Consumer Subcommittee of the MAAC

June 25, 2025

Consumers present: Sonia Brookins; Minta Livengood; Liz Healey; Meghann Luczkowski; Rochelle Jackson; Marsha White-Mathis; Spencer Duffee; Bethany Pancoast.

DHS representatives present: Sally Kozak, OMAP Deputy Secretary; Gwen Zander, OMAP Managed Care Bureau Director; Jocelyn Maddox, OMHSAS Bureau Director; Juliet Marsala, OLTL Deputy Secretary.

The meeting was called to order at 1:00pm

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>> ELISE GREGORY: Good afternoon, welcome to the Junior subcommittee meeting. Today is June 25, 2025. My name is Elise Gregory. This meeting is recorded and your continued participation is consent. If you don't wish to participate you can leave at any time. There is been an update to the go to webinar platform. Panels and speakers, if you have audio issues please go to the top right corner and find the gear wheel to fix settings and hardware. If you have difficulty please send a message in the chat. To avoid disruptions please remember to keep your microphone muted if not speaking. Life captioning, known as cart captions are available and a link has been included in the chat. Presenters should state their name clearly before speaking to assist the captioner. Representing the office of human services, Deputy Secretary, Sally Kozak. - - Gwendolyn Zander, Julia Marsella, from the office of mental health and substance abuse disorder, director of quality, management, Bill Posevac. Questions may submitted in the questions tab. If you have questions or need information please visit the consumer subcommittee webpage. Handing things over to the Consumer Subcommittee chair, Sonya Brookins.
>> SONIA BROOKINS: Good afternoon, thank you. Good afternoon and welcome to the consumer subcommittee. Once again, my name is Sonya Brookins and I will hand it over to Kyle.
>> KYLE FISHER: Apologies to everyone for the late start this afternoon, we have had more tech problems. A number of Consumers are trying to get on still; we don't have a full complement of those available. Trying to do introductions through those, hopefully those trying can figure this out. Do we have Meghann Luczkowski on the call?
>> MEGHANN LUCZKOWSKI: Yes, good afternoon.
>> Do we have Liz Healey?
>> LIZ HEALEY: Yes, good afternoon.
>> Thank you. Rochelle Jackson?

>> ROCHELLE JACKSON: Present.
>> KYLE: Marsha White-Mathis? Bethany Pancoast? Looks like we have Bethany on the call. Bethany, are you able to unmute? Do we have - - Lauren Hatcher? Lauren Henderson? Spencer Duffee? Jayme Scali? I am getting a note that Minta Livengood can hear me but cannot unmute. If you can hit that little wheel you should hopefully be able to change your audio setting. Fully, not sure why it defaulted to something else. - - Can you introduce yourself if you're able to? Any other consumers I may have missed? Okay. Thank you, handing it back to Elise for the presentation.
>> ELISE: For the OMAP presentation we have Deputy Secretary updates to start.

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

>> SALLY KOZAK: This is Sally, good afternoon everyone. I want to discuss impacts of the budget reconciliation bill at the federal level. You may be familiar with some of these stats but they are worth repeating as we talk about the impacts of the federal legislation. Currently in Pennsylvania Medicaid covers almost 3 million people, in fact I think it's a little over 3 million people. So that is about 23 percent of the state's population or about one in every four citizens. Of those, 750,000 people have coverage as a result of Medicaid expansion. 1.3 million of the people we serve are children. A little over 423,000 are individuals with a disability. 312,000 are individuals who are 65 years or older and we have almost 10,000 veterans that we cover through Medicaid or medical assistance. Every year, there are more than 175,000 Pennsylvanians on Medicaid who receive treatment for a substance use disorder, and over 200,000 people received treatment for diabetes. 192,000 older adults and people with disabilities in Pennsylvania receive care in their home or community-based settings instead of a nursing facility. We cover more than 45,000 areas across the Commonwealth and have 61,000 people who need treatment for heart failure. For fiscal year 24/25 the Commonwealth contributed more than $13 billion to the Medicaid program which was matched by more than $30 billion in federal funds. If you look at the next slide you can see some breakouts of medical assistance coverage by county. You can see where it is that has some of the impact across the state should the federal bill actually be passed. To talk a little bit about what we are hearing at the federal level and what the impacts would be is currently proposed and we know it is still changing at this time. A Senate bill is still working. We would have significant individuals who are cut off Pennsylvania's Medicaid program. Particularly individuals with disabilities, older adults and working families, and right now we estimate around 300,000 would lose coverage. Current legislation proposed could also lead to the closure of many rural hospitals across Pennsylvania. The legislation would cause delays in enrollment and increase administrative hurdles and eliminate retroactive coverage which would cause

financial hardship and disruptions in care for individuals that are covered. To stay within the limits created by financial cuts at the federal level we would likely be forced to make reductions and services provider reimbursement rates and as a result we would see care shift from being covered to uncompensated care. We could expect to see increased utilization of inpatient services as people lose their benefits. We expect we would begin to see exacerbation of some of the chronic conditions in individuals who lose their preventative services because they lose benefits. We could also see delays in seeking treatment which will lead to worsening of conditions. Beyond the impact to individuals we serve the bill would add significant unfunded mandates which would add significant costs of the program. There would be costs for the extra staff that we need to be able to implement the requirements and there would be costs to our IT systems as well. That was under the house proposed. On June 16 the Senate Finance Committee released its version and has released several comparison charts to both the House and Senate versions and you can find those at any number of the national Medicaid organizations tracking it. Kaiser foundation, Kaiser family foundation. Center for healthcare strategy, National Academy of state health policy. I encourage everybody to go ahead and take a look at those to see what the differences are between the Senate and the House version of the bill. Last we heard, it remains goal of the Senate leadership to hold a floor vote by the July 3 recess so it can be delivered to the President for signature. That's where we are in terms of what is happening at the federal level. Questions about that?
>> Go ahead.
>> SONIA: Go ahead. Who is?
>> LIZ HEALEY: Sally, this is Liz Healey. I saw in the newspaper, I think the New York Times about the governor saying Pennsylvania wasn't going to be able to pick up the cost they were going to lose federally. One of the changes he spoke about making was the elimination of access to the GLP-1 which I think are those weight loss medications. And in the times they made it seem like it was going to be a blanket thing that they weren't going to be covering. Can you clarify that?
>> SALLY: We have been talking about this publicly for some time and I think I spoke about it at the last MAAC ConSub meeting. I'm not sure what you are referring to in the New York Times. We are aware that Spotlight PA did an article that had misinformation that we reached out and asked them to correct. We have proposed new prior authorization criteria for GLP-1. GLP-1's are used to treat diabetes and obesity. The criteria we have proposed would put additional limits on treatment or on the use of the GLP-1's for treatment of obesity. There will be no additional restrictions put on the treatment for diabetes. We cover that and will continue to. For the treatment of obesity, we have structured their criteria in a way that people are most seriously impacted by obesity are the ones that will have access to that. For example, people who are morbidly obese and have a BMI greater

