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DATE: April 4, 2019

EVENT: Managed Long-Term Services and Supports Meeting

>> BARB POLZER: Good morning everyone we would like to get started in a few minutes.

Good morning, everyone. We're going to get started. I'm going to start with introductions -- um, Luba would you mind starting since --

>> SPEAKER: Sorry.

Luba Somitz, with the Bayat home health care.

>> SPEAKER: Estella Hyde.

>> SPEAKER: Hi Heshi Zinman, LGBT conserver advocate.

>> LYNN DELL: Linda Litto n advocate, participant.

>> JILL VOVAKES: Jill Vovakes Office of Long Term Living.

>> BARB POLZER: Barb poll sister, liberty community connections, would the committee members open the phone please identify themselves.

>> SPEAKER: Jim, consumer care.

>> SPEAKER: Jack.

>> SPEAKER: Talking over top of each other]

>> SPEAKER: He still la Hyde.

>> BARB POLZER: I heard Ralph trying to chime in.

>> SPEAKER: Jack Kane.

>> BARB POLZER: Hello Jack.

>> SPEAKER: Good morning.

>> SPEAKER: NinaDelGrande.

>> SPEAKER: Drew Nagele.

>> SPEAKER: Terry Brennan is here.

>> BARB POLZER: Good morning, thank you.

>> SPEAKER: Good morning,Neil Brady here.

>> BARB POLZER: Steve are you on the phone?

>> SPEAKER: Juanit Grey.

>> BARB POLZER: Good morning.

>> BARB POLZER: I'll start with the housekeeping points, committee rules please keep your language professional, direct your comments to the chairmaned wait until called upon and please limit your comments to two minutes.

All of our meeting minutes and meeting documents are posted on the Listserv at the underneath the MLTSS meeting minutes.

This meeting is being captioned and documented so please speak clearly and slowly. It is also being audio recorded.

Meeting scheduled until 1:00 and in order to comply with those

logistic call agreements we have to end promptly.

If you have any questions or comments that weren't heard please send them to the resource account at RA-PWCHC@pa.gov, the resource account is listed original the agenda we must keep the exit rows open, please don't block them.

Please turn off your cell phones and remember, upon leaving to please throw away any of your trash.

Public comments will be taken during the presentations instead of just being heard at the end of the meeting, however we always have the additional 15 minute comment period at the end for any additional comments.

All of our meeting minutes -- I'm sorry our meeting dates for 2019 are available on the DHS web site and now I'll turn to Linda for her debut on emergency evacuation procedures thank you Linda.

Linda.

>> SPEAKER: In the event of the emergency, we will proceed to the left of the Zion church on the corner of fourth and market. If you require assistance to evacuate you must go to the safe area, located right outside of the main doors of the honors Suite. OLTL staff will be in the safe area and stay with you until you are told you may go back into the honors Suite or to be evacuated.

Everyone must exit the building. Please take your belongings with

you. Do not operate cell phones. And do not use the elevators as they will be locked down.

We will use stairway one and stairway two to exit the building.

For stairway one, exit the doors through the main doors on the left side near the elevator turn right and go down halfway by the water fountain, stairwell one is on your left. For stairwell two, exit on the honors suite on the side doors on the right of the room or the back doors.

For those exiting from the side doors, turn left, and stairway two is directly in front of you.

For those exiting from the back doors make a left, make another left and stairway two is directly in front of you.

Keep to the inside of the stairwell, merge to the outside. Turn left and walk down Dewberry Alley to Chestnut Street, turn left to corner of Fourth Street, turn left on Blackberry street and cross Fourth Street to the train station. Thank you.

>> BARB POLZER: Thank you Linda, we'll turn it over to Jill, for the OLTL updates.

>> JILL VOVAKES: Good morning, everyone.

Kevin is out of town, so sorry to say, you've got me.

So our updates this time are going to be focused on the data requests that folks have been asking for, so we've gotten a lot of requests for

information.

And from all different sources. So what we're trying to do is keep a consistency across the different sub-MAACs, when it comes to presentation of data. So some of this, if you were attending the consumer sub you may have already seen some of this information.

If you don't see specifically what you have requested, um, we do have some data points that we're still working through.

And working with the MCOs to gather so there may be some additional information in July, it will be becoming available.

So today we're going to cover what we call the QMUM, we have a series of reports just level 7 everyone, their quality management utilization management reports. Or, operations reports. So when I say QMUM or Ops it's a category of reports that we've defined for our managed care organizations to report to us on a regular basis.

So QMUM7 captures denials. The Ops003 and 004 are capturing complaints and grievance information. Ops8 is our missed services that includes multiple categories of missed services. Op is s21 is the person centered service plan changes.

So we have loads of slides here and this is broken down multiple ways. So if it looks like we're running short on time, I'll probably run through some of these quicker than others. But you do have the slide deck available so if you want to ask additional questions about

the data, as you see it, please let me know.

Okay.

So let's start with QMUM7 denial log.

All right so this report, this report is monthly report that identifies denials of medical necessity, terminations reductions and changes for covered services.

So it provides updated home modification denials, provides denteddal denial rates and provides denial break outs by age, dual eligibles and non-duals and service types.

So as you can see on this slide, there's a pending so this is the information that we're still working on developing.

So we have -- we had a request for a number of home modification requests the length of time for those home mod requests to go from the request to approval, and completion. And also, looking for average length of time that home mods are in a pending status. So information is something that we are still working on developing.

Okay.

So for home and community based authorization denials, this graph it reflects the percent of the home and community based requests that were denied in the southwest.

And it includes denials due to the decisions by the MCOs at the end of temporary increases and voluntary reductions.

Okay.

All right. So this graph reflects the percent of the home and community based requests that were denied in the southwest. This one, the calculation is the number of denials issued for home and community based services in the month. And divided by the total of decisions made during that month you can see the break down for quarters 3 and four and for the month of January. This one is broken down by duals and non-duals.

Okay.

This one is -- reflects the home and community based request in southwest and it is number of denials issued for home and community based services in the month divided by the total of decisions May by the month this break down is 60 and over versus under 60. Specifically for the southwest and you can see your numbers for quarter 3, quarter 4 and then January all right.

The authorization denials -- so this is the home and community based denial rate for the southeast. And that includes denials that were due to decisions by MCOs the end of temporary increases and voluntary reductions. So the chart on the right shows the number of denials.

Okay.

All right.

This is dual versus non-dual for the southeast.

And again it is authorization denials and the calculation would be the number of denials issued divided by the total decisions made in the month. This is broken down by dual and non-dual.

Again, we have a broke down for 60 and over 60.

All right so this one is physical health prior authorization denials.

This chart reflects the physical health prior authorization requests that were denied in the southwest and the chart on the right shows the number, total number of denials. This is for all four quarters of 2018 and January.

Let's leave that one up little bit. There's a lot of information on there.

Okay.

This one is break down of third quarter and fourth quarter for January for the southwest. This is dual versus non-dual, physical health prior authorization denials.

Okay.

All right. So now, we're -- sure.

>> SPEAKER: I have a question.

>> JILL VOVAKES: Sure.

>> SPEAKER: I'm just -- this is Drew I was wondering for the people on the phone just give us a summary of the figures that you're

referring to obviously on the screen. You don't have to read them all, can you just summarize them?

>> JILL VOVAKES: I can try, Drew we have about 65 slides, um, but I can definitely try and give you a summary.

You don't have the PowerPoint?

>> SPEAKER: Is the PowerPoint available to us?

>> JILL VOVAKES: Do they have the PowerPoint.

>> SPEAKER: Not unless they're participating in the webinar.

>> JILL VOVAKES: In order to have access to the PowerPoint you would have to connect through the webinar.

So I can cite slide number and try to give you a summary.

Okay.

All right. So we are on slide 13.

>> SPEAKER: Question here if you don't mind.

Can you just identify how you're defining a denial? Sometimes you need a denial in order to get the service if you're a dual so -- I'm cleaned of losing perspective as far as you know how, what is the real denial and how are you defining in your slides?

>> JILL VOVAKES: For these, for these slides, this represents prior authorization denials. So it is a service that is coming in for prior authorization. It is prior to the service -- it has to be approved through a prior authorization process. That's what this represents.

A denial for prior authorization could be due to lack of necessary documentation or something like that. So there's multiple reasons and I -- I believe that we, I believe we also have a request for different denial reason codes.

So that's something that will be pending in the future reports.

>> SPEAKER: So this is Amy from the Pennsylvania health law project I understand that, when you're talking about the HCBS denials the first, does that include reductions in things like personal assistant services?

>> JILL VOVAKES: The slides that we're looking at right now are for prior authorization for physical health services.

>> SPEAKER: Right, previously you had stuff about HCBS is that correct?

>> JILL VOVAKES: Correct.

>> SPEAKER: Just going back I missed the chance.

>> JILL VOVAKES: Which slide do you want to go back to?

>> SPEAKER: Let me see.

It was I guess it was the HCBS authorization denials, that general category. You had different information. Different slides with different break downs. So I guess the questions are, does it include reductions in HCBS and when you were on the previous slides, comparing the number of requests versus the number of denials. Like the denials is a percentage of requests, did that include situations where someone

didn't request a change in service but the plan, assessed them and changed the services.

>> JILL VOVAKES: So these numbers include denials due to decisions by MCOs. So that would be based on a request or assessment.

The end of temporary increases and voluntary reductions.

>> SPEAKER: Okay.

It would include something where it was just, for example, assessment was done of someone and determine determination was made to reduce the personal assistant services even though there was no authorization period coming to an end it was just reassessed.

>> JILL VOVAKES: Yes,.

>> SPEAKER: Thank you.

>> JILL VOVAKES: Absolutely.

Okay.

So we're on slide 13, physical health prior authorization services.

This is a break down of 60 and over versus under 60 in the southwest.

For quarter 3, 2018, we're seeing a 50/50 percentage denial rate as well as for quarter 4, 49 percent, 51 percent and then in January we're seeing that 60 and over was a bit higher for those denial. So reminder this is a number of denials issued in the month, versus, divided by a

total decisions made during that month.

Okay.

So we're onto slide 14.

This is --

>> SPEAKER: Excuse me a question for you. It just seems it's very high for the over 60 population. Could you elaborate on that, please? >> JILL VOVAKES: I'm going to have to have the MCOs speak to why they would think that there would be a flux there it could have been more, services requested during that time.

I am not quite sure what that up tick would be for January.

We would have to go back and look at the data, specifically.

We can do that.

>> SPEAKER: I would appreciate that, we're talking about a population that is fairly vulnerable. They're NFCE and over the age of 60 those reasons are very important for us to take a look at.

>> JILL VOVAKES: Sure.

>> SPEAKER: Jill, actually, the concern are about the first two quarters, because proportion in the to the population is much moreover 60. So the under, 50 percent of the denials were for people under 60. So that is significantly, disproportionate to the population out there.

That would be the explanation we need to get.

>> JILL VOVAKES: All right. Well I think that we need to look at across the Board at this particular statistic and provided a bit more details so we can do that the next time.

>> SPEAKER: One thing I recall from the similar question, last month was that a significant portion were pharmacy denials and those are countedded as denials I believe it was explained by Kevin or someone or Jill, that they will, sometimes request a service or a formulary change or request a change in medication, the pharmacy has to call get the replacement medicine prescribed by the prescription, it still counts as a denial.

I think the data last month showed a pretty significant significance change in the health denials.

>> JILL VOVAKES: We'll talk it back and confirm for sure. Thank you Blair.

All right.

Slide 14. This is physical health prior authorization denials for the southeast.

We're looking at a very low number of denials so far.

Looks like we only have total number of denials on the slide is two.

Slide 15, physical health prior authorization denials broken down by dual and non-dual for the southeast.

We're showing 31 to 69 percent relationship.

And again broken down by 60 and over, and under 60 for the southeast.

41 to 59 percent.

I think it might be valuable to have the total number of denials on these slides for you.

All right. So now we're moving onto pharmacy prior authorization denials.

This is slide 17.

This is for the southwest and you'll see the things were pretty even across the MCOs for quarter one.

We had an up tick for PHW in quarter 2.

And up tick for AmeriHealth in quarter 3.

Quarter 4 things went down for AmeriHealth but remained approximately the same for the other two and then things looked to be pretty evened out for January. On the right-hand side of the slide you'll see the total number of prior authorization denials by MCO for each one of the quarters.

Here is an additional broke down for pharmacy denials broken down by null and non-dual.

You'll see a dual population has a much lower prior pharmacy prior authorization denial that's more than likely associated with the fact

that a lot of people have MED-D and this is for the

southwest.

Numbers are pretty even across all of the quarters including January.

Okay.

Again pharmacy prior authorization denials 60 and over and under 60 across the quarters again everything seems fairly level there across quarter one, two, three, four and January.

We are on slide 20.

