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DATE: September 5, 2019

EVENT: Managed Long-Term Services and Supports Meeting

BARBARA POLZER: Good morning everybody. We would like to get started in a minute please. Good morning everyone. Welcome to our.
MLTSS subcommittee meeting. I'm going to go over the house keeping talking points. We ask that you keep your language profession stall and direct your comments to the Chairman and wait until called upon and please limit your comments to two minutes. All of our meeting minutes, transcripts, meeting documents are posted on the list serve under the.
MLTSS meeting minutes. They are usually posted within a few minutes of the meeting. Please speak clearly and slowly and what the meeting is also being audio recorded and it too will be posted on the list serve under the M-L-T-S-S subcommittee. This meeting is scheduled until 1:00. To comply, we will end promptly at that time. If you have any questions or comments that weren't heard, please send them to the resource account at R A hyphen. C F.
That resource account is listed on your agenda.
Please keep the exit aisles open. Do not block them. Please turn your cell phones off. When you are leaving please throw away your empty cups, bottles and wrappers. Public comments will be taken during the presentation until waiting until the end of the meeting. We do allow the additional 15 minutes for any additional comments. Our 2019 and 2020.
MLTSS sub M-A-C -- meeting dates are available on the website. And now we have some new members at the table. I would like to have them go around and introduce themselves end. German would you mind starting.
GERMAN PARODI: Not at all. Thank you. My name is German. I live in Philadelphia. I'm a participant long term services and supports in Pennsylvania since I moved from Puerto Rico in 2004. I seen the change and I thank all of the Applicants for the system that really was one of the reasons why I moved to Pennsylvania. And have made it stronger since.
I am a member of C-I-L. I am also the president of disabled action of Pennsylvania. We focus on advocacy matters for people with disabilities in our state. And lastly, I do -- I am the united national focal point forepersons with disabilities in the Americas went to

Puerto Rico after the /HUR can and planning with the partnership to help them in B-A-H-A-M-A-S.
BARBARA POLZER: I made a miss neighboring. Go around the unable.
NINA DeLGRANDE: Representing life providers.
BLAIR BOROCH: Good morning Blair united hedge care.
STEVE GAMBLE: I'm with the Delaware County Area Agency of Aging and phase 2 of the community health choices. We provide both the assessment which the fed and we are involved in service coordination.
JIM PIEFFER: I'm Jim with Presbyterian senior care network and leading age Pennsylvania.
WILLIAM SPOTTS: William consumer.
JESSE WILDERMAN: With S T A U healthcare Pennsylvania.
RICHARD FARR: The Executive Director of rabbit transit providing public transportation in the 11 counties nearly 6,000 square miles in Central Pennsylvania. I'm excited to be a new member of the Committee. I have some learning to do and need to catch up and glad to be here. Thank you for the invitation.
GAIL WEIDMAN: Good morning. Director of policy with Pennsylvania healthcare association. Our association represents personal care homes, assistive living residents and nursing facilities. We also have providers that provide home health services and the life products. I have been with the association for ten years and my prior life I worked for the state for 28 years. 22 were in the long-term care in various capacities. I really am excited to be a member of the Committee and appreciate this opportunity.
MATT SEELEY: Good morning. Also a new member of the Committee. First and for most I'm a person with a disability. Surprise. I'm also the director of the statewide independent living council. We advocate for people with disabilities. Centers for independent living all across the state.
DAVID JOHNSON: Good morning. I'm with center for advocacy for the rights and interests of the elderly. I'm a new member and appreciate the opportunity to serve. Our organization is in Philadelphia and I live in Philadelphia and apart I'm also fostering more inclusive systems and environments for all individuals particularly those living with the cognitive impairment. Thank you for the opportunity.
HESHIE ZINMAN: I'm from Philadelphia and I'm from the L. Gee Bee T and I'm a consumer advocate.
MIKE GRIER: Hello. I'm the Executive Director of the Pennsylvania council on independent living.
It is a membership organization that supports people of all ages and I'll disability types across the state and I thank you for the opportunity to be on the Committee. I appreciate it.
LINDA LITTON: Co-chair of the meeting. And I am a consumer and an advocate. Thank you.

KEVIN HANCOCK: Good morning. I'm the Deputy Secretary for the Department of Human Services Office of Long-Term Living. Welcome new members.
BARBARA POLZER: Liberty community connections and welcome to all of our new members and would the members on the phone please identify themselves.
TELEPHONE: Denise C-U-R-R-Y is on the call.
BARBARA POLZER: Good morning Denise.
TELEPHONE: L-U-B-A.
BARBARA POLZER: Good morning.
TELEPHONE: Catherine.
BARBARA POLZER: Good morning sister Catherine. Neil Brady.
BARBARA POLZER: Good morning.
TELEPHONE: Good morning.
BARBARA POLZER: Any other Committee members?
All right. Thank you. I'm going to turn it over to Linda for the evacuation procedures.
LINDA LITTON: Thank you. In the event of an emergency or evacuation, we will proceed to the assembly area to the left of the /STKAOEU respond church on the corner of 4th and market. If you require assistance to evacuate you must go to the safe area located right outside the main doors of the honors suite. OLTL. Staff will be in the safe area with you until you are told you may go back in or evacuated. Everybody must exit the building and take your belongings with you. Do not operate cell phones. Do not try to use the elevators. They will be locked down. We will use stare 1 and stare 2 to exit the building. For stare 1, exit the honor suite through the main doors on the left side near the elevator turn right and go down the hallway by the water fountain. Stare 1 is on the left. For stare 2, exit the honor through the side doors on the right side of the room or the backdoors. For those exiting from the side door, turn left and stare 2 is directly in front of you. For those exiting from the backdoor, turn left and then left again and stare 2 is directly ahead of you. Keep to the inside of the stairwell, merge to the outside, turn left and walk down the alley to Chestnut Street. Turn left in the corner of 4th. Turn left again and cross the street to the train station. Thank you.
BARBARA POLZER: Thank you Linda. Next up on the agenda will be the OL.TL. Updates.
KEVIN HANCOCK: Good morning. Everybody. Thank you, Barb.
So today, we will be focusing on safety participant outreach for phase 3 of community outreach. And then Kristen will be providing on the imply takes much electronic visit verification which we know has to be implemented according to the Federal requirements on January 1, 2020.
Starting with C H C implementation in July and August, we began the participant outreach activities starting with on July 15th, the mailing of the initial touch point flyer as well as the life program flyer informing people of the fact that community health choices is going to be coming their way and providing information for the life program. On August 1st, the aging well session were mailed out to participants so that

participants not only knew when and where are the sessions were scheduled but also how to register for those sessions if they were planning to attend. Those aging well participant information sessions, which also will be involving the centers for independent living are designed to provide a detailed overview of community health choices, the life program, and the difference between community health choices and the participant's Medicare coverage and it is also designed to provide some instructions on how people would need to reach out to the independent enrollment broker to do plan selection. So we are planning 72 participant sessions throughout the three remaining zones for the states and we are trying to get those sessions as close to the participants as possible which means we will have a lot of sessions that will be occurring in some pretty rural areas. I did have a goal to have one in every county in the Pennsylvania T. I was overruled. Part of the reason I was overruled is people have heard me say this. Forest will have one C H C participant. I think we should have gone to that person's house and provided background information but I was overruled and I would have done it myself actually.
SPEAKER: You can can still go.
KEVIN HANCOCK: I can still go. Okay. I will.
We will be also conducting additional provider sessions and I'll touch on that in a little bit. In addition to these -- the aging well sessions, we also mail at the end of August and this is -- they have all been out for -- for the final phase the pretransition notices. Those are actually a formal notice that require -- that is required as part of the movement to a mandatory managed care program that lets people know that first, they will be moving into community health choices, second that they will be receiving an enrollment packet which will be providing more detail about the program and that the meaningful contact activity -- or that service coordinators and nursing facilities will be providing more information to them and third it also gives them information on appeals rights if they think that they are not actually part of the population that would be in the community health choices and an example of a person who may want to look at the appeal rights is someone who is currently enrolled in the O-B-R-A waiver and was not notified that they would be moving into community health choices or was notified potentially in error if they were moving into community health choices.
So in the prior two phase implementations we did have people go through the appeal process. Most of those were resolved fairly quickly but the pretransition does provide rights if they think they are not appropriate to be moving into the community health choices program.
So with the pretransition notices and I do want to highlight this, once a pretransition notice go out, there is no turning back really. We are in full implementation mode for phase 3. What it means in our eligibility system is that the prior programs are end dated. On January /# st, people will be moving into community health choices because there is no other program that they can stay in aside from the O-B-R-A waiver and have to have

the appropriate eligibility requirement for the B-O-R-A waiver. At this point and to be clear, we are full speed ahead on implementation for community health choices and there is no turning back.
And then in addition to the pretransition notices, the service coordinators in the nursing facilities are encouraged to begin for meaningful contact activities. We is have asked and allowing billable hours for service coordinators to reach out to their caseloads and talk about community health choices. We have a service coordinator specific training on our website that we encourage service coordinators to take to be able to communicate about community health choices and that contact activity we have sent out messages to service coordinators to begin that meaningful contact activity at the beginning of August. It should continue throughout the September and October time frames the the whole purpose is to help select the Managed Care Organizations. What they need to do with the physical health networks and the long-term support networks and to guide them through the process. The same activities will be involving nursing facilities as well. There is training specific on how to communicate this change to residents that will be moving into community health choices and we are asking the nursing facility staff most likely the social work staff to talk to residents and their families to talk about what this change means to them and to give their options and their choices and so that began in August as well.
In September and October, the participant sessions will be conducted. So all of those rural sessions that we just talked about will actually take place. I know that I'm going to be part of one. I'm looking forward to doing it in Erie in October at voices for independence with some people who are -- have been very engaged with the roll out of community health choices but many department staff and Department of Aging staff as well will be attending these sessions and also be there to provide background. The sessions will be either conducted by the centers for independent living service coordinators in the region or area agencies on aging to provide the background information for the change for community health choices as well as the life program and also, apprise representatives will be at every single one of those sessions as well to answer much more specific questions about participants Medicare coverage but we want to make sure and continue to convey in these participant sessions that participants do not need to make any changes to their Medicare coverage unless they want to make changes and to make sure that physical health providers also understand that this changes Medicaid change not a Medicare change.
So there will be multiple mailings of the enrollment packets and they will be going out throughout the month of September and they provide instructions for how participants select a Managed Care Organization and also differentiate the three Managed Care Organizations themselves. Also provide information on networks and how participants can do research on provider networks to be able to help do the best informed choice for the Managed Care Organizations that they want to select.

The participant outreach calls for Maximus this change will be coming their way and why it is a good idea for them to select their own Managed Care Organization. Then the service coordinators in the nursing facilities will counselor /TK-BGT the outreach --
GERMAN PARODI: Just to be clear, Maximus will not have any responsibility on guiding to choose an M C O.
KEVIN HANCOCK: It is a great question German. So they will have the responsibility to provide information. Differentiates between the Managed Care Organization. Like network information. Who is in a provider network for the Managed Care Organizations. The three Managed Care Organizations have a different valued service and they can provide that information. Maximus cannot guide people to a particular plan. They are prohibited from doing that. That is why they are independent and an independent enrollment broker. They have to be completely objective.
GERMAN PARODI: And follow-up, that documentation who approves it and who makes it.
KEVIN HANCOCK: You mean for communications with the participants.
GERMAN PARODI: Maximus presenting the participants what the M COs look like, who makes that document.
KEVIN HANCOCK: So that is a great question as well. The Managed Care Organizations -- I'll use the network information as an example and also the comparison chart /-FPL the network information is provided to Maximus by the three Managed Care Organizations and the department approves the format that is used and also the content and we also certify the networks themselves. Now, when you talk about the materials, the public materials, the department approves those materials. So the department -- it is a requirement that Maximus submits them to us and the Managed Care Organization submits them and the department has the approval.
SPEAKER: North central PA adapt. I have a question about the independent enrollment broker as well Maximus we heard just recently they will be doing the assessments in home assessment the first initial one. Could you please explain, there has been information from the state coming out about this.
KEVIN HANCOCK: Okay.
SPEAKER: We don't understand.
KEVIN HANCOCK: So they will not be doing the clinical assessments if that is what you are talking about the determination for nursing facility clinical eligibility. That is not a function of the independent enrollment broker.
SPEAKER: I'm talking about the intake.
KEVIN HANCOCK: What Maximus will be doing is returning to the practice -- so right now as part of the work flow for enrollment services, there is an in home visit. That occurs by Maximus after a person has been determined nursing home facility clinically eligible and that they are in need of long-term care. What is changing is that instead of having that visit happen after that determination is made, Maximus will be returning

back to the practice of meeting with participants at the beginning of the process. An Applicant will be calling Maximus and the first step in the process instead of referring for the clinical determination by aging well and aging well will continue to do this as nursing facility clinical assessments. /PHAUFPL I-M-U-S will be at the front of the process and will have the opportunity to help participants know what they need to do to complete the Medicaid application the 600 L.. The form 600 L. That is the long-term care application. We have decided to go in this direction -- first of all, this was the way that Maximus practiced the in home visit engagement prior to 2016 when we added the aging waiver to their services. We decided to move it back to the front of the process simply because we recognized that without that in home visit at the front of the process, there was a real decline of the Applicant's experience as they went through the process. The participants didn't know what they needed to do to complete the 600 L.. And my Maximus going in the front of the process it gives the opportunity to give the participants to know what they need to do for completing information, what types of information would be helpful to help them more successfully get through the process and helping them know what they need to do to move through the process as quickly as possible. In a nutshell the two objectives of moving the in home visit to the front of the process first is to improve Applicant experience so they need to know what to do to get through the process and second to get people through the process faster. Those are the two objectives. It is meant to be an improvement. It has nothing to do with the clinical assessment at this point but I do have to add. If you look at our concept paper and our draft, R F A for what they are planning to do with enrollment services. In the future the plan is to have all one entity doing that all in one place. That is not the way it works right now but that is the way it will work in the future. We are creating a one stop shop.

