StreamBox

[Captioner standing by]

>> Welcome to the October edition of the consumer subcommittee meeting. Today is Wednesday, October 25th, 2023.

Before we begin the meeting, I would like to go over a few housekeeping items.

This meeting is being recorded. Your continued participation in this meeting is your consent to be recorded. If you do not wish to be recorded, you may end your participation in the webinar at any time.

To help avoid any disruptions, please remember to keep your microphones muted if you are not speaking.

Live captions, always known as CART captions, is available for the meeting. The link is included in the chat. Presenters should state their names clearly before speaking to assist the captioner.

Representing the Department of Human Services today from the office of medical assistance programs, deputy secretary Sally Kozak.

From the office of long term living, deputy secretary Juliet Marsala. And from the office of income maintenance, Carl Feldman.

If you have questions related to the meeting or need additional information, please visit the consumer subcommittee web page.

I will now hand things over to the consumer subcommittee chair, Ms. Sonia Brookins.

>> Good afternoon, this is Kyle Fisher. Ms. Brookins is having difficulty with her audio. Let's try this again.

Sonia, do you have a mic?

A green mic in Go To Meeting, but I am not hearing you.

I think we can do introductions for subcommittee members. Then we'll come back and hopefully, the audio issue will be worked out.

Let me start with Minta Livengood, are you on?

>> Yes.

>> Do we have Rochelle Jackson on? Rochelle Jackson? I hope she's not having an audio problem as well. I see that

Marsha Mathis?

>> Yes, I'm on.

>> Great. Liz Heeling.

>> Yes.

>> Jamie?

>> I'm here. I'm sorry, this is Rochelle. I had problems with my mic. I'm here.

>> Thanks, Rochelle.

And I thought we had Jamie on. We may not. Jamie?

>> I'm here. Can you hear me?

>> We can. Great.

>> Okay. Perfect.

Do we have Lauren Henderson? Hopefully she's not on the attendee side. Lauren Henderson?

Okay. Kyle Fisher.

So we have Anna?

>> Yep, I'm here. Thank you.

>> And Amy Lowenstein?

>> Yes, I'm here as well.

>> Great. Thanks.

Let me go back to our chair, Ms. Brookins. Sonia, are you able to chime in?

>> She can hear you, she just can't get in. She's working on it.

>> Okay. And I did just get a message from Lauren. She is in the meeting and can hear us as well. She may need to be unmuted. She's trying to raise her hand.

All right. Working out the kinks here going back hybrid after a month of in person.

>> Hi.
>> Is that Lauren?
>> Can you guys hear me?
>> We can. Excellent. Thanks, Lauren.
>> I'm present.
>> Any other consumers on who haven't had a chance to introduce themselves?
>> Hi, this is Meghan.
>> Great. Hi, Meghan.

Okay. Sounds like Sonia is going to continue trying to work through her audio issues. In the meantime, we can hand this off, Sally, to you and the OMAP presentation.

>> Good afternoon to everybody. I just have a couple of quick updates. Kyle and other committee members. I see that I have 40 minutes scheduled to talk. So I don't know if there were other things that you want to add. I'm not sure if our colleagues from OIM and OLTL are going to be ready to present a little bit early.

So we'll see how that goes.

In terms of updates, I wanted to touch base on the quality management strategy, which you may recall that we released in early September and resolicited public comment on it. The strategy is required by CMS to be developed every three years. The last time we did it was in 2020.

So we shared that for punt comments due on October 23rd. We did receive feedback on it. We will receive the comments and make any changes to the final document before we submit it to CMS probably in late December.

Just as a reminder to folks, you can still find the current quality strategy available on our website. It does include the CHIP, the Medical Assistance Programs, including physical health, community health, behavioral health choices, as well as the adult community autism program. It describes the goals and objectives of the managed care quality strategy. How we will measure success of these goals and objectives, as well as the tools that we will use to help improve as well as ensure the quality of care.

So thank you to everybody that took the opportunity to review and comment on it. We always appreciate feedback.released probably shortly after we send it to CMS, which is probably late December of this year.

Any questions about that?

>> Sally, I know there's a lot in the quality strategy and much that you have discussed in different stakeholder meetings. Will the Department be publishing the comments it received?

>> You know what, let me ask the -- do we have the quality folks on the line? I want to say we typically do, so I don't know why we wouldn't. But I don't want to say

Okay. So nobody is speaking up. So I will commit that we will publish the summary. Decision made. How is that?

>> I like the way this is working. Thank you.

>> No problem.

>> Sure. Any other questions about that?

Okay.

>> Not on my end. Committee members? I don't know that we do. Thanks.

>> Okay. So if there's no questions on that, we will move on.

I want to talk a little bit about two new additional provider types that we are going to be adding to the fee schedule. Pharmacists and Doulas. Let me talk about the pharmacists.

We received requests from the Pennsylvania pharmacist association for additions to the program fee schedule that would allow for direct payments for pharmacist services that are provided in settings other than a pharmacy.

And we know that throughout the program, particularly in managed care, we have pharmacists doing home visits to do medication reconciliation, to do literally social assessments. We know that pharmacists are going into the community to do diabetes education, tobacco cessation counseling.

So we have known for a while that those providers are doing more than just dispensing medications.

So after careful consideration of their requests, we have decided that we will enroll and pay pharmacists not employed or under contract with the pharmacy beginning January 1 of 2024. This provides access to medication, immunizations, disease management by pharmacists in other settings. For example, as I said, physician's offices, the homes, clinics, and other nonpharmacy locations.

Pharmacists will be -- and this is technical, but will be enrolled as provider type 10, specialty 247. And we will update the MA program fee schedule by adding those provider type and specialty codes to it.

And then we will also add them to procedure codes that are already open, as well as four additional codes that pharmacists can bill under.

In December, we will publish a notice and issue a bulletin that announces these changes. And we are in the process of holding an enrollment training for pharmacists on December 5th. That invite has already been sent out. And we have had a number of pharmacists already register for this session. And we will be recording it and making it available to any of those pharmacists that are unable to attend.

And again, we did this because it expands access to care from your nontraditional provider types. I think if you have taken a look at what we have done over the past several months, and these have all been in the works for a while. As you know, nothing happens overnight. But our goal is really to be able to ensure that people are able to receive care where they need it when they need it.

So you have seen it introduce street medicine. And then subsequently expand street medicine. We are now about Doulas in a minute. And we continue to evaluate how we add additional locations and additional provider types.

Let me see if there's any questions in particular about pharmacists before I move on to Doulas.

>> Yes, one piece, Sally, just to clarify. Did you say in the managed care delivery system, many of these nontraditional settings for pharmacists is already happening? So will this change managed care practice or broaden what they're able to do with respect to paying pharmacists?

>> Yeah, that's a great question, Kyle. The managed care plans have been using pharmacists in a variety of capacities for a while now. Oh, I am tongue tied. This will neither expand what they're doing so much as it recognizes a lot of what they have really been doing.

The other benefit that it really adds for the managed care organizations is because there was not a provider type for a pharmacist or specialty codes associated with them,

they weren't able to actually in collecting counterdata and recognize what it is they are doing in this program.

So adding them allows us to accomplish that.

Some of the codes that we're adding are a little bit as to how they use the pharmacist to do that.

Does that answer your question?

>> It does, yeah. That's helpful. Thanks.

Will pharmacists, I know you said that this will be -- pharmacists can come on as providers if they're not employed with an existing pharmacy. Did I catch that right?

>> So the pharmacist can come on as an independent provider. They would have to be providing the service outside of the services that the pharmacy they're working with would provide.

>> Got it. Okay. Wonderful. Okay.

And just as a sort of kudos to this, I can personally say that with a very medically disabled son and another son who is autistic, getting out for vaccines is an incredible undertaking for us. And there's a pharmacy in Philadelphia who has continued to do home-based vaccinations for families with disabilitied or elderly who can't get out of the home. It's been an incredible help to maintaining our health and well-being and lowering stress.

