very vocal. - - Maybe the data is not - - or why. It is, how do - -
>> JAMIE BUCHENAUER: I don't want to speak for Jay but in my conversations he's not in the community for his program. Is Jay on the line?
>> - - I have similar problems. Caretaker shortage- - [Low audio] The caretaker shortages across all programs. Selecting data on - - and stuff like that. What we are talking about right now is - - so we have to take a look at - - to see what the problem is with those programs also.
>> This is Jeff from Pennsylvania, you stated - - formal request can acknowledge stakeholder groups see comparative data for all three OLTL programs, all choices waiver, and act 150. I think that would help to flesh this out a lot better. Just because they are all stating differently. They have new systems in terms of payment and things of that nature. Just able to see that data is comparative I think might help a little bit. Until we see it we really get - - on it. Thank you.
>> - - My question is we have talked about authorized versus utilized. Has anyone been tracking referrals? Because the ability to accept is impacted by the number of workers that an agency has. I know while we are able to accept more than we were six months ago. It is still a pretty high number, a high percentage of referral requests that we cannot accept. Because, I do believe in some areas the workforce issue is resolving itself. A little bit better. In other areas, - - throughout my community where if he were trying to get attendance and - - for example your stock.

Because I have people begging me to find the markers, I can't do it. I have people begging me to find workers. It really depends where the consumer is. And the referral issue is due to whether or not you see people being able to - - the program timely or not. Because director workforce - -.
>> We know we have problems in different areas, different populations. With healthcare workers. We are working with MCO to track new locations that is what we're doing now, tracking those that are not either fully put in the system so there is not an authorization in place because there's nowhere to take it. That's what we're trying to collect data of how many people are in - - we are working all night.
>> JAMIE BUCHENAUER: I will add, we can go to the next light, - - all MC was recently how they are tracking purchasing. Not just new purchases but like mentioned, individuals were looking for more hours and may need additional workers to fulfill all their authorized hours in their service plan. This slide, I kind of summarized it by MCO, all mechanisms that they are using to track this information, most of them are tracking with PPC critical incident reporting, incident reporting and authorized versus utilized number of hours. They're all doing a slightly different in terms of tracking conversations with obviously you know, they did have some common thread. The interesting thing, I'm looking at Anna. I don't know if you want to reiterate what Pennsylvania health and wellness is doing when you have new or authorized hours and you are trying to find an agency to staff them. Because we review the last process and it goes out for a period of time. If no one picks it up and no one responds you have slides in your system to let you know that obviously no one has offered to and has the availability in the case. A flag in new start targeted outreach. Calling providers to find a provider with a worker available to take on those hours and provide the care that is needed. There are some mechanisms like that. You can see describe the situation like that as well where they have nurses - - and there is, when I sent out that last, if no one responds there's actions they need to take to make sure individuals are getting the care they need. It was a very interesting conversation. I will just defer any of the CHC-MCO that want to talk about their processes. I'm talking about it as it explains to long-term living.
>> Hi everyone - - with health and wellness. Jamie shared, we track this information, Lee. We monitor it through a performance report and then we provide data every month to the OLTL. Last month in particular within - - we have staffed 90 percent of our home care requests that were new or changes to services. That remainder, goes to one of those buckets Jamie shared on the ops report. Items. For those individuals that are not easily stopped for some reason or another, we have a tearing system for providers involved in our DPT programs. Those providers are considered tier 1 providers because they are performing and assisting with quality metrics. If they are tier 1 they received a - - first then it goes out after 24 hours to our general provider group. Just a reminder there are over a thousand contracted providers in the network home care right now. As before PTO. Providers out there - - last. If they don't pick it up we start making individual calls to our tier 1 providers that may have missed it for some reason. Within our organization that's led by Cassandra - - her team knows a really great job of getting those services placed. We have not seen this as a red flag. With our

office metrics. They are doing a really great job getting placements.
>> JAMIE BUCHENAUER: To the slide again, when we talk about this issue how they are monitoring people that have services in place and obviously consecutive services for consecutive shifts that are missed through reaching out for participants talking about what's going on? Why are those shifts missed? Is there anything we need to do? Get any agency involved? Is there something going on with your health? A proactive reach out just using that missed shift. Different things that obviously, different tools that CHC-MCO's are using to monitor the workforce shortage to ensure individuals are getting care. Five consecutive shifts.
>> I have one question in the chat. From Karen - - are MCO's able to provide a way that providers can notify the MCO that a provider has available Staff in an area?
>> JAMIE BUCHENAUER: If I'm understanding correctly, they want to reach out to see if there is staff available in an area. So any participant coming on board and need staffing in a particular area. They know this agency has people available. I'm going to be speaking for the CHC-MCO's and Dan can provide additional information but I know there is an ability to choose an agency. The other pieces that a participant does not choose an agency or is open to working with an agency who has staff available, I believe most of the CHC-MCO's can go out to all of the agencies letting them know they have a participant in an area that would need a number of hours stopped that the agency would have the ability to respond to that blast.
>> DAVID JOHNSON: - - Was asking - - share with UPMC I believe five consecutive shifts can be quite a long amount of time. Is someone available to clarify what would constitute a shift here?
>> This is Jamie from UPMC that are not part of this process so I would not be able to it so I apologize, we have to get back to you.
>> DAVID JOHNSON: Thank you we can follow up.
>> JAMIE BUCHENAUER: To the other two CHC-MCO's want to come in?
>> This is just from CHC, our providers - - in certain areas.
>> Matt, the way we interpret that is - - services that could be home care, - - meal, when we see there has been five consecutive missed services, the service coordinator does reach out to the person to find out if they are ill, hospitalization, what is going on. We would not typically wait five days. It might be we just seea report and there has been some blanks.
>> By event or?
>> That's how we interpret it but it is by contract that we interpret it as five consecutive services missed other person was enrolled in the program.
>> How about other MCO's? Can you give us clarification on your policies on that? if you could please use the microphone so others can hear.
>> Matt you asked - - one day. I would guess maybe but not with our typical participants. We probably see it over three.
>> Hi this is just from - - again. Our response is you go off trigger event and will follow up if there is - -.
>> It's by event,Jess.
>> JESS:Yes.
>> Okay thank you. How aboutUPMC? If you could put that down so we can follow up, Thank you.

