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DATE: February 5, 2020

EVENT: Managed Long-Term Services and Supports Meeting

>> Barbara Polzer: Good morning, everybody. We will get started. Can we start with the board members introducing themselves? Blair, would you like to start please.

>> You united healthcare. [introductions]

>> Would the board members on the phone please identify themselves.

[introductions]

>> Barbara Polzer: Any other committee members?

[introductions]

>> Barbara Polzer: Thank you, Rich, thank you Neil.

Any other committee members? I will start with housekeeping. Please keep your language professional. Please direct your comments to the chairman and wait until called upon and limit your comments to 2 minutes. The meeting minutes are posted on the list serve under meeting minutes within a few days of meeting. We are being recorded today so please speak clearly and slowly and the meeting is also being captioned. The meeting schedule ends at 1. We must end promptly at that time. If you have any questions or comments that weren't heard please send them to the resource account and the E-mail address is listed on your agenda.

We must keep the exit aisles open. Please do not block them. Please turn off your cell phones and when leaving throw away your empty, cups, bottles and wrappers. We take public comments throughout the meeting. We always refer have a 15 minute at the end for comments.

The meeting dates are available on the DHS website with that I will turn it over to Linda Litton for emergency evacuation.

>> Linda Litton: In the event of an emergency or evacuation we will proceed to the assembly area in the west of the Zion church at fourth and market. If you require assistance to a evacuate you must go to the safe area located right outside the main doors. OLTL will be with you until you are told you may go back into the honor's suit or evacuated. Everyone must exit the building tell me take your belongings with you. Do not operate your cell phones. Do not try to use the elevators. They will be locked down. We will use stair 1 and stair 2 to exit the building. For stair 1 exit honors suit through the main doors on the left side near the elevator, turn right and go down the hallway by the water fountain.

Stair 1 is on the left. For stair 2, exit the honors suit through the side doors on the right side of the room or the back doors.

Those of you using the side door go out the right door, make a left and stairway 2 is right in front of you. Exiting from the back of the room go out, make a left, make another left and stairway 2 is in front of you again.

Keep to the inside of the stairwell, merge to the outside, turn left, walk down the alley to Chestnut Street. Turn left on fourth left. And cross fourth street to the train station. Thank you very much.

>> Barbara Polzer: Thank you, Linda. Before I turn it over to Jill for the OLTL update I would like to take some time to acknowledge that this is possibly the last time we are going to be seeing Marilyn. She is slate today retire April 3. I have to personally say I am so grateful for all of the support you have given me. The very first time I walked in the door as a member you were gracious, professional and I am going to miss you

[applause]

>> Marilyn will be replaced by Paula. I don't want to butcher your last name because I am not quite sure. Thank you, we look forward to working with you. With that I will turn it over to Jill.

>> Jill: Good morning, everyone. Today's agenda for the CHC update is to review our phase 3 implementation update, give you an update on enrollment and provide some monitoring report updates around service denials. A full monitoring report update has been provided in a separate document, but we will be touching on some highlights.

So just a reminder for folks our priorities through implementation have always been to ensure that we have no interruption of services to participants and no interruption to provider payments. We have taken multiple steps to ensure that we are on top of any distractions to those 2 items. So we do have launch indicators and you may recall that from phase 1 and phase 2 we have launch indicator reports. Those are reports based off of information that we gather from our managed care organizations during that first month of implementation in a particular phase.

They do not replace the operations reports. We have regular, ongoing quality management and operation monitoring reports. Randy and his team for the first couple of weeks of January held daily managed care organization meetings. They were held every meeting and touched on type of calls, amounts of calls that they were receiving from participants and providers. Any pertinent issues with claims payment or data exchange or service plans.

So Randy and his team the were on daily contact with each one of the managed care organizations. So our phase 3 plan selection, I would really like to highlight and I think Kevin probably highlighted this last time, we in Pennsylvania have surpassed national benchmarks for plan selection. what you have on the screen is for the northeast. You can see that 41.4% of our population selected a plan. And you can see that the population brackets are broken down for you. The goals have been traditionally the ones make being those choices most frequently. We are really proud of the selection rate it. shows a lot about how engaged our population in Pennsylvania is and how our communication strategy reached out to folks and really helped them make those plan selections.

The next slide you will see the selection rate from the northwest. 50.6% of that population had a plan selection. That is just amazing. I love it. Half of the individuals did make a plan selection. And Lehigh, that is the largest of the zones in phase 3, 40.2%. So something very much to be proud of in Pennsylvania that our participants are making a choice and we will be helping them provide their care.

So this is a breakdown of the phase 3 population as a whole. Then where we landed with who is in which MCO. So you can see total basic population. That is all zones. We ended up very close with AmeriHealth 37.3. UPMC36.1% and PA health and well under 26.6% of the population. And just a refresher there were 144,000 plus participants in phase 3 in all 3 zones.

So we want to take a moment to look at life enrollment. We had nice enrollment for the life program. The chart shows a steady increase. So the life program enrollment grew by 166 participants. Phase 3. 375 participants statewide.

You can see the increase. It clearly is for phase 3, it grew 11.6% and statewide by .42%.

Any questions?

>> AUDIENCE MEMBER: During this time period were there any counties that did not have life programs?

>> Jill: I can't see the counties for you. Maybe Randy can help. We can do a map for next time if you would like

>> Randy: We awarded those in the last 3 months we will be bringing those up. We will bring them back next month. It shows you what counties have a life program or have -- or will have a life program in the next year or so and what life providers are responsible for those counties so we can provide that to you.

>> Jill: Ultimately I am not sure if data would include --

>> Randy: These programs are not up and running. We just awarded the counties. The programs have to be

>> I'm wondering about the data transfer. I just have someone that comes at me. The struggle for just my mom who is a participant and has been a participant for 10, 15 years has been bad. So what is the data transfer, are the service plans getting connected? Is that straightened out? Is it just me? Am I the only one the one person not able to get services requested before January 1, still not getting them now, not knowing -- not even having contact with the MCO or service coordinator. I am in contact with the local service coordinator. They are doing everything they can. Are you getting more calls on that? Do people know what to do if there is a problem? Are you understanding my question. I'm struggling with lack of sleep because the issue has been asking for an increase in hours to cover for my mom at home and getting no response anyway. And then not knowing what she has a right to. I have all of the great packets. I am calling the places.

>> Misty: The roll out in region 3 did not -- [inaudible] to contact them MCOs and ultimately fix the plan. We still are limited in some cases have no access to the consumers we serve. We have an overflow of individuals like Pam's mom who are

without getting changes. We have been working with MCOs and talk to go them for 2 years prior to this. So I am very disappointed as a partner in this game that we're not able to help Pam's mom and many others in the situation. Our hands are literally tied because we are told by the MCO that we don't have access. The data dump didn't convert. So we are not in the system. Our consumers are not linked to us. What do we do?

>> We are still getting calls from people saying who is my service coordinator. At least on a daily basis 2 or 3 calls. We are trying to -- they need to know who do you want me to call? I call people, this person is calling me who doesn't know who their service coordinator is. Who do we contact?

>> However the managed care organization is.

>> They have no clue where to start. I tell them what do you get in the mail that kind of stuff.

>> Okay. They be the next step for providers who should be using the eligibility verification system to identify through the managed care organization it is individual. Go to the managed care organization. That managed care organization should be, you know, identifying who the service coordinator is and coordinating with the service coordinator to make sure that there are plans in place, the services are in place. And correct me if I am wrong, I haven't been hearing that they are outside of a couple of cases that were missed during the initial data exchange for the service plan. I haven't been hearing that we have problems with folks not having service coordinators not having service plans.

>> There have been some issues with HHA just like in the first 2 phases. It is not because lessons were not learned. It is because the data is not always the best that we have. And we worked really hard in phase 3 to clean up the data. There are still some issues. We talked about the amount of transfer that we had to do.

The MCOs should be able to work with you on that and you should be able to talk to your account managers and MCOs and work those situations out. If you are not getting resolve you can come into the provider hotline, you can come into me and I will work with the MCOs to resolve the issues going on. Where you have consumers that don't know which MCO they are with an they can't identify because they don't have access to the packet in their ID card, certainly you can call into the hot line and we can look those consumers up and figure out which MCO they belong to or enrolled with. The participant hot line can assist with that also.

>> Specifically, Pam, for your situation, if you want to speak to us after.

>> Which MRO are you working with?

>> I want to tell them my experience from calling. I did call as a representative of the participant and had some not so great experiences as well. I want them to know. If I still have trouble -- I am saying this far out in January and still getting no idea. They really are working hard. I am still trying to figure it out. I will talk the MCO and make sure I do that before I come in here.

>> You do not know your MCO?

>> The MCOs are here today. Talk to them today. But with situations going on if you are having issues talk to the MCOs. You can get the information from HHA and the authorization. Just know that the authorization should continue to provide services and pay for it. We will work through whatever issues are that you are not seeing authorization. Continue to provide the services. That's first and for most. We will work through the issues to make sure everything is cleaned up. The MCOs are commit today this and the department is committed to this. If you work with the MCO and you don't get the response you think you need, let us know and we will further the discussion.

