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>> The webinar will begin shortly. Please remain on the line. The broadcast is now starting. Awe awe all attendees are in listen only mode
>> Good afternoon and welcome to the September edition of the Consumer Subcommittee. Today is Wednesday, September, 27, 2023. Before we begin the meeting I would like to go over a few housekeeping items.

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Representing the Department of Human Services today from the Office of Medical Assistance programs, deputy secretary Sally. From the Office of Long Term Living, deputy sei secretary Juliette. From the Office of Income Maintanence the director of the bureau of policy, Car l. If you have any questions related to this meeting or need additional information, please visit the Consumer Subcommittee webpage.

I will hand things over to the Consumer Subcommittee chair, Miss Sonia.

>> [overlapping speakers]
>> I think they have audio again. All right.

Should we resume introductions for those participating by phone? Or webinar. If we go through the consumers I don't have the benefit of go to meetings pulled up here. I can go through consumers on the sub committee, do you have those? Do we have Jamie participating?
>> I do see her she's on the attendee side. I'm trying to move her but there's something with her connection. We can jot that down or I suppose the captioning will catch that. Do we have Lauren Henderson on the call this morning? We haven't heard anyone on the call so I'm not sure this is reliable.
>> [off microphone]
>> Just jump into the agenda
>> I'm Deb I'm on the call
>> Thank you for testing our audio for us.
>> This is Rochelle, can you hear me?
>> Yes, good morning or good afternoon, do we have other consumers in the meeting?
>> There aren't any showing. I'm looking on the attendee side and bringing them over but not at this time
>> I guess a couple of introductions of folks who joined us a minute ago from the Office of Long Term Living.
>> Office of Long Term Living
>> randy from the Office of Long Term Living
>> How are you?
>> We have one more we want to test online if we have them, Amy Lowenstein from the [off microphone] project on the call and able to speak? Are you able to unmute yourself?
>> Yes,
>> Very good, anyone else that you know of? All right, I think we are to the OMAP portion of the agenda OIM
>> I stand corrected. We have a change up.
>> This is Car l, can you hear me?
>> I would like to thank the sub committee for allowing me to go first. [off microphone] got rearranged. I received a some information about what the consumer sub was interested in. And I can start talking about that.

I think the thing on everybody's mind is the direction that the states receive from CMS around changes to the exparte process. CMS released thest not technically a director letter but the policy of director letter at the owned of

August it's stating that many states I think 27 to 30 in total have their exparte process working in such a way that [muffled] at the individual level they are reviewed at the case level. Pennsylvania is one of those states that has this problem. Based on what they said to us we immediately which I thinked our process to implement a mitigation, one of the mitigations outlined in the letter to states and we also do an evaluation right now to determine how many individuals we need to be reopened in their eligibility because they have not otherwise closed in this change if process.

So I think that's a good place to start. And we can get into details on that. I assume you have questions about it.
>> We do have questions. Thanks. We saw the CMS report that identifies Pennsylvania as one of two states where the estimated population impacted of over 100,000. Can you walk us through what that number is, be it 100,000 or a similar number, the number of households potentially impacted by this or individuals
>> Sure, rereported to CMS on the deadline they asked which I think was September 13. Was the total potential number of cases that may have a recipient that is affected by this change.

and the total potential cases we think is 37,000. We are currently going through the process of evaluating that [muffled] to try to figure out how many specifically need to be reopened. So when we were reported it we didn't really want to wait to get to the most precise figure we could identify because we felt that CMS would want to know if we could not give them a precise figure the total potential population. But we think the final population is going to be lower than what we initially reported.

>> That's helpful. If we could pause on that 76,000 number. Would that be 76,000 households that could have children or other individuals? So the individual is impacted number could be higher than that? Or is 76,000 in individual count? Your audio, Car l, you may have broken up up, can you hear us?
>> There we go. The 76,000 number is a case figure. So there are multiple individuals in a case. 76,000 is close to 190,000 recipients. But again, that is the total potential universe of recipients that might be impacted and we are going through the steps of trying to identify how many recipients need to be reinstated based on CMS guidance
>> This is Megan from the sub committee S it fair to say the word "cases" is being used because certain cases could be a household and other cases could be an individual of a household of one, for instance?
>> No they did not include cases including a household of one in the figures that we reported because they would not be impacted by the issue identified by CMS.
>> Okay
>> So, Car l. This is Sonia, what I'm suggesting, I may need you to think about this. If you could take the 76,000 and have some retirees or someone else beds your caseworkers to figure this out and let the other workers continue to do what they've been doing, do you think that's feasible to say that?
>> Well, right now we are at a place where we are doing evaluations within our system to determine the precise figure.

And that certainly is a taxing activity on myself and my staff. But that's a normal thing that we do here at the Department. When we get to the point of understanding the precise population that needs to be reinstated we will try and evaluate what the best course of action is to do that. And we are already in the process of beginning on people to assist in the workload challenging of the unwinding.

But until we know that precise population better and we understand all the tools that we have linked there on it, I don't think we can say what the actual process of that statement would look like. What we said to CMS is we intend to initiate reopenings in October. And we still intend to do that. But we don't know yet how that process will work. And we haven't not spoken to CMS about this. They said they'll speak to all states affected by it. So we think it will be instructed better
>> Karl, sounds like you are developing a mitigation plan going forward given that Pennsylvania can't do currently, the system does not do exparte review of at the level. So you are talking retroactive. So going back and identifying which individuals were eligible and determined eligible through the manual exparte. You are starting that latter part sound like in October. Do you have a sense for how long that might take? Given the CAO is also significant burdens just processing normal renewal activity going forward?
>> Well, I don't really want to say how long it's going to take. Because I don't think we know yet what the precise figure is going to be. And I don't think we know yet what the full tools we can bring to bear on the situation. If you read the guidance from CMS, they have a couple things in there about what states can do. One of them involves changing a renewal dates of affected individuals like a batch process.

That's on our mind. I wouldn't say we determined we are going to specifically do that at this time or we are came of doing it. But that's the kind of conversation we would like to have with CMS how some of those activities might work with the workload volume. And I guess as I said at the beginning that final number is very important. But you're right there's retrospective activity and prospective activity. With prospective activity we immediate lid implement admit gages that's in effect right now. We expanded the scope of the cases receiving a manual exparte review so if the manual doesn't do that our caseworkers are able to say that [off microphone].

>> Are you -- do you know right now of the 76,000 households do you know by case number of by name who those people are? Or you have to go back to all your files and figure out who are those people?
>> When I speak of the total possible universe that's the maximum amount of cases and people that are affected by this. We know who they are. We have information from our system about them. But the final precise figure is going to be smaller. And we'll take action to reinstate coverage for that population as soon as we can get some more direction from CMS about how that process is going to work.
>> Are you saying then in October you'll begin the process of case-by-case review to identify any eligible which I shall who may have been determined ineligible because of the method of exparte review you did? And how long do you anticipate it's going to take to go case-by-case to get through 76,000 f
>> Well that's why I say at this time I don't think we can say how long it will take to do this activity. Because we don't yet know how the activity will be conducted.

There might be things that CMS has identified with other states and that they'll allow which could expedite the process of reopening the eligibility for the population. It might be the case that the things they identified from working with other states on this are not able to be implemented because of contingencies with our system. We just don't know enough yet what that process is going to be
>> Carl, you aren't in a position to reactivate all of those cases now? And then in the review determine who is not eligible among those groups?
>> No, we're not
>> Car l, can I ask something, do you mind?

>> Please
>> I just want to share, I know Car l doesn't all have the answers you are looking for right now. But we are also working with CMS. They have shared some resources and toolkits for us. We just started having those conversations. And so a lot of the way we approach this may be influenced by what it is they share with us and the technical assistance they provide.