So I'm really happy to hear that the Department recognizes the value in services like that and that you're boosting it. So thanks.

>> Yeah, thank you for that feedback, Meghan. Again, our goal is to the extent that we are able is to meet people where they're at. And so we recognize that home care is an important component of this service delivery system. Like so that we are allowed to meet homeless individuals where they resident. So you will continue to see more of those efforts.

>> Sally, I want to say thank you again for that. Just thank you for doing that. We really appreciate it.

>> Thank you. You're welcome.

Let's talk about Doulas. I mentioned this earlier. I can't stress it enough. It has been wonderful working with these associations. It's also been a protractive process. We have

been working with the Pharmacy Association for I want to say close to two years now. And it's the same way with the Douls. We have been working with the association for close to two years to begin to figure out how we can appropriately and effectively use their services in the care delivery for our pregnant women.

So we have been working on developing a path that would allow for more comprehensive coverage of Doula services in the Medicaid program.

We are aware, once again, the Doulas have been covered by some of our managed care organizations as part of their maternity care bundles or community-based care management program.

We are also aware that some hospitals that participate in the Medicaid program have also been employing Doulas.

We know that outcomes with Doulas improve, that there are less complications, that the mortality rate is a little bit lower and there is improved follow-up after delivery.

So beginning January 1st, the managed care organizations will be required to include Doulas in the maternal care team that participate in the maternity care bundle arrangements. There is a little bit different from prior years where we suggested that as part of the team. A Doula will now have to be part of the team if they participate in the maternity care bundle, which is a gain share arrangement.

Additionally, beginning February 1st of 2024, we will begin to enroll Doulas in the MA program who are certified by the Pennsylvania certification board as a certified Perinatal Doulas. Again, what that will do is allow them to be a provider type, and we will be able to capture the information on their services.

As I said, our goal is really to begin to build the capacity of these nontraditional provider types in order to be able to meet people where they're at. Doulas are certainly part of that capacity building. And we want to ensure that we have statewide accessibility for the addition of Doulas before we add them to the state plan. For now, they will be a provider type. It will not quite yet be a state plan service. That will come after we expand the network of Doulas. Just to give people a perspective of what that means. I think right now statewide Eve and her team will correct me, we have 17 certified Doulas? Is that right?

>> We jumped up. Last week, it was 21. And I know they have several in the queue.

>> Okay. So clearly to add to the state plan, it needs to be available more broadly across the board. We will need more than 21 to add it to the state plan. We continue certification. So we believe that we will get there in the next year or so.

Questions about that?

>> Kyle: Given the scarcity of Doulas now, can you speak to how they're used through care management? Is there a pool of Doulas who don't have the certification that the managed care plans are working with?

>> Sally: It depends. There are several different paths for people to be recognized as a Doula. There are at least two internationally recognized certification organizations. There's an additional pathway, I think it is for nurses who want to also be a Doula. That's a third pathway.

And then there's the Pennsylvania certification, which really is what we need to be able to enroll people in the MA program.

So depending on how the plan or the health system is using them is really what they're requiring their background and training to be. And it really varies. They are in some instances part of the actual care team, meaning they are employed by the health system. In other instances, they are being contracted with by the managed care organizations to awement their care management, case management services.

So a variety of ways that they are contracting and using them, Kyle.

>> Kyle: Thank you.

I don't have further questions. I will just note that I think this is a very positive development. And obviously, the literature that we have seen, I think it was shared during the last presentation around the MCO's are using tied to Doulas are encouraging in the early results. Happy to hear that movement is underway to expand that view and hopefully build up the capacity to be much more widely available.

>> Sally: As I said, we are really excited about the additions that we have been able to make to the provider type and ensure that people have access to a full range of services that they can provide not only in the traditional clinical setting, but in other settings as well.

Okay. If there's no further question on Doulas, let me give a minute about parents as paid caregivers. As everyone knows, we recently allowed legally responsible relatives to be employed by home health agencies to provide home health aid services to these medically complex children.

As a result of that, we had to change the procedure codes and modifiers that providers use to bill for these services to reflect that they are now home health aid services.

We had to do that because currently the codes are identified as personal care services. With that change in the procedure codes will also come a change to the EVV requirements used by the home health agencies. Both the coding and EVV requirement changes are effective October 1st, just as a reminder.

And there were two bulletins sent out. 05-23-06, titled pediatric shift care services for beneficiaries under ages 21 which provides details on the new codes and modifiers.

And then the second bulletin is MAD02-23-08, entitled update to electronic visit verification requirements for pediatric home health aid services in the fee for service and managed care delivery systems.

So just to share that those changes are made and that folks should if they haven't already be implementing them and take a look at the bulletins that were issued.

So those are all of my updates. I'm happy to answer any questions or address any other issues or concerns that the committee members may have.

>> Kyle: Sally, since we're a little ahead of schedule, I will use the mention of the EVV codes and changes around shift care for children to note we had some discussion this morning around revisiting the shift care data that is provided around staffing for home health aid services and staffing for skilled nursing.

I don't believe WIN is on the call this afternoon. Maybe for the December meeting we can have that conversation again and look at the most recent data available to see if allowing parents to be paid caregivers to just revisit those figures in general and see if matter.

>> Sally: Sure. We will talk to Gwen and have that information for you.

>> Kyle: I don't know Liz or Meghan if there's anything you wanted to add to the summary?
>> Liz: I think we're interested in, as Kyle said, I think we're really interested in seeing what the impact of -- on the number of shifts that were not able to be able to become affiliated with home health agencies so interested in some of those questions. Look forward to it. Thank you.
>> Sally: Sure. Sure.
Other questions or issues?
>> Sonia: Nope. Sally, we appreciate it.
>> Elise: There are questions in the chat.
From Michelle, we have what is the rate for pharmacist providers?
>> Sally: Well, let me say this. The MCO's negotiate their own rates with providers. We have not released it on schedule once we put it out there.

>> Elise: And from Kathy Cubit, is there considerations for end of life Doulas?
>> Sally: Right now the Doulsa that we have focused on are peri natal. I recognize there is a range of Doulas. The ones certified with Peri Naten. There are post natal and end of life. We will have those conversations as we move forward.
what's new at OMAP page. That's available to the entire audience.
There are no more questions.

>> Sally: Okay. It's my understanding then that the folks from OIM, OLTL is next on the agenda. It's my understanding Juliet is on. So Sonia, Kyle, to let you know, I will be on for about 15 minutes and need to leave take them or pass them on to me. And I will I guess talk holiday meeting? So we're off?
>> Sonia: Yes. Happy Thanksgiving to you, Sally.
>> Sally: Thank you. Same to you, Sonia.
And Juliet, I will let you talk.
>> Meghan: We had one more quick thing actually. This is Meghan. On the pre-call, we did end up talking about the shift care initiative and the white paper recommendations. There was a lot of questions around the status of that from the larger consumer sub.
So we were thinking it would be great if we could off line

connect and maybe have a conversation around us were able to attend the larger update you did to all the stakeholders. But from a consumer sub perspective, we would love to talk on a side bar, if that's something we could set up.indicated, we have done a number of stakeholder calls and conversation.

>> Great, thank you.

>> Sally: Sure.
Okay. Now Juliet, I'm really going to let you talk now.
>> Jewel CLET: Quite all right. Talk all the --
>> Juliet: Quite all right. Take all the time you need. I am from the office of long term living and getting over the Phillies loss last night unfortunately.
I don't know if we're pulling up the PowerPoint. I'm seeing the agenda. I don't know if we need a few minutes for that. I can keep going if folks would like.

