Consumer Subcommittee of the MAAC

January 24, 2024

Consumers present: Minta Livengood, Liz Healey, Rochelle Jackson, Ronel Baccus, Meghann Luczkowski, Lauren Henderson, Jayme Scali, Lauren Hatcher.

DHS representatives present: Sally Kozak, OMAP Deputy Secretary; Eve Lickers, OMAP Policy Director; Alexis Deisenroth, OIM Policy; Jennifer Smith, OMHSAS Deputy Secretary; Juliet Marsala, OLTL Deputy Secretary; Randy Nolen, OLTL Bureau Director.

The meeting was called to order at 1:00pm.

[Captioning]

>> KAREN LOWERY: Welcome to the January 2024 consumer subcommittee meeting. Happy new year. Today is January 24th. I would like to go over a few item. This meeting is being recorded. Your continued participation in this meeting is your consent to be recorded. If you don't wish to be recorded you can end your participation in the webinar at any time. Please remember to keep your microphone muted if you are not speaking. Live captioning also know an cart captions are available for the meeting. Presenters should state their name clearly to assist the captioner. From the office of medical assistance programs deputy security Sally Kozak from the office from long term living deputy Julia. And Jen Smith. From the office of income maintenance for director of bureau policy Carl Feldman. If you have questions related to this visit the consumer subcommittee webpage. I will turn these over to the subcommittee Vice Chair.
>> MINTA LIVENGOOD: I have to make myself off mute. Do we need to -- Kyle, so we need to introduce all of our ones that we said on the committee?
>> KYLE FISHER: We do. Kyle Fisher, Pennsylvania health law project, counsel for the consumers. We are going to go through the attendance for committee members. Ronel Baccus, I saw you were on. Have you been unmuted?
>> RONEL BACCUS: I'm here. They didn't up mute until now.
>> KYLE FISHER: Thanks. Ms. He'lly are you on?
>> LIZ HEALEY: I'm on.
>> KYLE FISHER: Excellent. Do we have Rochelle Jackson?
>> ROCHELLE JACKSON: Present.
>> KYLE FISHER: Welcome Rochelle. Do we have Megan? Do we have Victorian G?

Do we have Lauren? Lauren Henderson?
>> LAUREN HENDERSON: Here.
>> KYLE FISHER: Thank you, Lauren. I know we had a number of consumers on the productive earlier that have not had a chance to introduce themselves. Do we have anyone on the subcommittee on this call? That I haven't introduced? Okay. I'm the subcommittee chair (indistinct) she is unavailable this afternoon. I this that's it in terms of introductions. Actually let me go from the health law project do we have Danna?
>> DANNA CASSERLY: Yes. I'm here. Thanks, Kyle
>> KYLE FISHER: Do we have Dana?
>> AMY LOWENSTEIN: Yes, I'm here.
>> KYLE FISHER:. Thank you, Amy. I know we have a full agenda today. I think we can jump in Sally, if you are ready.

- **OMAP Report**

>> SALLY KOZAK: I'm here. Good afternoon, everybody. Hope everybody is enjoying the lovely spring day that we are having here in Harris burg. I don't know what it's like where you are at. A little relief from the cold weather we have been experienceing. There's number of things on my talking points today. The first is OMAPs priority. I want to talk about a few today that are probably most pertinent in terms of the conversations we sure had over the last several months. Priorities for us include maternity care, improving access to care through policy, and our integrated value base strategy, and the work we are doing to continue to support children with complex medical needs. Let me talk about each of those individually for a few minutes. Maternity care. We know that across the common wealth our maternal mortality statistics are not good. We also know that we have counties and areas in Pennsylvania that have no access or extremely limited and difficult access to OB -- and prior to accepting her position stat on the statewide committee. It is of particular interest and near and dear to her heart. We have undertaken a strategic planning process. It is being led by Sarah who is a special advisor to the security. And we have been collaborating with the Department of Health as they also are addressing the issue from a statewide population perspective whereas we can focusing on the Medicaid population in particular. So those activities have already gotten underway. Some of the things we have done already have (indistinct). And I'm going to talk a little bit about that. We have expanded the requirements around our maternity care management bundle in the health choices program. And when I say expanded it, I mean that we have included the individuals or

expanded the individuals that should be in included in that care management team. And of course we continue expand access to the home visiting program. As part of that because we know that follow up care after delivery is extremely important and how it impacts maternal outcomes. So that's where we are at in terms of a strategy in the initial stages of those conversations and planning. We also are taking a look at the recent CMS release about help homes for program women. And there will be more to come on that as be begin to get more conversation. CMS is holding some informational meetings about it. They are not for a little bit yet. But we'll keep you up to date with that. So let me talk a little bit about this and say an important part of our maternity strategy we have been working with the duala association for some time. We have pleased that effective that 1-1-24 -- in the maternity care management teams that participate in the maternity care management bundle. In order to facilitate that beginning February of 24 we will begin to enroll dualas in the MA program that are certified by the as certified as Parry natal dualas. Within the managed care delivery system. And are goal is to continue to work the duala association to build the capacity of the number of certified dualas that we have statewide access and at such point in time we achieve that we will add the dualas to the state plan. Questions about the maternity strategy before I go ahead and talk a little bit about improving access to care through policy?
>> KYLE FISHER: And don't have any questions. I don't know if anybody in the committee does. Any questions? Doesn't sound like it. Thank you.
>> I would commend you for it.
>> SALLY KOZAK: It was a lot of worker for a lot of folks. We are pleased we are doing this. We have talked about improving care through access of policy. We actually started moving in this direction about midlast year. We recognize that not all care is rendered in a physicians office. We recognize other individuals licensed and nonlicensed play important roles in the delivery of care and the particular preventive services. So for that reason over the past 6 months we have sought to really expand access to those provider types. You may recall that I guess it was in October of last year we planned to pay for street medicine. And in October we expanded the provider types that are eligible to provide street medicine. And we will continue that expansion in increments as we are able. We are at the point now where we are bringing medicine to where folks are. Especially for those individuals that live unsheltered lives. We begin coverage and payment in January. We hope that will increase access to specialty care. A physician can call up a specialist and do a consultation between management of an individual and be able to bill for that. And the individual doesn't have to be in

present when that happens. But the service does need to be to the benefit of the individual they are calling about. I just mentioned that duala enrollment is going to be begin February 2024. Community health workers we continue to work with that association. And plan to add them to the MA program probably in 2025. Right now our manage care organizations are required to use community health workers as part of the compute based programs. (Indistinct) to be counted at an encounter type once we get them enrolled. And the last group we have currently been working with to enroll and hope to enroll very soon is pharmacists. We will enroll and pay pharmacists that are not employed or under contract I the pharmacy and that will begin to take place in March of 2024. By enrolling pharmacists we will increase access to medication immuneization and degrees and therapy manage in other settings. Like in a physicians office and nonpharmacy locations. We are slated to have a training through the pharmacies and that's going to take place on February 15. And the announcement for this training is on our provide enrollment documents webpage. Again, we are thrilled we are able to do this. We have been working with the pharmacy association for the better part of the last year to be able to make this happen. And as I just said, it's part of our strategy to improve access to care, we will continue to work different provider types to see how it is we can expand access in a safe and when possible an expeditious manner. Questions about that before I talk about value base punctuating?