>> We started to do that process. We are managing across the board weekly -- several times a week if we don't get the authorization we need, a lot of PPL consumer model started in January have not gotten paychecks they will not clock in.

>> That's a little bit of a different issue on the PPL side we did identify system issues with them. They work -- to my knowledge they have corrected the system issues if you are still seeing that workers are not getting paid you can certainly let us know and we will look into it. We had those discussion was PPL. They tell us that they corrected everything in the system and got back payment done. If you are still finding issues with that you can let us know.

>> The last comment I want to make is when we are out to the MCOs the time frame to expect a response. We want to do it as quick as possible for the participant. We are being told as soon as possible in a timely manner, as soon as we can. We are in the given any deadline, so we are having a hard time getting quick responses from the MCOs. There's been a big backlash right now. Like Pam was saying there are a lot of people in that situation. Quite a few up to this date.

But if we could get some time frames that we can expect that they will make changes in the plans, that would help.

>> How prevalent is the problem?

>> So how prevalent is the problem?

>> I would say we have over 1000 and we have probably a hundred people who are in a situation where they can't get changes quickly. Many people haven't had a change. Of those who need a need, quite a few haven't been able to get it resolved and a quick response.

>> I am going to put the MCOs on the spot right now. AmeriHealth, what is your response?

>> If it is urgent within 24 hours. If not urgent within 3 weeks. I am happy to meet with anyone if you are experiencing those challenges? You have to use the mic so the transcriber can hear you for the people behind me so the people behind me yell at me anymore.

>> If it is urgent our response should be within 24 hours. If it is not urgent it should be within 48. So I am happy to meet with anyone after the meeting if you are experiencing any of the challenges.

>> Thanks.

>> 24 hours for urgent. 48 hours if it is not urgent. I'm happy to meet with you afterwards if you are experiencing problems with our staff.

>> UPMC?

>> We have the same for urgent as well as general response of 48 hours. But then I would be happy to talk to you about specific issues as well.

>> Thank you, that's very helpful.

>> Barbara Polzer: Any other questions before we move on to the monitoring report?

>> I hate to be a negative Nancy, but it is a concern that they were bringing up even if they don't know who their MCO is, what does that say about your data? Is it

>> Well, the participants don't know. We just reviewed the selection rate. I know that statewide over 40% of the population chose their own plan. The MCOs are responsible for sending out packets. Prior to that when they make the selection, the enrollment send out a packet confirming the selection or the auto assignment and the MCO send out the membership cards et cetera.

So if a participant does not know who their MCO is they can always call OLTL as they have done in the past the participant line. I think what they are talking about with the data exchange specific to the service plan, information and the authorization through HHA exchange. And we are going to have to work through those issues.

>> What I am saying without reading that even individuals that did pick an MCO randomly pick one they can't [inaudible]

>> I wouldn't make that assumption at all. Um assuming that the individuals who made an accurate choice made an educated choice. There was counseling available. We had all of those participants face to face meetings, extensive outreach by existing service coordinators to participants to help educate them on how to make a choice. I wouldn't assume they were uneducated choices. In my opinion.

>> Sure.

>> I have a comment. I have a comment.

>> [beeping]

>> There is a comment that came through the phone. Can you please remind participants and their representatives to file complaints with the MCO to file complaint. The date tracks those complaints and that information is helpful to track problems.

>> That is 100% correct. That is the basic way to go back to their MCOs and work with them. We do track those and resolve those as necessary.

>> Barbara Polzer: Any other questions?

>> Is there always a service plan? So whether I pick an MCO or I am assigned one, am I supposed to be contacted by a service coordinator and the plan is put together?

>> The service plans are for individuals that have been determined to be nursing home facility clinically eligible. We have a large percentage of the population that is a nursing facility ineligible. They would not have a service plan or a service coordinator but they are contacted within is it 3 days? The first 3 days there is an assessment that is done over the phone typically to make sure that there is no unmet needs for an individual that haven't been nursing foam facility clinically eligible. For those in existing service plans are an individual that are home and community-based participants. Dual or non-dual that have a determination of nurseing facility clinically eligible. That service plan is supposed to be transferred from the department to the MCO and the MCOs transfer that information to HHA exchange. That handles service authorization.

>> So after that transfer takes place, if the consumer doesn't know who their FC, is it the FC's responsibility to reach out to them? Is it the consumer's responsibility to reach out and find out who their FC. Is there a time frame when the FC contact consumers?

>> The FC is the current FC that they had prior to transition to community health choices. And if for some reason that service coordinator was not going to continue to provide services they did notify us, the department, and the managed care organization. In those instances the managed care organization reached out to the participant to let them know, hey, your service coordinator has identified that they will not be continuing to provide services. We are going to help you select a service coordinator. And provide information about future contact to do that.

>> There are a fair number of people that don't know who their MCO is for whatever reason. And there are a fair number of people that are not necessarily being contacted by their MCO or anyone else regarding the services they are eligible for. That's sort of what I am hearing a little bit. I don't know the police. But there are a number of people in that category.

>> I don't know the scope of this. And we will ask our managed care organizations to ensure that they have contacted every single participant. It is an agreement requirement for managed care organizations to send the membership materials and identification cards within 5 days of the effective date. There is also a requirement to do outreach for nursing facility ineligible folks to identify any

potential gap in care and there is a requirement for them to do a home assessment for those individuals that have current service plans.

So I am not clear on how many individuals may not have been contacted by our managed care organizations but we can definitely follow up and make sure that the managed care organizations have done outreach to every single one of their members.

>> All 3 plans are here. In their Q&A section they can address that. What is the required time frame for them to do that assessment after the January 1 implementation for the contract?

>> For existing plans?

>> If an individual is nursing facility clinically eligible Jill mentioned there is a required home assessment. What is the time frame by which someone should have heard to do that home assessment.

>> For all of the participants in the program it is within 15 days of the MCOs knowing that is their participant. For the legacy plan throughout continuity of care period they will not do the assessment until the continuity of care period. They should reach out on a regular basis with consumers. There is time frame how often the FC should have contact face to face and over the phone. So there are regulations about that also.

>> I have a couple of comments. I would like to know from the MCOs if they do indeed have transportation set up throughout each zone. And then my second question was already answered as to who holds everybody's feet to the fire to make sure they are complying with each of their agreements.

>> You want them to answer that now or during their open session a little bit later on?

>> I would like to get answers now.

>> AmeriHealth?

>> And the difference between medical versus non-medical.

>> For medical they will [inaudible] we are contracted with transportation for non-medical, non-urgent throughout all of phase 3. We actually have a network report

that our MCOs all 3 [inaudible] the second part of the question is we are held accountable by OLTL and it is a report that is submitted and reviewed on a continual basis by OLTL.

>> Thank you.

>> Sure.

>> Wo also have a contract with MTM. They are a transportation bill. They have contact with the riders throughout all counties throughout the state. What was the other part of the question? We are held accountable to the state. A lot of reports as Jill started talking about there are launch indicates. There is a lot of oversight. We have daily calls with Randy to tell him where we are. A tremendous amount of monitoring.

>> I did have another part of the question. So the first MCO might want to come back to the table. What about somebody who is like myself wheelchair dependent. Say I get taken to the hospital on a stretcher. But I need to come home in my chair for some reason. There seems to be a difference in how stretchers are handled versus whole chairs. They don't seem to count them in the same respect.

>> That would have been a nursing situation medical transport between medical transportation provided. Then returning home would likely be through us through the managed care provider which we contact with MCM they would contract with a transportation provider in Philadelphia that would take you home.

>> Thank you.

>> So it would be handled differently.

>> Thank you.

>> For UPMC we contract with coordinated transportation solutions which is also a vendor that handles all of our transportation. They are fully [inaudible] continually building that. There are non-medical non-emergent transportation has not changed unless there is an exception we need to review. Any of the non-medical social transportation like that is going through the service coordinator on the service plan to get coordinated. The example that you stated I agree exactly. I am assuming when you went to the hospital it would have been an emergency trip. Then coming home your service coordinator can also be involved to get that transportation so we know it is getting coordinated appropriately.

>> Thank you.

>> Clarification to the last question, I think the question was she was taken by stretcher to the hospital. Her wheelchair is in her apartment. Coming back to her apartment if she needs a wheelchair to get there. That is part of your question.

>> I think Linda what you just brought up we are brainstorming with. What has come to light as lessoned learned is we are understanding that we have a stretcher definition. Let's just say you take yourself to the emergency room and you use your power chair and you are admitted, your transportation will get you home. The power chair which could be 400 pounds how do we get that home? That is an issue that has been brought to us because of the weight of some of the chairs. So we are trying to brainstorm to try to see how if the community becomes separated from the chair how do we get the chair home? Because the transportation is taking you. We run into the same situation say they were at a day program. They had an emergency then and the ambulance took them. But their chair is still at the day program because of the weight of the chair and fending on how long it has sat there the battery could have died. So we can't even power it up to get it on to a van. So we are trying to brainstorm in those situations coming up because it is not built into the transportation but we realize that we have to come up with a solution for it.

>> most wheelchairs do have clutches that you can pop and push it is a heavy push.