>> Kyle: We can hear you, Juliet. Welcome. I'm also seeing just the agenda. It sounds like you have a
>> Karen: I'm pulling it up. If the you will bear with me for a moment. I apologize.
>> Juliet: That's quite all right.
Well --

>> Elise: I think Carl came in early. We're having issues on our end trying to get it to pop up on the screen.
>> Carl: I am present on the call if you would like me to speak around OIM updates.
>> Juliet: I am happy to defer it back to Carl and have him do OIM updates. Carl, I will hand it over to you.
>> Carl: Thank you. Good afternoon, everyone. This is Carl Feldman, the director of the bureau of policy with the office of income maintenance here to speak with you about activities going on during the unwinding of the continuous coverage requirements.
I wanted to provide some updated information that the Department's received and also made available to the public recently. So I will start with what is new for us on our DHS website.
We launched a web page that includes final monthly and winding renewal outcomes that displays after the

reconsideration period what has happened to individuals who have potentially lost their coverage and can't come back to coverage. We think this is kind of a useful data point on understanding the impact of the unwinding on Pennsylvania Medicaid population. It's been broken out to a number of different demographics and geographical jurisdictions. We hope that you find that to be useful.

We also are -- we received information at the end of last week that indicated to us from CMS about how we will update our federal reports on the federal reporting tab of our unwinding web page.

The final disposition during an eligibility review. This has been something that this group's been interested in and waiting on. And CMS did tell us I think honestly early August it was something we were interested in. And we expected to get more direction from them sooner. But really only just got this news last Friday.

So we will be preparing to update those documents. I can tell you that they will take the same form that they exist in now. They won't change the data elements. It's just going to add to the existing data elements the remaining population that had to be evaluated for eligibility for that renewal cohort into their disposition when the eligibility is run.

So if the report was due for the month of April and half of the case work was not yet completed, the updated version of the report will include dispositions from that remaining half, how many of those people were found to be eligible at the time of the renewal, how many of the people were found to be ineligible and for what reasons.

Those are the big updates to share with you. And we understand that you have questions about our process in updating and restoring coverage to people due to CMS's direction on ex parte.

And we're open to questions about that too.

>> Kyle: This is Kyle. I appreciate the updates. I think we did spend a little time this morning looking at the most recently posted information through the final renewal unwinding information that you referenced a minute ago. Thank you for putting that up, first of all. It's good to see the complete picture going back to April and May.

One question that came up that the data you have

presented there, is there any way of knowing how many of the consumers in those termination columns, be it found ineligible or procedural terminations actually lost their coverage and came back on through appeals or reconsideration or anything else?

>> Carl: That's information we will be providing in the updated Federal reports. That's kind of what they indicated to us last week that they were looking for. We have some of that information now. I believe that of the people who were closed for the month of April, which is the only month I have this available for --

>> Kyle: The information is still forth coming.

>> Carl: I do have information from April I can share with you. Here we go. There were 15,000 people closed procedurally in April and then reopened. And there were 41,000 that closed procedurally and remained closed. The total universe of the total closures for the April cohort is 56,000.

>> Kyle: Walk through the numbers again. Sorry. 15,000 who were closed and re-opened? And the 41,000 is what is on the report on the website.

Okay. Is there a similar number for the found ineligible population?

>> Carl: There are updates to all of these data elements, but right now, the procedural one is the only one that I have available to share. And I expect the rest a component of the updates to the Federal reports because that's what the direction from CMS was that we provide. We'll continue to post those on our website too. I want to be clear about that as well.after April? That's from --

>> Carl: The 41,000 people are the number of people closed procedurally that were members of the April renewal cohort, which did not re-open. They remain closed.

>> Sonia: Okay. Will they be reopened? Or you have to do that when you do the updates?

>> Carl: For the purpose of this analysis, it's an analysis to just see what was the result after the reconsideration period closed? Did people return to coverage or not? There is a separate activity which is running right now to determine as a result of CMS's updated instructions around running ex parte reviews, if there are people who are procedurally closed that might need to be reopened. And some of those 41,000 people are likely in that population as

well. But we can't yet say how many people are in that population.

>> Kyle: I'm sorry, Carl, you lost me at the last point. What's the separate activity running?

>> Carl: I think what Sonia asked was of the 41,000, will any of them be reopened? I said that I believe that some of them will be reopened as a result of CMS's direction to reopen cases who are closed because ex parte separate process from the analysis that you're looking at around who closed and who remained closed and who remained open.

>> Kyle: And I guess to unpack that -- sorry, Sonia.

>> Sonia: I want to know the 41, you said what you said in reference so that you don't know how many will be reopened. But when we do find out, they're going to

>> Carl: When we go about doing the reopenings, they will be made whole. We will be conducting reopenings back to the point in time at which the person closed.

>> Sonia: Okay. Thank you for that. Go ahead, Kyle.

>> Kyle: Sorry. I just wanted to unpack the figures you gave us. And this is going back to the first month of the unwinding activity, April, when roughly 250, 260,000 folks, I do believe this is at the individual level -- had eligible renewed or redetermined.

Of those, looking now, you can see 41,000 were closed for procedural, paperwork issues. During the last six months or so, another 15,000 had been closed for procedural issues, but were reopened through reconsideration or an appeal that was resolved.

Would that include folks who just applied over again? Sort of the typical --

>> Carl: It includes anyone who returned to coverage under the reconsideration period.

>> Kyle: Okay. That's helpful.

In terms of the updated reporting to CMS, it sounds like you're adding a tab to track individuals whose renewal is not completed in the initial or the month it starts, which is what's captured now. Will those tabs be updated? Just to finish that thought -- sorry, go ahead.

>> Carl: If you look at the Federal report on the Federal reporting tab of the site, 5D, element 5D says of beneficiaries included in metric five, the number not that's the total universe who will be added to our updated report. And as you said, yes, there will be an additional column

added to that report to indicate the disposition of that 125,000-ish data set.

>> Kyle: Would that column be updated for each month of an ongoing basis?
>> Carl: Yes.
>> Kyle: Okay.
>> Carl: Sorry. I want to specify, will be updated. The report itself will be updated. We're not overwriting any of the columns. We're adding a column. You will be able to see what was done at the end of the reporting period initially according to CMS. And you will also see the updated version.
So if you want to see the total, you would add both columns.
>> Kyle: I guess -- sorry, just to clarify on that last piece. Will the new information being added, given that the numbers are continuing to change. As you noted three months out, four months out people are coming back in. Will that newly added column be modified each month? Or is that going to be something you're filling in --
>> Carl: No. What CMS is looking for is defined as the disposition from when the eligibility run occurred initially. So for the April renewal cohort, the 125,000 which was not completed by the point in time that CMS requested the data, what will be reported there in a secondary column is that one of those persons, one of the 125,000, were they procedurally closed, were they renewed? Were they closed for being over income? That's what will be added. There will be no indication if the person left and came back to coverage. No indication if the person was renewed, stayed in coverage and had a change of disposition when eligibility was finally run for that renewal cohort. For that reason, we don't need to go back

>> Kyle: That's helpful. Thank you.
Marsha, I apologize. You had a question?
>> Marsha: He just answered it. Thank you so much.

>> Kyle: Carl, you started to bring us up to speed last month about the ex parte renewals issue. You mentioned sort of retrospective plans, prospective mitigation plans. Can you provide that update?

>> Carl: Yes. I think we talked about the prospective activity being completed at this point in time. We changed our process so that all cases receive an enhanced back end ex parte that's occurring at the individual level. That was a big change that CMS indicated in other states. That's in place.

And we believe that's satisfactory for CMS. The additional component that we need to complete is the restoration of coverage to make people whole who were disenrolled due to not meeting CMS's expectations.