The NCOs are required to use them in the program. And they are using them primarily for compute outreach. Social assessments. Health risk assessments and other type of education. We are still working to finalize what our policy around community health workers will look like. As you know Medicare recently added community health workers as a reimburseable type in the Medicare program. We are taking a look at that if we want to mirror the Medicaid program. Kyle, we don't have an absolute answer for that yet.

>> KYLE FISHER: That's helpful. Sometime in 2025?

>> SALLY KOZAK: That's what we are aiming for.

We continue to work with the office of mental health and substance abuse services on what that will look for. Our goal for that is to make some enhancements to the agreement the 2025 agreement as people may recall we currently have a requirement for an integrated program for these. We are looking to see how it we can make improvements in that requirement. Questions?

Okay. And then my strategy, and know this is the one that everybody waits for, we continue to modernize our Medicaid management information system. I

know that at the end of the day that's not necessarily directly -- impact is not directly felt by the consumers. But it is felt by providers that serve the consumers. We have made steps to streamline the provider enrollment process. We had a significant backlog this time last year. The changes we have made have allowed us to get our timeframe for finalizing a completed application is right under 10 days now. Even though our goal is within 30 business days we are well below that. We have added some processes that allow providers to enroll in multiple locations in a much easier and expeditious fashion that did not exist prior. We are working towards procuring this. We are in the process of implementing a new prior authorization module. Which will allow for automated authorization. And allow for electronic admission of authorizations. At the end of the day it impacts how providers are able to do things on behalf of the consumers they serve. So we are really excited about the MMIS changes that are going to occur this year.
>> KYLE FISHER: The last piece of that I think a fair interest amongst the consumers. Electronic submission of prior (indistinct) we were talking about for service? Is that right?
>> SALLY KOZAK: MAP for service. Yes. Most of the plans are doing this. This is the fee for service program
>> KYLE FISHER: That's what I thought. What is the timeframe of this?
>> SALLY KOZAK: We have a vendor they are going through requirement sessions right now. We anticipate if I'm not mistaken it will be late spring of 2025. (Indistinct) I think is on it. Let me know if I gave you the wrong date.
>> KYLE FISHER: Sure.
>> SALLY KOZAK: The last big priority and these are our big priorities as I said earlier we have a lot of other priorities, is to continue to look at how it is we make improvements in the delivery of services to children with medically complex needs. We are still working with the healthcare quality units for them to serve as our pediatric resource centers. We anticipate still the first one will be operational early this summer. We have worked in partnered with the office of developmental programs to be able to increase the number of family facilitators that are available across the state through these pediatric resource centers. And we continue to work on how it is we can grow and refine our requirements for the -- we have so many acronyms. I don't know what you call them. Essentially the complex pediatric specialty medical homes we started requiring this year. That work continues and it will continue. There is joint work that is going on through the department. We are working closely with the office of developmental programs because many of our children have a diagnosis of

developmental disability. Not all. But many of them. We have conversations around how it is we begin to better rep services around them and their families earlier on. Right now we take until they are getting around that age 18 birth date to prepare there that. How do we start doing that sooner? You folks have probably seen some of the work that Jonathan has been doing around the individuals that have behavioral health and other conditions as well as some medical needs. We are working on how we integrate all that together. Questions about L maps large projects priorities for 2024?
>> KYLE FISHER: I want to post to the committee especially on the last item (indistinct) was a medical complexity. Questions? Okay. Doesn't sound like we do. Thank you.
>> SALLY KOZAK: Just a very quick update on the 1115 waver. The keystones for health for Pennsylvania, it has been developed and we anticipate submission to CMS very soon. Once the application is sent to CMS there's a 15 day review. And there is a 45 federal comment period. We went through the state public comment period before we submitted. We go over 600 comments that were overwhelmingly positive. So that has been an excellent response to it. I know we have a number of virtual sessions that were very, very well attended. We are excited and pleased to see the enthusiasm and support that we have out there for this waver. Questions?
>> This is liz he'lly. Do you anticipate from all the comments you got that you may incorporate some of those ideas into the final submission?
>> SALLY KOZAK: So the final -- the submission that we are doing is a template submission that's a high level outline of what it is we want to do. It's not necessarily include a lot of detail at this point in time. Because that detail is exactly what we are going to do. We'll come as we have conversations back and forth with CMS. That's a very long answer to your question, Liz. Which is yes, we move forward, yes, there's a good possibility will we incorporate questions from the public comment period.
>> Thank you.
>> SALLY KOZAK: Sure. Other questions? Okay. So I know this is jammed packed agenda today. Let me go to the last item on the list. I know dualas are up there and pharmacists are up there. I already talk about them. The last is the update of FLOEFB vent. It's an no one hailer in the treatment of asthma. Unfortunately brand name flow vent products have been discontinued by the manufacturers. They all contain a medication called a steroid. And while the active ingredients in the inhalers are different they all work the same way in the bodies. And used regularly these inhalers (indistinct). Flow vent and other similar medications are

included on the statewide PDL. In a class called glutcode cordcoids. That's a math full for me to say. Flow vent has been discontinued by the manufacturer. And there's only one manufacturer who is producing generic flow vent. The name of generic flow vent is (indistinct). And the cause to the MA program is significantly higher than the preferred brand name alternatives that we have on the preferred drug list. Preferring the generic of the flow vent versus the brand name alternatives we have would result in a 20 million increase to the medical assistance program. Back in September because we knew this was coming our pharmacy and therapeutics (indistinct) preferred on the statewide PDL to account for the brand name flow vent being discontinued. When we did this following the committee they followed with a asthma specialist that is a pediatrician. Which is what we did. We do have 3 drugs available for children in particular for the management of asthma. Beneficiaries that are switching to one of the preferred alternatives will need a new prescription for their prescriber. That notification has gone out to prescribers. As a remedialer there's no co-pay for asthma medications to beneficiaries and providers if there is somebody that has an absolute need for the generic version of it they can always do it through the prior authorization process. That's the update on flow vent.
>> KYLE FISHER: Were the parents of the consumers using these? (Indistinct).
>> SALLY KOZAK: Carry I don't know if our pharmacy is on to see whether or not we did the MP for service.
>> This is terry, hi. There's no notice sent to beneficiaries about that. The notice goes to the providers because the prescribers need to decide what to prescribe for their patients that are taking those medications. Some of our MCOs did notify their patients and they they needed a new prescription. But the negotiate went to the providers to let them know that flow vent the brand is still on the preferred drug list as preferred. But as surprised window in the market place start to not have that brand in stock anymore. They will also tell the patient you need a new prescription for one of the preferred medications.
>> SALLY KOZAK: If there's no questions for me, that's my update.
>> KYLE FISHER: Thank you, Sally. I think we had a couple other consumers if you want to do introductions. We have Megan on the phone.
>> MEGHANN LUCZKOWSKI: I'm here.
>> KYLE FISHER: Do we have Lauren Hatcher? I don't see her on the attendee side. Thank you again, Sally. I think next on the agenda we have OIM.