>> What are you doing now?

>> We are trying to use 2 men and a truck. We are trying to use a moving van, a truck, someone that can go to the day program that can help get the chair on. We did face an issue where the battery has died. We did get it on to the truck but it did present quite a challenge. So I didn't know about the clutch that is very helpful. Thank you. Again, I think it may become more as an issue moving forward with individuals especially in phase 3 in the more rural areas when they are separated from the chair if they go to the ER or day program, how do we get their transportation. Wither looking for contracts

>> William: You can get in contact with the social worker at the social. Whether or not they are aware I don't know. They would be your best bet for the first contact. They can get heat hold of transportation for you.

>> Linda: Thank you.

>> The center for independent living, we have historically done that as a rescue service for people to leave their chair. We eat that cost. So I think this is a way that MCOs could partner with the local centers for independent living. Also from an experience base and I deal with this frequently. Social workers at the hospital they don't know what to do. If they know about voices for independence or center for independent living they will call us to help anyway. That's how we got started helping people in the first place.

You have many partners in the independent living centers throughout Pennsylvania that's a great way to get that need met that maybe you haven't explored.

>> That's great.

>> Less eye?

>> We call it that. I look at it like the chair is that person's arms and legs and even if we know they are being transport today the hospital we know they are being transport today the hospital. As soon as we transport them to the hospital we get their chair for them. As a wheelchair user myself even if I am sick an can't get in my chair the idea that I don't have my chair creates more anxiety.

If you can see your chair and know if you had to get in that you could, it helps you heal. Also

My husband is a ventilator. When he is recovering, they can't put him in a chair. It goes way up and way down an they are not even. As soon as they put him in a chair that was fitted for him they are normal. So they then don't look at making more medical problems for something like a gal gladder. He was out of what can. They think he has a respiratory issue. They really don't. It is about positioning. It is a barrier for some people when they are in the hospital if they are not in the whole chair. We find immediately if we are aware to get it to them.

>> That's great thank you. That is a beauty of having committee meeting. Honestly it never came to mind. That is great. Thank you.

>> I agree. I just want to say so it sound like the rescue service was available in the future service system. You came up with a service. We need to see how MCO can partner with you to make it a real solution. I think the issue hire from my perspective this is a work in progress. We are learning how to do it. Your input and your questions are really helpful for us to get at issues that weren't even

contemplated at the beginning of developing -- it was not thought of what happens when a wheelchair is left behind. I think that is really helpful, thank you, Linda.

>> Do the hospitals have accountability. I like the analogy. Your wheelchair is your leg. Will the hospital sent you home without your legs? No. I know it is a weird analogy. Does the hospital have any accountability if you show up in a hospital and you are bound to that wheelchair.

>> You are in bed the whole time you are hospitalized because they won't get you up into a regular chair because they have no way of putting you back into the bed unless they have lifts available at the time.

>> It is also an issue I don't think hospitals take it seriously. They can go get the chair. They are going to do everything possible to not be responsible.

>> Can I ask a question about the transportation brokers. When somebody is in a county where there are perhaps more than one provider does the client have choice into which provider the transportation worker assigns them to? We have had a number of consumers who used to use one system have now been assign a different transportation provider. I am just wondering do they have a choice to go back and say that is not who I want, I want to use the old person that I was using?

>> The service coordinator can help get involved. They will make every effort to do that. It is not a guarantee. We have to make sure they have people available. They will make every effort to use the chosen provider.

>> There was one large system that did make a decision to not contract with any of the MCOs. So our brokers have been -- [inaudible] it is not an option we can grant because they simply will not contract with us. As long as it is availability, yes they should have a choice.

>> Are there brokers [inaudible] I am trying to get a non-medical trip across county lines. The ones that they are using the provider they are using, [inaudible]

>> We have to outline the reason for the missed transportation. Was someone not available? Did the driver have a flat on the way? Did we have to do a backup service? All 3 have to report it on the report.

>> Working through the cross-county line stuff. We are getting calls people saying I live Cumberland. Are you working through that? I can't imagine [inaudible]

>> I know we are working through it. We are looking at trends. We have had that example more so in southwest with some of the transportations not run ago cross county. We are just beginning to see if there is a picture in phase 3. We will do the same thing locking into trends our broker would reach out and we would brainstorm about any different types of arrangements contractually.

>> If our providers are not our brokers contact us and we will work with the member if need be and they have it coordinated to make sure they are trying to coordinate it. We are aware of the needs across county lines.

They should be talk took the service coordinators.

>> We spent a lot of advocacy around transportation in the western half of the state. In the northwest the only provider that will cross multiple counties is ATA out of St. Mary. It goes into Clearfield County. There are 3 or 4 different counties that it will cross and go throughout. It is the only provider that I know statewide that does that.

>> Are you talking [inaudible]

>> Non-medical.

>> Non-medical?

>> Non-medical? We have a lot of other options when you look at non-medical to find providers that know that they will go across cross county lines. The answer is they are getting reimbursed for the trips accordingly.

>> It was one that was inherited for many decades. It exists because of structural things with the Department of Transportation. And counties I think CHC offers an opportunity to get solutions around this because of the flexibility that managed care offers.

>> Are you using Uber to back up for some of the cross county

>> That's what I was getting at. We are working diligently to contract them all to do the non-medical. And we have many other solutions and many other provider base that's can do those transports. In general, our transportation provider will see through their list of providers and they have in their database who will and will not cross county lines. So their system is intelligent enough to understand which provider should be an appropriate provider.

>> How to partner with them and see how. The other thing we are doing is trying to create more education pieces about reimbursement to family and friends. We have been meeting with a number of faith-based groups. We are finding through their church their own networks they are trying to provide transportation, so we are trying to find a way to help them be able to get reimbursed to become a provider or mileage reimbursement for family and friends.

>> One follow up question about transportation and Patty' request about the medical if they go across county lines are they saying we cannot go across county lines? You know there are some issues in the northwest. I want to take non-medical transportation off the table. Say for medical transportation you are not hearing that a provider is saying we are not going transport you from Erie to Pittsburgh medical center because that is across county lines. They are not saying that?

>> We have not had that experience. Everyone who seeks medical treatment can get from Erie to Pittsburgh.

>> We had a comments come in over the phone. If the data is tracked can we get a transportation report? I know we had that presented. I am wondering can that be done on a monthly basis or is that unusual?

>> It is going to be on going we intend to -- we have been working through the final report.

>> So quarterly we provide monitoring reports to this group. Right now there are about 85 reports. We do not report it all he here we will exam an example of a denial report. If you look through the meeting documents every quarter we put on something called OPS8 that services report will outline transportation services we talked about today and [inaudible]

>> That is quarterly you said? Thank you.

>> What you were saying at the end the transcriber didn't catch it either.

>> The

>> The report includes missed transportation and it also breaks out when the transportation missed because transportation was unavailable, the participant

refused and the trip was late. It has all of the break outs we provide that quarterly as part of the meeting documents.

>> Rich: We would like to know how many trips are being performed. Pam sort of referenced are people crossing county lines and getting recreation trips? We don't get a sense of what the transportation really looks like.

>> We can take that back.

>> Rich: Thank you.

>> When we talk about what the non-surgerient non-medical looks like, I am not sure if just reporting gross numbers gives an accurate view because you have the difference of the membership side. You might have a core that is very active in the community and say they go to Bingo and here and the supermarket. You may have some participants that are actually making 5 or 6 round trips an then you may have others that they go to church on Sunday.

So we're not sure what type of picture that would be painting. It might be better to kind of define are you trying to identify if there's s a gap? Maybe what we could look at with that. First is the growth numbers without really breaking down all of the differences in the membership by county by their service plans that might be more difficult. I am not sure what kind of picture it will be. One made 50,000 round trips and another $30,000. It doesn't mean one is falling behind. It could be that the membership mix isn't out in the community or they might have more family support providing those services.

>> essence of time can we have Jill finish up her report.

>> Jill: Authorization denial. It includes denial due to decision by the MCOs, the end of temporary increases in voluntary reductions, the chart on the right shows the total number of decisions and those decisions -- an of those how many were denials by plan. Just as a reminder UPMC received approval to Guiness eyes denials in September. AmeriHealth received a approximate in November. P H.W. is not approved to issue dimes at this time. Is that correct? I am reading your notes.

No? Okay.

Call beinglation I would like Randy to confirm that if you could, please. Who is permitted to issue denials. Is everyone permit today issue denials at this time? Okay.

Thank you.

>> Randy: UPMC they can permit denial. They are issuing them. We are working on a backlog of cases that center around home mods. We had a discussion with them last week on trying to finalize that process. And AmeriHealth is allowed to issue denials. At this time we are working with them because there is some concern with their process. We are working with them to ensure that their processes are in place before they are going to start issue denials again there is a collapse for them. In this data that shows for quarter 4 it should be -- for early '19 they were issuing denials at that point.

>> Jill: Thank you for confirmation. Total [inaudible] during the month as you can see for quarter 1 the total decisions the chart is over on the right of the slide. Quarter 3 we had a pit of an uptick for UPMC.

>> Why the uptick? That is a big up tick.