This chart reflects pharmacy denials

for the southeast. You can see the prior authorization denials for the southeast across the plans, the total number of prior authorization denials are in the box on the right. And again, a lot of these prior authorization denials for pharmacy could be related to the fact it is a MED-D covered service.

We can get additional break down for you on reasons.

Okay.

So now we're moving onto slide 21. This is prior authorization

denials for pharmacy dual and non-dual for southeast.

Extremely low for duals.

I think we need to have the total number of denials on this slide.

Okay.

And again, 60 and over 60 for the southeast.

Now we're moving into dental. Dental prior authorization denial for the southwest.

Broken down by plan and we have one for the month of January.

And on slide 24, this is dual versus non-dual, southwest dental prior authorization denials.

Slide 25, dental prior authorization denials 60 and over and under 60, for the southwest.

For the month of January.

Slide 26, dental prior authorization denials for the southeast. You can see the break down in the chart on the right. And each one of the MCO totals in the box on the right.

Yes, ma'am?

>> SPEAKER: Yes, um, can you go -- can you request something from the dental and then denied, saying it is not a life and death situation the thing is when you have the problem and -- taste is -- it is sore you can't you can see that back.

You don't take -- you didn't -- you can't is you are vie.

>> JILL VOVAKES: I want to clarify your question, related to the dental prior authorization denials.

>> SPEAKER: Yes.

>> JILL VOVAKES: Okay.

>> SPEAKER: Because when they, when they send the letters, we're

denying you because of ABC, meaning, it is not basically a life or death situation, when you get your gums cleaned or whatever you need. It's then trying to -- take you have to eat. So you food start tasting sweet and sour, you don't want to eat because it tastes so bad. So I can -- isn't that to be considered a life or death situation?

>> JILL VOVAKES: Um, well for the prior authorization denials I mean, I think we would have to look at the cases and the reasons behind those which we can get for you next time, if you would like to look at that.

>> SPEAKER: Okay thank you.

>> JILL VOVAKES: Absolutely.

Okay.

So slide 27, denteddal prior authorization denials dual and non-dual for the southeast.

I think we can add the numbers to that.

As well as 60 and over 60 on slide 28.

Moving onto home modifications so these -- this slide 29 represents home modification authorization denials for the southwest. It looks like we had one in the month of January.

Slide 30 is home and vehicle modification and pest eradication authorization denials.

We will get you the total number on that.

Same for 31, this is a break down of the duals.

So we're onto slide 32, this provides a break down for any home modification authorization denials for the southeast. There were none.

Looks like there were no home and vehicle modification and pest eradication denials in the southeast for dual and non-dual.

>> SPEAKER: Can I ask a question?

>> JILL VOVAKES: Yes, ma'am.

>> SPEAKER: We're seeing there's no denials -- we are hearing there's no denials but what are the numbers of people that were actually requesting it, how do we know, there's nothing to compare to, we were asking the last time, with the home modifications stuff like that, there's nothing compare to. If we don't know what the SCs don't know what to do, they're frozen and not putting it in, that's still a denial.

>> JILL VOVAKES: So that was the list of our pending items we're still working through getting all of the collecting all of the data on that. You should have that in July. You'll see so it it's more meaningful for you at this point, we're collecting those authorization denials. But that is something that we're working on, is collecting the total number and then the average time between the request and the authorization and the project.

>> SPEAKER: Across the Board the home modifications, vehicle modifications -- all of that then.

>> SPEAKER: There were 82 that were requested.

>> BARB POLZER: In January.

>> SPEAKER: Yes.

>> JILL VOVAKES: Okay.

There's your total. 82 that were requested.

>> BARB POLZER: Just home mods.

>> SPEAKER: It's actually the whole category home mods, vehicle mods.

>> JILL VOVAKES: It's all in the same category.

>> SPEAKER: Yes.

>> JILL VOVAKES: Okay.

We'll have a better break down in July.

>> SPEAKER: How are you doing my name is -- I'm from Philadelphia, I've been denied, my medication, my high blood pressure pill and my I went to my doctors the other day and I -- they sent my prescription to the pharmacy I go to I called them to have it ready they said, one is is not covered I've been without it for a week or two weeks I guess you want me to get sick, wind up in the hospital and nursing home that's going to happen I have other people coming to me that is is in the house, they can't get out to go to the doctors, because they can't get their

equipment fixed.

They got to wait for approval.

I don't think that's fair.

For nobody. We got a lot of consumers complaining and none of them getting nothing, nothing getting done and you keep saying, you are doing it, we'll do this, we'll do that. We working on it, we'll -- I don't want to hear about all that I want to see what you're going to do today.

Because -- this is not fair.

I went to McGee to get my chair, I had to borrow this one, to get my chair so I can get where I got to go, they said, they were covering it, they're not with them.

Why do we have to go through this, we're consumers you all care about us?

Do you all really care about consumers or what are you all trying to do I don't understand I'm confused I come here all the time I'm still confused.

Now, it's happening to me and the people I live with, and my community.

This is not fair. A lot of people not getting their equipment, a lot of people not getting taken care of now you got these aids and -- coming to work free. They're not getting paid.

Then you have people to fix equipment, they are not sure they're

going to get paid or not because they have to do -- they don't want to see people hurt, I'm confused.

What are you going to do about that?

I want to know.

Numbers don't mean nothing I want to see what you'll do about our consumers I'm a consumer he is a consumer we have, this is why you are here because of the consumers I want to know what is going on.

>> JILL VOVAKES: So, specifically for your situation.

>> SPEAKER: I'm talking about everybody's situation not just mine, I'm talking about all the consumers not just mine I'm not coming here for me I'm coming for my consumers.

>> JILL VOVAKES: If we --

>> SPEAKER: I'm so upset because -- when it hits home, then you feel it.

I'm sick and tired of it, I'm tired, I'm not going to go for it no more I'm so tired of you all saying, what you all going to do, you all want to mess it up.

It was all right.

I never had no problem with my medicine, never had a problem with my chair, never had a problem with nothing you come over and take over and Philadelphia has big problems you say -- you don't do you know how many people are not approved in Philadelphia, not just two I don't know

where you get that number from. But -- okay.

You are right.

You are wrong too.

>> LINDA LITTON: I wanted to let you know that the FDA, did send a letter out that two of the high blood pressure medications were recalled --

>> SPEAKER: Mine was recalled but they gave me another one.

My doctor gave me another one, and --

>> LINDA LITTON: They denied.

>> SPEAKER: I could not get it, it was not covered.

That's what I don't don't understand you UPMC, all this -- it was okay.

>> JILL VOVAKES: We can have someone PHW, sitting behind you, work with you --

>> SPEAKER: I want to work with everybody not just me.

I want them to work with everybody not just me, don't fix me I want you to fix my people my consumers, that's what I want.

>> JILL VOVAKES: If you have specific information about the individuals that need assist -- send it out.

>> SPEAKER: You need an extension that's what we've been asking for since we got here. Every month.

Extension, extension, help our people. People can't speak for

themselves some people are scared to talk, some people are scared to come and talk I got to come up here and tell you all that.

That's not fair.

That is not fair, that our consumers some of them can't talk, some of them are really scared, some don't know what to do I got a guy, he -- he had a seizure wind up in the hospital because -- the insurance.

He can't get nowhere.

>> JILL VOVAKES: Well, um, I will see you after the meeting are you going to be here after the neating.

>> SPEAKER: I want you -- you are not understanding me I want you to help everyone not just me.

>> SPEAKER: This is Nancy from ADAPT if I can just say I don't think the slides are helping us because there's not a lot of good data.

So I know I'm having -- obviously Lou is is too, and until OLTL can give us real information of how many people, is just very confusing and just kind of upsetting.

>> JILL VOVAKES: Okay.

>> SPEAKER: It is Tanya, I have a suggestion that maybe it will give the gentleman and people in in his community help, let me just say I feel for you 100 percent and I'm going to see what I can do to help you get some of the stuff done.

Is there any way, that when we do participant advocacy phone calls

that this gentleman can forward the information about the consumers that are struggling to anyone at PHLP like, Levell or Amy or even Randy Nolen or Kevin Hancock so the specific cases and specific problems can be looked at and dealt with in a more timely fashion maybe?

And maybe there's a way someone can get back to the gentleman that was speaking in the room about the particular issues so they can get it solved faster?

>> JILL VOVAKES: Would you be willing to share that information with us I will give you my card afterwards.

>> SPEAKER: I'm like this, if I can bring, the whole consumers from Philadelphia in here, to fill this up they can complain I will feel better you have to change you have to thing that.

I've not talked to me and trying to reason with me. I have to change this now.

I have to change it it's not fair for nobody has to suffer and go in pain and maybe die because, they got to wait for their wages they have to wait for the insurance, to do this. No we didn't have this problem before. We never had this problem.

>> LINDA LITTON:

[inaudible]

>> SPEAKER: We never -- I'll be 48 years old, I will be 58 years old I never in my life -- through health insurance nothing had the

problems like we have today.

You all broke it up.

I really don't want -- you got it broken up you either extend it -- you extend it listen extend if you extend it right now I'm going to talk about it.

[talking over top of each other]

>> SPEAKER: It's wrong, that's what hurts me that's what makes me cry, it's not own me, I listen to this every day, people crying, suffering and -- can't get the equipment it is -- it's the most important thing I --

>> SPEAKER: If you have --

>> SPEAKER: It is the most important thing in our life we need our equipment, we need our medicine, we need our help.

You want us to decide then say it you want to put us in the grave go ahead. Right now, this is not fair. I'm not following for this no more, I've been listening to over and over we're doing this, we're working on this.

We've been asking for -- to extend it. Extend it. Extend it.

Extend it.

>> SPEAKER: My name is -- I'm from Philly Adapt you know someone died because they could not get what they need.

Waiting on you all.

The actions you take the machine they need you had all didn't pay for it they died. That's on you all.

In our family, it ain't on my mother and sister that's on you all.

It ain't a lie it is the truth it's in the news.

>> JILL VOVAKES: I'm sorry I'm not familiar.

>> SPEAKER: Sorry is is not going to get it. Which you don't understand, sorry ain't going to get you came here messed up the system that was already fixed.

You all broke it, for what?

For what? More money.

Is that what you're looking for, more money.

Money ain't going to fix the issue it's not.

People should not be waiting to get what they need from this state.

Pointblank period. He is waiting for his medicine and people waiting for medical equipment, wheelchairs crutches name it, they're waiting for it, you don't want to do the authorizations the way they have been doing it and messing it up.

>> JILL VOVAKES: Well, you can address specific.

>> SPEAKER: Always about address specific issues we're not addressing to nobody, we're addressing you you all, you're sitting at the table. No. No. We are at this table today we're addressing it

now, not with everybody else, with you all. Pointblank period. You all.

>> JILL VOVAKES: Later in the meeting.

>> SPEAKER: I don't want to late in the meeting I want to address it though.

>> JILL VOVAKES: Our MCOs have representation here you'll be able to address some of the issues, specifically, with each one of the managed care organizations.

We have that on our list today, to talk through some emergent issues if you have questions specifically for each one of the MCOs we would love if you bring those issues to us today.

I am running out of time so I just want to quickly get through the complaints and grievances.

>> SPEAKER: That's how I feel I'm running out of time too.

I am.

I'm running out of time.

MCOs are going to say the same thing they said the last month the following month the other month, the other month -- we don't want to hear that no more.

We want it fixed.

You know, if your car gets a flat you'll not get nowhere, fix it, right. Wire not getting anywhere, that's all we ask.

My team is asking that, how many times they come here before me, asking that.

Hits my home or my community, it hurts.

That really hurts.

You don't hurt, you're not in the wheelchair. You're not living with a disability.

You got to fall in this situation I wasn't born like this you have to fall in this situation and see how you -- you want to give up in life, how stressful you are, the anxiety and all, and then I'm all happy because I'm going get this medication and this and that, they tell me, my anxiety kicks in, my heart hurts and then, not because of me, I care about my community so much that I feed them I do everything for them when you all can't do nothing for them, I'm coming.

I might come -- I'm not going to come talk so for.

>> SPEAKER: Sir, listen to me it's Tanya I am in a wheelchair I have CP I'm consumer myself if you can please talk to the -- either the MCO representative which you might not be getting what you need from them, I understand --

>> SPEAKER: I do not want to talk to the MCOs.

My community, my people want to talk to them.

I don't want to talk to them I have been hearing them since I've been here. They ain't changed nothing.

>> SPEAKER: The gentleman's name I gave you, Mr. Wilson if you go to him, with --

>> SPEAKER: I'm sorry how are people who are scared to speak for themselves, how is that going to help.

>> SPEAKER: Can be brought up another meeting that specifically handles these issues, meet every Tuesday from for an hour, so we can get --

>> SPEAKER: That's why we come here to concerns the issues we have, we don't come here to baby-sit you and sit here and have a conversation have a party -- have a cook out. We came here to fix the situation we have. He said you said it, you're in a wheelchair I bet you got everything.

I bet you got everything.

But my people in Philadelphia is hurting.