than 45. People who have a high BMI and have one of the approved comorbid conditions that have been approved by the FDA. For individuals that do not have morbid obesity or do not have a comorbidity with their obesity. Those folks will have to demonstrate that they have tried and failed some other weight loss program or other weight loss medication. Those criteria were initially targeted to be implemented in July but at this time we are still awaiting final approval. Once we get final approval it will be 6 to 8 weeks until the criteria are implemented. We have sent all of that out for public comment. Which is posted on our website.
>> SONIA: Sally?
>> SALLY: Yes, Sonia.
>> SONIA: These 300,000 folks losing coverage is crazy but I know it's not our control. Do you think the Senate with its budget wants to cut off people? Is that correct or no? For Medicaid?
>> SALLY: I'm not sure I understand. Do you mean at the federal level?
>> SONIA: Federal level, I know the House passed this. Through the Senate, I'm not sure if you know the answer but do the Senate have anything they have to do with Medicaid cuts in it is what I'm asking.
>> SALLY: What we've seen is they have work requirements and them. They have redetermination every six months. So, yes. They do have provisions in their that could potentially cause individuals to lose Medicaid coverage.
>> KYLE: To follow-up, this is Kyle, thanks to DHS for putting up this information. I think helping people understand, educating the general public as well as numbers of Congress and Senators on the catastrophic impact, not just to the Medicaid program but rural hospitals, urban, suburban hospitals, healthcare systems is absolutely critical. So we appreciate you sharing this information. Follow-up to Sonia's question as we make sense of potential changes the Senate is making to this. With respect to the provider taxes in particular and reducing that safe harbor from six percent to 3.5% for certain provider assessments, has Pennsylvania done modeling? Are we looking at billions per year for PA? Is that something you can speak to?
>> SALLY: I can say this, that the provider tax assessment language has been up and down in the Senate over the last couple of days and it is still difficult to understand exactly where they are going to land. There has been a lot and I mean a lot of lobbying at the federal level from hospital associations, hospitals directly, states directly. So where they will land, we don't know. I know that our budget office has done some modeling of that. I have not seen it that I can share anything with you. At that point in time that they have it finalized I'm sure they will be sharing. Does that answer your question?
>> KYLE: It does. And I'm sure as one follow-up, it's fair to say, looking at the Medicaid budget, that Pennsylvania, like most other states, heavily relies on prior assessments?

>> SALLY: Correct.
>> LIZ: Sally, this is Liz. One final question. Given the uncertainty at this moment about the federal budget and state budget is supposed to be adopted by the end of June. Will the state legislature adopt a budget without knowing what the final figures are? Or do you anticipate that the legislature is not going to adopt a Pennsylvania budget until they know exactly what the federal allocations are going to be?
>> SALLY: That's a fair question. I can't anticipate what legislation will do at the state level.
>> LIZ: Thank you.

- **Community Health Workers (CHW) Updates**

>> SALLY: For folks interested, if you go to our website, DHS.PA.gov and you look for the tab that talks about research and data there is additional information about coverage going down to the district level. And it includes not only Medicaid data but it includes information on snap and other benefits as well. I would encourage you to go and take additional looks. Okay. With that, I'm going to move on to community health workers. Folks know that I have for a long time now said that we recognize that CHWs play an important role. Particularly with communities and individuals that we serve. In ways that traditional healthcare providers may not. They fill that gap in terms of outreach and education. For a number of years we have required the use of community health workers in our program with a requirement that they be part of our old BTM for any maternity care bundle. Providers can have patient centered medical homes with community health workers as part of their team and we have allowed NCOs to use community health workers as part of their healthcare management. We know there has been a push to increase the use of community health workers. We held a series of eight, I think it was a little bit more. Stakeholder sessions, eight listening sessions to engage in brainstorm with stakeholder groups. We also did some survey of folks to get input on how we want to move forward with incorporating community health workers. Each of the listening sessions we had focused on a specific stakeholder group and you can see them outlined there on the slide. During each of the listing sessions, questions were geared specifically to the stakeholder group we were targeting. Each session was open to the public. And most of them were really well attended. If we can go to the next slide, please. As we got done with collecting all of the information we did an analysis, a very high-level analysis and it revealed three priority areas that were used to form workgroups for the second phase of stakeholder initiatives. The priority areas were the role of the community health worker to better define it. The services they provide and the populations they serve. To better understand how we can support the integration and coordination of workers within care teams across diverse settings and to identify those practices for service initiation, CHW qualifications, work for

support, contracting, measuring outcomes and billing. Each of the workgroups we had had representation across stakeholder groups as well as other state agencies to focus on one of the identified priority areas. These workgroups provided stakeholder informed input for us to consider as we move forward with integrating CHW services more into the MA program. So if we can go to the next one. We have been reviewing the information we got from the stakeholders. Let me just say unlike other workgroups where we issued a paper, this was just a transcription of everything that happened during the sessions. Based on review we will be moving forward with strengthening the language in further declining services in the health choices agreement. Our goal is to add language to the 2026 health choices agreement but of course that is clearly dependent upon budget approval. We will continue to review stakeholder feedback as we consider whether or not to add CHW services to our estate plan going forward. Questions about that?
>> KYLE: This is Kyle. I think you mentioned a few situations where the program is already providing CHW services, such as patient centered medical homes, community based care management, and moving teams. So when you note a goal of further defining this in the help choices agreement and asking the MCOs to clarify how they are providing the service, is there also the ambition to expand the consumers for whom this is available? Are you looking to target additional populations?
>> SALLY: Let me say a couple of things about that. You know, you've all heard me say that I support the community health workers. However, I've also been very clear that I believe they need to be graded so if your question is asking whether or not we will allow them to independently enroll and fill the answer is no. Building expand the parameters and add some definition to how NCOs must use community health workers and how they must contract with community-based organizations ready services? Yes. Will we outline how it is that they must expand as part of their care management programs? Yes, we will do that as well. Will it totally open them up? No. We believe this should be an iterative approach. Does that answer your question, Kyle?
>> KYLE: I think it does, yes. So just clarifying roles under existing programs, it sounds as if DHS is very clearly saying we want clarity and are also looking to expand their use within managed care programs. Would you say expand parameters? They may not be universally available to all members but they should be increasingly.
>> SALLY: Yes and I can give you examples. The language is still in draft and not ready to be shared at this point in time because we are tweaking it, having conversations and need to price it as well. In the current agreement we say they can use community health workers for outreach and education. In the proposed language we are drafting we will be saying that they should be used for outreach and education related to some specific conditions that they should be part of the MCO care management initiatives as well. So yes. Add more definition to where they should be doing as part of their scope? Does that clarify for