So when we last spoke, we were in the process of evaluating the procedural terminated population to figure out who actually needs to have their service restored. And at the time of our speaking, we have narrowed that down to around 56,000 cases from 76,000 that corresponds to about 116,000 individuals and 105,000 of those individuals are in MAGI categories. We're working with Deloitte to use a tool to help us identify who of the MAGI category in particular could not be -- could not receive an ex parte review, which will indicate to us of the 105,000 who is left which needs to receive some kind of potential manual or systemic action to restore their coverage.

We also are engaged with code for America to assist us in bringing new tools to bear to expedite that process.

>> Kyle: I think the good news that the pool of potential consumers impacted is much smaller than you had initially thought. Last month, you mentioned initiating this review going backwards this month in October. As the manual reviews occurred, are you still identifying what can be done through systems activities tools before those manual reviews occur and reopens occur?

>> Carl: I mean, we hope to initiate reopenings in the month of October. I think we're still looking through the procedural closed population. And when we have completed that, we'll be able to say this is how many people we need to take action on.

Something that we have been told at DHS is that there is no state which initiated any kind of system build to automate the reopening of people who need to be reopened based on this because overall, the population that needed to be managed was considered to be small enough to be handled manually.

When we're finished looking through this list to see who is going to need to have a reopening activity, I think we'll be in a better position to be able to say of course how many people do we need to take action on, but how long is that going to take?

The direction we have gotten from CMS is they would like us to have the activity completed by November 30th. We have told them we're concerned about the deadline. That's why we're engaged with Code for America. And that's bottom of the list. And then figure out what's the best way that we can go about getting people's coverage restored.

>> Sonia: On that note, okay, so you have -- you're not you're saying?

>> Carl: That's correct, yeah. If the number turns out to be very large, we would be concerned. If it turns out to be under 10,000, that's a different conversation.

>> Sonia: Okay. So I'm going to say then in our December meeting, we'll have some kind of update from you in reference to that?

>> Carl: Okay.

>> Kyle: Carl, you mentioned 105 of the 116,000 now identified were in MAGI categories. Can you speak to how that impacts your efforts and sort of doing the reTRO review and restoring coverage? And can you speak to whether the ex parte review for something found ineligible based on the MAGI category, are they reviewing for other categories of coverage?

>> Carl: So the process that we are taking now is not a process that confers eligibility. We're taking that whole list of people that were closed procedurally and pulling out people who if we were to induct a retroactive ex parte today based on the date which the person closed, is it possible for them to have been eligible through an ex parte at that time? And if it's not, it means that we don't have the authority to confer eligibility to that person because we wouldn't have been able to have conveyed eligibility to them through an ex parte review.

The reason we're going the MAGI group first is because they have the, for lack of a better term, most simple eligibility rules, which means that the tool we're using to quick hit all of the data sources that the workers are checking in an automated fashion is just easier to do. So

when we get that back, that's going to tell us, again, who was it possible for us to have completed an ex parte review at the time of their closure? And if it wasn't possible to do that, then we should not be restoring their coverage. They would not had been determined eligible at the time had we done it correctly, or to CMS's specification.

>> This is Amy. I wanted to clarify that. If you pull out the people who are clearly ineligible, that's based on a MAGI review. I think what Kyle was asking is do you then look to see if they would have been eligible in another category? we're not looking at any other categories. We're just looking so see would they have been eligible at all? Could we have conducted an ex parte review at the point in time at which the closure occurred?

>> Amy: I had understood you were looking at just the Magi rules for that group, though, not other rules.identify if they would have -- if the ex parte would have been possible at that time. I think what you're saying is well, could you ex parte them into a different category other than MAGI? Is that what you're getting at?

>> Amy: Yes.

>> Carl: I believe that our tool is capable of doing of the different eligibility rules that we have into it. It's something we got from New Hampshire. Obviously, we share more about how the tool works at a later time.

>> Amy: Okay. That would help. So if someone has a disability, is that fed in there too?

>> Amy: Okay. But there's also healthy horizons if you're working with a disability because of the disregards. Yeah. So it would be good to know whether or not there's more to it than just the MAGI review.

>> Sonia: Can I ask a question? I want to know why? Why you can't do that for MAUD. Explain to me why.

>> Carl: Because the premise of the activity we're doing is that an E parte would have been conducted at the point in time that they didn't return a renewal, that's a back end ex parte. That's what the plan indicates about been able to have moved via the ex parte review after they already did not return a renewal into a different category.

>> Sonia: Okay.

>> Carl: They would have to premium or verify disability or something like that. It's not possible for us to do that via ex parte.

>> Kyle: This raises a couple of scenarios we discussed this morning during the pre-meeting. An abstract away in the ex parte. I appreciate the update you gave us. I appreciate lots of back end work is being done to try to remedy this and identify who do we know in the population continue to qualify and close regardless. So figuring out how to do that on top of your normal renewals that the counties are working with under the considerable workload pressure. We understand and appreciate.

But one thing we identified this morning is closures that are happening where the CAO caseworker has not reviewed other categories of coverage. MAUD is often one that comes up. Where -- and we think it clearly should have. I could speak on it more, but I feel like Liz had an example and Meghan had an example. I think you can probably both explain those better.

>> Liz: Carl, I have a friend who has an adult son who is on a waiver from ODP. So he's not in community health choices. But he has waiver services. He also works. And it's been an issue all along. But he was just on straight Medicaid.

And his -- the getting the wage stubs and stuff in all the time has been something that we have been doing regularly. So they were well aware that he was working.

He got a small increase because he also collects SSDI because he has enough work years in that he qualifies to collect a small SSDI. So he has several sources of income.

He got a slight increase in January in his SSDI. So when he was reviewed, that made him ineligible for regular Medicaid.

He was knocked off of his -- he was removed from Medicaid, didn't get a letter to tell him that. The way they found out was his waiver services stopped. He tried to appeal his waiver services. They said you can't appeal because you're not eligible for Medicaid.

Went back to the county office about the income question. Nobody informed him that he could continue to be eligible for Medicaid through MAUD. And his parents diligently over a couple of days worked really hard and discovered MAUD. And they felt strongly when people get a letter saying you're no longer eligible, it should be listed as here are other options. I think people are getting a letter

that says you can apply for Pennie. And they felt strongly that MAUD should be on the list for people to explore whether they would be eligible.

He lost his job coach. He lives independently and he has a aid who comes in and assists him with some of his independent living at home.

And he lost all those things temporarily. It was clear that he was going to continue to be eligible for Medicaid, just a different category. And the family couldn't understand why nobody communicated that to them. And I know that when we have talked about this at previous meetings, I know that kids were being moved to CHIP and there were efforts being made so that people wouldn't lose health care coverage altogether. So it seemed odd that since the CAO was well aware he was employed and had wages, there was nothing communicated to them about being eligible for MAUD.

>> Carl: I'm sorry to hear that was your experience. I think MAUD in particular can be a challenge because it exists somewhat outside of our eligibility cascade. We need to rely on our workers to properly implement the policy and policies that you check eligibility for other categories. We have put in a system request that it does make its way to the cascade. There's reasons it's not currently like that. But that's not a short-term fix that we're capable of putting in. And the best thing is that our workers follow the policy as it's written.

>> Liz: It couldn't be added to the letter that goes out saying you're no longer eligible? I appreciate that it's going to take time to --

>> Carl: Our eligibility notices are fairly standardized. MAUD is available, but not to all potential recipients. You have to be disabled, earning income. So it's another potential solution, I agree. But definitely not a short-term one.

>> Juliet: I need to step in for a second. This is Juliet, the deputy secretary. Not to get to individual situations. However, anyone receiving employment services and are in community choices who is working should have from their service coordinators been presented with services that include benefits counseling that would have provided information with regards to MAUD, PA Able, all of those

other things.

Just to let you know on my side, I will be putting a pin in my notes here to review that with the CHC managed care organizations to ensure that for everyone who is working that information is part of resources presented to them as all of the community health choices resources should be presented to every participant who receives the services on at least an annual basis of part of their person-centered planning process.