>> UPMC will have to speak to that.

>> Quarter 3 we did [inaudible] they did their care plans.

>> Jill: Physical health prior authorization denials. As you can see for 2019 up through quarter 3 we have a breakdown. You can see that the total denials for physical health went down for quarters 3 for all 3MCOs and your total denial numbers are on the right.

>> Will we hear later about the reason for those denials?

>> Jill: Excuse me if I am wrong it breaks down with reasons for denials is in the complete report. Is that an accurate statement? No? Okay.

>> that's what we have been after for months.

>> Jill: We will take that back. Physical health prior authorization denials. It is broken down for the south east. As you can see we go through quarters 3 here. We had a little bit of a reduction here. The numbers seem to be consistent across quarter 2 and quarter 3.

Pharmacy prior authorization this is for south west. As you can see the numbers are consistent pretty consistent across all 3MCOs and your breakdown is on the right. Again, pharmacy prior authorization denials for the southeast. Again, you can see that there was a little increase for quarter 3 for PHW and quarter 3 we will need to be total denials in that chart. Dental prior authorization --

>> If I read that correctly, 4 in 10 those are drugs requiring prior authorization. 4 out of 10 are denied?

>> I don't believe that's accurate.

>> Or even higher.

>> A lot of times it is because they have other insurance and the pharmacy doesn't bill first. That's where the denials are coming in.

Part D should be paying for it. It is an education issue with the pharmacies to make sure they are willing the proper insurance first. That's why the denials show up.

>> Jill: Dental prior authorizations this chart is for the southwest. Again, you can see pretty consistent numbers across the plans for all 3 quarters. The breakdown is on the right. Then dental for southeast again consist interest across the MCOs across the quarters with the breakdown on the right.

This one is <!0> home and vehicle modifications also with pest eradications. This is a new measure started for January for January of 2019. And you can see that quarter 3 we did have a higher number of denials for P H.W.

>> Is there a possibility of getting that broken down into 3 separate categories?

>> Yes, we can do that.

>> Home mod and vehicle mod. The reason for the increase in P H.W. they were requests for further information as they work with the participants and service coordinators they were not providing the information. So they close out the cases they send out design notices which told the individual if they don't submit the requested paperwork then it will be denied. That's why you see those for

>> Pam's question was why the spike. That is the reason behind it.

>> What is the follow-up with that? [inaudible] is this follow up? What happened do they state all of those as denials when they get the request for information if people get them what they needed; I am just wondering. A lot of confusion with stuff follow up would help people, PA health and wellness question.

>> I don't know if you have the follow-up on those numbers or if we can get the follow-up, I'm not sure what the numbers are.

>> Jill: I don't have the numbers on me we can get them for you. For the most part when people get the letters, they drop it or talk to their service coordinator. We do actively ask service coordinators when they get that notice to make sure they are checking in with the participant to see if they can get the information we need to carry out that. Do you know what other information is needed? Let me take that back and see. I will get back to you at the next meeting.

>> [inaudible] all of that stuff is what she follows up with. That stuff isn't generally missing. Having that one designated person helps that person. We don't have to put that request in that [inaudible] that is the benefit of it. I am just worried about all of those people I don't know what the numbers would be of people. They get a letter and they are not sure what to do with it or getting there and they don't get it. [inaudible]

>> Jill: That is a role of service coordination. That's what we do.

>> We have a home mod advisory committee next month. Maybe we can get more detail and be ready for our meeting next month after that

>> I will put that on the agenda.

>> Any more questions for Jill Randy?

>> For folks with questions how to contact us the RA box is a good place. If you don't know who to contact send it to the RA box the participator lines are also listed on that slide.

>> Mike: I just wanted to ask and make clear about Jill last time we met we talked about informed choice and how the list of service coordinators, the list of service coordinators without any other information isn't really an informed choice.

I just wanted to know what if anything has happened with that number 1, number 2, if there hasn't been anything happening, I would like to see if we -- I don't know what the process is about creating a motion. I would like to do a motion to do something to ensure that a directive comes from OTL requesting that the MCOs work with partnering agencies to ensure that they are providing a list that would allow for participants to make an informed choice.

>> So we do require managed care organizations to provide like you said a list of names. The expectation is that the MCO should be working with that participant to talk through what the individual needs or desires are with the service coordinator and help them make that choice. I don't know that we have required additional information to be listed on the letter that would go to the participant with a list of names. But it is my recollection that we are -- that communication is encouraging the participant to work with the managed care organizations to talk them through that so they can make a choice.

>> I have a question in that regard. Is there any way you can at least list the entity in which the service coordinator works with so that the participate and is able to understand and make a choice based on their history an knowledge of that entity? For instance, centers for independent living do provide a different service they have a staff and board of people with disabilities that can come from lived, learned experiences. I would like that to be part of the information provided so they are able to choose if that is the entity or the service coordinator that they would like.

>> I think the managed care organizations can certainly spoke to this as we get to their open Q&A. But the requirement is for a choice of an individual service coordinator and as you know each one of the MCOs does have a different model for service coordination because service coordination is an administrative function of the managed care organization.

So the department has not required a managed care organization to list the name of an entity. It is about helping the participant in selecting an individual service coordinator. So we can definitely ask the managed care organizations to talk through how they would communicate that to a participant when they are trying to make a selection.

>> Membership is very strong that a list is not an informed choice. A list is a list. It just seems like that there should be an openness to partner with organizations in reference to this. Because if I am a participant of CHC and I get a list, I don't know Jill's name from Misty's name. It doesn't mean anything to me.

However, had it a little more detail that says -- I don't know -- I know that's very cumbersome because people are changing all of the time. I get it. I think we have to do something. I know it is an administrative function. I think we have to do something different to give people choices. Right now the choices are that I like Matt's name better than Mike's name. Of course.

>> I remember last month he wasn't aware it was 2 names. To improve the program. So I guess our question is to the MCO and DHS, is anything being discussed to enhance ended choice?

>> We had discussion to ensure that choice is being provided. I don't know if the MCOs are ready to talk about that today or if it is a topic that we need to discuss with them and have on next month's agenda an have them show the forms will that they are utilizing and how they are notifying people of choice. I don't know how difficult it is to write up little bios. You are talking a lot that goes back and forth.

As Jill said, we require that they provide a list or a choice of service coordinators but not the service coordinator entities. There is a difference in the worded agreement. I don't know if they are ready to talk about this today or something for next month's meeting.

>> As a board if we need to make a motion to ensure that we move this process along to actually give people a choice, informed choice.

>> I'm not sure what motion. The board can put any motion forward that they want to. It is part of the MCO.

>> You have that that the department is working on it.

>> We do officer choice. The choice is related to desires in terms of what they want in a service coordinator. It is not a choice of an agency. It is a choice for example if they want a male or female. They might choose somebody who likes to cook. The consumers or the participants are expressing what they are looking for. They might want an older person. They might want somebody that lives in the neighborhood. It they might want somebody that speaks Spain. Those are the choices that we are offering because it is an administrative function of the MCOs.

>> I recall from last month's meeting discussion about what Michael was raising about informed choice. And sting up where [inaudible] the ambition for plans especially that have most of their service coordinators internal. Informed choice means who are they choosing.

So how do you make informed choice an how do consumers find out about all of the different things that she is describing? It language preference, if service coordinators we hope have disabilities, making sure that that's stated. I think there is an implementation issue how that gets conveyed. In the next month I know that health law project an folks from my staff are interested in it collecting and giving some consumer input about that. We are not holding ourselves out to say we are exclusive on the consumer input we are interested in getting to the thing that Michael is raising what does informed choice look like in Pennsylvania and how can it get implemented by the plans when a consumer wants to choose someone else within the administrative entity structure of the CHC.

>> Are you

>> I would like to hear the consumer input. It would help to solve the problem we are solving.

>> It is beyond service coordination frankly to provider agencies an understanding. This is alphabetical. It doesn't tell necessary anything if I am new coming into the system and I don't know who to turn to. So along with service coordination which is critical is also who is going to actually be the person providing the service to me, and who the actual person home and community services who is coming in my home. It feels like it is an opportunity to provide more choices around quality and understanding not just the name of the entity. How they function and questions about quality. Maybe their philosophy too. Their philosophy of care. You don't have to get into eye long detail. At least it would give you something if I wanted to do some digging on it it would do that. We don't have that right now.

>> I have a basic question on that which one do you choose first an agency and coordinator from that agency or do you choose a coordinator with whatever agency you are with.

>> Each one of the managed care organizations has a different model for service coordination. So there are some relationships with external entities as well as employees of the managed care organization.

So the individual is selecting in an individual service coordinator not an agency. Based on the seed back. I think it will be interesting to see the consumer feedback that has been help full. I think this is a great discussion. We may end up having to have a dedicated session to talk through what that may look like and each one of the managed care organizations will have to define what that is going to look like for them.

>> I would like to make a recommendation that we at least put it on the agenda for next month. This is something that -- you may not have your data ready by then. This is something that my membership, the centers for independent living across the state are really, really passionate about to be able to have informed choice. We just don't consider the current method to be that.

>> Maybe now to work magic with the agenda. It is full. I can see her face. We will see what we can do.