- **OIM Report**
  - **Unwinding Updates**

- **Continuous Eligibility for Children**
- **HCBS & MAWD**

>> This is Lexi Deisenroth, Direct of the division of health services. Bureau of policy. Carl Feldman is away at a conference. He's the director of the bureau policy. I'm a stand in. Thank you to be here.
>> KYLE FISHER: Thanks.
>> LEXI DEISENROTH: To walk through the outputs from unwinding that OM has I know we have some standing request for data actually. I want to say our unwinding data is available on the website. In both the unwinding data tracker. There's also federal reports available. And federal unwinding and outcomes available on the website. I'll make sure to post those links in the chat. So they are available. And know that we have some programming updates and data plans. I wanted to talk to you quickly about a connection we made with code for America. Code for America and DHS OIM connected in an engagement. To discuss ways we can improve our exper tay arrangement. I think it was probably coming up on 2 weeks now we concluded our engagement with CFA. And we are reviewing -- there were a number of different systematic policy and business operation recommendations they presented to us. And that included both things we can to in the short term. And then also some of the adaptations that we are taking and looking at in the long term resolution for ex parte in particular. Let's see here. I also do want to touch on our engagement with CMS regarding changes to federal reporting -- for case activity that goes into the next month. DHS is engaged can CMS. Who's renewal is not conducted by the initial reporting deadline each month. So I think if you following closely with our federal reporting that is found in reporting element 5D, DHS cannot provide the updated specific disposition of individuals in that element which was you know what was the outcome of the renewal the first time it was ran through? We are unable to do that in a federal unwinding reports in the way they have requested it. CMS is aware of those limitations currently. And we are working with them to determine alternate modes of providing this information. And how we do this going forward. Those are the larger bucket of items we have in terms of general unwinding. I can expound some more about ex parte. Is there any questions so far regarding unwinding before I jump into the exper tay kind of review of the issue and the solution we came up with that?
>> KYLE FISHER: I would say before you do the ex parte I think we can have a good conversation this morning. We looked at the unwinding data on the website. In particular tens of thousands of procedural terminations there were

some suggestions by the consumers that I think we wanted to raise. And if you are unable to unmute can you talk to this.
>> MINTA LIVENGOOD: Yes. One of the problems with renewals is that people have received the application in the mail. Was sent to them and like I'll give you an example was sent last Friday. You should have received it last Friday. And it was due Monday. So, this creates a problem and she had reached out to the case worker to say I can't complete this application in that short amount of time. And the work was said that's the post office's fault. So there's just some issues with mailing when it comes out of Harris burg or wherever it's coming from, it is on the main there it says this is the date it was sent. So say I'm just going to use an example. It was to be mailed on the 16th. And for some apparent reason it got held up at the main office and didn't get mailed to the next day. You are talking usually most times 3 days to get it to the person. So they have already lost 4 days of being able to complete this application. So it has created a problem. I am -- I set up an appointment with this young lady because she needs help filling out the application. She does not have a computer. She is not really up to date with a smart phone on how to complete everything. And send it electronically. So I will be assisting her to get this done. She's not the only one that has ran into receiving the letters in a short timeframe. Okay? And yes, I know personal service is slow, but we need to make sure that people understand that if it is stated the 16th and you don't get to the 20th and it's due the 23rd, not to be in a panic. Because maybe they need documentation from the bank. From life insurance policies. Various items that they may have, but it doesn't stop them from receiving benefits. So I know this has been a problem in the past. We had talked about maybe putting something on the front of the letter that this is time sensitive. Which is a good thing. But if you have someone that is unable to read our understand what the reading -- maybe put in there and say I have somebody to help me fill this out. But they are not coming for 4 days. It's in the pile waiting for that person to get there. Yes, I do know we can assign someone to assist was -- that they get the paperwork. But a lot of people prefer to receive the letters themselves. I don't know what -- how we can address this issue. But, like I said, there's ones that is very I'll say computer (indistinct) not familiar with how to run a computer.How to run a smart phone. And I will give you an example. I have a smart phone. But I can't take pictures because I shake too much. And when it comes through, it's not clear. So I have to find somebody to take that picture to get a clear picture. So I don't have somebody around --
>> KYLE FISHER: Right. Thank you. I think you raised a lot there. Lexi, do you

want a respond initially to add more to what they were saying? There's also this secondary question of whether there's any additional time given to individuals (indistinct) categories that have often having to provide resource documentation. And given the extra time it can take to obtain that for instance,. Apart from the mailing issues and sort of note this is important nail or put time sensitive on the envelopes to single to the folks handling it or people receiving that that they need that quickly. Reactions?
>> LEXI: That was a lot. I appreciate you bringing it to our attention. I will echo this is not the first time we have heard this. What I want to kind of walk back here and take a look at some of the things that I think I heard. As far as timeframes we can always take a look at you know what our (indistinct) and probabilities are for return. We can take that back and continue to see if there's ways to look at it from that end. With that being said, there are a few things that are built in for assistance when it comes to timeframes with some of the recurrent policies. We do and I know there's maybe a way to continue to draw attention to when people are making those phone calls to report them, I just got my renewal in the mail and it says I need to respond tomorrow, that phone call or that notification to the CAO in that you need a little bit more time should be able to grant some additional time to get the information that you needed for working in (indistinct) to be able to get information into inCAL prior to taking negative action in case with whatever policy we have there. That connection to the CAO and any respect it comes in whether it's coming in through something on compass and somebody doesn't have that text savvy ability, walking into the CAOs is another option. If you can -- if we sure the ability to get a connection with a person and know they are having issues we love to be able to take action to assist with that. I think let me -- one of the other things we do have in place for some of the issues that I think I'm hearing here are if people are being terminated within 90 days of when that RU newly is due the option for reconsideration is there. When we open people back to the date they were closed. If we don't have a connection with that person saying they need more time. We can take a look at the reconsideration. The time within the reconsideration and open back as long as they continue to be eligible back to the date of closure. And so I think some of the other options that may assist in some of the things that I heard areologist the different ways we have the submit a RU newly. I agree that not all our recipients are able to get online and submit things through the app or through compass. We also have a phone simple available through a vender called inspear tech that can assist us in taking those applications over the phone. And I'll be happy to put that information in the

