Consumer Subcommittee of the MAAC

May 22, 2024

Consumers present: Sonia Brookins, Minta Livengood, Marsha White-Mathis, Rochelle Jackson, Ronel Baccus, Meghann Luczkowski, Jayme Scali, Lauren Henderson (phone), Liz Healey (phone), Lauren Hatcher (phone).

DHS representatives present: Sally Kozak, OMAP Deputy Secretary; Gwen Zander, OMAP Managed Care Bureau Director; Angela Episale, CHIP Policy Director; Juliet Marsala, OLTL Deputy Secretary; Alexis Deisenroth, OIM Policy Director.

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

>>> ELISE GREGORY: Good afternoon, today is Wednesday, May 22, 2024. Before we begin the meeting I would like to go over housekeeping items. This meeting is being recorded. Your participation in the meeting is your consent to be recorded. If you do not wish to be recorded you can end your participation in the meeting any time. CART captioner is available. The captioner is documenting the meet regular motely so it is important for people to speak remotely and speak slowly and clearly otherwise the captioner may not be able to caption the conversation. In the case of an emergency evacuation, there are procedures posted on the wall next to the door of each exit. To avoid any disruptions all devices must have the sound turned down and microphones muted.
Representing the Department of Human Services Department from the Office of Medical Assistance Programs we have Deputy Secretary Sally Kozak; Director of Bureau of Managed Care Operations Gwen Zander; Angela Episale, Policy and planning for CHIP. From Office of Long-Term Living we have Deputy Secretary Juliet Marsala and from Office of income Maintenance policy Alexis Deisenroth. If you need more information visit the website. I will now hand things over to Subcommittee Chair Sonia Brookins.

>> SONIA BROOKINS: Hello, everyone.
So great to be here in person again. For introductions, to my right.
>>

[Inaudible]
>> Consumer Sub, Philadelphia county.
>> Afternoon. Kyle Fisher.
[Inaudible]
[Inaudible] On the phone?
>> Hi. This is Liz Healy from Allegheny county.
[Inaudible]
>> This is Lauren Henderson representing Allegheny county.
>> Thank you.

- **OMAP Report**

>> SALLY KOZAK: We can begin the meeting. I don't have a lot to update.
CMS recently issued a number of final rules related managed care and eligibility and enrollment. Rules came out about the financial piece. And they had all kind of FAQs, clarifications that came up.
So we continue to internally review them and to understand the implications. We will be prepared at some point in time before the end of summer for them and to everybody, what it is that is going to mean for advisory committees. We know in terms of consumer input and participation of the program, there are changes there. Kyle, I know that you have talked about that and as soon as we get through analysis of the rules, we will be figuring out where we are going to be and clearly anything that has an impact that consumers need, and all to be a part of. I want to let you know, that it is taking longer than anticipated. I think our first official week literally line by line is June 11, --
[Inaudible]
If we get through and have a plan -- we will be more than happy to share that.
We will see what they adopted and didn't adopt.
>> SONIA BROOKINS: Certainly. We won't have a meeting in August but maybe we could have an off-line meeting.
>> SALLY KOZAK: I know Jamie scheduled internal meetings. She is much more organized than I am. That's why I have people on it. Okay that was the only update I have. Gwen will go ahead and talk about hospital negotiation and issues we are having there as well as.

- **MCO/Hospital Contract Terminations**

>> GWEN ZANDER: Good afternoon, everyone. The first item I will talk about today is one we've been talking about for a couple of months here.
The Children's Hospital of Philadelphia (CHOP) and AmeriHealth Caritas/Keystone continue to have productive negotiations. I think that is good news.
We are meeting with the highest levels of leadership. And we find out how things are going. We are hopeful that this contract is not going to terminate.
But as a reminder, the termination date is June 30. So effective July 1 is the date this contract would be termed.
Because of that, if an agreement isn't reached by the end of the month, member notifications would have to go out. And you know, really hopeful that those don't ever have to hit mailboxes.
But they are starting to print them now just in case. And really hope they don't have to go but if so, they will be sent to around 125,000 members. So really large number of people who stand to be impacted by this. Of that 125,000, there are only 1,300 members that currently have open authorizations. Compared to the bigger number. It is not quite as scary.
But there are also about 82,000 of those members who have an affiliated primary care provider. So that is a big change. And then another 84,000 who have seen a CHOP specialist within the last 12 months.
We expect that if you belong that one of those belongs to multiple groups there is overall with the others.
But I just want to give you a sense of the -- so like I said, because definitely starting to hear from consumers from members concerned about this and asking about what options are. We do have a Commonwealth enrollment assistance contractor and although prepared to help with choice or anybody who would like to switch a plan or likes to find a new provider, help you understand how to address the condition that they offer.
If these letters do go out. Unfortunately, there was a request a month or two ago, and a special almost S.W.A.T. team style and unfortunately our contract with Maximus doesn't allow something like that.
[Inaudible]

As you are talking, friends and neighbors an anyone else, the 60-day continuity period, that is important to emphasize. That not like, come July 1, you're out and you've got 60 days to either transfer to a different plan, in network with all of the other plans, or to, like I said, find another provider if they would like to stay with their plan.
Any questions or anything about that?
>> MARSHA WHITE-MATHIS: There are going to be an influx of appointments, the way CHOP is handling this.
>> MEGHANN LUCZKOWSKI: We are hearing that many CHOP departments are refusing to make appointments for Keystone members past June, which undercuts any protection offered by the 60 day continuity period.
>> I know the department can't help on that but thinking about the --
>> SALLY KOZAK: We do not have the authority. We have had several conversations where I have made it clear and the secretary have made it clear that we did not appreciate how CHOP has created unnecessary alarm and additional burden on families.
[Inaudible]
We have shared with them that the information that they are using for beneficiary is out and out wrong. We essentially told them, stop it.
You know, to the extent that anybody wants to send examples, I'm more than happy to --
[Inaudible]
>> SONIA BROOKINS: I'm just going to leave it right there and hope everything goes right.
>> I've said please do not use our Medicaid customers as pawns when negotiating.
[Inaudible]
[Inaudible]
>> MEGHANN LUCZKOWSKI: You already answered all the questions. But your one statement made me think of something else.
I'm glad they are training Maximus mitigate for members for it to happen.
Do you know how often it updates different provider networks?
>> As long as a change was made within the last week, they get it every Friday night and it refreshes. So it is pretty good information.
>> I guess the concern with providers, and staff to spend the time it takes to look