you a little bit?
>> KYLE: I think it does. I don't think consumers will take issue that should be integrated into - - struggling to assist a family because that family needs a person who is able to communicate them with their language on the ground it makes sense that we would have a team be able to sit down and navigate. I don't know if other members of the committee had questions or follow-up?
>> LIZ: Sally, can you share what you think the timeframe would be and by when do you hope to have it in the state plan?
>> SALLY: You now, the work is ongoing. We are going to add it to the HealthChoices agreement. There is no need for us to add it to the state plan when we can add it to the contract. The only reason to add it to the state plan would be to recognize them as a new provider type that can build. And we are not there. And I'm not sure exactly when or if we would ever move in that direction.
>> Thank you.
>> SONIA: A long time coming, Sally.
>> SALLY: It has been. It has been. I'll say this. We are happy that we are able to do this. Like I said. We've always been supportive but the secretary and I have been supportive. We also recognize this is going to have to be an iterative process. We know there are folks out there that will come back and say you did not go for enough. I will not disagree with them when they tell me that but it's a foundation that will allow us to build upon going forward.
>> SONIA: Thank you for all of the work.

- **MA Fee-for-Service Prior Authorization/MMIS Updates**

>> SALLY: You are welcome. Okay, and then a couple of quick updates from me on prior authorization and fee per service. I think we talked about how we are updating our Medicaid management system and we are doing it in a modular manner which means we are taking individual components and functions and turning them into standalone systems that will link back together at the end of the day. So free for services implementing a new prior off all my authorization function. Moving to what we know as intelligence quality track application. Phase 1 already went into place in the second phase will occur will occur in 2025. And there will be a provider portal interface for fee-for-service submissions that will occur in the third quarter of 2025. The objectives we have that we can modernize and streamline modernization processes which is ensuring flexible Web-enabled solutions that integrate with our legacy systems which is promised for improved operational efficiency and claims processing. We will be upgrading features that offer real-time insights, automation, customizable notifications and secure, easy web access for authorization

management while still ensuring that all of it complies with federal requirements. So what we were doing is we are moving from a paper and fax -based prior authorization system to an electronic system that will give providers authorizations, approvals or denials in real time. Which will significantly streamline the process. We are really excited about that. For home health services we do telephonic reviews on home health agencies are currently not married to submit 30 and 60 days in advance. Home health aides are able to make one prior authorization and all visits require prior authorization. For new shift cases, home health aides are able to do on boarding assessment and paperwork. If there are cases where a baby is being discharged from the hospital we can assist care managers in getting kids discharged quickly. And we have a process in place, - - I keep saying aides. Home health agencies can initiate care when it's an emergency situation and submit the paperwork later within 30, 60 days. So that's where we are at with our prior authorization system. Updating it. In terms of CMS interoperability and prior authorization final rule, that was published in February 8, 2024. The rule establishes requirements for prior authorization and must be compiled with state Medicaid agencies including Medicaid NCOs and services as well as the CHIP program by - - receiving a request, expedited or current authorization request must have a decision rendered as expeditiously as the recipients required by no later than 72 hours. Notices of prior authorization. - - If prior authorization is denied again it means the recipient with a specific reason, one of the requests is denied. An extension of up to 14 calendar days must be granted. If the provider recipient or is - - best interest, there's a whole host of reporting we need to do on it. We are currently aligning with the time frames with federal regulations. And order to get that done by 2026 we are working on adjusting language in the agreement. And the HealthChoices agreement allows us to notify a provider within 48 hours if more information is needed. We will adjust language to allow for the extended, up to 14 day maximum the legislation says we can do. Questions about that?

>> KYLE: There is a lot of there, Sally. Thank you. On the promised modernization. For fee for service, I think will be very welcome news for home health agencies or others that have been submitting forms via fax and snail mail. In the type that you mentioned up to two months in advance which is a much longer timeframe than what you just talked about is required within managed care. In terms of the provider portal going live, did you mention third quarter of this calendar year? In the next three months, more or less?

>> SALLY: Right now that is the plan. That's the plan. Yes.

>> KYLE: On the horizon? Thank you.

>> SALLY: Yep. Yep. I know all of the IT stuff is hard when you talk about the requirements and stuff but I will just share, we are really excited about how our promise, I don't even know what we call it. Our promised transformation is moving along. We have implemented several new modules and every time we implement a new module we get

new capabilities that take us away from all of the paper and fax to base processes that we have in place and things are being streamlined. In most cases, clearly it's the providers that have to enroll and submit, that have to submit claims. We are really excited about it. It's going to transform the way that we do business. Okay. Hospital and MCO contract termination. Usually someone from BMCO talks about that and I don't know if anyone is on.
>> Hey Sally, it's Gwen. I'm here.

- **Hospital/MCO Contract Terminations**

>> GWEN ZANDER: This month, hospital contracts I'm reporting on include Suburban community Hospital in Montgomery County. They are closing their acute care hospital effective July 1. It's going to transition to become a facility that offers only behavioral health services. So it will no longer be in network with the physical health MCO's. A total of 1921 members across all physical health MCO's will be impacted by the closure of this acute care hospital. And they did receive notices that were mailed in mid-May, now seeing this. Most of them were Keystone members followed by health partners, then United. Another hospital closure to report on is the Heritage Valley Kennedy hospital, in Allegheny County. They are closing at the end of this month, June 30. A total of 2484 members across all MCO's were sent their notices in mid-May to announce that hospitals closure. And those were primarily UPMC members, followed by - - and Amera health. Ongoing negotiations continue between both HealthPartners and Keystone First continue to negotiate with Holy Redeemer. Neither of those are expecting termination but current contract expiration date for both is at the end of August, August 31. They continue to work on this and we hope for a new contract by the end of August and at least another extension. There would be 10,741 health partners, members and 7040 Keystone members that would be affected. If that contract were not extended or renewed. And so they would need to be sent notices by July 13. Again, we do not expect it to terminate though. Keystone First is also negotiating with the University of Pennsylvania health system which includes Doylestown Hospital. The current contract dates, and of August notices would need to be sent to a total of 53,322 members by July 15. That is a really sizable number so we are hopeful that the contract is either renewed or extended. We had previously reported on a couple of things I wanted to give you updates on. The first was United with Childrens Hosp of Philadelphia due to expire August 1. A new contract has been negotiated and is in effect until 2028. So that has been news. We reported United's contract with St. Luke's health system was scheduled to terminate this summer. The contract has been extended until December. So we will keep providing updates in the fall about member impact. United and Tower health has also extended their contract. New termination date is October 1. Lastly I wanted to talk about

