Consumer Subcommittee of the MAAC
April 23, 2025

Consumers present: Minta Livengood; Lauren Henderson; Liz Healey; Meghann Luczkowski; Spencer Duffee.

DHS representatives present: Sally Kozak, OMAP Deputy Secretary; Gwen Zander, OMAP Managed Care Bureau Director; Jen Smith, OMHSAS Deputy Secretary; Carl Feldman, OIM Policy Director; Randy Nolen, OLTL Bureau Director.

The meeting was called to order at 1:00pm

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>> The broadcast is now starting. All attendees are in listen only mode.
>>ELYSE: Good afternoon and welcome to the April edition of the consumer subcommittee meeting. Today is Wednesday, April 23, 2025. My name is Elyse Gregory. Before we begin the many I would like to go over some items. This meeting is being recorded and your continued participation in the meeting as her consent to be recorded. If you wish to not be recorded you can and participation in the webinar at any time. There has been another update to the go to webinar platform for panelists and speakers. If you're experiencing auto issues, go to the top right corner to find the gear wheel to adjust settings to the correct microphone and a speaker hardware. If you continue to experience difficulty, please send a message in the chat. To help avoid any distractions, please keep your microphone muted if you are not speaking. Life captioning, also known as CART captions are available for the meeting and the link is included in the chat. Presenters should estate their names clearly to assist the captioner. Representing the Department of Human Services today, Deputy Secretary Sally Kozak, office of long-term living, Deputy Secretary Juliet Marsala and income maintenance Bureau director, Carl Feldman, and from the office of mental health and substance abuse, Deputy Secretary Jennifer Smith, and with a special presentation on the 1115 demonstration waiver and continuous eligibility, Doctor David Grande and Evan Cole. Questions may be submitted in the questions tab of the webinar and if you have any questions related to the meeting or any additional information you may need, please visit the consumer subcommittee webpage. I want to hang things over to the consumer subcommittee cochair, Ms. Minta Livengood.
>> Minta, are you able to unmute?
>>MINTA LIVENGOOD: I did.
>> We can hear you now.
>>MINTA LIVENGOOD: Okay. Did we do the introductions?

>> That is what we should start to do if you want to welcome you folks to this month's meeting I can go through the members.
>>MINTA LIVENGOOD: Welcome, everybody, to participate in the monthly meeting and I'm going to turn over to Kyle to let you know who all is available.
>> Thank you Minta, this is Kyle Fisher. Thank you everyone for joining us for the April meeting. I know we have a full agenda. Hopefully we can get through introductions fairly quickly. Our chair is unable to attend, Ms. Brookins has a conflict this month. So Ms. Livengood is facilitating today. Going through member introductions here. Is Lauren Henderson on the call?
>> LAUREN HENDERSON: I am present pretty good afternoon, everybody.
>> Excellent, thank you. Do we have Liz Healey this morning? Liz, I see you are unmuted. Are you able to introduce yourself? I know Liz was having IT issues. She may join us shortly. Do we have Meghann Luczkowski on the call this morning? Marsha White-Mathis? Rochelle Jackson? Ronel Baccus? Spencer Duffee? Jayme Scali? Lauren Hatcher? Okay Minta and Lauren, some of the burden might be on your shoulders today. I know a number of members had conflicts come up. Unfortunately we are short on membership, but those that are here will be involved and engaged this afternoon. I will turn it over to OMAP and hopefully we will have more consumers joining shortly.
>>SALLY KOZAK: Good afternoon everybody. I know that Doctor Grande and Evan Cole are going to present on the 1115 waivers. If you have your slides ready to go, I will let you go ahead and start first.
>> We are getting them queued up now if you could give us a few seconds.
>>SALLY KOZAK: Sure.

- **Keystones of Health 1115 Demonstration Waiver**

>>DR. GRANDE: Perfect. I will go ahead and get us started. I want to start by thanking you all for giving me and members of our team the opportunity to provide an update on our demonstration waiver - Bridges to success: keystones of health for Pennsylvania. My name is David Grande and I'm - - in the Department of Human Sevice. I'm a special advisor in the Department of human services. I want to start with a few big picture updates on the status of the waiver. Most of our presentation today will be focused on an upcoming deliverable that is required by CMS for the demonstration waiver, which is an evaluation plan. Before we jump into that I want to give a broad status update and I will pass the baton to Evan Cole, who is our research and evaluation partner from University of Pittsburgh. Again, for starting with a status update on the overall demonstration. As many of you know, we received our approvals in late 2024 and as the secretary shared in the budget hearings this year, given uncertainties in the current federal landscape, we are moving forward on a phased stepwise manner with implementation and therefore the governor proposed a budget for the state fiscal year 25-26 focuses on just one of the four approved areas. The reentry initiative with the state fractional institutions. I also want to talk about the implementation of that

particular program, the reentry initiative, along with other components of the waiver are all contingent on budget appropriations from the General Assembly. So while these other portions of the waiver are not in the governor's proposed state fiscal year 25-26 budget and future implementation is contingent on the budget appropriations, we do have deadlines for CMS deliverables that we need to meet so we have access to these important (WORD?) and they are predicated in the future. At the CMS deliverables, one of which we will talk about today, which is an evaluation plan and another, which is an implementation plan are due in 2025, regardless of the year we ultimately implant. And so we do want to continue to focus our work on moving these deliverables ahead. Next slide, please.

So I know many of you on this call are already familiar with our demonstration waiver, but I want to take a moment again to share some background for those that are a little less familiar so we have a shared understanding of this work. Demonstration waivers, as you know, waive certain rules that govern state Medicaid programs and they are approved by the Center for Medicare and Medicaid services or CMS they are typically five years in duration and have a required independent evaluation requirement. They can be renewed and are focused on bringing innovation to state Medicaid programs to test and evaluate new tools and ultimately states can expand, adapt or end the programs depending on evaluation results. They are not new entitlements or state requirements, or obligations. There have been many states in recent years that have received approvals for waivers that are very much focused on strengthening the work on health related social needs and reentry programs. That is the focus of the waiver as well. Next slide, please.

CMS did create a framework for this work that has guided much of what we see in our waiver and waivers across the country. The framework is based on this critical connection that we know exist between unmet social needs and health conditions. The term you see there, health related social needs speaks to the instances when unmet social needs directly contribute to poor health and drive healthcare use. So the focus of a lot of this work is situations where, again, we can make the direct linkage between clinical risk and social risk, in instances such as food insecurity, impacting chronic conditions like heart failure or diabetes that leads to hospitalization. Tools through a demonstration waiver that is focused on health related social needs are time-limited during key life transitions when they can have large impact and they are not tools that are intended for unlimited support, but rather critical moments where intervention can have the biggest impact, reduce avoidable healthcare spending and help with health. Next, sigh. It.

The focus area of our demonstration waiver includes reentry sports, housing sports, food is medicine, and targeted continuous eligibility policies. It brings new tools to our own Medicaid program to work upstream. Ultimately those broad goals around these demonstration waivers including our own is to reduce avoidable healthcare use, while at the same time improving health. Much of what you see in these programs and our waiver builds on national research and many local pilots and programs across the