through for multiple providers.
>> That is something that will be asked about and I think if you are aware of anybody who is preparing to make that phone call, log on to the website, a recommendation would just be to gather your list of providers, have them handy with details. I know that especially they have them aware already.
It is not something to create.
But if you have that there, that makes the whole process move more quickly.
[Inaudible]
>> Not as many as I may have thought there would be given the messaging that has been out there.
But we are keeping an eye on it.
>> Yes, because representatives on the phone are using the --
[Inaudible]
>> Anything else?
>> A really quick question.
>> There is a process to use in situations. A case by case basis. We have a plan you'll work around but not a system wide approach.
>> With continuity should be above and allow --
>> Yes.
>> GWEN ZANDER: And we talked about this before. There needs to be no particular request for that continuity. Basically, anyone who has mailings should get it. It is like there is different messaging from years past around that. So it is hopeful to hear that the continuity coverage, should be covered, period.
>> No magic words.
>> With the obligation to cover it.
[Inaudible]
>> Let me just remind everybody. We have --
[Inaudible]
>> There is one concern with these papers and they are coming out and how many people actually pay attention to the notices from various reasons and I'll always say what about a person that can't read or can't comprehend what they are telling us. They can read but can't comprehend what is being said. That's always been my concern. And you will hear me say that this probably 10,000 more times.
But I'm always concerned about people understanding and what they are receiving

and how fortunate it is to pay attention to those notices.
>> Jamie, if you don't mind, I will use this example. Yeah, it is a process. Is there some way that special needs units could proactively initiate conversations with members who are impacted for instance, Jamie just had a scenario with her child where one of the companies that provides supplies stopped sending supplies. Thought it was a mistake at first. Then the following month didn't come again. She wasn't getting much communication from the company. Come to find, they went out of network. And no one alerted her.
So you know, perhaps and that is a scenario where there is a to that child. So if someone went out of network, you would hope that that important would have care coordination and keep you in the loop on those things, would have made you aware.
But that didn't happen.
>> SALLY KOZAK: I think it is a really reasonable question. Make a phone call to whoever is on your caseload.
[Inaudible]
>> We got to have that conversation.
[Inaudible]
>> GWEN ZANDER: I know this is an exciting topic for people right now. We are doing what we can from where we sit. As contracts come across our desk we are hoping for that.
>> They shared this morning that they would need to go out on the 30th.
>> They are printed but not mailed.
>> There are two smaller contract negotiations I wanted to mention as well. That are also on that July 1 timeline.
That is Butler memorial and AmeriHealth. And there are only 458 effective members here.
And the second is Keystone/AmeriHealth and Children's Dental Surgical Center. But that has the same date of May 30, unless something changes in the coming week. They provide the surgery services in Philadelphia. The same termination date. There are 107 members impacted and we believe that also those organizations have other alternative hospital providers to direct members to.
And this is the only in this area and that --
[Inaudible]

It is a small number but really tricky number.

- **Shift Care Prior Auth & Appeal Data**

GWEN ZANDER: So another topic and I will try to go quickly through this. I know that there are a million things.
But there are a couple corrections we need to make to numbers. I want to thank you all for your thoughtful questions that led us to dig in more deeply.
Megan, you have one question in particular about whether this record denials that were approved other than requested.
And what we learned is that it wasn't consistent across all MCOs so we corrected the data that now shows the partially denied or approved, they are now included as denials. And I do have updated slides that I can capture on the paper for folks. And we also have electronic copies to distribute out after the meeting. There were a couple other revisions made. You will see at UPMC's home health, with 25% denied, and skilled nursing rate is now 16% in 2023 Q4. A couple of corrections overall denial rate for health partners and united, which didn't have the health choices over all average.
One thing denying at a rate higher than overall --
[Inaudible]
[Inaudible]
There are higher denial rates which you will note on the slides. We will be able to answer any questions that you have or anything you are noticing that looks off or inexplicable, we are happy to dig in. And lot of thing, we continue to build out our ongoing monitoring and auditing activities for denials.
Specifically making sure that MCOs are adhering to the requirements and that we issued a year ago in May now, can you believe it.
We have been focused on reviewing some cry went that and we are now starting to sketch out with the ongoing plan for other agreement requirement which might have to do with a reduction that are previously authorized explaining.
So we have been reviewing a lot of denial cases lately.
So we are going to keep at it. So I think that's officially what I have.
>> SALLY KOZAK: One addition that I have spoke to three or four months ago. And we continue it see it happen on a regular basis. Where children who have skill

needs and the family is pressuring providers to order home health aide services. That's what the providers are ordering. And we see a HHA request for child on a ventilator.
The other piece that happens with that is just because a child --
[Inaudible]
Does not mean they don't need healthcare. Which is why there is an increase in denial because these kids need care, God help them, parents that are doing this, are creating some of their own issues and problems as we move forward.
And it is going to be very difficult for agencies to have --
[Inaudible]
We know parents take care of their children. I'm not saying that.
But right now, the rules for help agencies is you have to provide care and can't substitute. So I just encourage all of you folks out there having conversations with your families, encourage --
[Inaudible]
>> What we are looking at is getting more standard definition and instructions that we can use and this becomes a recurring report instead of just one time that you all asked for it. We are looking at incorporating some of these into our regular monitoring. So by doing that, I think we will have better data quality and see --
[Inaudible]
Either we have a wrong number there or we misinterpreted or instructions are unclear, any of those things, we will continue working with a more consistent recurring report. That's what we continue to monitor as we pull those random samples of cases to look at whether they are doing what they need to do. That continues to be a work in progress. I that I reviewing denial audits they are doing a tremendous job looking at this. These are complex.
But I feel like we are starting to get handle on it.
>> KYLE FISHER: I don't know if you know how much we appreciate you and your staff monitoring compliance here and helping ensure that families and kids get the services they deserve. Last month you talked about shifting a lot of auditing resources and staff proportional to the number of kids, members, getting services rather than equal to MCO. Now recognizing that there are clearly outliers in terms of plans that are denying services and far more frequently than counterparts. Is that is a factor that you plan to use in how to allocate your own limited internal