SPEAKER: And was there an opportunity for stakeholders to have input on this change, people that have been affected. You know, people that experienced it before and now how it is now and, you know, community stakeholder engagement.

KEVIN HANCOCK: So yes. So let me tell you how much stakeholder engagement has been.

So we were -- so the first engagement we had about moving the in home visit to the front of the process began almost immediately after we added the aging waiver. The stakeholder engagement began from entities like C-A-R-Y and the centers for independent living and so many entities stated that the department made a mistake by moving in home visit to a different part in the progress. We were aggressively encouraged to moving the in home visit to the front of the process since 2016. The reason why we didn't make that change early on was mostly because of the fact that there was a capacity issue with not only what Maximus was able to do with moving through the applications but the cost that would have been associated with it. Through some technical improvements the Maximus put in place and we knew we were planning

to go in this direction any way. We found a window of opportunity to meet the multiple stakeholder requests at -- in planning with Maximus earlier this year to begin the consideration and they were able to bring this new change which is actually returning back to the old process to the beginning of the process in September. We are happy about this. We are.
SPEAKER: So I-E-B is doing the application enrollment and approval of that.
KEVIN HANCOCK: No.
SPEAKER: Okay.
KEVIN HANCOCK: The department always approves eligibility.
SPEAKER: I'm explaining -- I think some written clarification about this is very necessary for our community and the providers that are going to be affected by these things and that are working with the IEB and consumers.
KEVIN HANCOCK: I'm going to be very honest. This is the first time we had any concern raised about this at all. We have gotten pretty much universal alleles /KHRAOEU /PHAEUGS that this is taking place.
SPEAKER: We get concerned because the IEB does not know what that person needs and C-I-Ls who do help with the application process know people's needs, the consumers and how to achieve that and the services and supports that would be applicable for them.
KEVIN HANCOCK: This is in no way impeding the C-I-Ls engagement. It is supporting the C-I-Ls it is focused on the Medicaid application. The C-I-Ls don't see everybody and you don't have the capacity to see everybody. Maximus as part of the responsibility will have some sort of engagement with everybody going through the application process by adding this step will be able to front load support for people as they are actually able to know what they need to do to be able to fill out the application. So happy if you want to send me an e-mail with any feedback you think would be helpful for any written clarification, we would be more than happy to do that. People are pretty happy about this. I think this is a benefit to any organization including the AA As and the C-I-Ls it is meant to be another process to get through the eligibility process.
MATT SEELEY: Just for -- I would like to echo what she said about C-I-Ls involvement in this process. I don't have an opinion either way. I don't understand why -- I guess I'm curious why did you change it in the first place.
KEVIN HANCOCK: Good question. So we -- we changed it in the first place because we thought it would make the process more quickly.
MATT SEELEY: Save money.
KEVIN HANCOCK: I think that -- to be honest that was probably part of the thinking at the time. I wasn't here then. I'm not taking the blame. I helped implement it. I have the blame for that.
It was a bad idea. Anything more I have to say about that -- Department of Human Services sometimes makes mistakes.

MATT SEELEY: We all do.
STEVE GAMBLE: Have you done anything to for phase 3 to sort of tweak to select a plan and not be auto assigned. Background point Pennsylvania for the first two phases has the national record of enrollment, plan selection enrollment for an.
MLTSS enrollment. What we have been doing is starting everything earlier and beefing up communication and we are hoping to encourage much more meaningful engagement with service coordinators and nursing facilities just continue to augment that. But just to set expectations and I'm going on the record I think the assignment rate in the final phase will probably still be higher. I was wrong in the southeast. I'm hoping I'm wrong in the final phase but the reality is we have a lot of people in the final phase, more people than the other phases that are in traditional Medicare and what that generally implies is that especially if they are dual and not in need of long term services and supports they don't pay attention to the Medicaid coverage. So it will be hard to get people engaged when they are focused on their Medicare coverage.
So for that reason, we are set expectations we hope it will be at least as good if not better but realistically, we are expecting it to be a little bit lower.
STEVE GAMBLE: Has the website included -- were you able to sort of come up with -- for the actual participants, there was in the works, there was supposed to be some kind of either commercial or process.
KEVIN HANCOCK: Participant training module. It is up now, isn't it.
SPEAKER: I'm getting verification on that whether it has been actually posted to the website but it is completed and in the process of getting loaded to the web.
KEVIN HANCOCK: What we would like to do potentially in the next May may sub M-A-C demo is get it up. We did use a lot of stakeholder feedback to make sure it was reaching the populations that we want to reach in the right way but -- but we think that that will be a tool that help people at least understand the program even if it doesn't necessarily encourage more active choice of plan selection. Thank you Steve for the question.
GERMAN PARODI: For the record, it would good when metrics are collected on this that those that you know use L. TSS had their select off the program. Thank you.
KEVIN HANCOCK: I'm going to echo your point German. The L. TSS population, we want them to select their plan just for the fact that they are going to be using as primary L. TSS services their M COs. We do -- we did have significant portions of the L. TSS population especially the population in the community made active plan selection in the prior two phases. We would want that to continue to phase 3. Just to be honest, because we are doing this with nursing facilities that has been our focus. Thank you very much for highlighting that.
SPEAKER: I'm -- my name is mark and I'm from Lemoyne Cumberland County and I received all of the mailings, which I'm very appreciative of. My service coordinator suggested that I go to one of these outreach sessions. And I looked at the paper. First I

looked at Cumberland County. And I realized that I can't get there. Then I looked at Dauphin County and I realized I can't get there either. Why can I not get there.
KEVIN HANCOCK: Is it transportation.
SPEAKER: Because I don't have any transportation and the same problem in Perry, Juniata and Mifflin County. They don't do them across county. So my question is how are people -- well, first of all, my question is, who designed this schedule without thinking about afternoon or transportation? That is my first question. And secondly, how is a person supposed to get this information that you want them to have if they can't get there?
KEVIN HANCOCK: I couldn't agree more on the last point. We want everybody to be able to go to the sessions.
So can I ask you a follow-up question.
SPEAKER: Yes, sir.
KEVIN HANCOCK: What is your primary barrier to be able to go to the session.
SPEAKER: Transportation because my transportation provider closes down at 6:00. And you have the ones that have several in Dauphin and Cumberland County would say P M only. And I think it is great. I'm not trying to come here and chew anybody out. I think it is great.
KEVIN HANCOCK: Feel free.
SPEAKER: On the other hand, the people that you want to reach can't get to the -- can't get to these sessions.
KEVIN HANCOCK: Can we talk to you afterwards a lot more specifically.
SPEAKER: Can we really talk about this this is going to be a region all over region 3.
SPEAKER: We need this answer too. Speak you know --
KEVIN HANCOCK: We might be able to address it on a more specific level.
SPEAKER: Like you said, I brought -- up talk about information and I brought all of my three mailings that I received so far.
KEVIN HANCOCK: I'm glad you got them.
SPEAKER: So the mailings are good but the information that you put in these mailings is -- may not be good because people can can't get to the meetings that you are trying to put on.
KEVIN HANCOCK: I'll go on the record saying that we know that transportation in phase 3 is a problem. It is a problem now and the fact that even the C H C isn't implemented there is limitations in your ability to be able to access these sessions because of transportation barriers is something first we are going to have to acknowledge and second, it is -- it is an existing infrastructure barrier in this final phase.
SPEAKER: Again. I'm not the only one.
KEVIN HANCOCK: I know you are not.
SPEAKER: It is a systematic issue.
STEVE GAMBLE: Could they offer an on line for people who couldn't get there.

KEVIN HANCOCK: The participant training will have a lot of the same contents that you referenced earlier. It will have a lot of the same content. We want these sessions to be available to people. I'm acknowledging the barrier for transportation in this final phase and it was certainly a barrier for the southeast as well. We on individual basis we might be able to figure out ways for people to be able to access these services that can be tailored to their needs but the reality is we don't have enough transportation in this state for the long-term care system. You can beat me up on this. I wish I could fix it tomorrow. It has been a problem in the system since the invention. We think that community health choices and with partners in the transportation system such as the transportation that is offered by Mr. F-A-R-R's organization will hopefully be able to target and buildup the infrastructure for transportation but I am not going to be able to sit here and tell you that I'm going to be able to fix it overnight or the Department of Human Services is going to be able to fix it overnight. It might be a generational problem. I wish I could say it was easier but we may be able to help with the individual cases.
SPEAKER: I'm going to suppose that these schedules are for the -- for the informational sessions were thought out. Whoever thought them out wasn't paying attention. Evening only.
SPEAKER: We have brought this to you so many times. Months and months and months ahead of time. Saying that region 3's transportation is not going to go as well as you say it is going to.
KEVIN HANCOCK: I never said it was going to go well.
SPEAKER: I don't know why we have don't have any solution to solve this problem.
KEVIN HANCOCK: What is your solution.
SPEAKER: I'm not the one getting paid to have the solution.
KEVIN HANCOCK: Like I have to say, one point -- correction I have to make is that I never said -- I have never said that transportation was going to be easy in the final stage.
SPEAKER: Everyone has been saying we are on top of transportation. We got it. It is going to be fine.
KEVIN HANCOCK: I don't think anybody ever said --
SPEAKER: I don't get it Kevin.
SPEAKER: What I'm saying is too when the schedule was planned out, somebody should have looked and say hey we don't have any -- we don't have any A-M meetings in Cumberland or Dauphin or Perry if I have Lynn and Juniata county. That is all I'm trying to say. And I believe from what I'm reading, from what I'm seeing, it wasn't done.
KEVIN HANCOCK: So timing certainly was a consideration. Your feedback is fair about these different areas but I have to -- I have to say that transportation was a consideration for the set up of these sessions as well as the facility space. We wanted to make sure every facility available was able to accommodate.

SPEAKER: I'm sorry. I understand what you are saying but I don't -- I don't believe it was considered or if it was considered, you would have at least one a.m. session in Cumberland Dauphin Perry Mifflin and Juniata. That is what I'm saying.
SPEAKER: Perhaps the folks that are doing the additional trainings can accommodate those times.
SPEAKER: We can't hear you.
KEVIN HANCOCK: Do you want to come up. Malt Matt it seems like we are talking about availability and timing and scheduling of the meetings.
KEVIN HANCOCK: They are two different things.
MATT SEELEY: Mark seems to be talking --
KEVIN HANCOCK: The later would be easier to solve than the former which is why we want to have a chance to talk to him and look for ways to accommodate the particular --
MATT SEELEY: The timing doesn't affect mark alone.
KEVIN HANCOCK: No. But hearing his particular situation may be a way that we can figure out the solution.
SPEAKER: So I just want to add. So for these participant sessions there is 72 sessions that are being conducted by aging well. And that is spread out over 48 counties. We also have additional sessions that are going to be conducted by other business partners, other entities. So we were hoping that they will be able to fill in some of the gap of availability times as they are scheduling for their participants that they serve. And we also have the on line additional on line training that is going to be posted any time now. So that will be available to everyone and we will be able to roll that out to everyone. So it is a challenge because it is a very large -- large area to cover. So these 72 sessions are actually part of a larger communication strategy for phase 3. It is not the only opportunity to do outreach to participants. We have engagement from stakeholders, folks that are doing that themselves. We have education being done within the nursing facilities. We have service coordinators being trained to do the education themselves. And we also have a grassroots vendor that we are bringing onto do targeted education for -- mainly for folks that, you know, specific cultural groups that may not have English as a primary language. So this is just one piece of the large communication strategy for phase 3. So specifically, if folks are having a challenge, do bring them to us because then we can gear them towards some of the other offerings that are occurring from now through the end of the year.
SPEAKER: I'm with the center --
KEVIN HANCOCK: Sorry microphone. The red light has to be on.
SPEAKER: I'm with the C-I-L of Central Pennsylvania so I'm in mark's area. And the concern is we don't have equal access. The informational sessions were scheduled without input from the C-I-L. They were all scheduled for 6:00 p.m. which if they would have talked to the C-I-L we would have told them that is not good but we don't have