>> JAMIE BUCHENAUER: I'm going to the next slide. Considering there were good questions, they asked if OLTL is tracking the funding rate increases and obviously the funds we sent out for strengthening the workforce and how work monitor and overall care for his - - level. We want to let the committee know we talked about a funding portal - - due November 30. There are questions and there for the number of employees hired as a result of strengthening the workforce. Payments or adult payments. A number of employees gained or lost since December 31, 2021, we are asking for data on their workforce. Typically here this workforce is made up of women. Typically it's older women primarily, we are trying to get some actual geographical information on what the workforce looks like for our personal service providers, home and health providers who received our strengthening the workforce payment. Hopefully we will have data to share in terms of gained and lost employees and with the workforce looks like. Any other questions? The question was in the room, what agency - - on the agenda and it was not.
>> Hi this is - - I just want an update on where that is because of course I would like to know what's happening.
>> JAMIE BUCHENAUER: We are going to be over in CHC waivers or are you referring to the actual procurement?
>> Change in process and programs they're going to bring agency of choice to one provider.
>> JAMIE BUCHENAUER: If you are asking aboutthe procurement particularly in the state you can check the website, the addendum gives updates on the agency procurement. It is currently due to multiple protests.
>> - -
>> JAMIE BUCHENAUER: Okay. I can say, we did do presentations on the - - and CHP labor amendment. I believe at the last MLTSS meeting and to the MLTSS meeting, the - - and CHC waiver will be published and open for public comment on November 12. We worked hard to gain the fourth we had a delay in the review process internally. So they will be published on the 12th. Any other questions before we move on?
>> Any questions for Jamie onOLTL? Is not it, Jamie?
>> JAMIE BUCHENAUER: Yeah.
>> Thank you. Moving on with the agenda we will go to the consumer assessment of healthcare providers and systems, CAHPS report, Abigail Coleman.
>> ABIGAIL COLEMAN: Hi everyone, I am Abigail - - today I'm going to be presenting some CAHPS HP results today. Just a bit of an overview, CAHPS HP is the consumer and providers healthcare assistance, - - community-based services, CAHPS survey within long-term. This is to the health plans. In community health, MCO's contract with independent vendors to conduct the CAHPS survey annually. And then there are results that will be presented today. The following slides are really looking at four years of data. Trending with the MCO's over three key areas. The first one being rating of access to care, rating health plans and ratings of personal doctors. Next slide. A bit of information about how the CHC-MCO conduct their survey, we do have the organizations divided into subpopulations. The first population is for participants who are Medicaid only. As well as participants who are in aligned - - with Medicare. We do that because we acknowledge participants may inadvertently answer the questions about their Medicare advantage plan and there CHC organization.

The question is asked at the beginning for them to confirm that whatever MCO's they are with. Hopefully they are answering about the CHC - - the second group is - - for service. Those are the two groups that we will be looking at today. Each slide I will go through will talk about these two groups, the aligned group and the unaligned group is sort of how they are categorized. One other thing to point out on this slide is that when you look over here it's not quite apples to apples obviously. CHC was rolled out over a three-year period. When we are looking at this reporting here 19 is for a calendar year, 2018 obviously that was only the Southwest region and reporting year 2020 would be for calendar year 2019 and so that includes both Southwest and Southeast. Reporting year 2021 that we are looking statewide data. With that I think we can jump into the data. The first area we will be looking at is ratings care. The first we are looking at here is a composite measure for getting needed care. Within the survey this include two different measures, getting needed care and treatments, - - again, for informational purposes for 2019 only in the southeast we will not have any data for 2019 for Keystone first. Keystone first and AmeriHealth reported separately because they have different accreditation numbers with MC QA. They are broken out with Keystone first. You will see the slide showing in 2020 there was no data reported. The other presentation PC data missing it slightly because a low denominator, low response rate for the question. There was no data reported on the measure. These measures are largely reported on the Likert scale. Participants could answer number, sometimes, usually or always. You take the questions and on the slide we are reporting the percentage of participants who reported either usually or always. There are a couple that are on there, 1 to 10 scale. I will point out as we go through the presentation. For this particular - - you can see PHW remains relatively stable. UPMC has seen an uptick in their numbers in the first three years in a small decline in the latest reporting here. Keystone first showed a - - from 2020 to 2021. But then had a little bit of a rebound in weighted reporting year. AmeriHealth also so I drop off in this latest year.
>> Can I ask you a question? I'm not a - - person so if I get the terminology wrong correct me. What is the response rate? How many people responded, all of that kind of stuff.
>> ABIGAIL COLEMAN: I don't have that information and I can tell you for each question it is different because differences can put you to pass a question. - - Does prescribe how many respondents - - except for one MCO, it is prescribed by a NCQA
- - basically the organization puts out technical specifications for this survey. While the data that the managed-care organizations present as well.
>> Follow-up on the - - go ahead.
>> Hey Abby this is Marcy, plans have response rates in their individual presentation so we will get that information to you following your presentation, that information is in the slide deck today.
>> Does it say the number of people it was sent to? Or did it just to say response rate?
>> MARCY: I will have to check but I was from AmeriHealth has the actual sample size as well as those that were completed. As we go through those, just feel free to ask

questions done.
>> Very good, thank you.
>> MARCY: Sure.
>> - - Wilson again from - - projects, question in the comments. One is about the definition of care and whether that is medical care like physician or whether we are talking about - - service. It says care but it was not clear to me, that's a big definition. So you are saying usually getting the care there's a lot of healthcare out there. So is it specific to seeing a physician? Or a physician specialist? And/or is it getting in home community-based services?
>> ABIGAIL COLEMAN: That's largely open to interpretation by whoever's answering. It is a generic term and you can see the questions that make it up there also reference getting treatment. As well as specifically the specialist in the second question that makes up these composite measures. They would definitely be included in the term care.
>> So it's everything? You have a bunch of different service plans, as well as if you have behavioral healthcare, if you had care delivered by a physician, it's a general generic question, are you getting the care? Okay.
>> ABIGAIL COLEMAN: Correct.
>> Other comments, it's just more timely. There's been a number of things that have come up in the last month prompted by an article that talked about access to physician care by people with disabilities. I think folks generally see in the new, number of folks have said frankly I'm disappointed that this is even acknowledged, we can do better. These numbers are really good in terms of if you look at it, there's a number of folks saying I'm always getting the care needed. It flies in the space of what's out there recently and some experience, and the last conversation we had before this comes up. I'm not really disputing the data are coming out OLTL. It's the context and these numbers are challenging that viewpoint. Thus my comment. Thanks.
>> ABIGAIL COLEMAN: I will point out the survey, these survey results were submitted in June. The survey was conducted earlier this year. Usually I believe January to March asked participants to consider over the last six months. It would have been the end of 2021 through the beginning of 2022 that they would be potentially responding to these questions.
>> DAVID JOHNSON: This is David, sorry, quick question regarding the second group with - - choices on Medicare. Or another Medicare advanced plan. I can understand and appreciate the interest in looking at outcomes results with alignment and alignment. This survey I can stratify groups for service Medicare and CHC and etiquette advanced plan or they just are together?
>> ABIGAIL COLEMAN: Together.
>> DAVID JOHNSON: Is there a reason why?
>> ABIGAIL COLEMAN: I mean if we want to stratify the, - - by the managed-care organization, additionally the survey has to align with how the managed-care organizations submitted their data and that would also require an additional permission for the MCO's.
>> DAVID JOHNSON: I appreciate that, to - -!, not to skew the data in the context we know. Access - - service plan so there is no separate data for services another