>> In order to be respectful of the other presenter's time we will move on. We have employment service presentation. Unfortunately, Ed butler could not be with us. Ryan will stand in for him. We have Ryan Hyde the OVR director of central operations.

>> Ryan:

>> Hello, I'm Ryan Hyde from the office of OVR I was asked to give a presentation on OVR services. I have a very brief overview of what we do and how we are funded. I have been with OVR for many years and my responsibilities include theth about et, contract and grant, policy and a bunch of other administrative support activities that support our field offices. So OVR's mission is to assist Pennsylvania I don't knows with disabilities to secure employment and independence. It was reauthorized under the workforce and innovation act of 2014. We have 4 bureaus. The bureau of rehab services. Most people are familiar with the bureau of rehab services that is typically what people think of as OVR. We also have the bureau of blindness and visual services. They serve people who are blind and visually impaired trying to get them employed or maintain their independence in their homes. We have the Hiram G Andrews center in it Johnstown. It is a

training facility that is 12-acres under roof. 40-acre property. They have degree programs and certificate programs there. All of the students are students with disabilities. We then have the bureau of central operations which is my bureau.

Again, it is the administrative support instructor for the other 3. In total we have just under a thousand staff. Our biggest population of staff are our counselors. We only have around 400 counselors to serve the entire state. OVR is unique in that we are one of 2 states in the country to have an OVR board. The OVR barred was established by the state act and it is a policy setting board. So when we go to change our policies on how services are provided, we have to present those policies to the board and get their approval.

We also have the Pennsylvania rehabilitation council which is federally mandated. They are an advisory council so basically everything has to run through them as well. They are often -- if they don't concur then the board usually doesn't support the change either. They are not policy setting they are advisory. Our funding structure is essentially 78.7% comes from the federal government. 21.3% comes from the state. We are a match program. If you do not receive state funds you do not draw federal fund. You have to have expenditures to get the federal match. The federal award is roughly 131, $132 million. The state is about $49 million. The federal award is all based on a formula. The formula clouds things like poverty level in the population. It is a mile long in the different factors put in there. When the federal budge government passes a budget all of the states are put in and they spit out what we are going to get for our portion. We must have state collars to be able to match that.

We have other programs in OVR the independent living and blind which is closest to some of the stuff you are talking about earlier. It is a very small program 1.5 or $1.7 million the intent of that program is to cope people who are blind and visually impaired in their homes for as long as possible. .

When our law changed in 2014, an entire new set of services were introduced to OVR. It requires OVR without any additional funding. We are now required to reserve 15% of our federal award for pre-employment transition services to students with disabilities. So that equates to roughly $20 million annually that we have to set aside for students with disabilities from high school. Job exploration counseling. Counseling of secondary, self-advocacy. Job readiness and work-based experiences. The 15% is also a minimal reserve it is not a maximum. So in Pennsylvania we have about 140,000 students with disabilities who have IEPs. We serve about 27, 28,000 last year. That number is huge for us. So we are trying to figure out how to best offer the services to the most services possible. Not penalize the adult population in the VR program. There are no a diagnosis funds provided when that requirement came to be. It was taken out of at adult program.

That leads me to the next thing I want to talk about which is the OVR order of selection. It is often confusing for people. Essentially the order of selection is a priority. When sufficient funding is not available to serve all people with disabilities within the state the state must go on an order of selection. This is a federally mandated process or a federally allowed process. We have actually been operating on an order of selection since the early '90s. However, we have been serving those most significantly disabled since that time.

We have 3 categories in our order of selection. Most significantly disabled. Significantly disabled non-significantly disabled. Our counselors are responsible for making that determination based on observable evidence, medical records or additional evaluation that's we would pay for. So for many years we only served people that are most significantly disabled during the era time several years ago we were able that drop down and serve the significantly disabled category. But primarily we have only been able to serve most significantly disabled.

This past summer we did close all order of selection categories and created a waiting list for services. We presently have about 6000 people on the waiting list. However, as of February 1, we have been able to take 2200 people off that list. So we are now in the process of notifying those individuals that services can proceed. A long with the order of selection the VR program that's an eligibility process. These are 2 separate and distinct decisions. So to be eligible for OVR services you must apply for services. You must have a physical or mental impairment that is documented or observable. The pair pair meant must result in a significant impediment to employment. OVR is a jobs program our intent is to help people become employed. You have to have impediment to employment to be determined to be eligible for services. The individual must require vocational rehabilitation services. You must have a demonstrated need for something that we can provide. The individual must intend to actually achieve employment. Again, being a jobs program all of our services are gored towards employment. So if you come to us saying I'm not interested in employment, then we are not the right program for you. If you come to us saying I would like to get a job, then we are the right program.

Again, our counselors make this decision. There is a process to it regarding interviews, medical records and things like that. One of the great things about OVR and one of our problems is that we are relatively flexible in the types of service that's we can provide. Essentially on a very basic level if it is maintaining employment, we can probably do it. So that is a double-edged sword so we can be so broad we are providing a lot of varied services.

Services must be documented on a plan for employment. Counselors that are customers that work on that plan together it must be mutely agreed upon. If you come to OVR and say I want to be a professional athlete and you have never played sports before, they are probably not going to agree to that.

That is a ridiculous example but it has to be reasonable that it is a job that you would be able to obtain. We have a ton of different services. Common things that we do. Pre-and post-services. Guidance to help people what they can do what is available in their community, what services they may need to be able to reach that goal. We do a lot of technology in durable medical goods. Wheelchairs, jaws, screen readers, apps, iPads things like that. We spend a significant amount of our services budget on training particularly college and technical training. So we send a lot of people to Millersville, Penn State, slippery rock within the state as well as your business technical schools. Again, you have to be seeking employment. We are not sending people to have an experience. We are sending people because eventually they will get a job. Our second highest expense is supported employment or customized employment. We spend eye lot of money on job coaching an do a lot of physical and restoration services, therapies, physical therapy, counseling that kind of thing.

To stay engaged with OVR you have to be actively participating in services. So if you have a pled callus you've that prevents you from proceeding with your goal, you may be asked is it temporary you will be able to recover? Are you not it going to be able to participate long term? If so your case would be closed you can reapply in the future. If you stop participating and fail to call us back, we can close your case as well because we have so many people that need services we have a constant resolving process. We are not a birth service. We are quick strike we are not intended to have cases open forever. Our goals we monitor them. Then we close the case.

Somebody asked me to talk about vehicle modifications. This is one of the services we offer. We have a multi-page policy on when and what we would procure. We do purchase rehabilitation technology associated with vehicle modification to make sure that you can access your vehicle or drive your vehicle. So we have put in hand controls. We have put in very complicated electronic driving systems and ramps and lowered floors and raised ceilings an all kinds of stuff associated to vehicle modifications. Again, our services have to be geared towards finding and maintaining employment. If you are coming to us seeking a vehicle modification you have no intention of working we will point you in another direction. If you are

working or you are looking to obtain employment, then you might be at the right place when you come to sew OVR.

We have a lot of ways that you can get in contact with OVR. Our number 1 process is is that you apply online through our case management system the Commonwealth workforce development system. It is also the -- we have an icon how to apply on the front page. You can also contact your local district office. We have 15 bureau vocational rehab services across the state, and we have 6 blindness and visual services across the state. They are located in the major metropolitan areas. They cover all 67 counties.

We have remained relatively stable in a number of refers and open cases that we have in the last several years. We have anywhere around 50 to 55,000 open cases in a given year we are here acting with 70 individuals in a given year. What has changed since the implementation of the workforce investment and opportunities act is that there is now about 54% of our open cases are students or youth because of the implementation of pre-employment transition services. So you have had a significant -- we always had a lot of students and youth any way but not nearly what we are experiencing currently. We have one of our other customers is businesses. We have business services units in all of our districts and under me in central office. The main goal of those services to interface with business and industry to identify opportunities for people with disabilities to start programs for hiring initiatives or make individual one-on-one placements.

So we have had partnerships with local mom an pops to Starbuck, Lowes, home depot, Hershey. It just depends on the region. We have had lots of different partnerships with employers over the years. We are always looking to expand. That is OVR. I am happy to answer any questions except from Matt Seeley.

>> Matt Seeley: The number you gave 6000 people on the waiting list. Can you give me an idea how fast that number is growing.

>> Ryan: Well, yeah. We didn't have a waiting list in July. We have had 6 think add. It is about 200 or so every woke that that number climbs.

>> Matt Seeley: In regard to the vehicle modification the waiting list how is that adaptive equipment, who you guys choosing -- I don't know how to say this. Is that affecting what services you are providing?

>> Ryan: I will read between the lines a little bit of your question since I have worked with you for many years. We are always looking for better ways to conserve

and use our resources. However, particularly with vehicle mods there are only certain things and vendors and equipment that you can purchase that are effective an safe. We would continue to get recommendations from experts on what needs to be utilized. Everybody would have an individual evaluation.

General services, again, assistive technology, medical goods are often recommended by somebody who has the expertise to make that recommendation. So then we would follow the recommendation. We do work for ways buying in bulk or looking for a cheaper alternative. But in the end if there is particular equipment or software that will meet the perpendicular's need, we would purchase that.