chat. Whenever we conclude. So that an option. And we do have assistance through the offices. I appreciate you working with the individual helping them get -- when they are having difficulty. And our community partners are so available in that. I hope I covered most of what you were looking for there. And I hope that helps with a response.
>> MINTA: Yes, you addressed many issues. Now, when this pertains to me, I know who to reach out for Indiana county. And the director worked well with me. I ordered (indistinct) county. Sometimes I have issues with the Wes morlen county. But I don't have anybody to connect with over there to say I have somebody here. We are working on this. Can you give her more time? Or him. I don't want to assume it's just women. (Laughter). So, if there's anyway that we could get people that -- workers you can connect with at the Department of Human services it would be appreciated.
>> Thanks for raising that. I know that when you are with somebody and you can contact the consumer service center, they can take those requests over the phone through that number. If you have a complex need or a complex case in Wes morland I can get you the MA ombudsman information. Those are established individuals in those counties that can help was those harder issues.
>> That would be fine.
>> KYLE FISHER: Okay. Appreciate your time. Walking through that. A little off the agenda. We are bit short on time. Do you mind skip to go the MAWD & HCBS updates? And continuing that conversation?
>> Sure. I know we had some of our conversation last month. I know Carl was here and able to provide an update going on this space. I know there are some closures (indistinct) based on income where mod was not reviewed. We have been able to take a look a little closer at these. And able to identify approximately 75 individuals in the list from I think it was April 1 going forward. Where if CVS individuals looks like we needed to some review for mod in cases where they met that income criteria and had the presence of a certified disability. We were able to do outreach and make phone calls to these individuals. In addition a mailing list developed to be issued to individuals that coverage -- where mawd criteria was met. Looking at that letter the individuals we couldn't reach through phone call were mailed the letter. And the letter indicates that if the individual wishes to receive mawd, if they inform them of that and are willing to pay that premium associated with the benefit, then we can go ahead and restore that individual back to the date of closure. They will be given those individuals the contracts were back will be given good cause for payment of premiums in the months that were reopened retrospectively. So I'll

pause there if you have questions on that process about those individuals that were identified.
>> KYLE FISHER: Certainly appreciate the department. Doing the activity. And identifying them. Reaching out to them. You know of any of the 75 have been enrolled or reinstated?
>> I'll have to look back. I want to -- I feel like there were individuals that had either previously indicated that they did not want mod or had reviewed for mod and there was another eligibility factor there. I think I will try to get some better outcomes of where that landed. If we can get a current snapshot of what is in that project. I appreciate it. We'll take a look at that. See if we can get different updates on that particular population and what the status ended up being throughout. Let me see here. And I -- we did have ongoing activity. To take a look at different things. I want to instead of the mod population, I know that you had some questions about the HCVS waiver closures. Are we okay to move on to that?
>> KYLE FISHER: We are aware of new instances where individuals are on both waiver and MAWD and lost their benefits. The activity to identify the 75, that was HCBS closures only? Right? Any insight what any 2 individuals would waiver at mod? Which I think ties into this. Without notice. Explanations and identifications of what the root cause was? What they might do to prevent the closures from happening?
>> We have taken a look at quite a few of these cases. And there's some data entry that is complex. To say the least. And you know kind of the chicken or the egg. You have to do one thing before another thing. And there's a current system bug that is under review for I think repair coming up in an upcoming release that will assist in getting rid of this issue. So we do think there is a complex data entry issue/just system bug that is adding to some of this. So, to combat that currently until a system can go in we are working with the bureau of operations in getting some real extreme clarity to the process that are team has to take in that data entry to insure the steps are very clear. The education is there for individuals to be able to follow to get from A to Z in these cases. And insure that we are continuing benefits as necessary. You know, it's not something we want to see and we absolutely want to look for a resolution to that.
>> KYLE FISHER: Go ahead.
>> AMY LOWENSTEIN: We appreciate the response. I wanted to clarify something. Would the 75 people that identified you said they were terminated for income. Were any of those people already on MAWD? Or were those people

that weren't on MAWD?
>> I believe those were people were thought on mod. In which we wanted to do the research to determine if a mod review had been ton prior to closure.
>> LIZ HEALEY: This is Liz. I was trying to understand are you saying for people who were not enrolled in mod but had an income increase, there was no review about whether they might qualify for mod? Are you talking about people that are already enrolled in mod had an income increase?
>> It's the first one. So it was people that were not enrolled in mod that had an income increase. I think the 75 is an overall identification number of like by termination code. The fact they were HCVS. And when we take a look at the project we did within that 75 people there were a number of people were reviewed for mod. I think 75 is the total. I want to get a current SHAP shot and a better result of what was going on there. Within that 75 there were some people that were reviewed for mod. Or would not have been eligible for mod based on another particular criteria. We have to take a look a little further of where that landed. And I'll be happy to supply some additional information.
>> LIZ: Do you feel that you have put in a process going forward beyond these 75 so that people aren't going to lose their home and community based services because they weren't notified they might qualify for mod and maintain the home and community based services by being able by enrolling in mod?
>> We are continuing to look at that. And looking at other opportunities to connect I case workers. As well as ensuring we are trying to systematically be able to review mod within our cascades. Everything that we are able to input systematically comes at a certain you know prioritization level and a lot that is based on things that are mandated by federal system times the prioritization of you know the things we like to do for categories like mod to make this a little bit more seamless. Takes a little bit longer. We are going to do the best we can. In providing some more guidance in our field in the meantime. Until systematic updates can be made.
>> When do you think you'll be able to report back to us on how you have been able to put a fix into this issue? At this point people who are getting home and compute based services who lose their services because they were medical assistance determination have concluded they are not eligible. Without notice they use their home and community base services. For some people it's overwhelmingly devastating. They need some support in their homes. Having aids. Their have aids stop immediately. People risk losing their jobs. They can potentially lose the ability to live independently. It's devastating. Can you give us an update then when you feel like you have this corrected so it won't be

happening in the future?
>> Certainly.
>> Thank you.
>> This is Amy again. I have a couple follow ups. One, in terms of the population that is on mod and getting terminated, I -- we would hope that you would look to do an audit to see when that is happening as well. And not just people that should have been reviewed for mod. But people that were on mod and terminated. Going forward since the fix is not clear when there's a fix to this cascade issue. And I understand there's been education about mod. But these are still happening. Is there any plan to do a monthly audit to check to see that people with income on waiver are being terminated with earned income?
>> Let me make sure I got that. Amy, I think you are just looking for a follow-up on regular follow up on mod households or mod individuals that are terminated that maybe shouldn't have when they had the earned income in place, is that correct?
>> The MAWD folks on waiver. People on MAWD are reviewed for mod except for on waiver. And then the glitch happens and then they get terminated. I hadn't heard anything of what has been identified with that population and make sure they don't have breaks in coverage. And the second was a suggestion of doing a monthly audit at the end of the month to see if anyone was terminated that was on moded waiver for income. Or any with waiver with earned income was terminated. Seems to me there needs to be something in place until there's a systematic fix.
>> I'll have to take it back to take a look at where we can go with that. Currently there's nowhere in the system to kind of for case workers to say I reviewed for mod outside of checking narrative on each case. I think we'd have to take that back and see if there are further ability to review.
>> Thank you.
>> To insure the different clarifications. Are getting where they need to in the field.
>> I understand that. I lost you for a minute. I don't know if was my end. Or generally. If you can look -- if you can take that that would be great. I think there's considering the impact that this can have when you lose waiver especially when working it impacts people's health and likelihood. It's something we should assume. There needs to be a notation of people.
>> There's an a notation when individuals are being asked about mod in the narrative. There's not an easy way to filter that and get that information in reporting. But we can certainly take a look at what we can do is circle back with