Commonwealth that have been led by community-based organizations, managed care organizations, hospitals, healthcare providers, among other organizations. These tools would be targeted and focused on high risk populations. Next slide, please. It.
So where are we in the overall process? Phase 1, which started in mid 2023 and concluded in early 24 was focused on developing our application, and in the process we learned a great deal about some of the remarkable work across the Commonwealth that we could build on, as well as success in other states. We appreciate those tickled her engagement and public, and input along the way in this transport, frankly, that we heard for this work. Then phase 2 started after submission in early 2024 and concluded in late 24, which was focused on negotiations with CMS for the final approval, terms and conditions with respect to the authorized federal dollars and specific new tools that would be available to us and the populations that could be served for these programs. Next slide.
Looking ahead at next ups, I mentioned CMS deliverables. They are due later this year, and again, while they don't obligate us to move forward, they are absolutely necessary to have these tools available to us, regardless of when we implement. We will need to submit an evaluation plan, as well as an implementation plan later this year, valuation plan is due in late June and the implantation plan is due in the fall. We have started some - just this week, some targeted stakeholder engagement sessions. By targeted, I mean focused on one component of the waiver. In that was "food is medicine" tools and programs. To form the implementation plan and hear from stakeholders to determine what would be needed to maximize the impact of these programs. Today, we want to share updates on our evaluation plan, which again, is another CMS deliverable, and with that, I would like to introduce Doctor Evan Cole, Doctor Evan Cole is an associate professor of public health at the University of Pittsburgh and director of the PIP Medicaid research Center and our partner on this important evaluation work. Let me turn things over to Evan.
>>DR. COLE: Good afternoon, thanks, Dave. I think you can go to the next slide. Can folks hear me okay?
>>DR. GRANDE: Yes. They are probably switching things.
>> We are switching slide decks right now.
>> We've had a couple other members of the committee join. If we could do introductions. Megan, can you hear us? Do you have volume?
>> MEGHANN LUCZKOWSKI: This is Megan, can you hear me?
>> Yes, excellent.
>> Liz, I know you're sorting out the audio issue.
>> LIZ HEALEY: Can you hear me now?
>>KYLE FISHER: Perfect. Now we can. Any other members of the committee that have joined and have not introduced themselves? Okay, very good. The floor is yours again, Evan. Thank you.
>>EVAN COLE: Good afternoon everyone, next slide, please. Okay, I'm just going to provide a high-level overview of where we are right now in designing this evaluation plan

with the deferment of human services. Really, it is two plans because of the way that part of these waiver services, mainly the continuous eligibility part or amended to the existing SU D 1115 waiver. We have to submit that separately as its own plan and secondly, a much broader plan to look at the housing services and the food nutrition or food is medicine services as well. How we have been approaching this really - there are four main things that have been guiding and informing us thus far. First we have to design this evaluation plan that is directly responsive to the hypotheses that were included in the waiver application to CMS. Second, when CMS approved the waivers, excuse me. They also released a document called the "special terms and conditions". It provides clear guidance from CMS on what they expect to see in the evaluation plan as well. We need to make sure we are checking the boxes there and responding to what CMS expects. Then I have been joining a lot of DHS workgroup meetings, planning for the waiver, chiming in about the evaluation plan as needed and hearing from DHS staff on how to design this evaluation. Then lastly, we have looked at what other states have done for their own evaluation plans for similar waiver services that CMS has approved previously to give us a good sense of, again, how we can address what CMS is looking for. Next slide, please.

I am first going to touch on the continuous eligibility part. It is a little more brief in terms of what we need to cover for that. It is not as expensive as the other health-related social needs waiver services. The research questions for the continuous eligibility evaluation plan that you see here. We are primarily interested in - what was the effect of this change in enrollment policy, particularly on in and out of the Medicaid program. We expect that the policies would really reduce enrollment turn during the time period. It is a primary research question for us. We also will be looking at administrative burden in terms of did this reduction in the number of determinations that DHS would have to make - does that reduce ministry to burden for the department? Ultimately, how does this policy change affect healthcare utilization for enrollees? Does it increase the use of the type of utilization we would want to see increased. Preventative and outpatient healthcare and do we see the utilization we would like to see decline - also affected such as avoidable inpatient and ED visits. Next slide, please.

CMS is pretty clear that they want evaluators to use the scientific rigorous approach is possible and that often includes comparison groups when feasible. I want to talk about that for just a moment. For the reentry population for the continuous enrollment policy change, there is not a simple comparison population for them for us to use in this evaluation, simply because the policy will be adopted stateside simultaneously. What we can do instead and that CMS has approved these plans instead is look before and after the policy change for the population. Do we see the changes in the outcomes that I just referenced in the last slide move in the way that we thought they would? If the department does phase in the enrollment for children's ages of 0-5. We can use the data from other state Medicaid programs that have comparable enrollment policies, but have not adopted a similar policy of continuous enrollment between ages 0-5. We've already had some preliminary discussions with OIM about what the other states

might be that have similar enrollment processes that we can use in that case. Next slide, please.
For the health-related social needs evaluation, which covers housing, food and nutrition and prerelease services for the reentry population. If you want to think about this high-level, big picture of what we are trying to do here is we are trying to measure the changes in services that enrollees experience. How that affects changes in social needs, in this case homelessness, food insecurity, etc. and how does that ultimately change the health outcomes for enrollees? Next slide, please. To do that, we need a variety of data here, but I think you can categorize this really into three main groups. Administrator of data, enrollee reported data and implementation data. For administrative data, across-the-board we will be using DHS data that come from Medicaid claims, Medicaid enrollment data to look at individuals receiving services in looking at those health outcomes and healthcare utilization changes, but for each one of these components we need to look at other forms of administrative data. For example, you would be getting data from the Department of Corrections to understand when Medicaid enrollees were incarcerated and released. For housing data we would rely on homelessness management system data or OMHSAS data to see when people are utilizing services like emergency shelter or other HUD services like permanent supportive housing. For nutrition services we would want to see what other food sports our vigils are receiving in the form of SNAP benefits or WIC benefits. We also want to understand from the enrollee perspective, what is the impact of the waiver services? For reentry and housing we would do longitudinal interviews with enrollees. What that means is we would try to identify individuals who write when they begin receiving waiver services do an interview with them, basically a baseline interview, if you will and follow-up with them about halfway through them receiving waiver services a few months later and do 1/3 interview months after they have received waiver services to see how their health is at that point and how their social needs have changed due to the waiver services. We anticipate for example, for the reentry initiative that we would be looking to complete these longitudinal key informant interviews with about 60 enrollees per year of the waiver. For the nutrition benefits it is a little different. There are more individuals who would be potentially eligible because food insecurity is more prevalent than homelessness or individuals reentering the community and we would have the sample size to be able to do a larger survey of individuals so we could, in that case, hear more from individuals at a broader scale than we could for housing or reentry. Lastly, CMS is very clear that they want evaluators to really understand how services were implemented in the states also, what were the main barriers and facilitators that Medicaid programs experienced? For that, we would do a variety of stakeholder key informant interviews and this would include individuals from DHS, DOC, from counties. They might help administer some of these services, as well as the providers of housing and nutrition services under the waiver to get a holistic understanding of how services got implemented. Next slide, please.
Talked about the data. What are the outcomes we are looking for? Again, we want to

see, how do social needs change? Would be interviewing and surveying individuals about how their housing and security or food insecurity has changed due to waiver services. After receiving services, do enrollees return to homelessness or incarceration, or back to food insecurity? What is the long-lasting effects of these waiver services? Are they using other programs that could help for the social needs such as HUD funded housing or NOT or WIC that I mentioned on the previous site.
, Please. Of course we want to understand changes in health outcomes and the social needs can have a broad impact on individuals health. So we have got a corresponding long a broad list of different health outcomes that we would look at. That includes enrollee experience and the perceived access to healthcare and social services, and how the waiver impacts that. Inpatient emergency permit, behavioral health services, preventative services, avoidable acute events. A pretty long list. CMS also is requiring evaluators to look at mortality for individuals entering the community and causes of mortality like overdose. Also, for nutrition sensitive conditions, looking at how chronic disease management changes under waiver services and since pregnant enrollees can be eligible for nutritional services and housing services, we would also want to look at maternal health outcomes and how waivers impact those outcomes. Lastly, we want to understand how these services affect healthcare spending in other parts of the Medicaid program for these individuals and we hypothesize that there would be some reduction in those in healthcare spending services for those. Next slide, please.
So for comparison groups, again, we want to make this as robust of an evaluation as we can. The comparison groups would vary a bit depending on the waiver service. For reentry, we anticipate that we would leverage the phasing in of reentry services across - whether it is phased-in during different SCI's or by county. However the ends up being fomented we would and despite using that staggered implementation to look at within state comparison group of individuals that are not eligible for reentry services. For housing we would rely on administrative data, in this case the HMI asked data to identify individual's who are clinically audible and are also experiencing episodes of homelessness to identify comparison populations. For food and nutrition services this would be based on the enrollee survey, where we would use administer data to invite individuals that are clinically eligible for services and contact them to see if they are experiencing food and security and identify our comparison population next like, please.
Finally, CMS, again is clear that they want a robust understanding of how the services are implemented and what are some of the challenges to implement in the services and how Medicaid programs overcame those challenges. These include these five main questions that I have posted on this site, mainly, what are the strategies that stakeholders used to and Clement the services? How does infrastructure change? What were some of the internal or external conditions that affected and limitation and how different stakeholders view the barriers and facilitators to implementation? Also, CMS wants to understand, what is the overall cost of administering the services just like I noticed we want to understand how cost changes for healthcare services. As Dave