>> Matt Seeley: What I am asking is, because of the financial constraints that you are under you are more inclined -- is OVR more inclined to provide -- I will try to think of something that is cheaper than a vehicle mod, $30,000, $60,000. Hearing aids they are not cheap, but they are less expensive than a vehicle mod. Are you more inclined to provide those kind of services than vehicle mods? It

>> Ryan: The rehab act doesn't allow for what you are saying. We would provide counseling and guidance on what services they may need. That is often when we wo reach out to experts in the field and say what does this person need? We are not going to tell somebody what hearing aid they need. We will send them to the doctor an they will make that prescription.

You can't set caps or restrictions on the rehab act. It is necessary to maintain that is something we consider. Exploring alternatives for people. A vehicle mod if you can get to work on the bus, is take being the bus more appropriate than the vehicle? We would have that conversations. The services and goal have to be mutely agreed upon. If there are other alternatives, we may discuss those.

>> I wonder -- I have a couple of questions but also wonder if you could double check my understanding about some recent changes that have come up with regard to the participants that need employment support and how OVR can serve them the CHC participants.

>> I will be addressing that coming up.

>> I will present from the OLTL. If everyone is done with questions for Ryan I will get into that a little bit.

>> I am anticipating one question that might come up. If a participant needs services in the area of job finding an job coaching let's start with job finding. How long would it take OVR generally to I had fight employment for someone?

>> Ryan: That depends on the person and the area.

>> You must have an average.

>> Ryan: We have an average case closer. It is not down to the job coaching and how long it takes from the time we implement a coaching contract to the end. We have overall statistics.

>> What struck me is I was so impressed with the bandwidth and resources of OVR. You described that you are statewide. You have lots of relationships with corporations to get participants engaged. As we look to the next press en thattation where the CHC MCOs may not have the same sort of band width to help their members, given all of the history and resources that OVR, it just seems like that is a challenge that is ahead for the CHC-MCO compared to the resources of OVR. I guess the waiting list is 6000?

>> Ryan: Roughly, yeah.

>> Do you anticipate you will have the resources going forward that that will continue to grow?

>> Ryan: That is the $100 million question. That you are we going to be able to adjust will our federal and state funding remain stable? Can we find ways to provide services more effectively and more cost effectively? Our total budget is around $200 million which sounds like a not it is not when you are talking 57 counties and customers. We have a lot of connections. We are good at certain things. The problem that VR is facing nationally now that we are being asked it do this other stuff, the core of the program vocational rehabilitation, is being impacted.

>> I think the question was all of the people on the waiting list and all of the changes that it you are going to have to do are you finding now more the counselors may be finding people too disabled for OVR or non-employable. When Steve Serovick you are not allowed to use the term not employable ten years ago. Is that happening? I have heard the term, is that being put out there? We have really high categories. Is that something that is occurring now?

>> Ryan: Under the rehab act that is an allowable thing. So there is as process to it during the eligibility process a person has to be able to engage in employment activities. So if it is determined that they are not capable of participating in employment activities then they can be considered too significant to participate. It is a very small number when that happens. We have very few of those cases, but they do happen. Like I said it is a multi-month process of evaluation to determine if that person could participate and what services they would need

>> This is a question on the issue of OLTL that OVR wasn't in the room for. An update on how OVR provides health pods to folks in CHC and other OLTL act 150 something like that. You have the CMS for community health choices maybe you could talk about how that works. Thanks.

>> Ryan: I can take it from the VR perspective. If you are found eligible and you are placed on the order of selection and you are able to proceed with the order of selection with a plan and the service to maintain employment, we offer home mods. We have 4 or 5 page policy on what we are capable of doing. Usually it is getting into a home in the bathroom. But that stuff is discussed. All of our services are determined on an individual basis. So counselor would sit down and talk about their needs. We would have an evaluation usually somebody would come in and term what is actually needed to get the person in and out of the home to go to work. We have a whole process how the service would be procured. They can be a little bit of large ticket or high-ticket price we don't do a ton of them when we do them they are extremely expensive often.

>> Can I ask you for a candid service [inaudible]

>> Ryan. Tell me generally yes.

>> Would you say they are comparable to what OVR can provide?

>> Ryan:. In VR we are still learning. The VR act allows for pretty significant flexibility if it is related to employment. Generally speaking it is doable once you have been determined eligible placed on the order and have an individual plan for employment. So I can only really say from my perspective that we have done eye lot of things for a lot people that is related obtaining employment to home and vehicle pods, training, special programs we developed special programmed. We interface with employers. I only know enough to be dangerous about the managed care process. So I would say from what I have heard they are not there yet.

>> All of the MCO have employment specialists that work connecting people with employment services. The 5 services are benefit counseling, career assessment, employment skills, job coaching and job finding. The change that occurred effective January 1, 2020 that we are talking about so effective 2020 by revised these waivers adding lapping to address unemployment services through the waiver can be provided should OVR close the order of selection which is currently the case. We also added language that OVR services are not available if OVR hasn't made an eligibility determination in 120 days. Anybody on that list that is a CHC participant would be able to access services through us.

Now OVR temporarily closed the order of selection [inaudible] the process, prior to adding one the OLTL services to a participate apt's service coordinator would status the case with OVR. A participant who has been referred to OVR has not had an individualized plan for blame [inaudible] immediately. Eye participant who is not been offered to OVR may receive OLTL without the referral to OVR. Closed order of selection they should start receiving services immediately through OLTL and MCOs rather than be referred and put on the waiting list at OVR. When OVR -- when the closed order of selection is lifted the process the 120 day time frame would come into affect. Under that process, individuals can receive OLTL services if an individual that's been determined ineligible for OVR services their case was closed by OVR or they are not [inaudible]

If he will the ability is not determined within 120 days from the referral, OLTL employment services are considered to not be available and received through the CHC and waivers.

We have drafted some guidance related this that will go out to the MCOs and we have revised the employment and employment-related services bulletin which will have the same guidance in it we have also started tracking employment data in the last couple of months getting monthly reports from each of the MCO on the number of people with employment on their PCP the type of services receiving and if they are employed what category of employment are they in and how many hours are they working.

Anyone have any questions.

>> I have a question.

>> I just wanted to ask, go back to Ryan. Ryan, you said 2200 came off the waiting list. Now you have to go back and check and make sure that they still need

vocational services and that. Do you have any idea how many of that 2200 will actually be engaged?

>> Ryan: Not just considering we just did it January 1. Would I say it would probably be at least 75, 85% based on other things. This is a little uncharted water for OVR we have never had the order of selection he is checked before. We have never taken people off before, so we don't have any long-term information to guide that. We set 10 days for every person to be notified in writing. And then we set 90 dies for them to move along with their lives or have a plan written for services. We will be monitoring that very closely.

>> So there may be an instance where you would pick up people let's say 500 fell off it could be 50 more would be on or would you wait until the next time you open it up?

>> Ryan: We would have to wait until the next time we open up. The selection criteria is specific. I believe our goal is to get on a rolling order of selection wherever I so many months we take a specific anybody or whatever number we can based on the availability of funds. So we will be looking again in the spring to see how these cases have progressed and sigh if we can take any more.

>> Great. Thank you.

>> My question is how does this vocational rehabilitation affect somebody's CHC or planned care or does it affect how many hours a certain person would get because they are considered employable?

>> Benefit counseling is one of the services offered to make sure that you won't make so much money that it would affect your services. Obviously, it is more important.

>> People wouldn't want to be employed.

that is a good first step when you are starting to look at employment is to receive the benefit counseling fist, find out how many hours you can work and not touch your benefits.

>> Thank you.

>> My understanding is that there was an application made to CMS for people to be able to be exempt from having to be turned down by OVR in order to access

the CHC services. I'm wondering is that correct? It do we have any kind of an update on where we are with that exemption? If because I'm hearing you say that in order to access the CHC they have to be deemed ineligible by OVR and we have got this big wait list. I'm wondering can they access CHC services immediately?

>> Yes, during the closed-door selection which is now they would be able to receive from the CHC program immediately. So CHC participants who might happen to already be on the OVR selection would be able to receive services too. The only time they are going to have to white is when the order of selection is no longer closed. Then they would go to the regular process of referred to OVR if they wouldn't receive services in 120 days then it would go to the CHC process.

>> Matt Seeley: Can I ask the other side of that coin. Provision of OLTL services does that have any effect on OVR eligibility or provision of services for OVR?

>> Ryan: Generally, no. We are required by the rehab act to explore comparable benefits. So we would do that. However, if comparable benefits were not available through other sources then OVR would pro side. This is one of our normal processes. We have had to look at comparable benefits forever. We have tried to do that and utilize other people's money when people. But our services are often unique and not funded by other agencies.

>> Misty: In regard to the participants being put on the wait list, are you talking referrals? I guess it is 2 questions. Are you making referrals? Are you tracking referrals for those people that are not able to obtain those services from the employment network or centers for independent living? Is it

>> We started tracking the OVR referrals the MCO report monthly on the number of referrals to OVR and the process. Now with the closed order of selection it won't be made any more. In our perspective the rehab act when we are not able to provide a service to provide, they would prefer people based on their unique needs. We do not have a way to track those referrals in our case management system.