So as Karl says we are noel absolutely certain yet that may change with the technical assistance or with great ther frequency. We've been in contact with them but it's increasing.
>> So one of the options we know with CMS provided to states was following the procedural enrollment until the issue around exparte is resolve. I guess it would be useful to hear DHS's response in terms of consideration whether it will pause going forward. Carl mentioned expanding the scope of the manual exparte which gets to the issue but sounds labor intensive. And we know there's workload challenges at the county level already
>> I think what [overlapping speakers]. Sorry.
>> Go ahead,
>> What I was going to say is what you said that states could pause this until they resolve the issue, I think indicates where we are right now. We did change our process in order to conduct this level of review that CMS expects. And we will continue to do that manual process until it can be made into a system process, which will take some time.

Soyou are manual exparte is the fix until we can get it into our system. At this time, we don't intend to pause our unwinding processes because we are doing what we believe we need to be doing.
>> Go ahead
>> So these kids who may be eligible but who are not currently enrolled in medical assistance, is it safe to assume they were then not automatically enrolled in CHIP? So these kids are going without insurance for health care during this time?
>> We don't know the transfers of kids from MA to CHIP if they are closed due to a procedural reason. We don't know what eligibility category they should be put into for CHIP.
>> I have a note just asking folks on the call who are not speaking if they could mute their phones. There could be background coming through
>> Let me say this. And then Carl, I don't mean to step on your toes here. Throughout this entire process our goal has always been to ensure every single individual that's eligible for coverage maintained eligibility. And we have taken advantage of some of the exflexibilities offered like the retroreinstatement. We worked hard to communicate the message out. Our radio pots and MPOs have been excellent partners news to outreaching to everybody. And we said all along the best thing everybody can do is fill out your application.

We believe we are in a good position at moment. I appreciate there are individuals that fall through. And again we try to prevent that as much as we can. As long as we hear about an individual that's fallen through it's addressed whether a CHIP child or a medical assistance. And same for adults. Clearly children are a little bit different but we have adult need as well.
We do have the manual process that Car l described. We believe we are still in a good position even though we can't give you the exact number, Car l mentioned 76,000 cases we don't know how many individuals that translates to. We found with the IT transition it was a loss less individuals we thought once we got from the cases so we have historical reason to believe it won't be overwhelmingly high. As carl said we are staffing up and you heard we talk about the we have the ability to lift the CHIP work because we have the regional centers to be able to do that
For all of those reasons at this time we are not going to pause because we believe we are in a good position. Again the goal is to ensure sure that every

person that's covered remains covered recognizing that unfortunately we will miss hopefully help minimize anyone we miss and we'll address them as soon as we hear about them. We'll continue to provide you updates as we move forward. We are also availing ourselves of all the technical assistance that CMS is offering us.

>> That's helpful. Certainly on the issue of prospective relief and not wanting to put a pause in place we can understand the state's considerations Mr.. I would like to circle back to Liz's question around why DHS might not be reinstating the procedural determination so that universe of 190,000 folks some subset of which I think it's an acknowledged likely children have are eligible given the data sources the state has available to it. Exparte done on an individual level would find typically those children eligible. So possibly tens of thousands. And understanding there's a significant pull on the workers with the workload and figuring out the CHIP issues and everything else they are doing and now expanded scope of the manual exparte review going forward given the amount of time it might take for the system fixes. It seems from our vantage point acknowledging there's this subset of individuals within the 190,000 who likely do qualify or they do
based on information the state has. And knowing it's going to take some time to have workers individually review all of those cases. Again. That are not closed.

Why not reopen those households? Granted it's a larger population than what we found people ultimately qualify but they close them as the state undergoes that retroactive mitigation rather than the other way around
>> I'm not exactly sure what it is describing we do. Some of what you said is something we started to look at and try to figure out how to do that. The state does have information about the added sources available to us. And we are using that to try to identify who would have otherwise not been closed and we end tend to talk to CMS how that would work. But either way, whether we work really fast to get that particular subset tomorrow or it takes a little while long tore get the whole thing that's still a manual process.

And we are trying to figure out is there a way to do that more quickly that puts less burden on the workers who need to do the activity? I guess I'm saying I don't think we disagree. But at this present moment we have to get to a particular population that requires reopening. And we want to hear from CMS about how this would be done so that we can do it correctly.

>> I'm not sure I fully understand the response. And it may be we misunderstand what the system is capable of. But Car l, do I hear you saying that essentially restoring coverage for the full 190,000 individuals, 76,000 cases could take adds long or might take nearly as long as doing the individual exparte review for each individual? [overlapping speakers] restore for everyone and then do the review?
>> Yeah I think we are matching up different things. So there's no button we can push to reinstate coverage of people across the board. We think right now unless we figure out something different that expert of what we are working on is a manual process. So what we want to do is we want to identify the people that we need to send out to be reopened. And then also try and figure out ways to expedite that possibly [muffled] the batch processes that we haven't yet considered or worked out. So I guess my point is that we are not waiting to do anything in particular. We are trying to get to the bottom of the question of, what is the scope of people who need to be reopened? So that we can work through the process of reopening

And there's no button to wish for that. It's manual work that's what we think right now.

>> So I mean, clearly we understand your concern. We do. And I want to assure you that we consistently, constantly, on a almost daily basis reassess where we are at. And some things sound easy. Like what you said. But at the end of the day, they are not as easy and as straightforward as you would think. And everything we do has an I mean impact somewhere else whether it's the workload, whether it changes the way you do this, everything has an impact. So we have folks routinely assessing all that. And we stand prepared to make changes as the situation changes and as our information changes.

Again, we think that right now right where we are at we are in a good spot.

To manage it. If we get information tomorrow that says no, [off microphone] we'll pivot again we have that ability to redeploy resources and realign them where the need fits. So that has always been our strategy. It will continue. It's a proactive strategy that allows us to be reactive.
>> Do you think it's simplify [off microphone] I know you can't just push one button.
>> I think that you could think it's too simplified to fix it. And let me say this. I am not an IT person. But
>> Between the health choice implementation and the algorithm and between the tip IT transition and everything like that and between the MMIA system take over I know enough to be dangerous and I know this, our systems are very complicated. And what seeps straightforward makes this change because we have very old systems, we find out it has unintended consequences.

I think we saw that in the CHIP transition, we moved everything successful, we moved all by 64 kids. And by any stretch of the imagination in the private sector or public sector, huge success. The next thing is move them into ESIS and promise. And oops when we moved them from EPSIS to this whatever reason they all [off microphone]. So that's what I mean. It sound straightforward. And I don't think you folks oversimplified it at all. That's like the same questions we ask internally. Like okay why did it bump them up a row? We had no idea no one knew because the system -- so it becomes the same thing with this. Can we move them ahead? I don't know what it means now maybe Sonia is related in the same household because the kids got moved with other families.
>> [off microphone] I bet consumer [off microphone] why is that budget so high for IT. [off microphone]
>> Pennsylvania has moving towards push the button like Amazon and Google for those QVC shoppers out there but we are not there yet so we work with a older system
>> Is the length of time to do that individual review of those 76,000 cases is it because of mass fort allocation? I don't know whether those reviews have to be done by the individual county or will the states can pull up those cases and do that review. Is it simply that you need more man power to be able to shorten the length of time to be able to do those reviews?
>> I'm not the person to answer that. And Carl, I don't know if you are operations can you answer that question or not?
>> What I've been triking to convey is of course everything we do involves man power ultimately. But if there's ways that we can do that that involveless man power we can attempting to do that. So I feel [muffled] to be able to say how long is this going to be?
>> I suggest we talk about CHIP more. But if you have another one on exparte
>> Maybe my final thoughts on the exparte there's 76,000 cases potentially however many members of households within those cases are now going without coverage. Erroneously, we can't make them hold proactively. We'll potentially reactively make them work down the line. And we know the systems cases offices are dealing with the any CHIP. They have that on their plate. And they have the reassessment. And there's already a significant higher level of workload during the time where every industry is impacted by workforce

shortages.