Medicare advantages. That one group is combined together?
>> ABIGAIL COLEMAN: Correct.
>> DAVID JOHNSON: Thank you.
>> ABIGAIL COLEMAN: Going through this data quickly, seeing measures, composite measures, reviewing unaligned groups. He can see UPMC and pH W has been consistent in the last two years and AmeriHealth saw a small bump on one percentage point and - - saw a small drop off. Next slide, please. The next slide is looking at getting care quickly. As a composite measure that has two measures that comprise a measure. The first is care - - needed right away as well as a checkup orbiting appointment as soon as needed. In 2019 data, AmeriHealth had a low denominator for 2019 and 2020. However, you can see the ratings across the plans that are pretty consistent. UPMC members rating down a little higher thus the drop off in 2022. For UPMC. PH W did see a three percent increase on this composite measure. From 2021 until 2022. Next slide. Again, seeing measures were participants who don't have an aligned - - we have UPMC number pretty consistent again. AmeriHealth and PHW seeing a drop in numbers from 2021 two 2022. Next slide. I am going to try to get this quickly because MCO's are going to present after I think I'm a little over time. The next section is looking at ratings of health plans. Next slide. The first measure is looking out satisfaction with the health plan. The first category we are looking at is Medicaid only and aligned members. This is a measure where - - provides a rating from 1 to 10. As you can see on the slide a percentage of participants rated their health plan eight or above, so eight, nine, 10 are included in percentages. You can see that satisfaction increased over the years for all MCO's. Fairly large increases from looking at in 2019 till 2022 data. Improvements across the board. With UPMC rating the highest consistently. Next slide. Same measure, just with the unaligned population. And for the most recent years AmeriHealth had a pretty big - - as well as changes from 2019 all the way to 2022, pretty big improvements for that. We see - - dropped off a little bit since 2020 among unaligned members. In the most recent years, MPO C also saw an increase from 2019 until 2022. Next slide. The next slide, question.
>> - -
>> Can you turn the mic on?
>> The last three slides I struggle with is, can you go back one slide? Satisfaction with the health plan. Given the terminology you say how come that is - - especially with the health plan? Because you are looking at service performance of Medicaid CHC and the Medicare advantage whether that advantage - - consumers as I hear you saying are asked are you satisfied with the plan? But they are in two different plans. They are in a - - and they are in a CHC-MCO. Even if aligned, those are two separate benefits. Satisfaction with the plan is are you satisfied? I get you are asking about this through a CHC lens but the consumer when being asked the question is not really being asked about what do you think if you are a waiver participant about your satisfaction with services that AHC, - - UPMC deliver? They may well be saying I'm satisfied with my - -
>> ABIGAIL COLEMAN: - - To minimize that and get to the core of are they truly answering about the health plan. In addition to that the first question on the survey is is your plan and then fill in the MCO's name. They should be answering

knowing that we ask is this your plan?
>> Even the slide before this. This is unaligned but Medicaid and aligned. This answer is about are you satisfied with your Keystone first plan. If you are answering that, not Medicaid only. I want to go back, the aligned, which is probably most folks. This response is, they are answering, are you satisfied with Keystone first? Not are you satisfied with Keystone first. For the sake of saying it, a hi Mark.
>> ABIGAIL COLEMAN: They specifically ask this is your health plan. They are asked to confirm and say no, then they provide who they believe is there - -
>> Okay. I'm not shooting the messenger, I'm just trying to really understand the data and what is getting asked. The satisfaction with the health care plan is an important question. I want to make sure I understand what they are satisfied with. Thanks for your patience with me.
>> Can I follow-up? - - Acronym used in HTC national, are these standardized questions? Missouri is asking the same kind of question?
>> ABIGAIL COLEMAN: Yep.
>> My second question is if you go back to the charts we are dealing with. Satisfaction with the, like this one. Again, I don't know anything about - -
>> Expect a dip in the heart of COVID? Or arise with the increase of telemedicine? When you expect something like that? Different ways of getting - -
>> ABIGAIL COLEMAN: That's a good question.
>> - - Again, a lot of these- - 80 or 90 percent.
>> ABIGAIL COLEMAN: Surveys are conducted with one third party vendor.
>> - - Doctors - - weren't there three doctors we had? Asked University of Pittsburgh I think.
>> ABIGAIL COLEMAN: Not University of Pittsburgh, each MCO has a vendor to conduct the survey.
>> This is admitted through MCO's themselves?
>> ABIGAIL COLEMAN: Now that's what I'm saying, they each use a vendor to conduct this survey.
>> So three different vendors?
>> ABIGAIL COLEMAN:I believe - - but yes.
>> Okay, you agree you would expect some kind of dip or raise depending on whether people were having an easier time or hard time?
>> ABIGAIL COLEMAN: I mean I guess it would depend on the participant and whether they were seeking care during that time. MCO's will also be able to will have an opportunity after I present to explain why they feel that they are seeing the results they are whether it's a drop or increase or whatever. They will have better insight into that than me.
>> Thank you.
>> ABIGAIL COLEMAN: Okay. Okay, yeah but this is unaligned. Okay. All right, okay. So the next slide we are looking at is the customer service composite. This is comprised of two measures. Customer service provided information or help to the participant and service to get the member with courtesy and respect. This is talking about the health plan customer service. Again, on a Likert scale of never, sometimes, usually or always. Again we are looking at usually or always numbers.

And so for this particular measure you see PHW has an increase from 2021 till 2022 as well as UPMC did and AmeriHealth had a small drop off. Keystone first remains stable for this particular measure among Medicaid only and aligned participants. Next slide. Again, same measures, looking out unaligned here. Here we see somewhat opposite of what we saw in previous slide where AmeriHealth saw two percent point increase - - three percent point increase and PHW saw - -. The final topic we will talk about today is ratings of personal doctors. Next slide please. This measure is looking at satisfaction with personal doctor. You can see that PHW saw an increase in this measure. And the other AmeriHealth and Keystone first side drop off whereas UPMC remains pretty consistent throughout the past couple of years at 86 percent. Next slide. I did point out in the last slide this is where members are asked to rate on a scale of 1 to 10. We are reporting where participants responded with at least a score of eight. For the unaligned population satisfaction with personal doctor, AmeriHealth remained steady at 89 percent. From 2021 until 2022. Keystone first saw an increase of three percent to 87 percent in 2022. And then however, they did have a pretty sharp drop off after 2020 until 2021 where they dropped from 91 to 84 percent. They saw a bit of a rebound this year. PHW saw an increase from 2019 but decreases from 2020 February 20, 2021 and also 2022. Next slide, please. The next slide is looking at your doctor being informed and up-to-date on care. This measure is for Medicaid and aligned members. Across all plans members consistently rated their doctor being informed and up-to-date on their care across all MCO's for all years. But for the latest report and, PHW and UPMC dropped to 93 percent and 91 percent respectively in their ratings. Next slide. Again looking at is your doctor informed and up-to-date on your care. Pretty highly rated, these numbers are slightly lower than the aligned population. AmeriHealth saw increase in this measure where we saw a bit of a drop off and PHW and UPMC saw 91 percent respectively. Next slide. The final measure we look at today is how well do your doctors communicate. This is another composite measure made up of four sub- measures, looking at if your personal doctor explains things, listens carefully. Shows respect and spends time with the participant. We can see all four health plans performed really well on this measure. All well above the 90 percent mark. All performing pretty well. UPMC, PHW, Keystone first all saw an increase in this measure. AmeriHealth saw a one percent drop in this measure for unaligned and Medicaid only members. Next slide.

>> Hang on just a second, Sean.

>> Have to ask, I agree there is a disconnect between healthcare services and community-based services. The reason I say that is because I cannot tell you how many physician that we engage with that serve consumers we serve that have no idea what - - community-based services are. I cannot tell you how many times we get calls from people in the hospital. In the hospital has no idea what it means when the consumer says I'm going home with my Attendant. This data is only useful to appoint because it does not give a comprehensive look of where we are with attendant care or with community-based services. I think until we do that we cannot look at the well-being, we cannot look at - - care. Well-being of individuals with disabilities receiving the services because clearly the medical professional do not understand these benefits.