the equal access. All we are asking for was to do -- and transportation is not the issue in this case. It was not considering consumer needs. I think it is only -- I don't want to think about that. I'm just going to say there was a lot more thought that could have been put into it if we would have collaborated more with the C-I-Ls so now --
KEVIN HANCOCK: Can I -- so we actually have a contract engagement with the C-I-Ls for education and outreach. I'm going to turn it over to Mike to talk about that engagement.
SPEAKER: Before we do. This is misty and I'm actually part of the Pennsylvania council on independent living. I'm sure Mike will explain more. I wanted to point out that the curriculum and the proposal and the contract that we finally got done through P-C-I-L so we could help provide more education in our region is that was a -- it -- it took a long time and by the time we sent the curriculum and hearing we have had no collaboration with aging well. We need to have stakeholder engagement now and be able to offer other options, I think, webinar opportunities. I mean, have C-I-Ls involved and continue to have --
RICHARD FARR: Is it not possible to Adam additional day because, you know, as the transportation guy I need to say something about transportation. The shared ride can provide Monday through Friday in all 11 counties that I serve anywhere between 6 and 6:00. Any time midday, we can accommodate that. Is it the size of the venue is the concern or is the contract done where you can't add additional locations at this time.
MIKE GRIER: No. We are adding additional locations at this time. We just haven't set the dates or times yet.
RICHARD FARR: What I'm hearing from the folks I work with regularly is that transportation isn't an issue timing is an issue. We need midday.
KEVIN HANCOCK: I would submit that both are -- transportation can be a challenge per its availability but as Mike was pointing out, we are adding additional sessions in all of -- all three of the zones to be able to -- hopefully be able to be more accommodating. This feedback is going to be helpful for us to do the scheduling for those different types of sessions but I also will like to highlight that we might be able to learn a lot from your case and other individual cases, mark, where -- where you have specific barriers that you want us to be able to address in the planning of these sessions.
SPEAKER: Thank you very much. I'm -- I'm not trying to chew anybody's head off. If I want to and if other people want to get to these -- get to a session so we can learn more about what is happening and if you move away -- if you move away all of the junk, that is what we all really want. Am I correct.
KEVIN HANCOCK: Absolutely.
SPEAKER: Very good. Thank you very much.
SPEAKER: Can I say one last thing about the education sessions. As we move forward and we talked a little bit -- Kevin you talked about sessions happening in the nursing homes, the nursing facilities as they are happening, I mean, can we work with P-C-I-L to

have more sessions and nursing home transition providers to do those meaningful contacts with the nursing facilities in all of the areas and like the service coordinators are doing. I think that would give us a chance. This is the first time C-I-Ls have had an opportunity to start reaching out to our participants to start educating them and we are going to hear a lot more of this, even more in our region because the transportation and much more.
KEVIN HANCOCK: To your point, there is more nursing -- especially in the northeast, there is more nursing facility long-term care than any other part of the state proportion nationally. That is an interesting idea. We can talk to each C-I-L for how nursing home transition engagement could be part of the communication facility with nursing facilities. I like that idea.
DAVID JOHNSON: How will the availability of the on line module be communicated to participants.
KEVIN HANCOCK: How will the availability of the on line module be communicated to the participants.
SPEAKER: We are going to be sending information out through the list serve. So service coordinators will be engaged, nursing facilities will be engaged. We will put something out on the web. Anybody that is also signed up on our list serve will receive that information. And we can also add that so call scripts and that kind of thing. We didn't talk about that but if that is something that folks think would be a good idea we can add that to call scripts to make sure people know that there is training out there.
KEVIN HANCOCK: And we are obviously open to suggestions.
DAVID JOHNSON: It would be in the mailings.
SPEAKER: We do not have a flyer to include in the mailings because the mailings are going out now. We don't have a separate postcard or something like that. We are intending to have a postcard sent out to our common law employers through the participant driven model because that part of the reason for the development of the training was based on feedback from that stakeholder group about wanting to watch that training with their direct care workers. So we will be doing additional education through PPL for folks so that they know that it is out there.
MATT SEELEY: Can I ask you a follow-up on what you were talking about earlier. I may have missed this. You refer to a grassroots vendor. Is that with P-C-I-L.
SPEAKER: /THAPBS addition. Remember in the southeast, we had a vendor do some dedicated sessions with the Latino group. We had Korean -- I think Kevin was on the Russian -- was it Russian.
KEVIN HANCOCK: I was on Russian radio. I also attended the session with --
SPEAKER: There was a faith based organization event. So they were dedicated events to certain groups within the community to try and make sure that the word got out to folks about community health choices. So that vendor will be putting together a communication strategy for that type of communication and be doing that across the T.

So that will be an addition. That is kind of where I was going with. This is a much larger area to cover. So we have a much larger and more expansive communication strategy. It is -- we are not going to touch everyone in one way. So we are trying to have different components to reach different groups and that way we can ensure that we are touching as many people as we can.
MATT SEELEY: Thank you.
KEVIN HANCOCK: All right. So just to close on the participant outreach activities the last day for plan section will be November 13th for auto assignment and then from that point on, people can continue to change the Managed Care Organization that either they select or was auto assigned to them until December 20th and still have that effective on January 1 st.
I'm going to jump.
GERMAN PARODI: Could you close up how long will the medical continued care will be.
KEVIN HANCOCK: Sure as a reminder we have three different types of continuity of care in communicate health choices. The first is for those individuals receiving language term care in the community. The continuity care period will be 180 days or roughly 6 months and in the final phase it will extend from January 1, 2020 to June 30, 2020. For nursing facilities if a person is enrolled in Medicaid long-term care and receiving their long-term care in a nursing facility, that continuity of care will continue indefinitely as long as the nursing facility is enrolled in the program. They will have to develop and in network or out of network relationship with a nursing facility but the participant will never have to move unless the nursing home facility elects to no longer be enrolled in the program. The third is for physical health services. If a person is receiving physical health services in the fee for service, the continuity of care period will be 60 days and what that means is for a person who is receiving services from a provider such as dialysis services, and they transition to a Managed Care Organization where the provider is not part of the network, they will be able to continue to receive those services for a 60-day period and then transition that into and in network provider. The standard continuity of care after the other two continuity care periods expire, the nursing facilities do not expire as part of the implementation will be 60 days. The that is the standard continuity of care after C H C is fully implemented.
GERMAN PARODI: Will the M COs identify people that need -- that receive this kind and really try to fix this before it ends -- thank you.
KEVIN HANCOCK: German is pointing to a problem that you were -- helped us educated us about the southeast in terms of communication and one of the providers. So the Managed Care Organization will know if people are receiving services prior to the implementation if they know who their participants will be and they should be managing that continuity of care period from day one. So the answer to that will be yes. Will it be -- will there be problems? Likely here and there. One difference about the final phase for physical health services, like with long-term care is that there are fewer

providers which should make the communication work more completely but then the other issue is that there are fewer providers so the access is challenged in a lot of the rural areas. I think access across the board is going to be the biggest challenge we have and that includes transportation.
That is a good segue about talking about provider workshops. One lesson we learned is to do a second set of provider workshops in the fall to talk about the enrollments and we do have three scheduled /-FPL the registration is open for all providers providing long-term care to go to an additional session to have your questions answered about the community health choices for the northwest the session will be held at Clarion University and it will be on October 8th and it will be and all day event. For the northeast, that would be at Mary wood university on October 21 st and then for the Lehigh capital zone it will be Kutztown University. It is cuts town on October 28th. And the sessions will include obviously an overview of community health choices and six break out sessions including home and community based services. Service coordination which I will facilitate. Nursing facilities, services, behavioral health services and physical health services and we are adding transportation as a break out session as well because we do recognize that it is a very big problem in this final phase and we know that we are not going to fix it overnight. But we are hoping that with the Managed Care Organizations engagement with transportation providers such as being represented by Mr. F-A-R-R we will be able to better address the population's needs.
So always remember that all of this information including the transcripts for these. MLTSS are on the health choices website and as well as the trainings and the participant training will be on this website as well once it has been published.
SPEAKER: Tomorrow.
KEVIN HANCOCK: Apparently, it is published tomorrow. We are open to suggestion on how to get the it out.
If you look on the screen, this information can be found for participants on the community health choices landing page. And we also encourage people to subscribe to the list serve so they can continue to receive the latest C H C news and then the landing page for specifically for participants that have translations in both English and panish is listed on this slide and includes all of the informational flyers that has gone out and this is likely the landing page for the participant training and also the presentations in multiple language for the aging well presentations and sessions and information on the life program as well. And with that, if there are not anymore questions, I'm going to turn it over to Kristin to provide an update on the implementation of electronic visit verification.
SPEAKER: I can can just sit here.
Good morning. I'm going to provide a brief update on electronic visit verification. As a remainder, the state is pursuing an open vendor model. We received a lot of feedback from providers that they wanted to keep their E-V-V system and if they had invested

and implemented one. So any providers that have their own E V. V. System can continue to use that. Providers that do not have their own system, there will be a free system made available to them. If they are in the community health choices they can work with the M COs to begin using H H H exchange. If they are in the fee for service system, which is O-B-R-A, act 150 or any of the O D P programs subjected to E V. V. They can use the state system that being offered. Next step providers should be taking if they have their own system are reviewing and complying with the technical specifications that have been provided on the D H S website. Whether you are going to be working with the Managed Care Organization or the data you are going to have to make sure your system can meet the technical specifications to be able to send data to those entities. For providers that do not have their own system and intend to use the state San data system we have sent out -- for training. Those trainings will be late September and the entire month of October and that registration can be found on the website if you do not see the list or announcement for that.

The D H S E V. V. Trainings for the San data system will include the in person training that is what the registration is for or it will also include instructor led webinars that will be interactive or if you do not have time to attend one of those scheduled trainings there will be a self paced on line training for you or your staff to attend. We do ask for the in person training because it is limited to two individuals from each agency. So the self paced on line training is really a good resource for your other staff members who may not be the front line for billing or training staff within your agency but who you want to still be able to access those trainings.

So a little update on the participant directed model as a reminder PPL did elect to use their own EVV. Which is called time 4 care. And their system did go live on September 1 st. It is a soft go live. So not everyone has begun using the system but they wanted to make is available as soon as possible with the understanding that the more time you have to get this implemented the more time to work to get everyone comfortable with the system and work out any kinks before the mandated deadline of January 1 st. They did conduct quite a few webinar trainings. And there will be additional webinar trainings offered in October. Throughout September and October, they will also provide in person trainings throughout the state and they will be on-site at all of the participant information sessions for C H C not only to answer questions about PPL and their daily operations and Customer Service but also to assist with E V. V. If you happen to be there and have any questions for them then.

The last slide here is just the updated resources that are available for you. The frequently asked questions are posted on our website and they are constantly being updated based on questions we receive from our public meetings based on our two public meetings we have received over 500 questions so they are slowly being added to the document as we complete those answers. We also have the technical specifications posted on the website that is listed here for you. And please, if you have not subscribed

for the E V. V. And that is the best way to get reminders. Our next public meeting will be September 17th, from 1:00 To 3:30 and you can register for that on the website. Any questions.
SPEAKER: One thing I want to bring to your --
BARBARA POLZER: Please come to the microphone.
SPEAKER: I just had major surgery.
SPEAKER: One thing I wanted to bring to your attention not all attendants have computer access and I know two of them right now that do not know the process to do this. They are trying to learn the computer, but it is very difficult. A lot of our attendants do not have access and either they don't have a computer or they have never been on a computer. So you need to take that into consideration as well. Because I know as of January 2000 everyone's sign sheet will be on the computer and not everybody has access to it.
SPEAKER: Are you specifically referring to the webinar training being conducted by PPL. A couple of things there. PPL did send out mailings to direct care workers and common law employers.
SPEAKER: I seen one.
SPEAKER: It did include paper documents with instructions for the application the web app that you would use on a phone or a tablet but there is also additional communication that will be sent out regarding the telephone option. There will be an option to use a landline telephone to meet the E V. V. Requirements. Unfortunately PPL encountered some last minute delays and so the details for releasing that have been delayed. If you call Customer Service with PPL, they will record the contact information for anyone interested in T-E-L-E-P-H-O-N-Y and directly reach out to them in October when the system goes live on October 1st. They will reach out to them and the next steps. Until them, direct care workers can /TOEUPB use --
SPEAKER: But I'm just bringing that into consideration because --
SPEAKER: Absolutely.
SPEAKER: I know a lot of attendants. Some of them have never been on a computer. Some of them don't have computers.
SPEAKER: Absolutely. Understood.
SPEAKER: So it is very difficult for them.
GERMAN PARODI: Two quick, just last time a few months ago when we asked about this, they -- attendants will still get paid if the times are not submitted and whatnot.
SPEAKER: Yes.
GERMAN PARODI: And sendly, I have followed the policy -- I'm hearing that some states are getting extensions on this? Oh --
SPEAKER: They are.
GERMAN PARODI: Can you talk about that.