the closure of Crozer. The patients who were previously being served by Crozer are now going to Riddle Memorial Hospital, Mercy Fitzgerald and - -. Mainline health system has absorbed many of their former patients. We've also been made aware that Christiana care will have a new hospital in Chester County second half of next year and another one in the second half of this year and another one in Delaware County next year. So that is some good news for the region. MCO's continue to assist members with identifying alternate in network providers for continuity of care purposes. Then my final update has to do with Rite Aid pharmacies. Many, if not all rights - - been difficult to get information about exactly which locations are closing on which date. But MCO's are alerting members with prescriptions filled through Rite Aid about what is available to them and what will continue to be available in the future including pharmacy, delivery, or meltwater options available. So we are very disappointed to see Rite Aid locations closing. It will have an impact due to a number of stores across Pennsylvania because of Rite Aid being a Pennsylvania headquartered company. But MCO's are doing the best they can with the information available to them through the bankruptcy proceedings. Those are the updates I have this month. Any questions?
>> KYLE: A lot there as usual, Gwen. Thank you for those reports.
>> Gwen? Go ahead, Kyle.
>> KYLE: I just wanted to ask with respect to Keystone and the contract that is going to be extremely significant with 50,000+ members impacted. Does the Penn health system have contracts with other Medicaid MCOs?
>> GWEN: Yes I believe they are in the southeast but I will have to verify that.
>> LIZ: Glenn, this is Liz Healy. Wondering if going forward it's possible to create a map in Pennsylvania where, just like when people talk about food deserts, places where hospital care, especially maternity care may no longer be available and considerable areas in the state. Is that something that is doable?
>> GWEN: It's something we may want to bring to colleagues at the Department of Health given they have oversight responsibility for hospitals and the information about what types of services and units are operational at each hospital but I think that's a message or request we could share with the Department of Health.
>> LIZ: Thank you.
>> KYLE: Gwen, you started us with hospital closure updates. It's hard not to connect that back to the information we have seen including impacts of the hospital here around the danger of additional hospitals closing. Worth noting that we are already seeing hospital closures. In the current reimbursement environment. It's definitely daunting to think that reimbursement could fall on uncompensated care levels with these facilities and increase in the short term. No responsive here is necessary. I do want to note that if more members have a question we had a few more joined since we did introductions. We have Marsha

White-Mathis on. Marsha, do you have audio? It appears Marsha is on that we may not have audio. Spencer Duffee, do we have audio for you?
>>: SPENCER DUFFEE - - Can you hear me?
>> KYLE: It's muffled but we can hear you are on. I will try Minta Livengood all my time. Do you have audio?
>> MARSHA WHITE-MATHIS: Do you guys hear me? Because it did say - -
>> KYLE: We can hear you now, Marsha.
>> And like why did it say listen only mode?
>> KYLE: Anyone else with questions for Gwen?
>> I'm sorry, I'm trying to get into, am sorry. I was talking earlier about, I hate to break this down to the question.
>> KYLE: Any other questions before we ship?
>> SONIA: Not a question but thank you, one. I know it's hard for you to explain closures. Not your fault. I just want you to know I hear you and feel you. I do.
>> I appreciate the information. I'm sorry - -
[INDISCERNABLE]
>> GWEN: I'm happy to present this and I did get confirmation all southeast MCO's have UPenn in their networks and this was reported two weeks ago so we believe that to be accurate.
>> KYLE: Great, thank you.
>> SONIA: Thank you again, Gwen.
>> This is Meghann, I know there's a hand raised. Don't know we want to wait to address it.
>> KYLE: Are we picking up your microphone? I don't know, Elise, do you want to pause for questions?
>> ELISE: We do have a question from Barbara Danz about CHW, are they being added to HealthChoices for behavior health and physical health MCO's? And will there be alternative payment for these like PMPM - -, ability populations being considered would CHW work?
>> SALLY: CHW's will be added to the HealthChoices physical health choices agreement. The behavioral health program uses other peer support specialists and something else, I forget what they are titled. The CHC program covers assessments. It's primarily going to be a physical health initiative in the HealthChoices agreement. And I'm not clear what she means by PMPM. We would not pay community health workers with PMPM. - - are free to reimburse providers that are employing community health workers the way they do with any other provider type.
>> SONIA: Anything else on the chat?
>> ELISE: Yes, from Jeff Eiseman we have if the federal budget will impact MAT P and if it

will impact across PA? Has that ever been addressed in both versions of the federal bill?
>> SALLY: You know, I'm not seeing anything specific to MAT P. That doesn't mean that there isn't something in the building. But I'm just not seeing anything specifically pointed out.
>> SONIA: Anything else in the chat?
>> ELISE: No other questions in the chat. We have a person of the public with a hand raised requesting public comment. We can wait till public comment at the end of the meeting.
>> SONIA: Okay, thank you, Sally and the department. Thank you all. I just need to do some more housekeeping here. I hear feedback. Please put your phone on mute. Please. If you are not speaking please put it on mute. Thank you so much. Next on the agenda is OMHSAS.