>> To pick up on Shawna's plan, this data, you said slides about doctors, doesn't really get out the point she was making about how - - are performing on delivery of home and community based services which is their contract. Doctors are paid far and wide by Medicare. We are not interested in Medicare data. Clearly you are not showing Medicare data, - - you can see they are not paying the doctors, Medicare is. Data is not helpful in terms of an evaluation of how plans are performing on H CBS and leaning into it more. I have to say I have to disbelieve the data. I don't give my doctor 90 percent ratings of satisfaction. Of communication and figures. These are really good numbers. I'm eager to hear the plans response to the, not the OLTL's response, I'm eager to hear how the plans response. This data is not helpful. If you are trying to take this data and act better as planned, hearing about how your members communicate with the doctor in a totally separate Medicare advantage network is not helpful. It does not move the needle.
>> Hey, this is Joan - - I don't know if folks recall, we did present the H CBS CAHPS information in August with follow-up questions. We provided a link of all measures and I think it's important to note that this is a NCQ S requirement - - assessor. And you know, the process does give us direct feedback from consumers because these are consumers being interviewed by an independent entity. We have also had MRC during independent study over the last seven or so years. Periodically reporting on their findings to us. This is just one piece I think is important to note this is just one piece of multiple sources of information. I just wanted to point that out because we are losing track of the fact that this is just one component. This is focused on the CAHPS survey for the health plan performance.
>> I appreciate that. You are giving me broader context about H CBS CAHPS data as well but even looking at performance of Medicare advantage and - -. It's important to see the whole picture as well. I think in future months ahead we will be interested in understanding plan performance. This really is not getting at key - - plan performance.
>> Corrects, this is not getting a decent performance because it's not an evaluation of the - -. I have not gone on to the CMS website, I think this is something we should look at because the centers for Medicaid and Medicare services do evaluate evaluations of the - - because they are providing Medicare service. While the state has - - contract, the - - are in Medicare products and I know Medicare has some ratings on the individual plans. He were correct, it is not the - - center being evaluated in these CAHPS services. The surveys are for an evaluation for the CHC health plans as well as home and community-based services and Reno, it supports the requirements from NC QA for the healthcare accreditations the DMC owes us to have. That's the purpose of this group of surveys.
>> I do get what you are saying. Ratings of personal doctors in the five - - associated with it is to my mind, a proxy for Medicare performance. It is about, those are doctors that are far and wide in a Medicare advantage. Network, or a deeper service original. By asking these questions about how would you rate your personal doctors and showing across that x-axis this is what, this is how HC does and Keystone first does, it's not their network. It is not their responsibility. It's not really going to be all that helpful. I get the point that - - we have to present the data, but it does not really help us. That's what Shawna is saying. I

want to know about, let's go back to office data and make it about events of H CBS. All questions around ratings and personal doctors, that's not in your area unless you are in a Medicare only plan then we want to know. If you are Medicaid only that's on you, CHC-MCO, that's the data and answers I would be most interested in. If you have Medicaid only, all of your healthcare medical services and long-term care for it services, - - methodology, lumping it all in. It's just, I think it creates more questions than answers.
>> Thank you. - -?
>> I just want to jump in whenever someone on the phone talks because by - - person is having a hard time?
>> I don't know if everyone heard that, for folks communicating on the phone, if you could go a little slower so the person can capture all of your information for the permanent record. Thank you. So had Jeff.
>> JEFF: This is Jeff from - - maybe this is more broad rushed than Medicaid service, people in this room, we have a number of possible closures, more recently the Southeast. That impacted quality of services. Our survey says there will be questions maybe going forward, some closures have happened this year, Chester County and a couple other places. That address bigger service interruption. People finding alternatives. That would be one. The other question I had is telehealth. We don't - - substance abuse talk a lot about telehealth, OLTL does not seem to talk about telehealth as much. Just kind of wondering if we can included the, those two issues. Telehealth and major service losses like - - closures or something like that. Thanks.
>> ABIGAIL COLEMAN: To respond, these are national surveys as discussed. As the option to ask specific questions. We could certainly consider that for future years. We would need to have further discussion on what those questions would look like. Just to correct one point previously made, this is not saying the participant rated their doctors at 90 percent. This is saying, rental, 95 percent of participant surveys responded with a mark of eight or above. I just want to clarify that point. So, I cannot remember if I covered this slide or not. This is how well your doctors communicated. A composite score, looking at how well your doctor explains things, listens carefully, should respect and spend time with the participant. This is a measure where all of our plans releases - - did well on this measure. Doctors communication was consistently highly rated for all composite scores. At least 91 percent for all plans, for all four years. They did score highly in the latest years, - - increase, AmeriHealth had a drop of and remains highly rated. Next slide. Again, similar to the aligned population, this subpopulation ranked their doctors communication very highly. You can see a higher rating by Medicaid only and aligned members on these particular measures. There are unaligned measures and AmeriHealth, Keystone first were rated high by their unaligned members than Medicaid only. And aligned members on this particular measure. That concludes my portion of the presentation.
>> DAVID JOHNSON: Thank you for your presentation, there was a comment in coming years there's an opportunity to ask state specific questions to these CAHPS surveys. Subcommittee would be interested in understanding if there is opportunity for stakeholder input for these state specific questions. I share a lot of concerns or

questions involved, would be a good opportunity for us to try to capture more nuanced status in upcoming years.
>> LLOYD WERTZ: This is why, I would like to add to that. Since Pennsylvania is a carveout state for the behavioral health services and offer uniquely in each county by one specific code, that perhaps following up on those types of referrals it might be handled by the physician or by the plan and service corridors. Would be a good place to begin to get some of those services and their delivery to the CHC enrollees.
>> MICHAEL GRIER: Absently right.
>> LLOYD WERTZ: Thanks Mike,I thought my Microsoft.
>> MICHAEL GRIER: No, are there any other questions from the committee for audience numbers? Thank you Abby. Next up we will go to the next item on our agenda. Health plans are a result. Looks like Pennsylvania health and wellness is up, AmeriHealth, and UPMC you are in the hold.
>> RACHEL: - - I want to review with you CAHPS results and strategies in place in preparation for next year's CAHPS survey. Next slide. First I want to provide an overview of our rates by Medicaid not aligned and also Medicaid aligned duals. (We Will focus on Medicaid not aligned duals. I want to highlight COVID-19 has had a significant impact and disruption on a lot of these metrics throughout most of 2020 and we are continuing to see that impacted today's results as well. For our Medicaid nonaligned duels we decreased a few metrics but did see increase in rating of healthcare. Coordination of care also. Looking at 2022 response rate trending at the bottom beneath that graph we have 401 completed surveys from a sample size of 1823. With oversampling of 35 percent. Overall response rate for the survey was 22.6 percent. I also want to highlight we have a response rate that is higher than the higher - - 12.2 percent. I want to highlight industry trends show a continuous decline year-over-year. We are looking at new ways to potentially increase oversampling to combat those lower response rates. Looking at Medicaid non-*UNTRAN3* and aligned duels on the right-hand side you see Rita decline in for metrics. But did see - - industry trends highlighted declines and a lot of these measures I think it speaks volumes to the work we are doing at PA health and wellness as we see increases in seven of these measures. Looking at the response rate trending for this line of business at the bottom. For 2022 we had 345 completed surveys out of a total sample size of 1499, 11 percent oversampling with response rate being 23.5 percent. Again over the - - response rate of 12.2 percent. Next slide. Looking at area of focus bottom three measures on the left for nonaligned duels bottom rating are health plan - - on the right-hand side for non-duals and aligned duels bottom rating of specialist, healthcare and health plan. Next slide. Now that we have reviewed results for this year's survey I want to highlight a few strategies we have in place to impact 2023 CAHPS survey. Broken down by plan, provider and participant bogus. First we will focus on improving plan processes. We are periodically working with corporate partners to discuss strategy and alignment with corporate goals. They have a member experienced hearing committee we are involved with and meet monthly with a corporate CAHPS strategist. To talk about ideas we have in place to impact CAHPS. We have internal CAHPS work meeting where we have stakeholders across the organization discuss participant