pointed out, the evaluation plans are due in the next couple of months - the continuous eligibility part is due to CMS next month. The reentry and health related social needs evaluation plan is due in June and it CMS does post those evaluation plans on their website once they are approved and we are happy to provide updates to the MAAC and provide interim findings as we get them throughout the course of the waiver. I'm happy to come back and report back and be helpful in any way I can.
I will stop there.
>> KYLE FISHER: Thank you for that. We know a lot of work went into creating the waiver and approval was CMS. Thank you for the continued efforts towards keeping this option alive and giving it implementation at this stage to the reentry component. Members of the committee? Any questions for Doctor Grande or Evan Cole?
>>KYLE FISHER: I am not hearing any, but was there anything else related to the 1115 waiver you wanted present before we move on to the OMAP portion of the meeting?
>>DR. GRANDE: I think that is everything we wanted to cover for today, but as Evan mentioned, happy to reconnect as we move forward.
>>KYLE FISHER: Excellent. Thank you both.
>>DR. GRANDE: Thank you.
>>KYLE FISHER: Sally, I believe we are back to your portion if you're ready to go.

- **OMAP Report**
    - **Deputy Secretary Updates**
    - **Doula Services**

>>SALLY KOZAK: I am and I am talking on mute. I wanted to say thank you for the presentation. I just have a couple of things on the update here today. First I want to talk a little bit about Doula services, GLP-1, we will give some updates on the hospital statuses and I want to mention about parents as caregivers. Let me start with the GLP-1's and this will be short and sweet. As you know, we are planning on making changes to the prior authorization guidelines for GLP-1's and so we are currently - it is going on while we are meeting, having a public pharmacy and therapeutics committee session. It started this morning at 10:30 a.m.. There are any number of individuals providing testimony and we will talk a little bit more at MAAC tomorrow about the specifics of the criteria, but I want to remind you that there will be a 10 day period to comment in writing and the information will be posted on our website. Just wanted to remind about that.
>>KYLE FISHER: When does that 10 day period begin?
>>SALLY KOZAK: It should begin tomorrow. After we announce it at MAAC.
>>KYLE FISHER: Okay, thank you.
>>SALLY KOZAK: It has been on the website for a while that we were accepting public comment. I know Terry has received written comment in advance. Okay, folks asked about Doula's. As you know, we were submitting a state plan and it was approved the beginning of April with an effective date of January 1, 2025. In December, we had published the corresponding public notice and issued the MA bulletin related to

coverage as well. All of that is completed. Just to give you an update, there are 187 perinatal Doula's in 25 counties in the Commonwealth. Of those, 55 of the certified perinatal Doula in the 13 counties are enrolled in the MA program. So again, we have 55 Doulas covering 13 counties that have enrolled in the Medicaid program. Of those, there are 80 individual service locations and they are enrolled as 14 Doula groups, recognizing that many of the Doula groups are enrolled as a group of one. So we have the counties being served Allegheny, with eight, Chester with one, Columbia with one, Crawford with money, Dalton County has four Doula's, Delaware County has six, Erie has six, Lackawanna has one, Lancaster has seven, was there and has three, Mercer has five, Northampton has four, Philadelphia has 31 and Wayne has one. That is a breakdown of where we are with the Doula enrollment. Questions?
>>KYLE FISHER: I think you covered a lot there. Thank you, Sally. I will back up a little bit because I think we went over some similar numbers during the pre-meeting, but we did not have these updated. I believe you mentioned 187 certified Doula's statewide. Did you mention they are also in all of the counties? How many counties are the certified Doula's in statewide?
>>SALLY KOZAK: 187 statewide are located in 25 counties and I don't have the break down of that. Just a breakdown of the Medicaid enrolled Doula's.
>>KYLE FISHER: That is fine. Not close to all of the counties. Of the enrolled Doula's, you said there were 55. A little less than 1/3 of the universe of certified Doulas. During earlier conversations we had heard that only a fraction of those MA enrolled Doula's are network providers in the managed-care system. Is that still the case? Do you know how many of the 55 are working with MCOs?
>> SALLY KOZAK: Currently we have 13 Doulas that are in the MCO networks at a rate of five in Philadelphia, two in Erie, and then we have one each in Crawford, Dauphin, Lancaster, Lackawanna, Luzern, and Wayne counties.
>>KYLE FISHER: That is kind of the struggle. CMS has approved the state plan amendment here. If we understand correctly, roughly 40,000 births or so are covered by Medicaid each year. 13 Doula in network is not going to cover very many of those consumers, or even the 55 doulas in the program generally. I guess, can you speak to some of the efforts the department is taking to increase enrollment and Medicaid generally and eventually, network status with the MCO's?
>>SALLY KOZAK: We have worked with the Doula commission for quite some time. We worked with them in developing the spa. We worked with them on enrolling Doula's. I know our fee for service, Michelle Robison and her staff had several training sessions to help facilitate enrollment of Doula's and I know Gwen and the managed-care plans have had a several sessions as well around how to enroll in a managed-care network, how to contract with them and get through the credentialing process. We promote Doula's anytime anybody is out and about at any maternity event. If you have heard the Secretary talk, if you have heard Sarah Nemec, the special advisor that focuses on our maternal health strategy. If you have heard any of us out there anytime we talk about maternity care, we encourage people to enroll in the Medicaid program and we

encourage people to seek Doula certification. In the beginning we did some public events with the Doula commission. We are certainly open to ideas and opportunities, but we think we have been pretty vocal and supportive in our visibility and support for Doula's.
>>LIZ HEALY: Sally, this is Liz Healy. Are the Doula's being used by consumers?
>>SALLY KOZAK: We do not have anybody getting Doula in fee for service, but we have people in managed-care using Doulas. We know some of the MCO's were employing Doulas and using them before we even put them into the state plan amendment.
>>LIZ HEALY: Thank you.
>>KYLE FISHER: It is Kyle again. I appreciate the context and some of the comments. It seems like this is a work in progress. It is now a state plan benefit and enrollment is continuing. Sounds like an area where we could continue to watch and hopefully enrollment will improve. Utilization will increase and if we have ideas to sort of propose related to increasing that enrollment, I think we can certainly pass them through. I don't know if the committee has those suggestions now?
>>SALLY KOZAK: We would absolutely welcome suggestions. If there are no more questions about Doulas, I'm going to go ahead and let Gwen talk about hospital terminations and closure as well and she will hand it back over to me for a couple of points on parents as caregivers. Gwen, you are on, right?

- **Hospital/MCO Contract Terminations**

>>GWEN ZANDER: Yes, thank you, Sally. As far as upcoming MCO and hospital negotiations, I have a few to share this month. United is in their contract renewal season. There are a few hospitals that they are negotiating with right now. The United contract with the Children's Hospital of Philadelphia CHOP has an expiration date of July 1. Letters would need to be sent to 18,623 members by May 14. I will say negotiations are ongoing and progressing well. There is no expectation that the letters will actually need to go. United also has a contract in the pipeline with Tower health, which includes Reading, Pottstown and Phoenixville hospitals, United's contract with that system has an expiration date of August 1. Letters would need to be sent to 2,272 members across all three of those hospitals by June 14 and again, those negotiations are also ongoing.
Health partners and Keystone First both continue their negotiations with Holy Redeemer Hospital. Both of those contracts have an expiration date of June 30. Letters would need to be sent by May 13. Health partners would need to send letters to 10,741 members and Keystone first would need to send letters to 7,195 members. Again, those negotiations are ongoing as well.