- **OMHSAS Report**
    - **Deputy Secretary Updates**
    - **Magellan Denials**

>> JOCELYN MADDOX: Deputy Secretary Smith is absent. We will provide you with a couple of updates, let us know if you have any questions. Before return it over to the team that will formally present I understand there were questions for OMHSAS. One you asked for a new - - update and I want to let you know we continue to work with Deloitte on network adequacy dashboards. We are not quite ready for prime time yet. However, once we get in our geography up and going we will be able to measure time and distance according to CMS requirements. Another tool the resource will offer is we will be able to the members address and to better locate providers. Network adequacy also to identify where there may be gaps in treatment. Where it might not be ready yet, we continue to work with Deloitte. My next update related to - - sorry?
>> KYLE: Yes, quick question related to that. I appreciate the report back and I know there is excitement about these dashboards. When Secretary Smith spoke about this. When does OMHSAS expect these to be in place?
>> JOCELYN: Great question, network geography testing begins next month. I don't have a formal timeline for network adequacy. As soon as we have a more definitive timeline we can come back to the group with an update.
>> KYLE: Thank you.
>> JOCELYN: Another area we are doing further development in the MEMM system is related to complaints, grievances and hearings. Our current system is pretty antiquated and requires external partners to retain an older system in order to do reporting for complaints and grievances. We have met with the other program offices and Deloitte to

learn what they are doing in this space to see if it is able to meet OMHSAS needs or do what others are doing to adequately monitor grievances and fair hearings. We do have the initial kickoff meeting in April, sorry, June. And we have follow-up meetings scheduled in two weeks. To talk with Deloitte more about how we can establish a new monitoring system. Not the one that we have doesn't give us information, however, we know times are changing and with all of the technology that there are other methodologies available to track information and when they get more automated for external partners as well as staff who are tasked with monitoring these activities. More to come on that. Hopefully we will have an update for you all in a few meetings or so. If there are any questions about complaints, grievances or fair hearings that can move to the next topic which was related to denial. I can pause for a moment to see if someone is coming off of mute. I assume the hand raised is going to be reserving that for public comment time. Correct?
>> ELISE: Correct.
>> JOCELYN: Okay thank you. So deputy Secretary Smith did presentations related to OMHSAS complaints, grievances and denials. Able to get a snapshot portion of 2024 when Debbie Secretary Smith did her presentation and - - was able to present a full year's worth of data 2024. Since that time as indicated by Deputy Secretary Smith we have met with Magellan. She had meetings with providers who raise concerns about denial rates. As it stands now we believe we are at a good place with the denials were addressing this outstanding issue with denials. During that meeting they explained to us that a lot of times when they denied services it was because they felt members were more appropriate for higher-level care. They continued to work with the providers located in their catchment area. Providing training and one-on-one technical assistance. Their ultimate goal is to ensure providers are aligned with criteria as well as ensuring members are getting the care they need. We encourage provider communities to continue to work with the behavioral healthcare managed organizations in your area and primary contractors. If you see these arising early please reach out, have a conversation, OMHSAS, DHS is always happy to intervene but there is an opportunity for you all to resolve any discrepancies that may come up but we encourage you to do that first. Any questions related to Magellan denials?
>> KYLE: Jocelyn, it's Kyle. Trying to make sure I understand what you just reported. Magellan's investigation, so we saw in the data reported in previous meetings that Magellan had essentially a fivefold increase in denials between 2023 going into 2024. We understand OMHSAS was investigating that and talking to the primary contractors which are providers. Is the result of that investigation that OMHSAS determines the bulk of those denials were appropriate?
>> JOCELYN: I just want to let you know we did not do formal chart reviews. To determine the degree of those denials we would've had to have done that probably over the quality management division does conduct annual reviews of denial letters. And from what we

have seen, the denials we have reviewed seem to be appropriate. Again, the goal for Magellan is to ensure that providers are using criteria when making referrals for services. And through monetary and other avenues there were concerns raised by our operations staff indicating there might have been some providers in the Magellan area that were not 100 percent ASAM aligned. That did result in some issues when making referrals for treatment. So I cannot definitively say that all of the denials were appropriate. However, we do believe that Magellan is following ASAM criteria.
>> KYLE: Has Magellan provided data on how many of these denials, how often it approved a higher, more intensive level of service?
>> JOCELYN: They are working to gather that information. It was requested.
>> KYLE: I guess the other comment, you mentioned that OMHSAS is not doing chart reviews. On an ongoing basis, will you be pulling denials to review clinical information submitted and ensure any denial decisions by the BH MCO are is appropriate going forward?
>> JOCELYN: The way that we do that, Kyle, is going through annual denial letter review. So we pull from managed healthcare organizations that we identify based on the current number of enrollees. We also conducted a triannual review every three years with contractors as well where we have an opportunity to do a full chart audit and that is when we will take a closer look at Magellan's denials as well as complaints and grievances. Magellan is slated to be a part of our next review. Also, I just want to note that PC is also ongoing monitoring the charts and letters as well. So we do work together to ensure members are getting the care they need.
>> KYLE: It's good to know there is an ongoing process where you pull denials as well as information on the chart to do full review. Given the data we have been talking about during the past few meetings with OMHSAS, the extent to which Magellan is an extreme outlier with its denials. Is the office not doing a more intensive review of its, particularly it's non hospital residential substance abuse service treatment denials now? Are you not able to focus that auditing activity given the data we are looking at that you shared?
>> JOCELYN: We do reserve the right to do that. However, as I indicated, what we have found is that largely part of the issue is the providers in that area are not compliant which is a large contribute infected to denials. Magellan is continuing to provide education for those providers to ensure they are staying compliant. There is also a workforce shortage. Lots of turnover that Magellan noted as a contributing factor. So when newer staff in training periods, they may not include the necessary details in an authorization request. So that is another challenge that we have. And are addressing through provider training.
>> KYLE: Thank you. I don't know if members of the committee have additional questions. I will pause, I do not.
>> SONIA: Any questions? Seems we don't have any. Thank you so much for your

important work, we appreciate you.
>> JOCELYN: Okay. I'm going to turn it over to my other colleagues on the line with me for the network adequacy and workforce shortage update. On the line we have Scott Talley, Director for the children's Bureau. Scott Lytic and - - on the line with me this afternoon. I'm going to turn it over to them and they will share additional information.
>> SONIA: Okay thank you.