So many people in Philly is hurting right now. And it's like I'm like -- why.

Why?

You can't help everybody right.

Because -- those numbers up there are not working.

You can put anything on this -- all you put on there. Don't really mean nothing to me tell me what you really do, my consumers, my community comes to me and say I got what I got.

I got what I want.

I am happy, I'm good. Then I'll be happy.

And the GPS stuff, you will put on my phone I don't want you to know where I'm at all the time, this is my business.

That's my business where I go, whatever I do.

Come on now.

Now you want to see where the consumer and the aid are at. Are you serious.

You all really trying to make things if you want to know fraud go to the house.

Phone call. You ain't got to put me -- on that -- whatever you call it.

You're crazy.

>> JILL VOVAKES: So in the essence of time I think we're going to move on everybody does and will have access to the slide deck.

We really like to bring the MCOs up now.

To address some of the emergentish you anothers we did get some specific requests to have the MCOs talk through the current emerging issues which are related to he emergency repair, home modifications, and personal assistant services monthly authorizations so this the be your opportunity to ask some specific questions of our managed care organizations, so -- at this time I would

like to ask those representatives from the MCOs to come up and -- we'll go through some of those issues with questions from the group.

>> JILL VOVAKES: Okay.

Fest question for the MCOs regarding emergency repair.

Any questions specifically related to emergency repair for the MCOs?

>> SPEAKER: Yeah so -- what's the process for emergency repairs from each of the MCOs.

>> SPEAKER: So the first thing that the service coordinator has to do is determine -- the durable medical equipment --

>> SPEAKER: Introduce.

>> SPEAKER: Al Rex Crawford from UPMC this is my first meeting at the sub-MAAC I'm happy to be here and -- you know to hear these questions, hear these concerns I do believe it is all of our goal, everyone's goal to make things better.

The first thing that the service coordinator has to do really is to determine should the DME repair be covered under Medicare, the participants managed care plan or through CHC.

The vast majority of durable medical equipment is covered under the primary Medicare or managed care plan. So if it is covered under Medicare, the service coordinator would assist the participant, in contacting the durable medical equipment provider to have the DME item repaired, if it's under a managed care plan, including UPMC's managed

care plan, the participant would contact the care manager, assist the participant in contacting the care manager with the managed care plan.

And then, if under UPMC the service coordinator would make the arrangements, with the durable medical equipment provider take the case, through our authorization review process and assist the participant in getting the item.

I know I heard a question about parts and I have heard in some cases it's a unique part it can take awhile for that part to come in.

>> BARB POLZER: Would it be more helpful if we present a scenario you could respond to?

So.

>> SPEAKER: That's all good and well what's the time frame?

>> BARB POLZER: This is what I want -- so here's a situation where a gentleman has a stair glide that needs batteries replaced.

Five months later, I'm sorry, five weeks later, with a Commode on the first floor for him to use during the day but his bathroom in and his bedroom is on the second floor he leans on attend want to go up and down the stairs for five weeks over a battery replacement, that costs 300-dollars.

So could you respond what would be the process there?

>> SPEAKER: I don't know why it would take that length of time.

Unless there was, some extenuating circumstance I would have to look

into the specific case because in that type of situation, I am not sure why it would take --

>> BARB POLZER: I'm not trying to put you on the spot, not trying to put anyone on the spot I'm just trying to throw out there the situations that are are occurring that should be addressed within a day or two and do you believe that? If so, what is your process to make it happen.

>> SPEAKER: So I am -- Dr. Orden the chief medical director for Pennsylvania Health & Wellness, about two weeks ago we met with some of the advocates in the State that have expressed concerns about this.

And, we are equally concerned.

So, we appreciate that, these things are being brought to our attention.

Our emergency response process for home adaptations is that one is needed we actually take the call through the call center. Anyone can call that in it doesn't have to be the service coordinator and -- we have an internal team, around home adaptation that fast tracks any requests like that and, the goal is to have that done within a couple of days.

So it is a new process. It is a separate process. And we recognize that this has not been where we want it to be or where our

participants want it to be, we are committed to having it right.

>> SPEAKER: Good morning this is Jens Rodgers of LTSS for community health communications with AmeriHealth Caritas. So really, I don't see the difference how it was done before as to how it is done today. So the situation you described Barb, scenario I think is a case by case basis. Service coordinators alerted there's a need for replacement battery we check the warranty. We check to see if it is a repair or' replacement if this has happened before, all that information flows through the service coordinator that authorization is submitted, to our LTSS reviewers for approval.

So I don't think, for us, that it is overcomplicated process.

>> BARB POLZER: Jen, do you have a time frame that you think that could be --

>> SPEAKER: So thank you for that.

I think that to differentiate between urgent and nonurgent so -- um, if something is urgent, we want to get that in front of us as quickly as possible and circle back to it later. So if there's more to it, let's fix the immediate issue and then do a comprehensive needs assessment to see, is this the right equipment? Does it continually break? Is there a different option, different solution.

But I -- we're required by our agreement, to to review and -- approve these types of requests timely within two days of being made

aware.

>> SPEAKER: Barb I think you were asking -- obviously a week or two weeks is not really acceptable, when it is urgent.

So we mark it as urgent and then we follow-up with it, so it is our our goal to have it looked at as quickly as possible. And replace it or fix it.

>> SPEAKER: I want to add to for our plan, we have service coordinators, at all the entities and our internal folks who are able to conduct comprehensive needs assessment, conduct visits, get this information, and enter it into our system, and, they also have our senior service coordinators if there's help on how to enter the authorizations or -- I need to escalate this because it is important, it is hindering someone's independence and hindering their opinion to get up and down out of bed that information flows to the top for us.

Everybody here knows that we have our senior service coordination team that, their sole job is to work to make sure, service coordinators, internal or external, know how to get these things approved.

>> JILL VOVAKES: Any other questions regarding emergency speak.

>> BARB POLZER: UPMC I don't know if you want to speak towards that scenario.

>> SPEAKER: Certainly this is David Gingrich, community

HealthChoices UPMC we have on call process so for emergent issues if something is brought up at any time or you know after hours we do have coordinators who can help us if it's not the coordinator specifically with the plan. And they you know, can help on evenings and weekends we do work on turning those around within you know short period of time with the next day or, within a few days so it should never take that long.

>> SPEAKER: This is Liam Doughetey from Philly ADAPT I want to echo what Barb and what Lou was saying before, we have all heard of people that, you know, can't use the bathroom for a month because they're waiting on authorization.

I know that a consumer had to wait a week to miss a therapy appointment because his lift was broken he could not get out of the house for a week and then his provider ended up fixing the lift any way, even though they weren't paid because it did seem like a matter of life and death, this is not uncommon I think, the process, has to get better, I -- I don't understand what was said before this authorization process seems completely different, so correct me if I'm wrong, this is a whole new element to the process that was not needed before.

I think it's absurd that we have consumers risking their livers, some are dying because they're waiting on very simple things, like batteries and they could be fixed very easily.

I also want maybe the urgency element to be addressed a little further.

Because I think that is a really critical thing that consumers need to know about.

I -- but I mean, I think speaking as a consumer, someone in the community, everything is urgent.

I understand the need for prioritization but you know, in order to lead my life, you know, it is like everyone else I need certain things in place that should be guaranteed to me as civil rights.

>> SPEAKER: My name is Karen from if I wily ADAPT this is for keystone Mercy health.

I have two scenarios.

Just can happen anyone, specifically -- it specifically happened to me.

This is a new cherry got this chair October 1st a couple months ago.

I know all the rules and stuff of how to go about getting it I've been through it for years.

I got the approval back they said well we're approving the chair but we're not approving the reclined part of your chair because of they said the power lift power lift should do what that does.

That doesn't make any sense to me because the chair, I mean I was --

the previous chair chair, I was in had

a tilt and recline. This had the same thing and number two, I did go through all of the requirements of the repair process and all that, they still denied it.

So, and because I knew, because -- and things have gotten bad, real bad for me and the previous one the seat belt -- I was going around without a seat belt number one. Number two, eventually, the reclined part of the chair actually broke.

So I'm in the chair, I'm leaning back just collapsed on me.

So and at that point, it was already denied one time.

So I said well you know what, forget it. Because if I go through the repairs, going through all of that, I would not have gotten this chair until they denied that and approved or not approved it.

I said well you know, the hell with it. Just give me the chair. Because I am on the bus going places, having to be scared to death for going down that ramp, without a seat belt on.

You know what? Forget it.

I am getting tired of it, give me the chair as is.

That's number one.

Number.

>> SPEAKER: May I respond to number one.

>> SPEAKER: Okay.

>> SPEAKER: Okay.

Let's fix that.

Right.

So, so I think that we need to, that is something that we need to address for you specifically, we're talking about your needs.

There's the chair approval and then there's also part of your LTSS benefit, the durable medical equipment if there are adaptations needed to be maded to your chair your service coordinator facilitates that meeting we authorization those things.

I'm sorry that you've become exhausted by the process. So we need to do better we can.

>> SPEAKER: Okay and number 2, I'm like, the chair is perfectly brand new I did have an accident, they did fix it, they did fix the particular accident part of it, what happened was -- but, since I gotten it, as of the day before yesterday, I got new batteries.

The thing is I mean, I mean, I have tried the chair the chair every night until I go to bed in the morning, until I get up I charge it for the next day.

Wherever I go places, the battery, the -- it didn't even last two hours so I'm having to carry my charger everywhere with me I live up 3 hills.

So I get off the bus I have to go up 3 hills to get to my house.

My chair, this one has a kind of brake, when you get to a certain point it totally stops.

>> SPEAKER: Okay.

>> SPEAKER: So it -- if the chair is supposedly brand new, why are you getting used batteries in the chair.

Two days ago, I'm dealing with a battery that is not even -- so I mean, not even good. So I mean -- I did tell them check out, check batteries.

They forgot.

But I did I did call I said I need a new battedry, my chair is going dead.

Keeps going dead every five minutes and I've had to carry my charger with me. Which I shouldn't have to.

I should be able to go places without carrying my battery around, just charging it when I get home.

>> SPEAKER: I 100 percent agree with you I think that the opportunity here is we want to see service coordinators working with the people who are experts on their experts and their needs.

To proactively manage this, to proactively care plan these types of situations so that we don't have situations where you need to carry your batteries we might have a battery or a replacement battery, let me just finish just getting to the root of the problem we want to -- that's

proactive service coordination planning for these what if scenarios so this can be something had
your person centered plan to get the equipment you need, maintain the independence, 3 hills that will wear on your battery let's talk about it,
make sure we get you the right equipment you need it starts with your service coordinator starts with that conversation.
>> SPEAKER: I mean -- when you give -- when you give anyone a brand new chair everything should be new, not just --
>> SPEAKER: I agree with you.
>> LINDA LITTON: So the MCOs, refurbished batteries are not an option. I've gone through this personally myself.
Refurbished batteries are not an option.
I was told that my batteries were running out every six months, and they said well that's how long a battery should last. No.
When I got a new chair that I paid for by myself, the battery lasted 2 years so why am I getting batteries that only last six months?
They should be brand new batteries.
>> SPEAKER: Right. Right. Thank you.
>> SPEAKER: Just wanted to address being proactive.
That can't happen with you know, with emergency repairs that I think when you think about repairing a lift or something, there's nothing that

is intrinsic and everything that things break down I don't think that we can point fingers at the service coordinator level. The problem is the time line on authorizations.

>> SPEAKER: So we talked about that previously.

I see a difference between a regular repair, we at our plan, see a difference between regular repairs and emergency repairs, absolutely.

Also part of our service plan, there's a section for equipment assistive tech everything, that's listed. Who is your warranty through, who is the contractor that installed your equipment, what equipment do you use?

Trying to steer us in the direction of being proactive. If this then, this is my first call, right.

But it is a case by case basis.

I hear you and I agree with you that if this is an emergency it needs to be dealt with in an emergency manner. We've trained to it, we can retrain to it, but it does start with the service coordinator, meeting you with you you or participants to let us know what happened and then take through the process to get it fixed.

>> SPEAKER: I also wanted to say from Pennsylvania health wellness's perspective you mentioned this time consuming authorization process, so for an emergency repair the only reason the authorization

needs to happen is to allow payments to the vendor.

That comes out and firms it. So we would not delay the repair waiting for "Authorization" that's not relevant to the issue at hand eventually the authorization will get done.

But that's no longer part of the emergency repair process for us.

>> SPEAKER: But would that require approval to do a service without being paid?

>> SPEAKER: No.

What we would tell the provider is that the service is approved and we would continue to process the authorization even if that happened after the provider came out and completed the repair.

The authorization process itself is, is not that -- is not long.

If we -- we separate authorization versus determination, so an authorization just means, um, that -- is a permitted and will be paid for service.

Determination as whether or not it's appropriate and in the case of an emergency repair there's no determination it is always appropriate.

>> SPEAKER: Quick question, um, if we can take a step back and define emergency that may be helpful.