someone of the things we came up with.
>> Right. As a matter of process if somebody says they don't want mod that should be included in the denial notice. To show it was asked and give an opportunity for the person to challenge the decision.
>> Okay. I'll take note of that. And when we are reviewing for the systematic fixes and see if that's something we are able and -- I would have to check it back for our team to review. If they can include that. So thanks for raising that. I took note of that and we'll apply that to discussions when we get to this.
>> I just wanted to mention some of the notices that come out when you are dealing with Medicaid, it doesn't necessarily say what you are -- you do not qualify for. Okay? Because we have so many different things. We have mod. We have the waiver.
>> KYLE: A lot of different categories.
>> MINTA: It doesn't mention the thing you are applying for. When somebody gets that. It's like I don't qualify. It's not saying you don't qualify I don't think necessarily the waiver, but I do know if somebody does the buy in, it says you are not qualified for Medicaid. It doesn't say you don't qualify for the buy in to pay for your Medicare. Or it doesn't say you don't qualify for a specific category in Medicaid. Because you have so many different categories for Medicaid that it's confusing.
>> KYLE: I think you are raising an excellent question and topic. And I know Lexi has been very generous with her time. The requirement to review for all categories has been dept policy for a long time. We have talked about the challenges the state has had in getting this applied. Putting this in the review into the notice would certainly improve the process for consumers and understanding what they have been reviewed for or what they might not have been reviewed for. How they might continue to qualify for mod. I think we don't have time for that conversation today. We are unfortunately a little behind schedule already. So if you are okay with it, I propose we end this portion of the discussion.
>> That's fine.
>> KYLE FISHER: Lexi, thank you so much for your time and consideration to your suggestions this afternoon.
>> Absolutely. I appreciate being a part of the group. Thanks so much. Have a great day, everyone.
>> KYLE FISHER: Next up I believe we have office of mental health and substance abuse services. Welcome.

- **OMHSAS Report**
  - **Network Adequacy & Workforce Shortages**

>> JENNIFER SMITH: Perfect. Well I have 5 minutes. I'm just kidding. (Laughter). I can't get it done in 5 minutes but I'll do my best. And please know as I know you do that we are happy to take questions outside of the meeting or schedule a separate time if there's particular topics you want to hear more about. But I don't have time to cover in detail. So I'm going to hit on a few things that were specifically requested by the group. So this is definitely not representative of everything that is happening in OMHSAS. This is something of the topics I had presented on previously to this group and that were requested. So the first is an update on what we call M E M M.
OMHSAS is starting to take advantage of the capabilities the tool is going to offer.
We are looking to roll out enhancements in February. The dashboard helps our staff understand and oversee the bim co and primary contract provider networks. So it gives us information to help better understand what those networks look like. So we are currently on enhancing that. At this point we collect 24 different provider type files on a weekly basis. And those files then populate this dashboard. And the dashboard has a number of different types of filters that give us a graphic depiction of provider networks on a map across Pennsylvania. If we want to see where we have shortages of certain provider types within the network and things like that we can see that. A really important distinction that I should make here quickly while we are talking about this, this again would be the map of providers that are part of our bim co properly contractor networks. This would not be a map equivalent to the licensed mental health providers in Pennsylvania. Those would be 2 different sets of data. So this tool shows us providers that are part of the network not necessarily providers that are licensed to provide services in the state of Pennsylvania. That's an important distinction. The second dashboard is our network aticacy dashboard. It's nearing the end of the development. We are expecting this to be done by June this year. This dashboard will help us monitor for the time and distance standards we have in the contracts. And subsequently the bim cos. Specialty and service type to insure they are in compliance with their contracttual requirement as it relates to time and distance standards. The third area which has yet to be developed we are only now gatherer the requirements and finalizing those before it will be built, and that's the network geography application. And this will actually be able to help calculate drive time for us. To see just how far way different services are for individuals who are seeking them. So we'd be able to

actually calculate how long would it take an individual who is home is here and the provider is there, and you know what kind of travel time would be required? Because as we know, calculating distance is one thing, but actually looking at real drive time is something entirely different. So that as I said is in progress. The development of the IT solution is going to begin this quarter. I don't have a date for the completion of that just yet. But I would expect probably this fiscal year or this calendar year or perhaps early.
>> KYLE FISHER: I think one question. I think this goes nicely from the last conversation in spring. When this was in it's infancy. Can you speak to any degree -- the extent to which the dashboard indicate or monitor actual agency staffing capacity? As to providers and agencies in network?
>> JEN SMITH: You are getting to the question about workforce. I have a slide that talks a little bit about workforce. But I can address it here, too. Actually if you don't mind, can you advance to the slide that says OMHSAS and primary contractor efforts? Sorry, I'm being difficult. I'm jumping around there slide deck. I think it's 2 more slides. There we go. It was also asked we talk about what is happening with workforce shortages. It's no secret that we are having issues in the behavioral health workforce space. What we can say is there are some properly KASHTHers and providers that are doing more in-depth studies about resource planning. BHARP is one of those. And I believe they are slated to present to the manage care delivery system subcommittee group in March. Another month or so from now. And there are also properly contactors that are utilizing reinvestment dollars around retaining staff. What you were getting at is what is OMHSAS doing? How are we collecting information and using it? And the answer is we really don't have that information. And it makes it very difficult for us to gather that information. So for example, you know from a licensing stand point there's some providers or some types of providers where we license where we know a capacity number. We know the maximum number of individuals that they might be serving. And through that capacity number we would know how many staff approximately they would needs to support that in order to meet regulatory or policy requirements. We do not maintain either through a licensing perspective or through our relationships with the properly contractors and bim cos a real time assessment of how many staff work for providers. And we have had the question, well, can't we build a system to collect that? Yes, you can build a system to do just about anything these days. The real question is how do you implement the collection of that data from providers? You know, a regular and I'll use the word complaint we received from providers is that the state these a lot of administrative burdens placed on them. Worth it's

filling out forms. Whether it's multiple agencies coming from site visits. This requires them to reduce the amount of direct services they can provide to consumers because they are spending time instead filling out paperwork and responding to requests and things like that. We try to balance what is required of them with health and safety. With knowing there's a workforce shortage. And we desperately need in some areas to expand capacity. Could there be a system developed to collect said information instead filling out paperwork and responding to requests and things like that. We try to balance what is required of them with health and safety. With knowing there's a workforce shortage. And we desperately need in some areas to expand capacity. Could there be a system developed to information? Of course there could be. The question is is worth building a system that requires additional work from providers to apply that information? How do we insure it's kept current? If you ask them to complete it today by the weekend it's potentially outdated. So just a lot of challenges in really understanding the full scope of workforce challenges and that's not unique to OMHSAS. That's true of the entire behavioral health system really nationwide. There's many states that face the same challenges we do in terms of not having concrete data to show where we have X number of LSWs and we need this number. There's very few states or even you know areas that would be able to say we have that kind of data and we maintain it in a real time basis. I think it's a general struggle across the field. But that doesn't mean there aren't things we can't do to address the workforce issues. And we can't look at it. I think what B harp is doing is setting a potential tone for other properly contractorers to also to be able to do the assessing within their attachment areas. Certainly there's opportunities for us to do something at the state level based on their work we would be happy to entertain that, too. I wish we had a better answer that we can magically share that information with you. But the reality is we don't have that kind of insight.