- **Network Adequacy & Workforce Shortages**

>> Bill, are we starting with you?
>> I think we have network adequacy up first. If we can go to the next slide.
>> SCOTT LYTIC: I can cover this, Bill. This is Scott Lytic. Operations. So as Jocelyn mentioned since we do not have MEMM at this moment to use for monitoring we are providing this snapshot of network exceptions across the state to show where gaps in accessibility are found. Before I go over the numbers let me explain what the network adequacy process is. Every year we require a health choices MCO to submit an analysis of their provider network and not membership data to show geographically accessibility of the networks. I would like to know this is geographic accessibility, not capacity. Looking at provider location to member location. Another important clarification that this is only for child and adolescent services, required by the Medicaid State plan. A network exception is less than 90 percent of members in a county. Specifically a - - County where they do not have access to a particular level of care within standards. For choices, this is based on drivetime. For RTF services we have two providers required within 30 minutes of urban areas and 60 minute drive time in rural areas. For mobile and residential services, one provider must be within the same time standard, 30 minutes, 60. With another available provider in the network. The slide is showing the number of exceptions request made by - - past couple of years. You'll see family -based had one request, I believe that was from Beaver County in the past two years. These two very large bars are for inpatient management and services. These are those hospital-based detox services that we just don't have any providers in the state. We don't get any request for this level of care across the state and MCO's don't receive - -. Looking at inpatient child, inpatient is pretty constant. This really only fluctuates when providers open or close or maybe relationships occur within hospitals. And children and adolescents will receive this level of care when needed but may be, it may be farther away from their home base. Out-of-network hospital. - - Remained constant with little to partial. Prioritizing home amd school community-based services to meet the need of that population. Peer support is the same. Pretty constant. With peer support, child and adolescent, some are reluctant to provide the service. Or may have trouble finding appropriate staff to provide that population. For RTF

there was a slight change in the last year. This is due to a new RTF that opened in - - County reducing the number of exceptions for that level of care. Just a snapshot of access. We do pretty extensive monitoring through our quarterly monitoring with each contractor. We look at things like addition, closures, provider networks, we look at out-of-network service requests. Complaints regarding access to care. And specifically for all of these levels of care where public exception is requested. We certainly make sure that the services are being received either in or out of network. I think that is all I have to say about this slide if there are any questions.
>> Which one of these categories would show in home or school services for a child? Would that be under family based mental health services?
>> SCOTT: Family based is one, BHS would be another, outpatient and schools. Probably - -
>> IBHS, is that shown in this chart?
>> SCOTT: It is not. Simply because as I mentioned, this is just looking at geographic accessibility. So I BHS is a mobile service. There's only one provider required to be within drivetime standard for members. So this doesn't necessarily look at capacity. That providers availability to serve the family.
>> Thank you.
>> SCOTT: Yes, we do look at that through monitoring and we have other reporting tools that we look at. Things like time from written assessments or time from assessment to actually receiving the service. But that is why this particular level of care is not in that slide.
>> KYLE: Helpful to hear. Those last metrics mentioned, I don't know if you can expound on that. We had extensive discussion premeeting about assessments occurring, orders being placed and then families having very long wait times for staffing. For IBHS services. Particularly. I don't know if Megan is on. If you want to talk anymore about that?
>> MEGHANN LUCZKOWSKI: Yes, hi, this is Meghann Luczkowski. Southeast region, Philadelphia area. Just reporting out to lift up what's happening on the ground. We are still experiencing overall in this region, I don't believe that this chart addresses the wait times for the actual initial evaluations. Possibly. But there are still significant wait listS for initial evaluations for children who are trying to get in for behavioral health assessments, particularly autism assessments. And the time between an assessment and in order being written can be a significant wait time. Because staff availability for doing the skills assessments needed to identify what recommended ours would be. To put through the order as Kyle mentioned, there is a number of family, mine included who were just still waiting for any providers to provide supports. Particularly in the home and school settings. We've had a lot of providers in the region and again, I am in a semi-suburban area of Philadelphia. We really benefit from probably one of the more robust areas of providers.

But we have a lot of clinics open where they will do clinic space services but not home and school-based services. Just to share a personal experience, my son was diagnosed with autism in March 2023. His assessment, an order was completed in May 2023 with one provider. Who was very clear they could do the assessment and evaluation but that was not necessarily a promise to provide services. We have since done a reevaluation and reassessment order and he's had a zero hours delivered since May of 2023. So we are on two years now. In our region because we cannot used clinic-based services and we need his services to be at home and at school. We have not been able to provide services. I will give the caveat we are one of the families with the primary insurance. So this is not all specific to our Medicaid behavioral health MCO's. However families in my region that I support are experiencing similar wait times for services. I know that your gathering data. I think that it's really useful to see this. But just connect that information.
>> SCOTT TALLEY: - - director of the Bureau. We are aware of those issues and those are issues we are definitely working on. Definitely working with our managed-care organizations and primary contractors. Like everybody else we definitely are staffing shortages. Trying to work through some of those. Some waivers at some point to get staff in. But in all services we are seeing. Certainly those ways, we do want to hear about that. We do want to know what the issues are. So we are trying our best to find out and locate where we are seeing long wait times and also work with organizations and providers in those areas. To see what we can do. You are heard and I'm sorry that that's happening to you.
>> MEGHANN: I appreciate that and I always tried to highlight that my background is in special education. - - I stood on the consumer subcommittee, stood for families. This is, I am experiencing these barriers and I know how the systems work. My concern is for families who don't necessarily know how all of the system trickle through to each other. We are experiencing additional barriers of having - - first in case that is something that is not on your radar. For the provider network, primary rates are higher for providers that we have fewer providers in our network that - - limits access to those other providers who are in the network in the MCO's because they are not necessarily willing, because those are not willing to take us on because we have Medicaid as a secondary. Unique barriers that families are trying to work through, providers do not have the knowledge to push us to the right path. You, at your level, do you have any recommendations or thoughts on how to address those barriers? Theoretically because they have primary insurance should have easier access but are experiencing more difficulty because providers don't necessarily want to be in both networks.
>> SCOTT: Yes, what you're saying is because primary may not cover a longer period of time. And they may end up on MA, using MA, they won't take it because of secondary piece of using MA.