I just wanted to hop in on that from program perspective with regards to medical assistance for disabilities and all the other array of services to help individuals with disabilities who are employed stay employed and continue to receive the benefits and services that they should be able to receive through each and every one of those mechanisms.

Lastly, I want to point out for anyone who may be listening who may be aware of a similar situation, should anyone who is working in community health choices programs find themselves without services for eligibility reasons and they still need a job coach that the office of vocational rehabilitation is an incredible resource and has the ability to provide emergency supports and assistance to fast track eligibility to prevent them from losing their job if they need job supports. I wanted to put in a plug for the office of vocational rehabilitation as well. Thank you.

>> Liz: Thank you. This gentleman was not in CHC. His waiver was through ODP. So unfortunately, those things didn't happen. Yeah. As soon as ODP heard that -- had gotten a notice that he was no longer financially eligible according to the county office, all of his services were an opportunity to share OLTL's perspective. But I don't believe Kristen is on for ODP. Sorry.

>> Liz: Thank you.

>> Amy: This is Amy. I wanted to follow up on the importance of getting MAUD into the cascade as soon as possible. We had a client this past week who was getting -- she has a lot of needs, was getting many hours of services, including to support her at work, through CHC, Juliet. And also at home. And was suddenly terminated from the CHC waiver.

This person had been on MAUD before and during the pandemic and for some reason switched to just waiver.

There were actually somebody who was COVID maintained, but the worker terminated them without a renewal anyway. And there was a flurry of activity to get the services. This person wouldn't be able to be in the home or do the job without the supports.

A bunch of things went wrong in the case, including the early termination. But also missing MAUD for somebody what had been on it in the past for a waiver.

I think it's critical that this happened and that there be more education to the workers about the importance of MAUD and MAUD with waiver in particular. That gets missed a lot as well.

One issue actually even came up in the case where the worker when I was trying to get the person back on questioned how somebody could have as many services as this person had and work.

So I think there needs to be education about these are programs that support people to work. And this is not -- it was kind of a defensive question, frankly, when it was asked. I answered as a generalization about the importance of work as work is a goal in CHC.

But I think there needs to be more education and really prioritizing getting MAUD into that cascade.

>> Sonia: And I will back you on that. I think that we should -- at least think about it and go back and see what can be done about MAUD. It really is important for people to be able to access it.

>> Carl: Thanks. I think we agree with that. It certainly was a goal of the previous administration, and as I know, a goal of the current that we make sure that people are able to get employment services that they need to continue to make that a big part of their life, if that's the right thing for them. And MAUD is a part of that too.

We have a potential change for the system to be able to do that. It's just a matter of prioritization.

>> Kyle: Can you elaborate on the potential time line for when that change will happen?

>> Carl: I don't have a lot of information about that right now. I think that at one point this was something for 2024. But that was pre-unwinding. Things reshuffled as a result of that.

>> Kyle: We appreciate you engaging us on this topic. We

have often brought up situations where individuals who are not facially eligible for MAUD could have established eligibility if they had been made aware of the program and caseworkers knew to explain to them if you work any amount at all you could qualify and keep the services you depend on.

I think what is particularly challenging and troubling to us is situations like the one Amy described, like the one Liz described where someone presenting to the CAO already on disability or waiver, already working. So really the only question for the recipient would be do you want this program? Are you willing to pay the premium? Too many of these appear to be falling between the cracks as well. We do appreciate you walking us through this and hearing this message and I guess taking it back when you speak about the administrative priorities and what the subcommittee, for instance, is wishing.

>> Carl: Yes, we will absolutely do that.

>> Kyle: We did have another case example where other categories of eligibility were not reviewed for a child losing SSI. Sonia or Meghan, do you want to relay that one?

>> This is Meghan. Yeah. As long as everybody is okay on time, I will try to do it real quick.

We did -- hi, this is Meghan. I was supporting a family in Lehigh County where the daughter, young girl five years old, is very medically complex, eligible for shift nursing in the home, has historically been eligible for PH95. Mom's income goes up and down, so the child is occasionally eligible for SSI. Historically when the mother's employment increases again and SSI ends, the child has automatically been considered eligible for medical assistance.

This time around for whatever reason, that did not happen. The Lehigh CAO when they received the information that SSI was no longer eligible, they automatically terminated her medical assistance as well.

There was no termination letter sent also unfortunately in this instance.

And in this particular instance, the -- for whatever reason, the mother was receiving alerts, as we all were hoping to receive to make sure that renewal information and paperwork was filed even though that wasn't

necessarily their eligibility. They never received a renewal packet. This family was proactively contacting the CAO because they were confused about the reminders and shut down and told there's no issue, there's no issue. Come to find that she was actually terminated because of the SSI termination.

I will say I think this is just sort of illustrative of the fact that maybe the CAO's, we know that they are overwhelmed right now. It may benefit to have a reminder just to make sure that all CAO's are doing their due diligence in exploring other criteria and exploring these other eligibility possibilities.

This was definitely an instance that could have been avoided had the CAO caseworker done those steps and not been sort of argumentative with the family who was trying to investigate this.

I will also -- I do want to say that the Lehigh CAO supervisor we worked with was ability phenomenal. And took care of the issue after the fact. But it did leave this child without coverage for ten-plus days. To the point where the nursing agencies were pulling services because they didn't know who they could or should bill at that point because they were no longer in an MCO.

So these are we think last month we talked about unintended consequences or the fall out. This is the sort of snow ball effect for individuals who are losing coverage. Thankfully in this instance, the CAO supervisor was wonderful and fixed things and did their due diligence. But it was after the fact. If we could get more information or figure out how to support the CAO's in everybody would be appreciative of that.

>> Carl: Just so I'm clear on the basic fact of the case, this person was on SSI. SSI ended and they were not explored for a different category?

>> Meghan: That's my understanding from what the CAO staff indicated to me. Yeah.

>> Carl: Okay. Okay. Yeah. That's very unfortunate. I messaging system and generally yes, it is the case that we expect them to --

>> Kyle: This is Kyle. Carl, I am losing your audio. Are others able to hear him?

>> Meghan: I'm also losing Carl.we're exploring for other categories, we can work on a reminder through our

messaging system that talks about exploring other categories, which is relevant for MAUD and SSI and just that I'm sorry to hear that that occurred.
>> Sonia: Yeah, I think that they need some education. I think it has to funnel from the top down so that when stuff --
[no audio]

>> Kyle: I believe a lot of us are having audio issues this afternoon.
Sonia?
>> Yes. I'm on again. I don't know what happened. The phone went out. Carl, I think that it needs to funnel from the top down. It's unfortunate that this happened. And I think that the caseworker could have done more.
>> Carl: Were there other questions you would like to ask around unwinding hits or other eligibility -- activities or other eligibility related issues?

>> Kyle: Appreciate your time.
>> Carl: I will talk to many of you tomorrow and in the near future too. Thank you for your time.
>> Meghan: Thanks, Carl.

>> Juliet: Hello. Good afternoon. Juliet Marsala. I am back and I am ready. You ready for me?
>> Yes.
>> And we can see the PowerPoint too.
>> Juliet: Great. All right.
So the OLTL update. I have a few updates for you. And then I have some numbers with regards to the waiver determinations that my staff shared with me to go over as well.
So the updates slide on slide four. We wanted to bring to everyone's attention that we have officially shared the summary document on the listen and learn tour via the listserv. All of our listservs that went out on October 23rd. But you heard a read out of it at the prior meeting. So I won't go into a read out. I wanted everyone to be aware that it has been shared.
The other thing I wanted to start off with, as my usual, is

we have procurements that are active or in process or in development. So I cannot speak to any specific questions related to the community health choices request for application, related to the agency with choice participant self-direction model, related to the independent enrollment broker contract, or related to the financial management services contracting. Those are on my cannot speak about list for the meeting today.

