Consumer Subcommittee of the MAAC

May 21, 2025

Consumers present: Sonia Brookins; Lauren Henderson; Marsha White-Mathis; Liz Healey; Meghann Luczkowski; Rochelle Jackson, Spencer Duffee.

DHS representatives present: Eve Lickers, OMAP Policy Director; Kristen Figueroa and Angela Gumby, OMAP Bureau of Managed Care Operations; Montrell Fletcher, OLTL Executive Office; William Posavec, OMHSAS.

The meeting was called to order at 1:00pm

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>> ELYSE GREGORY: Good morning, welcome to the subcommittee meeting. Today is May 21, 2025. This meeting is being recorded. Your continued participation is your consent to being recorded. If you do not consent, you can end the webinar at any time. There are updates for panelists and speakers. If you are experiencing audio issues, go to the top right corner to find the gear wheel to find the correct microphone and speaker hardware. If you continue to experience difficulty, please send a message in the chat. To help avoid any disruptions, please remember to keep your microphone muted if you are not speaking. Live captions, also known as CART captioning, are available in this meeting. The link is included in the chat. Presenters should state their name clearly to assist the captioner. Representing the office of medical assistance programs, Eve Lickers.
Questions may be submitted in the questions tab of the webinar. If you have any questions related to this meeting or need any additional information please visit consumer subcommittee web page. I will hand things over to consumer subcommittee chair, Ms. Sonia Brookins.
>> SONIA BROOKINS: Hi, thank you, Elise. Good afternoon, everyone. Welcome back it the consumer subcommittee. I will turn it over to Kyle fisher.
Thank you so much.
>> KYLE FISHER: Thank you, Sonia. Kyle Fisher with the PA Health Law Project, counsel for the subcommittee. We will go through member introductions here. Do we have Rochelle Jackson on the line.
>> ROCHELLE JACKSON: Present.
>> Thank you, Rochelle. Do we have Liz Healey?
>> LIZ HEALEY: Yes, I'm here, Kyle.
>> All right. Spencer Duffee?
>> SPENCER DUFFEE: Yes, Kyle, I'm here.
>> Very good. Meghann.

>> MEGHANN LUCZKOWSKI: Good afternoon, this is Meghann.
>> Do we have Marsha White-Mathis? Marsha called in but we may still be working on her audio. Lauren Henderson?
>> LAUREN HENDERSON: Present.
>> Jayme Scali?
>> Anyone I'm overlooking here?
>> Bethany on the attendee side. Okay. On the panel -- excuse me, on the counsel side. Amy?
>> AMY LOWENSTEIN: Yes.
>> Welcome, Amy. I believe Dana will join us later. I will hand the time back to OMAP. Thank you.

- **OMAP Report**
    - **Deputy Secretary Updates**

>> EVE LICKERS: Good afternoon, this is Eve Lickers. I'm the Director for the Bureau of policy, planning, and analysis in the Office of Medical Assistance Programs. I will be presenting for OMAP, least under the deputy's update this morning for Deputy Secretary Kozak who is unable to attend today. She is presenting for the insurance department for the women's health month. May is women's health month. So she is speaking for them at an event. So thank you, very much, for your attention this morning. For some reason I'm stuck on the morning. I do apologize.
I will address one thing that is not actually on the agenda. I'm sure everyone is wanting to hear and has questions about the legislation that is going on in the federal level.
We are currently, obviously, watching this very closely. We continue to evaluate the information that we are receiving, and the changes that are happening. And so, I think until things are finalized, and the dust settles, I don't think we are ready to provide direct statements or plans outlining anything at this point.
But we are definitely paying attention to what is happening.
We will probably talk about that at a future meeting. Today we will talk about a final rule that CMS released. Released last year. That's ensuring medical care to access rule. Released April 27 of 2024. Part of this rule addresses new requirements for the MAAC as well as consumer subcommittee. These are federal Medicaid regulations currently. And so we are at place where we have to put these pieces into place.
These changes are effective July 9 of 2025. And so it will also be a progression but right now there are basic requirements that have to be in effect in July. So it will begin and be in effect at our July meeting.
One of the requirements for the state is to is to establish a committee. Majority of states have an established, what they call, a MAC. So the rule also require estates to establish a Beneficiary Advisory Council. This rule states that the current established consumer subcommittee, which has been around for over 40 years, also would serve as this Beneficiary Advisory Council (BAC).

I do want to make mention, because we have presented on this on a federal level to talk about our current consumer subcommittee and all of the great work you do and in actuality, even though there are a few provisions that we definitely push back on, a lot of the rule that you saw or have seen if anyone looked at this, is really based a lot on what we are actually doing here in Pennsylvania and they have added some things that they would like to see. They being CMS. Overall, I think it is pretty, a pretty, I think, nice statement to say that what the Federal Government is framing their advisory committee is based on Pennsylvania's. I think that's pretty exciting. There are 22 requirements in this final rule for both consumer subcommittee and for the MAAC. Currently we are compliant with half of these.
So again, not all of these have to be implemented as of July 9 of 2025. Next slide, please.
>> Eve -- sorry to interrupt, but if I may.
>> Go ahead.
>> KYLE FISHER: The subcommittee spent a fair amount of time this morning talking about the proposed federal legislation and potential impacts on Pennsylvania's program from a caution perspective, also from a coverage loss perspective. And I hear what you are saying. That certainly the parameters are changing, the legislation seems to be changing hour by hour. Day by day here. You can speak to whether DHS will put out any analysis of this legislation? How it could impact Pennsylvania? Is that something under way? If you're able to speak to that now?
>> EVE LICKERS: I'm not able to speak to that now. I way that we have said in the past and is still the case is we want to see what is definitely put forth and passed before we, you know, continue to go down on the road of the what-ifs. We would like to see concrete guidance and statute put in place before, you know, we, I think, raise undue concerns with the public. I think it is already heightened enough. We are all on edge and all watching and aware that you know, there could be significant changes in areas that we have not traditionally had to make changes to. Particularly with work requirements, some of the cautionary requirements, and some of the other coverage pieces. And then also, you know, a lot of the payment pieces that we're looking at as well could significantly impact Pennsylvania as currently proposed.
But we are watching and we are evaluating and there is some modeling being done. So as soon as the department is, you know, has something to put out, we will definitely be presenting it t to the consumer subcommittee and the MAAC.
>> KYLE FISHER: That is very reassuring. I think the modeling piece in particular. So obviously we have proposed legislation. I do sort of concede it is changing. Clearly. But given the proposals that have been under debate in various committees at the House of Representatives, we think it would be a good idea for Pennsylvania to follow the lead of some other states like Wisconsin and Michigan and New York. And sharing with the public what some of the consequences of this legislation would be for our state Medicaid program. So we can share some of the analysis coming out of other state Medicaid programs if it would be helpful.

But it is good news to hear that Pennsylvania's program is also doing some modeling analysis of the impact of this legislation, least in its current form, to share with the public before anything is finalized. Obviously that has not quite happened. Once it is finalized, I think that the usefulness of that information is going to be far less important.
>> EVE LICKERS: Sure. And you are more than welcome to, you know, share the information but I also know we are watching what is happening in other places. We are involved with other national groups that we are on these national calls where we are talking about what is happening with other states and sharing information.
And so, as I said, we are watching, evaluating, and we will be ready to share as soon as things are on a concrete basis.
>> SONIA BROOKINS: Thank you for that, Eve. I had a feeling you were working on that anyway.
>> EVE LICKERS: Yes.
>> SONIA BROOKINS: We never doubted it. We just wanted to know, you know, for sure you were working on it.
But I never doubted that you wasn't working on it. So it will be good to see once you get to the final, so everybody can see the impacts on Pennsylvania.
>> EVE LICKERS: Absolutely. Thank you.
>> SONIA BROOKINS: Thank you. Anybody else?
Anything in the chat?
>> LIZ HEALEY: This is Liz, I'm assuming that as soon as it comes out of the rules committee that we will know what is contained in it that goes to the house floor. And that could be today or tomorrow.
>> EVE LICKERS: Again, we are watching the legislation. I know once it goes to the next step and again once it is finalized because even when it moves to the next phase, there is going to be likely some other changes to it. So again we are watching. And you know, when things are more concrete, and we are also working with CMS, regarding the requirements, so we will be able to put out something at a future time.
But right now we are not prepared to speak to that.
>> EVE LICKERS: Thank you.
It looked like someone else had their hand up but I'm not sure if there was a question.
>> SONIA BROOKINS: Okay.
Eve off all right. So are we ready to go to --
>> I'm not seeing any other questions in the question tab at this time.
>> EVE LICKERS: Okay, great. Thank you.
As I mentioned about the new MAC and BAC as they are referred to on the federal level, so of the requirements we are compliant with, we have an established Medicaid advisory committee or medical assistance advisory committee, that is the MAAC. And we have an established Beneficiary Advisory Council that is consumer subcommittee. So the committees meet already on more than a quarterly basis. That's the minimum. And we also, these are also sunshine notices where we provide the public notice of the date, location, time of the meetings and all of our materials are publicly available as