You can see our concern how this might play out with getting things made whole for these individuals going without insurance in Pennsylvania. All that said, if that's the process the state is taken, I do want everybody to just consider when we are talking about unintended consequentses all these individual members who are found to have actually been eligible and then need to get reinstated however many months later if they were without insurance now no longer have the preauthorization or the enhanced rates agree to with their MCOs. That's significant amount of administrative work that has to be backtracked for that individual. Is OIM prepared to in some set up a process that will automatically do that for the member so it's not an individual member that is chasing all that down?
>> Iwill say that. The individual member should not have to take anything down it's up to the provider to submit the authorization request. The author says requests are usually for an extended period of time 30 days to 6 months depending on the service. I don't know what you mean about the advanced rates
>> We have some cases of individuals taken off whether a procedural error or for whatever reason they were eligible they got put back on Medicaid.

But unfortunately, in that time frame it's almost like everything resets. Now you are this is putting a undue burden on providers. And to reprovide all of these letters of medical necessity or preauthorization. And these things aren't feesly caught right away. So it's not until the member discovers that something that was covered is not covered didn't carry over when they were taken off Medicaid and put back it reset them in the system in some capacity
>> Like medications a authorization how to [off microphone] their medication because they needed that authorization like vanish sod you start that process over again
>> Here's what I'll say to that and if that's happening let us know. Buzz because the MCOs are conscious of this. And they are taking extra steps to prevent this disconnect in continuity of care. So I'm getting it's if something like that happened it's possible a provider wasn't aware. We have any number of providers in the assist state they are good at getting this word out like hey can you see these folks? That's when we on the CHIP side as well.

If it's happening we would like to hear so we can identify what the systems issue is. We have not heard back.
>> [off microphone].
>> All right, sally, I think you segued us into the CHIP IT transition which is another question we had lined up. [overlapping speakers]. All joking aside we have heard too many instances of children terminate from the MA and enrollment into CHIP delayed. So they are having lapses in their coverage, sometimes several months. Seems like it could be systems changes and IT changes. So Sally, can you speak to this?
>> There was a period of time where children were lowing community because of a IT glitch. And I think it impacted 9500 kids in total. Here's what happened. In health choices you are eligible for MA. And then you go into fee for service window depending when you get in, the 16th of the month and 45 days [off microphone] when we programmed the system and these decisions were made four years ago, people said we are going to do what we do if health choices and they move the kids to nonexistent fees for service. To fix it we had to close the cases and change their eligibility date. Which unfortunately, pushed them ahead the following month.

So logic pushed them ahead to the following month. So these children ended up being terminated with a 30-60 day gap if coverage. We as soon as we became aware of that we started running proactive report. And the CHIPs staff literally was working on a clock like we did with provider enrollment, working

around the clock to clean that up, literally, people working at 2:00 a.m., we had them retroactively manually enrolling these children. We thought we had the fix. Not quite. It happened a second time.

So yes, there was a really funky glitch that happened. As of the end of August, August 29th, I think, question had every single child reconciled. We ran the reports for this month and moving children to that nonexistent fee for service space is not happening. And children are not being moved forward. So that's issue number 1.

It's resolved but yes we acknowledge there was a glitch. Issue number 2. And this is actually impacting a smaller number of people and it's an informational piece. It used to be when you enrolled in CHIP you called up the plan and did your eligibility and you said you are enrolled to the first of the next month. We had about 60% of our kids coming through CHIP anyway. And they were used to that. And you got to go through the whole process and it takes 30 days and you are not eligible. We are hearing from the families last time I called and I was enrolled the next day. No, you have to go back through the whole evaluation process. And that takes 30 days. To get enrolled. Some of those are experiencing because they are ignoring the letters coming. But we are hearing from them, I didn't apply for any service through the state.

Well you applied through CHIP and there's a new process. So the CHIP plan has been working on reaching out and making sure that messaging gets out there. So that is still exists. And that's a knowledge gap on the part of people that are interested in CHIP.

>> That's helpful but this year they are not ones that we discussed or were aware of. I think I suppose the one issue we discussed and I'm wondering if there are systems impact here, again, as the CAO level where a worker is running a determination or renewal where they find the child is no longer income eligible for Medicaid. And they are stopping Medicaid and issuing and taking action to stop that, the enrollment into CHIP appears to be delayed and I don't know if that's because it's requiring a manual action.

It's not a system action. And in some cases many cases the Medicaid termination notice isn't mentioning that and you are found eligible for CHIP at all. And the phone call is oh yes your CHIP enrollment will be effective November 1 or something along those lines
>> I'll go back and follow up. I know it took time for all the education and change of processes to get communicated down to all of the CAOs. And I know in the very initial days there was a little bit of a hiccup there.

Especially with the upper income families that are eligible for CHIP because they wanted to put them through the whole MA process and it's like but I make 423% of it. There's rules that said you said to be denied for MA. So they put a temporary work around and we put a permanent fix. If those are still happening it would be helpful to hear that so we can look and track down why. At this point in time, and I know there's still some old stories out there in the newspaper. I just saw the other day but that was published three weeks after that individual's enrollment issues were resolved.

Some of these stories are lingering old stories. We in the past three weeks didn't receive calls from Senators offices or legislators offices or individuals. We think we are really good with CHIP right now.

>> I do think it needs to be more educational tumbling down to the CAO. Some know and some don't
>> That's been ongoing. As with anything. I mean, we if OMAP have to do

ongoing education as well.
>> Just point out to the chair we are behind on the OIM piece. We should keep going.
>> Thank you, Carl, appreciate it
>> One last thing. Is it possible by next month if we have some real numbers on 76,000? It may be less than 7 6,000
>> I sure hope we don't have to wait another month to get the precise figures we want to take action to reopen the cases well before that
>> Okay, thank you so much. Appreciate you.

>> I'm up? Okay I feel like I've been up already. Okay. Let me give you a quick couple of budget updates and then I'll talk about dental and paid parents. The governor signed the 23-24 common law budget on August 3. However we are still waiting for the leg to sign appropriations bills that need to happen if you are us to get the money out. Some money has been allocated and gone out. They went back in session end of August to do that. But we are still waiting for some of the funding. So that's my update.

In terms of the federal we know that there is a high probability that we will hit a federal budget impasse on the 30th which is Thursday or Friday.

It will not impact Medicare or Medicaid. CMS the fully funded for Medicare. And Medicaid is fully funded for five months wort is what we hear from the Feds. It will impact some response times from CMS because their staff will be gone until the budget impasse is over.

We don't think that will have any significant impasse at this point in time on anything we are planning or we have in the works.

so that's where we are at with budget issues.
>> I want to go back to the state budget briefly. I think they proposed dental rate increases that make it through
>> The dental increase did not make it into the budget. The department is very supportive of dental increases as well as expansions of this dental benefits. [off microphone].

We continue to work toward the achieving that. And we will continue to submit requests to make that happen.

But it did not make it into the budget. We were disappointed as well. Questions about that?

Which brings uses to the dental BLE monitoring. As you guys will recall about two years or so ago we streamlined the dental BLE process. And people with diagnoses and developmental disabilities, neck cancer, and cardiac disease, I forget the fifth one automatically went to dental, medical necessity review.

And there was any way you could get there your dentist could check if you have one of those conditions on the form. The plan had to do a search and see if they had a claim of it. And there was to longer this need for you to run around collect 9 million pieces of paper to prove you needed the dental medical exception. That's the five that automatically get to dental review.

We are enhancing our monitoring around those dental reviews that are occurring. Because we've been hearing that people can't get a BLE. All the plans had to submit a policy. We reviewed all their policies. They had to make changes with requests like we did with any other pry morization policy. And we are starting that process whereby we are reviewing the denials happening.

We know our dental approval rates are somewhat low. That doesn't -- that really doesn't tell you anything. It's possible those denials are appropriate. And I'll give you an example.

I recently had a tooth that had all three surfaces filled. And it needed work and the dentist said no your only option is an implant. Can't restore it anymore.

And it's not recommended to restore a tooth that has that many surfaces because it will crumble and break anyway. So what we are seeing with denial might be those type of cases the unfortunate piece with that is I could get an implant put in and we don't pay for implants by dental plan doesn't pay for implants either. So we don't know those denials are all inappropriate.