Moving away from contracting and toward hospital closures. The first to report is Heritage Valley Kennedy Hospital in Allegheny County. The hospital is scheduled to close on June 30. Letters will be sent by May 13 to 870 Highmark members and 93

AmeriHealth members. We do not have concerns about continued access in those areas for those MCO's and we appreciate the lead time leading up to the hospital's closure to make alternative arrangements for those members.
The other closure I need to report on is related to Prospect Medical Holdings, which is the owner of Crozer Keystone healthcare system and affiliated healthcare providers that includes the Crozer Chester Medical Center and Taylor Hospital. You might recall that prospect has been in bankruptcy proceedings for the last several months and the significant efforts have been undertaken by the Commonwealth Delaware County, as well as charitable organizations to ensure the hospitals could remain open during the bankruptcy proceedings. Despite the efforts on Monday, prospect announced the hospitals will be closing. The hospitals will begin winding down services immediately and intended to be closed completely by next Friday, May 2, 2025. The emergency departments at those two hospitals stopped receiving patients from EMS this morning. The emergency departments will remain open until healthcare services are no longer being offered at those hospitals. Again, most likely by next Friday. The ambulatory surgery and imaging centers at Renton Lake, Haverford and media will remain open. Prospect has identified the cases for whom discharge planning is most difficult and DHS has alerted the MCO's who have numbers on the list. The MCO's are working with the Crozer social workers to make discharge plans and MCO's are also assisting with discharge planning for any members that are not on the difficult to discharge list, but are still admitted inpatient at one of the two hospitals. As well as working to identify alternate providers for members with open authorizations for services at these hospitals. MCO's are sending closure notices to all impacted members as soon as possible. There is a total of 28,897 health choices members that will receive these notices. 21,772 are Keystone first members and 20 are Amerihealth members. 4,209 are Healthpartners members and 1,418 are United members, 843 are UPMC members, 594 are Geisinger members and 31 Highmark members. Here at DHS we believe there are adequate alternate providers in the MCO's networks to meet the needs of these members, but we acknowledge the stress that this will place on others health system such as Mainline health. I regret to come to the committee with that news, but that is everything we know about the situation at this time.
>>KYLE FISHER: Thank you, Gwen. You covered a lot there and the closure of Crozer and Taylor hospitals has been a hot topic the last couple days. Something we also touched on this morning. If I understand that you right, just shy of 30,000 health members have been using these facilities and should get paperwork from their managed-care plans to notify them of the closures. I guess, can you speak more to the list, the share or volume of Medicaid consumers included in the difficult to discharge plans or the inpatient numbers with the NCOs and the expectation of the department on the MCO's and transferring them to another facility or helping them discharge?
>>GWEN ZANDER: The rest of the highest priority discharge cases contain somewhere between 20 and 25 cases on the list and four of them were physical health choices members. There were some that were CHC members as well. I don't have numbers on

that, but others were Medicare commercial, TRICARE, etc. Physical health choices made up, I don't know, 1/4 to 1/5 of those most difficult to discharge cases. The MCO's enhanced member units, case managers have been working with the hospital social workers to identify facilities that would accept these individuals. They are difficult to discharge for a variety of different reasons. Some medical, some behavioral. Some social and so EMSUs are working with the hospital social workers on a case-by-case basis to find the best place for those folks to go next.
>>KYLE FISHER: Helpful, thank you. Committee members, any questions around these or anything that Gwen presented on? Go ahead, please.
>>LIZ HEALEY: I have one question about the hospital closures that are happening and some have already happened. I understood from our meeting this morning that the governor might have a proposal that might address the venture capital firms that are buying hospitals and stripping out the assets and then closing them. Do we have any information on that?
>> Liz, there is nothing I can share. I'm not sure exactly what you are referring to this morning.
>>LIZ HEALEY: Okay, thank you. Just a concern. There is less here in Pennsylvania, but several hospitals that have been sold to venture capitalists.
>>SALLY KOZAK: We know in his budget address he talked about it as an issue. We know the legislation has - the legislature has been concerned about it, too. I don't have anything definitive of what happened this morning.
>>LIZ HEALEY: It is unfortunate.
>>KYLE FISHER: One piece related to this, you mentioned the second hospital in Allegheny County where there is much more lead time to the closure. Could you repeat the name of that hospital? Heritage Valley, perhaps?
>>SALLY KOZAK: Heritage Valley Kennedy is the name of that hospital.
>>KYLE FISHER: Sounds like it's solving a smaller proportion of Medicaid population roughly 1000 members? Is that right?
>>SALLY KOZAK: Yes.
>>GWEN ZANDER: One thing I want to share the people who are used to getting bad news, Sharon Regional Medical Center that we have discussed in the past, but it had closed a couple lines of service is preparing to bring some of those lines back on. So a potential reopening and expansion of offerings upcoming at Sharon regional medical center. But as one bright spot on this landscape.
>>KYLE FISHER: Take any good news we can get. Any proposed date or timeline on that?
>> I will have to check on that one. I was reading it mostly in the news, but I can get some official word from the department of health.
>>KYLE FISHER: Any questions?
>> We have one question in the chat from Jeff Eiseman, they would appreciate if there's a way they could get the number for how many members of CHC members would be impacted by the two Delaware County hospital closures.

>>RANDOLPH NOLEN: I will check with the MCO's to see what the participant population is that utilizes these two facilities. I will check with them and follow. CHC and MCO's are working with Crozer right now, especially there are two, maybe three hard to place individuals there.
They are also working on the general population for anyone inpatient right now. I will get the information.
>>ELISE GREGORY: There are no more questions in the chat.
>>KYLE FISHER: Thank you, Elise. Gwen, anything else you want to present before we go on?
>>SALLY KOZAK: I've quickly wanted to do some reminders as parents as caregivers. The last two weeks I have gotten feedback from providers that they are feeling pressured by parents to order skilled nursing services, in fact I saw a copy of the letter for an individual that was on a ventilator and had a tube feeding as specified the name of the parent and the child. So I want to issue a reminder that parents that are serving as a home health aide must be appropriately trained and employed by a home health agency. Parents that are home health aides not allowed to perform higher level skilled care without appropriate qualifications. I know there is an entire issue of clocking in and clocking out. What I will also say with this is that parents who are taking care of their child and being paid as a home health aide, they need to be taking care of the child. Attending to other household tasks or other childcare for other children in the family is not allowed while you are being paid as a home health aide for that one child. Being paid as a home health aide to take care of your child is a job. I will just issue those reminders.
>> MEGHANN LUCZKOWSKI: Hey Sally, thank you for that. This is Meghann. I know we talked about this before. There are some provider agencies that are indicating that parents that all they have to do is get a letter that states such and such and they will be able to pay them as the child's paid caregiver for skilled nursing.
As advocates we are trying to cut that off, but we also implore the provider networks not to share information that cannot be done. It is a confusing landscape. We will bring these issues to you when we find them, but there has been some massive miscommunication from some providers in the Pennsylvania region, indicating to parents that they can be paid as skilled caregivers without a credential. Just to put on the radar that this is coming from the home health providers or the home health providers urging parents to request this. I am glad to know that when it gets to perhaps the prescribing provider or the MCO level that the parents are getting the correct information, but it is important for the health home agency provider networks to understand that this is not an option at this time.
>>SALLY KOZAK: I do not disagree with you. We have heard the same thing. I do attend the PA home care associations pediatric cabinet meetings from time to time and the stress this last time I was there and I will do so again the next time that I am there. We know - I have seen photos of them. I've not seen the actual ones themselves, the billboards that say "get paid to take care of your child". I will continue to stress that

certainly we are supportive of parents being able to be employed as a home health aides in order to care for their children or provide unskilled needs for their children, but it needs to be done in the correct manner. My concern is first and foremost safety, but because the parents and the agencies are in a potential position for fraud and we do not want to see that.
>>MEGHANN LUCZKOWSKI: Absolutely. Yeah. I know we have talked about this before and just make sure everyone is clear, we are all aware that parents are providing this extraordinaire care regardless of whether they are paid or not. In fact there is no nurse for my son right now. I'm double duty right now listening and on the call and hanging out with my little guy, and providing medical care. Just to make sure - exactly. Safety first and it is, again, a confusing landscape and I understand that. If you get a little mixed up about certain things, but I appreciate that you're trying to keep the motions clear and we will do the same on the advocacy level as well.
>>SALLY KOZAK: Appreciate that. Thank you. Okay! Kyle, I think that is it for OMAP. We can move on with the agenda.
>>KYLE FISHER: Thank you, Sally. Next up we have OMHSAS. Do we have the deputy?