resources?
>> GWEN ZANDER: I think it needs to be and when you look at one plan for example that has 0 or 1% denial, probably not going to devote a whole lot of our internal resources. There is some sample of denial, but yeah, I think this has definitely highlighted some areas where some oversight makes sense.
>> I think you read our minds where new contract submissions are going to change before services. You can say to whether you've seen compliance or incremental and consistent compliance by the plan with that?
>> Not a specific thing we've been monitoring for. I'm not able to give you a sense of what we are seeing or not seeing but that's part of the next upon tier that we are with oversight now and starting to feel like okay I'm forgetting it and ones that maybe have been slower to implement changes.
And specific recommendations.
>> SONIA BROOKINS: Are you doing on-site visits? Yes. That is something we have done. We have gone back and corrected date where so we know that any of the partials now got included in the denial bucket.
>> We haven't done many physical on-sites recently. I know that they do them and that is something we explored and continued on our compliance.
Yeah.
>> You can participate in grievances, or not participate but call in and listen to hearings or grievance proceedings. Things like that. That's a good source of information for them. You know, not in-person.
But on the phone, hearing it, live, taking notes.
>> KYLE FISHER: I want to also highlight how appreciative we are that this is now even in the contract. And you know, having to justify the reduction and tying it to a change. So you know, that is a big change and that is a positive change.
>> So you mentioned building this in to the regular reporting, where MCOs rountinely give you this denials data. We thought about how to then share publicly, it goes to our earlier conversation about transparency. I think is huge especially we have 125,000 families, for example, asking if we are changing where do we go? And on an occasion like this, it is not publicly available now. Outside of fairly dense and dated MPAR reports.
>> GWEN ZANDER: I think sharting with us publishing for example great prints we can look at. There is transparency to dig into and probably our website where I can

think about that stuff starting to fit in. Next frontier for us, starting with requirements under the new managed care rule.
>> SALLY KOZAK: With transparency we've been having that conversation so there is support for getting it out there.
>> Thank you. Thank you all.
>> We're happy to do it.
>> Thanks for your time.

- **CHIP Report**

>> ANGELA EPISALE: Hi, everybody. Again, my name is Angela. I'm division director for CHIP. I will go over some talking points.
[Inaudible]
First, I want to make sure that I get to you guys first. The question is from the paperwork here. How many transitions from CHIP coverage from 2023. It is taking more time than expected. Working to provide data ahead of the next meeting and we apologize for delay.
Can share this total increase from April 2023, when CHIP's enrollment is at 125,169. It is now 172,213. We are researching the enrollments that came from MA transfers.
>> We do hear about that regularly. I actually got -- that aspect and they have that facility to work with the family as well. And if the family cannot afford their monthly premium, change in income, for reassessment and new income and so always okay and you take a second look. And process or change in circumstance.
>> A question related to that. If a child transferred to CHIP and reduced cost premium, do I need to take any action? Or consent to that before enrollment or does that happen with me potentially on the hook for that premium whether I want it or not?
>> Good question.
When you get that bill, if you don't pay it, it is not like you have -- you know, you get the bill and if you don't pay it, you don't have to say you don't want it coverage for that time and we can just enroll you. However, honestly, we get more questions but not a lot of people saying, no, no. It is more of a little bit confused or you know wondering if it is new now that they go right to the chat page. I think there's been a

lot of positive feedback as far as making it go right to that so it is not a new application process. More about the education piece than anything.
>> KYLE FISHER: That obligation to pay the first month doesn't stand?
>> Right. They have to make that first payment to be satisfied.
>> We have a number of families that change had their mind and.
[Inaudible]
>> I know it is hard to participate in meetings.
But in person, give them the chance.
Any questions from the --
[Inaudible]
>> The Consumers asked - the last meeting regarding CHIP the department noted a number of IT challenges and eligibility. And is that are there any pending challenges or promises to changes planned?
>> And we are happy to report that. Major challenges causing negative impact and have been resolved. That month in April of 2024, CHIP deploy to something to prevent gap in coverage. And make sure eligibility dates and enrollment dates are aligned to ensure no gap in coverage.
That overall we are currently stabilizing since the IT transition. Both being diligent that children are under healthcare coverage. And providing training to staff and MCOs and everyone working toward our common goal. Currently developing system updates to comply with CMS and final rules and eligibility requirements. Some of those changes include 90-day look out. Removing the 90-day lookout. And final from our director is we will have an Advisory Council on May 29 at 10 a.m. If you would like to hear me talk about continued eligibility again, you can be there. If you would like to attend, contact us and let us know.
Okay.
If there are questions or CHIP and then I have jump into continuous eligibility.
>> I just want to say that --
[Inaudible]
I think overcome everything in the system is not to correct the system to figure out what a manageable sustainable work around is. And our contractors are, when they make partners, in all of the -- and that IT contracts of our CHIP managed care program as well.
And it is a part of it that everybody's main goal is ensuring that children did not use