>> I appreciate you walking us through this. When we looked at the data that you gave us back in May. And this was a follow up conversation. You might recall this chart that went provided. I don't know you don't have it in front of you. But I guess it's significant and it goes back to BLE approval rates and I apologize I don't think anyone listening at home will see the chart.

But what was stark from that main meeting is the high markers that is almost a gateway the high approval rate has a full implementation of this shout out. And they were well over 50%, over 66%, 2/3 for most of the quarter's post-imp policemennation, so the Mother PCO was no gain. So I think the other plans didn't implement this process in a meaningful way. And the formulation was the medical side somehow was not conveying that diagnosis information to the dental subcontractors. That clearly was a barrier that high market figured out.

I know OMAP was going back to have those conversations again the MCOs were reassessing their processes. So that their dental benefits, managers had that diagnosis of information they need to streamline. And it's certainly is still the case, I might have diabetes or intellectual disabilities or any of these conditions and may not have root canals or issues with medically necessary for me. There could still be low denial. But we would think. And maybe we don't have enough data since the revision to their processes that there would be a difference in the approval rating and we would see some change in the way that high marks dental approval rates was significant.

>> As I said, we enhanced our monitoring of it. I don't know if numbers really give us any story at this point in time. They are just a point of information until we continue to monitor and dig deeper. Gwen, are you on?
>> Yes, Sally, I'm here. I was wanted to share that we did go back and look into the processes that each of the MCOs are using. And what we found was that that initial hypothesis I had that maybe the medical information was not making its way to the dental managers that not the explanation for the difference here. All of the MCOs do have a process similar to the one that high mark has to share medical information.

Not quite in realtime but in frequent cadences with their dental benefit managers. So like Sally said, we are continuing to look into everything, turn over every rock we can think of to try to figure out what those numbers mean. But we just don't have a good sense right now.

>> Are you telling me that -- hi, how are you doing -- are are you assaying they have the information that high mark has and they are not using it or what is it?
>> I don't know that, Sonia, all I know is they have the same access to the same medical information. I don't know what utilization of that information looks like yet. That's the piece we are looking into.

>> Is DHS committed to -- best practice if we discuss this a long, long time ago, if one of the MCOs has something that is working but they would share that information. So all the consumers would get the best care
>> They do share information and best practices with each other. And we have a if you remember of forms that maintain that. We have regular association meets with them and they do it through the medical directors meeting, the 360 meeting with each plan to identify best practices and everything like that.

The dental BLE for years it was no. And you would think when I send out a letter with yes that people listen to me. It takes a while for that yes to filter through. And some plans filter in more quickly than others. So that's Gwen and her team are monitoring it. And when we see there's an issue, it's like anything else we intensify our monitoring and that's where we are at with it now I think you met Sean our new officer in our meeting and he's all over this. And the secretary is very publicly supportive of the importance of oral health. And why we need to reinstate the adult dental benefit. So yeah, we need best practices when it comes to dental quality out there.

And we are moving in that direction.

>> I appreciate that. But I think that details plans and MCOs if they want this. You know what I'm saying, they would want to have these numbers. [off microphone].
>> I don't disagree with you. I would be embarrassed by this number
>> I want to know if they shared. And I do know they share things with the each plan. But I'm saying for the record that I think that when this case they would have more high mark was the gateway they would have got together and say let just do this. Let's post these numbers up. That's why we ask
>> No, I fully appreciate. I don't disagree with you at all.

>> Sounds like from what Gwen said, and correct me if I'm wrong, this is Megan, hi. It's like high mark has a special process and no one figured out what that special process is. The plans are doing what we thought was maybe the barrier. The plans are actually doing that. So that wasn't the kick off. They are all they do have a streamlined process for sharing that medical data that's necessary to utilize the BLE in a meaningful way. It's not that you are looking to figure out what it is that high mark does it's what the other MCOs have not done yet
>> That's right. Once we can figure that out we will absolutely be sharing it with all of the MCOs. We just don't quite know what it is yet
>> Given this chart that we are looking at that I apoll use you can't see
>> I have memorized
>> Yeah, so that was Q42022. We are coming up on Q42023, is this going to be a tool you utilize to compare and see where things are? And can we see that next time?
>> Yes this is one of the most important tools that we have. This going forward. So we'll be using it. And we can share that information with this sub committee.
>> We appreciate that. I think we would like to see that.
>> I do appreciate you are continuing to look into this. And Sally you are well aware how long it took to developed that streamline process in the bulletin and the goals and the promise of making these BLEs really more available for people who need them.

Than right now it's clear from the data you shared last that they are available if you are high mark. And otherwise, this process doesn't make much of a difference than looking at the approval rates from preprocess. So appreciate the commitment there. And sounds like we'll have more conversation. And hopefully more data to look at
>> Absolutely we will share.

>> I have one quick question on the budget impasse. I heard Ca rl saying eferl sims he was expecting guidance from CMS next week. If there's a shutdown --
>> There's key leaders working at CMS. Like if the state shutdown I would still be here
>> Okay so it won't hold up that process of getting guidance.
>> [Laughter]. Okaying [overlapping speakers]
>> Let the record reflect [overlapping speakers]
>> [off microphone]
>> sally not everybody is as dedicated as you.
>> Senior leadership will still be working at CMS
>> I think we can do the next item quickly. Guidance on parents and paid caregivers
>> The guidance is out. We sent it into the plans we did the coding update. I need to share something really important with folks. And I need folks to truly, truly understand this from from our perspective. And a regulatory and safety and legal perspective.

We are now hearing loudly out here in the community that parents are pushing providers to order [off microphone] services when a child needs skilled care. We have literally heard the parents are threatening providers to say don't do that. So what we see is the MCOs are getting requests ordered by a physician for home health aid services when the child needs skilled care. We are seeing home health agencies to provide home health aid services and when they go in the child has a skills need.

What we have been telling providers and the MCOs is they have an obligation to ensure the level of care that is delivered to that child metes the child's nude need. If the child needs skilled care they need skilled care and the parent as a home health aid cannot provide skilled care unless the parent is a register nurse or respiratory therapist.

Having said that the issue these parents are aggressively pushing the providers to order these services because they believe they are entitled to it are putting themselves at risk when the home healths a agencies plan have to start recording suspected abuse. So I would encourage everybody, we are more than willing and we took great strides to ensure that we would be able to cover a parent providing home health aid services
>> [overlapping speakers]
>> Who need home health aid services. We cannot abide by parents pressuring providers and agencies in and our MCOs to authorize care that is not indicated.

>> I will say, this is Megan -- there's a lot of confusion on a community level about what this parent or caregiver allowance is. People hear oh you can now be paid to be your child's caregiver. And parent is like myself whose child rely on skilled nursing think I've been doing this free medical care all these years and now I'll get paid for it. And we have to tamp that down and explain that's not the case. And there are some providers who will then recommend the parent [off microphone] or provider will recommend perhaps we can get a authorization that allows for skilled nursing, unless a nurse is not available. And then the medically trained parent can step in as an HHA. And that I think we certainly heard about people submitting that request. We definitely hear about people who are fired up and want to make it happen in some way.

But it is for sure I think we as a committee understand that the limitation is simply is a liability. It's a skilled care it's a difference of level of care. Now, that's not to athe parents like myself aren't trained in doing this regardless.

But we understand the differentiation. It's again one of those similar [off microphone] CAO not necessarily knowing all the newest and the latest and greatest. There's just some filtering of that information, there's confusion

across the board.

And I know we in the community that we can we try to clear it up. All that said, obviously there's still that need somehow, some way there's those parents that are providing skilled level care that are in that same boat, they can't be responsible outside of the household because they are still not enough nurses, et cetera, et cetera. But one thing doesn't necessarily -- one thing should not impact the other. So we hear that. And I appreciate -- we appreciate that.

>> I think I shared this story of the mother that called me and told me the father was quitting his job because he was getting paid and I said no your child doesn't qualify [off microphone]

Having said that, and you have all heard me say this since the day I moved into this position. I know that parents who are doing this care out there. And I know that parents have been appropriately trained can do it just as well as any clinician that will come in to help. We continue to have conversations with other states. We continue to have conversations about what a longer term solution looks like.