SPEAKER: To speak to your first question, if there are any sort of systematic issues that should not delay payment. The important thing to remember is PPL if you can cannot enter that time however you are using E V. V. They still need to be made aware in some regard of the time so they have it for payroll. Whether it is the web portal or through the phone. So still be aware. For the extension, there is a good fake exemption offered by C MS that states can apply to. Some states have applied. We have not because they have viewed us on a good track but if there is something that were to arise that would be some sort of insurmountable system issue. We have evaluated the requirements and what we would need to do to do that but at this time, we are on track.
GERMAN PARODI: Thank you.
JESSE WILDERMAN: Just I think C MS issued some additional guidance around live in family providers and their requirement on E V. V.. Has that had any impact or change on how the state is approaching it and that is one question and then I'll wait until you answer that and then I have a second.
SPEAKER: C MS released guidance addressing a couple of different elements. There were some elements regarding D M E and home modifications and that any type of requirements with E V. V. And they precluded that from E V. V. And then they also included an explanation for the option to exempt live in workers and then they provided some additional clarification on the expectation requirement. At this time, we are evaluating that guidance and how we could or could not integrate that with the system as it currently stands and we will release official response for that.
JESSE WILDERMAN: Just so I understand, at the moment, live in direct care workers -- the expectation is they will be required to adhere to the E V. V. Requirement.
SPEAKER: Yes. All of the guidance provided by C MS did leave it up to the discretion of the states as to how we would handle that guidance.
JESSE WILDERMAN: The second question. I raised this before. So there are bound to be technical challenges on -- on the -- whether it is on the person directed services or on the agency provider level. And one of the concerns that we have is that that will result in not only people not getting paid in the immediate term, right, which we -- I think we are trying to build back up system and so onto make sure people get paid no matter what. I think it is a good thing. But that provider agencies in other situations may say this wasn't entered correctly or this wasn't done effectively so we can't pay you for those hours. And I'm trying to figure out what a direct care worker does in that situation because they -- even if they do EV. V. Correctly, they need to be paid. If they made a mistake, they need to be paid. There aren't a lot of resources right now for direct care workers who get stuck in that situation. You are not sure who to call. You call your provider agency and don't get a satisfactory answer there. So how do we create a resource for direct care workers who are in a situation where they are learning E V. V.. They did something incorrectly but they worked the hours and now they are being told

they are not going to be paid for those things. How do we get them to a place where they can get help and get that issue resolved.
SPEAKER: I think it is a fairly broad question and there could be different scenarios where they are talking about major system issues and the process for a direct care worker to work with the agency or PPL to make sure that time is accounted for or if there are perceived errors on the agency side that they feel need corrected because all of the systems are extremely different and we have an open vendor model, this is going to fall primarily on the agencies to develop back up plans. We do have that expectation and that will be communicated more clearly this fall. They will need to establish back up plans and when there are systems outages to make sure everyone is communicating properly and they are going to need to develop expectations for correct entry of time. We can always offer our provider complaint line -- our provider assistance line through O L. T L. If there are some insurmountable issues. For the most part, this is a direct care worker agency relationship.
KEVIN HANCOCK: The only thing I would add to that is -- I mean, the provider -- the provider help line would be the best resource for the direct care workers to go. The scenario that you are describing and correct me if I am wrong is really between in the agency model. PPL would probably be the first stop for a direct care worker who is supporting some of the consumer directed model and PPL would have the information available, readily available for the direct care worker if some sort of correction needs to be made that would be holding up payment. In an agency model as she had pointed out, it is a lot more agency specific and it should be between the agency and the direct care worker to have something like this resolved but if we have some broader systemic issue with an agency that is not using it to pay their direct care workers in a perfect world would never happen but we definitely don't live in a perfect world then that is a provider complaint. We see that as the same.
JESSE WILDERMAN: I guess what I'm -- there is the systemic issue and the individual way I worked these hours but I forgot to clock in and I go to make -- somebody is supposed to make a manual adjustment to my hours and when I'm learning the system and they don't do manual adjustment and I'm out of luck and not getting paid. In other situations, particularly when there is dramatic changes, the department has contracted and worked with the Pennsylvania health law project and without side entities that can be a resource for consumers, for example, who are having trouble navigating or running into challenges with managed care and so on and I'm just wondering if we should be considering for the initial launch of this some sort of hotline just beyond a provider hotline. Some sort of entity even for a short period of time for the first six months or something where a direct care worker can say I get independent support on this to resolve problems where I may not be able to go directly to my employer or my employer is telling me something that doesn't seem right. It is a huge shift for, you

know, the direct care workers. Just something that might be worth considering for at least the initial launch.
KEVIN HANCOCK: We have to think about that. Because there does have to be an employer employee relationship that is directly involved in the scenarios that you are describing. Not doing an justment for making sure -- I'm not aware of it. Not doing an adjustment for a person who isn't getting paid for hours they worked, I think is a violation of the fair labor standards act. I actually don't think that -- I mean, they can call us and tell us about it but I mean, they have -- I mean, they have an actionable case in that type of situation. So I'm not sure how the Department of Human Services -- I mean, the only way we would be able to do something if it was a provider specific issue. And they are using E V. V. As an excuse. That is where we would be able to intervene what you are describing is an employer employee relationship where we don't have jurisdiction.
JESSE WILDERMAN: I get that. I totally understand that. I think that is right. What I'm totally trying to lift up is when you get to these low income -- most of the direct care workers are low income folks and don't have access to their own legal team or, you know, know who to call if there is a wage an hour violation. I don't know how many -- some very very large number of home care agencies all of whom operate a little bit differently at different times, you know, and so much like the department at different times has understood that for -- for consumers independent outside resource that can help manage major changes to the people that have the resources to figure out where to go and what to do. I'm afraid if I'm a direct care worker and I run into an individual situation like that and I call the hotline, you know, they are going to give an answer, which is probably the right answer, that is between you and your employer. And then as a direct care worker, I'm kind of stuck and we are going end up with frankly a lot of direct care workers who are just learning a new system and a major transition who are going to get shorted a lot of hours because they don't do it right on the first couple of tries and having an independent resource that can at least direct them to the right places for, you know, figure out how they can navigate that relationship and figure out how to navigate that relationship with the employer would be worth thinking about. But any way. A recommendation.
KEVIN HANCOCK: It is a tricky situation for the employer employee relationship. I'm happy to think about it and we will have conversation about it as well.
BARBARA POLZER: Two questions came in over the phone. The first one is there any guidance on preferred nonpreferred exceptions.
SPEAKER: So I'm not sure I completely understand the question. And if I don't understand it, please submit maybe an additional question. So the department does not have any preference when it comes to what type of exception may have needed to be corrected or occurred in the system and what needed to be manually edited. With any E V. V. System, there is the option to set exceptions that would be flagged and prevent

that visit from being completed until a manual correction was made. For the Department of Human Services, we wanted to make some as flexible as possible. The only time we set exceptions in our system would be when one of the major elements of the K-U-R-I-Z-A-K requirement is not available. If it was submitted for the appropriate elements for location, with the appropriate elements to identify the direct care worker providing the services, the individual receiving the services, the services provided, those type of missing elements would be the only thing that we have programed to generate an exception that needs a manual correction. So we don't have any type of preference for, you know, at what point that is edited or how it is edited. Those just need to be met. I hope that answers the question.
BARBARA POLZER: If not, I'm sure we will get another one. The second one is what is the threshold for allowing time sheets when folks run into problems with E V. V.
SPEAKER: So as of -- we have received guidance from C MS as of January 1 st, 2020, paper time sheets can cannot be accepted. Now, for every system, there are several opportunities to make those corrections. So you can make corrections when you, you know, if you -- your phone broke for the day and you are not able to put in your hours. You could make those corrections the next day or the next week, whenever you needed to make those. You can also contact your agency, if you are a direct care worker with an agency or PPL if you need to make those corrections. But we will not be regularly accepting paper time sheets as an alternative to E V. V.
BARBARA POLZER: Thank you.
SPEAKER: Good morning. Sort of piggy backing on the systemic challenges involving transportation for the implementation of.
MLTSS and other perspective or aspect that really impacts the successful implementation of.
MLTSS is network adequacy with respect to direct care workers.
We know that many attendants and caregivers are low income, many work without healthcare benefits, are not paid over time, don't receive training and paid time off, all of the things that workers in other industries routinely receive and for the continued success of M L. TSS, we really need to improve the direct care workforce and the retention of the direct care workforce. So I'm suggesting that this committee consider adopt -- formally adopting on the record the very good recommendations that came out of the Department of Aging's long-term care council, the blue print report for direct care workers and recommendations that focus on improved the living wages for workers, training to improve the skill set of home care workers as well as healthcare benefits and other aspects that will hopefully provide us with a good workforce of attendant caregivers as M L. T T continues to expand including region 3 or phase 3. And the report many of you have looked at it, it has been shared. The governor has promoted it himself. And it also parallels many of the recommendations of the M L. TSS workforce report that N-A-S-Q-A-T did this year. Sharon Alexander AmeriHealth Caritas

was one of the authors. These reports really quantify and make very good recommendations about improvements for the direct care workforce including agency and participant models. So I hope that somebody from this Committee can maybe consider making a motion to adopt the blue print. And do what it can as a sub M-A-C working with the long-term care council, P-C-I-L, the statewide independent living council and the governor's advisory direct care workforce advisory group. We really need to work with the Legislature to improve the living wages for home caregivers, the two percent raise that was recently passed in the state budget while it is a step forward, it really is a tiny increase and we are not even sure how much of that the managed care companies will be providing passing forward through to the direct care workers themselves who are the intended recipient of that. So if we could please have a motion to adopt a blue print and promote it across agency, across Committee so that we can convince the Legislature in the upcoming budget year to do the right thing.
HESHIE ZINMAN: Can we do that. So we have the opportunity to review the blue print.
MATT SEELEY: I will second that motion if that is something this Committee can do.
KEVIN HANCOCK: That is a matter of discussion. I'm an Ex-officio yo member of the Committee. As a matter of suggestion, I would suggest that -- that -- that your -- your idea be taken under advisement by the Committee and then discussed in the next M-L-T-S-S in October. If the Committee wants to adopt it and the reason why is because I'm not sure if the new members have had a chance to review the report. I'm just going to go on the record saying, I was certainly involved in the discussions associated with the blue print and I'm certainly supportive but I'm not sure it would be fair for everybody who is new on the Committee to -- vote on something that they may not be --
SPEAKER: That would be fine perhaps Barb or Kevin can circulate the blue print to all of the Committee members so at the next meeting it can be voted on. It is kind of a no brainer and it really -- we really need to begin coordinated efforts among these committees, advisory groups to really move the big ball forward and get a systemic change in place. So the next meeting would be great, if you could circulate it before that.
BARBARA POLZER: Thank you. We will get that out to the remembers within the next day or two.
SPEAKER: Hi there. I'm Pam silver from the Pennsylvania health law project. I actually wanted to return to the EVV Discussion and specifically to Michelle's question about how attendants and providers with lower level of technical lit is I are going to use this system.
I understand that PPL and other providers are going to be working to make sure that they can use the telephone and landlines to -- to do EVV. But my question is more about the training side of it. A lot of the training and outreach that you have described is on line, the website, these webinars and that is all fantastic but for the attendant or provider who Michelle was describing who isn't -- doesn't have access to that, what

opportunities do they have specifically for training and to get up to speed before EVV Launches. You know, are there other alternatives to this in person session that you know, so -- to train them on these issues so they know what their responsibilities are without having to find someone to do this webinar.
SPEAKER: So I'm going to answer your question two ways. On the participant directed side, we did mail out the instructional documents and F A Qs so people could have them on hand. We do have the on line resources through PPL. We have the webinar trainings as well as in person trainings that are being planned but we can absolutely consider other areas particularly as we start to see, you know, who we are and are not reaching. We can start to see what other options we can do to outreach to those specific individuals. On the agency side, when we talk about training, that is really going to fall to the agency to train their staff and the reason that is is because that agency could be using any number of systems. If that agency is going to use the A G G system with the M COs agency providers should be trained and then pass that onto their staff. Same thing with the San data system. If they are going to use that, agency staff should attend that and then pass that knowledge onto the other staff in the agency but we do not have specific trainings for every direct care worker on the agency side because it is really up to the agency and what system they use.
SPEAKER: I think that a lot of the concern would be more on the participant side and the participant directed side. So I would encourage O L. T L. To work with stakeholders like Michelle and others to make sure that there are materials and training opportunities available for people who don't have access to these webinars.
SPEAKER: The reason why I brought this question is because attendants are asking these questions. It is not only people that I know but people that I see that are -- they are like what are we going to do when it is time for us to do it. A lot of them don't have computer access. A lot of them -- even though you sent out the instructions, they may not be able to understand it. I know it is one two three for us, but it is not going to be the same for other consumers that are not familiar with the computer, that don't have access to a computer. I mean, I know this is the computer years but not everybody, especially our attendants. Some of them are a little bit older, they never really even got into a computer.
SPEAKER: I absolutely -- understood. And they should -- the PPL Customer Service staff have been trained on how to assist workers and common law employers with questions they have surrounding EVV And the different options. I want to highlight, this is part of why we started EVV. With the participant directed population as early as we could because we wanted to have additional time to build in more resources and adapt to, you know, individuals who are not able to access what we currently have. So I will take that back to kind of discuss what other options we have for outreach.
SPEAKER: I'm just saying you are going to expect this to go into effect as of January and I already know that a lot of people are not going to be up to that point. A lot of people's