- **OMHSAS Report**
    - **Deputy Secretary Updates**
    - **BH MCO Denials & Appeal Data**

>>JENNIFER SMITH: I am here, Kyle. Can you hear me?
>>JENNIFER SMITH: Full disclosure, I have a hard stop at 2:30 PM today. I was allotted 25 minutes. That should get us right before 230, but in case there are questions that take us past a point, I have two staff members, Joslyn and Bill on the call and would be happy to take questions or bring things back if in fact I needed to hop off before our portion of the meeting is done.
Before we get into the slides that you see here, which is some data that I want to share around denials, grievances and complaints. Gwen's update regarding some things happening with the physical health managed-care plans reminded me that there is probably an announcement worthy of noting to this group. In the behavioral health health choices program, one of our primary contractors, which is the primary contractor that serves Bedford and Somerset Counties. They will be transitioning from their current behavioral health managed-care organization, which is CCBH to Magellan on November 1 and their members were first notified. They have about 24,000 members. They were notified late last week. For the first time there will be a series of notifications that goes out to members, but just wanted to make this group aware, it is not often that our counties transition from one dim code to another. It did indeed happen that this calendar year and so again, that is Bedford, Somerset and that will take place November 1 and that they are transferring from CCBH to Magellan. Any questions about that before I move on?
Okay. Good. What I wanted to share with you all today and hopefully members received

a copy of this prior to today and maybe have had a chance to take a peek at it, but wanted to share a little bit about data regarding denials, grievances and complaints. This is specific to the behavioral health health choices program. This is a specific request that came out of the MAAC and we thought it made a whole lot of sense to present the same information to consumers hub, just so you were all getting that information as well. I will start off with just trying to define in people's minds, the differences between these three terms that I am going to use because they sound sort of similar and I think sometimes some people use them interchangeably, but because we are presenting data related to these three categories, I wanted to make sure that we were clear about what we meant when we used these terms as it relates to the data that we are going to be presenting. When we say a "denial" in today's presentation, what we are talking about is when one of our managed-care organizations or I will use the word BH-MCO here. If they deny a service, the frequency of the service, the amount of the service or the particular type of service. That denial or the request for those things could be submitted by a member, a representative of the member or the provider. This is where a BH-MCO is saying, no, we either partially or fully do not agree with providing the service in the amount of units and is often you are requesting for it to be provided. A grievance then would be when a member or their representative, which could include the provider on their behalf asks the BH-MCO to review a decision that they have already made and that often happens as a result of a denial. If the BH-MCO denies partially or fully a particular service or amount of a service, the member or representative may grieve that and say, we are asking you to reconsider that decision that you have made.

Complaint is slightly different in that complaints are not necessarily related to a denial of service, but rather to be any dissatisfaction with either the managed care organization or a provider. So they could be dissatisfied with the quality of the services that they received. They may file a complaint because they believe that the BH-MCO did not meet the required timelines associated with may be the grievance process. It might be related to a complaint that the particular service that was provided was not the service that had been agreed to. Complaints could be any number of issues that are not necessarily tied to a denial or a grievance related to service provision. It might be related to quality of services or just the way that a member or a provider was treated through that process. Those are kind of the three categories that we are going to talk about today. We are going to start with talking about those denials. So you can flip one more. There we go. Before we get to the data, we kind of put some frequently asked questions here that we thought might be helpful - both to set the stage for folks and in case anybody wants to use the slide deck and be able to share it out after the meeting. One question we get sometimes is why does the BH-MCO have to approve or deny the services that are being requested? The responses that one of the key responsibilities of a BH-MCO, which is similar to that of a commercial insurance or an employer-sponsored insurance provider is that they prior authorize or review services before the services begin to ensure that what is being requested meets certain criteria. We call

those medical necessity criteria. For example, I will use a physical health example because people seem to understand those better. If a provider is requesting heart surgery, but the individual does not have a heart condition, it would be important for the insurance company to say no, we're not going to pay for heart surgery because you do not meet the criteria for needing that particular service. That is the thing where talking about here. That is why they need to look at what is being requested to ensure that it is an appropriate service for the needs of the individual. That means they do have the ability to either approve or deny the services that are being requested. If in fact they are determining that the service being requested is not appropriate for you, what they can and should do is approve another service that would meet the needs that you have. If they are indicating to you that they do not believe residential services are medically necessary for you and so they are going to deny your request for residential services. They may say, however, you are approved for intensive outpatient services or something similar. That is something that is an example. Does OMHSAS monitor the BH-MCO's to make sure that they are appropriately approving and denying services? Yes we do. We have a whole team of people that is responsible for reviewing this denial data and they do some sampling to actually dig in to some of these denial letters they will do a review of that data in the decision-making process surrounding it. That is a little bit of background on denials and why they happen, how they happen and who monitors it. Now I think if you go to the next slide, yeah, I think we made a boo-boo. If you could go forward to slide number seven. Oh, back one. Back one more to seven. Perfect!

We got the slides a little out of order. My apologies for that. We jumped from 4 to 7 for those following along on your own copy. What you see is service denial data for calendar years 22, 23 and 24 through quarter three of 2024. These are the raw data numbers. You certainly could look at this in a chart or bar graph format, but I thought this was probably the easiest in terms of looking at the volume of the types of denials. If you are looking at the chart and you see a place that says "less than 11". That means there were less than 11, but for data integrity purposes we are not allowed to share those specific numbers. Anything less than 11 is reported as such on this chart. On the top of the slide it shows you the volume of denials by service type. For example, crisis intervention services, which there might be a host of different services. They are all lumped into that one particular service type and the bottom of the slide reflects the volume of those denials by BH-MCO so you can see the trend of the numbers of denials by managed care organizations. If you're looking at the top, the largest number of denials are occurring in the IBHS service space and there were some very recent developments in this arena in terms of the publication of new regulations and requirements for providers to adhere to those regulations. And criteria around those services. There is also a significant volume in the nonhospital residential withdrawal management rehab and halfway house services for drug and alcohol or substance use disorder. I can tell you that, you know, one of the reasons we see some change their is over the last eight years, DDAP and OMHSAS have been working on the ASAM criteria,

American Society of addiction medicine. It is a set of criteria that is used by drug and alcohol treatment providers to assess need and determine appropriate treatment plans, levels of care, length of stay, etc. We have been working with providers to make that transition from an older model of that tool to the ASAM criteria and as a result of that, there have been some changed expectations around what providers should be offering in terms of drug and alcohol treatment at different levels of care. You know, we have seen some shift from folks who historically would have been approved for residential treatment services who, you know, when you put in the ASAM criteria would not require residential treatment services, but might require intensive outpatient services with some other wraparound services. There has been a little bit of a bumpy road in terms of making that switch to a new set of criteria and providers kind of retraining themselves around the way they assess need for services and the types of services that they request.

That is probably the area we see the biggest jump on here and there have been some meetings and groups of people convening to try to discuss those challenges and work through some of those issues.

>>KYLE FISHER: If we can, I appreciate you walking us through all of this and we noticed for this particular category, the spike in denials and 2024 for those services. I guess the other piece, if you could speak to it, it seems like the increase - by looking at the chart below, it was primarily driven by just one of the BH-MCO's. Can you tease out why Magellan had a spike going into 2024 and not the other MCO's. Especially with the implementation of the ASAM criteria, which presumably would have been done by the other plans as well.

>>JENNIFER SMITH: Right, yes. The ASAM was one of the factors. It not the sole factor. When I mentioned that we are digging into this and working with folks to uncover a little more information. I'm specifically referring to some providers within the Magellan network. We have had meetings with Magellan and the primary networks that work with Magellan and providers having conversations specifically in this space and I don't think we have gotten to a place where I have much to share publicly about that. Just that we are continuing to dig a little deeper into what might have caused the number of denials to increase so sharply, specifically for that BH-MCO. Happy to follow-up with this group once we know a little bit more.