eligibility and never mind-
[--
[Inaudible]
So we thank everybody for that. CHIP is becoming more and more integrating into Medicaid, which we always needed to do as well and CHIP in and of itself is now integrated which should be --
[Inaudible]
I think starting right around 2016 or so. So before I came and I came in 2017.
So this has been a 10-year journey that is realizing that its full potential and and thank you to consumers an families.
>> Okay, in September, there was an official SHO letter from CMS about integrating changes. And our families and try get as little process as in the -- and but started with before 2024, and the exceptions for continuous eligibility, where the child turns 19, and the child representative requested voluntarily eligibility. Child can be a resident of the state. And determination or redetermination. And child becomes eligible for Medicaid for failing it pay the initial premium and in addition to those prior to January 1, if they did not pay and one of their ongoing premiums or if they have other health insurance and that they would also be disenrolled. As of January 1. We are protecting those children's enrollment and there will be no more exception for failure to pay premium and no more exception for health insurance dooring the eligibility. I have the next slide if people want it follow along. So what does this mean for CHIP families?
As of January 1, no adverse action due to income or other insurance can be taken with continuous eligibility periods. We were discussing earlier if you are now through Medicaid and you have been put this chip and went up a little bit get the initial premium and if you don't make the initial premium payment, if you didn't want it, but if you do make the initial premium payment you are protecting your child for the full year so adverse action means if their income went up and they are going to be having to pay more money like go into a lot more costly, we would not move them to a more costly tier.
That will happen at application but not during eligibility period. And also, disenroll if other insurance is found during eligibility process. I mean, during continuous eligibility period.
Okay.

>> For that year.
>> Yes. For that year. January through December. Your next eligibility period is when we have an opportunity to look at your income and see if you should be looking at category or if you get help, to get insurance.
>> And you don't have to pay for the whole year.
>> No Ma'am. No. You are not going to be stuck with a high are bill because by found out that six months ago you got a raise. We're not doing that.
So what by are doing, focus on eligibility change possess them is meant to protect families, children's and benefits. What we don't want is people out there, like you are mentioning, and saying, I'm not putting my benefits and you never did and now you know, now what?
So we are trying to make sure that they know they can voluntarily disenroll. You dent want the insurance, now give us a call. We may be able to work on payments like we mentioned. It is flexible and also possible that -- yeah. That you can voluntarily withdraw if you want to. Not receive CHIP and not be responsible for any more payments. If they don't tell us they don't want it, we will keep giving kiddos the benefits and they might be able to get caught up with the bills later. In addition for third party, for another insurance, if they say, get another insurance two months later we are not going to kick them off of CHIP. We will let them know that if they want to get off of CHIP that they have the goal. The idea is not to make people pay two bills. Don't pay work insurance, pay CHIP insurance, we want them to have the option to not lose their doctor in the network or something like that. So managed care and advocates have been awesome. Outreach letters that they publish drafts. We have managed care organization. We have had an in-person meeting with managed care. And we have a second meeting for educating on the renewal process. We know that might look different to have changes fall out at one stop. We want to make sure we know how to have managed care organizations as well. There are processes in place right now to protect families while working to get them changes to accommodate all of this. So this is not instantly we can't go from September to January and say, okay, we did it all, thanks for the direction and we are done.
But by are making sure that we are doing a lot of manual work and we have recently shared our proposed plan with CMS so they can give us informal review to make sure everything goes through the process smoothly and so we did have one

final slide but I'm not going to -- Sally touched on it enough. There are links to final rules as far as streamlining final rules. I can pause here but I don't think that it is something that we need to delve into. Like Sally said, we are looking at whether changes will look like. We will get great education.
But we do have links to final rules on the slide deck if you want to see those things. Okay.
>> MINTA LIVENGOOD: Okay, I have a question.
They are paying you for that insurance so sometimes they are eligible to get help to pay for that insurance instead of paying for the CHIP. We can then let them know you have options to apply to see if we can help you pay for your premiums to take you out of the CHIP that you don't have to pay for.
That's an area and sometimes you still have to pay a portion of that premium and it covers the whole family.
Ment.
>> Yeah, I get it.
There is a more focus on Medicaid than CHIP because the idea behind the program is a paid premium than it is in Medicaid.
And with the CHIP program, we have our --
[Inaudible]
And it really only impacts the low-cost and there is not a whole lot of those with the income requirement.
There are automatic processes. And with the integrity and every week --
[Inaudible]
>> Smp comes in and you have to explain what their options are.
I always try to when they are trying to get ahead, of what their option is, to not put a strain on the household. Because if you start a job today and tomorrow you lose things, then they are like, now what do I do?
[Inaudible]
>> And our goal, around the table, I'm sure, is to help people achieve coverage, not lose it.
>> Right. We don't want anyone quitting a job because it costs too much to have health insurance. Yeah.
[Inaudible]
>> Thank you so much.

- **OLTL Report**

>> JULIET MARSALA: Good afternoon, everybody.
All right. I will go straight into my disclaimer and then update.
We have a couple topics today.
We will have a directed work group recommendation. We will talk about changes with CHC agreement.
But it is still not fully approved by CMS.
And we will skip over final rules and we will see if additional ones to touch on. All right. Let's get two slides ahead. There we go. General disclaimer slide. Of our procurement update. You know it is live and any questions have to be addressed to the procurement email. We are in blackout.
[Inaudible]
Right? E-mail right there.
[Inaudible]
Any changes within the contract because they were awarded. The procurement to continue to be our independent broker.
And then, finally, no additional updates to share there.
And I am going to go to the next slide.
And since I have extra time, there is information about the program as well. On our LIFE program and I realize that we will talk about it and so if there is time I would like to share that critical program.