>> MEGHANN: Exactly. If the primary, if the order is covered by the primary in the contracted, however it works. Whatever the contractual agreement as between primary insurance and that provider. If that benefit runs out beforehand then you know, ideally they are going to bill MAA for that. For the remainder of the services that were ordered and I won't throw any providers under the bus publicly right now but a great number of providers that we have spoken to you are not willing to take him on unless we, because we have Medicaid as a secondary and I am not the only family I know that experiences that barrier and we hear that that is not supposed to be happening. That providers shouldn't be able to do that but that is the reality of what is happening.
>> SCOTT: Yeah and maybe that is something we need to work with our partners at the Department of Insurance with. I think we've had conversations related to that in the past. But I would be curious about who the providers were and maybe take a bigger look at it. At least try to find out if it is specific to some providers and maybe having the conversation of why this is. See if they're having barriers.
>> MEGHANN: I do appreciate that and I always want to give folks the benefit of the doubt. So I can reconnect with providers that have had that experience in the past to see what their current take is on that. Let's it from us and I'm happy to connect the consumer subcommittee or bring it up through Sonia. Some examples for you guys.
>> Happy to take a look.
>> MEGHANN: I appreciate the concern that you are maybe willing to push a little bit on that. It certainly not what we want happening.
>> ,Yes, we want them to be able to - -
>> MEGHANN: Thank you so much.
>> You are welcome.
>> KYLE: I think we have another committee member with their hand up. Marsha?
>> MARSHA: Good afternoon, Scott. Meghann shared her experience with a service for years that she hasn't received. Is this an anomaly? He spoke about barriers and I'm trying to figure out from your perspective have you heard about this? An extensive wait, for two years for child in need services.
>> SCOTT: Normally if it is that long we definitely hear back. We do have resources and we will go through there and try to work back through to see what is going on. I don't know if it's an anomaly. It's not the norm, I will say that. But wait times can vary by the area. It can vary by the provider. It can sometimes be, sometimes that they're waiting for a specific provider and wait longer for that. If we hear about it we try to do the follow-up. And see what is going on.
>> MARSHA: Because those like myself and Meghann are trying to figure out that area. I was trying to figure out because this is so extreme to me. - -
[INDISCERNABLE]

So this is not normal for it to take this long. Because I have worked with students with cerebral palsy. Students in desperate need of services and I just can't imagine a parent going that long approved for services but not getting it. I just need to know that this is not normal.
>> SCOTT: Anecdotally, I believe it's not normal. Scott working in a field office would have a different thought than idea. Normally when we hear about it on our level it's because of that long wait, someone reaching out saying what are we going to do? I don't get a lot of that. So sometimes they will help resolve it quicker but as we get more information we get a better understanding of what the average times are and that's what we're trying to get to the bottom of all of that.
>> MARSHA: Thank you for addressing that.
>> SONIA: Okay, Scott, this is what we are going to do. We are going to get some stuff over to you, Meghann, get it to us and we are going to see if anything can be done. Hoping something can be done.
>> SCOTT: Happy to take a look. That's why when I said to come in here I want to hear what you all have to say because that can help inform us as well.
>> SONIA: Thank you so much, we will be in touch.
>> SCOTT: Okay, if you don't have my email it is - - before any other questions, anything in the chat? Any questions for Scott?
>> KYLE: One quick clarification, you mentioned an average wait time for IBHS services. What's the timeframe on when OMHSAS will know those wait times?
>> SCOTT: I don't know if I can give you, Jocelyn, I hate not being able to answer you but because there are a lot of things that we need to fully understand and analyze, we are working with MCO's right now. Some of the things that have come from litigation, we want to make sure we cover all of that as well. I'm hoping by the end of the year we can provide more information but once we have that information like Jocelyn said we can find and present it once we have it.
>> SONIA: Anything in the chat?
>> ELISE: No specific questions in chat at this time.
>> SONIA: Thank you. Thank you again, Scott.
>> SCOTT: You're welcome.
>> SONIA: Next on the agenda is OLTL.
>> SCOTT: We did have additional slides related to RTF program to go over. So I will defer to you, Sonia if we want to kick this to another meeting. I know we are running behind.
>> SONIA: Yeah, committee, what do y'all want to do? I am leaving it up to you. Kyle?
>> KYLE: I don't know if you want to do a very quick overview. It might be worth going through RTF data in a couple of minutes.
>> Sure, I can do that. If we advance the next slide to give context to the slides we have,

folks, feel free to take a look and come back with questions. At any time. We are happy to help. Just to give some context to the RTF program. What we are displaying here is a monthly snapshot of the sentences for the RTF program across our network. As you can see each MCO has its own colored line there. You can see that most of our behavioral health MCO's are being covered under the dotted line. Representing the average of all of the state and monthly totals which you know, running in the 230 area there. But what we, what I think is important to note here is in general our senses totals have been increasing steadily since January 2020. The light blue line represents CCB H, community care behavioral health. UPMC subsidiary. They have the highest market share in Pennsylvania for our behavioral health MCO which is why they are appearing there. But it's not surprising that they have the highest RTF census. They remain clustered together as senses totals align with each other. When the data is viewed as a per 1000 enrollees it does in fact demonstrate clearly that they are clustered together demonstrating we really don't have any cause for concern related to RTF utilization. Our data table does show you the statewide total and what you can see from that as of October 24 if you are comparing to previous years we can see we remain well below pre-pandemic senses totals which is a good thing. Moving onto the next slide. This will give context to that information. In general senses totals have been decreasing steadily since 2020. And this demonstrates the year-to-year comparison with key performance indicators that we monitor. Data for 2024 is not a full year because - - data warehouse and read – tools. The November, December data is not included and I did include a footnote. The senses continues trending downward as community supports are being made available as we shared on the last chart. You can see the downward trend. We did repeat the senses total to give context but what we want to show is look at the number of discharges occurring. Discharge percentages are presented to be about the same as what they were in 2023, 2024 calendar year. What I have not shown is the number of emissions. Our number of emissions are trending slightly downward. We are projecting in 2024 there were slightly less, more discharges than in 2023. We are moving in the right direction. In general, what you can see here, I'm sorry, I meant admissions. Our admissions are running around the same time there. You can see our discharge, the 2024 is a partial calendar year. And it is projected. Still running at a lower rate than what we had in 2023. The big take away is really showing the number of 180 day readmissions and the number of 30 day readmissions. Those, we certainly want to see those a lot less. They are coming in - - previous years, are happy that we are trending downward since 2021 for the readmissions were 30 day readmissions are fairly flat. Those tend to be caused for various variety of reasons why there is a 30 day readmission. Most likely the acuity level and the difficulty of the individual needing additional treatment. Also 30 day readmissions that can be captured sometimes when there is like a discharge because the school is ending, families take kids home for periods