We're using that term a lot but, I don't know if there's -- is there a concrete definition of emergency within each -- everybody's handbook or is it a judgment call, by the service coordinator how is that

decided?

>> SPEAKER: I will say for PHW, we rely on the expertise of the coordinator or the concern level of the participant we don't have a defined definition if you believe it's an emergency, you know we'll take it as such.

Just like I would being as a physician I don't tell a patient whether or not they're having an emergency or not if that's what they think it is, I treat it as such.

>> SPEAKER: Could we use Barb's example of the chair, would that be an emergency? Battery for the chair?

>> SPEAKER: Yes.

>> SPEAKER: Yes.

>> SPEAKER: Yeah.

>> SPEAKER: So I don't know the specifics of that, of this example however, the service coordinator working with the participant to identify it as an emergency repair and in this case the stair glide would probably involve a home modification we've got a home modification team, the home mod itch indication team would be notified that it's an escalated issue, we turn these around quickly.

>> BARB POLZER: Pam, come to the mic please.

>> SPEAKER: Yes, ma'am.

[laughter? .

>> BARB POLZER: She and I have this thing going on about the mic.

[laughter]

>> SPEAKER: Um, I don't know if you were going to ask this, I have two questions. But the one question that a lot of us have on our mind is between emergency and nonemergency, is there a definition, do you have this stuff listed where consumers can know, most of our consumers we love our service coordinators we can't rely on them all the time we need to have this information for ourselves and I -- I am glad you have such faith in your service coordinators to make those kinds of decisions but you need a definition.

And but -- where is it that the consumers are going to be able to do it, is it in the consumer handbook what happens if your stuff breaks as well as all of these guys itch a consumer who has been in bed for 3 weeks I just found out about it after the fact because his hoyer lift, basic as a lift is not working he could not get authorization, could not get the vendor to do anything.

There's was no prior authorization or any authorization so he waited 3 weeks you know, that's endangering his health and his life and when we're talking about wounds and things that can happy don't want to see you're telling us this and not be listed somewhere that consumers can access so if you have that already out there --

>> SPEAKER: Yeah I just wanted to clarify I I am sorry I misstated

earlier I would say the majority of the requests that come in for

emergency repairs are not from the coordinators themselves. They can

be from participants or whoever calls our team.

And so often times it is skipping the coordinator it does not rely

on his or her expertise I would rely on the participant him or herself

to make that determination. So I will say currently we don't have the

definition we lean on the individual to determine that for him or

herself.

>> SPEAKER: Generally, if it impacts any form of health or safety

it is considered emergen emergency for us. We have a telephone line that can be called the

service coordinator is contacted and then the service coordinator

would escalate this, we also have an

internal excalation process where they can escalate to a supervisor so

it can get turned around to the right hands quickly.

>> SPEAKER: Same, with AmeriHealth keystone there's 24/7 line so

irthat not dependent upon waiting for service coordinator to be

available, during their Monday to Friday or Saturday whichever hours and

then those contact centers staff and personal connections I'm

sure they know how to make the response they can reach out to the

senior service coordinator or one of the executive lead teams but they

don't have to wait for an authorization the same as PA health and wellness

they can take action I'm not sure about, I mean, I think it's hard to put in writing what is emergency.

We encourage them the number is on the back of their card, they can call the contact center is available 24/7 and again if a participants views it as urgent we treat it that way.

>> SPEAKER: My name is Mar Edwards I'm a volunteer with the Center of Independent Living and I'm also.

[mark]

I'm the chairman of our wheels in motion advocacy group.

I would like to know, I think, my question was already answered so I'll ask another one.

[laughter]

Awhile ago I needed a battery for my wheelchair it was dying and this is, this is my first wheelchair so I am still learning.

I'm learning with the ins and outs of my power chair.

I was told at the time that my repair vendor was backed up 3 weeks and they told me to -- I had to wait 3 weeks for a battery in this case, if you're told that what should you do?

>> SPEAKER: So my recommendation in that situation is this is PA health and wellness there's a couple of ways we could go about that on our -- the exceptional DME team one would be to talk to the vendor that supplied the chair. If that's known and ask them to facilitate a

loaner for you.

And then if that is possible. And then, if it is not possible, we would look at any other options that we could find to have you still access what you need to access given that your chair is not functioning the way that it should.

>> SPEAKER: Because again I was going through a transition in my life and I needed it. And because of that transition, I moved and it took me four months to get the battery.

And that should not happen.

I guess, what I'm going to ask my question any way, even though it may have been asked, answered rather.

What is considered again an emergency and nonemergency. And in regards to durable medical equipment and again, who makes that decision thank you very much.

>> SPEAKER: For Pennsylvania Health & Wellness that's the participant or if the participant has not made that decision it's the coordinator. So either one can determine that based on their assessment of the situation.

>> SPEAKER: Anything that impacts health and safety is considered an emergency this is Alex Crowford, at UTPMC, four months sounds like ash incredible amount of time, service coordinator should be working with the utilization management department, either within their

own organization -- to get that expedited or assisting the participant in contacting their primary Medicare plan or their other managed care plan if that's the case to get it covered. covereed through the medical plan.

>> SPEAKER: We would say the same the other thing I would remind you from AmeriHealth keystone you can always call if you feel that you want to speak to someone else you can ask to speak with a senior service coordinator or manager. But also please take advantage of your right to file a complaint or grievance.

I mean that's something that we, we have to by contract act on. It is all of your rights so if you do have something it is taking that long which is an unacceptable amount of time unless there's an scene waiting circumstance, then you can always call the number 24/7 and tell them that you want to lodge a complaint or a grievance and there's an entire process team that will follow-up with you and work through that.

>> SPEAKER: Thank you.

>> SPEAKER: Your welcome. Speak.

>> LINDA LITTON: I have two issues to bring up, sometimes with a new chair, battery problems can be as simple as a cell that is not good, just pass that information along.

And I for get what the second point was, okay.

>> SPEAKER: Theo.

>> SPEAKER: Yeah, I'm sitting here and listening I'm hearing some

things that I do believe the MCOs have good intentions I do.

I think there's a disconnect with what you're all saying and what

people with disabilities actually go through through when they are seeking out repairs.

I think we have to figure that out.

You know as as a person with a disability I've been through this

thing so many times even with my private insurance I can't even imagine

what it goes on with people who rely on Medicaid and Medicare.

But when I go to my DEM provider, it's like your home repair person, you get one that works you want to keep

it a secret you don't want them to get over burdened with doing other

stuff.

And I guarantee you this is reality, it ain't something you make up.

There's not enough DME providers out there.

I am wondering whether the MCOs know that.

Because when you get one that works you really want to keep it a

secret.

Because there's not available, to do what you call emergency repairs

and the reality is that disconnect is that as a person with a disability

you rely on durable medical equipment which goes in various degrees

people with disabilities, are stuck you know, and all kinds of stuff

can happen even with controllers and tires and wiring being loose and

that don't seem like an emergency but you're stuck when a piece of wire

is stuck and your wheelchair doesn't work and allots of the DMEs don't even make home visits. You have to figure out how to get there.

Then that becomes a whole other problem with transportation and all of that stuff.

It's a disconnect.

I know MCOs have good intentions I really do.

I believe you want to do it right. But there's a difference between what you're talking about that is working and what an actual person with disability is going through. And trust me people are going without.

When they're going without and they're trying to talk to someone that doesn't get it, it becomes a major problem. And as much confidence you have in your SCs they can't do everything.

>> SPEAKER: My name is Brandon, from Philly ADAPT I don't understand people use wheelchairs they still need to get them around I get tons of phone calls from my friends, Randy my chair is broke.

You know how to fix it? I know how to fix it, what's going on the insurance said I have to wait 2-3 months for a set of tires I'll put temporary tires on it, let's call the people to find out what is going on, okay.

We did not get the authorization yet for this and for that.

Or, the prescription never came over.

And the person is stuck in the house. Just when they get a brand new wheelchair, I just got my chair my batteries are dead.

Well let's call up the people. Find out what is going onments you got to send a prescription over.

They're waiting two weeks I said give it two weeks two weeks come, nothing.

I called back for them. Such and such is waiting for their batteries

oh we never got it.

Or you all got it, you never called the person to tell them you got the prescription.

To even change batteries.

A controller a thousand dollar controller -- come on.

I don't understand, these wheelchairs this medical equipment is for people who need to get around.

And they need it, it's part of their life it should not be sitting there and saying okay I sent the prescription over getting a call back and say oh, no we never got it, they got the prove and the fax they faxed it to you all you never got it on your end.

I got a friend now, who is sent in what they need to get their chair fixed that was 3 months ago.

3 months ago.

He is still waiting to get his chair fixed.

He can't go nowhere.

Dead batteries, worn out tires, joy stick broke I've done everything in my power to help this man, to get this man's chair up and running.

Nothing.

He says well Brandon, what am I to do? I said man I exhausted all my possibilities to get your chair running now we got to wait for them.

Wait 3 months in, this man is sitting in his house, no chair running.

But you all put in the paperwork when they call and ask for a loaner we don't do loaners.

Calling to see if they give you a loaner we don't give them out, stuck again.

Simple as a set of batteries to be changed, simple as a joy stick, simple screw, to fix the chair they got to wait for.

Wait 3 months, versus waiting a couple of days.

Then, when they finally get the person to come out, well we got to order parts your part is in back order.

That's another 3 months. months of the person not doing what they want to do and need to do, when it comes to the chair.

Even when they go get fitted for the chair you have these people

losing paperwork after they do that fitting.

They do the fitting for the chair, I have consumers tell me I just got my fitting I go to get my second one, oh they lost the paperwork they have to go all the way back to the doctor start all over again.

That's about another four months.

How are you all going to fix that.

These people should not be waiting this long to get their chair fixed for a simple as batteries a controller, I got one of my friends dead in the water outside -- completely shut off.

Tried to switch underneath the chair, everything.

Chair never turned over.

And then when you all give these consumers their chairs there's already something wrong with them.

Right off the line I just got my chair yesterday I'm getting a fault code.

I don't know what the fault code is.

Knowing of my knowledge of the chairs is I'll tell you what the fault is, it's a communication error mind you I near went to school for this, I know what it is. Here's what you need, you all hire these people to fix these chairs, guess what?

Some of them rely on me to fix the chair.

They get paid for it.

But I don't. How are you going to fix that.

>> SPEAKER: PHW I would say two things first of all thank you for sharing that concern. The -- the first thing I would say is, if there is a prolonged delay to providing an item like that, and the DME provider would not, does not have the loaner available, we would generally attempt to get a rental, to bridge the time. That will be the first thing.

And then the second thing is, we do have within PHW orach I had response team, which is a team across the company that touches almost every department, that for situations like this, whether it is at the DME provider level or some other level, that things are not happening, we have a team that gets together on a regular basis and tries to trouble shoot escalated issues like this.

Yes go ahead.

>> SPEAKER: So Brandon the other piece what I'm hearing you say is that it some of it has to do with the quality assurance on the part of the DME provider we're the payor. So we'll pay for it.

But if you're not getting things turned around quickly, and it is just wait, wait,est wait it's on order that's a quality assurance issue we want to know what provider you're waiting. And then we want to follow-up because they're under contract with us to turn things around quickly.

>> SPEAKER: But they -- they are stated in the contract -- but even if they call after 2 and 3 weeks they keep hearing the same thing, I have had consumers coming to me crying.

>> SPEAKER: Encourage to call the health plan saying they're not getting what they need from the DME provider we'll follow-up on that. Because they're under contract to provide that service to you.

>> SPEAKER: So I brought up an issue with my wheelchair the last meeting I'm not going to to go through the whole thing again but -- one of the major issues was authorization issue, from the MCO what happened was before January 1st, specifically, on December 3rd my chair was taken in for repairs and it had been approved I'm a dual beneficiary it had been approved through Medicare and Medicaid. And what happened was right before it was scheduled to be delivered and literally the day before they told me that they now had to wait on authorization from the MCO.

So they told me it should take a day or two.

It took approximately 2 and a half more weeks for the MCO to send authorization over and mind you this was already approved through Medicare and it already been approved through the prior Medicaid system.

And then, what happens is I think the tie in is that these authorizations lag, is that the return or repairs can't happen because then it takes the provider at least two weeks to be able to schedule

delivery. So I hear what you guys are saying.

I would really like some more information especially if there are teams like that assigned to handle issues like that. Because I really, when I called my MCO, I was just told that they would look into it.

And then, two and a half weeks later for a chair that had already been out since December 3rd so never mind it was supposed to be delivered back to me on January 11th. It takes until close the end of January for me to even have it scheduled to be returned I didn't receive my chair back until the first week back in February. So I work during the day and as many of the other individuals here rely heavily on my chair to do everything. So if there is a team or a process for this because they didn't offer me a loaner and they normally do not I'm not sure if the MCOs are aware of this, but that's not normally something that is offered and normally, we are told that's not something they have on hand. If there is a process for each MCO, that you know we need to make specific teams aware of it, because other than calling the participant hot line we didn't know what to do I was just told that they would look into it. So I had to wait.