You guys know I remain committed as long as I am in this position and continue to move forward what it is we can do to these children ease and these families so that commitment still remains.

We may see some business we may not. But we continue to try and continue to have those conversations.

>> sal sally, I would suggest if you are open we have success with the health cure procurement project that [off microphone] that OMAP sat in on we had thousands of people registered
>> We could do that
>> If we could get the application out to show the parameters. I agree with Megan I think there's confusion in the community what caregiver means in this setting
>> We would be happy to do that. Gwen and her folks also three weeks ago posted an educational session for the MCOs on how to review these because we had also heard there were limits you can only get 20 hours a week. No, it also starts with the child. And how much do they need. And let's go if there.
>> [off microphone]. It may work the same [overlapping speakers].
>> [off microphone].
>> We would be happy to have a session like that.
>> I think that would be helpful
>> I want to mention limit there's been some guidance before OMAP released the May MCO bulletin. Some MCOs had working imoid yans that prescroibed that maximum hours for parents providing care for their own child. The have the MCOs u. that written guidance at that point?
>> Gwen has to answer that, I believe so
>> Hi, Kyle, all of the MCOs have revised and resubmitted and had their authorization policies approved pediatric care
>> One of the things that happens over time is people move on and you lose the source of knowledge. So it's dawned on me one day as I was having a conversation with one of the planned case managers directors like you really don't get it do you. And I realized she's only been working there a year.

That's a lot of what Gweing n and her staff did, let's reeducate everybody in level where we need to be. That was a good reminder to us we can't presume the program comes along the program changes because people change.
>> And there was this whole pandemic flip. And I think anybody on boarded to a position like that during that time where everything was wildly different I think

you all know the before times this transition back to similar situations that worked before is all new to them.st so that's a good point. [off microphone].
>> [overlapping speakers]
>> I don't do any of this. [Laughter]. [overlapping speakers].
>> [off microphone]. As we continue to have a shortage of nurses. We'll keep working on it.
>> And then the last thing. As you know, we do a quality management study for the state Medicaid program as well as the CHIP program. We are required to do it every three years. Our goals and objectives for the program. And that is now due up to CMS by the end of the year. And it is out on our website for comment.

Managed care quality strategy and PA.gov. And I'm on there. We also list where it is that you can submit comments to.

So we would encourage everybody to take a look at that. The 30-day comment period closes when? I think it went out there the other day
>> October 23rd.
>> Thank you.
>> Can I quick talking now?
>> Oh, no, Sally, keep going, please.
>> We want to thank you all especially Sally and the team for all that you do. So we don't [overlapping speakers] we want to let you all know we appreciate [overlapping speakers] and what you stand for. All right.
>> Thank you. Hi.
>> Sally could have kept talking all the way until 3:00.
>> Thank you. [Laughter].
>> [off microphone]
>> She'll point back to me.

>> Great. [off microph [off microphone]

>> I like to fly under the radar.
>> Good afternoon, for those joining us remotely, deputy secretary for the Office of Long Term Living. And here to give the OLTL updates. And answer some of the agenda topics that we have. So sort of [off microphone] we'll make up time, short today. And I'll do updates and talk about the annual waiver determination, and the questions that somebody submitted to our team. The next slide we'll dig into the updates the first thing is the statewide listen and learn tour. We are getting ready to issue the summary. And we are hoping by the end of September to make sha deadline. We may make that deadline or not. It may go to first week of October but we want to get that out for folks however we can do a preview of some of the topics that's being finalized.

So as we know we went across and visited all five regions. Across the commonwealth that was great community partners who set up and worked with us on some listen and learn sessions as part part of my onboarding into this position. So we had a great opportunity to engage with hundreds of folks across the commonwealth. And talk about all things OLTL.

And all of our programs. So some of the things we heard back that you'll see in the summarized documents is topics such as folks wanted to see stronger language around nursing home transition. They wanted to see improvements in the processes. They wanted to see that grow.

So folks were interested in whether or not we could think more about diversion programs in nursing home transition programs and things of nature. That was a topic of interest. And we heard how can we encourage more pilot programs with the MCO? With different different providers on different topics and things on that nature. We heard about the need to kind of reduce ad administrative

burdens on providers. Where there are ways of streamline billing and authorization and things of that nature. These are issues that are not new to OLTL. That the team has had ongoing throughout the years.

There was a recommendations and appreciation for the benefits counseling that's provided through the waiver program that no longer need to go through OVR it was ongoing. But with that it was like how do we streamline the process and mic itier for folks who want to go to work and maintain benefits. As you here know it can get complicated between all of the different tools of the able accounts that are available. And medical assistance for people with disabilities and tall different pathways that people can do. This is feedback we are not solutioning. So we wanted to hear everything. And we heard a lot of great.

There's some discussion about insurance authorizations within our program. There was a highlighting of specialized services. A health statement services. And looking at expanding that for individuals particularly those who have maintenance programs that don't need a skilled nurse for 6 hours at a time but need a skill that skilled service to be independent and remain in their homes and remained employed. And et cetera. And we heard about the independent broker process. And looking again how do we streamline things and improve education? There are certain steps that are required by CMS that we can't get rid of. But certainly how can we ensure that folks understand that whole process and why there are different agencies for different things.

We heard about from shelters the need and the opportunity to improve coordination with shelters, particularly for older adults that are finding themselves howing insecure or homeless.
that are winding up seeking services from shelters or being dropped off by shelters or to shelters and how to better coordinate those services through the providers who whoever it may be. And we are hearing issues we don't necessarily hear every day.

There was a lot of feedback with regards to transportation. Transportation challenges. Rural areas. Those in urban areas. It's that time of the listen and learn in the southeast area.

So there's been ongoing work there. And I'm not going to put it [off microphone] today. They are doing a lot of work there to help sort out the process. A lot of discussion and feedback as you know about the service coordinator and participant relationship and the service coordinator and the care relationship. The having really great dedicated support coordinators and the challenge of them having to know a lot of information.

And with workforce challenges turn over with supports coordinator. And feeling of them being overwhelmed, maybe having to too high case loads, et cetera. There was some discussion of the way things used to be and how they are now. And a great discussion how today they are asking more with regards to health and community-based services where in the olden days when I was in the support coordination in the field it was just home and community-based services. While in some areas seemed perhaps better in the past there's some things better now.

So it's a supports coordination that's considerably different than what it was when I was there. And talk about home modifications in particular. Supply chain issues. Delay issues. Time it takes to do the assessment. Challenges those providers are having. As well as participants in therm terms of their experience. And a lot in with the direct care workforce. And living wages. Increased wages. Really want to support the director of workforce training and things of that nature across the board.
And significant impact it has on apartments. And their ability to remain

independent and reach their goals.

So a lot of time was spent discussing that. Some of these are got -- these are issues we expected to hear. We heard discussions about the different models. There's the agency model. And then there's apartment self-directive model of services and there's also services my way which is a participant self-directed budget authority model.

And kind of an opportunity to really increase the awareness of the self-directed model and the services model that gives participateses more autonomy in their services.

We heard a lot of great information about challenges in rural Pennsylvania. We had a great visit in PA at the adult aid center and it servinged as a great community hub. But we heard things in rural PA in particular about the importance of building analog land lines versus the new voiceover IP land line and how the transition to the new voiceover IP land lines in the rural areas has you been intended qens that can impact health and safety.

And that folks may not be aware of that glitch without additional education. So that for someone in a rural area where they may experience high levels of losing power, a voice over IP system means they lose their phone line. Where an log would stay connected. So they lose their ability to call 911. Or utilize their curs or even check ins. Et cetera. It indicate creates a more significant need to have a more robust back up emergency back up planning and/or education and awareness of the unintended consequences of upgrading their phone, what have you. That wasn't on my radar but has real implications.

All this to say there's also discussions about how we have the appendix K and how to allow more virtual telehealth options and to have the reach and positive of that and barriers to that. And a lot of things for consideration for future waiver amendments or state plan amendments so a lot of good stuff. We hope to have that out for folks. Any questions on that?