And then I wanted to share something that I'm excited about. OLTL staff are receiving the trauma-informed 101 training. All of our staff in the office of long-term living and our contractors are receiving this. And our goal is to have the staff trained by the end of this year.

And this is critically important to us and to me at the office of long-term living because trauma is a widespread harmful and costly to our health systems. And it has been recognized for a long time now as a real public health problem that occurs as a result of individuals experiencing violence or abuse or neglect or loss or disaster, war, and other emotionally harmful experiences.

And it's been recognized that trauma, the impacts of trauma have no boundaries with regards to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. We recognize that individuals in the OLTL programs are likely to have experienced trauma in their lifetimes and have likely experienced trauma at a higher prevalence than the general population.

And so it's important for us and it's important that our team at OLTL is trauma informed. Trauma informed is an evidence-based practice. So we are receiving this training because we want to hopefully use this training as a start to explore ways to make our services more responsive to people who have experienced trauma and to help us continue to be hopefully in a position to help resolve trauma and not be in a position that may exacerbate any trauma-related issues that a person may have experienced.

And so just to kind of level set for everyone, trauma-informed care really as a philosophy shifts the focus from saying things like what's wrong with you to what happened to you? And this shift in focus is very important. It's further aligning with the strength-based approaches, with independent living philosophy. And it acknowledges that we need to have a complete picture of a person's life situation,

what has happened in the past, where are they at in the present? And this is important as we consider the whole person, past, present, and future goals in order to provide effective services through all of our OLTL programs. We hope this helps us better meet people where they are at and have an improved understanding of what is important, why is it important, what potential barriers may be, and why certainly barriers may be certain barriers.

With all of this said, we have started along this path. It is our expectation that all of the OLTL staff, both those who would be public facing, as well as those on our more sort of in-house administrative teams receive the trauma-informed training 101 by the end of the year.

And so I'm excited about this. And I'm extremely grateful to our sister office OMHSAS because resources available and partnerships they have really been instrumental in helping us make the effort possible for the OLTL team.

So I think I will pause there. Any questions at this point? No?

Okay.

Moving on to the next slide.

We wanted to let folks know that we are -- we have started our rate discussions as part of our annual rate discussion with our community health choices managed care organizations. We conducted the technical assistance session in September on September 20th. We have also held our individual sessions as is our usual process with each of the managed care organizations in the second week of October.

This is ongoing. And we'll do so until we finalize those contracts, which hopefully will be done soon.

And so with that, let's go on to the annual waiver determinations.

All right.

So my team has provided for us there's been a lot of focus on the annual waiver redeterminations. And this is a redetermination process that has happened in the waiver programs for a very long time. It is not a new process with regards to our waiver regulations require that on an annual basis, we do a clinical redetermination to ensure that individuals who are receiving our LTSS services do meet nursing facility clinical eligibility as required by our waiver programs.

It has been noted that as more recently with the return potentially due to return to in-home assessments as folks may recall during the public health emergency, we had an Appendix K waiver. Part of that was an allowance to do assessments virtually or telephonically. With the ending of the Appendix K waiver for the OLTL, that allowance went away. And all redeterminations are done in person.

And so more recently since that has occurred, we have been seeing an uptick in nursing facility ineligibility determinations when the original assessment is done.

So the data that is put forward here is the data for those individuals who through that clinical re-determination process were determined as potentially -- and I say potentially because all of these individuals have not gone through the whole consideration process -- have been identified as nursing facility ineligible by the community health choices managed care organizations through the use of our clinical determination tool, as you know, the nationally normed inter-RAI tool.

So we have the numbers here as it was requested by each of the managed care organizations reported to us.

So this is from November 2022 through October 2023.

We do not have this broken out by month. It is more of a manual process. But our team is working on that.

So as you can see here, there's a total of 7,065 individuals who are identified through the process as potentially nursing facility ineligible.

>> Marsha: Can I ask a question? So like these folks are going to be really losing eligibility. They're going to be losing their waiver services?

>> Juliet: Potentially. The next slide with regard to the waiver determinations. Part of the process is if through the re-determine assessment the tool they're starting the questions embedded within that tool that may identify someone as having a change to their nursing facility clinical eligibility status, changing it to a potential nursing facility ineligibility determination.

From there, there is a request to get physician certifications. So there's outreach done to the primary care physician or specialist who is serving as a primary care physician or other evaluator, other licensed health care practitioner. Those who are eligible to provide what we call

our physician certification.

And on that physician certification, there are questions related to do you believe this individual has a disability? Is this disability long term? Does this disability rise to the level of nursing facility clinical eligibility? We look for that physician certification as well. Okay?

My understanding is there's a mismatch between the physician certification, the physician certification says NFCE. The assessment says NFCI. There is a medical director's review through our medical director, Dr. Apel.

So as you can see here, our medical director has reviewed 2,444 instances whereby he has determined that 46 of them in his medical and professional experience under his review should have been NFCE. So those situations, they do not get terminated. The medical director overturned the NFI determination. Those individuals resume services. They don't get a notice. Nothing happens to them.

When you look back at the 7,000 plus or minus number, there were 2,395 individuals who were kind of moved forward as we do believe these individuals maybe are nursing facility ineligible. And for those individuals, there were change form notices sent to the county assistant's offices. And notices sent to the participant that informs them of their nursing facility and eligibility determination. Okay?

So of those 2,395, 1774 notices were sent. And the reason for the difference, as my staff have explained it to me, is that the county assistant's office did not send the required waiver end dates. So the independent assessment entity could not send the ineligibility notices at that time. So there are some pending a notice. If they are pending a notice, they are still receiving services.

Of the 1774 individuals, my understanding is that 949 of them submitted an appeal, a request to appeal. Of those 949 requests for an appeal to reconsider the NFI determination to provide additional information, et cetera, 777 people who did submit their appeal timely are receiving continuing benefits pending the outcome of that appeal.

So there were additional questions that were put forward by the subcommittee. If we go to the next slide.

We do not have full data to show how many NFI determinations have been overturned either by a new

assessment or by a successful hearing. This has not been a data point that we have been tracking. That may change in the future.

In addition, the data isn't separated by month. So we can't answer the additional questions that were related to those monthly questions. So we can't do that kind of comparison from what's happening October 2022 to October 2023. But our team is looking into that as well so we can possible.

So I wanted to provide that information for you as well.

>> Marsha: I hear everything you're saying. I'm just concerned about the folks, all these folks that might lose their waiver. And I understand you got to go back and do all that to see if some could not lose their eligibility.

I'm just concerned about the numbers. That's a lot of people.

>> Juliet: Yeah. Yeah. I am with you. And we wanted to look At -- and we're grateful to our advocates when they see these things and they bring these to our attention, it's really, really important. It gives us that opportunity to really look at things, question how things are going, see if there's improvements that can be made. And so our team has done that. And is in the process of doing that and making adjustments to the process.

I understand that it's concerning when you see one managed care organization's number is higher in proportion to the individuals that they served could indicate there's a problem, or it may not. It's hard to put absolutes when you drill down into root causes for why numbers are showing the way they're showing. It's easy to make inferences. Those may not be what's happening. We don't know.

What we have done is looked at whether or not we could see patterns with regards to the NFI or the NFI determinations. So my team looked at was there -- could we drill it down to a single SC that had a higher prevalence of NFI determinations? And we couldn't find any pattern that would say here is one or two SC's that need retraining. So we weren't seeing that.

We looked at was this an issue, we heard that there was questioning because someone had an NFCE assessment to get into the program. That happened recently. And now

they're being found NFI.

So why would someone who was NFCE a couple of months ago automatically turn NFI? And that's a very fair question.