experience metrics and strategy. Those discussions include update on progress of goals and resources from the CAHPS team. We also have been doing a lot of nonemployee training. We implemented a CAHPS overview and understanding impact training in a platform called - - University so all participant facing staff have completed the survey and that will be an annual training. We have also been engaging in one-on-one meetings with participant facing teams to review CAHPS best practices. We also are incorporating a CAHPS review during new employee orientation. So every new employee coming into our organization understands what CAHPS as and how they fit into that overall picture. Finally, doing an annual CAHPS employee knowledge check activity. We recently did this knowledge check where we asked different employees to answer different questions about the CAHPS survey and provide ideas for how they can improve rating of health plan. Next we are doing annual focus groups with employees. These focus groups bring individuals from multiple departments and are aimed at identifying barriers that impact CAHPS and participant experience. We are using feedback from those focus groups to improve processes and strategies. laint and grievances - - entering complaints and grievances are processed correctly. Utilization management, we have an ongoing deep dive on those denials looking at monthly trends such as what was the denial, who was the reviewer and looking at language of these decisions sent to participants. Next slide. For part of our plan strategy we have a customer service focus, reviewing all after call voicemails to review satisfaction and experience. We have transportation concierge within our program coordination team that assists participants with scheduling transportation to appointments. For pharmacy we have ongoing pharmacy coordinator outreach to close care gaps related measures and assist with medication adherence. For our satisfaction survey analysis our survey coronation team is asking participant satisfaction through telephone outreach and - - health plan. Those metrics reviewed periodically in our monthly CAHPS record. Finally plan strategy processes we are doing ongoing community connect monitoring for social determinants of health to monitor those internal and external search results from the community platform. Next slide. Looking at a provider strategy and improving provider partnerships for 2023 CAHPS Inc. provider training on a monthly basis. Provider education is provided at bridging gaps between providers participant on plans. Educating providers on CAHPS issues and educating on cultural sensitivity. In our newsletters by God to providers we are incorporating CAHPS content into those court newsletters. - - Getting care quickly. For the corporate CAHPS provider Summit our corporate CAHPS team is hosting a summit that will engage providers on CAHPS best practices. With an interactive experience so this corporate CAHPS provider Summit is going to occur this month. For PA health and wellness provider webinars our local team focused webinars on providing key quality control related processes, access dinners, formulary changes and it also provides an opportunity to review CAHPS and HE DIS data. Reconciliation is an ongoing process to ensure network validation that we have data integrity maintenance in place. Next slide. For our third component of strategy we are focusing on improving participant engagement. The ways we are doing that is through participant advisory committee meetings. In those pack meetings were engage in conversations with participants to assess barriers that may impact CAHPS scores. A recent meeting asked about barriers

to specialist care and identifying what those barriers are. For our newsletters we are taking a similar approach. Incorporating that CAHPS content and quarterly newsletters use those keywords within CAHPS. Next we have care engagement outreach. Through this program, personal phone calls are going out by care engagement specialists to participants using health coach models. To educate and assist with closing care gaps and these outreaches participants are assisted with appointment scheduling and transportation. Then using new or existing member touch points to navigate members without an assigned PCP. Also we've incorporated fluid reminders as of September of this year. Next our point-of-care program is a community care program for participants with an unmet need or gap in care. As a result of chronic manure disease, chronic kidney disease, renal disease, diabetes or hypertension diagnosis. Or have a social determinants of - - gap identified. We have two flu programs to our corporate caps team. With powerful campaign aimed at educating, encouraging and coordinating access for annual flu vaccinations. We are also doing a flu thank you campaign. For participants who received a flu vaccine they will receive a thank you mail - - for the upcoming survey. Next slide. That was all of the interventions and strategies we have in place for CAHPS, are there any questions for PA health and wellness?
>> Thank you very much. Sorry.
>> Go ahead.
>> LLOYD WERTZ: Thank you for your presentation, appreciate it. On the health side, we have a habit of including consumers of behavioral health services very directly. And the planning for those services since we believe they are in the best position of telling us whether what we are doing works. And what we might change to make it work better. The points at which there are joint committee meetings that occur with executive staff or perhaps the individual level within the organization. Of course a more direct service level folks with consumers of the given services.
>> - -
>> LLOYD WERTZ: - - Under the MCO's. Whether you meet face-to-face with staff to give them an idea what their consumers are reporting and feeling. And to give the consumers an idea of how to speak into the impact of the services they are getting provision of leaders.
>> RACHEL: Is a really good question. I am not aware of any current meetings where that information gathering would take place per se. I can definitely get an answer for you. I will say what we are also doing with this year's CAHPS results is our vendor gave us a health equity breakdown and segmentation of rates by each region. We are able to see which regions performed lower on those areas such as getting care quickly. What we are looking to potentially do next year is look at those regions that are maybe scoring lower and potentially hosting a participant for him. Just to get that feedback from participants to assess what are the barriers with getting an appointment as soon as you need. What are the barriers with getting access to specialists. Those kinds of things.
>> LLOYD WERTZ: Thank you, I know a participant forum is kind of a one-time event. If you are to have an ongoing group over maybe three or four times a year, maybe even two. You make - - my get more consistent responses and the ability to communicate more effectively to get an idea of how services are being delivered at

the consumer level. And how they are appreciated or sometimes not appreciated and can be improved. Thank you.
>> RACHEL: Absolutely I agree. Thank you.
>> Thank you Lord, any other questions from committee members or audience? - -
>> DAVID JOHNSON: thank you for the presentation, I'm looking at the numbers for - - Alliant duels. When the survey is administered and participant offers their rating, is any additional information captured, - - five at a 10. Captures why that rating was the case and if there are subsequent reviews of that.
>> RACHEL: No, looking out the survey results you are correct. They are given a score of how they would rate the quality of their healthcare. We are not able to dig down deeper into that to find out what that reason might be.
>> DAVID JOHNSON: Okay thank you.
>> I think my question is going to be the same with AmeriHealth and UPMC, we have a number of patient experience with mostly doctors. That are more often than not in a Medicare network. The question that I asked each plan to respond to is how do you use your service coordinators who express dissatisfaction with a doctor? I - - responses just now, we might help them get an appointment. Or is there any other conversation, ever, about changing MCO for Medicare advantage from one MCO to another. What sort of, if known, how do you deploy a service coordinator who has conversation with their participant about access to doctors? And what is, you know, the rules of engagement. Not rules for engagement, how does your service coordinator engage in talking to their participant about dissatisfaction? If you are not ready to answer the question we can defer. I think trying to understand that will, in our - - system is the question.
>> RACHEL: I do not have an answer to that question but I want to see if anyone else on the line from PA health and wellness does. If not I can take that back.
>> ANA: Hey Rachel, Anna - - probably need to come up from PA health and wellness query our service coordination to find out how they are doing specifically. I would be providing a guess that this is a conversation that happens in assessments. When care visits take place, if a participant is dissatisfied with anything, including their physician, the service corner we have a responsibility to educate them about their choices and assist in coordinating those benefits or changes to their care. We can ask service grenade is how that is done.
>> DAVID JOHNSON: Thank you Anna. I have a my question, you mentioned utilized a vendor to collect data and the one that is reporting that back. I wanted to double check with you, does the vendor have a test for validity of sample size, number of responses, I just want to ask if the vendor had ever mentioned checking the validity of responses.
>> RACHEL: Another great question, I do not know specifically what our vendor does to check validity.
>> DAVID JOHNSON: It's not just for you, like - - said this is for everyone. We want to make sure we are doing actual valid data. Go ahead.
>> I kind of gotthe impression, are all MCO's using the same measure? Are you able to tell through the vendor?
>> RACHEL: PA health and wellness uses - - analytics, I'm not sure what other MCO's are using.