>> KYLE FISHER: I appreciate those considerations. I think we here what you are saying. From consumer perspective the struggle is really -- the access issue. Getting a list of provider agencies from bim co and outreaching and them telling there's no staff to send out. To see next number of agencies within this county or service area is of really little value of the participant to the consumers they can't actually get the services questioned.

>> I understand it as a consumer of services. I have a child with intellectual disabilities. And a child with behavioral health diagnosis. And myself have had difficulty navigating the system. And trying to find providers giving him the services when he needs them. I'm not feeding you a line of a state government

official. I'm too am a consumer of services. I'm frustrated by all the things that many of you are frustrated by on the phone.
>> KYLE FISHER: Consumers might have questions here. One quick question here for you. What does telehealth (indistinct) are providers that are possibly -- how do they factor into the dash boards and just walk us through.
>> Yeah, so in terms of how they relate to these specific dash boards, the dashboards are based on the provider type. So you know just because they provide telehealth services wouldn't change the provider type. What we are doing on the telehealth side of things which is a slightly different conversation than these dashboards, we are embarking in some indepth stakeholder conversations of what to do with the future of telebehavioral health in Pennsylvania We are launching a series of webinars starting on Monday. There will be a webinar focus on payers. Properly contractorers and counties and et cetera. There will be a webinar for providers. To here from their perspective. What is working. And what is not? What can be level? And a third webinar on individuals that use the services. I think some of those announcements went out yesterday or today. If you are interested in getting that, we can make sure that you are provided the link to that webinar if you want to send it out to the subcommittee members. We want to encourage folks to attend the appropriate session. Just because it eases the discussion and keeps us focused in one direction as opposed to trying to address issues from multiple lenses. That is the first step in many conversations toward developing a plan for how we need to address telehealth in Pennsylvania in there health system. It's likely -- regulatory updates. Policy changes. Perhaps some legislative or statutory changes that might happen faster. There's a lot happening on the telehealth front in terms of assessing what the needs are. And gathering input for how services should be delivered moving forward. That is all sort of independent of what is reflected in these dashboards in them. Does that make sense?
>> KYLE FISHER: It does. Thank you.
>> Good. Okay.
>> Well I will if you don't mind flipping back 2 slides, (laughter), I will cover the IBHS reporting. Great. So an update on where we stand with reporting related to IBHS services. So in 2023 bim cos were required to report their data based on a standardized data set. And we spent the majority of that year reviews the data coming in. And looking at where there were discrepancies within the reporting. And realized in some cases because of of the terms used in the standard data sets were not defined or operationalizeed consistently we were getting some funky data reporting and analysis. They did some deep dives into how data was

being pulled. What the definition was for look back periods. They looked at where bim cos were reporting 0 responses. And did that mean the same thing across every bim co. And all those cases led to the realization there needed to be update to the parameters and definitions to the expectations around that data reporting. So that was issued. Those revised parameters and expectations were issued and they went into effect starting the last month. So December 15. So data submissions moving from that date should adhere to those more standardized and defined requirements which will help us be able to compare and contrast and analyze data more of easily because we are having a more consistent approach to how it's being reported. In 2024 we are going to continue analyzing the reports that are coming in just to make sure we didn't miss any revisions that need to be made. We are also going to start looking at trends. Assessing where we see certain outliers. And investigating more deeply why those outliers exist. And of course offering some technical assistance. So making sure our manage care organizations are very clear about what data is coming in. How it's being interpreted. And then assist them in helping to use the data that's being reported to do their job more effectively. So we don't want this to be an exercise in oh, the state is making us submit this data. And it's useless to us. We want them to get value out of reporting this data. And us to be able to report back across all the managed care organizations so they can sort of see where they fall in relationship to others across the state.
Um, the other thing we are working on this calendar year is creating a dashboard for our staff that will make retrieving all this information a lot easier. And so when we get requests from the consumer subcommittee from the MAAC and provider associations and what not, we'll be able to much more easily filter, sort, extract data and provide reports on demand for individuals that needs them. Instead of relying on systems people to do that, we are going to build a dashboard that's more user friendly so our own staff can pull them as they need them. This should be helpful especially for groups like this. Can you send me the latest information around X, Y, Z in the system and we can provide and pull it out relatively quickly. So good things happening there. Questions on that one?
>> KYLE: The system reporting requirements publicly available if we wanted to look at those or look at how they are changing is there something we can find on the website?
>> Excellent question. I will make sure we get back to you, unless I have staff on the phone that know the answer to that question.
>> KYLE: If you don't mind you can send it to us. Or the changes being made. (Indistinct).

>> Yep. Will do. Okay.
Very quickly the next slide we were asked specifically related to one of the managed care organizations that had sent out a survey. And there were questions whether we should expect other bim cos to be sending out similar surveys. Wanted to help you quickly understand where that survey came from. Properly contractors and bim cos are required to be assessed be iour external quality review organization. Which is currently I pro. That's outlined in the act that's listed there from 1997 through CMS. As part of the review process, (indistinct) partial compliant in the areas listed there on the screen. When on organization is not found to be fully compliant, they need the submit what is a quality improvement plan or a quip. To address those areas that are listed there. And what they decided is part of their improvement plan they decided that doing this survey was a means of collecting data to help them address some of these deficiencies. The fact they did a survey was a choice that care lawn made. We don't dictate what those improvement plans need to look like. Or how they would address deficiencies. This was their choice. They determined that a survey was the best way to do that. If you are interested in learning more about this report that I prodoes in terms of you know assessing imminus, it is publicly available. And we put the link there on the slide for you to take a look at. Hopefully that clears things up about where that survey was coming from. And why it was done. There won't necessarily be one comes out for every bim co.
>> KYLE FISHER: Is that being shared with OMHSAS?
>> I don't know the answer to that question. I would guess they would probably publicize the results of the survey. Typically that's that what happens when you do a survey like that. I don't know for certain. We'll get back to you.
>> KYLE FISHER:. Thank you.
>> Sure. Sorry. I'm taking a quick note there. You can go ahead and flip to the next. One more. There we go. This is an FIY slide more than anything. I'm not going to read it to you. It was letting this subcommittee know about how OMHSAS is providing some financial support to address the workforce challenges. There's different funding opportunities that went tout to several different provider types. There's also as you see towards the bottom of the list some dollars that went for peer training and certification. And then some dollars that were allocated for telehealth equipment. And that was targeted specifically at smaller providers that may have more financial difficulty obtaining HIPAA compliant software and tools necessary to properly conduct telehealth services. So that was just an FYI more than anything.
And the last slide I have for you I believe last year around this time we reported