So we looked at were we seeing patterns of differences between how the independent assessment entity was doing in conducting the tool and how the CHC MCO's were doing it. We did not find a discernible pattern when we looked at the process. We couldn't definitively say oh, it's a difference in how the tool is being implemented. We couldn't say that with any kind of certainty.

What we can do is put in the additional safeguards to ensure that the data that we're seeing from the re-determination process is sort of more stringently validated before it goes to a termination notification. So looking at that in the process, looking at if this information is coming up this way, if we're not -- and I'm going to share it is getting increasingly difficult to have primary care physicians or licensed health care professionals to return physician certification requirements. Unfortunately. And/or some are trying to say that our participants are required to pay for such a physician certification, which is very disturbing to me. And I certainly do recognize that part of this is on the constraints of the workforce. And we're all doing the best that we can.

So with that, we're looking at if we do not get a physician certification within 60 days, and the MCO's have been doing a diligent job to reach out to the physicians to get the physician certification, we will be looking at having the independent assessment entity go out and do an additional functional eligibility determination. Okay?

If we do receive the physician certification within the 60 days and the physician certification lists the participants as nursing facility clinically eligible and the documentation that we received is NFI, that is going to go to your medical director review, as it always has.

And if the medical director overturns and says yes, we do believe this is NFCE and concurs, nothing will happen to the participant services.

If the director finds that the participant agrees with the functional eligibility determination and the participant is then determined as nursing facility ineligible, then the county assistants and the participant will be notified about

their hearing and appeal rights.

And if we do receive the physician certification and the physician certification does indicate that a person is nursing facility ineligible, we will move forward with a notification with regards to potential termination and providing the hearing and appeals rights.

So that is to say that there is a piece in there that we don't want to delay an individual's determination process. So there may be times when we will be asking the independent assessment entity to go out and do an additional functional eligibility determination. And that is done so that the person is not being put at risk to be terminated unnecessarily.

And we can get more clarity on the determination process.

We are not able to stop the clinical re-determination process. It is part of the waiver services and program requirements. It is an annual clinical re-determination that will continue until such time as those regulations change.

And then I do have that's not on this PowerPoint because we didn't have the data cleared yet, but it got cleared this morning. We can provide, if you would like, procedural closures. If I have time to do so. If the committee would like to hear those numbers.

>> Kyle: I'm sorry, can you clarify what you're referring to?

>> Juliet: So the OLTL has been asked to provide community health choices closure data based on the 042 reason code, which is the procedural closures as part of committee would like to hear them. We share them and they have being asked for in the MLTSS committee. I'm happy to share them here too, if you would like.

>> Kyle: That's fine.

Juliet: Okay. The month of September. We look at every month and try to provide lists of individuals to the managed care organizations so that they can also follow up because we do want to ensure that everyone has the opportunity and understands the importance of the re-determination and the public health emergency unwinding efforts.

So for September, and again, I caveat this with these are the September numbers. These numbers will likely go down. They should not go up, but they will likely go down because they're still within that 90-day eligibility period and re-consideration period and hearings and appeals period.

Okay?

So there are a grand total of 2,237 community health choices participants that were identified for closure based on procedural reasons. And that 042 reason code.

The largest number of individuals that were identified did fall in the community health choices nursing facility ineligibility category. There were 1,749 individuals who were CHC NFI identified for closure.

The next was the community health choices dually eligible individuals, dual eligible Medicaid, Medicare, 389.

And the community health choices long term care dually eligible individuals with Medicare and Medicaid who were in a nursing facility or long-term care facility, there were 71 individuals.

And then in the last two categories, the Medicaid only or nondual community health choices HCBS individuals, that data is suppressed because there were less than 10 individuals identified.

In addition in the community health choices Medicaid only nonduals population for the long-term care individuals in long-term care facilities, that number was also less than 10.

So that data is suppressed.

So I just wanted to give that high level. And we can certainly share out to the group those numbers if the you would like.

Or I could pop them into the chat.

If that's helpful.

Any questions there?

>> Kyle: This is Kyle. We certainly appreciate you coming back and bringing the data you did around the NFI determinations.

One question to sort of clarify and make sure I'm understanding this correctly. You mentioned a little over 2400 medical director reviews have been done by OLTL in the last year. But only 46 were overturned. So these are situations where the physician certification came back and this waiver participant's PCP or treating doctor of some sort thought they still qualified for waiver, they were still a candidate.

>> Juliet: Or there was no PCP. It's either a no physician certification at all that was obtained within the time frame.

>> Kyle: So some of these cases have gone to medical

director review without a physician certification?it 4,000PC's have not been returned? The relevant slide is not up. What accounts for some still going to medical director review and the others on hold, if you will.
>> Juliet: I can't hear you.
>> Kyle: What accounts for some of these cases going to medical director review without a physician certification and others being put on hold, the much
>> Juliet: 60 days. Some of these individuals are still within that 60 days of waiting for a physician certification.
>> Kyle: Okay.
>> Marsha: So let me ask a question. If in 60 days, if they don't have no physician certification, then what happens?
>> Juliet: Our medical director reviews the situation. And throughout this whole time, they are receiving services. I want to make that clear.
>> Sure. I understand that part. I was trying to find out within the 60 days, if they don't -- you're saying that the medical director will review these cases?
>> Juliet: Correct.
>> Kyle: I guess to get back to what I was really concerned about is 46 being overturned out of over 2400. Less than 2%. Less than 2% where most of these cases, the treating physician is saying this person is still a candidate for a nursing facility.
>> Juliet: I would not necessarily make that case, no.
>> Kyle: Is the 2% figure or less than 2% figure concerning at all to you? Or can you speak more to what the medical director review process entails from the individuals reviewing those 2400?
>> Juliet: I cannot speak to that. I'm not going to make assumptions based on how -- our medical director has medical training. I'm not going to try and take a guess at that.
>> Kyle: Another issue I think you mentioned earlier and discussed briefly and we see in the data, I know we discussed this last month as well is a disproportional number of the waiver determinations coming from UPMC participants. So the data, the 3500 out of 7,000 or so, so basically half, our understanding is that that one managed care plan has about 25% of the HCBS population, which would mean that plan's members are ability twice as likely to receive a waiver termination saying you no longer qualify

clinically.

I know last month we had discussion of this was an issue, a problem, discussions were ongoing with the plan around this. Can you speak to any changes that have occurred or whether more recent NFI numbers have shown that trend or that disparity closing?

>> Juliet: I don't have that data because we don't have the data listed out month by month. That's what our team is looking into. And I think as you heard me say that our team looked at is a specific SC, is it specific -- are there differences between aging well and how the MCO is doing it?

So we aren't able to find a root cause. And sometimes numbers can be numbers for good reason. It's We cannot say this is done this way and this issue is because of that reason. There wasn't anything that pointed to that definitively.

>> Amy: I was going to go into another question. Go ahead, Sonia.

>> I wanted to know about the list. Who would have it? Don't nobody know? Maybe I missed it.

>> Juliet: What list?

>> The last question you were answering and I was trying to figure out what you were saying.

>> Juliet: I was saying that we don't have the data by month at this point in time. It's something my team is looking at. So Kyle's question where he's saying have you seen a change in the monthly numbers by the UPMC and can I don't have the data in front of me to be able to look at and provide that information.

>> Okay. When you do get it, will you be able to share it then?

>> Juliet: Absolutely.

>> Sure. That's what we want, Kyle. We want to see the information and maybe we can see it before our next meeting. And then we could -- I just want to say that it eligibility on waivers is very concerning. I want you to know that.

>> Juliet: Uh-huh.

>> Amy: Hi, this is Amy. I just had a few more questions about the data. Thank you so much for sharing it. It's really helpful to see.

So I noticed the data starts from November of last year. And we had previously understood that people who had an NFI determination in November, December, or January, January of this year, were not going to receive a -- were not going to be disenrolled, that they would have a new determination. Is that still the case? Or did they also termination?