And that's part of what I think Brandon is trying to say.

Thank you.

>> SPEAKER: Only a --

[inaudible]

>> BARB POLZER: Can we --

>> SPEAKER: Can we get some clarification for each of the MCOs as to, you know the gentleman from PA health and wellness was talking about a team that is designated to handle that, could we just get some information on the record.

>> SPEAKER: Sure, so if that situation, for PHW.

Ant we would ask you call the 800 number and ask for your issue to be looked at by the rapid response team that's what we call the team.

>> SPEAKER: Okay.

Thank you and to the other MCOs do you have any input for people that are with the different plans.

>> SPEAKER: This is Alex from UPMC and thank you everyone for your comments.

The service coordinator is the primary contact to assist and I realize every case is different but when things have gotten stuck in the process, we work very closely with our network teams our network providers to get the equipment that is needed. Or to get the rental equipment if it is needed.

So, we do you know, we do realize that sometimes things can get stuck in the process. And to your point, sir, we definitely value our DME providers and recognize the ones that get continually perform

services.

>> SPEAKER: I'm sorry, maybe I -- maybe I'm just not clear or maybe it's just the process different process for UPMC. But usually my chair just goes through both insurances so my as much as coordinator because it's not actually going through the waiver, really I mean I can fill her in on it she is not really the start person, usually just you know I get the proper documentation from my doctor it goes through the insurances. And that's really what happened it was a hold up from the, MCO as the secondary. So my coordinator really wasn't involved so I'm sorry are you saying that, for UPMC that we should always be contacting the coordinator?

>> SPEAKER: The service coordinator even if you have a different primary medical plan, a different MCO, the service coordinator is available to assist the participant in this process.

Including contacting the care managers of the other plans.

>> SPEAKER: Okay.

Thank you for your information.

>> SPEAKER: And we, AmeriHealth Caritas, keystone similar process, instead of rapid response we call them personal care connectors so whether you have a service coordinator or not, when you call into that 800 line when you say it's an urgent situation, they will connect you to our personal care connector team. But also one of the things I know

this is all very frustrating I want to thank you for kind of sharing your thoughts on that, because you know one of the things we're always doing is trying to even help our personal care connectors, our contact center staff, to kind of be at tuned to when they're listening and when they're talking to kind of listening to the tone that you might have you've mention it had a couple of times, I wrote it down, someone keeps saying we'll look into it I understand how that could seem very open-ended. So one of the things we'll go back and talk to our staff about maybe using a different terminology and making sure that we commit that we will call you back set up a follow-up time, that way it doesn't sound like we just said, or someone said we'll look into it and then you wonder if we're ever going to call you back.

>> SPEAKER: Exactly.

>> SPEAKER: Can I ask a follow-up question, how do we know about the rapid response team and your personal care connectors how is that communicated.

>> SPEAKER: It's in the participant handbook, we do talk about it at orientation it is on our webinar. Our sorry. Our web site.

And the personal -- if you do have a as much as coordinator, the service coordinator should be kind of informing you of that as we go through the checklist of going through the participant handbook with you . But when you call that 800 number on the book, there's no wrong door

so it doesn't matter if you know the right terminology, if you're saying this is what I need, then internally the team should know where to direct your call in order to help you.

>> SPEAKER: So the consumer doesn't have to say I need this to escalate? That's what you're saying.

>> SPEAKER: No if you're saying it's urgent. Obviously it's very helpful when you call in to say, this is an emergency.

Or this is urgent.

But either way they're going to address the topic or the issue, but I meant you don't have to be able to know to say I need to talk to a personal care connector.

>> SPEAKER: Thank you.

>> SPEAKER: You're welcome.

>> LINDA LITTON: I'm sorry.

>> BARB POLZER: Go ahead.

>> LINDA LITTON: All 3 MCOs sit here today I hope you realize that for the consumers our wheels are our legs and everything is emergent, batteries, Hoyer lifts everything for someone in our situation.

Everything is emergent I hope you take that away, with you and get something done about it.

Thank you.

>> BARB POLZER: Let's move onto home modifications. And see if there's any issues we need to bring to the MCOs attention for home mods.

Nancy?

>> SPEAKER: So how long are people waiting to get home mods because we're hearing from people that they're not denied they're just waiting for something.

>> SPEAKER: I think each situation may vary I know we had a discussion at OLTL, we know there's some delay we have run into challenges of having enough PTOT therapist toss do evaluations for us, any modification does require an evaluation.

So we did get clarification from OLTL and they did indicate that every modification regardless of size or type does require evaluation. So we are aware that may cause some delays of having that PTOP therapist to go out.

Each situation may vary our commitment is to get the home modification to get it finished as soon as possible.

>> BARB POLZER: Pam come to the mic please.

[laughter]

>> SPEAKER: This is for OLTL why did we take a step backwards then to make it harder to get the home modifications by requiring the OTPT,

when there were people in the state who were doing the evaluations on homes and doing a great job and saving the State money who are not OTPT, why when did that change that you have to have the OTPT evaluation and then, why would we do that?

>> SPEAKER: Actually I'm not aware that was a change.

Anyone can speak to that?

>> SPEAKER: What I don't understand why do you believe OTPT can actually do it? It blows my mind.

[laughter]

>> SPEAKER: Over the years, we have had although it's not consistently across the State we have had entities who have built up a model of service where there is someone at the agency who has specialized in really working with the participant in doing an assessment for the participant of the actual area of the actual adaptation being requested. And unfortunately over the years we've not been able to necessarily have that assigned specifically. It is not a separate OT or PT entity that is doing that.

And I am going to have to take this back and work with our folks in policy I don't know is Jen or someone else from policy here?

>> SPEAKER: We're looking it upright now.

>> SPEAKER: So -- so we're going to have to look at that.

>> SPEAKER: It has been problematic over -TS years because like I said, it has not been a consistent entity that exists across the State. And we, do think it is important for there to be an evaluation so we know exactly what the person needs and that whatever adaptation is occurring is actually going to meet the person's needs. So that is important.

>> SPEAKER: One last comment.

And this is a challenge for the MCOs to think about this because you're taking a step back. Moving back to the medical model that we fought so hard to eliminate and stop and understand is you know, one of the -- one of the major barriers we have fought for, for so long is to stop people coming in and you know, based upon medical model telling people with disabilities who know actually best, in regard to those things that work in their life we created a model where people would with life and experience and in regard to people with disabilities who have that knowledge and address those concerns and issues with people with disabilities are actually living independently in the community. And I just don't see how OT or OP who were taught the medical model ever deliver that I hope you hear me this is a step back.

I know you believe it is not.

But it is a step back.

>> SPEAKER: I think, Theo the otPT can have a role depending upon

the kind of, what is being requested, but I do agree with you, that we have possibly should look at if there are other kinds of assessments that can be looked at, in order to meet those needs.

I agree.

>> SPEAKER: I have a comment my name is Jeanneta green I represent the center for independent of living for Central Pennsylvania and we dealt with this issue, several years ago, with OLTL because we do provide home modifications and we did have an issue with I think it was the definition to provide that service, that had to be done by OT or PT I thought the language was expanded to include other professionals with experience.

And the reason I say that is we have been doing home modifications for over ten years and a lot of what we do is we go in and we fix what PT's said could or could not be done because their expertise is so different . It is not in construction.

So, they don't know if a wall can come down if it's load bearing it's very important that you know we include all of the professionals where needed.

>> SPEAKER: I know there have been some conversations about that and the other kind of professional language these guys will check what is in the waiver definition I know that there was some significant discussion at one point about the professionals that could

be used for that assessment discussion. So sorry to leave that kind of vague for you all. Theo is correct there's been a kind of a amalgamation of propositionals used in the past.

>> SPEAKER: We still got that flat --

>> SPEAKER: That's wonderful we can just talk about that and then just -- be able to I think just look collectively as to how we would be able to bill for that, that type of individual that might be deemed but is not --

>> SPEAKER: This is Patty Clark I'm with Office of Long Term Living in the policy bureau and, one of the roles I have is is helping to write some of the service definitions and I'm looking at the current service definition for home adaptations in the community HealthChoices waiver and as far as the independent assessment it is required and the language is, it says depending upon the type of adaptation and accordance with the scope of practice and expertise the individual evaluation may be conducted by an occupational therapist, speech therapist, hearing and language therapist or physical therapist.

While meeting the required standards.

So I know that we have had discussions about this, in the past.

The way the current service definition is written it doesn't allow for other type of individual to complete the assessment but it is definitely something we could, we could look into, I know there's been discussion

in the past.

I do remember a number of years ago I think the reason for adding the requirement is as Ginny was discussing a little bit was we did have some conflicts of interest where there might have been companies that were organizations not only completing the adaptation but also making the recommendations for what was needed. So we do want to stay away from that conflict of interest someone that could benefit financially from doing the home adaptation should not be recommending what should be done. So that's also a consideration.

>> SPEAKER: So there's an amendment to amend the waiver, amend that language there's somewhere else, something else that was just put out recently about CHC was there has to be a doctor authorization for certain things, under our evaluations for home and community based services and things. And that is another area where we're going backwards, medical model is there an opportunity for CHC to be amended under some of these issues that are -- that should not be medical.

There's got to be a way to word it where you're not have the conflict of interest you'll not jam everybody up because you need a PT or OT that may not know what they're doing.

>> SPEAKER: There definitely is, we're always looking at the waiver and the service definitions for waiver amends.

The community HealthChoices waiver is the next big renewal where we would be looking at changes is for next June 30th is when the actual waiver expires then we'll have to renew it.

But we're also continually kind of looking at doing updates to it.

>> SPEAKER: We need to help give you guys language before June 30th what we think should be, should be changed to?

>> SPEAKER: Yes. Yes. So, for the waiver renewal what OLTL will be doing is we'll be as we normally do with waiver renewals we put out announcements saying hey we're getting ready to renew the waiver if you have comments and suggestions on amendments that should be made, then we ask for public input on that.

>> SPEAKER: You said it says May, it does not say shall, shall you have to, may you do not have to.

There are two different wards.

words.

>> SPEAKER: Judy.

>> SPEAKER: My name is Judy nail or united disabled services we provide home modifications it is very clear to me that the waiver, at one point, indicated other qualified providers because we had worked with OLTL to make sure we were considered another qualified provider and could provide that level of service service. Or assessment the language and definition you

mentioned doesn't match at all with what is very clear in my mind so, maybe that's changed I'm not familiar with when that changed, um, but -- you know there are definitely other providers in the State of Pennsylvania, that -- provide this service into do a great job I certainly would like to better understand when that definition changed, because it is not at all consistent with our knowledge we did work with OLTL, to make sure that we were considered other qualified provider. Okay.

>> SPEAKER: We should definitely discuss it I mean what happened with the community HealthChoices waiver is this, this is basically a compilation of a lot of different waivers that it was attendant care independence aging waiver, all of those went, any language that was in those waivers which for years we had been working to make sure that the language was consistent from one waiver to the other, but what happened was when we created CHC we took a lot of different waivers and rolled them into one.

So I mean -- it is possible that the language was not carried over at that time.

>> SPEAKER: Each of the CHC drafts came out to providers we provided comment on each one of those revisions so -- you know, I'm still a little puzzled when that would have changed we watch each one of those pretty carefully so everyone that you.

>> SPEAKER: Just to add, I -- I also think that when we I am

remembering when we were looking atmosphere other qualified providers what is that? What level of certification? What level of professional, what is the information that could be included in the waiver, um, so that another certified or certain level of professional can do those, that work.

So if you have ideas about what those are, I think that we would be very happy to accept that information.

>> BARB POLZER: We have a question that came in over the phone for the MCOs.

Is there a specific process or group that needs to be called to request the OT or PT evaluation?

>> SPEAKER: For us, the starting point for UPMC the starting pointer is the service coordinator. And then, they're responsible for coordinating all the activities following up for evaluation or helping work with our home modification team to set all that up.

>> SPEAKER: And I would just say, in certain cases, um the service coordinator will coordinate with UPMC center for assisted lives for that PT/OT evaluation, the goal is to really, ensure that the adaptation is person centered is going to meet the participants need afford them the ability to live as independently as possible.

>> SPEAKER: This is Jen the specific OT or PT, specifically.

>> SPEAKER: Defer to Pat who typed the text.

>> SPEAKER: That's correct.

>> SPEAKER: Okay.

So for us that would be no. And you know, we want to engage with PT and OT evaluators that are familiar with, LTSS needs we have taken recommendations from Center of Independent Living in the southwest recommending PT/OT evaluators that are skilled at helping us get this assessment done.

>> SPEAKER: For Pennsylvania Health & Wellness, the service coordinator's role here is just to develop the plan with the participant and put in the service request.