paychecks are going to get frustrated and it is going to affect the consumer. Because if they don't get paid, they are not going to want to come to work.
SPEAKER: Understood and part of the soft launch, one of the things we are doing as we move forward this fall, we are going to be looking at who is not using it, whether it is a specific agency not using EVV. Or a direct care worker or a common law employer participant direction and we are going to do direct outreach to those individual today's talk to them about what the issue is. Are they having problems accessing. What are the barriers for them to begin using this. So we do have plan direct outreach because it is going to be a case by case scenario. We can't predict what the barriers for each individual but we will reach out to them.
JESSE WILDERMAN: Just to build on this. We had about 40 workers who met with PPL to get a live demo of how this thing works and be able to learn how it works and I will just say there is a seconding of the hands on see it in front of you live engagement actually reduced a lot of anxiety that a lot of people had that I can do this when they were able to see it and really have it right there in front of them and imagine themselves with their own phones and doing it. And I'm appreciative that the department -- there is some group of people, I think they reported to us about 1,000 participant directed direct care workers have participated on the on line experience of learning about EVV. There are 17, 18,000, you know, of these folks so that is a -- that is a start but there is still lots of folks who haven't been exposed to it at all. And so figuring out and maybe there is some -- having the department be able to tell us, okay, this many people are live using it, you know, and this people have been through trainings and zeroing in on the group of people who are going to need that hands on support of how to down load the app, how to get into it and manually adjust their time and deal with problems as they arise is just going to be critical and we are willing to help with that. We want all of the folks willing to help with that. I continued to phrase this before. On the agency side, I'm wondering what the same kind of analysis is in terms of how close we are getting and how ready people are and how successful we are going to be at launching it. I understand that the department can't drive the training when you have all of the different vendors and they have slightly different systems so on and so /SORPBLG. It does seem we may be able to measure before we go live what number of agencies are ready and what number of direct care workers are ready and I where are we going to have to have more proactive training.
SPEAKER: Yes. And we do plan to do that at the agency level as well. On the PPL side, I can give you the numbers as of last week. As of last week and I know it has increased this week I don't have the exact numbers. We have over 20 percent of direct care workers in the PPL program using the app. We anticipate that to have increased this week because this was the first week that app transitioned from an electronic time sheet to the actual E V. V. System. I can also say that we know that about 70 percent of people are using electronic time sheets. So we are more comfortable with them being able to

adapt to E V. V.. The population we are specifically analyzing right now and going to target first are people still using time sheets. We anticipate they will have the most significant struggle.
SPEAKER: There is a number of questions that I have in regards to this. I have put in someone put.
In regards to the PPL training this past month. I was able to be on a number of calls. Some I was able to ask questions from a Verizon fiber line. So hopefully that is going to -- on other ones, I was not able to ask questions. When they unmuted it didn't happen. The webinar people that they had on the chat, they seemed to be able to address that on those at least in my case, I was not able to get through in a number of sessions and ask questions. One of those happened out of your West Virginia trainer Justin cotton. So that was a concern. The effect of what is going on, interesting term if you have never heard it before. So if you get hit on the head and the brain gets injured it is the soft tissue damage and this whole thing, what is happening with the C-O-N-T-R-A-T-U effect. I will go to another one on that. The phone the weakness with the safe link. So we are saying to people that can't afford a phone or are getting a new smart phone. They use the attendant and the participant. Let's say they both have a safe link phone and the phone gets dropped or it it gets damaged. Now, earlier you said, oh, if it is out of service for a day, then you go back on and you can do it tomorrow. Well, have you ever tried to get a safe link phone replaced?
SPEAKER: I have not but that is not the only option to make those corrections.
SPEAKER: I understand but it becomes important. Often they don't want to do it, pay for it. You wait a month or whatever to get a new phone. So that is one of the issues that the standard data rates apply.
Have you been doing tracking on these PPL calls for people calling in because you do caller ID people with your 800 numbers.
SPEAKER: So we are expecting -- this is the first week that the E V. V. App is live. So we are expecting a Customer Service report reporting back on the first week of Customer Service activity.
SPEAKER: I'm talking about direct care workers and participants calling in?
SPEAKER: I'm not sure I understand the question.
SPEAKER: Okay. When you dial an 800 number, the person is paying the bill knows who is calling. Have you been tracking all of those numbers that are calling in.
SPEAKER: I would have to check with PPL and the detail they collected regarding those calls.
SPEAKER: When I'm looking at the different population ranges, an older group versus the younger may be more used to using a computer and the older group struggling with it etc. Those who mentally they find it a challenge, not all people are configured the same way. Some things become an immense challenge other things are easy for them. I'm noting that.

That was one of those questions.
The training with public partnerships just focusing on the webinar people, that seems to have been a weakness and we hope that somehow that gets addressed.
SPEAKER: Are there specific weakness that you can can highlight with the webinar other that many the difficulty with being unmuted and asking questions. Are there other weaknesses that you can identify that we can address.
SPEAKER: Honestly, yes. I found that instead of being an educator, it was like high pressure sales and doing it extremely quickly. So people that don't have a -- great ability to pick up on things even on a webinar questions like what is a port hole, how do I turn on my computer, et cetera, etc. And when people rush through those training sessions that doesn't happen and the other weakness that I identify is what you have in a course even on line. It is happening too quickly. You are not getting the people that are slower to catch up and get on the page with you. You are waiting until the end to identify all of the questions and why then the person that has already been -- it is like you are out there with a little snow shovel and the big flow P-L-O-W and came by and came by and you give up. And then the -- the obvious response to the snow P-L-O-W going by and burying you three times are things that I observe.
SPEAKER: I can speak with the trainers about that.
GERMAN PARODI: It would be great if we could perhaps at the next meeting or be shown -- develop a document showing what will be a contingency plan to prevent turn over as a direct cost of something that even if we -- someone didn't put the geo fencing right, the person didn't get paid and should get paid. I just thought that that would be great, perhaps, you know, I was -- I know that I have to take -- I gathered how much time is each thing going to happen. That was over a decade ago. I was a consumer. I know that.
I don't know. I mean, initially, it is too much time. If it is hours that I normally get weren't recorded on week one, I would love a call. Hey, is everything okay. Maybe there is something wrong. PPL doesn't.
SPEAKER: The one benefit especially, I can't speak to all provider systems because they all function differently the one thing I can speak to when it comes to time sheet issues is that -- now T-E-L-E-P-H-O-N-Y is a little bit different but with the app, one thing that is going to do now is it is going to visually alert the direct care worker and the common law employer immediately after a shift alleles completed if for some reasons the hours were not correct for that participant or they ran out of hours, so they will be alerted immediately rather than potentially looking when they go two weeks later to approve the time sheet for payroll. So hopefully that will assist with being more proactive about addressing these issues earlier.
GERMAN PARODI: Sure. That is a contingency for those using virtual -- I don't know if in the next month we hear that so we are more sure. We won't lose attendants due to this.
SPEAKER: I can follow-up on that.

BARBARA POLZER: All right. Thank you. Next up on the agenda is pharmacy services and we have Dr. Terry with long with the pharmacy directors for AmeriHealth Caritas PA health and wellness and UPMC.
DR. TERRI CATHERS: Good morning everyone. I'm the department's pharmacy director and so what that means is that I oversee the pharmacy benefits that are provided directly from the department. So if you have fee for service as your pharmacy benefit, that is the benefit that I oversee.
And I know that a lot of the population that is in community health choices is dual eligible. So they have Medicare and Medicaid. And primarily, your prescription benefit is provided by Medicare part D. Medicaid would wrap around and pay for those medications like over the counters, select vitamins and minerals. Kevin asked me to come today and talk to you about pharmacy services and I was thinking, well, the big thing on my agenda right now in pharmacy services is that the department intends to implement a statewide preferred drug list in January of 2020. Currently, all of the M COs develop their own formularies or preferred drug list and that essentially means they determine what drugs are going to be preferred or on formulary versus those that are nonpreferred or nonformulary and would require a prior authorization. The fee more service program likewise has a preferred drug list. So right now, as it stands, all nine M COs have different P.D. F and fee for service. So the idea is that we are going to have 1p D L. Applied to all Medicaid M COs and fee for service. So there wouldn't be discrepancy if you move from one M C O to another in terms of what medications are preferred and nonpreferred.
So the department's pharmacy and therapeutics Committee or P and T Committee developed the statewide preferred drug list. We did this at two meetings in May and June and the recommendations from the P and T Committee were considered by the secretary of human services and she approved those recommendations. So we are in the process now of sharing detailed information about the preferred drug list with our Managed Care Organizations and putting all of the preparations in place for an implementation in January.
The prior authorization guidelines that will be used to determine medical necessity of nonpreferred medications will all be the same for the statewide preferred drug list. So that means that Managed Care Organizations will use the department's prior authorization guidelines. So your prescribers wouldn't have to look at different prior authorization requirements depending on what plan you are in because we will all be using the same.
MATT SEELEY: Can I ask what happens if you need a drug that is not on that list who do you go to.
DR. TERRI CATHERS: So today, it would work the same way as it does today, your prescriber would contact your Managed Care Organization and request prior authorization. So the Managed Care Organizations will continue to review for prior

authorization, nonpreferred drugs and make that determination of medical necessity and all appeals would continue to go through that Managed Care Organization.
MATT SEELEY: So it doesn't have to go to the department.
DR. TERRI CATHERS: Correct.
GERMAN PARODI: This only applies to fee for service C H C or --
DR. TERRI CATHERS: It applies to health choices Managed Care Organizations and community health choices Managed Care Organizations and fee for service. So we would all be aligned from the standpoint of the preferred drug list and prior authorization guidelines for those drugs.
MATT SEELEY: Can I just follow that logic through. Why are you bothering this to do this then if they can overrule it. It doesn't sound like anything is changing. I don't understand why is the department getting involved in making a standard drug list then.
DR. TERRI CATHERS: Well, there is a couple of reasons. We are anticipating cost savings but it also provides consistency across all of the Managed Care Organizations and fee for service. If a patient is newly eligible to Medicaid they come into the fee for service program. Fee for service uses a preferred drug list and would have certain drugs preferred and nonpreferred. They are in service for 45 days and then transition to a Managed Care Organization. That Managed Care Organization may have some of the same preferred drugs but they also might have different medications that are preferred. So that that means that that patient at that point, the continuity of care period would apply. So that is a minimum of 60 days that they have to honor and allow that patient to continue to get that preferred drug but after the 60 days they can ask them to change their medication. So having one preferred drug list eliminates the need for the patient to change because everybody is going to have the same /HREULS of preferred drugs. But the department is going to collect benefits from collecting additional drug rebates and looking across the entire scope of the statewide preferred drug list and choosing what is most cost effective from the department standpoint. Right now, the Managed Care Organizations make determinations about what is most cost effective for their organization. Not for the Commonwealth.
MATT SEELEY: I guess I just anticipate I'm on certain drugs. I'm not a user of M L. TSS but I'm addicted to certain drugs because of my disability and this they are not on that list, I would -- I can see a lot of people talking to their doctors and wanting to get on the drugs that they want.
DR. TERRI CATHERS: The same would be true if your Managed Care Organization made medication nonpreferred or you switched to another Managed Care Organization that had them as nonpreferred. The department's pharmacy and therapeutics Committee is open to the public. We allow public testimony, there is a lot more transparency than there is today in how the Managed Care Organizations are developing their own P.D. L.s. Yes?

SPEAKER: Hi there. Thank you for sharing all of this. My question is are these standardized prior authorization criteria going to be publicly available. So if I want to find out if, first of all, if insert drug here is covered if it is preferred and if not, what are the prior authorization criteria, I have to work with my doctor to meet. Are those going to be available to the general public.
DR. TERRI CATHERS: Yes. They will. So the P and T Committee for the drugs that are included on the statewide P.D. L. Work to develop what medications would be included in as preferred versus nonpreferred but they also worked on making sure that the prior authorization guidelines were appropriate for those medications in those drug classes. After those recommendations were taken to the secretary, all prior authorization guidelines go to the Medical Assistance advisory Committee or the M-A-C and allow for public input before they are published and they are published by the department on line in the way of a Medical Assistance provider bulletin. So all providers that are enrolled in Medicaid receive that information. Those guidelines are available on line and the Managed Care Organizations likewise have to make the preferred drug list and the prior authorization guidelines available on line.
SPEAKER: Thank you.
GERMAN PARODI: Two questions on my end. For those that don't have on line accessibility will M COs or another entity, you know, kind of like send this new list out next year.
DR. TERRI CATHERS: I'm not sure that the M COs would be proactively sending them out to members but upon request, they must make it available to you. And the same way fee for service if we receive a phone call and someone doesn't have on line access, which is absolutely entirely possible, we will send that to them.
GERMAN PARODI: Thank you. Lastly, just a little bit different but because C H C and your pharmacy and talking, it is not necessarily a question. I don't know if you can address it. Here it is. Pharmacies throughout region 3, all of them are not going to know about this C H C transition and Philly -- earlier when I was taking this, I don't know this, I'm not going to give you medication. Whatever can be done from your end to help pharmacies the need in region 3 that will be great.
DR. TERRI CATHERS: We have been working very closely with the pharmacist association and that includes many of the independent pharmacy retailers, Community Pharmacies. And also, notifying the national chain drugstores. We have started that outreach already. They will receive that information probably by the end of September or early October. And that information will be available on the department's website as well. Because you are right, the pharmacies need to plan as well.
I know that my colleagues are directly across from me. So if you have questions for the M C O pharmacy directors, they are available.
KEVIN HANCOCK: Not one question for the M COs.
DR. TERRI CATHERS: We are not getting off that easy.