>> Shawna: I know voices is getting a tremendous amount of referrals people who can't access services through OVR and are being turned away. We are get a tremendous amount of individuals looking for employment services. We are trying to meet those needs. Again, we need to partner with OVR and OLTL and the MCOs to make that a more viable option for people because since the order of selection of closure was announced we are getting [inaudible]

>> following up on that when the networks were built for phase 1, phase 2 and phase 3 it was with the expectation that OVR would be providing much of the employment reports. Given what has occurred and changes that are now take ago effect trying to get a better understanding isn't the expectation that you will have to do more. You were supposed to do employment. OVR would be the first. They have waiting lists. The comments that were raised leads to the concern about their band width. It is what it is. The expectation that they need to be hiring more people to provide and deliver these services where MCOs are in that expectation. Are plans hiring more?

>> There honestly hasn't been a need to the numbers are so small of people attempting to get employment services we have had no reports coming to us and saying they can't access services.

>> Looking ahead because command for participants is mostly about [inaudible] of the 5 services that you describe we are very interested in that. It is the expectation that the MCOs are providing. I get if you take a picture of that right now it would be minimal. We have a lot of folks generally under 60. But also I am make being stereotypes of people interested in working that might not be fully appropriate. They are we would like to see what the utilization is not next month and not necessarily -- we would like to take a look.

>> Right now we have been collecting collection on an add hoc basis. The numbers are fluctuating which causes us to believe that they are not accurate. They should be status quo with the people involved and people on their PSP. Trying to get the data to a point where we are ready to release it to the public an show the numbers that the data will improve. The numbers we are seeing right now are very low. So hopefully that will people up steam to allow us to serve them the individuals that can't get services through OVR we will have to wait and see.

>> this is a question I don't know the answer to about the companies that need assessment I am assuming it is asked to a participate want do you work. If the answer is yes, I do no need for job finding and job coaching. But it would be helpful to know for the community are they working without trying to figure out if they are utilize. Do you want to work. Then we get a chance to see if the MCO doing what they need to do to help that participate have a meaningful life.

>> We are getting the data of people already employed with the question are you employed and then there is also the question of did the MCO help you achieve employment. A lot of people who just got employment on their own. We want to

know the individuals that got employment on their own compared to the individuals that went through the process of the MCO to gain employment.

>> Matt Seeley: Can you give us a ballpark percentage of the participate ants?

>> Interest in employment is fairly high. Pitting it on their PCP as a goal is low. They don't physical they are physically ready for employment. . They volunteer. They have family obligations that keep them from working. So we did poll the people. We saw disparity between interest to on the PSP and a variety of issues -- the main issue is fear of losing your benefits. That is number 1 issue.

>> Thank you for setting that up. We knew that in the order of selection [inaudible] they were waiting for the list to clear up. What is the department and what are MCOs going to do to first educate the consumer that they can go through benefits counseling. That's available even before they do anything. They can do it tomorrow. Why aren't we encouraging people to do that so they learn how it impacts services. Second what are we actually doing to build the network? There are providers ready to take consumers today. They are ready to employ employment services. We have been talking about it for five years. I bet we can't provide 20 Reuters ready to accept consumers. So it is self-defeating.

>> We did just recently look at the number of providers it is currently 107 in the state that will employ employment and employment related services. So the expectation would be now that this change has been made when the MCO are meeting with individuals and going -- asking about employment services and their interest would be to let them know that we can help you with this right away. You don't have to wait for OVR to make a determination at that point. It is a closed order of selection. So that is the expectation we drafted. Communication to be used by the MCOs to explain this to everyone.

>> I would like to, speaking for myself, but probably a number of people, I would like to see us take a more proactive approach to help consumers. We do a lot of great flyers. You have good communications going out there explain to go people explaining that there is a change, a very significant change in the way they can access this service. It is important for the departments to take a leadership role on.

>> I will take that back. Thank you.

>> Shawna.

I know that for me as an employer I have about 8 people that work 12 hours a week or under because we took a risk and said we'll work with you to go to your benefit counselor to figure out how many hours a week you can work and maintain your benefits. In knowing that because those folks didn't want to lose their benefits which is exactly what you said, they also hadn't thought about how do I survive in the workplace? We as the employer had to take a peer support role in helping them work through high they are going to do all of that. I don't think there's any anyone providing that kind of assistance. I think that is a big missing niche basically. It would encourage more people with disabilities to begin to work part time an see that it can work and take the leap of faith to jump off and do the more full time work. But everything that you said you are right. There are so many of the soft skills when you talk to OVR about soft skills they need you to be employment

ready when you go to OVR. So that makes people pause and say I don't know if I am ready because I don't know how to solve these problems. I want to work. Interest and people going out and working.

I kind of know why. I think a lot of us understand why. A big part of the why. How are we fixing it?

>> Part of the process the career assessment is looking at depending on your disability what you are capable of doing looking at the jobs that would be flexible and possibly working from home things like that. Then developing the skills would be part of the job coaching role. You talked about working as a peer role in assisting people. That would be the job coach's role to get them comfortable with the new employment position.

>> Ryan: From OVR you do not have to be job ready. We do a ton of services to get people job ready from supported employment to specialized programs to build people's interpersonal skills. We send tons of people to training. It is preparing people for work. We do a lot of that. I just want to correct that.

>> Any more questions? Is

>> Matt Seeley: I anticipate the role change TMS role change can will help alleviate the load for OVR?

>> [inaudible] it might alleviate a little bit but not have a huge impact.

>> Ryan: I agree with that. I don't think that is a magic bullet. A lot of our customers are ID. Mental health. There is some disbursed across all disability's

types. One of the advantages with ODP we have a data exchange so we can see who is receiving services across both programs we don't have that OLTL. That is something that we talked about maybe in the future that would help us know that and be able to track that information. It is my understanding that the numbers are very low.

>> Matt Seeley: You don't anticipate that happening soon?

>> Ryan: It took me 2 years to get the one off the ground. I don't soon is relevant. There are a lot of legal loopholes we have to work through and the data systems have to be built to talk to each other.

>> Matt Seeley: Just quickly, secretary e the secretary was proposing some sort of system where a lot of the stats could be shared between your agencies and others as well. Is that not going anywhere? If

>> Ryan: There's been talk about having a broader data exchange between multiple entities. Again, I haven't heard anything about it recently. I just know there is a confidentiality rule across all programs and they are different. There is a lot of legality that you have to figure out. I believe it is still being looked into.

>> I am going to [inaudible]

As a person with a disability you just heard from 2 people with disabilities that gave you great input. Those of us sitting around that know them and heard what they say you did not understand it. you may have heard it you are not understanding what they are saying. Is there a way to bring people bike Betty and Shawna together with y'all to explain? That gap that you talked about was very interesting the gap in people who are interested in working and those that want to put it in their service plan. They gave you the reason why. What do you do to get around that? That is for both y'all not to be insulting. [inaudible] you need to work more directly with some of the people who are trying to use the input that you need on how to be in touch in it getting them in. Just my thoughts as a person with a disabilities sitting there to their incredible input and hearing your response to it. There needs to be a offline conversation to help take what they said and build from it. That's my thoughts.

>> We would be open to meeting with everyone to get their information. The more information you get the better.

>> What Shawna was saying, there are job coaches they can do some of the skill stuff not just stuff that a one-on-one person will tell another person. They might not be telling you. They might have [inaudible] they are not going to tell you dude, how am I supposed to manage my attendant so the attendants get in here at certain times so I get my butt out of bed and get the transportation to figure out [if inaudible] the job coach doesn't have a disability and hasn't lived that life. They are not going to be able to understand and say to you the two of them are incredible wealth of knowledge.

>> Quite frankly as an employer for people with disabilities and providing employment network services I have seen it take well over a year for us to get through that using peer mentors which is only been successful the only way we have done it because for people to consider given up benefits that make it possible for them to work by gaining employment and superseding the income levels that are allowed. The only way it has been successful is by saying, Shawna, how did you do it and seeing it. No other way is working that is the main issue.

>> If you want to schedule a meeting, we are happy to do that. Back to my talking points. Matt Seeley sits on the PA rehabilitation council and that is our advisory group. We have 4 meetings a year so you are welcome to come to that and provide feedback or give a presentation. You have a state board. We have 4 meetings a year. You can come to that and provide public comment. We are happy to meet with everybody reach out to me and we will set something up.

>> Matt Seeley: Mr. Butler, I don't know where he is, he used to have an employment -- I don't want to call it an advisory group, but Theo and myself were on that at some point. I don't know why that was disbanded. It seemed like good things were happening we were looking agent the employment plans from the MCOs. Reestablishing that and inviting misty, Shawna and having an open forum for input I would think would be a good thing.

>> I agree. I will talk to him and see about getting that up an running again. Thank you.

>> Some of it would come down to [inaudible]

Knowing the right questions to be asking. You don't know what to ask until you open up the dialogue

>> Any other questions for Ryan squared. Thank you so much for coming. We appreciate it.