>> MARCY:- - We all use - - to complete surveys.
>> DAVID JOHNSON: Thank you very much. Any other questions for PHW? Great we will move on to AmeriHealth, Keystone first. You are up.
>> MARCY: Good afternoon everyone, Marcy Kramer, director for long-term support here. We can move to the next slide. I'm going to go ahead and talk about our response rates because that is something we are looking at all the time. Our qualified respondents, they are 18 years or older as of December 31. Measurement here, they must be continuously enrolled for five of the last six months of measurement here. This is the same across all CHC MCO's. - - For the South East zone, Keystone first is 27.6 percent. For our unaligned D snippet is 23.2 percent. We can move to the next slide, please. What I did here was put the measures RB had almost like comparing all other three CHC-MCO's. We are pleased to see the majority of our rates have increased from 2021 reported rates. The rates you see here, none of them have had a significantly statistically significant increase or decrease given the red and green rates here. You can see the customer service composite for the unaligned D snap remained constant from the prior year at 91.8 percent. Next slide, please. Now I'm going to visit the AmeriHealth Southeast, East and Northwest zones. You can see here same slide as the southeast his own. We had a 24.6 percent response rate for Medicaid only and aligned duels special need plan. We had a 26.8 percent response for our unaligned D snap You can see the whole numbers here. Next slide please. You can see for AmeriHealth toss majority of rates improved from prior year, we have a few in the red that the client. Not statistically significant. - - AmeriHealth toss. We can move to the next slide please. We will provide a summary here. As you saw from the previous class, majority of our measures remain the same or exceeded prior year's rate. For 18 of - - low response rates for AmeriHealth Caritas response rates 23.2 percent to 27.6 percent. What we are doing to address low response rates is providing text messages and outbound recorded calls. We sent those to the entire eligible population to notify them the survey was coming. These messages specifically encourage participants to complete a survey is contacted as part of the sample. In addition like PHW, we work with participant advisory committee and inform them of the upcoming survey and asked to participate if they were part of the sample. One of the things we are focusing on is culturally competent care. Goals are to provide culturally responsive care resources and training to network providers. One of the things we have found is that the culturally responsive and competent care are issues with our African-American and Hispanic populations. Working to provide resources such as training to provide network in regards to culturally responsive care. Recruiting and retaining culturally diverse providers across community health choices market. The other thing we found is a limited number of doctors to choose who share the same culture or language as participants. We are recruiting and retraining, retaining culturally diverse providers across the market particularly within high diversity. We have a race, ethnicity and language dashboard assisting us in identifying targeted population. Relatively new, we are working without to identify populations to target for care. Move to the next slide, please. Some contribute factors to improve rates are robust, culturally diverse provider network. As mentioned previously we are still working on developing more diverse provider networks. Also

ongoing efforts to stay connected to participants. What we feel are contribute factors to declining rates is anecdotal data, it's taking time to get well visit appointments which impacts getting care quickly. As Rachel mentioned, not long ago, there are still backups from COVID-19 impact. Our service coordinators are reporting that some participants are reluctant to have face-to-face visits. We think those factors combined are really impacting our rates for those that have declined from the prior year. Next slide, please. Thank you for your attention. Do you have any questions for me today?
>> DAVID JOHNSON: Any questions for AmeriHealth, Keystone first? Thank you for your presentation, I appreciate the end of your presentation, assessment for an understanding of understanding contribute factors to declines. Imagine anecdotal reports, wellness appointments, what are the sources of these anecdotal reports and how are you collecting them?
>> PATRICIA CANELA-DUCKETT: Three service coronation, responses from service coronation, service coordinators in the field working with participants.
>> DAVID JOHNSON: That's great. - - Service corners to relay those anecdotal reports to the plan or specific staff?
>> MARCY: Absolutely, the quality department is working closely with the coordination department to collect data but I think we need to put a more formalized mechanism in place to collect data beyond the anecdotal numbers.
>> DAVID JOHNSON: I appreciate that,inky.
>> MARCY: Sure.
>> Thanks for the presentation, thank you earlier for the presentation, two. The same side you were on, to go back to it just before the thank you. The last bullet point caught my attention, service corners are reporting some participants are reluctant to have face-to-face visits. Can you expand on that? I know some but you have a lot of folks in your network. Is it where case that folks are reluctant to have face-to-face visits?
>> MARCY: I think that is something I need to get back to you on because at this point is anecdotal. We need to figure out a way to quantify that information. If I could divert to getting that information for you. That would be great.
>> Sure, off-topic from what you presented, I'm going to circle back to the same question, different version of PHW. If you can your will of service correlator. I use an example, if your service corridor is talking to a participant in the topic comes up of the cultural incompetence of a doctor in a Medicare network, how does your service correlator raise, if at all, those issues? Do they talk about moving to another Medicare network? Do they make a call saying can I help you find another Medicare provider? How do you approach that?
>> MARCY: So, from a high level, our service corners would assist the participant in finding a new provider and guiding them to member services if needed. One of the things we are working on actively is to find a provider application and making sure that we include the cultural and diversity preferences within to find a provider. An ongoing effort at this time. We are really trying to focus on diversity and equity of our population. does that answer your question? Yes, o
>> Yes one follow-up. - -
>> MARCY: I have to get back to you on that. I have to talk to our staff.

>> That's fine.
>> MARCY: I will get back to you on that. I will make a note on that. We are wondering we are not sure from a compliant standpoint if we can do that.
>> Other questions for AmeriHealth? Thank you very much for the presentation. Let's move on to UPMC.
>> JAMIE: This is Jamie, can you hear me okay?
>> We can.
>> JAMIE: I'm Jamie Kennedy, Director of quality for community services at UPMC and I will dive into the same topic everyone else has. Next slide. I appreciate the conversation and questions that are asked so hopefully I am able to get to those in upcoming slides. I want to start out with recently we got great news that UPMC for life, the plans Medicare advantage plan earned a five out of five overall. Star rating in 2022 according to ratings released by the centers for Medicare and Medicaid services. DMS. Additionally our Transvaal, special needs plan, and central PA received a corporate five out of five overall star rating for Medicare for 2023. 2022. Making it the highest rated plan in Pennsylvania. We believe these ratings show commitment to bringing excellence in service to our members. That help them live their healthiest lives. We believe in building strong partnerships with members, partners and the - - health plan to provide quality care and will continue to expand benefits and innovate our personalized care program. The areas that CMS feedback about service and care members who have left or stayed with the plan. Number of complaints Medicare got about the plan. Doctors and hospitals that work with the plan. A large portion of the rating is based on member experience. It's going to be increasing even more in 2023. The weighted average of member experiences going to influence the scores even more than ratings. That means CAHPS plan survey is becoming increasingly important for health plans to inform strategies and performance. I will continue to adjust a few of the other comments in future slides. Next slide. Taking a closer look at the survey process. Here's an overview for UPMC's CHC survey. Sample is 1350 names pulled for each population. One for the aligned CHC participants and unaligned participants. That total is 2700 participant names in the sample. Survey has a male and or phone response option. The survey vendor which we use SPH analytics as well provides multiple opportunities to respond. First a questionnaire, mailed on March 8. A second mailed on April 12. Follow-up calls to nonresponders during mid-May. The last day to accept surveys is May 18. For the CHC aligned population, 92.93 percent of respondents completed it by mail and 7.07 completed by phone. Unaligned, 88.66 percent completed by mail and 11.44 percent completed by phone. Across the country our survey vendor reports response rates for these types of surveys continues to decline each year. We are feeling and similar to what the other MCO's were discussing. Response rates for the aligned declined by 7.3 percent points in 2022 to 30.1 percent. Unaligned response rate dropped by 1.8 percent points in 2022 to 23.3 percent compared to 2021. Next slide. Survey vendor SPH compared performance to Medicare products. So we have a basis for comparison on how we perform compared to similar products. And the UPMC CHC aligned population it is performing exceedingly well with survey responses we got back. We got back or above the 90 percentile and almost all composite areas except rating of specialists near or