GERMAN PARODI: Well, since you insist.
Question, if I'm hospitalized, I understand that when discharged that I may need some assessment that needs to happen. I would like to hear some about that and -- I knew I would need to inform that there is special services that need to stop so there is no double dipping and I get that. But I -- if a new -- another assessment that was nine hours ago needs to happen exiting the hospital, can this be part of the discharge while I'm there if this happens. Please?
SPEAKER: Hi rob I'm with UPMC,. So we have a comprehensive approach to discharge plan that includes our care managers as well as a care team made up of pharmacists that participate in that. They do an assessment specifically around medications post discharge. We want to make sure anything that was prescribed while someone was inpatient is accommodated for as they transition to that lower level of care.
GERMAN PARODI: Just that sounded a little bit confusing. Thank you. I want to know that when I leave -- if I have to be hospitalized when I get home or when I exit the door of the hospital, I can have my attendant start working.
SPEAKER: I'm not sure that is a pharmacy related question.
GERMAN PARODI: No it is not but as far as if there is -- let me make it better. If there is an assessment based on the Managed Care Organizations, will that be for surely done before the discharge plan.
SPEAKER: Again, I think I would have to defer to somebody on the operations side. That is not really a pharmacy related matter.
GERMAN PARODI: Thank you.
BARBARA POLZER: I have --
KEVIN HANCOCK: Our expectation at the department the answer would be yes. I would love to have the M COs confirm that.
GERMAN PARODI: Thank you.
SPEAKER: I do have a pharmacy related question sort of along the lines -- I'm sorry. Of German's question. My husband is a 24-hour a day ventilator user and he will be shifting to C H C and recently we have had a number of hospitalizations as a result of changes in his condition. So my question is that currently, he is on certain prescriptions. And my understanding is that the hospitalization is seen as a change in condition. So at the point of which he is discharged, all bets are off from the standpoint of -- of everything that we knew before he into the hospital could be different including an assessment phase of does he need the same number of hours. Would that also include the evaluation of all of the medicines that he is on and would we then be required to -- because there is some medicines that have been tested and over time and have been proven to work better for him than other medicines and what happens if he comes out of that hospital and now those medicines are not on the list. And we have to make abrupt changes. How do -- he is nonverbal. So I'm his -- I'm his mouth piece. I went through in the last six months three major appeals with his insurance carrier because

they weren't going to pay his hospital bills because there was a whole lot of confusion around Medicare and his primary insurance and I'm just gearing up for what fight am I going to have going forward because I know that, you know, probably in two months he will be back in the hospital for seven days. So I just need to know, like, what is the plan going forward? How will it change for people that are in that situation.
DR. TERRI CATHERS: Is your husband covered by Medicare primary.
SPEAKER: That is an interesting question because I have fought that battle and won because his primary health insurance is my health insurance and while it was listed on the paperwork that his primary health insurance was my health insurance, my health insurance carrier pushed a button on January 8th and it messed a whole lot of things up and I had to fight for about four months to get him covered with health insurance again and I was getting hospital bills for about $500,000 every other week in my mail because they were all pointing fingers at each other and said no I'm not primary, no I'm not primary. And it took -- it took me fighting and threatening and advocating on his behalf to get it all straightened out. So I don't know the answer to that question. I believe his primary insurance is my healthcare.
DR. TERRI CATHERS: Okay. So your primary insurer would determine what medications are preferred or nonpreferred because they probably have their own formulary or list. If Medicaid plays any roll for wrap around for part B covered drugs injectables. That would -- all of us, fee for service and the Managed Care Organizations would wrap Medicare part B as in boy payment. You know, up to our responsibility and there would be no formulary consideration. We would just make that payment because the primary already made the main payment.
SPEAKER: So I'm using him as an example but let's just say that -- that money comes in to C H C and they are a new -- in region 3, my region, they are new participant, and they come in and they have their -- their traditional list of medications for bladder spasms, for whatever and now they are in C H C and go through the continuity of care period and then the world changes as they know it.
How -- how would they -- would they be able to file an appeal? Is there -- is there --
DR. TERRI CATHERS: It wouldn't be an appeal. It would be a prior authorization request and you would make that to your Managed Care Organization.
SPEAKER: And what is the likelihood that they would -- they would win that prior authorization?
DR. TERRI CATHERS: I can't speak to that.
SPEAKER: So with the prior authorizations. This Michelle. With the prior authorization they are criteria. As long as the criteria is met and approved, the medication would be approved.
SPEAKER: That is consistent across the board.
MATT SEELEY: Can I ask a follow-up. Can you tell what the average time is for someone to request and be awarded approved, whatever a medicine that is not on the P.D. L.?

SPEAKER: A prior authorization request the decision must be rendered within 24 hours.
MATT SEELEY: If I ask for a medicine right now I should have the medicine by tomorrow.
SPEAKER: You will have the decision by tomorrow.
MATT SEELEY: When will I have the medication.
SPEAKER: When you get to your pharmacy.
SPEAKER: There are provisions in place that would allow for a temporary supply for that medication while the decision is being made.
MATT SEELEY: Thank you.
BARBARA POLZER: Are there plans to notify participants of the changes.
SPEAKER: Absolutely.
SPEAKER: Yes. We received a template that was reviewed by the health law project.
DR. TERRI CATHERS: The consumer subcommittee of the Medical Assistance advisory Committee.
SPEAKER: We received that. I can speak those notifications will be sent out as early as possible.
BARBARA POLZER: Would there be any way of having the service coordinator be made aware of that also? Because my fear is a consumer would receive that letter not understand what is going on and if -- typically they would call a service coordinator for assistance. So is there any way to get that information relayed to a service coordinator also. Preferably not by mail.
DR. TERRI CATHERS: The service coordinators within the Managed Care Organizations or --
BARBARA POLZER: External.
DR. TERRI CATHERS: Oh external.
BARBARA POLZER: I'm talking about external. I'm speaking for myself.
DR. TERRI CATHERS: So if they are Medicaid enrolled providers, they are going to receive these Medical Assistance bulletins announcing the statewide preferred drug list as well as the prior authorization guidelines.
BARBARA POLZER: I guess what I'm asking for is specific to the consumers that are being served their specific medications if they are going to be changed.
DR. TERRI CATHERS: Is there a way that the Managed Care Organization would know who they would be.
BARBARA POLZER: That is what I'm hoping.
GERMAN PARODI: Does the healthcare organization -- you have -- can you identify once the new list comes out, you know your patients, you know they are on this list, the drug is not going to on this list.
SPEAKER: Speaking from UPMC perspective. I would need to understand more related to the potential privacy issues. I'm not certain that we can share the information without the member's consent. But certainly that is an opportunity to share that information. We put together a comprehensive communication plan for the members themselves as well

as their prescribers as Terry has alluded to and we are going to work to make out reach calls as well to make sure there is a smooth transition.
GERMAN PARODI: I completely -- we need HIPAA completely and that is why I asked my healthcare -- our healthcare company, you have -- you have agreed for you to look into my healthcare and as a patient, if my drug is changing and thousands of them will not know that, you will, I would appreciate you let me know as a patient.
SPEAKER: Absolutely.
BARBARA POLZER: I guess my question about the HIPAA as a service coordinator, we have to go out and list the medications every time we visit or document a change. Maybe I'm just being obtuse today. I don't know.
SPEAKER: Again, with the qualification, I think we would have to understand that relationship if we are allowed to share that information --
LINDA LITTON: I would like to address the elephant in the room and I hope HIPAA does not, you know, stop me from doing that. I know that opioids have been in the news and a lot of people are dying from use of them. But a lot of people that are wheelchair users do take opioids to help them with their pain levels and that type of thing. So when you say changing medicine, it kind of scares me a little bit. And also with benzodiazepine -- or, you know, what I'm talking about, I will give my own situation because I really don't care about HIPAA for me.
I take Valium and I know that if they stop Valium, the drug of choice would be Ativan. You give me Ativan, I'm off the wall. That is why I am on the Valium. See what I'm saying. So to change around drugs, I think needs a little more thought as to how it is going to affect your community that you are supporting. Thank you.
DR. TERRI CATHERS: I would just like to add that there are probably fewer changes that the M COs will be making than what you probably are thinking in your heads you probably think oh my God every drug we take is going to have to change. That is really not the case. It turns out that fee for service and the Managed Care Organization were pretty closely aligned with our preferred drug list in terms of what drugs are preferred and not preferred. I don't know your situation if Medicare is your primary. But if Medicare part D is your primary then your opioids and your Valium will not change. Medicaid is not responsible for either one of them. And the vast majority of patients receiving their benefits from community health choices, that is the situation. Medicare -- and the part D plans that you are enrolled in and their preferred drug list have absolutely nothing to do with the Medicaid statewide preferred drug list and the disruption we are anticipating is not nearly as great as what I think /S*EU sitting here not seeing the preferred drug list can create in your minds.
BARBARA POLZER: Anyone else have any questions for the panel? Well, thank very much. I appreciate it. And now we are going to open it up to a Q and A for the M COs.
SPEAKER: I'm first.
GERMAN PARODI: You beat me to it.

SPEAKER: So I had asked last week to be on the agenda that I want to know from each M C O what is the turn around time for an emergency increase in hours for a consumer due to a medical condition?
KEVIN HANCOCK: So we made the M COs aware of this question coming their way and we are -- it would be great if they could come up to the table and provide that background information. I hope everyone won't jump up at once. Let's start is AmeriHealth Caritas.
SPEAKER: Go to someone else. Patti is out in the hall.
KEVIN HANCOCK: Missy can do it. We live in a small and confusing world.
SPEAKER: Thank you for the question. This is Missy week land. If we have an emergent need for an increase in hours, we can -- we do have to complete the comprehensive needs assessment to justify the increase if there is an emergency, we can accommodate a visit the same day. If the service coordinator is not able to -- the assigned service coordinator is not able to go out onto visit, we will look for another service coordinator. We can get the request through the approval process if it even needs to go through an approval process the same day to accommodate those requests.
KEVIN HANCOCK: So same day is what you are saying.
SPEAKER: Same day but that really didn't happen but I will go to who is next.
KEVIN HANCOCK: Pennsylvania health and wellness .
SPEAKER: Similar to -- similar to AmeriHealth, we have a 24-hour turn around time so that if the service coordinator would get the call, it would come in as request, a physician utilization management would work on as an emergent request, the physician would approve, services would be then authorized within that 24-hour period.
SPEAKER: So do you need to do an assessment or you would authorize the hours.
SPEAKER: A comprehensive assessment at a time certain would need to be made. However, if it is deemed an emergency situation, we are going to take care of that individual right away and then work the paperwork on the back end.
SPEAKER: That is a good answer. Thanks. The other one was not a good answer.
SPEAKER: Thank you Kevin for that.
KEVIN HANCOCK: UPMC.
SPEAKER: So we are actually similar to PA health and wellness where we can do an emergency increase prior to doing that assessment, if it needs to be done. We will schedule that assessment within 24 hours but we can do an emergency assessment at the time of the request prior to and in person assessment being conducted.
SPEAKER: So thank you. That was a good answer.
KEVIN HANCOCK: Can I ask a favor. You gave background for this question. Would you be able to provide some of that information.
SPEAKER: We would. First the way the state did it it was within a few hours or 24 hours. So the system work /-LD much better before than now. Michelle is here with me. An integrated care didn't work because nobody knew she was in the hospital. She had to

start dialysis. She was in the hospital and had to start dialysis at a time she didn't choose and days she didn't choose because dialysis system is ten times as worse. She had to get up in the middle of the night to get to dialysis by 6:00 in the morning. It took three weeks to get that response. So they did pay -- so the attendant who she has known for forever who saved the M C O a ton of money by not having her go back in the hospital to get dialysis did not get paid for one week. They did back pay two weeks but didn't pay the last week. I find that -- I'm not going to let that go until that person gets paid because that is wrong. Due to the circumstances, myself was already in the hospital for three weeks so that an M C O should have known from day one she was in the hospital and started dialysis. M C O had no idea. There is no integrated care. Nobody knows anything. So she comes out and starts dialysis and takes another three weeks after she is out to get an approval on something that could be temporary because she doesn't have to go in the middle of the night but this is unconscionable and outrageous. When we were fee for service, there was a great response time from O L. T L. For everything and now I can't say that in her case this worked out at all. And whatever happened to the supposedly the integrated care the M C O will know about your hospitalization. They didn't know anything. They were of no help and going to a dialysis center, they cannot take you. She had to wait and find a third one that would take her and because she has a physical disability and born with, they didn't want to take it because she can't get out of the chair herself. There were huge fights of which the M C O was no participation whatsoever. Huge fights to even get her into a place and to get what she needed and she still have to transfer her. So the whole thing is outrageous but in dialysis, you don't have a choice. She didn't have a choice. If she stopped dialysis then she would just die. Maybe that was a saving measure. Come over here and use the microphone.
KEVIN HANCOCK: In your chair we can hear you by the microphone.
SPEAKER: I get up at 1:00. I got to be on the machine by 6:00. Most of the time the transportation is not accessible or does not come.
When I get on at 6:00, they have to put me in their hospital chair which is not accessible as a wheelchair. The hospital bed no longer works. So I'm sitting on this pillow laying in a chair. When I said to them politely I can do it in my chair and I can lien back, this would be more comfortable. They said because of the insurance, we are not allowed to do this. We cannot make any accommodations. My attendant hadn't been paid. I basically have been begging and pleading with him for over two months. He finally got paid. But many attendants will not do this. I don't want to see them get stuck. I have been lucky that the gentleman has been with me for many years. But attendants, if they are not getting paid, they are not going to do it and I can see a lot of people getting stuck. When I go to the facility like I said, they have to put me -- they have to pick me up in a how higher lift and put me in a chair and make sure I don't fall over because their chair is not accommodating for me. The hospital bed, again, does not work. When I ask them of a possibility of actually doing it in my chair because my chair liens back like