- **Participant Direction Workgroup Recommendations**

>> JULIET MARSALA: You heard me talk about that along the way. And that work group is going on and in the report of recommendations. And the report that direct work group recommendations, what posted, to our website and so everyone can take a look at this. Take a look at the methodology. Learn more about the survey process.
Recommendations were received by me and Secretary Arkoosh for review and to look at all of that valuable feedback from that group. And we're already working on some of the recommendations. For example tempus and the MCOs are working on trainings. The quality of support and recommendations and with regards to training

reimbursement for direct care workers. That is being looked at. And there are recommendations with regards to easier access to the website to clear and available instructions.
For participants who are employers and for the direct care workers that they employ. It easier for people to understand the processes, how to enroll participants direct care worker and what supports are provided for the voarnd of,.
[Inaudible]
The managed care organization is working to make these fixes.
In addition one of the things that we heard, one of the things in the Office of Long-Term Living is under participant direction. Workers were being paid at their highest possible wage.
A question we have, right? Part of the work group at that question and they determined that it isn't easy for participants it see and figure out under the participant directed model, participant of the employer, how much could I pay my worker?
There is great tangible feedback.
And on that wage calculator to make it easier to make you know instructions better so that information is is out there.
Yes Ma'am?
>> ROCHELLE JACKSON: So you say that participant could choose to pay their caregiver more or less, according to a regional payscale? How do they access this if they’re not tech literate?
[Inaudible]
>> So under participant self direction, and preferred model where participants have most control.
And hiring direct care workers and the way that program is set up with funding, is that there is a maximum range. Right? So a participant can choose to pay an attendant anywhere between a state and federal law which is minimum wage. 7.25. All the way to as high as they can go and still cover the required taxes and workers' compensation. And other Medicare and all that other stuff.
That combined with their wage, the participant, they can choose. Like Philadelphia for over $15 an hour. Under self direction.
So help me understand.
>> So participants, like any other employer, know when have you a position that is

kind of budgeted, and an employer might decide I want all of my workers to come in at one level and as they stay with me I won't give them raises or bonuses. Raises year over year, right? So they come in at a certain range.
And you know what, I want my healthcare worker --
[Inaudible]
I will put them at the top.
>> Is clearer for members now. And there t is under way and I'm not sure if they came out with the new calculator but definitely a priority. And because they mention, you know, under the office of long-term live weeing have one vendor for fee for service and MCOs have theirs. So there was commentary about how this is working but not so well there.
>> Webbing site is dedicated to participant self direction. All of the forms are on the Tempus website. The calculator is on there. I don't know if the new calculator is on there. Requirements, wages, yeah. All on the website.
>> I have two questions. One is --
[Inaudible]
>> Yep, very good question. Maximum rate is regional, based on region. So each rate has a region.
And this space on labor and actuarial review.
>> My other question is any thought put into --
[Inaudible]
In terms of being the employer are older, right. So she was not able to navigate that information. And with a stranger, you know what I mean, how are we able to get that information to understand their role and ability to determine what they pay and you know, they can't even get into it.
But you know, not savvy.
>> Absolutely.
>> Multiple options for that.
One of the things about community health choice says a wave of program that has 32 services. And the service coordinator. So depending on thed into the, the service coordinator potentially offering community, and the community integration services. And that's a great service that will work with the participants or like 16 weeks on learning a new skill or achieving a new goal. That could fall under that kind of service. And it is something that is just a walk through step-by-step. That is

something a service coordinator could support with. And if they, depending on the situation, if there is informal support, right? And they should be connected to skill training, through local resource.
But for independent living often times have trainings and resources. And support that goes on. So someone a a support that best fits them. Sort of the design.
But if anyone needs help, they should make it known to the service coordinator.
The service coordinator's primary role is the connector.
[Inaudible]
>> That is not necessarily your payer --
[Inaudible]
Does that make sense? That's what I heard from members. You know.
>> So once you've got a new hire, the whole rate calculation.
They are limited by a new hire.
>> May be a factor.
But least not in the required.
And you know, really good.
>> Definitely, yeah.
>> If I can figure out who the folks were then it is, what's going on under managed care? What is going on under the fee for service, for OLTL. So really, yeah. Which one is it?
So, the other thing and this ties to the 2025 agreement as well, we have in the agreement for requirement for participant directory and for direct care worker registry or batching, you may have heard at the federal level, this is a best practice and emerging best practice for direct care workers and matching with participants but particularly when we are in a direct care worker shortage to make sure that folks who are looking for work and participants who have needs that they are looking no fill can be met.
So we put this in the agreement to roll out in managed care and community health choices for parties path direction.
Initially.
So under participant direction we see this hopefully matching registry come on-line in this upcoming year.
That recommendation has been in the works.
>> Is that MCOs on the issue of --

>> Sure.
>> Yeah. So similar to how the MCOs decide to do it themselves and more collectively find a vendor, it is the same thing.
How they collect and design a process.
They push to another MCO and they access, and have access to the full, you know, dugout, if you will, of that's the direction we are going in. And continue to work towards the date.
And you know many rate setting.
Process. And we talk about the wage care study is required. In addition to our debate service rate setting, which you know, is a subset of services that we are evaluating which is personal services and a big one.
So we are looking at this one for agency model and participants self direction.
To get all of that data. For the rate setting we are hoping to have that finalized by August. And it is a fast, fast timeline. It is a process and it is sort of like that, but right now, and right now with because it is so important, so we are leveraging the committee time. And quite a bit this summer.
And with the proprietor rate and we use the knowledge from the group and building on what we have learned there. A great deal for the participant self-directed side.
[Inaudible]
So today like the agency rate-cutting process, and includes the materials like all sort of different things. And participant direction. They have both the rate for the financial management services portion and then the direct worker.
So agencies for directive and it is similar but the rates will certainly be different.
>> And my understanding, both,.
[Inaudible]
>> I wouldn't be able to set my rate here. It might pay more than an agency or are they looking to raise the rates for all caretakers?
And the agency.
>> Making money for all of DHS and programs, my hope would be that we were able to raise direct care workers regardless of what model they are in.
>> So DHC managed care, undergoes the process every year.
There is a study of the region that --
That direct care workers who are --