slightly below getting there quickly. For the unaligned population we rank 90 percentile in five areas, showing opportunities for improvement with customer service, rating of healthcare, care coronation, rating of specialists and smoking advice. Next slide. CAHPS measures composite scores which are derived from specific questions. As Abby was explaining it looks back and asks for respondents to look back at the last six months of the services they have received. It will ask questions like how many times did you have an in person, phone or video visit with your doctor about your health? How often did your personal doctor explain things in a way that was easy to understand? How often do your personal doctor listen carefully to you, how often did your personal doctor show respect for you and what you had to say? How often did your personal doctor spend enough time with you? When we get into that level of granularity in survey responses it really helps a health plan to be able to hone in on specific strategies where we might be weak. Then also build upon areas that we can say our strengths or successes. So when we build our relationships with our provider base, our physician, we go out to our practices, provide education and tools to them. And we are blinded to any doctors like we don't receive the results for - - provider agency over here were specific Doctor X over here. We have to be blinded from those specific types of results. Overall, we are able to use focused responses, composite responses, in certain areas. To help no where we need to provide better tools or education for our providers so they in turn can provide better care, easier access, easier forms to people who are receiving their services. Our five-star estimated ratings were in the areas of the rating of health plan, rating of personal doctor, flu vaccination, and advice to quit smoking. Our four-star estimated ratings were in the areas of rating of healthcare, getting needed care, getting care quickly, rating of specialists and care coronation. On the right we show areas where we have improved. Care coordination, a tough one. It's not care coordination as we might have talked about in other sub meetings. From service court Nader's or - - care coordination. It is really coordination, doctors and specialists who might have to communicate with each other on the care of a person is receiving. So that they are aware of what each other are doing. And hopefully can coordinate better in all treatment plans. That one is a complex one to get improvement on. We are excited we were able to get a 4.1 percent improvement percentage point improvement from last time. Going to more details in the next slide as to what we are doing with these results. Improvement efforts are annual process for health plans and as my counterpart explained. It goes across many teams. It's very dynamic and how we all approach this. At UPMC we have recently launched a new member experience committee. We had one ongoing for several years but we needed to breathe fresh life into it. We used different insights, different marketing team, focused groups. With various members and just learning more about certain target populations. That will combine with survey results, help us with reviewing our current strategies. And the feedback we have received. Look at ideas we have in place or improving services and member experience. Brainstorm ideas that are new to improve access and care coordination across all different lines of business we have. We are promoting equity by using culturally competent messaging and support and prioritizing under survey neighborhoods with new outreach strategies. We developed a rapid response team and

are collaborating with various partners to secure vaccine appointments for healthcare plan members. And have newer housing employment strategies deployed as well to adjust social determinants of how that will also lead to better health outcomes. This past year we have engaged with participant advisory Council and - - committees regarding programs and quality initiatives. We would like to utilize the feedback we received to inform future strategies and feedback on things that are working well. Or need work. Then we regularly use survey responses in various meetings we have so we can make data-driven decisions. And look at some of those target results for specific questions or composites so that we can follow what we are doing well and build upon their strengths. We also have continuous enhancing ideas to engage with participants because we talk about participants regularly. We have phone calls and campaigns. But we know through the pandemic there has been changes in the way people want to engage with their health plan. And want to access information. We have to ensure our websites are updated regularly and as we get new questions, new concerns, new opportunities, Linda, different things we've had to pop up during the pandemic period. These are essential during the last few years in the pandemic. We heavily rely on provider partnerships to make appointment process is easy and quick as possible. Engage with those practices with education and tools on the different product lines like community health choices. Also try to figure out how we can help them improve their touch points with participants so they can build a trusting relationship with the people they serve. Next slide. Based on the CAHPS scores we received targeted feedback that we need to improve some of our outreach and communication. And so we adjusted some supports. As well as - - participants based on the answers to some questions. Implemented a text messaging outreach. Medicare members with straining gaps. Determined what should go in a wellness kit for 2022. Beginning the first week in October all CHC participants will receive a wellness kit. Hopefully they did. Kids will be mailed over a three-week period, there's about 50,000 kits. The image on the right is was included in these kits. Tied to specific health improvement strategies based on the health assessment data that we received from our members. We are also planning to align Medicare flex benefits with incentives on once it is easier to use as well. In response to the question that came up about how do we use service coordinate is when a participant expresses dissatisfaction with their doctor. Part of the service coordination monitoring calls to members to participants is to ask how services are going which includes services from doctors or specialists or the hospitals they've attended. If dissatisfaction is shared the service coordinator will assist them in a few different ways, it can help them understand the complaint process and how to file a complaint with health services. They can discuss how to select a new provider. And if it is a provider issue, specific position issue or specific provider issue we have a provider selecting web based resource to help provide additional choices of providers. Our service coordinators can assist in making put appointments and finding a new PCP if that is what they need is. If it is dissatisfaction with the plan we would talk to them and tried to educate them and provide resources during open wellness and explain the member concierge line is another place they can call and get things better explained to them if that would help. But we know this is a personal choice. We can help gather information. Let them know what their choices

and options are. Then we have to stay very neutral in the support we provide so we are not imposing bias or otherwise. If there are other issues with Medicare benefits help is provided through aligned clinical care management on that support care team. If there is unaligned issues brought up then we try to coordinate with that alternate - - which is much as we can with the service system. Who unfortunately does not have care management to see if we can help with any of those unaligned insurer issues. - - Also does - - visits, the first opportunity they can after a visit they can provide feedback or discuss a complaint or issue they have after a visit with a UPMC provider and of course member services is always available to help members filing complaints as well. And I'm going to hand not to them. Moving on to more on this slide, to improve getting care quickly our improvement efforts for preventative care have included the call center support increasing for either accessing results through their UPMC account, helping them navigate where to look for that. Also assisting more during that first call to the concierge scientists schedule appointments - - scans and encouraging them to do self scheduling for things like mammograms if they do use the UPMC app. Then we are continuing to expand call center services. Scheduling capabilities, so as much help a person can get is conducted with satisfaction. - - Management team and outreach to CHC nursing facility and - - participants post discharge to coordinating follow-up with instruction. Then we have efforts for unaligned participants where we are trying to actively work with the dual needs, dual special needs plan to coordinate care, regularly setting referral forms to them when we have a complex care case or feel we need to do outreach to a member due to - - discharge from other health systems. We implemented an auto tasking approach to get notifications out as soon as possible to all team members internally so they can do outreach quickly. To help with scheduling either medical transport follow-up appointments, medication reconciliation or other things that might be needed. You can see also holds quarterly meetings with descents to make sure lines of communication - - members is strong. Next slide. I will close briefly explaining we get positive participant experience, comments and letters and compliments get escalated to a manager director of our participants. We are excited to share these stories especially internally to give back to their service coordinators and care managers making a difference in people's lives. I know we are short on time so I won't read through each of these specifically. Due to the care coordination people are receiving we are helping members address their housing issues, look for signs in our conversations with them they are not managing their condition well so we can introduce ideas like in the first example. Getting a - - in education on blood sugar and diabetic, education meal prep ideas, identified through the conversation DCM was having helping to get an appointment with PCP and a follow-up with an endocrinologist. He talks to the PCM the next month like while this engagement - - went above and beyond in the little conversation they had. To introduce things that help them. We see that time and time again with people who need assistance from housing strategy team. Helping find addiction support. Getting people to a safe place where they can maintain sobriety and get support and services they need in their home so they can feel safe and maximize their health and safety. PMC, thank you for letting me share and I will turn it back to you.