well as bylaws and membership.
So also, we are offering a rotating variety of meeting attendance options so we have in-person and virtual. We are moving towards a hybrid meeting. And so, right now we are in compliance with this. Also we have our staff facilitating the meetings. Our staff meaning the department staff. Also I have the requirement to have the consumer subcommittee in the BAC being held separately and in advance of MAAC meetings. We have been doing that as long as I'm aware of and have been participating.
Currently 10%, so the final rule does dictate the membership of the MAAC that has to come from the consumer subcommittee. It isn't enough that we have consumer representation. The Federal Government is dictating that that consumer participation come through and from the consumer subcommittee. We are able to have additional consumers on the MAAC.
But there is a requirement that by July of this year that we have 10% of the consumer participation on the MAAC come from the consumer subcommittee. And we are currently compliant with that. Because we have Sonia and Minta participating. So we appreciate that. The topics of discussion are based on what we identify here in this state. And they are to be determined in collaboration with the MAAC and consumer subcommittee to address those matters related to Medicaid and we currently do that. We meet with the executive group of each of those committees and establish the agenda and that is based on what is happening now, the questions and concerns and you can tell that by the topics that we go over.
So what are the requirements where we are needing to make changes and this to me is basically, I think, the key, one of the key provisions that one, we need input. We would like input from the committees.
But also, that has the most impactful. This is the term limits. So in the regulation, that these terms may not be consecutive, and they must be limited from anywhere to 2 to 6 years. So I just want to put a pin in that and come back. So while I'm talking about the other pieces, I would like for the committees to be thinking about this. We have pushed back on this and we were hoping to see some movement. We continue to raise this with CMS. So we are hoping to see some flexibility there.
But as of right now, this is what is currently in the regulation.
MAAC membership must have one officio member and we are evaluating what agency that will be at this time. And the consumer subcommittee members have the option to be anonymous. Currently they are identified on the DHS website.
But we have, and CMS, provided guidance on how we might maintain the anonymity of our consumer subcommittees if that is their choice. We will need to amend bylaws to identify consumer subcommittee as the committee meeting. The back requirement and we also will be making other updates to bring it current. So we will also be providing our meeting agendas -- oh, sorry. Meeting agendas have to include a public comment period. So even though we have feedback in our participants can ask questions during the meeting, there is a requirement for a dedicated period of time in which the participants attendees could actually provide comment.

That is another change we need to be attentive to. Also we need to have, allow time on the agenda to be members and the public to disclose any conflicts of interest, whether perceived actual or apparent. And then also, meeting attendees list, basically those sign-in sheets, will have to be made publicly available for both meetings as well. And states must take reasonable steps to provide meaningful access to individuals with limited English proficiency. And if we could go to the next slide, I want to recap then come back it talk about membership. In speaking on the membership requirements, so from July 10 of 2026 through July 10 of 2027, we will need to increase the consumer subcommittee participation in the MAAC membership to 20%.
Ultimately, by July 2027, we will need to have -- we will need to have 25% of the membership. So just for us to be aware. And we recognize dates are off.
But this is what was provided. So I'm not sure they realize the dates were off. And then states will have to create and publicly post an annual report that summarizes the MAAC and consumer subcommittee activities. Basically topics that we talk about and the department's response to them and the first report is due July of 2026.
So after the report is finalized, we will have 30 days to post the annual report. If we can go back to the previous slide, that would be great. So I do want to open up for a few minutes for any feedback on particularly the member term limits.
But anything else that the committee would like to talk about.
And so, and being mindful that I would like to hear, we would like to hear recommendations or your thoughts on how we could approach the term limits and the length of time currently the terms are two-year terms. So it would be great to hear from you all on this.
>> LIZ HEALEY: Eve, this is Liz Healey. I have a question. I don't know how many people are currently on the MAAC.
>> EVE LICKERS: So as of right now, the membership that is allowable on the MAAC is 25 members.
>> LIZ: And talking about increasing it to 10% and eventually up to 25%, are you anticipating that some of the current MAAC members may step off or that over all size of the MAAC will continue to grow as the number of consumers participating increase.
>> EVE LICKERS: I think that's a great question. I think that's a great question. Right now we are not at our full complement for the MAAC. So there is space for more consumer voice, and we would like to have more consumer voice as well as other providers. I think probably Elise or one of our staff have the actual current members. I know there were some adjustments.
>> ELISE GREGORY: Currently two members are from the consumer subcommittee. So you know, less than 20 members to, that's 10%.
So we need about 6 members by the final to get 25.
>> EVE LICKERS: Thank you, Elise. And we understand, too, and one of the things we brought back to CMS and we are hoping for flexibility on this, we recognize that consumer participate on other committees. It can be, I think, a little overwhelming and you know, for to be on say three committees or four committees. So that is something

we raised to CMS but we have not seen any movement as of yet on this. And so, one of the considerations is, and part of the conversation has been, will we need to increase the limits for, you know, the number of members that can be on any of the committees. Because right now, the MAAC is limited to 15 as well.
But I do not believe we're at full complement.
>> KYLE FISHER: So rather than having that discussion in a public meeting, would it be okay if consumers reconvene on this privately and come back to you for recommendations?
>> EVE LICKERS: Absolutely. Absolutely. I know we had, you know, some of us had spoken about this previously, and you know, the community was aware -- some of the committee was aware about concerns about the term limits. So we definitely would love to hear, and we can schedule time to talk about that. So are there any questions or any comments about any of the other requirements? I think you know, as I've said, to me, that is you know, between that and the requirement for all of the consumer -- not all consumer participation, but up to 25% of the consumer participation to come through the consumer subcommittee. Those to me are the two, I think, pressing provision he of the role.
>> KYLE FISHER: Okay. And certainly a number of other committee members on the MAAC who would meet criteria for serving on the consumer subcommittee. And I think we can have more conversations about potentially identifying them and seeing if there is a willingness on their behalf to join the consumer subcommittee as well to help the state come into compliance with this new rule.
But I think that at this stage, it would be useful from, maybe I should point to the subcommittee to have more internal discussion around this and come back to you with recommendations.
Sonia, if that makes sense to you.
>> SONIA BROOKINS: It does make a hundred percent sense to me.
And I that I given us a chance to talk about it, and we probably will get back to you in June.
>> SONIA BROOKINS: That sounds good --
>> That sounds good.
>> For me, it is about all of the consumers in all walks of life. That's where I stand.
>> Absolutely, I shared with you before when we presented this and shared the PowerPoint we presented, you know, that one of the -- one of the key things that I had seen was you know, Estelle Richmond when she talked about the former chair that said, “nothing about us, without us.”
>> SONIA BROOKINS: That's right.
>> EVE LICKERS: So I definitely keep that in mind. I feel privileged it even be a part of this for as long as I have and knowing the strong legacy of the consumer subcommittee. We recognize that this is the life work of, you know, several of you and so, and that you are trusted members of the consumer, you know, community. And so, you know, you are valued for your work and for your contributions and commitment to, you know, our

work here with the medical assistance program. We just appreciate you.
So this is, to me, is you know, this is a monumental change. Especially when we in Pennsylvania have been the standard setters for these committees. There aren't other places that have the subcommittee structure that we do. They have reached out to us for guidance even how to establish the structure we have in Pennsylvania. We are hoping, you know, hoping upon hoping that some of the individuality that we have that CMS will reconsider. More to come on that.
>> SONIA BROOKINS: Yes, thank you for that. And we appreciate you. So thank you.
>> EVE LICKERS: Yes. So we do have a couple other things if there are no more questions about this. That the committee actually asked us to provide updates related to. And so, I believe Kristin Figueroa is on and can provide updates related to the MCO and hospital contract negotiations.
>> Can you hear me?
>> KYLE FISHER: I can just jump in and check in. Marsha, do you have audio? Are you able to speak?
>> SONIA BROOKINS: No.
>> KYLE FISHER: All right. Maybe with the I.T. folks can work with her. I see her on the panelist side as unmuted. I don't know if she can unmute herself. Thank you, Kristen.
>> SONIA BROOKINS: Go for it, Kristen.