[Inaudible]
>> So for the direct care worker wage study, we are looking at direct care workers in all settings.
Direct care workers working personal care roles. And nursing facilities.
And agencies.
And participant direction.
So a survey that goes out and specific questions and really looking at average pay of healthcare workers. And they get an annual increase every year. What is that increase? You know, for the last three years.
And also employment specialists.
>> It doesn't matter which program they're in.
[Inaudible]
>> So they have no authority to tell the employer what to play employees, what is required by law. That agency didn't give them a raise year over year, that would be in the report and share with the --
>> If you see that across the agency, and perhaps at best, it is not necessarily that we could, you could turn around and say agency acd, you better start getting raises, but it does show a pattern for --
>> One of the questions would be we gave% increase in 2021.
>> We won't necessarily be able to make decisions.
[Inaudible]
>> One more question. When you look at each, and there is a question for what program they work under.
And we can see the situation for like with the child turns 21 they get a pay cut because --
[Inaudible]
We are looking very specifically at the Office of Long-Term Living program.
>> That makes sense.
But it is just with OLTL and --
[Inaudible]
>> The challenge you mentioned, is that around how much of the rate they received into direct care worker?
And can you speak some to upcoming federal requirements the 80% threshold and how that is enforced?

>> And to return with obligations on network providers around that?
>> All really good questions, Kyle. Really one question on that as 4 to 16 and that we are to go back to valley point and we are speaking into that and we are in early stages.
>> I will be here. If there are other questions, we are on the fast track to get data out. We will share it as best we can. In the best form we can, hopefully on the timeline. It will require a lot of work and support everyone across the system. When that report comes out, the real work will have to happen and the real work, I have submitted and everyone around the table, because you have to really push education and T.O. get what we need.
And so increase training program knowledge is another recommendation and improving. MCOs who are part of that work group. I hear feedback directly. See survey results. Taking it very seriously.
The impact going back and the services that are updated. These are the specific recommendations where there are increased rates. As you know, that's a much bigger situation.
It is a longer road in the process.
These are the ones with action being taken. We are evaluating that again a policy inventory list. And but that takes more.
>> Real quick to ask about training, is that training with the MCO or is to you know, training for everyone or is it -- how is training --
>> So in participants self direction there is a step for 8 hours, I believe it is, of standardized training for direct care workers participants, self direction.
There is information, time sheets, that every healthcare worker is required to go through. Last year it was optional. We said, if you go through this, we will give you a bonus. We will pay for your training. Now it is mandatory for every direct care worker.
[Inaudible]
>> Is not mandatory --
>> No, it is mandatory. The training additional training on those requirements --
>> Oh, okay. All right.
>> So in participant self direction traditionally, the participant would be able to do all the training themselves if they wanted to. So the change is building in a required training for every direct care worker. They all have a standard amount of training.

We've gotten really great responses from. From direct care workers.
Because they connect them with other direct care workers. And they start building their direct care workers. And I've been to their first graduation. And so now that it is mandatory, you know, they have four months by which to complete the training.
>> Takes care of the family.
[Inaudible]
>> Yeah. The training vendor pipeline and so they do the standardized training and some of it is virtual. A person. Different components for virtual.
[Inaudible]
>> All right.
>> That might be a hurdle for bringing someone on board. Well you have to do this eight-hour training. It doesn't sound like a lot, but --
>> They give you four months.
>> And within eight hours that includes the CPR and it can be like an sure or two hours.
I suspect --
>> An agency model they require training.
>> Yeah.
>> Even in the directive, if you hire somebody, they have to have their CPRcert.
>> No.
>> Oh, no?
>> Workers feel prepared. And I'm sorry. And for direct care workers, are there employment requirements.
Beyond tempus, but yes, to require maybe -- and maybe I'm getting into the weeds. But documentation. And if they are hiring, education. Can anybody do the training as long as they are eligible for becoming part of -- the participants of direction. Yeah.
>> Okay.
[Inaudible]
>> LAUREN HATCHER: Excuse me. Excuse me. I have a follow-up question.
As far as CPR training goes, are there a list of available sites where people can go to get their training done? Or is this at work?
>> Do have you a direct care worker and if you are someone you know within the participants directed model, I would recommend that they check the website or to

contact their service coordinator who could get them the specific information. With regards to training and things of that nature. I don't have them in my -- I don't have them right now. I apologize. I would encourage you contacting the service coordinator.
>> The training vendor for tempus --
[Inaudible]
Under community --
[Inaudible]
>> Anyone else?
>> I have more slides.
Okay.
All right.
I think we're good.

- **Programmatic Changes to CHC Agreement**

>> JULIET MARSALA: So programmatic changes to Community HealthChoices. Usually in March in terms of specific recommendations. So OLTL considers recommendations that come up through all of our subcommittees.
Public comments. At which we have public comment periods. Each of our meetings. And you know, now that we merged so there is lots of public comment opportunities.
Any kind of public comments that you might have. RFI. We are constantly looking at ways to improve throughout. One example is the language regarding an MCO having to justify denial of services where previously approved, which can be added to the 2025 agreement.
>> KYLE FISHER: We appreciate OLTL agreeing to add that additional language there, and requiring the common sense addition that denying a service that was previously should be explained.
>> JULIET MARSALA: So I will skip over this slide. I also wanted to highlight --
[Inaudible]
The Office of Long-Term Living, as you may know, we service individuals age 18 to 59.
From 18 to 59 Adult Protective Services, that is our responsibility in the Office of