[off microphone]

>> Like I said, this is the feedback part so now we have the roll up our sleeves and really dig into this.
>> I was at a meeting and they were rural. They were saying when the factories come on the lights flicker and they lose the electricity for hours and there's no other electric company. I'm from Philly and I'm like really? Hours and they know and they expect it. [off microphone].

>> What was really great about this center is they have two townships I believe townships that came together. And he's nodding at me and he doesn't know what I'm [off microphone] together and figured out like a creative transportation solution for their sort of senior centers and addressing the needs where they build the community transportation options at a reduced rate and partnership with the community partner. And I think a couple of the health plans that seems to be working well for them. So it was great to hear that too.

That really in the rural areas really getting hit with what is happening at the township level and building this partnership that very locally. [off microphone].

>> I hear a lot of information you are processing and you have to go back and do what you do. And then that might take how long
>> Well [off microphone] the solutioning for some of these issues transportation we've been talking about for decades. So I would love to a fix for that but I don't think I have a timeline

>> I kind of figured that
>> Are you thinking the information you learned here [off microphone] you are going to use and putting together the procurement process [off microphone]
>> I would say all the feedback that we received is absolutely considered for the design of our program.

I can't answer a specific procurement. [overlapping speakers].

Sorry. [Laughter].
>> I think we probably got as much information as we'll go from the RFA here that's fine. We know we had procurement challenges with other managed care programs that [overlapping speakers] I appreciate the caution. It's fine.

[off microphone]

[overlapping speakers]

>> We are in a black out period. But for procurement [off microphone]. Not to be rude.
>> I don't think Liz really realized that. [off microphone] in a black out they can't talk about it
>> It's nice to hear you did that [off microphone]. We look forward to getting the information. So we can go out and share it.
>> And feedback is not a one time opportunity. I do encourage folks public comment periods in this building and LTSS and MLTSS and et cetera. At any point our participate help line is available. And the staff are available to get feedback. The listen and learn was not a one and done. [off microphone] are you going to do this ongoing and we were like we do this ongoing and we ask for public comments.

So I just wanted to put that out there.

The official CHC request for application update is we have no updates as of today's meeting. Any changes to the timeline will be posted to the e-marketplace. And we are in a black out period.

Okay. So I also wanted to as I do often every opportunity I can this is another area of feedback. Pennsylvania Department of Aging master plan on aging. Still accepting comments they would love to hear from folks. And they are going to be holding listening sessions across the commonwealth and every county. Please encourage consumers, family members to submit comments on the master plan of aging. And aging plan at PA.gov. I hope all of us have that privilege.

And if we do we are all aging. So it impacted all of us. And it's an evolving plan. So even the younger folks were not thinking about aging are impacted by aging needs issues. So again wanted to do a plug for that.

Um, okay. So go to the next slide we'll switch gears and talk about the annual waiver determination. Then we received some questions on the agenda. I believe it was last week. So in terms of the data app they are going through our data review. So I hope to be able to get you data soon. I need to go through that review process first because I want to ensure accuracy.

So we did have a couple questions with regards to LTSS services end dating the service specifically being how why is it the in home and community based services or LTSS services portion are ended at the date a decision is made. But the individual is still enrolled and the we have CHC MCO has until the end of the month. And the reason is it has to do with the regulation in terms of the labor the services fall under. CHC falls under I'll get technical the 1915 fee waiver and

those fee regulations and the LTSS services and you have the 1915 (b) waiver that's [off microphone]
So they have different regulations in how they operate. And rules to redetermination. So that's why CHC services and the date for the redetermination or the clinical el eligibility ndz date specific. However because of the physical medical need falls under a different portion they continue to the end.

>> If we can pause there. I certainly appreciate the medical portion is through a 1915 (b) waiver like with the health choices program and HTSS proportion is through the fee waiver. I guess it would be helpful to understand how that difference makes a difference.

With MA determinations they are often the month and the services continue. Is the OLTL captation so to the CHC plan tied to a specific point in the month?
>> It's tied to the clinical determination.
>> um,
>> And so I get what you are getting at. And I have asked that question. I don't have the specifics on that with regards to the capitation but it is tied to the requirements of the 1915 waiver why that happens and it's not tied to the financial aspect of the program
>> Okay so even though the enrollment in that plan continues on and it's possible --
>> For the medical not for the LTSS.
>> Right.I suppose it would be useful to sort of know a bit more than it's on that the policy is to stark different by those two plan types and you may have this on the agenda but with the issues we have seen with issues pending appeal and some people losing the coverage in a month some of the harm could be avoided if the plan continued to provide the services through the month. In a way they are not now.

So we are seeing authorization in mid-month even though the person's enrollment continued
>> For the health or just the LTSS?
>> For the waiver benefits. LTSS. And this may be further on in the agenda that you have. But one problem we have seen with a lot of these NFI determination folks determined to be no longer eligible for waiver is disenrolled is when they file their appeals even though they are timely and we would like clarification whether the assessment is using 10 or 15 days
>> It's right there.
>> The timely time frame. The benefits are still stopping. I think that's seems to us the various pieces of communication between aging well and OTL and back. So the almost the circular pieces where so many parties have to take manual action often sometimes something breaks down and there's a delay in the benefits continuation there. If the benefit continues to the end of the month sometimes those delays could have been fixed. Two different issues
>> Two different issues
>> Is there investigation into the practice of changing? Or is it OLTL's position the mid month end to feel waiver of the benefit is required by the 19125 waiver?
>> That's our current understanding I'm open to going back in and looking at it. Certainly. Seeing if there's flexibilities there.
That's where we are today.
>> We have a couple asks for OLTL. One is about the grievance.
>> We have a lot of tied to the NFSS determinations we can talk about. And the guidance to aging well the and the note the consumers are nail mailed mentions 10 days for the appeal. Did that change?
>> I know we had conversations about this and the office was seeing updated [off microphone] 15 days.
>> Good to hear that, thank you
>> That's a good ask. Another thing --

>> If I say anything wrong, Randy will jump up and down and do a cart wheel.
>> I haven't done a cart wheel in a long time
>> Another thing when a person gets redetermination and then when they go back in like they get cut off, but when they go back in and the worker put them and tell them about the waiver services they need -- we ask them if they can go back retrospective. The reason is base the person caring for the person they continue doing the service. So they don't get paid.

So they take it retrospective it will be forever to get paid. What happens is the client still need services. You talk about children or adults. So --
>> Not children
>> Well, adults some children [overlapping speakers]
>> Not in CHC
>> [overlapping speakers]
>> I'm just saying could we be able to go back retrospective so the person taking care of the person [off microphone] that's a lot of the problems happe. You can get back to us on that. But I'm just saying. I would like to add when I get the phone call [off microphone] from the service providers [off microphone] don't leave them hanging. I'm not asking to work without pay until we get it fixed but don't leave these people [off microphone]
>> That's an interesting point you bring up because we do see some things things reported to us that are prop problematic. We hear -- and certainly does impact participants a lot when they have their really great attendant they don't want to lose. And losing an hour or less a day can be detrimental to losing [off microphone] that issue is not lost on me. And there's individual cases where that occurs.

But the retrospective it's really complicated to say yes across the board. There's situations where that does happen. And there's situations where it's part of the hearing and appeals process with the pending if the individual not timely submitting it would be a consideration of those situations. But when aid is -- when services continue during the appeal process that was filed timely the individual does get paid. Should get paid.

So just needing to unpack that ask a bit.
>> Sometimes given just -- we are just asking you to ask. What's the ask
>> Absolutely. We do get concerns when we hear that the agency is keeping someone on. And saying we'll pay you only if we get paid and we have concerns about that process. We don't want anyone taken advantage of in that way. And if someone is we hope they report that issue to the Department of Labor.
>> It's more so is more vulnerable that need these services and that a parent can't do it. [off microphone].

Should be doing it. So I'm just if the medical -- like we have a case that's happening now. In Dauphin county it was an error so they put it back on but [off microphone]
>> Not OLTL
>> No I'm just saying. But the same thing happens.
>> And with that it's certainly not a perfect system and we have individuals that again it's the case-by-case situations are handle as quickly as possible. We are not seeing that as across the board [off microphone].