- **HealthChoices Issues**
    - **Hospital/MCO Contract Terminations**

>> KRISTEN FIGUEROA: Okay, good afternoon, everyone. My name is Kristen Figueroa. I'm the division director of division of monitoring and compliance of OMAP's care operations. I won the hospital termination report out today in Gwen and Sally's absence. So I will start with the report out on the hospitals that are closing across all of the managed care organizations. So meaning they are no longer accessible regardless of what MCO, what they are participating with. I think we are aware from Gwen's last report of the Crozer Chester and Taylor closures as much 5/5/2025. 28,438 is the effected number. The break down of that per MCO is as follows, so united with 1,418 members. HPP with 4,041 members. UPMC, had 853 members. Geisinger health plan family, 923 members. High mark whole care, 4 members. AmeriHealth Caritas with 20, and the biggest MCO with Keystone first with 21,179 members.
At this point in time, all of the MCOs have sent member hospital closure notices. They went out between 4/30/25 and May 14.
At this time, DHS outreached all MCOs to inquire on the status of their contact with Crozer affiliated providers and we are waiting responses at this time. Nothing to report on PCPs or specialists at the moment. But we can update everyone when we have more information.
The other hospital that effects all MCOs is Heritage Valley Kennedy hospital, which is due to close on June 30. The total impact, member impact, is 2,484 members. And that

break down goes as follows. Health partners plans with 94 members. UPMC with 1428 members.
Amerihealth caritas it is a with the 2 and Highmark with 870 members. Notices have also been sent for UPMC sent 5/3. Ahera health 5/15 and high mark 5/16. Have notices date sent for HPP but they should have been sent at this time.
>> KYLE FISHER: Kristen, if I can ask a couple questions here.
>> Sure.
>> KYLE FISHER: We heard Gwen last month speak to healthcare management staff with MCOs working with closure social workers on those to discharge patients who were still in-patient at Taylor or Crozer chester helping to find either transfer locations for them or get discharge situations in place. We have since heard from some home health agencies that children with PCPs or prescribing doctors, in the chester affiliated system, having a hard time getting plans of care in place for them. So doctors who are no longer accessible.
Are the physical health MCOs offering enhanced case management? Are they doing outreach to families impacted by this to help transition to new doctors in general? Or at least the sort of subset of the impacted members who have these sort of ongoing needs for prescriptions to continue their home health aid or shift nursing services?
>> KRISTEN FIGUEROA: So Kyle, my response is, they should be. And I don't have details that I can report to you today.
But we can most definitely follow up with MCOs that do have any of these members in their care that are having issues.
I am aware of some outreach that has occurred from a home health agency at this point in time.
But I don't have details to report on for you today. I will have to use that as a take back to give you more details at a later time.
>> KYLE FISHER: Okay. The mail-ins you mentioned that went to, sounds like, 28,000 or so members, are these the standard provider termination? It is not quite a provider termination mail. So a former template approved by the department? Can you say whether it was inviting members to contact member services if they need additional assistance?
>> Yeah. A standard template that is associated with the health choices agreement and all of the MCOs did use the standard template. There is member services contact information included on every single one of the notices. Yes.
>> SONIA BROOKINS: Kristen, are you aware that a hospital that closed had a baby that wasn't breathing. And the nurse there, even though the hospital was closed, they had a baby. Are you aware of that?
>> KRISTEN FIGUEROA: Personally, I'm not, Sonia. Sorry.
>> SONIA BROOKINS: It happened. It was on the news. Yeah.
Okay.
>> Is it specific to Crozer?
>> SONIA BROOKINS: Yes, the hospital that was closed. The baby that wasn't breathing

and obviously paramedics took the baby there but the nurse saved the baby. It was all on the news.
>> MEGHANN LUCZKOWSKI: This is Meghann. The mother brought the baby to the hospital not realizing it was closed. There were nurses there that were able to help. There is confusion about the hospital closures. There was a lot of, I live in the southeast, there was a lot of confusion about which site would be closed when.
So I think we are just seeing some incidents, some very scary, and thankfully that one had a, an okay outcome. But there are still some incidents of members of the community not being aware that the local hospital is not available.
>> KRISTEN FIGUEROA: I definitely hear what you are saying. Noted. I can just confirm, reconfirm again, that all of our MCOs have sent member notices. So I mean, there is always a chance if an address hasn't been updated et cetera, there may be a delay in mail forwarding. If the address hasn't been updated. You know, those things happen pretty frequently.
So what we can manage is, you know, dictating and laying out regulations as to what the MCOs need to be doing. At this point they have all sent appropriate notification of the particular closures. So if the folks are receiving them on the other end, they should be at the address they have on file with DHS. And with the MCO.
>> SONIA BROOKINS: Okay, thank you for that.
>> No problem. I do have more of the individual closures that are pending dependent upon individual MCOs. Do have you more questions on closures specifically?
>> SONIA BROOKINS: No, you can go forward.
>> KRISTEN FIGUEROA: Okay. All right. So the additional closures, and again, I think Gwen reiterated the fact that it is contract renewal season for united in some regards. There are a couple here that fall under United:
One is St. Christopher's. Term date is August 1. The number of members affected is 1886. And notice dates should be sent member notices should be sent by June 14 for that one. There is CHOP in Philly with also a term date of August 1. There are 17,505 members associated with the CHOP pending termination with a member notices being sent June 14 as well. There is a Tower health contact negotiation in place for reading, potsville, also on August 1. 1321 members associated with that pending closure with member notices going out again 6/14/2025. And last but not least, there is St. Luke's on the list. This actually, the contract has been extended to December of 2025 or 1484 members. So there was a negotiation that resulted in a contract extension. That one is off the immediate list over the next few months.
I'm going to move on to Health Partners plans: There is Suburban Community hospital term date July 1, 403 members affected and the notices were sent on May 13. And Holy Redeemer term date August 31, 10,741 members associated with notices to be sent by July 13.
And then Keystone First also has suburban community hospital negotiations happening. Term date 7/1. Members affected, 1236. And those member notices will be going out June 12.

And last but not least, Holy Redeemer -- excuse my dog -- term date, August 31, 2025. 7,109 members affected and the member notices are scheduled to go out on July 15 of 2025. That is it for hospital terminations.
>> KYLE FISHER: Kristen, on the Suburban contract for for Keystone, I believe you mentioned July 1 termination date. Is that right?
>> Sorry, Kyle, I scrolled. I did.
>> KYLE FISHER: Have notices already gone out for that as well?
>> I recorded that notices went out for HPP on May 13. And I have Keystone's recorded as 6/12 which may be a typo. So let me move some screens around here and see if I can verify that for you in a second.
>> KYLE FISHER: The general framework would be the same?
>> Yeah. Should be 45-day advance notice. 5/27/ 25. Thank you to my staff who are feeding me information on the side.
>> KYLE FISHER: 5/27. Still not quite 45 days in advance.
But notices should be going out?
Maybe the department could look into that one.
>> Suburban community hospital notices for Keystone went out 5/27.
>> KYLE FISHER: That is next week.
But wouldn't be providing 45-day notice.
>> Right, shorter notification so turn around time was more difficult.
We can address as we become aware of information. So yeah. I don't have an excuse. I can just tell you we are doing the best we can with short turn around times when we are made aware of them.
The providers have to notify in a certain amount of time as well. So they may have been in touch with one MCO sooner than another. I'm not sure what happened on the back end.
But we can look into that.
>> KYLE FISHER: Okay. And I think the larger context here, the notice period of 45 days is new as of this calendar year. The consumer subcommittee has been clear, we appreciate the change, coming out of contract negotiations that happened last fall and the short amount of notice given to potential impacted consumers. Just gave them much less time to figure out, do they need to change their plan or change their doctor. We do appreciate the new 45-daytime frame that's in place. Seems like there are still some logistics being worked out by MCOs and maybe the impact of the provider health systems as well. Thank you for looking into the Keystone suburban situation more as you are able to. And hopefully, you have been through a lot of contracts that are coming up with expirations soon. Hopefully all of these will extend, or at least most of them.
>> KRISTEN FIGUEROA: Yeah. That would be our hope as well.
But again, it is up to MCOs and providers to make negotiations. I've been seeing a lot of extensions happen. Like the example I gave earlier where one of the just extended the current contract until the end of December rather than making it a year contract or what not.