Then we actually have a home adaptation team that takes in that request and is responsible for connecting with the independent assessor and therapist so, the participant just needs to work with the coordinator to identify the needs.

>> SPEAKER: Quick comment.

I never had to go through service coordinator I've always went to my doctor, got the script and took it over, right over to the hospital.

I never had to do any specific going to my service coordinator for that particular subject.

I'm just letting you know.

>> SPEAKER: So for most needs yes. But I think specifically for home modifications as part of the requirement we need a PT/OT evaluation

and that a service coordinator can help with and should help with.

>> BARB POLZER: We'll move on we've got a pretty robust agenda left for the rest of the day I'm sure this next one is going to be a hot topic PAS monthly authorizations.

This is shocking.

Consumers do you have any input that you want to share with the MCOs regarding PPL issues or PAS issues, authorizations. And your attendants getting paid?

>> SPEAKER: Dennis, with Philly ADAPT.

I'm speaking for myself last week PA health well necessary addressed my issues started in January got fixed a couple of weeks ago.

Within the continuity of care.

Our issue is, why do we keep having issues that are happening through continuity of care services have been provided equally from what it was last year and is obviously not, not only with PAS but through the list as we're seeing.

Now the, it is a problem when attendants don't get paid.

I cannot get out of bed if my attendants don't come, my attendant is not getting paid whatever they need to pay for, think need to get another job.

If I cannot get out of bed I end up in a nursing home which costs more takes my independence away.

We have repeated this, many of the same issues. So we would like to know, seeing the reports of how many apparently little issues were shown earlier in the meeting.

It really, understates what we are very much hearing in the southeast.

At the least start with the MCOs could report what up acknowledged to be issues with the PAS service delivery of payments to attendants, please?

>> SPEAKER: Sure. Hi.

So I want to talk to you about process and I want to talk about change.

So I can speak from personal experience I worked in the fee for service waivers and for the under 60 population for many, many years, the authorization was annual.

With the change over -- annual authorizations from July 1 to June 30th, there was a number of authorizations available were participants who chose to use the participant directed model.

We made the decision to switch to LIFE over 60 and monthly authorization for both participants regardless of age if you're under 60 or over 60, everyone in CHC has a monthly authorization for both their over time and regular time for their consumer directed participant directed services.

So what that means is you have from the first of the month, to the 30th of the month, there's a set number of authorizations.

PPL which is the fiscal agent for all 3 plans, has required us to put a send them a file of authorization from 1/1 let's use January 1 to 1/31, we received the data from the continuity of care file, that was voted into the PPL system. So let me speak specifically to keystone and AmeriHealth.

Service coordinators can have participants with keystone AmeriHealth have direct access to our system which they were trained on, to change, amend increase, decrease whatever put in the over time, put in the regular time authorizations.

So if it wasn't right if the data wasn't correct, as it came to us, service coordinators can fix that.

They can also look in the PPL portal to say, okay.

I am the source of truth with the participant.

I know what was authorized, prior to go live.

I know what is needed.

I am the care planned with this participant.

Is this adding up? Is the math right?

Okay.

They can look in the LTSS they can look in the PPL portal.

When it is not right, they can fix it.

If they can't fix it, they have subject matter experts, at keystone

at AmeriHealth that spend all day, every day, fixing authorizations and interfacing with PPL where necessary to make sure we get it

right.

That's our process. We have documentation available to every

service coordinator in the southeast there are hundreds of as much as

coordinators that have access to our system, who have examples,

training guides, job aids so that they know exactly how to enter PPL

authorizations.

>> SPEAKER: Now there was a because it was a change for some of the

service coordinators existing legacy service coordinators I think

that's why there may have been some pumps earlier on, in their mind

they were thinking, they were told the new requirement from PPL is that

all have to be put in per month, many of them they were interpreting

that as 30 days they were putting in Auth for 30 days, February only has

28 days some months have 31 days I don't remember that rhyme at all.

[laughter]

So I know we have spent a lot of time with the service coordinators

because it whats a change in the process due to PPL's requirement.

Of helping them understand that don't think 30 days you have to

realize what month you're in.

And it has to be from day one, to the last day of the month. So I

think that this, now it's becoming repetitive and again as Jen mentioned for us we give the service coordinators full access into our system so I think, now we're seeing a vast improvement in that, hopefully that should help eliminate some of those issues.

>> SPEAKER: Thank you.

>> SPEAKER: Thank you.

>> SPEAKER: I just wanted to know if the other MCOs have the same process or, possibly more so the same -- if their care coordinators have the same access thank you for explaining the days of the month thing to me -- I was told that before it was an issue early on how many days were actually in each month and how many units were being forced.

So, for the other MCOs -- do coordinators have the same access to your systems as keystone.

>> SPEAKER: For UPMC, community HealthChoices the service coordination entities don't have access to the case management sex but they would work through UPMC service coordinator could make those changes within the system.

One of the additional kind of issues that we saw in the change from the annual to the monthly authorization was also the need to have kind of clean month authorizations.

So, instead of going from you know if you start on April 4th, you know you don't go until May fourth you need to go to the end of April

and that was something that I know in working with external service coordination entities has gotten significantly better.

But was something that early on, was a learning curves that provided needed to become accustomed to.

>> SPEAKER: PHW our our external service coordinators do have portal access. And then they also have internal supervisor who is a PHW employee that interfaces with them to, they would interface with their internal contact, -- the supervisor.

>> SPEAKER: Is it a concern for the MCOs that -- is it a concern that is this one person or, is it a team of people because -- if it is each one person, are you concerned that, there would be a gap, between one person being able to answer basically, you know, any number of coordinators.

Who might be needing assistance with the since they have to deal with the internal contact.

>> SPEAKER: Right PHW we eventually have teams external coordinators have a internal person that works with a subset of them it's not just the tingle person that works with all external coordinators.

>> SPEAKER: Thank you very much.

>> SPEAKER: And part of that is because our PA health wellness electronic health record does not allow external service coordinators full access of the system it's the way it is designed they have to have

support inside to get the changes made.

>> SPEAKER: Thank you UPMC.

>> SPEAKER: For UPMC there's a coordinator, assigned for each plan we have a team of individuals who can people with PPL and financial management issues.

>> SPEAKER: Thank you very much.

>> SPEAKER: And thank you for that, quick follow-up not to keystone I presume, the supports coordinator should be informing the consumer if they made the change they made the change themselves regarding the two MCOs if there's a change in the plan are you informing consumers or will you make changes to best accommodate the consumers plan withouts informing the consumer of that change so for example, if you -- change over it's not the full amount of hours someone gets a week, the split up between regular hours and over time hours if you make a change to that, to make sure the attendants get paid are you informing the consumer of the that change in the ISP?

>> SPEAKER: Yeah if we're making changes to a service plan for participant to address any PPL issues like the example you used changing from regular to over time we're working with the external service coordination entity who is in communication with a participant on those changes.

They would be a -- made aware of changes to their plan to

accommodate any changes whether it be an additional need or for payment purposes.

>> SPEAKER: They at the end they the supports coordinator, you're telling me, you're telling us that keystone administration tells the SC that there's a change.

Are you -- sorry -- are you instructing that SC to tell the consumer or are you telling the consumer? Are you telling the SC.

>> SPEAKER: For UPMC we're communicating through the service coordinator who is primarily in contact with that participant.

>> SPEAKER: Sorry, are you, if you make a change in the SP, you're informing the supports coordinator, are you instructing the supports coordinator to -- to inform the consumer?

>> SPEAKER: Yes.

>> SPEAKER: Thank you.

>> SPEAKER: Yes.

>> SPEAKER: Zach.

>> SPEAKER: Well I would like --

>> SPEAKER: I would like to hear from the PA health wellness.

>> SPEAKER: I'll wait.

>> SPEAKER: I was talking to Dr. Winberg about this I wasn't quite sure with when you have regular hours over time hours with PPL, for example, and something has to be adjusted we would notify the consumer

and often that is done if there's an adjustment it would be by letter, but if it is something, where, if it's ISP your service coordinator go out to you and talk to you and have you sign a change but you would be apart of that process, at least that's the way we train them.

If there's a discrepancy we need to know that. We cannot initiate an ISP or a PCSP without your signature.

>> SPEAKER: That includes moving -- yeah it does. Thank you.

>> BARB POLZER: Zach.

>> SPEAKER: I was asking myself that includes moving regular hours and over time hours, not moving the total amount of hours.

>> SPEAKER: For let me confirm that I don't want to give you the wrong information.

I will confirm that let you know.

>> SPEAKER: Thank you.

I appreciate that.

>> BARB POLZER: Zach?

>> SPEAKER: This is Zach from Philadelphia ADAPT I guess my question is as far as PPL, when I ask for contact information and PPL in Philadelphia, maybe over a year ago, and it was given to me, I was given a number and, when I you know looked up the number and looked up the information I was told it is in Philadelphia. And you know, brought

this to you guys' attention before it's not in, it's not in Philadelphia, and the number is like a I guess 1800 call number, no one that you speak to you leave a message. They say it's by appointment only, when I was able to find out what the exact location was, like, there was notches space there. There was an office space but, it's been vacant for a long time.

My question is like, how are we supposed to be able to speak to someone when it comes to PPL face-to-face when my attendants check is not right.

What am I supposed to do with that I have to call way out to Boston to figure it out. Like, that's unacceptable.

I asked for a phone number you guys gave me a number, the number was crap. It was just a call in number.

I leave a message by appointment only, when we, I went to the building, it's not too far from I live it's not even in Philadelphia.

>> JILL VOVAKES: So PPL should have that number staffed, have people help you if you're having difficulty getting in touch with someone to work through any of the billing or payment issues, I can give you my contact information.

I'll assist you in getting someone from PPL to assist you.

>> SPEAKER: I can find it I mean I can call the 800 number you've -- the committee specifically gave me a number that was supposed to be

for a location in Philadelphia.

A Philadelphia location.

There's no Philadelphia location.

And they do not return calls.

>> JILL VOVAKES: If you're having a problem getting a call back I would need to know that I can follow-up with you, to get your information.

>> BARB POLZER: We had a question come in -- sorry Theo, do you want to say something?

>> SPEAKER: Yes.

Just a personal observation actually.

And maybe for the record, because I think sometimes, we need to do this. Because this is probably going to come back and bite us all in the butt.

You are giving a lot of responsibility to the service coordinators, it's blowing my mind.

And, each one of these the committee for employment plans submitted by each MCO even there -- you are putting your as much as coordinator I don't see how you will have to pay your service coordinator a lot of money, to do all of these responsibilities.

That you're all calling them to do.

I think this is going to come back and really be a flaw, in this

whole, MCO implementation.

>> SPEAKER: To add to add Theo's point my name is Shayla,

Philly ADAPT not only is it a lot of work for the SCs some of them are

working for all these 3 of the MCOs all 3 are not working together to

have an easy process for everybody.

To understand, as pretty clear what this PAS hours have keystone can

let their SCs authorize but PA health wellness UPMC cannot that's a huge

issue, because our consumers are going directly to the service

coordinators expecting them to be able to solve these problems

immediately and now, they're being held up by -- weeks months at a time, and -- are at a very high risk of losing their services and --

getting, a disruption of service during that period of time. Whether

it's in the mids will of the month, during the transition changes are

happening.

I work as an attendant I can tell you that I have not gotten paid my

-- normal, regular hours in the full paycheck that I'm supposed to. Several

times now, since -- the continuity of care period started we were told

that nothing was supposed to go wrong during this period and no changes,

outs of the ordinary were supposed to happen.

And we're hearing nothing but that at this point I think that's the

point we're trying to get across to all of you today is that, at the end

of the day the consumers the participants are the one that's are

suffering.

And -- we just want everybody, all 3 MCOs, OLTL the State to work together to work with us to really hear what we're saying today and take it back and -- really work on it, bring something back to us next meeting that's actually meaningful not a PowerPoint with data points no one can read back here.

But, some real information.

Thank you.

>> BARB POLZER: We have a question that came in over the phone, does the monthly authorization requirement only apply to the consumer directed model or does it also apply to agencies?

So I can speak to that.

The service -- it is really a factor how it is entered. So, um for PPL, they want to see, monthly authorizations from the calendar beginning to the calendar end. Service coordinators can put those in.

For 3, 6 months at a time.

For the same goes for past agencies however there's more flexibility within our system on how authorizations can be entered for PAS agencies.

So, it is not as stringent with the date being, following the calendar date it can be end of month, it can be -- I guess for simplicity purposes it is simpler for us, to accommodates, PAS agency authorizations when it is crossing months.

Okay.

But, service coordinators have been trained, that -- this is how you enter PPL authorization this is how you enter an agency authorization and as soon as they get that down, it is pretty easy, to ensure that -- when you look at your 3 months, six month organization authorizations in our system I did it according to how it needs to be data entered.