Long-Term Living. So the Department of Health and Human Services, through the administration of community living, has put out their first ever final role for protective services. Most states have one adult protective service agency organization. So you know, anything for OLTL and we are working with the Department of Aging to go through regulations to combine our regulations together. As you may know with Adult Protective Services, finalizing regulations to from our state perspective to come out and we are still on track for that.
But we are pausing because this came out a couple weeks ago. To make sure that we don't have to kind of go back and redo everything.
That can create confusion. So we are taking a breath. We will go through the regulations. Line it with what we have so far and then make changes and things that might be require bid this final rule. And then put us law that that process as well.
So we are very pleased to see there is finally a sort of combination to align us all with our efforts and you know, supporting people with where they are and make sure that --
[Inaudible]
All right. The other one I wanted to bring up that I think is really important for everyone to be aware of, is the rehabilitation act of 1973. It's been around for a while.
And rehabilitation act of 1973, a very important section, called section 504. At the federal level, they have issued a final rule related to section 504 of rehabilitation act.
And rehabilitation act came out to support veterans with disabilities and a lot for increasing accessibility but it is a very important act. And so the final rule related to section 504 that has come out really strengthens protections against disabilities discrimination and all services that receive any help with department health. So that is OLTL and our Medicaid program.
And so the new regulations advance equity standards, they advance if both protections for people with disability. Under section 504. It clarifies and strengthens rights protections to access. And it addresses discrimination. For example, if you go to a doctor's office they should have acceptable medical equipment. They should have a table. That is part of their accessibility standard. This goes through all of those things.

And brings expectations as well. We are going through this act. It also standardizes the minimum requirements for successful web context and mobile app locations on your phone.
If you are in a program receiving Medicaid services through the Department of Human Services and an app, that mobile app with accessibility standards is outlined.
And final goal.
We are looking that and Pennsylvania is at most of our peers and that is by no means, means there isn't room for improvement. So we are taking a look at where we can improve and we have access for that and so --
[Inaudible]
And I could go on and on, but in the interest of time, I wanted it talk about the light program but I can save that for a future meeting.
>> I do want to say this, we need to talk about, I don't know who, but whoever it is, we need o have a conversation.
>> Okay, so the Department of Health licenses for accessibility, the licensing and that is the Department of Health. And you know, the facility services and our network and you pay for disability services to those that accept Medicaid. And have so happy to talk, let it all out. And if f it is regarding the facility licensing regulations. That's the Department of Health.
[Inaudible]
>> Right. And I would also say, I always like to take opportunities to, if anyone is in a nursing home and there is also the assessment that they can call and access at any time. I encourage nursing facility residents to reach out to the ombudsman offices. The ombudsman number should be, in any nursing facility and if it is not, that's problem.
There is also the state number.
And then also residents or family member and at the Department of Health has a very easy process and the process on their website and in addition to having a Toll-free number for complaints that should also be posted in every nursing that silt and part of every nursing facility welcome packet, and if a person is a resident and they also have our community health choices and they can share any complaint or confirm with service coordinators. And residents and nursing facility who alters the community choices services is their own service coordinator.

But that should be meeting with them regularly so they should help them with that. I want to know all of those nursing facilities, Sonia.
>> Thank you, thank you.

- **OIM Report**

>> ALEXIS DEISENROTH: So I think with updates, we will start with unwinding. I want to say we are down to under 5,000 statewide. So a huge hurdle thinking of 3.6 million, I think, we were at. Or 3.7 million we started with. So that hurdle is remarkable.
I'm not sure if it was mentioned last month, we expect to process all of those renewals no later than 6/14. To allow for some protection and the appropriate amount of process should anything close and by the end of June.
And this process will be done by 14 of June. Hopefully unwinding, fingers crossed, we can all put this behind us by the 1st of July.
We want to keep an eye on the policies. What policies we have to change and get that information in the right place right now. So there are quite a few policies that you will see come out and published publicly. And we are publishing the COVID policy but also, the same as we have some policies that we go back to. We have some policies that CMS is raising in the interim and we have maybe some new policies taking place for deadlines. So there is a balance of being able to publish what things are temporary policies that were completely going back to specific policies. And then also I think focused on changes of policy that happened within the unwinding. I think a lot of that was surrounding the return of updates and ways we work with MCOs. Under the flexibility that CMS has given us to through next year, they have kind of been pushing out our waiver flexibilities. So we are looking forward to seeing which of those waiver flexibilities are going to be maybe on a permanent basis. We are hoping for a lot of different flexibilities to be available going forward.
So the two flexibilities that will continue to make process through June, are the ability to work MCO verified information. And there are facilities taking and we can get exparte. And we can be ahead of any burden --
[Inaudible]
Those are some of the things coming done the lane policy wise for OIM. Check my

notes.
>> Part of the flexibility with respect to MCO reported address changes, and will that end next month or is that continuing?
>> >>: Is considered (e)14 waiver flexibility. So there is an expiration date of June of next year. So the first of unwinding, they pushed it to end of December of this year and then EMS updated it again. And so flexibility are available through I think June of the following year, '25.
To touch on exparte a little more. We've had our eye on to come into compliance. And expectations for review at an individual level for Medicaid application renewal. And currently our process, at a powerful level. And that speaks to a lot of things that weren't clarified I think prior to unwinding which helps us in a lot of ways. To understand how to best serve.
But it also requires a lot of work to get from the plates we started 12 years ago.
I want different administration. And now we're if a place to look at individuals a lot closer in their own circumstances. And so, being able to put it at individual level certainly help us have more kids and individuals eligible through that process that it is incremental for the next couple of years. So we both, we will start to see different policies coming into play between now and the end of our relationship plan which is 2026 and so the first thing that will come out is exparte, talking about some of the clarification that CMS made in December. For policies on, and I think in relation to, allowable program movements. And acceptable coverage shifts. And exparte both for the renewal and then we would do a second exparte review prior to any procedure. That is something that even our staff will be thankful for. To be able to use those to take a look at, to look closer, in terms of what happens at an individual level. Right now, it hasn't been a helpful level. So we are manually doing a lot of work around that until --
[Inaudible]
So that's the main unwinding updates that I have today. I don't know if you have further questions there.
Okay.
So I think the second thing, on our agenda today is near and dear to all our hearts and we are looking forward to hopefully making some headway with MAWD. And so, I know that there was some questions about the initial 75 that we took a look at, then a question about the letter we are sending out. First let me give an update on