So we will keep you posted.
>> SONIA BROOKINS: All right. Thank you.
>> I appreciate the time. Thank you, all.
>> SONIA BROOKINS: All right.
Folks, performance, who is doing the update?
>> Good afternoon, can you hear me this is.
>> SONIA BROOKINS: Yes.

- **Pay for Performance (P4P) Trending Report**

>> ANGELA GUMBY: All right. Good afternoon, everyone. My name is Angela Gumby. I'm division director for quality and special needs coordination. I actually work for Gwen. I will be doing pay for performance presentation today.
Gwen had another event she needed to attend. So I too drew a short straw, but I'm happy to be here. I also have on line bridget gill bibson and bridget put information together. Information comes out of our quality area. She may chime in if there are questions that I may not have the direct detail. Thank you, Bridgette, for joining us as well.
>> Sure.
>> Okay.
Next slide.
When the department developed our MCOP4P program we have incentives for three areas. Focus on quality to encourage better MCO performance and pr 340E9 better health within the health choices population.
The other thing is access. And this is to promote preventive care as well as improve access to PCPs and medical homes.
And the last part of the graphic is efficiency. This is achieved by awarding program improvement as we move toward those types of value-based arrange 789s. I know Gwen has done talking with the consumer subcommittee about those things being planned on that front in the future.
So how does this currently work?
For the next few slides we will be talking about the P4P program. And the measures, quality measures, that are incorporated. And in 2024, the MCO P4P program included measures including two PA specific performance measures and maternal home visiting measure for a total of 12. There were also several ways that an MCO can earn an incentive in the 2024MCO P4P model. We have model that is set up in an Excel format that calculates all of the different types of payments when it has to do with these types of incentives that we are talking about. So DHS put this information together and for the payout structure, it includes five different ways to earn and incentive. So the five we have listed there on the slide are by meeting a certain benchmark and goals. Second by looking at incremental improvement. Little bit over the year to year from a previous year. And by meeting a certain performance letter for a bundle of measures or

benchmark bundle performance and for incremental improvement for the previous year for afterly can American population rate, in terms of health equity. And finally, for the maternal home visiting program.
This PA specific measures are PAPM on this slide. There should be two.
Number 6 for child and adult annual dental visit. And number 11, developmental screening, first three years of life.
And then bolded measure, number 6, is a new measure. So then we will talk about a few changes that have happened.
Some changes from 2023 to 2024 is heedist. Retiring in 2024, here at the department we created the child and adult annual dental visit PAPM which identical to headist measure for P4P and this is so we have something to bridge the gap for 1 year.
Over all, there were some changes and other factors that we know can impact the health choices agreement. And particularly the procurement process. So for 2024, measurement year 2023, that is the first full year for the MCOs operating in their new zones.
So a few plan changes to note are for example mare health. For guyinger, the footprint, previously only in the northeast. For health partners gaining statewide.
But they were previously only in the southeast zone. And then for high mark whole care they lost northwest zone. They have high cap in southwest zone now. Keystone first, no changes. United health lost high cap in southwest so only operate in southeast now and UPMC gained northeast so they now operate statewide. So depending on how the changes are made, zones canning gained or lost and those could have factors.
Or some type of impact.
When it comes to MCO was P4P.
So this is demonstrating the statewide average across 3 years, what that is, on this slide, lower rate indicates better performance for measures with the orange columns. And A1C and plan of all cause and readmissions are the ones there on the end in the orange.
So for PCR, the plan on cause remissions, observe to expected ratio indicates whether the plan was more successful at preventing readmissions be than expected. That is given types of cases treated in the health plan.
So the ratio was w a value of less than 1.0 or less successful ratio with greater value of, greater than 1.0.
However due to limited time we chose to focus on and present a handful of measures that stood out us to. I will show those on the next few slides.
Sometimes this shows better performance for heebo globein control, less than 9%. And what this is showing is over the past three years from 2022 to 2024, overall weighted average decreased 4.8, 5 percentage points. 36 .05% to 31.2%.
That is noting better performance downward but that means better.
Now this did decrease 1.2.
1.12 percentage points from 2023 to 2024. So we look at that overall across the three years and then the jump in between from 23 to 24, just to highlight. So in comparison to

the national benchmarks, is something we keep in our files and something that is outlined in our health choices agreement.
Our physical health choice a2K3WR50E789. What happens is one plan performed better than the 75 percent tile plan and weighted average performing better than the 50th percentile benchmark and one plan performing lower than the 50th percentile benchmark.
>> KYLE FISHER: If I can jump in here. We did go through these, I appreciate you sharing them in advance. I guess a basic question. Because we are not really used to delving into more technical HEDIS measures. These are 2024HEDIS results. I see the parenthesis there for 2023. Is that measure year the calendar year or something else?
>> Yeah. Measured year should be the calendar year. Following year would be the reporting year.
>> Okay.
So I guess, someone sells jumping in in.
>> SONIA BROOKINS: Yeah. I was going to ask, I was waiting for them to finish. These are like 70-something pages. We did go through, I went through some of them.
But i wanted to ask for records for us, what do you see most important that you would like to see improved through this HEDIS process? Thank you.
>> So you are just asking in general?
>> SONIA BROOKINS: Yes. What would you like to see most improved? Like you see the numbers, some numbers are good.
But what would you like as a whole, not just you but you know your team, you know. What would you like to see most improved with these HEDIS measurements?
>> ANGELA GUMBY: When I highlight sustained improvement, we are curious on both sides. We notice that all-cause readmission.
And across the health choices program and are those measures you identify as sort of areas where there is room for improvement or others you would highlight for us?
>> I think that what we basically do, is again it can be technical eaj complex behind the scenes because we have this model, like I mentioned, and we are only giving you a snapshot of the overall.
But behind the scenes we look at this, trends and patterns, across the plans as whole and then put the individual plan. So it really depends on the performance, especially when we get to the individual plans as to, you know, how we are going to move forward with looking at improvement. And sometimes when you are looking at an agreement, we will see where the cut-off is for receiving an incentive payment. So higher amounts, higher percentages would yield an incentive. So we try to start around the 75th percentile and go up from there and if something indicates poorer performance we work with those measures and work with a plan to see what can be done to show improvement in the area.
But we could probably if you have specific concerns, you know, talk off line or have Gwen, you know, to put something together that you can get more information. I understand she's done presentations and things in the past and again, there is a lot