>>KYLE FISHER: Yeah, that is helpful. I appreciate you sharing the data to shed light on this. I know it is something that we were aware of otherwise. I guess, one other piece and I know the MAAC requested this data. Usually it is the consumer subcommittee requesting denials data again and again. I'm sure OLTL and OMAP are tired of hearing it on their sides. For future iterations it might be useful to know what the universe of prior authorization requests are to see percentage denied. As well as the absolute denials. It is just the denials here. For the future slides we spent a little time on them earlier I don't think there's anything particularly surprising to the group, but grievance outcomes information is valuable. We'd ask for that in the future, too. I would be curious, again, sticking with this Magellan line with the sharp uptake in the denials to see how many of

those were grieved and the outcomes of the grievances. Maybe that is something you are already looking into.
>>JENNIFER SMITH: That is one of the pieces we are getting to the bottom of, right? Just because there's a denial, doesn't mean it was upheld. It could very well be that the service was then provided to the individual. There could be a lot of reasons or increased denials. It could be new staff members that were hired there that were misinterpreting some of the policies or over interpreting things and so that could have been corrected through a grievance process or even through communication between the provider and the BH-MCO before it resulted in a grievance. There is a lot of moving pieces and complexities to the data, which is why it is important that we talk about instead of me just sending the data and saying, here's what you asked for. Okay, I will keep us moving so I tried to get us through and we can take questions or follow-up if we need to after the meeting. Jim let's shift. You need to go back to slide six. Just back one. We were just talking about - perfect. We were just talking about denials and that we are shifting into the second category of grievances. This would be when a member, the representative or the provider is dissatisfied with the denial that occurred and is asking for a review of that decision. A couple of quick FAQs. What if I disagree with the decision to deny my request for services? You have a right to grieve that within 60 days of the BH-MCO's decision and the grievance is when they are asking the BH-MCO to review the decision that had been made on a service that was requested and how you file the grievance, what happens after you file it. You do that by contacting the BH-MCO. Either by phone or in writing. Within 30 days they are required to hold a meeting with you. If for example they do not do that within 30 days, that might result in the filing of a complaint, which is the third category that we will talk about in a few minutes. Once they hold that meeting within 30 days you can attend that either in person, you can do it over the phone or through video. And also bring individuals with you if you'd like and that will consist of a committee of three or more people. That has to include a licensed doctor or psychologist and at least one person who does not work for the BH-MCO in this process is called the "grievance review". The BH-MCO that participate in this review are not the same people that were involved with the original determination or denial that is being grieved. Even though there are folks from outside the BH-MCO participating, the folks within the BH-MCO participate in are not the ones who originally made the decision. The effort is really made to ensure that there is sort of an objective opinion here, fresh set of eyes on the situation. Okay. Now if we could go to slide eight?? Great, thank you by the way for whoever's navigating the sides. You're doing a great job hopping around for me. So this chart shows us both mental health and SUD grievances by what we are calling service group. So again, it is a category of services. We did indicate in the chart, which of those are mental health related versus substance use disorder related. As you will see, a number of these categories, there are very few, if any grievances being reported. Most of the grievances are coming through in just a handful of different categories. So if we go to slide nine, this is looking at the same data from slide eight, but instead we are looking at a chart or a graph view. There it is. These are just the mental

health categories. So when we were looking at the table on slide eight, we had indicated MH or SUD. Just ones and negative for mental health and only the ones that had more than 11 grievance instances because again, anything less than 10, for data integrity purposes we are not supposed to be reporting really. So here are those three categories. We have the IB HS services. Inpatient psych hospital services and those are not services provided in a state mental hospital for clarity. Residential treatment services for children and adolescents. The reason it is nice to look at the data in a little different view is to be able to see the movement over time visually. So what is notable here is that all three of those lines sort of seem to be heading downward as we are looking toward quarter four, however when you look at those lines over time, the inpatient psych is still higher than it has been in the last couple calendar years. Whereas residential treatment services was higher than it was it dipped way down and now it seems to be leveling out somewhere in between those two extremes. Same data here that was on the previous slide, but showing you in a little different visual format. If we go to the next slide, number 10, this is the substance use disorder category that had significant enough numbers to be reporting and it is that nonhospital withdrawal management rehab halfway house services. That's a big category and there's a lot of different services that fall into this category, but you can see that there has been a pretty steady increase since the beginning of calendar year 2023. With these grievances, and again, some of that does equate to the changes that have been happening and that the real implementation of those criteria - we have been working on it for about eight years, but compliance with that criteria has only started to be looked at by our BH-MCO's and the single County authorities over the last couple of years. It does seem like there is a correlation there. If you move to the next slide, what we are looking at here are grievances. Talking about the second category, but by the primary nature of the dispute, and honestly there is really only about two dispute reasons. There are two others, but they have such minimal reporting that they are statistically insignificant. Really the nature of the dispute falls into one of two categories. It is either MH related or SUD related and it is because of a termination or reduction of a previously authorized service. Okay, I will keep us trucking knowing that I'm watching the time. If we move ahead to slide 13 - we are headed into the third category, which are complaints. This is when you are dissatisfied with any aspect of what is happening, either with the BH-MCO or the provider. There are three levels of complaints. All complaints are initially logged as a level I complaint and they are investigated by the BH-MCO. They can then be excluded to a level II complaint of the members not satisfied with the outcome of the level I review. Level II complaints are reviewed by a complaint review committee that consists of three or more individuals and then there is what is called external review complaints, which are complaints made directly to the Pennsylvania Department of insurance. One note that my stuff wanted everyone to know, complaints can be expedited through this process of someone's health and safety is in jeopardy. If this is an immediate need to address - if there's a quality of care concern, these things can be escalated very quickly to ensure that we are addressing

the health and safety concerns. Okay, the next slide - I know it is busy, but stay with me. The left-hand column are the complaints by these service groups. The types of services are grouped into these categories.
And then the columns represent by quarter, each calendar year and so again, we don't have the fourth quarter from 2024 because we did not have the date at the time that we prepared this presentation. Thought it was nice to be able to see the details of the types of complaints that are coming in and what categories they are typically falling into. I would say there are not huge outliers when you look at this chart. Not like the slide we saw earlier with denials where there was a really big jump. You do not really see that in this data. There are some fluctuations here or there, but nothing that is really, really significant. Nothing that seems to be exceptionally concerning just from the number perspective. If you look at the next slide, 15, this depicts for you, the mental health complaints. The service groups that are related to mental health service provisions. You will see sort of for the most part a downward trend. There were a couple spikes with the psychiatric outpatient clinic in the inpatient psych hospital services. There was a bit of a jump from the end of 2023 to the beginning of 2024. Throughout the 2024 calendar year they were all trending downward. Substance use disorders by service group and what I will call my attention to here is if you look at 2024, quarter two-quarter three, there were two service groups where we saw increases and those are drug and alcohol rehab and outpatient services that include outpatient and methadone maintenance. It is not a huge jump, but we saw an increase there. We we will take a look at what happens in quarter four to see if the trend continues or see if it levels off or declines. Overall, you can see those lines are fairly stable. Some movement up and down, but fairly stable. Then slide 17 shows you the complaints by the primary dispute reason. What was the cause of the particular complaint? On this particular chart, I think the one that really sticks out to us is near the middle there, the category says complaint related to BH-MCO or provider customer service you will see that it was 68 in 2022. There were 91 complaints in 2023 and 111 in 2024. Remember, that is only three quarters worth of that calendar year. That is a little bit concerning to us that there has been such an increase in complaints related to customer service. Then the last two slides, 18 and 19 are that different depiction of the same data that we were just talking about on the slide 17.
>>KYLE FISHER: I wish we had more time because it's nice to have someone who so thoroughly enjoys this data and reporting it in-depth. Thank you for that. We do appreciate all of your time today walking through the appeal data. I want to say that we had teed up questions related to provider capacity, and access, and network adequacy. We would love to have you come back to continue that conversation if we can get on your calendar again for a future meeting.
>> JENNIFER SMITH: Definitely. If you have questions about the data now, please feel free, my staff are on. I just have to hop to another important call. I appreciate you all so much. Thank you for the ability to present you all today. I hope you have a great rest of your week.