or maybe it was just in the last meeting we had reported to you around the number of complaints and grieveances. This is just an update to that. You see it's through November. So the numbers will likely go up slightly once why get information in from December. But there you see broken down by bim co the total at this point stands at 2, 121 complaints and grievances. The total last calendar year was 2, 244. We are in a pretty similar stated. We are under that at this point. But like I said, that's the data through November. It probably will go slightly.
>> KYLE FISHER: This is hopefully. Thank you for circling back to this item. I think it would be useful if you can distinction between complaints and grievances. And on the complaint side any that are related to access issues. We had focused on that as a proxy in the past.
>> I think last year we broke them out by access versus quality. So we can look to do that again for you with this particular data set here.
>> KYLE FISHER: Okay.
>> Yep.
>> KYLE FISHER: Thank you for going through all these slides. I think we can pause briefly if any of the consumers have questions. Otherwise I think you might be off the hook. (Laughter). Consumers? Anyone else? Thank you so much for your time.
>> Yeah.
>> MINTA LIVENGOOD: She can move on. (Laughter).
>> KYLE FISHER: You are free to go. We do appreciate the time. We'll try to have you back before 7 months next time. (Laughter).
>> Okay. Thanks everybody. (Laughter).
>> KYLE FISHER: I think we are short enough on time that it makes sense that we don't get to the last thing. I'm not sure who is presenting. I think the remainder of the time we can use for OLTL.

- **OLTL Report**
  - **Annual Waiver Redeterminations**
  - **Appeal Reporting**
  - **CHC Employment Supports**

>> JULIET MARSALA: We do have me, Juliette. Before I get started I'll try to be mindful of the time. If we can go to the next slide. There's our agenda for today. I'll walk through it. We'll hit each of the points. Procurement updates. We are not allowed to state any specific to the community health choices. Or agency with choice. (Indistinct) broker contract is on the awarded status. The contract by

maximus it is retro to 2024. (Indistinct). It is still in the process with the state. It's not 100 percent (indistinct). We are well on our way. And the (indistinct) will be working with maximus to implement the purpose ends (audio distortion). (Indistinct). That worked is to begin now that it has been officially awarded. If it we go to the next slide. I wanted to take a minute to (audio distortion) (indistinct). All our stakeholders and our providers and our partners. (Audio distortion) (indistinct). I announce this next update. So the office of long term living for our waiver programs are required to submit an evidence based review final report to our CMS prior to the timeline of our next labor (indistinct). The labor will be renewing January 21, 2025. There's a lot of work that going up to that renewal application that the OLTL team will be dead waited to. In laying the groundwork is submitting a review report. Recording out the findings and all the waiver assurances of the community health choices team. This requires a lot of team collaboration. A lot of data collection. And analysis. Requesting of reports from the MCOs. (Indistinct) to meet the CMS assurances within the program. We received the findings from CMS. It was unprecedented for the office of long term living was that CMS found that we were compliant in all of the 6 categories of the final report. Which includes the administrative authority and a level of care. Having qualified providers. The service planning health and welfare participants in the compute health choices. And our financial accountability. Ensuring that we are sound stewards of every dollar spent. Also that we have a budget neutrality. The report found we were in compliance with all 6 categories without any comments or needs or recommendations for improvement. This is never achieved with an OLTL prior. It it's pretty unprecedented for this program. I want to take this moment to share this moment of the OLTL team. And also to recognize this can't be done without all our stakeholders partnerships in hand. And providing service delivering partners as well. Very excited on the next slide here.

A workgroup that OLTL has convened with stakeholders. We tackle big topics within OLTL. This a pilot model of the workgroup we have convened. We can convened that (indistinct) self directored service models over the years. The participant direct model has seen significant reductions in the number of individuals within community health places. (Indistinct) as their model of choice. It is the most flexible model. For personal attended services. (Indistinct) to what is happening here. And so in order to address that and dive into the issue, we convene that participant more clearly. (Indistinct) approximately 40 people. Different stakeholders coming together. We can look at the issue and understand the issues. From multiple vantage points. (Indistinct) we can really

work into the weeds of understanding root causes and potential recommendations. So 40 people consisting of direct care workers, common law employers, which could be the participant. Or be the participants legal representative. The state staff. That are part of this workgroup on the state staff side. Michael is our bureau direct of the services that is leading these efforts. We have members that represent the direct care workers that is also kind of in partnership with the training piece. We have the vendor for financial management services and followups. We manage care organizations are involved. The workgroup will be sending out a survey. Participants and (indistinct) to a larger group so that we can get even more input and information data on what the certain state is. What any barriers are. Thoughts and preferences and things of that nature. The workgroup is also doing journey mapping. To the human center design process. To walk through the operational process and the participants experience with participant direct services and the experience when rolling in participant direct services. And through that through the process of the person's journey and what they might experience and different steps along the way we hope that will provide some learnings that we can kind of work on and put into an OLTL action plan. Once that concludes which we hope is by the end of March, this is not planned to be long term, we hope to be able present a summary of those findings from that workgroup. And kind of build that road map of what we can prioritize and what we can impact and what is sort of operational timeline would look like. Pause there to see if there's any questions.
>> KYLE FISHER: I don't think so. Thank you.
>> JULIET MARSALA: Going to the next topic. A very important topic. We discussed the questions we received with regards to the annual labor determinations. I may be pulling on my OLTL team members as well. I will present this high level of information and see if there's additional questions. For nursing facility and enjoyable terms from October to December. Here are the numbers of individuals that had a determination and was found nursing facility ineligible.
(Reading.)
And December 509. So that's our last quarter. The total number of NFI determinations for 2023, this does include this. (Reading.) That's kind of when the data collection started it's 8,786. That was a very significant manual process at this point. We have currently possible to have a much better data reporting process on a multiple basis moving forward. OLTL is working to determine how NFI determinations were overturned by a new assessment. My team is still

working to gather that information. We certainly will be prepared to (indistinct) future date once we are in the data review. We also requested to provide if we go to the next slide sample language that is being provided to explain why another assessment is required. There is concerns related to how the process is being explained. So here is a sample of what a participant might receive with regards to an outreach cause. The step in the example is the reason I am calling is to set up a time for me/an assessor to come out to your home to complete a few functional assessment. A new assessment is needed to determine if you continue to qualify for your services under community health choices. (Reading.) So that is a sample language of what an assessor would utilize when they are doing outreach to schedule someone's redetermination assessment.
>> KYLE FISHER: If I can jump in. I'm encouraged to see the script language. We have shareD and seen letters from at least one county aging office in this context where language along these lines was not used. It was language from a new application context that didn't really fit. (Indistinct). Is there template notices they have developed for the office to use as well? That uses language along these lines?
>> I know we working with them for improvements. (Indistinct) there's additional focus on work on new initiatives that can come out of that. I don't know if Randy was able to join us. He's not listed as a panelist. I'm not sure sure if he was able to join. We can see if he is. On the call. He can certainly provide additional context to the details. Otherwise I can certainly have him follow up with this.
>> I am seeing Randy is here.
>> Randy came over to my office he can speak to it
>> RANDY NOLEN: This is Randy. What is the question again?
>> The question is with regard to aging well and templates for written notifications you know are we working with aging well to evaluate and update the written templates that may be more assigned with the sample language that we have provided that we be relayed by a phone call?
>> We are working with the agent to make sure the templates have enough information. So we are working with them on that.
>> KYLE FISHER: Just the context for this and I think we are pleased to see this script to be used when as our context here just because I don't know we have focus on it, for individuals who's assessment from the plan is found to be NFI with (indistinct) form is not returned for them, agent (indistinct) has been doing new assessments. This is in the context of the aging office to reach out to the individuals. Doing this prior (indistinct). We have seen at least one instance here and this is a letter, where the letter reads: we have received a referral. We