involved behind the scenes I guess is what I'm trying to say.
>> KYLE FISHER: I guess it would be helpful to hear more. We did see one metric for 2025. And or change perhaps. Child and adult annual dental visit. That measure voted. Can you unlock that. What the change was? Why that change is made?
>> I can answer this question.
>> Okay let's talk about the retired measure. I think we have a slide.
But go ahead, Bridgette.
>> In the P4P program we had the HEDIS measure, annual dental visits, so it was capturing dental visits for ages 2 to 20. HEDIS retired that measure so we today create a P4P capturing 2 to 20 age so it is identical to the HEDIS measure to retire but the reason being is beginning 2025 we are going to switch over to using the oral evaluation dental services that will then begin capturing the lower age band of 2 to 20. Only reason we created that child and adult annual visit was just to gap the HEDIS retiring old 2 to 20 and bringing in the new oral dental evaluation services.
And decrease that you are seeing for child annual dental visits, we are actually seeing from my understanding a decrease in dental viceets over all. Not just in Pennsylvania. And unfortunately since HEDIS retired the annual dental visits we don't have benchmarks for that year to see how other states were doing with it. So we won't have like a better response on that performance until we see the 2025 results for dental.
>> KYLE FISHER: That is helpful. So essentially you are continuing the same measure. Just using it as a newly measure because HEDIS no longer tracks.
>> Correct. Tracking the same population as HEDIS was.
>> KYLE FISHER: And given its identical trend through years is still sort of valid, right? You wouldn't expect the metrics to change because you are using the same sort of methodology, I suppose.
>> Correct. We make sure it was comparable.
>> KYLE FISHER: One other question we have when looking at some of the payouts, looks like there were also financial penalties for very low performance. Did we understand that correctly? Is that something possible for any or all of these measures?
>> When you say penalties, we have the percentages and so yes, there will be no payout if you do not meet a certain percentage --
>> KYLE FISHER: For metrics, payout was -- sorry, go ahead.
>> So yes, there is, when you say penalty, there won't be a payout. There won't be an incentive. A lot of this, again, is detailed in the health choices agreement. If one would delve into that, which of course managed care plans have that as a guide, and we do work with through Pam to talk about trends and information presented, so we have an exhibit that kind of lays it out more, in more detail.
It can get complicated.
But if you have a specific example you want to break down something other than what you've seen in slides et cetera, then we can provide that to you.
>> SONIA BROOKINS: I think, Kyle, from what we are seeing, they have a lot of good stuff in here. I think what we should do, we should go and go through it with the

committee and then if we have questions or if we want to revisit these and bring them back and so they can go through it throughly, I'm fine with that.
>> KYLE FISHER: Yeah, good idea.
>> >>: Diphone a friend. And specifically for the 50 percentile benchmark we penalize for that if it is under 550%. Or 50th percentile, excuse me.
Again, you know, --
>> KYLE FISHER: I appreciate that. And one last question, and I appreciate Sonia's piece and we should take it back and digest it more and come back with particular questions. Big picture, 2%, capitation maximum. Is this a withhold from capitation payments and you earn back the maximum of 2% overall? Or is that in addition to the normal cap payments to the MCS?
>> ANGELA GUMBY: It is not withhold. It should be in addition to. It should be equal to 2%.
>> KYLE FISHER: Helpful. Thank you.
>> Sure. I know we skipped ahead to at least the child and adult dental. I don't know that we need to delve into that one. That again is PAPM. We have a couple other I believe in the deck, the HEDIS. So if you would like to go back, we can cover those quickly. That would be the prenatal care in the first trimester.
>> I don't know if you have questions but you can see the weighted percentages from various years and in comparison for behind the seens when you look at national benchmarks, three plans and weighted average above the 75 percentile benchmark and four plans above the benchmark. So no penalty.
But it was a little bit lower.
For some plans. Excuse me. Next slide.
Okay. We talked about the child and adult dental visit.
So to the next one with as medication ratio.
There is one where there is focus. Over the past that he years, weighted average, you can see increases and percentage points from the years.
And in comparison to the national benchmarks, of the 7 plans, 3 plans above the 75th percentile benchmark. And three plans above and one plan below the 50th percentile benchmark.
I believe we have one separate. It is not in a bundle. We continue to keep our finger on the pulse with this actual measure.
Next slide.
>> So over the past three years, this is the child and adult or adolescent well care visit. HEDIS measure. Over the past three years you see the overall weighted average. Increased points.
Across the years and percentage points and in comparison behind the scenes with the national benchmark five plans and weighted average above the benchmark and two plans above the 50th percentile benchmark.
Again, continue to monitor for improvement. Next slide.
Same format, this is a HEDIS measure.

Over the past three years, the overall weighted average and increase is showing. A little bit smaller there but you can see some of the differences.
With the percentage and in comparison to the national benchmark five plans and weighted average are above the 90% percentile benchmark. And then we have the remaining two plans, again, in our model, we can see two of the plans are above the 75th percentile benchmark.
We keep focus on screenings and we have educational etch or the and in collaboration with the Department of Health. And that is something that is on the radar, continues to be on the radar.
Next slide.
>> KYLE FISHER: I know we had fairly extensive conversation about this years ago. After the Flint, MI episode. Do the MCOs now have more providers in network for the environmental screening to test homes? For lead?
>> Are you talking about like an abatement program?
>> KYLE FISHER: The Medicaid service and abatement to follow up. I'm not sure if that is Medicaid coverage but the screening piece, the benefit for these families that identify a child with elevated blood levels.
>> ANGELA GUMBY: That's one of the things that we talked about yesterday in our meeting.
We are trying to ensure that there is not just testing but follow-up, and not fall off the radar to understand what has happened. If there is a positive screen elevated blood levels, but we do monitor the plans on a quarterly basis. The behind the scenes is we understand which plans are doing better than others.
And we continue to work with them and get additional support like I said from Department of Health, et cetera, to be able to do educational efforts, outreach, et cetera. And to look more at the type of abatement programs and things that can be done to mitigate whatever circumstances may be contributing, whether in the home, day care, wherever there might be a source.
>> SONIA BROOKINS: Angela, I would love to keep you on.
But we will look through this again and if we have questions, we will send them to you. But again we would love to have you back, you know, to address issues if we have any. But we shouldn't. To have you come back and do this.
>> Absolutely.
Are we going through any more of the measures?
>> SONIA BROOKINS: No. We have to stop because we have to go on to the next --
>> KYLE FISHER: We have fallen behind.
>> Absolutely.
>> KYLE FISHER: Partly because of my questions.
But thank you.
>> No, no, that's fine. Sit with that more and talk to Gwen and our team here and we can certainly have additional conversations.
>> SONIA BROOKINS: Okay, thank you so much. We appreciate it. We will be back to

you, okay?
>> Okay.
>> SONIA BROOKINS: Thank you. All right. All right.
OLTL.
>> Good afternoon, everyone. Can you hear me?
>> SONIA BROOKINS: Yes, good afternoon, Montrell.

- OLTL Report
    - Deputy Secretary Updates
    - Chore Services

>> MONTRELL FLETCHER: Good afternoon, I'm Montrell Fletcher, and I will be providing updates today on behalf of Juliet. If you go to the next slide. Presentation will include usual procurement updates and update on current updates from MCOs on chore services.
As you can see here, there are no updates to the CHC procurement and the program will continue to operate under the current MCO structure until further notice. No surprises there.
So I wanted to provide feedback on chore services as it is of interest to the committee. Starting off with AmeriHealth care it is a Keystone first, they are amending participating providers contract to include chore services. That provider is voices for independence which is a SIL who once their contracting process is complete we will be working under a broker model. And that will be providing coverage to the entire state.
To date there are fewer than 10 requests for chore services. There is agreement with VFI and will continue to do so until the amendment is fully executed. They have additionally trained all of the service coordinators and are in the on board training for new hires. They have operational process in time to begin taking requests for chore services but encountered some delays due to providers inability to register as a chore services provider within the promise system.
PHW has two providers to provide coverage across the state. That is VFI again and center for independent living north central office which is formerly roads to freedom. In north central.
A third provider, they are looking to bring on board, is liberty resources Inc. in the southeast region and they are currently going through with the process to become a provider.
To date PHW has been received in requests for services p.m. and PHW have not received any requests for training from chore services.
All right. For UPMC, currently in the process of finalizing chore services amendment with internal counsel that frames the scope of work to allow subcontracting by contracting enrolled providers. Once that is finalized they intend to contact final providers to finalize contracts to begin providing chore services. As you can see they have several possible network providers identified who will be able to provide chore