the letter. We did mail the letter are last week to about 2,000 people.
And in order to communicate with the department, and instruction to expect in regard to when they should be if someone calls about receiving a letter. And so does the let are go out to a thousand individuals that we pulled through January? Of 2024. So.
[Inaudible]
They were individuals that looked like they could be eligible for MAWD is because of disability determination and who had earned income.
[Inaudible]
>> Happening in the past month --
>> There were a lot of priorities, and a lot of different things happening, --
[Inaudible]
>> KYLE FISHER: For folks that received that letter, and they want it raise their hand, please review. Is there an application required? Or something else?
>> ALEXIS DEISENROTH: No. We are looking at it as though someone is in the reconsideration period.
>> MINTA LIVENGOOD: I have a question. I have had two consumers apply for MAWD. That is before you have stepped up to the plate to say, hey, people are not aware. The one person that in one county and they had to complete the application, take all the paperwork to the doctor.
And they did follow an pale just to loosen their medical until they got approved. So that put a strain on them because their doctors wasn't just a --
[Inaudible]
They had specialists and stuff like that. And then, I had -- played for MAWD and I think this is excellent. Have paper to send to the doctor. They signed a release. Doctor sent the information. And they was approved.
Why didn't the other county do the same thing? It's like each county is doing their own process of accountability for MAWD. We need to get them all and make it as easy as possible with the one that has bought their medical, to get MAWD without jumping through this much paperwork.
>> We are working on that. Thank you for raising that. That is important --
[Inaudible]
When we look at the process of kind of --
[Inaudible]

And I think that you know, we are taking a kind of all hand on deck approach. And we are taking your feedback. We are -- we did have a call with a training supervisor across the state this month. And MAWD is a big focus of that call. So walk through and MAWD policy, I don't know if the -- responsibility of identifying who needs to be reviewed for MAWD.
So that is something we are working on with a supervisor and getting the information out on what is required to be done.
And also taking best practices on really having done work on getting that process right.
So we are working on that.
And you know, there are some booked Marked things that we have Marked and we always have a couple months of being priorities, which you know, oodles of what CMS has coming our way. And it takes precedent. And do have you them bookmarked and we are looking into it.
And we are continuing to look.
>> MINTA LIVENGOOD: I think that second way was best way.
It was like, okay, you take these to the doctor. You get them this -- you sign it, take it to the doctor, and then they send it to the process of being eligible for MAWD.
And the other way was just, I mean, I saw the paperwork and it was this thick. And I know that once the MAWD application was pretty simple. And they walk in with this thick pack of paper and it is like, okay, we will do that. They got the MAWD but it was a process.
>> I think is the county.
>> It was two different counties.
>> And if you have examples, I will gladly take them. And look at the process that different people are using.
>> They filled it out, we made sure. I can tell you which county.
>> Okay.
>> It looked at okay this is the process. And that is something we can capitalize on right now.
>> I can get you the names. And then, the county, Indiana county was good one. Westmoreland county, --
>> I don't deal with west moreland county.
I can give them a call.

[Laughter]
>> A question?
[Inaudible]
>> SALLY KOZAK: I know this from my own personal experience, when you do a MAWD application on-line, there is no box to check saying you want to apply for MAWD. So I wrote it in every single open box, and still got a denial back that said you do not qualify for MA.
[Inaudible]
I had to to all this intervention and I work here.
And this is extremely difficult.
So I need to echo.
[Inaudible]
I agree.
We are trying that suppose. And. [Inaudible]
>> We're working on it.
[Inaudible]
>> I didn't even know about MAWD.
[Inaudible]
>> ALEXIS DEISENROTH: I don't want to say it's challenging but --
[Inaudible]
>> SONIA BROOKINS: You know in Philadelphia, and I can see that the training and the main office is normally getting it right. But the workers elsewhere don't know.
>> KYLE FISHER: Sometimes feels like beating a dead horse here. But I want to come back to the systems issue. Updating the MA cascade to take it away from individual caseworkers to understand and applicants to have to ask for it. We understand you have certain priorities and there are requirements from CMS on ex parte, for example.
But it sounds like there is increasing acknowledgment for the need to push it out and put it on the runway and give it a timeframe if you can.
>> MEGHANN LUCZKOWSKI: Since we're talking about systems problems and COMPASS--
[Inaudible]
So far, Jamie and a number of other members that I connected with recently, are experiencing an issue when they are uploading supplemental documents they are

still getting notification that they were not submitted. I don't know if it is become uploading and maybe it is the app and not necessarily the website.
But just putting that on the radar.
And another issue by are encountering and encountered with a number of families at this point is when benefits have been terminated, and you should have review, for members and support folks are told the member has to submit an entirely new application rather than, I always bring it up on my phone. And the number of times -- which leads me to -- and I now at this point say in the medical assistance and eligibility of 39.3 and the renewal states they have 90 days.
>> Have you it memorized.
>> Not quite but, it is on my phone. So it is something to think about.
>> And you know, I think there will be, I know there is a lot of talk about that now. And there are changes to reconsideration within that final rule so there is more execution with that but there is always the opportunity to outline more through the other channels.
You know, I will see if we can get something in the newsletter and figure it out.
>> Thank you.
[Inaudible]
I'm like, wait, again? So I will say, you know, we are making adjustments to hopefully off-set some of that confusion. And I think that the trigger for those text messages aren't always the -- they can be helpful to remind people that haven't done it, but it doesn't happen before you actually, like you know, you have done everything and that you second-guess yourself. So I do think that there were some adjustments to help to offset something like if you have done the message or something to that nature. So we can figure it out.
I appreciate that. If you want to send that to me, and I can forward that to our group to continue to monitor.
>> Anything else?
>> Thanks so much.
>> SONIA BROOKINS: Thank you, everybody.
>> Before we go. Apologies it our guests out there. We will go around the room and introduce you and I didn't do that. I apologize.
I do appreciate you all coming out.
That goes for all of you. Thank you so much. I appreciate it.