So we can now open it up for the MCO Q&A people to ask questions or have concerns that they want to bring to their attention. While people are trying to compose their thoughts, I did get a text come through and I will probably butcher this woman's name I will apologize. Janice Meinart would love to be the contact person for folks who want to be part of the informed choice discussion her E-mail address I am hoping that we can somehow get this out Marilyn to the membership. E-mail address is jmeinert@phlp.org.

>> Since this wasn't covered in Jill's update and since we are 2 years and 2 months into the initial implementation of CHC I keep getting recovered -- I'm talking about behavioral health issues. I get referred back to OMSAS that might be able to help us to understand usage of the behavioral health services by the population. Will a member of OMSAS please step forward. I think that is the issue. We don't have one.

So at what point will we start to learn about the implementation of CHC and the coordination with behavioral health services that are essential for people living in their own homes recognizing that the rate of depression for folks that are institutionalized is well above 50% and when are we going to learn about when those are a prepared and addressed in this overall program of care? Maybe some of the managed care organizations could offer insight into that which I wasn't able to get through the initial report.

>> I do not have an update for you today. I do know that OMSAS and OLTL have been working together to finalize utilization numbers for services. It is my recommendation that they were planning on presenting that in a future meeting. Maybe at the MAC or a sub MAC. I can follow up with you and make sure that you know when it will be.

>> I heard that. I wanted to hear if the individual MCO had a substantive update in that regard. Thank you.

>> Anyone else have any questions or comments for the managed care organizations or for anything else? It

>> Yes, this is Linda speaking. There are services for the YMCA if you have to get therapy for certain aislements. [inaudible]

>> We didn't understand what you were saying.

>> From Keystone first and one being able to get help from the YMCA for its acqua therapy they were offering in mow built when you have joint problems. They said it wasn't covered any more due to you get home service or you have that. I am not understanding how they can offer employment and not help you with physical therapy where you were receiving it before. That is one thing.

>> If I am hearing you correctly you are saying that Keystone first offered therapy at the YMCA and now they are saying they have to be home therapy?

>> Yes, which you can't get acqua therapy at home.

>> But you can't get Acqua therapy at home. Barb it is a committee member.

>> If you have a committee member's information it looks like it might be something specific to an individual service plan reach out to them.

>> Thank you so much.

>> Misty: I have 2 questions for the life program. Is there a policy that states or prevents people using a mobility device from being part of the life program? And what is the time frame and process for somebody who is trying to leave the life program and go to CHC services?

>> You know I can't answer those. Right?

>> I do. There is a life representative.

>> She is not here.

>> I oversee the life program. We can go over the question again, please.

>> Is there a policy that disallows somebody using a mobility device from receive life services in their facility?

>> No, there is no limitation as long as they are 55 and older and meet the definition.

>> We have a few members that have been indicating that because they are icing a mobility device, they were preventing from having life services so I can follow you up.

>> Follow me directly with me people have discussions.

>> Can you tell us the process and timeline a person is to follow from the life program pack to community choices?

>> For the life program when they enroll in the life program the start date is the first of the month. If they disenroll it is the end of the month if they want to move to CHC in March, the life program provides services through December 29. On March 1 they go into CHC. It is by. In CHC new participants they can come in in any time when they need services. Life program goes from the first to the end of the month.

>> What you are saying it is less than a month to move from the life program to CHC?

>> It could be more depending on when they make the decision because of the timing for CHC. If somebody decides on February 18 to leave the life program and move to CHC based on the timing they would go no CHC on April 1. The life program would be responsible for that individual for the rest of February an throughout March and their disenrollment would be March 30 or 3 is and they would go into CHC.

>> They should not have to have another assess meant or would they expect to have another assessment?

>> I don't know fully what has to be done. They have to let them know they are changing programs just like when they change MCOs. The assessment they shouldn't have to have an assessment redone. They should be able to provide their care to the receiving MCO would who follow that plan and care until they get their assessment.

>> There was a question that came through over the phone. If there is an up role on the RSA [inaudible]

>> In regards to the enrollment RFA? Not at this point. We have plans this month to get it out. We are putting the final touches on it.

>> Where would we fine the processes, the steps that the life program or consumer need to take so switch from the life program back to CHC and not have to go through a full enrollment? Is there a place defined in writing the steps it takes to switch from life to CHC that we can give out to people? I am happy if it goes from life to CHC. That is not what we are hearing. Where can we get something in

writing that the responsibilities are what the processes are so we are ensuring that they are not getting a gap in services.

>> I'm not sure if there is anything in writing between the transition of programs accept the information in the EEP. The life program part of their contract that they have with individuals that come no their program part of the agreement they have with them should list everything they are allowed to do. List their appeal rights and their ability to terminate out of the life program to disenroll out of the life program, to receive services through the life program all that have should be in the packet of information that they get from the life provider.

>> How can we get that? People are coming to us saying we have been told by our life program that our disability is too expensive for them to provide care or something like that. We will not be getting life services. What do we tell them and how do we get information? Is there something out there that CHC puts out or the state puts out, something that we can hand to them to say to the consumer these are the steps you need to take or life, you are required to do these steps so we can help those people.

>> That I would have to check on to see what documentation we have. If a life program says that they have the right to appeal that like they have the right to appeal anything from the Medicare program. If they say it an individual we don't think we can provide the care for you, they can appeal that decision if they don't agree with it.

>> You are off the hook right now, wrappedy. Now we have it from the MCO. Can you ask each MCO to clarify what they said about their response time when a new or increased HTSS need is identified in is it 48 hours after a new inter RAI is done? If so what is the time frame to have the new inter RAI completed?

>> So for a general inquiry or need that comes in it is 24 hours emergency and 48 hour for additional. For a new, we have to go out and do that assessment within a 5 day time period. We prioritize that to make that outreach the next day when we receive that. Get their identity. If there is a need like request for additional hours or change in service that is another trigger event. It needs to be resolved within the 14 day time period. That is in the contract for all of us.

>> I guess I spoke for all 3.

>> Anyone else have questions? Comments? Janetta?

>> I'm Janetta from the September are for begin endent living in central Pennsylvania. I just wanted to make a comment when MCOs are need to go brainstorm which I really love to brainstorm, but to contact your local CILs no matter where it is contact your local CILs not only do you have the wealth of people that are living disability day by day you have the we will I think of the entire association in Pennsylvania. We can reach out to each other. Don't forget about us. We are a wonderful resource.

>> Thank you for that comment. Pam.

>> Pam: Going back to the employment stuff and discussion about the different providers. I was just wondering with the MCs rolling having training with employment providers and if so when? What do they look like? Because I know we as a CIL are trying to do some employment stuff. I was wondering when we can lock to be contacted to do some -- >> [up audible] that they have to have. All of the persons all of the agency that's we are contracted with are already certified to be trained.

I can think of the top of my head of of the name of the certification we have been working closely with Ed Butler who are educate our service providers and participants that we have. For P H.W. we have [inaudible] because of the rules through OVR we are educating our service coordinators and advocates [inaudible]

>> Whatever certifications that the state requires through CHC is what we have. I don't know if we have been contacted by the MCOs I am not sure what your requirements are or. [inaudible] who have you contracted with so far in is it some of the providers that already have that certification pre-CHC?

>> If could you see me afterwards I have a list of some of the agency that's we are contracted with.

>> Just to that point, part of it is that the providers in the employment network today game from the [inaudible] they are all approaching this with a different mind set about what employment is all about. Part of what we would hope that MCOs are going to do is reach out to those providers an make sure they have the actual readiness to provide services. We are using a different tool boxes. When I said there may be 20 providers regard to do this. They are using an oiled toolbox not appropriate for this population. So we need you to help us in getting that network of providers truly ready to serve this population. It's going to help you. That's it going to be the mix of services that helps people.

>> I'm the manager for AmeriHealth. We have April employment coordinator who works with providing technical assistance and support to our service coordinators. We have to have a training that's developed and in the process of being redeveloped and redefined as you had mentioned my colleague had mentioned because of the changes. We want to make sure that our service coordinators are up to date on any of the changes and how that impacts individuals that we all serve.

Regarding the providers, we do have a network we network of add o vehicle see for providers. I do understand what Bonnie was saying about historically some of those come from the world of we serve people with intellectual disabilities. We have providers that specialize in brain injury and so forth. Our account executives with our network provide support to those providers as well with any kind of questions that they may have regard ago built and so forth.

>> [inaudible]

>> Anything else? Misty?

>> I just wanted to meet out the CSP training they are ODP mandated. We have been doing that as a center for independent living network. I have been working with all 3MCOs for the last 2 years. Our frustration is we still don't have any contracts or actual substance communication to start working on those areas. We haven't been given the opportunity to provide those services for you. To my point earlier we are still trying to get the same contracts for nursing home transition for care management and we had a lot of your services this is what I meant by lessons learned. We have been involved for 2 years. So we are frustrate today hear that you are still not reaching out to the CIL and employment network through the providers that have been doing this for a long time. Thank you.

>> Barbara Polzer: Anyone else? All right, thank you, everyone, for your participation. I hope to see you next meeting, March 4. Have a great one.