services. They include cozy caregivers home care. Be loving home healthcare. JH community services. SIL north central office. VFI. Sunshines loving hands. UPMC will continue their subcontract -- excuse me, will continue to monitor their subcontracting agreement to ensure there is access to service delivery across the state. Chore services has not been requested nor identified in a service plan to date for UPMC but they are prepared to support service delivery through single case agreements until the amendment process is finalized.
A quick side note, on January 1 of this year, OLTL did release an updated ops memo with procedure codes. So all of the MCOs should have everything that they need to, again, begin taking on chore services and begin providing that to participants. So with that, hopefully I bought us back some time. And if you move to the next slide, I can take any questions.
>> KYLE FISHER: Appreciate you presenting this data. It is a bit surprising given the presentation on chore services that we had back in January when it was approved. If we recall, OLTL reported MCOs were aware of this as proposed benefit when it was relayed to CMS so they should have been through the process of identifying providers and certainly the hope that this would be effectively available to consumers before now. Five months into the year. And at least available to members.
But for the other two plans to not have provided this service as all to any of their members at this stage is a little surprising.
Can you speak to the expectation to the plans in terms of informing their members that this benefit is supposed to be available now?
>> MONTRELL FLETCHER: Well, I don't know that it is not a matter of the plans not offering it. I just think that, like you said, awareness might not be there since it is something that is newly coming on board.
And sounds like MCOs are beginning that process of creating for the service and getting their servicers trained and to begin pitching it. I don't think the awareness is there. So fortunately for AmeriHealth, they have received some requests for chore services.
But I don't think that the others, you know, since they are still going through the motions, they haven't received any.
So I'm sure once we begin to see, you know, more awareness and people beginning to see what they get with the services, we will see the numbers increase.
>> SONIA BROOKINS: When did you start it, Montrell?
>> Yes, so that became effective this year.
Chore services was built into the agreement for this year.
>> SONIA BROOKINS: And they are just getting on board now?
>> Yeah. So you know, there were delays, like I mentioned, with providers getting credentials.
So you know, once they guest past that roadblock, they will, you know, will begin to see numbers increase. And for the cases that have come in, they did have the ability to use the single case agreement. Which a couple of the MCOs have done.
So you know, like I said, it is a slow-rolling process. I think that once everybody is fully

engaged and this they have their providers up and running, everything should begin to take off from there.
>> SONIA BROOKINS: Well I'm hoping they will be ready. Anyone can make a phone call in services. So I hope that they will be aware and be prepared to service the client as needed.
>> Yep. Yep. And I can say confidently that they are.
It is just a matter of providers being up and running. And like I said, the awareness being put out there that chore services is a new service and you know, the MCOs should be able to, if they don't have their providers up and running yet, they can utilize that single case agreement if necessary.
>> Thank you, Montrell. This is Amy. Oh, sorry, Sonia. Did you have another question?
>> SONIA BROOKINS: No. I was saying thank you to Montrell.
>> AMY LOWENSTEIN: Okay. I agree with Sonia that, you know, that we hope to see more people taking this up. I do think that there are some concerns there is not a lot of education going on. We had a client who specifically asked for chore service through UPMC and told it is not implemented yet. I'm not sure the service coordinators are really aware of the chore service. It's been in effect since January.
[Inaudible]
So I hope this improves.
>> SONIA BROOKINS: That might be. Might be what you just said. I didn't know that. But that right there, Montrell, that cannot happen. They have to address it, and they need to fix it. You can't say it is not available and you have to -- and have you stuff in place. So once again, this is what I'm talking about. That should not have happened. They should have accommodated that client and handled that. In the right way. Not saying it is not available. They should have done something right there. That's what I'm talking about right there.
So that needs to be addressed, Montrell. Whoever the client is, UPMC needs it handle that. That's all I'm saying.
>> MONTRELL FLETCHER: Yep. And Amy, as always, if you have the specifics, you know, you can get that over to us.
But yes, I a hundred percent agree. We have to, you know, increase that awareness and the training that goes along with it.
And we shouldn't have individuals being turned away if a service is available. So I agree.
>> Thanks, Montrell.
[Inaudible]
It has been resolved from their perspective.
>> Sorry. You broke up a little bit for me.
[Inaudible]
I can follow up with the client.
>> Okay, thank you.
>> SONIA BROOKINS: Anyone else have anything for Montrell?
>> ELISE GREGORY: We have questions from Bethany in the chat. It states on the slide,

not receiving requests for chore services. I didn't hear you mention about training staff. How do you know what determines which consumers will learn about this. Is there a protocol for disseminating new information about this service?
>> MONTRELL FLETCHER: I do know we release listserves. I'm not sure if this information went out on a list serve but I can take that back and provide follow-up in a future meeting.
>> KYLE FISHER: There is a wide array of waiver services. And MCOs complain that participants disproportionately want PAS, personal assistance services. Are SCs supposed to be educating participants during any needs assessments or check-ins about the wider range of services available? Which at this point should include chore services as well?
>> Yeah. So that should be a staple in the conversation that service coordinators are having with participants. And so, all of the service coordinators should be aware of all of the services.
And that are available. And based on a participants needs they should be offering, you know, whatever is necessary for that participant. So you know, it may, because this is on the newer end as we are getting people up and running, it just may be that, you know, there is some lapses somewhere that we'll be sure to kind of work through.
But yes, they should be, if it is something that the participant needs and is of interest to them, it should be offered.
>> KYLE FISHER: And one more and I think what came up in this specific example that Amy shared is this chicken or the egg problem. If health plan knows it has not yet secured a vendor or broker to perform the service, it is not surprising that it is not encouraging its service coordinators to offer to participants. And an SC may say it is not yet implemented. Which takes me to the initial question of OLTL's expectation. Even if there are not yet finalized contracts, are you expecting this through single-case agreements and what sort of follow-up is there? Or timeframes they have within which to finalize agreements so the service is actually provided at scale for members?
>> MONTRELL FLETCHER: Yes, I took that back, Kyle. As to, you know, what follow-up we are doing.
But yes, the OLTL's expectation is if it's a service, it's a service to everyone. Regardless of the MCO or the scenario. If someone requests chore services or any service for that matter, the MCO should be providing that service.
>> KYLE FISHER: Thank you.
>> All right. Any other questions ?
>> SONIA BROOKINS: Any other questions for Montrell?
>> ELISE GREGORY: No more questions in the chat at this time.
>> SONIA BROOKINS: All right. Thank you, Montrell.
>> Thank you.
>> SONIA BROOKINS: All righty.
OMHSAS. Hello?

- OLTL Report
    - Deputy Secretary Updates
    - Denials & Appeals Data

>> BILL POSAVEC: Hello. Good afternoon, everybody. I'm Bill Posavec, filling in for Jen and Justin who unfortunately couldn't be here today. I'm division director for division of quality management. I get pulled together a lot of this data we looked at at the last MAAC. I believe the request was for us to come back, add fourth quarter data in. Additionally add some prepandemic numbers so we can see how we are fairing with regards to prepandemic and then lastly, to add some additional rate per member enrollees. So we can normalize our behavioral health MCOs and numbers associated with them. You know, developing a rate per 1,000, 10,000 or 100,000 enrollees allows us to kind of put them all on an equal playing field. Because BIMCOs serve a different volume of Pennsylvanians across the state. With that said we will just jump right into the next slide.

Thank you.

So a lot of these slides are slides we had already presented in the past. I just kept them in here for the sake of everyone's benefits. So you had the definition and the terms here. And so just a refresh, you know, denial is denial of a service that requires prior authorization. And so that service may be either partially or fully denied in a frequency or an amount or type of service that is being requested by a member representative or provider. And a grievance is when a member for the representative including provider asked the BIMCO to review a decision about whether a service is necessary, appropriate or effective so if someone is unhappy with a denial they have the ability to file a grief once the termination of that service which required prior authorization to come through. Then lastly a complaint is really just a formal expression of dissatisfaction with any aspect of care, operations, activities, anything happening at the provider level that is really a catch-all complaint and really just the typical definition of how we would all see a complaint.

Okay.