>> Members of the committee - I think we have had a member or two join us since we did introductions. Seeing Mr. Duffy, Spencer, do you want to introduce yourself? If you are able to come off of mute? Maybe not.
>>SPENCER DUFFY: I am here. I'm here, sorry. Yeah, Spencer Duffy, I'm a consumer from Warren County, Pennsylvania.
>>KYLE FISHER: - - (echo). Spencer, need you to go on mute unless you have a question.
>>LIZ HEALY: Kyle, this is Liz. I know earlier we were talking about the difference between authorized and scheduled. Is that relevant for this area that we're talking about right now? No?
>>KYLE FISHER: For these appeals, it could show up in the complaint data and I suppose for the OMHSAS staff here, the question really goes to capacity issues. What is the best recourse for somebody who has a service authorized, but there is not a direct care worker or a private duty nurse or in this instance ABA staff to provide the services for consumers that are calling the MCO around that. Would the best recourse be filing a complaint? Is that where we might see that in this data?
>> BILL ?: Quick hello, this is Bill positive Eric, divisional quality management. To answer your specific question, yes. A complaint Avenue would be the correct mode to take for that particular scenario that you brought up. Just scanning through the categories there, the complaints by primary dispute reason. It is not jumping out where I would put that, but I think it would be complaint related to - that could be a quality of care issue. Actually, that is probably where I would fit it.
>>KYLE FISHER: Perhaps treatment delays towards the bottom?
>> Oh, you know what, great eyes. That would be a great one as well.
>>KYLE FISHER: - -
>> Am not sure if that is just for implementation of the service, but I think, you know, we do not necessarily have specific operational definitions for each of these terms. So you know, that is certainly feedback that we can take back and if there are - if we are noticing among - that that is a systemic problem where individuals are authorized for services, but there is not staff capacity to deliver the authorized service as scheduled by the individual, we can look to add that as a particular group to carve that out.
>> I think that would be helpful, thank you.
>> Sure. We will definitely take that back. Appreciate it.
>> Hearing no other questions, I think we are behind schedule and we can keep this moving. Thank you Bill and others at OMHSAS and to the deputy. Who do we have next?

- **OIM Report**
    - **County Assistance Office (CAO) Operations**
    - **Disabled Adult Children**

>> CARL FELDMAN: Good afternoon. This is Carl Feldman, director of the Bureau policy with the office of income maintenance. I am here today to share some information that

you requested regarding the office of income maintenance activity. Good afternoon.
>>KYLE FISHER: Good afternoon, Carl.
>>CARL FELDMAN: We have been reporting to you at your request, information about CAO timeliness. What I can say is the average days to process and approval for March is for the Medicaid program, 14.3 days. That is down three days from the previous month for the waiver program, 17.6 days, that is about one day from the previous month and long term care is that 17.8 days. A three day change, we think is substantial and we are happy to say that we think we might have finally shook off the long tail of a system latency that occurred primarily in the month of November. We have also seen a drop in the volume of activity, which we think is kind of a seasonal occurrence. To get back to where we wanted to be, change some of the things that we were doing to get there. We offered overtime in each of the previous months and are offering overtime in this month as well. Workers can really focus on their activities and not be disturbed by outside contacts. We also changed around to some of the activities of the processing centers that we have to focus more on working eligibility and the belief is that focusing on eligibility work and processing that would overall reduce the call volume that comes in because it's part of a vicious cycle you can get into if Bureau of Operations is unable to handle the workload processing. People call asking what is going on, and if you're processing the work you cannot answer the phones, or vice versa. So you have to make a decision of how to manage that based on what we know. That is what we did. We focused on processing. We can also say that for the Medicaid program, we were at 90.4% completed within 30 days. Which in the month of March, which was down - I'm sorry, it was up 5% from the previous month. That is a big improvement. For the waiver program we are at 79.7% completed in 30 days, which is a little bit down from February and for the long-term care services we are at 81.3% completed in 30 days, which is down 1%. That is information about our timeliness and separately we were asked but a related question, which was staffing.
For April 2025, we can say that we are statewide and filled at about 93%. Specifically in area one, the Philadelphia County assistance office and the district offices were at 85% and in area five Allegheny assistance office in the district offices were at 89%. That is a demonstrated improvement from where we were at this time last year. This time last year we were only at 91% statewide. Allegheny was at 84% and PCAO was at 81%. There is definitely a way to go, but the changes taking place - we are happy to see some progress there. So I will stop for questions you might have about our operational activities.
>> I want to pause and give space. I don't know if members of the committee have questions?
>> We had one question in the chat from Ashley right. Can you repeat the number of days it took for CAO's to process applications?
>> Average days for approval in March for Medicaid cases, straight Medicaid cases, there were 14.3, which is down three days from the previous month. For waiver it was 17.6, which was up one day and for long-term care it was 17.3, which is up one day from

the previous month.
>>KYLE FISHER: I think those numbers on the average days to process dropping three days is excellent news. It is good to hear and I appreciate you sharing that and the other data. I will also share that what motivated this question is really anecdotal reports from consumers, and legal aid offices, of continued struggles with the CAO processing of applications and paperwork, and also processing of appeals. I think we have seen multiple instances where timely appeals were received, but they were not processed until after the closure had gone through. Which given the way that monthly capitations work for managed care may not always have an impact for coverage through Healthchoices, but for individuals getting waivers, it can be a huge problem. I guess one question related to that - is there any way you are able to monitor how quickly appeals are processed or is there a policy related to how quickly you expect CAOs to manage the appeals?
>>CARL FELDMAN: I don't know specifically what you are referring to be cuts if the person feels timely, benefits can continue in the Bureau of hearings and appeals sets the hearing dates to which we attend and of course the consumer can attend as well. Do not really have the ability to dictate when BHA sets the hearings for.
>>KYLE FISHER: I should have been more clear. Filing the fair hearing request with the County that took the adverse action. At the county level, staff has to put in process the appeal so the action does not go through, right? And also process it with BHA. We have seen delays in the County caseworkers processing that appeal on the front end.
>> You are saying people that are appealing timely, but benefits are not continuing?
>>KYLE FISHER: Right. Until there is intervention by whatever regional legal aid office or our office or something else. That seems to be more than a single instance here or there. Where someone is connecting with legal aid, they are often able to get it resolved, but the issue is that there is a lapse in the benefit that should not have occurred, right? Our understanding is that counties are supposed to process the appeals immediately, but I don't know if that is accurate that is part of why I was asking you to clarify if there is a policy or if there is any monitoring of how quickly counties are actually processing appeals.
>>CARL FELDMAN: I'm not sure, but I can look into it. The question on the policy, I do think we have something in our supplement handbook, chapter 870. Handbooks are publicly accessible. Maybe you will get there faster than I will, but that is something we are happy to follow up with you about.
>>KYLE FISHER: Thank you for that. Consumers, members of the committee? Any other questions on this topic? ... Great, hearing none. Carl, any updates on disabled adult children?
>>CARL FELDMAN: I don't have any new report from the previous month I don't believe, but I will repeat what was said previously. At this time, no decision has been made to change the CAO role specialization for DAC, I can tell you the number of monthly DAC closures and re-openings for December of last year - there were 126 closures, 58 of which were reopened. In January, there were 133 closures, 44 of which reopened. In

February there were 135 closures, 64 of which were reopened. I suspect I will have a figure for March very soon, but I do not have them today.
>>KYLE FISHER: Does not sound like members of the committee have questions on that. We do appreciate OIM continuing to run the report and circulate it to the counties to have these cases reviewed, reconsidered. It is disturbing that so many of them are reopened. For those December and February numbers, it was nearly half that were reopened. It provides further evidence of the need to have specialists to get these right on the front end, if at all possible. Understanding this is still a small number of cases and scheme of Medicaid processing activity, the numbers here are not encouraging.
>>LIZ HEALEY: Thank you, Kyle. I wanted to reinforce that. Having one person in each office who specialized in these cases could probably change those numbers substantially. I continue to urge you to consider that.
>>CARL FELDMAN: Thank you.
>>KYLE FISHER: Thank you, Carl. Appreciate OIM's report. We are running a little behind so let's hold other questions or public comments until after the OLTL report. Not sure who we have presenting for OLTL today.