the cherry chair does. They said no way the insurance will not allow us. That is against you. When I get transportation, if I have an emergency , and I need transportation to get things repaired, I have to get a pump that I have to take the dialysis repaired the same day. I wasn't able to do it because the transportation wasn't accessible. It is accessible to them because a person can transfer out of a manual chair into their van, or automobile. So I had to physically do it myself, get up there, but then when I got to the center, people had to pick me up and put me on the table. They said we don't have this equipment. They could have turned me away and I would have had to go to the hospital. You need to get these facilities more accessible to consumers. Because I know I'm not the only one going through this. There are tons of people that don't know their rights. Apparently, I don't want to get an ambulance to come and bring me and take me home. That is over $600 for you guys to be paying. Do you want us to be cheaper or more -- more expensive? Because that is what you are doing to consumers right now. If they cannot get up and pivot, they are being brought in by an ambulance, shifted over, because the facility will not touch the consumer otherwise. So I feel like I'm stuck between hell and high water because if this happens again and somebody -- and I go into this place and somebody is not willing to do it, then I'm screwed. I wind up back in the hospital and I'm sorry for using the language that I'm using but it gets very frustrating. You are wondering what is the next day going to bring.
LINDA LITTON: Is your graft site easily accessible from the chair.
SPEAKER: Yes. It is in my chest and they put one in my arm.
LINDA LITTON: Hello.
SPEAKER: It is not that that question. It is the rule if you have to transfer to the Jerry chair or a bed --
LINDA LITTON: Then something needs to be changed with that rule.
SPEAKER: They want you to be able to tilt back. So what is the condition when the chair tilts back.
LINDA LITTON: It is the same thing.
SPEAKER: You say that and I say that but the insurance is not saying that.
LINDA LITTON: How do they even know if you are transferred to that chair? See what I'm saying? I know but --
SPEAKER: Many consumers are in nursing homes and getting the ambulance to come and bring them. The person in the facility will touch the wound and will put the things on their -- wherever their arm or their chest but they will not transfer the consumer. I'm just lucky that the extender that I got approved to after four -- not three, four and I'm going to be in trouble when it starts snowing outside because transportation is not an easy thing even in the snow. And the center that I go to, it is extremely far for me to even ride in my chair.
SPEAKER: And if you are late, you get reduced dialysis. It is amazing to me that they can reduce it but that is just the way it is. Something needs to change. M COs can help. I

also want to know what do I have to do to get her attendant paid tore for the week he did not get paid. He is her attendant. Not an informal support. Michelle doesn't have informal supports. You need to pay the poorest people that there are.
SPEAKER: Have you looked at other alternatives.
SPEAKER: Home based dialysis, you have to be on it every night for six days. I'm sorry. I run around. I'm sitting here at this meeting. How would I do that if I'm on the dialysis six days a week. When I get off dialysis, I'm usually asleep when I get home. I fall right now. People say you can sleep when you are in the chair. You don't sleep in a place that you are not familiar with. That you don't feel comfortable. So I don't know -- at home dialysis is for a person that never goes out and never does anything or is ambulatory and can get up and do it after they have done it for so long. So --
SPEAKER: And then you would have a real increase in her hours.
SPEAKER: Then I would be 24 hours. That would be 24-hour care. That wouldn't be what I'm doing now.
KEVIN HANCOCK: So our MCOs heard the feedback. The one question I have and the M COs can answer it and they don't have to do it now. Is there anything about the structure that we have for requirements for community health choices that is inhibiting the flexibility that you have and the way you are accessing dialysis and transportation.
SPEAKER: I don't know. I have been in the hospital. Nobody from the insurance came to me. I had an advocate from the hospital. She didn't know how to deal with the insurance. I was promised one thing when I was in. Everything would be one /-PB two three. I would be home in three days. Three days turned into three weeks. Even after three weeks, I went to -- I put an application in for three centers. They were all close by. The fourth center is a little further away but they did accept me. And it is not a center that I'm used to but it has been very helpful but any way, shape or time, things could change. When I need transportation for that same day if something goes wrong with the thing in my chest or my arm, I have to wait until the next day to go get it repaired. The facility doesn't have a wheelchair accessible van. They have a van but it is not wheelchair accessible. So I have to physically get on the bus and go out to a very long distance to get there. Usually, at 6:00 or 7:00 in the morning. It is now getting a little dark when you get up in the morning. So sitting up there waiting on a bus is not so safe. And that is the -- if the transportation decides to not show up, which has happened, you know, or they -- you are in a wheelchair and they send a vehicle that is not transferrable or not able for me to get into, that has happened. They need to make sure that these places know the criteria for those that live at home and need to get out there to do these things. Not take the chance and move to their chairs if they are not feeling secure because they will help you move but you are taking a chance of falling on that floor. I'm not ready for that. I use an H-O-Y-E-R lift. They had one consumer that was in a wheelchair from a nursing home so they didn't have to worry about it. So I'm their guinea pig.

SPEAKER: This was a whole new experience didn't realize dialysis could choose you or throw you away. They didn't understand a person who could not walk. They really didn't get that concept but I mean, it was so outrageous to us what you had to put up with. It wasn't the days or times that Michelle wanted to. There is no choice. If there is an opening, she can go to a regular time in the day and use those hours. There was no choice. There was no help. I think the hospital sucked. There was no help from the insurance. And then the day that she got there, there was a major fight with these people that she couldn't stay in her chair. Now she had to switch toy P-O-Y-E-R lift. These were people going to lift her that she doesn't know if they are capable.
SPEAKER: They didn't know how to do it. They did not. I had to help from my experience with H-O-Y-E-R lifts and I had to be willing to take a chance. I have had several --
SPEAKER: And she has no balance. We wanted her to stay in the chair where she felt secure. There is no balance and how is she going to keep from sliding. She came home the first couple of times practically falling out of her chair because they didn't know how to put her in her chair. These things are ridiculous and outrageous but the worse part was not getting the approved hours.
KEVIN HANCOCK: Happy to talk about the extra week that was characterized as informal supports. We can work with the M COs to talk about that. The broader issue Michelle that you are talking about is provider education especially working with people with disabilities. The expectation -- so especially in the physical health system. Nancy knows it better than I do. I know it pretty well too. The physical health has a lot of gaps when it comes to managing care for people with physical disabilities. It is not just dialysis unfortunately. It is across the system.
SPEAKER: It is not just dialysis but if they don't know that these things could be changed, they are going by what you guys put as the rule. That chair is your rule. So it is up to you guys to make that change. They are not going to make any changes unless you guys make it first. They say it is the insurance's priority to make sure that our buts are the Jerry chair or the hospital bed.
KEVIN HANCOCK: What is sounds like to me, it is not health insurance, it is their physical plant insurance. Their facility insurance that is require it go.
SPEAKER: I think it is a combination of both. Neither knows what the other is doing. Neither one.
MATT SEELEY: Can I ask, putting aside the disability etiquette. Is there any state or M C O or C H C or Medicare Medicaid restrictions on provision of dialysis that you have to be in a chair all of that kind of stuff.
KEVIN HANCOCK: Not to my knowledge.
SPEAKER: That is what they told me. I cannot have dialysis unless I'm in a bed or a Jerry chair.
SPEAKER: I think a part of it is it is a liability issue.
SPEAKER: Who is the difference from them helping you transfer into the chair.

SPEAKER: Liability.
SPEAKER: But you are able to stand up. You are able to stand up and pivot and say your foot slides, what is the difference with that?
SPEAKER: Okay. Do you have that written down from a physical therapist. Maybe that would help that you can prove through a physical therapist assessment that it would work.
SPEAKER: That what would work? The chair. They won't bring anybody else in. They say the things that are regulations that people have. They will not Brian outsider in to do an evaluation.
KEVIN HANCOCK: So I would just thinking it through, your question, I would think the C H C and M COs and they can speak for themselves if I'm mischaracterizing their position, it is part of their provider agreements. They would require the providers to have liability insurance.
SPEAKER: As soon as you ask for that, they are going to turn us away. I know it is not going to only be me. A lot of our community has been having kidney failure. When I have been in the doctor's office, I have seen a lot of people in wheelchair and a lot of them can't transfer. What are you going to say to them.
KEVIN HANCOCK: A provider -- as part of the licensure would be required normally to have that type of liability insurance as well. So it is -- like, indirectly, there might be a relationship between the M COs and liability insurance but I mean, all providers have it. Nursing facilities -- heaven knows nursing facilities has to have it. The question is --
SPEAKER: They have to have it.
KEVIN HANCOCK: The question is whether or not the liability insurance requires the transfer from your -- your wheelchair to the chair -- or is it something the providers themselves.
SPEAKER: They said they were told by the state that this was a requirement. They cannot change it unless the state changes it.
NINA DeLGRANDE: I'm not sure if they are giving you misinformation. I represent the life providers and we transport a lot of our own participants.
SPEAKER: Life is usually an ambulance.
NINA DeLGRANDE: We transport a lot of our participants and a lot of them have to go on a stretcher but we can't leave them -- when we take them there, we can't leave them on a stretcher. I'm in a different service area than you but I think it is all dieal as I say. I think it is their liability insurance. I think that is how it is.
SPEAKER: What I have to say is people that are wheelchair users don't want to go in an ambulance. They want their wheelchair with them. That is their independence and if they have somewhere to go afterwards. We find this a big problem when you go to the hospital because they don't transport your chair. We have a lot of people be sick and wheel to the emergency room. We have had wheelchairs left on the street if someone

had to call 911. And if they know us, they will call us to pick up the wheelchair which costs thousands of dollars just laying there. That is an everyday occurrence.
NINA DeLGRANDE: I'm trying to address the issue with dialysis centers in general that I believe they have issues at every center and liability rules that you cannot stay -- whether you are ambulance transport or wheelchair transport you have to be in their bed, their Jerry chair, their equipment. It has to do if there is an emergency, some kind of pro /SRAOED /STPUR needs done, whatever, they want you in their equipment that they know how to use, something happens to you and you become unresponsive and they need to treat you they don't know how to use your chair. A lot of it is --
SPEAKER: They have you laying down in a position. As you guys have seen sitting here. I have tilted my chair back to relief pressure. That is all I would have to do for that to happen. So, you know, for us laying back in our chairs, it is much more comfortable than sitting in a seat. If I didn't have a pillow that they provided, that lady paid out of her pocket to go get, if she didn't do that, I wouldn't be in there. I would probably be in the hospital.
SPEAKER: You know, we were concerned about pressure sores because you are there for several hours and that is going to be another problem because if you get into something you are not -- your body is not used to then that becomes a big issue but they didn't seem to have, you know, any care about that. My other issue if you can answer, Kevin, is where is our integrated care that the M C O will know what is happening to somebody when they get discharged. There doesn't seem to be any of that going on.
SPEAKER: There is no communication.
SPEAKER: From the day myself went in, she started dialysis in the hospital.
KEVIN HANCOCK: We were talking about that a little bit earlier when we were talking about the pharmacy related services. The expectation is the M COs would be engaged with the participant /TKEURing an inpatient stay if they didn't, they just dropped the ball.
SPEAKER: It does happen. But it doesn't happen in my shell's case.
SPEAKER: If it didn't happen in my case --
SPEAKER: What type of Medicare model do you have. What Medicare.
SPEAKER: Keystone.
SPEAKER: So you have for Medicare, you have Keystone.
SPEAKER: Medicare and Medicaid.
KEVIN HANCOCK: Are both Keystone. We don't want to call them out in this particular case but we will give them a chance to respond to it here. If you have Medicare advantage dual special needs plan and the Medicaid plan, the hope is that that truly represents an integrated model of care or communication would happen --
SPEAKER: They went to Medicaid first.