So I think the next slide just, yeah, sets the stage for denial. And the next slide is actually just for the sake of consistency -- oh, sorry, I forgot about this one. This gives details about why services are prior authorized. Why does the BHMCO have the ability to approve or deny a service and what the next steps are and lastly know that OMHSAS quality management, my division, and our operations staff as well, we reviewed data quarterly and look at that annually when conducting our performance evaluation of the behavioral health MCO. We also review a sample of the denial letters annually and we actually listen to any kind of grievance cases that may be happening when there's you know somebody is grieving denial of service. So we do audits of those as well and provide feedback and corrective action to behavioral health MCOs where warranted there. The next slide I believe is just -- or the original slide that I, that Jen went over last month, so I labeled it original slide. So folks had for that recollection of h is what we

looked at before. And these will be the slides I've updated for today's purposes. Then gave additional information as well. Just a reminder that in the 2024 date on the previous slide, the fourth quarter date where was not included. And so we went ahead and refreshed our data as that information has move edits way through to us and we had that and were able to provide. So you will see differences in the 2023 and 24 data as those records are finalized and moved on the way. Okay, next slide then, take a look. These are the final numbers essentially for the 2024 calendar year.
But as requested, we also provided the 2028 and 2019 numbers to set the stage for where we were with regards it a volume of service denials. Prepandemic. As we knew the pan emic up-ended a lot of things. And a lot of our BM-MCOs during the pandemic we were making sure that individuals got the services that they needed and a lot of services that you know have rigorous prior authorization requirements, you know, prepandemic during the pandemic some of the things were alleviated. Because again, the goal was really just to make sure everybody got what they needed and worry about the payment and all of those kind of things later on. So as you can kind of see, you know with cries I intervention service, very little services have any kind of denials. Our big ones tent to be in the space of, and in fact, actually, those are very big numbers, and I apologize for not removing those. The IVHS, I did want it clear those out in 2018 and 2019 because they are outlier numbers and that was because -- that was before the IVHS regulations were put in place. So those numbers are a little inflated with old processes and things. It is not really an apples to apples comparison when we are looking at this 2018 and 2019 numbers and comparing it to like the 20204.
But what you can see at least is in the IVHS space, you know, there is a tick up as a result of the pandemic looking at like the 2021, 2023, 2024 numbers.
But again we are continuing to watch for that.
But also, know that with regards to IVHS services, there is usually bundle of services happening at the time of a prior authorization request. And someone may ask for wrap-around service. Mobile therapy. Behavioral specialist services. And so when there is a denial, that comes in, it sometimes can be triple counted. All three services may be denied. So you know, we currently aren't really breaking that out for this reporting here. As to kind of the specifics there.
But I just wanted to set the stage for folks and know that in the space of the IVHS services, again, there is usually multiple services that are part of the denial event that ended up getting denied. Which is why that number is a little large.
Our next largest number is I think the one that has been the hot topic lately is the nonhospital residential withdraw management rehabilitation and half way house services for drug and alcohol abuse and SUD. As you can see, that is an area where we are seeing an uptick in our volume of denials. Again this is just volume of denials. You know, what is not here is like the number that has been overturned or uphold. The disposition, if there was a grievance, what that may have looked like. Certainly additional detail we could provide later.
But for the purposes of today, we can see the general volume of service denials and

again, the nonhospital residential withdrawal we be a and half way how the services are things we are seeing the highest rate increase on and something we are definitely following up on working with our behavioral health MCOs and primary contractors it understand the climate of what is going on and making sure that members aren't incorrectly being afforded services for which you know, they would qualify for or meet the medical necessity criteria for. There are some difficulties among the provider network with regards it meeting the new ASAM criteria for medical necessity criteria. So that does in fact lead Louisianaed to some denials and back and forth with the provider to kind of get what is needed. And then ensure that the member is afforded the service for which they are eligible for.

Probably the next item kind of of interest, is the psychiatric outpatient clinic services. 195 denials in 2024 for that. Where as during the pandemic, and in 2023, you know we were under a hundred.

So we are watching that one as well.

But similarly to the nonhospital residential and psych outpatient clinic, you can see the 2018 and 2019 numbers are significantly higher. And so again, we are happy that we are not back at the prepandemic levels of denials but we understand that you know as our system is writing itself from the pandemic, it is natural for things to kind of, you know, move back up to where they were given the starch decrease this occurred between 2018 and 2020, 2021 as a result of business operation changes there at the MCO level.

Okay, I will go ahead and move on to the next slide, then I'm happy to take questions if anyone has any questions, the f that's okay. So this goal here is to set the stage of what, you know, this is the total volume of Medicaid enrollees. So we are using a 100,000 rate because of course our Pennsylvania population is so large. This is really just giving a rate associated with that and like I said, you know, previously, and you could see it from just the sheer volume. The IVHS, the nonhospital residential. And the psych outpatient and additionally the psych hospital services, the fourth one down, they are experiencing the highest rates that we see. You know, with regards to service denials here among our population.

And if we go on to the next slide we will get more granular and look at behavioral health MCOs. So what we can see here is how total denials are shaping up for our, like MCOs, managed care. Obviously our behavioral health MCO Magellan does have the highest volume we are looking at here. And again, it is primarily due to that nonhospital residential withdraw and we are looking at this. Working with them. And you know, know they are actively working with a provide are network to make sure that the providers are submitting what is required. And in an effort to kind of now we be throw off that initial denial. And kind of eliminate some of the back and forth with regards to getting additional information and paperwork to have the provider demonstrate that the person meets the medical necessity criteria for the service and allow that member to get the service. With regards to you know our other plans, things are pretty flat. So as you can see, you know, still, things are kicking up a little bit from the pandemic and the 2021 time when we were really in the middle of that public health emergency. Again

very little service denials happening. And things are you know, increasing.
But certainly not at a rate to where we were in 2018 and 2019 which I think is a success all around.
And if we look at next slide, this is where I applied for you all a rate per 1,000 enrollees. So this is really, again, kind of showing what you could have gleaned from total volume. And this here I gave a nice easy to look at graphic. You folks remember some of our other graphics were a lot of up and downs. This is easier and flat to see. We can see that Magellan is kind of, had a starch increase between 2023 and 2024. And that has certainly been validated through data. The anecdota information we were hearing from folks around concerns on this particular behavioral health plan with regards to that particular service of that nonhospital residential withdraw management. We have been working with Magellan to better understand and a lot of the denials are the result of the issues with needing extended stays due to not having alternative discharge plan for someone currently in a nonhospital residential situation. Or you know, someone who may need that service but doesn't quite meet the medical necessity criteria and it is determined a lower level of care is more beneficial to the member than you know, than that residential service there.
>> KYLE FISHER: Yeah, thank you for -- actually, thank you very much for presenting this data. Sort of to fill in the gaps from last month. And also to present it visually the way you have here. I think this slide in particular shows the extent to which Magellan is an outlier in services and it is clear that with earlier slides with the services for SUD treatment particularly that it is denying. I know the deputy last month spoke about ongoing conversations with Magellan and the relevant primary contractors and larger residential providers to try to understand what is happening here. Am I understanding you to say largely that in this investigation that OMHSAS is finding that these increased denials are appropriate denials?
>> BILL POSAVEC: I would not say we are there yet as finalizing our investigation. We are listening to the information that Magellan is providing. And we are doing that deeper dive into that information.
But you know, we are hearing lots of information from the primary contractor, hearing information from Magellan. We are hearing information from you know, the providers directly and through their trade associations. So we are hearing a lot of different things and everything is making sense. And folks, those parties are you know, explaining what their take on the situation with that information, but you know, we are looking to kind of do a deeper dive and kind of do validation to just make sure that that is exactly what it is. As far as our oversight.
>> SONIA BROOKINS: William, this is Sonia Brookins.
I hear you loud and clear.
But 819.
That is an awfully a lot of people. And I'm not saying that they are doing anything wrong, but I do know that people get, you know, pushed to the side, like through the cracks.
So I would appreciate it if when you do complete the investigation, that you would let us

know if there was any denied wrongfully. I would like to know that. I really would. That is a lot of people being denied. And so, you know, we have to be careful of how we do people and treat people.
And but just because they are in these places, we still have to do right by them.
So I'm not saying that they are doing anything wrong, I don't know.
But I know that's awfully a lot of people.
>> BILL POSAVEC: Thank you, Sonia. And yes, you know, we certainly understood your perspective and from a Commonwealth perspective we feel the exact same way. We want to make sure our Pennsylvanians are getting the services they need. A little point of clarification. What we are looking at here is just total denials.
So that is not necessarily speaking to individuals. Individuals, there could be services for which they were approved and then a subsequent denial. I like use cases because I think that helps put things into context. So like one example, you know, that we are aware of and we are looking deeper into, is there wasn't an approval for the service.
Someone may have been or someone was in a service for, let's say, 15 days.
Then the provider was feeling that the person needed to stay at that provider.
But yet, the person's goals were met. Their needs were being met. And so the provider may have been asking for additional days beyond the 15 that were originally authorized for. So maybe they needed an extra five days. And this may have been what was denied.
It is not that necessarily in all case he the person was denied a total service out right. It just may have been that there was additional days of a particular service that may have been denied. And in some of the cases that again we're hearing from the primary contractor and Magellan is unfortunately that that person met all of the goals to be discharged at day 15 but there wasn't a safe discharge plan for the person to go to. Meaning no alternative housing option that they could have went to and so as a result, the provider will submit a request in order to continue a stay at the funding of the insurance, at funding of the behavioral health.
But unfortunately the person doesn't meet the criteria to allow for the payment with tax dollars, you know, to cover that additional days. And so that would be an example after denial that we would be seeing. It is not that the person didn't receive the treatment they needed. It was just maybe the reason for the stay was more of a housing issue or not having a discharge plan in place that was effective. And that could have been, you know, the cause for the denial. So that is what we are looking at. There is a myriad of scenarios, you know, that lead it a denial. And that is kind of what we are sifting through.
But to your point, if we do see anything where there were members who needed a service, were entitled to the service but failed to get it because of one reason or another, we certainly would be issuing a corrective action plan to that behavioral health insurance company and requiring them to do a quality improvement plan so that that doesn't recur for another member.
So that would be essentially how we approach when we see these kind of, what I would loosely call a violation of our requirements there.