- **OLTL Report**
    - **PAS Staffing Data**

>>RANDY NOLEN: It is me, Randy.
>>KYLE FISHER: Sorry for leaving you 15 minutes behind.
>>RANDY NOLEN: It is okay. I'm not sure I have enough voice to speak for more than 15 minutes. For the record this is Randy Nolan, I'm the director of correlating integrated services in the office of long-term living. We will talk about OLTL updates with recent medications and some PAS service staffing issues that we are going to talk about. Next slide. Procedure updates, effective March 31 of 2025, the agency choice procurement has been canceled. It don't know what the future will be for that, but we have canceled the current procurement. Community health choices request for application continues as it has in the past. We announce the applicants back in August 2024. It is currently in a stay. Anything pertaining to it - we are having discussions about and if you have any questions about the RFA or procurement for CHC, you can send those to the RA resource account listed on the site. No further word on that.
We'll talk about the communications that we sent out. OLTL pointed services provided guidance on the Pennsylvania office of vocational rehabs 25 order of selection. On April 15 OLTL least a listserv notification provided guidance to the following entities regarding the referral of participants to the OVR program a. It went out through the managed care organization, service coordinator's, service coordinator entities and agencies and to service providers. OVR recognizes three distinct categories. Nonsignificant disability, significant and most significant disability. The April 1, 2025 is a wait list of participants who fall within the nonsignificant disability and significant disability categories. Participants who are determined by OVR to fall within the most

severe disability category will continue to get OVR services. Part of this being a partial OOS closure, participants are requesting plumbing services must continue to be referred to OVR or determine eligibility. That ListServ went out last week and yeah, last week.
There have been questions about PAS services and staffing and missed shifts we have talked about missed shifts that we were able to collect information on the shift. On some of our operation reports and the missed shifts, we have a number of categories. Some are that the worker did not show up for the participant themselves canceled the direct care worker, participant may have been away or in the hospital. The agency may not have had staff to fill that. We have talked about that and released data on that and we know out of the past services that we provide, we are seeing less than 1% of missed shifts occurring out there. Now there has been some other questions that have come up and I wanted to get clarification on what the committee wanted as we are looking through this. I know there have been questions that have come up on shifts that may have been - a person may have been assessed for them, but they were not authorized because there was not a actual service provided. And I just need clarification back from the committee on that. I think what you're looking for is a person, for example is assessed in a person centered service plan comes up and they need 100 hours of PAS services. If 55 of those are authorized in the system, meaning that they are out there in HHA and that there is a provider that has picked up the 50 hours, those 50 hours are good. The other 50 hours are not sitting in HHA that are authorized because they cannot find a provider for whatever reason to provide the 50 hours. I think that is what you guys are asking for and I just need some clarification on that. I don't know, Kyle, if you can provide that or somebody on the committee can provide.
>>KYLE FISHER: I think you got it exactly, Randy. We were looking for the overall rate at which authorized hours are being filled. Last month at the MAAC, ODP mentioned a “vacancy rate” for their DSPs. With FFS, it's probably easier for them to track hours authorized versus hours filled. That is essentially what we would like from OLTL as well. I think unlike the pediatric situation where in our experience, most of the home health aide or skilled nursing authorizations are picked up by an agency. So then when the agency is doing whatever report to show what was filled and what wasn't and why, it is capturing pretty much the full universe of authorized hours. For PAS, that seems less common. We found people with authorized hours and in the example you gave where there is a chunk of that that is not picked up by an agency. In the agency reporting around what they filled, or did not fill, is not encompassing the full hours and that is what we were looking to see. The full universe of hours versus those actually provided.
>>RANDY NOLEN: I thought that is what you were looking for, but I appreciate you clarifying it for me. I discussed with the MCO on how to collect the data of the hours that are sitting there that are approved, but not authorized it because there is no provider. The system does not allow them to pull an easy report on that. One of the things we're doing and I'm actually meeting later this afternoon to discuss creating an operation report that will potentially allow us to work with the MCO's to collect the data.

We are in the process of doing that, as you know, we have 50+ operations reports right now. We're going to look at whether we can add this to a current operations report or whether we are going to create a new one that allows us to collect this data on probably a monthly basis. So out of the 100,000 hours that were approved, past hours that were approved for the month, 99,000 have been covered and 1000 have been uncovered. We are working through that so it might take us a little time to get that report done and to make sure we collect that data and its valid data when it is coming back in. We are working on that process now.
>>AMY LOWENSTEIN: This is Amy, thank you. We appreciate you are working on that. I have one question on how to think about this. If a MCO has approved hours in the PCSP, I feel like we have had cases where people have the past provider that will take some hours, but they have not been able to fill them all. Is there a way to capture that as well or is that getting too complicated? That's why we have been thinking about encounter data. Comparing encounter data to authorization - how many hours were approved and then deducting the sick callouts and things like that.
>>RANDY NOLEN: You are right. We have encounter data on how many hours have been provided. We do not have - OLTL does not have the authorized hours. That is the point we have to get to because we do not have the authorized hours. We have the used hours are the provided hours, but you are right, when we take a look at this we are going to be looking at authorized hours that if an agency has taken the hours and there is authorization and there, it should be shown up in these steps, but I don't know that the agencies are properly reporting that. So that is part of how we developed this report.
>>LIZ HEALEY: I think that is important because from a consumer perspective, if you are authorized for 100 hours in one agency says, well, I can do 50 of them and you are reporting, oh, 49 of the 50 hours are filled, that is great, but from the consumer's perspective, less than half of the time they are authorized for is covered. I think we need to be able to compare what was authorized and what was delivered.
>>KYLE FISHER: I appreciate we are having these conversations and that you taking it back to be able to collect and report this data. Thank you for the quick turnaround.
>> Hopefully I can provide more information as we move forward with this at a public meeting.
>>LIZ HEALY: Thank you.
>>RANDY NOLEN: Kyle, I want to make another point here. You had asked about our discussions earlier about closure of Crozer Hospital. I reached back out today when that conversation was going on throughout the CMO's to ask them what the potential participant numbers are. I've information that has come in from Keystone first, which Keystone First CHC will probably have the majority of the participants in the area and they are looking at - they report from Crozer health. Those numbers are low, but they are reporting that it affects about 4700 participants. These are participants that utilize those hospitals in the past for services. They are working with other area hospitals to get contracts into place. They are negotiating contracts with St. Francis and Wilmington hospital. Realizing that some of them are in Delaware. We have to negotiate those with

the closings. They are working with those areas and also working on identifying gaps on services that will be needed here. Keystone the First is moving forward and I know that they had, I think nine participants that were impatient in place. They are working through this. PHW had - initially they reported they had 19 individuals in the hospital, 18 of the 19 had been discharged. They were regular admissions to the hospital. So they are working on the last individual that is in a hard place. We are working with the closure and we have a contact there and we're correlating stuff with DOH to assist with that. The primary care for a lot of the individuals in the hospital are Medicare, Medicare advantage plans. So that CHC MCO will be working on that and we will work on that this week to make sure people get appropriate placement.
>>KYLE FISHER: Thank you for that, Randy. Closing the circle here. Any questions from the consumers? Okay, we will save what remains with your voice. Appreciate this afternoon.
>>RANDY NOLEN: It has been a rough season here. Upper respiratory infection to sinuses. Not fun.
>>KYLE FISHER: Thank you for your time this afternoon giving us the report you did. I believe we are through the agenda. Just barely on time. Minta, do you want to make a motion to adjourn?
>>MINTA LIVENGOOD: I would like to see if any of the ones on the committee would like to make a motion to adjourn ? If not, I make a motion to adjourn. There you go.
>> Okay.
>>MINTA LIVENGOOD: The meeting is now adjourned. R