So that's where you have that challenge. But absolutely. [off microphone].

[overlapping speakers]
>> Did you say we should not be getting those calls. I get calls from caretakers working and didn't know the paperwork doesn't put through for the people they were taking care of and the agency said you can't get paid because we didn't get paid. Are you saying I shouldn't be getting those calls?
>> I'm not a labor expert but if someone is working as an employee of a

company when you work you get paid.

>> Those people are employees of the patient.
>> Consumer direct access
>> The consumer is the one that [off microphone] responsible for their employee but the agency is the people the money is filtered through. So I'm getting those calls from the caregivers saying agencies said not paying and then when I do my research the patient usually is someone who is not physically well. And didn't get the paperwork in time
>> So that's a couple of things there. So if the person is agency model they are an employee of the agency. Fair labor standard wages all of those laws were enactedded if they weren't, they get paid. Under the self-direction model that's where the participant is the employer. They have a financial management services agency. Either tempest or PPL doing the paperwork processing.

So a couple of things in that if the participant is enrolling into self-direction, they need to be to a good to go status as in they need to be set up to be the employer. All of that has to be done and completed prior to them even being able to hire someone. The direct care worker has to get to a good to go status. And they have to have all that you are employer verification and background checks, et cetera, done before they could go to get their pay.

So and all of this is explained to individuals in the self-direction model, which -- and so they have to be at that status. Anything done before the good to go status they weren't an employee they weren'ting recognized as an employee. Or registered as an employee
>> After [off microphone] a break in service because they [off microphone].and renewal issue.
>> That's something we are going to have to look at and go back in to be honest, the self-direction model is for participants who can self-direct. Who take on the responsibilities of self-direction as the employer. And take on the responsibilities of being the employer.

They pay through the program or whether they pay out-of-pocket there's self-direction of that so they get paid through the program, some folks do private hire, what have you.

The apartments takes on the responsibility [off microphone].
>> How does the care workers in that situation have access to seeing whether or not a person is still eligible? Like the nursing agency can look. But can the --
>> I don't think if you have been in the tempest or PPL system the direct care workers can see if the consumers are good to go.
>> Consumers can but I don't think the direct care worker can
>> [overlapping speakers]
>> The direct care workers take [overlapping speakers].
>> I wanted to ask about the identified determination. Disparities between the CHC and COs where these cases are coming from. And one thing we talked about this morning which is somewhat surprising is that benefit seen a highly disproportionate number of waiver determinations with PMC participants and anecdotal the project we have over 3 dozen of these. But nearly 2/3 of those are coming in the new [off microphone]. Obviously it's market share it's much smaller than 2/3, maybe 1/3.

It does raise this concern of consistency. The idea of interrater reliability we heard about from the MPOs I think there's the issue of, one, the a county aging office finding someone qualified for the waiver. And you have the feds [off microphone]. And then an MCO finding that you don't. Sometimes until truly afterwards. Between the ages offices and the plans but then there also seems to be a significant difference between the MCO, at least again in our anecdotal

experience. Whether it qualifies or waiver shouldn't depend on which MCO I end up in. reactions to that? Is this something you observed with looking at this issue and what next I suppose?
>> And confirm whether the observations [off microphone]
>> The observations correct we are seeing more on UFPC than the other two
>> [off microphone]. We are looking at this process so you understand. The individuals get a determination done by the AA that determines whether NFC or NFI. And every year we have to assess a person to make sure they meet the level of care. And we do that through the assessment process of the MCO. One assessment tool we mandate they fill out is called the interRI. There's a subset of questions on there that are the same questions on the Fed. When they submit that to the system and guess to our systems to aging well and aging well is looking at that subset of questions and determining the NFY or NFC that's what we are doing every year. We are concerned with the numbers we are seeing of people coming back with NFY not a disparity [off microphone] I had discussions with each medical director of the plan and and discussions with the plans and they need training with the SCs to make sure they are filling them out completely and working through that process.

We are also looking at an intern process how do we handle this? Because there's more cases than I expected and it's burdening the system because DOJ is getting those processes and the problem is the aging assessor is going to the hearing and saying, you know, we are not going to fight this. Because because they didn't make the decision it came from the NRI. So we are looking for a best decision process how to handle this. And I'm working with the staff tomorrow to have some conversations about where do we go from here?

How do we fix this process? What are steps put in place to lessen the burden on the systems here. So more to come on this. But we recognize the crown and the UMPC. We had more conversations with them about it. But all three MCOs are seeing the identified cases come through they have
>> Is it possible -- shouldn't be all be on one page like the acts say one thing. And then --
>> When you go out and assess someone can I send three of you out to do the Fed on the person and come back with three different feds because it could be the time of day it was done. It could be the assessor's ability to dive a little bit deeper in getting answers from our participants. Sometimes participants may say I can do this. And an assessor may take that at face value. And another assessor may say can you do X, Y, andZ in this process? And the overall answer is no. That's the different answer to the question. So there's some assessor-related issues. And when you got the SC doing the interRI that's a large document they are doing the and the Fed questions are a subset of it. So there is concerns there could be differences on that.

So we are looking at that and trying to determine are we having issues with the assessors doing the Fed? Or have we having issues with with the SC doing the interRI? So we are looking to push where the education has to be for that.
>> On the MCO side or are the MCOs responsible for delivering that training? Or is there potential for the training to come from higher?
>> They are responsible for providing the training we mandate to them what the training -- they have to train on it. We do look at their training materials so we know what the trainings are being done
>> [off microphone] require assert if Id trainer for the [off microphone]. For the assessment tool. Putting my educator hat on. For quality controlling how a lessen plan is being implemented and perhaps it's not it's the implementation of that plan at the future level it's not a curriculum problem. I think that's why they use the interRI role that has that required certified training program.
So part of that [off microphone].

>> Thank you.
>> In context taste helpful. One piece I'll share we experienced and I know you are familiar with the issues around appeals and benefits continuing. And we do think there's some systems issues that play in there part of the complexity of the process going back to the OIM conversation which you may not have heard. Paula you ask the case work ears the county level I think that plays into some issues we have seen. But on the issue of assessment, many of the individual cases we are aware of and other legal aid programs have handled have been resolved by new assessment. But it raise this is issue of consistency. The Fed is the Fed is the Fed. But it appears when the county is doing the assessment often times the aging office is the MCE when the SCs are doing it, for whatever reason, be it training or their case leads or not taking the time to ensure that someone with cognitive limitation has a family member or someone else present we are seeing more NFI resolutions many
of the cases we reso l solved. And I'll put it out there. Certainly there are individuals who shouldn't be on [off microphone] we have seen cases where there's NFI findings and we don't disagree and it's an awkward conversation but we don't think you have a plausible basis to be on waiver. This this was a right to enroll. But many of the other ones new assessments have resulted in waiver eligibility
>> As Randy said we are looking into it. The aiming aging well is not contesting anything so that's resolved anyway [off microphone] we can't tell you, you would have a easy win on that, Kyle. I'm not surprised to hear that
>> And I don't think a judge is ordering it. And I should clarify. Some cases have been resolved by the SC going out. At the MCO level with prodding from an advocate, and sort of educational and what we think went wrong the first time around
>> And this is why we are focusing on looking at that in the training and the assessment.
>> It's a work if progress at this point. The good thing for me is I control both ends. Aging well contracts with us. So I can control that. And the MCOs so I can control that. So not me personally. OLTL. OLTL. [overlapping speakers]. [Laughter].

>> I'm deputy secretary I do whatever Randy said
>> I'm losing my mind but OLTL has oversight of both systems so we can make fixes. And we don't have to work with another department or this and that. So we are able to be able to do that. So we are able to look at the data on both sides because we have the data.
>> You look forward to that data
>> We ask for that data.
>> This came longer for the [overlapping speakers]
>> Going back to that control question. Acknowledging there are some problems there are some fixes that needs to happen. Can this not be paused in the interim?
>> No, cannot be paused
>> We have participants having their services pulled entirely. Who should. And whose reassessment is showing they belong inware and they are getting services and they need those services.