>> Thank you for the presentation we are going to move to the next agenda item which is additional public comment. Paula, we will get to the - - in just a second. Any additional public comment from the audience or committee members? Sean?
>> I want to talk today about- - I'm coming here wearing two hats, one is a provider. And you as a consumer. - - Independence was recently audited. And we had - - where we were at had to pay that money to one of the MCO's. The reason we were asked to pay back money is because the consumer of services did not have a landline but a cell phone. The number we get for the consumer - - record comes from the CAO office. When we get it we don't know whether it's a cell phone or a landline. During the audit process we were told consumers cannot have, we have 177 consumers. Who have cell phones and a lot of attendance who don't have a cell phone adequate enough to have the app on it. Those attendance is the consumer's phone to clock in and out. How can as a provider how can anyone, any provider be accountable to pay back money because the consumer we serve cannot afford a landline? And how can we force an attendant was already at a - - income bracket to buy better cell phone plan so that they can afford to have the app on their phone so they can clock in and out? From the consumer perspective I think it's more accurate if the attendant is using a consumer cell phone. That means they are with the consumer when clocking in. And also icon for one, don't have a home phone. Nobody has a home phone anymore. In fact I talked with an MCO recently and one of the MCO staff who I was talking to admitted that he did not have a home phone. How many of us in this room actually have land lines? Even if you have a phone in your house, what if it is an Internet-based phone? That's not a landline. That's an Internet-based phone. I'm asking that OLTL request that all three MCO's - - enforcement of collecting revenue back from providers based on this issue. I'm also asking that we work together, consumers, providers and OLTL to solve the problem because how can we, we have to fix this before we start addressing the taking back of money. In addition, one - - to fix it and of the state would reimburse providers for giving direct care workers adequate cell phones. If we are not allowed to use the consumer phone and providers outweigh the cost of cell phones for the direct care workers that should be a reimbursable expense. By doing this you are basically taking the community out of community-based services. We have already seen reduction in service hours consumers received over the last year or so affecting their ability to engage in the community. I for one have my attendants meet me in public places frequently. I for one have my attendants clocking out at my place of employment. In the middle of the day. I can speak about my example because it's me and there's no confidentiality issue. There's hundreds of people with the same issue I have. Maybe they have their attendance meet them at a restaurant because they need help eating or going to the bathroom. If they go to the house, clock and, transit, not soaks up precious hours somebody with a disability has and maybe now they have fewer because their hours have been reduced. We need help to fix this problem. From a provider side and a consumer side. That's why I brought it here today. B
>> Thank you - - what's the issue with the landline? My 80-year-old mother has an landline that she cannot let go of. You are right, no one has one.
>> According to the individual scale that audited me, a cell phone is not a replacement. You cannot use the consumer's cell phone. If you don't, the worker do

not have a cell phone, adequate for clocking in and out. You either have to use a - - where the consumers landline. Two things, land lines, 477 and my folks don't have one. Why would we require a consumer with low income to pay to have a landline? And a cell phone when they are using transit and taking the phone with them everywhere for safety? Secondary issue is the - - according to everything I understand have to be adhered to. That requires me, Shauna - - not being able to meet my attendant anywhere in public and sucking up my attendant care hours in transit. When many of my folks, not me, I drive. But many of my folks use paratransit and can be on the bus for an hour or more. Why would they arrange their workers to meet them where they're going especially when they don't need assistance in the ride? That's an issue. We have to fix the problem because it's affecting consumers and dependents. And it's affecting provider payment which in turn for many of us is going to affect the quality of care that we can give to the consumer and the direct care worker that we are trying so desperately to keep.
>> Karen?
>> KAREN: - - This is a statewide issue, there's a lot of confusion about the ability or inability to use a client cell phone. Unavailability from other options. Even for those who understand a landline can be preferred if the caregiver doesn't have a cell phone that can accommodate. - - This conversation, at the OLTL level and some of the MCO's we've had fairly recent conversations about how we are hopeful stakeholders can come together to have more conversation about creative solutions here, certainly additional education and perhaps funding to support technology. I will add one more point, the clocking in and clocking out in the community when someone is getting services at their home. It is also an ongoing and increasing issue because even if you are doing everything else correctly the only way to do that now, you are not going to add every single location and secondary location. Results in manual - - at least value-based purchasing incentive. Time to meet a compliance threshold, there's a - - which are really supporting the intent of home and community-based services are actually going to be - - provider doing everything I can to meet the compliance threshold. Thank you.
>> Thank you Karen.
>> I guess my final comment is what can we do to fix this moving forward? I think we should send enforcement of collecting these fees until we figure something out. I also think because I anticipate the response from OLTL may be that this is a DMS issue, - - yes I think we should figure out how we are going to band together to say this isn't working. My gut tells me it's not a CMS issue, my gut tells me there are other states using cell phones because when this all started we were worried about the use of cell phones for - -. My gut tells me I'm going to do research to figure out which states allow cell phone usage but if this is a CMS issue then we need to go United with a request to resolve the issue. If it cannot be resolved that way, then we need to figure out how to get additional funding so that direct care workers can have reliable cell phone that they use to clock in and out.
>> Jamie do you want to comment on this?
>> JAMIE: - - Rates for OLTL a couple times and I think, I know there is - - stakeholder meetings because I'm not sure it's a OLTL specific answer. I'm not saying it's a CMS response but I think it is a DHS wide issue and we are not from

our home office. Working internally to make sure the other program offices that are impacted by - - including ODP and - - specifically. On these responses. I know CHC-MCO that were doing an audit. We probably need to have more conversation of what they are looking for. The only things I would say in terms of the EBV compliance, you have - - value-based purchasing incentive mostly. For compliance on EBV so I'm assuming additional payments to personal service providers and healthcare providers can maybe use EBV lines they're looking for. Additional revenue there, I don't know specifics other than that. [Lost audio]
>> Did everybody lose sound? Did everyone lose sound?
>> There we go. We just got notification - - our folks on the phone able to hear us?
>> Now, we couldn't before. It was in the middle of when Jamie was talking.
>> Okay thank you, sorry for that.
>> I guess my question is are you verifying - -
>> I don't know anything about that, I'm assuming it's a form they use for EBV compliance, I don't know.
>> They are probably - -
>> Okay. I don't know.
>> All right, thank you Jamie. We are at our scheduled time. We need to stop. Anything in the chat we will get out to folks.
>> We will follow-up.
>> We will do follow-up and report it at the next meeting. I appreciate anyone's participation. A lot of good dialogue. I will see everyone on December 7. Thank you.