>> Juliet: I believe that's still the case that they weren't being -- they did not receive a termination in

>> Amy: Okay. So they're going to be reassessed, the people who had NFI's in those three months?

>> Juliet: An individual can be reassessed annually or any time there's a trigger event.December, or January determination of NFI. So if it was,

>> Juliet: Right. It would come from a later event.

>> Amy: So they would have to be reassessed before a termination

>> Juliet: Correct.

>> Amy: Okay. I wanted to make sure.

And then -- so I just did a little bit of quick math. And it looks like it's 6% of the waiver population that has -- about 6% that has an NFI determination. Has OLTL looked or talked to other states to see what rate of ineligibility for clinical reasons other states have for their physical disability or aging waivers to see how things stack up, whether this is normal, whether this is high, low?

>> Juliet: So not at this time. We are certainly happy to do that. But, Amy, as you know, when you see one state's Medicaid program, you see one state's Medicaid program. And every state's Medicaid programs are designed a little differently with different populations. So you would not have an apples to apples comparison. But we can certainly take a look and generally speaking see -- reach or another association.

But I do want to make it clear that one state's Medicaid program is very unique to that state and that state's population.

>> Amy: Sure. Definitely. I agree.

And that's why I was limiting it a little bit to the physical disability and aging waivers. Especially aging waivers are more likely to have the NFCE. And everybody's NFCE requirements are different too.

>> Juliet: Correct. Coming from someone who spent time

as a national consultant, I can assure you that every comparable, when you get to the policies and regulations, et cetera, it's very different.

So I would not use it as an apples to apples comparison by any means at all.

>> Amy: Yeah. I would just see if there's a general -- maybe there's themes across the board.

I think the last question I had was -- and I don't expect you to know the answer. But it struck me. I saw that 621 people who had a 1768 sent to the CAO have not had a termination notice from OLTL. And I know the process is that CAO needs to say okay, ready to send.notices only from the CAO. Has OLTL been able to determine how many of those 621 people received a termination notice from the CAO instead? Or may have been otherwise terminated without an OLTL notice?

>> Juliet: I don't know that off the top of my head. As you know, Amy, and as I believe Carl has presented in the past, OIM and OLTL have worked together for that new of memo that will hopefully address this issue.

However, both the county assistant's office and the independent assessment entity and OLTL, we recognize any assistant's office and not the IAE and appealed the county assistant's office, both the county assistant's office and OLTL recognizes that appeal request.

>> Amy: Okay. Yeah. And I remember seeing that as well.

So the 949 appeals could include people who only appealed the CAO notice.

>> Juliet: Correct.

>> Amy: And we have seen people that the CAO doesn't tell OLTO or the independent assessment entity and lose the appeal because it's a financial. That's another issue. They're found financially ineligible because they're no longer in the waiver.

It would be interesting and helpful I think to dig into those folks who 1768's haven't been fully processed get to the updated ofs memo. We will be watching the Ops memo and taking a look at it and hopefully improve that difference.

>> Amy: Do you have an estimate of when the Ops memo

You guys let Carl go. I don't know if Carl is still on the

line. I think it's very close, if it's not already out. I just don't recall from the top of my head wherer.
>> Amy: Okay. That's fine. We can follow up with Carl.

>> Kyle: On the subject of the 4,000 or so cases where OLTL is waiting for the physician certification to move forward, you had mentioned engaging the independent assessment to go out and have the eligibility determinations done in the community for those individuals. Has that started? Or is that about to start?
>> Juliet: That's going come online very shortly. That's about to start.
>> Kyle: And that would be for folks whose doctor, PCP, they haven't had a physician certification returned after 60 days, is that right?
>> Juliet: I believe so. Sorry. I don't have that document. I closed it. We're going to go back to that. Let me pull that back up.

So if there is not a physician certification within 60 days, the intention is for the IAE to conduct a new in-person functional eligibility determination. If that new functional eligibility determination identifies as an NFCE status, that individual will receive services ongoing. They won't be terminated. They won't get a notice of termination.

If the in-person functional determination results as NFI aligned with the MCO's process for re-determination that resulted in that initial NFI, then the participant's county assistance office will be notified of the NFI determination. And the county assistance office will provide to the IAE that waiver -- potential waiver end date. And the participant won't receive their notice.

With all the hearing appeals rights of that NFI determination. So I believe you heard me correctly that without a PC within 60 days, a new functional eligibility determination will be done by the independent assessment entity.

>> Kyle: And the process currently if the PCP hasn't come in in 60 days, it's going to medical director review anyways? Did I understand that correctly?
>> Juliet: So the process currently, my understanding is the process currently is that new FED is not being down and the NFI determination is being sent out.

>> Kyle: Okay.
>> Juliet: I could be wrong on that. I don't have Randy on the line today. Randy is on site doing intensive monitoring and review of everything.

>> Minta has a question. You want me to do it?
>> Minta: You have to refresh my memory. What was it?
>> About UPMC?
>> Minta: Yes. I don't understand why people would be using their waiver services from UPMC? Could you explain that to me?
>> Juliet: So a person could lose their waiver services from any of the community health choices managed care organizations. They can lose their home and community-based services if they no longer meet Medicaid eligibility criteria, either financially or what have you. Or if they no longer meet the nursing facility clinical eligibility level of care that is required to use -- to get HCDF services.

Reasons why a person might have at one point be nursing facility clinically eligible and then become ineligible could be for a wide variety of reasons. For example, there could be improvements in medication. There could be improvements in the person's own condition and how it's being managed. It could be that a person perhaps in their course of treatment thought that they had one method, the whole treatment medical team thought it was one diagnosis. I don't know, rheumatoid arthritis, perhaps. When in fact it potentially was a misdiagnosis and it was then diagnosed a different way with different medications. And that person's chronic pain or what have you or whatever, the root cause of that, the reason for the person's long-term disability changed. So they no longer meet nursing facility clinical eligibility.

So there could be a variety of reasons why someone would no longer meet that definition. And I would not be able to give you every single one of the reasons. They're very varied.

>> Minta: I just wondered -- I will say this. Because I am an under the waiver program. Okay? And when my case manager come to go re-evaluation, it was of all days my feet decided to do what I have been explaining to people that one day I can walk, and the next day, I can't.

And my feet did it. So he took a picture of it to more or less say look, this is a true issue. It's not something that she's just saying.

So it explains a little bit why he was more attentive to all my conditions. Okay?

So yeah. I was glad I didn't lose it. But I'm just concerned with other ones out there because even though they misdiagnose stuff, there's usually some other reason. Because arthritis never goes away. Okay? And it just is a concern that maybe one doctor will say no, it's not that. And another doctor will say it's that.

>> Juliet: I should clarify, the reason I used that specific example was because that was my own lived experience.

>> Minta: Okay.

>> But this is Ms. Brookins again. What I would like to see, because high numbers, I would hope that before these folks get taken off that it be some evaluations in these cases. I really do. Because I don't want people to get cut off if they really need the services.

>> Juliet: I absolutely agree with you.

It is not lost on us that if an individual loses eligibility and HGBS services, the gravity of that is not lost on us.

But we do continually want to improve and look at things and evaluate everything and do the best that we can. Do we want a perfect system? Absolutely. Are we all perfect? No. No, we're not. We certainly always want to strive to continually improve.

>> And I thank you for that.

>> Minta: Does the consumer have the right to appeal their decision?

>> Juliet: Absolutely. Each and every time.

>> Minta: Okay.

>> Thank you.

Thank you for that. We appreciate it.

Anybody else?

>> Elise: The time is now 3:06 and our captioner does have to leave.

>> Okay. >> And I secornd it. This is Minta.

>> Thank you all. HAnd I hope everybody has a happy Thanksgiving. And I saw y'all in December. Thank you so mouch.

>>ion?ks so much.