>> SPEAKER: For UPMC, the -- um, PPL, or -- the participant directed personal assistant services are the only authorization that need to be on a monthly basis that is in large part because -- well really because of how we have to feed the information to PPL the other authorizations can be -- time period that span months, um, as you know as many as six months but also, don't have to have like a solid you know beginning of the calendar month, to start.

>> SPEAKER: And at PHW our process is similar to both of the other MCOs.

>> BARB POLZER: Okay.

>> SPEAKER: Ours is is similar to UPMCs, that's ok.

Annual authorizations are often put in but they can be in different time spans if the person is in need of something, at like an emergency service, it might be -- um, put into the system, for -- 60 days, and

then, it is reviewed, in that time period, if they still need that -- that additional support.

>> BARB POLZER: Thank you to the plans to discuss the emerging issues we're going to move onto the MCO example scenarios the fest one is service increase and decrease. Oh, I'm sorry ma'am I --

>> SPEAKER: I just had a PPL question.

I am Amber from the human services.

We're seeing a over time issues with the PPL units on months that have 31 days or five weeks so the way, that they're also being entered is the weekly unit total, divided by 7, and then multiplied by the number of days in the week. The problem is, over time units are not used daily they're used, at the end of the week, once the worker goes over 40 so every month, that has five weeks, it is having an issue and then our SCs are inundated with calls because workers are not getting paid, so February we're fine I expect in the next week or two, it will come up again for March.

>> BARB POLZER: That's correct.

You're correct.

Then typically the SC is the person who gets extremed at.

>> SPEAKER: Right. And it is, all these calls are taking away from them being able to address all the other needs of the participants and completing these really important assessments and visits.

>> BARB POLZER: I agree.

>> SPEAKER: Is there any plan on modifying the way that the over time authorizations are going to be sent to PPL? Because answer we got is call us to trouble shoot when it happens, but that's taking valuable time out of the SCs day.

>> BARB POLZER: Okay.

No?

Okay.

Go ahead David.

>> SPEAKER: If you want to answer it.

[laughter]

>> SPEAKER: Okay.

I think -- as far as, to a point, um, that was made earlier in the conversation is proactive service planning, to be able to plan for you know, the next month, if you're going to need those additional over time units to carry into the beginning of that, that pay period.

Because we do submit them on a monthly basis, you know we can only put in you know for February you know the first to the 28th then from March through the 31st.

So, so really kind of planning for that. And addressing it, I know you know, initially, it is -- there's a statewide learning curve for the

service coordinators after they get it one bad month, often leads to helping kind of resolve that for the future.

>> SPEAKER: So Amber, only thing I would add to that is we maintain the service coordinator is the source of truth it gets down to participants need to communicate to them their needed schedule, who is living inside the home, who is living out so we can determine, who qualifies for OT and who doesn't.

Right?

And then, think about what days, does this month end on?

So we can make sure that our math is right, to put enough units in the over time and enough units in the regular pay, and look at it from a monthly standpoint because that's the requirement from PPL.

So, for those scenarios that was a hurdle we heard us speak to, once service coordinators know and participants know I need OTs and Thursdays and March ends on Thursday we can get those units right.

>> SPEAKER: I think, in keystone's system because the SC can manipulate it, it is easier for them because they don't have to then call and wait for something to happen. They can put it in, it's authorized but maybe even moving forward instead of doing it, daily, could the over time just be put in, for weekly, so if there's five weeks in the month, rather than trying to divide it by days and the multiply about the number of days in a week, or in the month, sorry.

>> SPEAKER: Thank you.

>> SPEAKER: Thanks.

>> BARB POLZER: Okay.

We're -- Herman.

>> SPEAKER: It is just real quick. If maybe it will be real quick,

when PPL put out this new -- is this new as far as January or have been gone on.

>> JILL VOVAKES: Actually they have always been doing monthlies for over 60. So with implementation of community HealthChoices and the exchange with the MCOs it started with the southwest, um, so that is when it changed for the under 670s.

>> SPEAKER: Thank you. And seeing how

perhaps it wasn't a lesson learned in the southwest it is a very much happening almost until the end of the continuity of care in the southeast, what happens on June 30th this continues to happen, because it -- this obviously went on past the continuity of care in the southwest.

It looks like it will continue on, is it to be expected next,

into -- next year's roll out and then again? The same conversation in region 3 is that what you're preparing to do?

Or no?

>> JILL VOVAKES: The system, the system is set up yes for monthly authorizations. There was a lot of communication and training for the SCs we can ramp that up again we intend to do that earlier for phase 3 because that, that was a lesson learned making sure we had more frequent and earlier engagement and communication with SCs so they would know what to expect. And I think that basically the difference in the challenges right now, that are being realized is because, um, you know the SCs are trying to identify what is needed for one MCO versus the other.

But the PPL system has -- allows for a monthly authorization file from the MCOs and that's been in place since last year.

>> SPEAKER: It just seems that I don't -- I don't, I don't maybe I'm missing it I just don't see any lessons learned being implemented.

On the second roll out.

>> SPEAKER: So to add to Herman's point it sounds like right now in the southwest and southeast there hasn't been any information being distributed to consumers that this is a possibility that could happen to them during this time. During the continuity of care period extended beyond that, when MCOs start coming into their region, so -- for the next region, region 3, are we going to be working on informing consumers that hey, there is a new process of authorization it is not the way that it used to be. And this is what it is going to be this is

what to expect, you can expect some glitches in that process. But being more transparent to our consumers especially going into region 3, which is very rural and, has 3 zones for it, because it is so large that we're rolling out to, don't you think that we need to be implementing some lessons learned that is Herman is getting to, what are those lessons learned and solutions for region 3?

I myself from Williamsport it's a very small town surrounded by many more more small towns and people don't get information the same way that they do here in Harrisburg, maybe, even Philadelphia, Pittsburgh et cetera.

So just what are we doing for our folks in the region 3, I think it will be great if one of these meetings we had, a lot of time allocated to what is happening with region 3, what is to be expected, what were lessons learned from the past two regions that we'll be using as we go into region 3. Because it is bigger than anything else than we've gone through yet and, it is way more rural than anything else in the State. And I don't think that people are realizing that the -- the serious things that can happen, amongest, services, the disruption of services, medical services, for instance I have friends in Williams port who travel to Philadelphia to see medical providers specialists and they are concerned that once MCOs are throughout the entire state that if they have UPMC at home, and they go to that specialist in Philadelphia

that does not serve UPMC they're not going to be able to see their specialist anymore. So there's a lot of things that are moving forward that I don't think we're even thinking about and discussing here and, really focusing on region 3 as we're moving forward, what were the lessons learned how can we implement them moving forward.

>> JILL VOVAKES: I will think the last meeting we did touch on some lessons learned we definitely intend to do, have future discussions about that for phase 3.

One of the specific things you're touching on is the SC engagement and what we're defining as meaningful contact, right?

So for southeast that was a bigger lift and a bigger push to engage all of the SCs into doing meaningful contact with their participants.

And that education, from aging well to our service coordinators has started earlier. So we are expecting that SCs are going to be making meaningful contact with each and every participant through phase 3.

We're also engaging other stakeholders in our participant education we think we touched on that the last time, in addition, to our regular participant sessions participant education sessions, that we did for the southeast, aging well will be doing at least the same amount 70-72 sessions at various locations but we're expanding those locations we're engaging other stakeholders to do participant education. We've also looked at where we would host those sessions.

So there's going to be a lot more consumer education. There's also going to be follow-up provider education after the consumer notices go out. So that we'll have additional engagement and education for providers for people to be able to speak to any questions that a participant may have. So there are a lot of those lessons learned that are being applied to our communications strategy for phase 3. And, yes , it is, it does cover 48 counties. And we are looking at touching every single county with education for the consumers. There's also some additional participant education materials that are currently being developed to use by additional stakeholders, community groups and that, that type of thing, it will be posted on the web for people to use.

So, we are doing additional outreach there, but I think, the key for you is, with the items that you raised are, is that, we are definitely, engaging the SCs more for phase 3 to do and ensure there's meaningful contacts are made because we know that that's something we can do better from phase one, ditch knitly improved for phase two, we intend on improving it even more for phase 3.

>> SPEAKER: My question is for the MCO when it comes to power wheelchair my question is how come if I decide to get my chair fixed by someone it's not -- I sit there tell us okay if this person touches the chair, it voids the warranty.

Instead of us having to wait for insurance to come outs and fix it,

why is that?

If I know someone that knows how to properly fix my cherry didn't go under the insurance to get it fixed but, they can't touch it because it has a warranty on it, if they do touch it, it voids the warranty.

Why is that?

>> SPEAKER: This is just -- I would have to look into the specifications but I know many other items manufacturers have policies and terms of if you try and fix it yourself, it will void the warranty.

And then the coverage of the fix in the future.

>> SPEAKER: The person has to wait even if they know the person knows how to fix it, the person still has to wait to get it fixed.

So if they know a faster way to get it fixed to stay rolling and moving around to keep their independence, why would that even matter.

>> SPEAKER: It is really, going to -- I mean it's not necessarily something from the MCOs it's more from the supplier or manufacturer of the product that governs the rules for appropriate handling of it. So we would not necessarily have to say in in that, that would be the manufacturer supplier that would deck in dictate the appropriate care.

>> SPEAKER: The chair is already paid for you're only paying for the repairs.

>> SPEAKER: But there's still maybe a warranties or coverage, through them, that they would govern not specifically that -- the

insurance plan.

>> SPEAKER: If I decided to say I lost a tire, I got to wait 3, 6

weeks when I know someone who knows how to take my tire off put it back

on that's going to void my warranty.

>> BARB POLZER: I don't know anyone knows the answer to that

Brandon.

Okay.

Let's move on, I'm sorry.

Let's move onto the MCO example scenarios, please I'm not sure how

we'll handle this, are you guys taking one at a time?

>> SPEAKER: Barb I know some of these were discussed before -- I

don't know if I know one topic there have been questions on, but not

necessarily been a topic on here is dental, so if we want to start with

that it's doing smirch you doing something different I don't think that's a topic that we've had

a chance to discuss in other previous meetings.

>> BARB POLZER: Let's go for it.

>> SPEAKER: Any questions regarding dental.

[laughter]

>> SPEAKER: Yes.

I've been to the dentist in more than one occasion he told me I have

to get teeth pulled all right.

But, what I want them to do they tell me they can't do it because it's cosmetic, why is that?

>> SPEAKER: I'm sorry.

>> SPEAKER: If they pull my teeth I told them I want to put implants in my mouth, to replace the teeth that were pulled, they tell me I can't do it, because it's cosmetic.

>> SPEAKER: Implants are not covered as much as under the any MA program.

Also, we do pay for partial dentures to replace that.

>> SPEAKER: What if I don't want them I want my teeth back in my mouth.

>> SPEAKER: I understand that.

>> SPEAKER: Implants are not covered.

>> SPEAKER: That's crazy.

I -- you have to change that.

>> SPEAKER: Brandon -- Brandon --

>> SPEAKER: Telling you the truth up front.

>> SPEAKER: Brandon, one area you can, you can look for let me just say that you're not left with a question mark there.

Look at your Medicare provider.

A lot of Medicare providers, provide dental they will do implants, okay.

>> SPEAKER: I've called them --

>> SPEAKER: Okay.

But if you look there's a number of Medicare providers out there and some do cover dental and some have extensive coverage of dental.

So that's your issue look at your Medicare provider because that's where it would go first.

>> SPEAKER: I have called --

>> SPEAKER: Could I say -- DSNPS they do have like a set figure dollar amount that they will pay like annually or bi annually which we run into, from experience, implants, crowns over implants, den yours attached to implants, chances are very good you're going over that dollar amount, that Medicare supplement -- is --

>> SPEAKER: You know I told they do one crown every 3 years.

>> SPEAKER: Medicare --

>> SPEAKER: One crown every 3 years if I need to get crowns I have to wait, I got one I have to weights 3 years for another one.

>> SPEAKER: That's not the CHC side, sir.

>> SPEAKER: That makes no sense.

I don't understand that. That makes no sense.

>> SPEAKER: I'm sorry.

>> SPEAKER: That's all right.

>> SPEAKER: Just one statement in

dental service, a Mary caritas, launched April 1st inclusive dental, a quick word it's in conjunction with -- one of the things that drives this is of course the network.

There's just not enough dentists trained in treatment of special needs.

needs. For a variety of reasons a lot of that starts in the dental schools.

So, in conjunction with Penn and Temple, keystone offered continuing education courses in fact just last weekend on the treatment for inclues I have dental, the program rolled out actually, April 1st.

Trying to add more dentist into the keystone network around the southeast market in the treatment of special needs for a variety of reasons all the way from taking them from the office, all the way up to rendering anesthesia for the services rendered.

Just a little update for incl for for, inclusive dental.

>> BARB POLZER: I'm sorry I had to step out what did I miss I beg your pardon?

>> SPEAKER: Preimplants from everybody.

[laughter]

Okay.

We voted on had a? . Laughter]

Okay.