KEVIN HANCOCK: So we have as a requirement in the program that inpatient hospital stays in an emergent event that requires an assessment that would have been able to address and pick up those hours that would be needed for additional service such as dialysis. So I mean, the --
SPEAKER: The counselor that I worked with, did not have any idea that it would be so difficult for a person in a wheelchair to be on dialysis.
SPEAKER: From the hospital. A hospital person. If you just have Medicare and Medicaid and Medicaid is your M C O, they are not going to know anything about your hospitalization.
SPEAKER: They go for the Medicaid first.
SPEAKER: No I'm asking.
KEVIN HANCOCK: So Medicaid for the hospital stay is usually the primary payer. The expectation is there is communication with a participant's Medicare and their Medicaid coverage.
SPEAKER: Through the hospital.
KEVIN HANCOCK: The hospital will know as part of their intake process whether a person is both enrolled in Medicare or Medicare advantage plan and a Medicaid plan.
SPEAKER: But I'm saying they would contact the M C O. When will the M C O find out the supports coordinator is not going to know.
KEVIN HANCOCK: I think each of the M COs have their own role when they expect a hospital to contact them especially if it is a participating hospital. Does anybody from the M COs want to answer the time frame if you know it. If not, we can get back to you. At one point, I believe it was within -- within 24 hours.
SPEAKER: Yeah but they knew I was in the hospital for three weeks they should have known.
SPEAKER: They didn't know.
SPEAKER: Not the service coordinator but the insurances.
SPEAKER: I don't know if they told the M C O.
KEVIN HANCOCK: The insurances offer prior authorization. There is about this particular case that we need to learn more about.
SPEAKER: I'm one of one particular case and how many more are being messed up like this.
SPEAKER: A lot of consumers don't come to these meetings and when I'm sitting in the hospital, I see a lot more than what you guys are seeing at this table. That is why we come to these meetings so that you do know but you can't assume it is only going to be one particular case. This is affecting other people. They just don't know how to speak up. And that is why we are here.
KEVIN HANCOCK: And that is why we appreciate you coming in and telling the story.
SPEAKER: Thank you for sharing your story. Typically the hospitals will notify the primary insurance but it is not uncommon for the hospital to not notify the secondary insurance.

So I'm curious, if the community health choices plan requires in hospital contracts. For example, that they are notified even if they are secondary. So if you were to have -- it may not be your case but a lot of people going through this, if they have traditional Medicare a traditional plan would the community health choices plan know if a participant was hospitalized?
TELEPHONE: This is sister Catherine. I would just like to make a comment while I have -- I have experience I want to honestly say as a person responsible for that health and wellness of our congregation about 145 sisters and I'm a caregiver for a 90 year old person. I have noted in the past several months there has been a person centered care is much more obvious to me and I really appreciate that. I wanted to offer that as a positive in regards to all of the work that has been done in these past few years and I'm grateful for that.
KEVIN HANCOCK: Thank you, sister.
BARBARA POLZER: Pam.
SPEAKER: Is it okay if I jump topics. I just wanted to ask about transportation. We talked about it before. Where are the M COs with transportation and getting contracts so that we -- we have it when we roll out because I'm -- I'm kind of nervous about it and is there a way for the Committee to -- or the providers to have their brokers here to speak up too because I'm curious and I'm hearing some conflicting things. We are getting providers but then the providers critical to our areas, we are not getting a call back. We talk to the providers and the providers say we hear from them. We are not getting questions answered and things we need to know so what is really happening and how do we get them to work together and I appreciate having rich on the Committee now. Having a transportation provider on the Committee but where are the M COs with our rural providers that are integral to our state and the community?
KEVIN HANCOCK: So you want the individual M COs so answer the status of the build out.
SPEAKER: And about get a broker here to talk about what they are really doing.
KEVIN HANCOCK: If the Committee wants to have a presentation from the brokers from the M COs we can certainly have that arranged. Do the M COs want to step up and answer the question about the development for transportation. We will start with UPMC? They are really hesitant today Brendan Harris speaking of the strange small world we live in.
SPEAKER: Good morning. You know, we have done a lot of work and continue to do work to get the transportation on and our CT R S vendor is doing work. I don't have specific numbers but it report them to the Committee when we get them but we made significant progress on when we updated back in July at the sub M-A-C.
KEVIN HANCOCK: So just to broaden the question a little bit when you do report out the specific numbers, the reality is that we know that transportation in phase 3 is an existing problem. The question is how are you at least -- the point that we continue to

make, we make and we encourage the M COs to make is to at least have the infrastructure that is in place now be adopted as part of community health choices. So my request for the M COs may be in October and a future discussion for transportation because of the critical it for a phase 3 is how network development are you going to be at least at a minimum replicate the level of -- of -- of providers that are available and services that are available now so that we don't break anything that has been working.
SPEAKER: And that has been our focus in the network built up to this point that we are able to maintain what is currently in place. We are also looking at different opportunities to improve. You know, because I think ultimately understanding that this is a significant challenge for phase 3, we, you know, are really trying to work with our subcontractor to make sure we have as much transportation as possible because the geography does create some significant problems for us.
THE COURT: Pennsylvania health and wellness .
SPEAKER: Good morning. Norris bends from PA health and wellness . Happy to report the numbers. I don't have them right in front of me. We believe we are making significant progress. We are ahead of where we were initially. Transportation is a little different in the T zone than it is in the southeast. I think the infrastructure in the southeast is more compact but I think we learned a lot from the first two phases and I think we are certainly will improve upon the transportation from phase 1 and we think that everything will be ready to go come January 1.
KEVIN HANCOCK: So just to echo the point that Pam was making earlier and what I had just said the expectation for future reporting out for transportation, for this Committee at least for the department is that -- that you demonstrate how you are replicating the available transportation that currently exists. So we are focusing just to be clear on medical transportation. The nonemergency medical trans for significance that Michelle was kind of highlighting associated with some of her -- some of her treatment is not part -- directly part of community health choices but it is part of the Medicaid program in general and it also has some challenges in this region. We are hoping that through better coordination that can be better addressed. Okay.
SPEAKER: We certainly will be able to do that.
KEVIN HANCOCK: Great. And then AmeriHealth Keystone.
SPEAKER: Hi everyone. So Chris isn't here today but I was able to get an update. We are in the process with a number of transportation brokers for network and adequacy. I do think it is important to echo what UPMC has said given the challenges of the geography. We are looking at solutions and opportunities to go beyond the O L. T L. Established network to meet the needs of our participants. We also want to stress the importance that this is nonmedical transportation. It is not M A T P. That is not changing but, you know, if the providers are out there, we want to encourage them to become a network with us but also importantly, nothing changes during the C O C period. All willing and

participating providers will still be able to provide the rides that they were providing in December on January 1 st.
KEVIN HANCOCK: Thank you. So I think we want to have this -- I agree very strongly that this is a topic that should be reported back to the Committee. If Barb is okay with that.
BARBARA POLZER: Yes.
STEVE GAMBLE: Can I ask you to include the integration of shared ride in that because I think it is really critical that shared ride providers are involved especially if they are getting the lottery subsidy. And then trying to find innovative ways to address the gaps for transportation and through the brokers.
KEVIN HANCOCK: So I think that -- to just restate your ask. Rich was hitting on this a little earlier about shared ride during those hours and talking about how there is integration and available transportation resources how that is occurring and what the brokers are doing to be able to support that and also extending and building out on network for nonmedical transportation. I do think that we do sometimes confuse the offering for community health choices with the Medical Assistance transportation program. The Medical Assistance transportation program as is stands right now is not changing. There was a delay requiring a study for moving the program to a broker model. So for the foreseeable future, there is no change that is on the deck for the medical transportation program. The hope with community health choices is that there is better coordination between nonemergency medical transportation and nonmedical transportation. Sometimes it is helpful to show a presentation to show how incredibly complex it is for this population. Just showing the complexity and reminding people of the complexity is helpful in and of itself. Maybe we will ask rich to be part of the presentation.
RICHARD FARR: Would love that.
SPEAKER: One of the concerns with medical transportation, which would include doctor appointments dialysis treatment is oftentimes when you get a ride, you get a complication with somebody just going to the grocery store. So you could be riding for over an hour and end up late for your appointment. And if you are 15 minutes late or even more, you may not have that appointment. Is there a way to address that.
KEVIN HANCOCK: So just to recharacterize the point you are making or the question, you think that there should be a priority for the available transportation for medical related services compared to nonmedical related services. Is that a true statement.
WILLIAM SPOTTS: Yes, it is within reason, of course. However, like for dialysis treatment, if you show up a half hour late, well, that shoves you back to when you can be returned by another half hour. Four hours no negotiation on that no matter what time you get there. Maybe a priority or a little more -- I don't know. Alleles tense to it.
KEVIN HANCOCK: I think it is a fair comment. So that ultimate hope would be enough transportation available to that everybody gets the ride when they need it no matter

what the reason but unfortunately, that system as it exists doesn't have that type of capacity to support it. So it certainly is a worthwhile discussion to talk about priority of transportation and transportation providers.
BARBARA POLZER: Do we have anymore questions for the M COs?
SPEAKER: I have one question. We have known about the transportation problem in Pennsylvania for decades and --
KEVIN HANCOCK: Many decades. Yes.
SPEAKER: There are organizations out there like centers for independent living who have in small ways tried to mitigate the transportation concerns of the people we serve. And some of us have vehicles that we, if somebody within our organization needs a nonmedical ride, often it is to our center, they can get that. However, what I'm hearing is that in order for that to be a service that -- that is -- is is reimbursed by the M COs, all of those little -- like I have three vehicles but I'm not -- I haven't gone through the PUC process to get them registered, I guess.
KEVIN HANCOCK: That is our requirement. That is not the M C O requirement.
SPEAKER: And so I was wondering if there could be some examination of that process? Because I think there is organizations out there that -- like I don't know that I have the revenue or the time to go through the PUC process but if of the people that I serve somebody needs a ride somewhere, we often do that. And so through my organization's insurance etc. And we often provide, like, for example, emergency rides when somebody breaks down in their wheelchair on the side of the road, they need a ride home. We provide that. That is not something you can get para transit to do. We can't get reimbursed for that.
SPEAKER: Just throwing it out there, I mean, our M C O transportation brokers are enrolled and they -- the M COs do reimburse informal supports for transportation for participants. So why wouldn't that scenario fall under that type of payment mechanism.
KEVIN HANCOCK: I think -- I think it would be a discussion that we have with the M COs that they may be interpreting our provider requirements that the department developed for nontransportation literally. They have to have a PUC license.
MATT SEELEY: Can you define informal supports?
KEVIN HANCOCK: You called it informal supports. I don't think that is exactly what --
SPEAKER: Like a friend or family member.
SPEAKER: Couldn't that be a taxi. Like, for example --
KEVIN HANCOCK: Taxi all have PUC licenses.
SPEAKER: Would they still reimburse them if somebody used a taxi on a holiday to go to dialysis. I'm.
KEVIN HANCOCK: I'm going to put you on the spot. The life model has -- the life concept, uses transportation as essential pay to coordinate care in addition to interdisciplinary team. Do you in your facility require a PUC license for your transportation.

NINA DeLGRANDE: Yeah.
KEVIN HANCOCK: Is it a requirement for the program?
SPEAKER: I can double-check on that.
KEVIN HANCOCK: Okay. Be curious to know how -- the life program actually -- the life program fixed this because it is an integrated service delivery model with transportation as a central component that relates to the transportation for nonmedical and nonemergency medical transportation and access to community engagement. They use transportation for all of those different things and the whole model is not only built on the life centers but the availability of transportation as a central component to the delivery model.
So the system can work. The problem is the payor sources in the broader Medicaid system has people going to all different places to access it and that lack of integration can sometimes be a barrier to address the problems that you are bringing up and it was brought up earlier by Pam and others. It is the payor. The payor sources and the way the program is designed it be sometimes pretty challenging. And to be perfectly honest there are a lot of invested stakeholders that -- that are advocating for the status quo because it is a system that has worked for them for quite a long time.
SPEAKER: I can only tell you that when people receive services from an organization they trust, we are the first person they call at 10:00 p.m. when they have been out to dinner with a friend and on the way home their chair broke down. We do it but, you know, I don't have a driver on staff. So I'm calling my PA S supervisors often to come and pick up the vehicle to go wherever the person is, to pick them up. And I pay them but I'm eating the cost of that. Because I don't want to leave somebody stranded at 10:00 at night.
KEVIN HANCOCK: I hear you.
SPEAKER: I'm asking that we look at that.
KEVIN HANCOCK: When it comes to transportation, we have had the guided principle for phase 3, not the /TKPWRAEFTest and not working. We will have to continue to do that at the same time develop. It is a really tough problem.
BARBARA POLZER: Jeff?
SPEAKER: This is Jeff from PA transportation alliance and PA C-I-L. Just to go back to the question earlier, you were mentioning about /-TD study. Act 19 that was passed this year for the transportation broker I was wondering if you can offer any comments as to D H S's participation. I know they are supposed to lead the study as well with PennDOT and aging and some of the issues we are talking about might possibly be included in the study being done right now.
KEVIN HANCOCK: So I was looking to see if we had anybody from our office of Medical Assistance Programs. We are not prepared to answer that question at this point but we will be happy to get the feedback obviously the M A T P study that you are referring to

is something that will be a department wide effort but it will be led by our office of Medical Assistance Programs and I would have to get the update from them.
SPEAKER: The study also includes C H C transportation too though correct.
KEVIN HANCOCK: It would include anybody eligible for M A T P which includes C H C participants that is absolutely right. It will -- so to answer your question more specifically about C H C. C H C is a -- it would be -- it would be an indirect party to the study because the services that C H C provides are covered under a waiver and separate payor authority. So it wouldn't be -- the focus study will the M A T P. C H C will be a consideration.
SPEAKER: I think some of the impacts on some of the other senior shared rides are going to be looked at. None of these things can be looked at in isolation of the others.
KEVIN HANCOCK: Agree agreed. All of these different types of sources -- all of these different types of sources would have to be a consideration, that is correct. Thank you Jeff.
BARBARA POLZER: All right. I guess we are going to wrap it up for this month. Thank you everybody for your attendance and participation. Our next meeting is October 2nd.