haven't been able to reach you. If you don't respond your application for (indistinct) funded long term living services will be withdrawn. Which means you have to reply for services. Clearly this is something they have repurposed. The context doesn't apply to somebody that's receives these services. There's no reference to this. So it sounds like you are developing a template notice that the aging office can use in this context to people are not getting this confused.
>> RANDY NOLEN: When they are out there doing the feds there's 4 possible outcomes. Services continue as they are. They do the fed and it comes back at NFI. They have letters going to individuals. We have had a handful of people that haven't had the assessment done. And the fourth outcome is the number -- the (indistinct) are not able to reach. They did before I knew if they were SENDing that letter out they just referenced. I told them to put a hold on people they can't reach. To reach out to those participants to confirm and explain to the participant why the new fed needs to be done. To get appropriate contact information from the person. So the triple A can contact them. We are working on that process. It's something we started new that came to my attention at the end of the last week. So we are working on it right now.
>> KYLE FISHER: That's helpful. Thank you. I guess we are going back to the data. Juliette thank you for presenting the slide before. I think last month you presented some break down from (indistinct). Is that information you have for the -- it's the 500 cases or so from December?
>> I can ask my team to see if they can get that to you.
>> We actually have. I got an update yesterday and that's the file I'm working off for the time period from December to January. Once I finalize that I will share that with Juliette and we can share with the group. The numbers have gone down significantly.
>> KYLE FISHER: Okay. Good to hear. Consumers (indistinct) or others have questions on this before we go to the next slide? Okay.
Sounds like we don't. We have short on time. Whatever you have next, thank you.
>> Great. We are going to transition to the appeal reporting. Reporting out information with regards to appeals. At this time OLTL has no category specific to grievances or external reviews which are rejected or dismissed by the CHC-MCO's due to timeliness requirements. (Reading.)
Just in case Randy doesn't hear me, Randy don't leave the office just yet. We have and will take the suggestion that this is a specific occur to add for consideration in the 2025 agreement we are looking to update those reports in the different elements that go into getting that data in there category added. So

for dismissed or rejected external reviews, the requester work with the Pennsylvania insurance department. This is due to the office of long term -- they are not part of the insurance departments external review and notification process. We want to insure that folks were aware of the correct place to go for that specific information. Randy, is there anything you want to add to the PR reporting?
>> No, I think you covered it with the slide here.
>> KYLE FISHER: I appreciate you taking the consideration back. And one area and I will add this is broader than just external reviews that have been dismissed. A grievance (indistinct) the difficulty from the consumer side is when they are filing often by a felon it seems like the managed care plan is processing it. What we have discovered and this is reoccurred over the years not often in (indistinct), but often enough we want to raise again, is a plan dismissing that appeal after the fact. If the plan argues the appeal is not timely, or the person didn't have adequate authority to file it on their behalf, the participant should have an opportunity to respond to that. The suggestion around a template form in part was to increase transparency here. Something the plans can report back OLTL. Or OMAP. Some record here of how often it's happening. And whether it's appropriate. Does that make sense? Are there questions about that?
>> JULIET MARSALA: Certainly. It does make sense. So we'll include that in the internal evaluations for the future.
>> KYLE FISHER: Thank you for that. If we see more individual instances where it makes sense to raise them to illustrate this issue we'll do that as well.
>> Yes. Please. If there are examples that they are -- that don't hold back from sending them in, Randy's e-mail is (indistinct). Please raise nose issues. That was part of the due process. There is an issue. To be made aware. All right. So moving on to community health choices and employment supports. As I have mentioned before, employment for people with disabilities is incredibly important to me. It's part of my background. There were some questions and concerns raised. Which are certainly shared. So when a participant is referred to the office of (indistinct) rehabilitation and (indistinct) and assistance program. What is CHCs (indistinct)? There's no shared data process available today. Where by they can integrate the data. (Indistinct) for a variety of both technical and legal reasons. And because of that there isn't the transfer of data regarding if someone is an OVR. And if someone is a participant and connecting both of them. They might not be fully aware the participant having active involvement with this. Unless the participant chooses to make them aware of that. And have the MCO have it included to this. However in an ideal world we hope that the

participant would choose to share that so that there's an active employment goal on the person's center support plan. And things can be integrated. OVR is a great partner to DHS. In addition to OLTL. We have been having meetings to look at how we improve that connection with regards to the coordinators and the OVR programs of how available it is to have those connections in place. We are looking how we address that from what resources we can use to address that and potential innovations in that space.
>> KYLE FISHER: And provide you had so little time. And you had slides from the December meeting that we did not get to today. I think we had a member of the subcommittee with a question about the last topic we wanted to raise it before we close. Are you unmuted?
>> RONEL BACCUS: Yes, I am. My question is because I have been putting in grievances since October. No notice. Nothing about a hearing. And regarding with the service. Especially with the service coordinator. Getting advocacy. No comment. No nothing. They point my service coordinator now. We don't have that choice. I filed a grievance. And nothing happened. There is 15 grievances since today.
>> KYLE FISHER: Grievances or complaints?
>> Yes.
>> What I'm going to ask if you can Randy can connect so key can get the additional details so we can follow up with the (indistinct). And the grievances. But most importantly insure you get the support that you need to worth having the grievance process all and through in the way it should be to really insure have access to all your rights.
>> Yes, I have been out of the service coordinator since June.
>> You haven't had a service coordinator since June?
>> Correct.
>> One thing I want to clarify with regards to service coordination choice you should absolutely have a choice of service coordinators that align with your preferences and goals. This is concerning to me. And this is concerning to Randy as well. Kyle, if we can insure connections are made we'll make sure there's immediate follow up.
>> KYLE FISHER:. Okay. Thank you. I'm glad you had a chance to put that out there. I think we have hit the 3:00 hour. Do you have -- are we okay to close?
>> Yes, we are. We have a motion adjourned.
>> KYLE FISHER: Before we do that can you continue the conversation in the next meeting?
>> I would request to be considered earlier in the agenda. (Laughter).

>> KYLE FISHER: Understand. Correct. (Laughter). Third times a charm hopefully.
>> This is Liz and I wonder if we should think about reordering the agenda next meeting so we make sure we have time for these things we had time to push back.
>> KYLE FISHER: And can see why you would suggest that.
>> And I like to make the notion or second the notion adjourn.
>> All in favor?
>> I.
>> We'll see you next month.
>> KYLE FISHER: Thank you, all. Thanks.

Chat

Guest: Are there any updates on either MATP or Human Services Transportation Study which PA DHS participated in? Thanks.