>> KYLE FISHER: That is good to hear that. We sort of feel the same way. Can we back up one slide?
>> Certainly.
There we go.
>> KYLE FISHER: I wanted to have the updated for numbers for 2024 as well. Everything you were saying there makes sense. There is a red flag of the increase, the sharp increase in denials were really just one of the BH-MCOs here. Magellan increasing five-fold. And none of the other plans have an appreciable increase. I don't doubt there are certain situations where a provider may be requesting services that are really not medically necessary because the patient has no housing alternative. But it would be surprising if that's limited to the counties in which Magellan operates.
We absolutely appreciate that the county is auditing the cases and looking into this further and talking to stakeholders and looking into whether the uptick in denials was by and large appropriate or putting Magellan into corrective action or improvement plan and a remedy for the particular consumers involved. Many of whom were in recovery at a time, at place in their journey where they were seeking services or trying to continue them. It is not at all clear that going back and contacting them is six months later after the fact and to invite them to seek services again with a meaningful remedy at this point.
So we appreciate that. You've heard the concern. We know we heard from the deputy last month that OMHSAS continues to have those conversations. One more question, have you seen into whether or not this increase in denials continues through 2025 with Magellan in particular?
>> BILL POSAVEC: No, we haven't had the resources to dive into the 2025 data but that is certainly information we are interested into looking at and will prioritize as quickly as we can. My assumption is, I'm sure the trend is, I'm hoping flatlined but certainly hasn't increased. We will look into it more once we have resources to do the deeper dive. And in fact we are meeting with, in a few weeks, with Magellan and the primary contractors again. And you know, a good point to really make sure that we have that information for 2025. Least for the first quarter, January, February, March, ready for that discussion because that can certainly be a talking point that we could use to really question, was this a point in time issue where some things were kind of getting, you know, cleaned up with regards to the provide are network. Sometimes the review criteria, if things are missing or you know, there are the ASAM criteria put in place, and there are some providers who are following and aligned with the ASAM criteria then providers who have not yet moved forward with aligning.
With the ASAM criteria. We could see a higher efficiency in denial.
But work is under way by DDAP and Magellan to educate provide rs. In fact I saw a flyer that Magellan put out. They are doing a training next month with their provider network on ACM cryterra and doing more education for those folks who submit utilization review information to Magellan to help them understand, these are the key points we're looking at. Be sure to emphasize on this, that or the other thing and that would eliminate some

of the back and forth and potential denials that were happening.
Yes and thank you for bringing my attention to the original. Sonia, I wondered where you got the 819. I will call it out. When we refresh numbers from 819 to 1,190 for Magellan. Again, we are certainly alarmed as what this group is and we are continuing to have conversations and better understand all of the different factors that are leading to this starch increase and to your point, we aren't necessarily seeing that among the others at such a starch increase.
>> SONIA BROOKINS: Absolutely. I appreciate that you are going to take a look that. Because you don't know, you just don't never know what is going on. You have facts but until you dive in, as we have been going over this for a long time over the years, not just with y'all but other ones and you don't know who is by the way side until you dig deep and find out when you find out and you are kind of shocked.
But I hope that it turns out to be what you say it is and nothing else. I do hope that for the sake of the clients.
>> And we can drill into the 1190s and see if in fact there was another level of care like a lower level of care approved. So while that higher level of care more intensive, may have led to a denial, was there, or that's a question I would want to ask Magellan, is there evidence they have to support the denial case and the individual is able to receive a lower level of care and that the individual was actively participating in those services. It is one thing for us to say, hey we are denying this but approving you for something less intensive but if the person isn't able to attend or take advantage of that service, that certainly is of concern as well. We want to make sure that the individuals are getting the services that they need that is the purpose of our program and we want to make sure that folks have access to service and are receiving high quality services from the department. We will definitely -- I will dig in on that. And if anything pops up, I'm happy to bring those findings back to this group and we can continue to discuss.
>> SONIA BROOKINS: Okay, thank you very much. Anyone else have questions for William?
>> I do have more slides.
But I don't know if I'm at my time. I don't want to take over others. Maybe if we can jump ahead just to slide 10.
So advance two slides for me. Kind of the same, but here, this is the rate per 10,000 enrollees. And this graphic here is what we refer to as an area chart. And what you can see is in the prepandemic, you know, is it is the orange, which is CVH. Philadelphia MCO was carrying a bulk of our denials for this nonhospital residential withdraw management. Now you can see where we are in 2024 that the large part of our graphic is blue. Which is the Magellan color. I thought this would be a nice graphic for h group to kind of see. I love my area map. So area charts where I can use them. Sometimes not the easiest to use because you don't see the change.
But this this one you can visually see that you know prepandemic where we were seeing the highest volume and rates these are actually rates for denial because these are normalized among our population. So the rate of denials is much higher in the CVH

area. And as you can see today, Magellan has the highest rate. And it is certainly one that is eye-catching with the rate between 20 denials per 10,000 enrollees. So that is something for us to look at.
Deeper.
>> Sure.
Questions?
In the chat?
>> ELISE GREGORY: They are looking if there is specific use case information as a general overall overview of the statewide information.
But the fact that each one of the case is potential someone showing up for help and getting denied, that gets lost in aggregate data. That's from codey Jones.
>> BILL POSAVEC: Codey, good point. For those of us that work with numbers a lot, we have to anchor ourselves back into, there is a person behind this. So yes, I agree. The use cases are always so important to kind of think about. Because while it is easy, when we are grouping such high volume of numbers together for the sake of data reporting, you really have to recognize that, you know, each case is unique in and of itself. Most of the individuals have different levels of need. So sometimes grouping things together can be dangerous and you do lose that human component.
You know, to it. That's why we pull a sample of the records. And it is difficult to look at each and every case and we pull a representative sample and do clinical reviews of the records and again if there are things that are of concern we will include that in a corrective action plan and then move forward with the quality improvement plan and team with Magellan to help support them so they can bring that improvement necessary and prevent recurrence from happening to others if in fact it was not in accordance with the rules, policies and regulations.
I appreciate that call-out. Thank you.
>> SONIA BROOKINS: Anyone else?
Well, William, thank you so much. We do appreciate it. We will be inviting you back.
>> Okay, sounds good. And I did go ahead and provide updates on grievance data as well as complaint data. Lappie to go over that with this group at a later time knowing my time is short.
But if anyone has any questions, feel free reach out. I know the questions will flow back to me, and I'm happy to answer them as I'm able. Thank you, all.
>> SONIA BROOKINS: Thank you. All right.
Next, public comment.
Hearing none. Eve?
>> EVE LICKERS: Yes, Ma'am?
>> SONIA BROOKINS: Public comment?
Lees losses we have a few you public comments in the chat. Paula is in the Magellan area and is not surprised. Dandrea was asking about capacity but we don't know what capacity area. That's all the public comments in the chat.
>> SONIA BROOKINS: Okay. Anyone on the board have anything?

Okay.
Old business, new business?
I would like to thank everyone on this call. Appreciate everyone on this call.
Appreciate all of the feedback, all of the comments. We just appreciate it. Can I get a motion to adjourn the meeting, please?
>> SONIA BROOKINS: I'll make the motion.
Okay. Thank you all. Appreciate you.
Bye.