>> BARB POLZER: So keystone addressed it, do any of the other plans have anything to say though?

Dentsal Dental denials or the free implants.

implants.

No. Are there any other denial examples you want to address?

Or the audience wants to hear them address?

Come on guys we can't end this meeting early that would be breaking a record.

[laughter]

>> SPEAKER: You can't answer mine I already asked mine.

You can't answer mine.

>> BARB POLZER: Are you asking for when you say examples of scenarios I'm not quite sure what you're asking for.

Can anyone articulate specifics?

>> SPEAKER: Look at the agenda.

>> SPEAKER: Agenda.

>> SPEAKER: I have a question -- I have a scenario this is Juanit Grey.

I went to dentist I don't have enough teeth missing for placement of a partial, half of my mouth on one side, I don't have teeth.

And then I have -- I have different spots and so they would not authorize a partial, I can't chew my food up.

It's difficult it causes me to swallow some of my food whole causes me indigesttion problems I had major surgery on my intest continue I've been in excruciating pain, there's no resolution since -- we don't we're not allowed to get implants the extended coverage there's not money in the budget for or not just budgets but, um, they had not implemented the extensive services for in which I think they should look into that.

If it is for health reasons.

>> SPEAKER: I can try to address this.

In terms of the service coordinator, you may want to ask your service coordinator to assist you in filing an appeal for that decision.

>> SPEAKER: Okay.

>> SPEAKER: Thank you so much I appreciate that.

>> SPEAKER: This is Karen again.

To piggy back of what Brandon was saying, I had mentioned this before awhile back.

The thing is, so for me to be able to get my -- to be done I have to be a diabetic that's the only way, for them for people with diabetes, they get more services under dental than anything else.

So I have to be sicker than I already a.m. to am am, to get scaling done.

I may not be able to eat my food is is not enough.

>> SPEAKER: Can I ask you if your experience with not having it covered was with just your Medicaid community HealthChoices or plan or also, through Medicare, do you have Medicare and if you don't mind me asking.

>> SPEAKER: I think it's -- I keystone health choices.

>> SPEAKER: HealthChoices,.

>> SPEAKER: Okay.

They have -- I asked my dentist how much in cash would it be 580s half of my check every month, I get, that's my gas, my rent, my everything.

I put out 580 to get my mouth cleaned out.

>> SPEAKER: Yeah.

>> SPEAKER: Right now, I can't taste my food the way I want to.

Everything is -- they did take -- one of the things that was paid for was the removal of a decaying tooth.

That was it. And follow-up after.

Other than that, I had to pay 580 to get a whole mouth scaling done.

>> SPEAKER: The reason I ask, kind of goes to Anna's point, unfortunately Medicaid, and community HealthChoices are limited dental benefit in terms of services covered I know a lot of people with community HealthChoices are also dual eligible for Medicare, traditional

Medicare, also has a limited part A and B there are a lot of Medicare advantage plans 9 or 10 in Pennsylvania most of them have a co-comprehensive dental benefit and it is something that, people, if they have Medicare also, should consider up to make sure though that plan, has your other doctors in those plans that are -- you don't have as many choices of physicians as Medicare part A and B.

>> SPEAKER: If I had -- would I have gotten that done.

>> SPEAKER: So the coverage varies is what they call value add benefit additional service that a lot of Medicare they call DSNP, dual special needs plans offer, a lot of them have comprehensive benefits, sometimes it's a budget maybe it's $3,000 a year for coverage of those benefits or $2,000 a year for coverage they have -- some of them have fairly comprehensive benefit I know community HealthChoices plans are observe DSNPS there's also 6 or 7 other Medicare advantage plans in Pennsylvania to look at and -- see if you have an option to get, more comprehensive dental benefit but it is, it is for people who are dual eliminate Jill for Medicare if you only have community HealthChoices and no other coverage, that is not an option. So -- okay.

>> SPEAKER: Right.

>> BARB POLZER: Okay.

>> SPEAKER: Could I say really quick the dental benefits under community HealthChoices are different from under real HealthChoices,

community HealthChoices is does not include the benefit exception and the process.

>> BARB POLZER: We got a couple of questions that came in over the phone.

The fest one is related to the PPL authorizations.

In the southeast, can authorizations be submitted for 3 months and six months, to stop delay in services as the month, to month is not adequate and causing serious delays in services?

>> SPEAKER: Barb I can answer that, let me clarify yes.

They can be answered in 3, 6, 8, 10, 12 months at a time. However, because of how the data needs to be shared, from the MCOs system to the PPL system they have to entered in monthly segments from the fists of the month, it the 31st of the month, 28th ever the month, 38th of the month, so it is -- like that's the clarification you can enter multiple months at a time they just need to follow that data requirement.

>> BARB POLZER: Thank you. There's a home mod question.

How long does the review process take once the two bids are received. So I guess each plan needs to respond to this one.

>> SPEAKER: Yeah.

It really does vary on the home modification itself.

Um, having the home modification company go out to the house, to do the assessment.

You know, we -- it's kind much a many, many variables, involved.

It depends upon depending upon the scope of what needs to be completed.

And the availability of the contractor to perform when they can do the job as well.

It is very, very similar. I'm having some work done on my house right now I find it to be somewhat of a similar process. I've gotten a couple of bids.

Accepted one of the bids the contractor took a different bid could not take that job so I called the other one. And you know they basically have told me, in my personal situation, that they could do the job in you know the next 3 weeks.

>> SPEAKER: PHW for home adaptation the timing the longest period of time is the collection of information. So once the bids are received,

there's actually a very short time frame I would not give it a specific number of days because as mentioned, there's some issues around you know the contractors availability, but, it is a very short period of time once bids are received.

The delays are generally up front in trying to get all of the necessary information from the participant or homeowner.

>> SPEAKER: So I can tell you in the southeast we just finished 3 series of trainings for service coordinators to know exactly what the

process is for collecting the information required by the agreement for home modifications.

We want to be as transparent in the agreement, PT/OT evaluation, comprehensive needs assessment want we've built in a checklist to help service coordinators in this process, how long does it take, it does vary together all that information but -- those are the items required to determine, the mod itch indication meeting the participants needs.

>> BARB POLZER: And then any idea how long it will take once they submit the two bids and all the documentation?

>> SPEAKER: So.

>> BARB POLZER: How long it would take to review that.

>> SPEAKER: Thank you the decision process is outlined in the agreement Barb I think then we are, also needing to build in time, pulling permits, scheduling the work with the contractors.

Those things do take time because they're a limited number of contractors to do the work we are required to make the decisions timely as outlined in the agreements.

>> BARB POLZER: Thank you here's another one for the 3 plans.

What performance measures are used by the MCOs to determine which external SCs retain contracts?

>> SPEAKER: Can I grab that first?

>> BARB POLZER: Absolutely.

>> SPEAKER: I think I said add nauseum, with all the calls on Tuesday, PA health wellness made the decision early on we would work with service coordination entity its committed to quality, internally we monitor, compliance scores, based on all of the contractual requirements that we have as a health plan. And in addition to that, we go in and look at the person centered service plans to ensure that the service coordinators, are documenting in such a way that, it demonstrates the need for the individual, but also, that -- other things are met, did they talk about cultural issues or choices the person has about how they want to live their life how they want to be independent.

So, as we're going through the that we do have a scoring mechanism one side is, is -- numerical and the other side is yes and no. We pull a certain number of files and we, rate the SCE, based on quality.

What we found in the southwest because it took a little bit of time to get our process in place, is we kept SCEs on probably a little longer,

recently we have seen some SCEs make the decision they're going to leave our network of providers -- simply because in many regards we had strong conversations about quality.

As we move into the southeast, that will be the similar process.

So, as we have said over and over again we will continue to contract

with those entities the value of quality and can meet our performance standards of 90 percent or above with their he had audits we're giving them that information every week.

Through their account managers that's been our process for several months now.

>> SPEAKER: For UPMC we look at quality as well.

We look at the quality of the service plans we've developed the accuracy of the InterRAI if it's completed for the participants as well as communication and timely ins.

In responses for inqueries from participants as well as communication with the plan.

In making those determinations.

>> SPEAKER: We have a similar process within compliance we also have an audit tool. But it also takes into account the participant, the case load with an agency, and then of course, as you leave continuity of care period, then there's also, rate discussions that occur that will happen between the MCO and the service coordination entities.

>> BARB POLZER: Another question came in through the phone. How do we handle this issue -- I'm working with a consumer who received waiver/attendant care services through a service coordination entity for years she is married, due to her husband's income and re

certificatation paperwork she gets cut off, from services.

Do the MCOs provide support, with the eligibility appeal even though had he she is determined do they continue providing any supports.

>> SPEAKER: Once a participant, once a participant is disenrolled, we are not really permitted to interact, provide services because they're no longer our participant.

>> SPEAKER: Ann is nodding the same.

>> SPEAKER: It's just the way -- we do encourage service coordinators to -- through they're training they're supposed to assist the individual in their -- um, eligibility annually, beyond that if they're no longer eligible we're, we really it's like Patty we don't have anything we can really do there.

>> SPEAKER: Similar for us.

>> BARB POLZER: Another one.

Well MCOs require PA S agencies to be accredited, part one, and will they pay morpho accreditation, will they reduce the PA agencies they work with, as they have SCEs.

>> SPEAKER: I'm not sure what the accreditation is, that's what Jen and I were just talking about I would have to get more information on the accreditation for keystone AmeriHealth, our intention in the southeast as it has been in the southwest is the continuing to work with all of our providers our attendant care agencies unless we identify, a

quality issue.

We're not using any type of, measurement, such as, membership size, or their client list size to determine whether they're too small or -- too large to continue with us it's based upon quality.

>> SPEAKER: I would say it's a similar process.

Just, just -- in the demographics I think we need as many PAS workers as, um, you know, going into the field as we possibly can.

So I don't foresee, any reductions of the PAS workers reduced need for PAS workers actually I foresee over time, even greater need for PAS workers in terms of, the accreditation, I'm not aware of any plans to require accreditation. However, we always look at different ways to reward performance based upon quality and so it is something that, we do evaluate in terms of you know, how can we incent, some of the providers to continue to provide quality or increased quality over time.

And then that's -- you know, that's I think really a value based approach and, um, one of the things that we do when we evaluate these types of programs we want to make sure that any incentive flows directly to the direct care workers, um and that just part of our -- our value system.

>> SPEAKER: Um accreditation, no. We're not discussing thatments we are discussing quality measures. How an entity can partner with us to address different quality initiatives we're doing internally like monitoring diabetes fall risk identification, how do they identify those, bring a change of condition to our attention so we be can be able to assist that individual if there's greater need.

And then we're also, identifying service coordination entities have a PAS arm we want to know if those exist and identify those as well. Just so we're aware of it, that's about as far along that track we are with that.

>> BARB POLZER: Herman can you do it in 3 months.

>> SPEAKER: One minute to.

>> SPEAKER: I want today ask, this is Zach from Philly ADAPT I want to ask -- when you do identify those workers that are doing well, what type of benefits do you pass down to them?

>> SPEAKER: I think you're asking like, throughout a specific contracting and that would be more of a network conversation that's something I could not answer, it's just something that is evaluated as part of the contracting approach, ensuring that, you know what is the quality is, being delivered and that we differentiate some you know, differentiate over time based upon quality of providers.

>> SPEAKER: Keystone we're in the process of developing a mentorship program. Vicki and others have brought to our attention that existed at once and ran out of funds so we're in the process of developing that then we'll be meeting with the attendant agencies to see how we can implement that.

>> SPEAKER: We are talking about how we do value based incentives we just, still building it out, creating those relationships and determining how we would measure that, to identify -- who is helping us -- meet certain quality expectations and others, that are not. But once we identify those partners, then we really want to start engaging in those value based incentive programs.

We're still learning it.

>> SPEAKER: One, it will be very useful if everyone can get information about how to join each advisory committee for the MCOs.

Please, again, and -- to OLTL I was told last meeting here that we were going to have a 15 minute EBB presentation by hancock and -- no EBV, electronic benefits verification we never talked about it, that's a big problem. And -- my last minute.

>> SPEAKER: Thank you Herman, this is Jeff, from PA SILC my boss was unable holding a state plan holding over in reading today, he asked me to bring up an issue employment, about having OLTL not just bring the outreach person but to bring whatever coordinates the

payment but the PMCs and invite OVR, Ryan Hyde mentioned there's not been engagement with employment and perhaps they could bring their own fiscal person as well.

It might also be good to have the M COs to talk about their employment processes just in the future and just like how the payments work and perhaps, invite like health law project and client assistance program or CAP because they're probably going to get these appeal issues and things of that nature.

And -- just one quick point on oral health care, if folks are interested in that, PA oral health.org, coalition for oral health is doing outreach on that issue thank you.

>> BARB POLZER: Okay.

Thank you Jeff.

Thank you everyone for attending and participating really appreciate it and hope to see you next month, May 3