>> We appreciate the ask, Kyle. It's not happening at this time.

>> All right, I guess moving into another fun topic here we have a performance improvement plan left on the agenda. With 3 minutes. However you want to address it. Julia.
>> Performance improvement plan updates.
>> [off microphone]
>> That's right. Shiv I didn't have that on my --

>> We are continuing to review one of the things we did when we put the plan into place with them we wanted to start reviewing some records in a more closer to live time than 3 months down the road. To one of the things put into place they have to send us a certain amount of cases a week for the modern team review them to make sure the notes are appropriate and the service coordinator notes are good and all the documentation is appropriate. And it goes up to our medical director to review. He's working on the reviews fa. For some reason the last two weeks he didn't do the work because he was in Italy.

I can understand that but you know. So he's back this week.
>> He gets to have some time off too
>> Yeah, [overlapping speakers]
>> The medical director gets paid time off.
>> So we are starting to look at those cases. He has direct contact with the medical director at keystone he runs cases through. We go back and ask them for additional things. One of the things we asked them to do in their documentation is a 24-hour snippet of a person's life.

To get a better idea of what their needs actually are. not just looking at that 10-12 time when you were in the house but looking at that 10-10 time. What happens in the evening, happens over night for the individual. So we ask the keystone to put stuff like that into place so we get an better idea what the actual needs of a person is over a 24-hour period instead of a snapshot when they do the assessment. So I think they are seeing differences with that.

the other thing we've required them to do that wasn't happening was to have better interaction between the SCs and the UM department. The way it was is the SCs would do the assessment. They shift into UM department who would like at the paperwork and make decisions and there's no conversations between them.

We told them that conversation has to happen. The SC is critical in looking at and they are the ones who have seen the participant. So they are doing that. They are having daily rounds. Where the SC and UM departments are meeting so there's improvement on that communication piece also so we are seeing improvement in the process but we want get through these case so we where we are at. Some reductions are probably right. Some reductions are being found in favor of the Merihealth at the DAJ level. So that's where we are at with the process right now.

The hope is that we will see all this improvement put into place that will start seeing less of the drat tick reductions we've been saying for the last couple months.
>> I know we are short on time.
>> Can I ask Randy a question
>> I have a question as well.
>> Randy. I'm keystone. And you want to look at files and I can pick them and get them to you, [off microphone] I'm going to pick three files I know you can't question to give them to you. Do you think --
>> We pick the file. They give us a list of participants who had a reduction for that week and we pick the files
>> That's what I mean
>> Randomly
>> I wanted to know because if I'm from keystone [overlapping speakers] shh randy knows the tricks
>> I won't give you any discussion [overlapping speakers]
>> The problem I have is that you said [off microphone] were not communicating with one another. How long has it been? Since they communicated. They never communicated with each other?
>> I think there was some in the beginning but as they changed their model over

and get UM more involved about 6 month ago, I think that piece is not worked. So we told them that it's certainly something when we did the reduction review project, that was a big glaring thing that stuck out to us. There was no interaction.

So that's one of the things we told them in the improvement plan you had to do. And they've done that. And put policies into place and put processes into place to do that.

But there's probably a 6-month period whereas it transitioned from UM making a decision there wasn't great communication between them. They had their service coordinator notes and if a service coordinator woe good notes then you had some good documentation but if they didn't write good notes then there was gaps and that's difficult when you are looking at paper instead of talking to people.

>> The data you gave us in the last meeting showed keystone's appeal activity really sharply jumped end of last year and doubled and triple going to first quarter of this year. We shared some concerns we have with how keystone is processing those appeals and the 15-minute windows. Participants being told telling us they are rushed off they are cut short they don't have time to present their cases.
>> OLTL's reaction to that?
>> We've been in discussion with them now and I'll continue to have a discussion with them about that. In fact, we are in a process now and setting up on sit visits for a all three MCOs one thing we'll do in the visits is listen in on hearings and we'll look at their processes. That's one thing that hopefully as we go forward and continue as moderning this, we'll sit on some of those hearings here and there randomly.
>> [off microphone]
>> They will when we're on the onsite but when we are do the monitoring we'll call them and say hey do you have a hearing this morning? We'll jump on the call
>> The participant is I'm notified my call is being recorded are you able to pull random samples of those?
>> Yeah and we do. So if you got a specification for today, Mr. So-and-so only had 10 minutes in his grievance hearing we don't think that was appropriate you give me that name and date xf the hearing I can pull the report. [overlapping speakers].

Certainly that help us correct the issues. I can say to them look I'm hearing from advocates that this is what is happening with the grievances but if I can listen to it and hear it's only 10 minutes long and they gave the participants 2 minutes to speak I can pull that up and say, look, we identified this there through your recording that there's a problem
>> I appreciate that you had the conversation. Sounds like you told them you expect their practices to change. Going back to the volume piece of the processing if they are processing 1,000 of these in a month, have you told them 15 minutes is unacceptable? Should we anticipate that people will be given a different length of time
>> We had that discussion with them. So how I'll ereiterate it with them again but people should be getting the time they need
>> And they should be held accountable if they are not doing what they need to do [off microph [off microphone]
This is a problem. It's really a problem. I shouldn't have to call. And if I call I get results. But everybody ain't me.
You see? So it should just be across the board they need to do what they need to do.
>> I agree.

>> Well.
>> We can end on agreement. [Laughter].
>> One thing I found that we were discussing this morning I found particularly [off microphone] the standard hearing if they are scheduling in 15 minute increments unless you have representation and then if you have representation you get 30 minutes. One would think a representative would be able to get to the point quickly and say it and 15 minutes would be more appropriate. And if you don't have representation, you should be able to have adequate time to lay out the case
>> I think the reason they give more time with representation is they know that lawyers can't stop in 15 minutes. [Laughter]. [overlapping speakers].

>> Regardless if you have representation of not everyone should have the time they need
>> To present whatever documents they have. Everything.
>> documentation piece also follows a part of a conversation we had earlier. I don't know if you want to hear we have more clients about the health grievance, ensure that consumers mail documents that the panel says they don't have. I don't know if you want to elaborate on that
>> [off microphone]. You can say it's a culture of that organization, perhaps. Their documentation that was provided was not received by keystone first reported. Our -- my hearing started 10 minutes late because of technical difficulties with the medical director insigning on and the confusion around why the panel didn't have the documents we provided but when my 30 minute time frame came up and I was going over time chided for going over time and reminded I was taking time away from other members. On the health choices side. But sounds like the same system they are utilizing so I can give you that personal example of that problematic system.
I'm not the only consumer we heard keystone did not get the documents.
>> Are you still have monthly calls with keystone?
>> Not monthly
>> Bimonthly
>> We had calls but not with any regularity.

We certainly appreciate that you are looking at their appeal systems from our vantage point I think the increased volume you see in the data led to realize their staff in the department is not being able to handle that buy in and not afford participants a meaningful opportunity to present a case. And you can see that also in the outcomes you shared last meeting as well. Where keystone favorable outcome at the grievance level is about 1/2 of the other two, CHC MCOs I doubt [off microphone] it happens there's no way to know what the right outcome should be. That also sort of confirms our anecdotal experience that people aren't given much of a chance to submit a case and if they are submitting doctor's letters the panel haven't have [off microphone]
>> Randy [off microphone] action plan a while back, PH and LLPL?
>> No,
>> It was something else I was thinking of.
>> Didn't we have this agenda again next month to revisit where we are with this. We had a short amount of time with this. [off microphone]
>> I'm late for another meeting.
>> We do appreciate you all coming out and spending the time. Thank you for listening to us. Thank you for the input.
>> For me to randomly pull agreements here and there to listen to, --
>> We'll figure it out. We'll get it to you
>> It's helpful to know you want them. We hear from --
>> I listened to them before. So I have no problem listening to them.
>> Thank you all. Appreciate you. Thank you.
[end of call]