of time to spend the summer with folks. Soon we do see our discharge is increasing. At near the end of this video and then up taking with readmissions that are occurring as school gets back into session as there is some folks that the local school districts just aren't able to support the children's needs. And RTF is that alternative placement there. Moving onto the next slide. And I think this is a good slide for folks. This shows average length of stay at discharge. You can see in 2021 average length of stay was 315 days. For folks discharged, all children discharged in that calendar year, what was the average day? In 2021 the average length of stay was around 315 and you can see in 2020 for a couple of months short, but in general for the population that was discharged to date in 2024, the average was 346 days. What that is saying is, you may think that folks are spending a large amount of time in the RTF but in fact, what this is really telling us is folks that have had the longer stays are in fact getting discharged. Additionally. I have provided a median day as well to show that the median, the average days and median days are very closely related. This indicates a real systemic distribution without a greater weight being attributed to one factor or outliers. Each person that is discharged and had a long stay there was another person who is discharged who had a very short stay. I'm happy to take any questions on this individually on the next slide this kind of represents the average length of stay. If we go to the next slide, it's a very busy slide so I apologize for this. This demonstrates the concept. This chart shows the average length of stay. The time to discharge. The take away here is we want to see those extreme peaks. Those tall peaks that you can kind of see in the blue and pink. Those extreme peaks are indicating that those are children who have had a long stays in and RTF. Sometimes multiple years. The number of dates is on the chart there. The scale is the number of days. Some of those kids have been there for multiple years. You can see that we are charging placements for some of those children who have had rather long and lengthy stays. - - This is a chart where we want to see those peaks. Where we know that some of our individuals who have those stays are finding a successful community services. And were able to support them in the community and not in more of the RTF facility. This is all I have prepared other than the last slide which is to talk about three of the great initiatives underway as part of our value performance initiative. Our primary contractors managed performance-based initiatives, three that target specifically RTF improvement. CBH in the Philadelphia area have a value based performance area with goals related to symptom reduction, community tenure and family group therapy. See CBH has a value based performance initiative focused on discharge planning and readmission prevention. Starting the discharge planning process as soon as the child is admitted to RTF. That way discharge planning on looking for alternative placements holding someone at RTF longer than they are willing to stay. Lastly, performed care. I've always had family based services and systemic planning from RTF placement. They have quite a strong team that works on those efforts. And so we see some solid value

based performance initiatives coming out. In general, all three of these programs do really work with their families. To transfer the skill to the families to help them know how to best support their loved one and child. In an effort to decrease those potential readmissions and working on that whole person care, whole family care initiative as well. That has been truly successful in moving the needle on RTF success. Sorry that was probably more than a couple of minutes but happy to take any questions. If folks need to marinate on this a little bit, happy to come back.
>> SONIA: Questions, anyone? Okay, well thank you again. And if we do have questions we will get back to you. So I think this we will get back to you with questions. Clark sounds good, Sonia, thank you. I will Scott and we will circle back. Thank you for your time.
>> SONIA: And thank you. Okay. Next on the agenda, OLTL.

- **OLTL Report**
    - **Deputy Secretary Updates**

>> JULIET MARSALA: Good afternoon. This is - - here to give OLTL updates which will be brief for good reason. If we go to the next slide. To start our agenda today is going to be fairly short. If we go to the next slide there were no new updates related to procurements at this time. It continues to operate, current managed-care organizations until further notice. If we go to the next slide. There was a request from this committee, a good request with regards to collecting and devising a way to identify both personal assistance services staffing data, network adequacy in addition to further evaluating how well are we covering shifts that may be in the time immediately before our missed shifts, standardized mist shift reporting. So we have begun working with CHC MCO's to outline the process and develop something in our systems and their systems to be able to collect that data. There is a process to make sure that data is the data we are capturing and that data is accurate., Addressing the questions that we have that we want to draw from that data. The process is in the early stages. And we do intend to have that data captured in a new operations report. And are fully committed to being able to develop the data that the consumer subcommittee has recommended we collect. We will certainly keep you part of the process as that continues forward. In addition we do have to report on the next slide. There was a request for grievance. Before we go to the next slide, sorry. There was request for grievance and appeals data. And we were preparing to report that out this month. Unfortunately, with great sadness, we had a unexpected death on our OLTL staff prohibiting us from furnishing that presentation right now. We believe that we can put that on the September subcommittee agenda and intend to do so. That is why it is on the agenda but not in the data discussion today. We go to the next slide. Just some general updates. For the awareness of the subcommittee. I - - in order to present testimony - -

nursing facility cost for reimbursements. We will be presenting testimony, related to this change. In short. It's one piece of a much larger cost methodology process. And they data element that we are switching out. Is the rug resource utilization group. Because that is no longer supported by CMS, that is a CMS data element. That is used to identify the case acuity of the population serves. Again, it is one small piece. Part of the process we are ending the rug utilization group data element. And replacing it with patient driven payment model. Data elements that is supported from CNS. We've known this is a long time coming. CNS made those announcements over five years ago. Nursing facilities have been using PDP M model and Medicare, maintaining a lot of work in researching and identifying how do we move forward away from the rug that is no longer supported? And utilized or inserted data element that would not be too disruptive to the industry and would fit pretty seamlessly into the methodology. This is just a data element switch. We are going before the IRC for this change. Lastly, our community HealthChoices agreement has been with Medicaid services for quite some time now. It is still pending approval. And CNS is not indicated when the process will conclude. We've had some multiple rounds of questions back and forth with them. And so that process continues forward. We are ever hopeful. But I don't have a timeframe for when that might be approved from CMS. And I believe those are all of our updates for today. Certainly happy to answer any questions that folks may have.
>> SONIA: No one has any questions for Juliet? - - Amy?
>> KYLE: Thank you, Juliet, for wrapping up in the short amount of time.
>> JULIET: Want to wish everyone a happy early Independence Day.
>> SONIA: Thank you so much for sharing. Well we have public comment.
>> ELISE: Right now I have sent messages to the people who had requested public comments to put what they would like to have shared in public comment in a message. I haven't gotten anything back from the person with their hand raised. I do have a few comments from Jess Eiseman. Noting there was an article in the Pittsburgh Tribune review related to Medicare and Medicare authorizations. And they - - from Paula Hunter asking if the user being sent out of state for services and how often is this occurring and how many? There was one other comment. From Nicole - - the Center for rural PA released a report in May 2025 titled labor and delivery services and include the statewide map including the link. If you'd like I will send out the article link and let PA rural access support link out to the rest of the audience if you would like me to do that, Sonia.
>> SONIA: It's fine. Ms. Mathis, your hand is up?
>> Sorry, I thought it was down. Thank you, sorry.
>> SONIA: All right. That's fine with me. No problems with that. I appreciate it. Anyone else have anything for - -?
>> ELISE: Public comment concerns civil and due process rights for every person operating

under the 19 2060 - - waiver?
>> SALLY: Thank you for sharing that. Is there anything else on the comments?
>> ELISE: Paulette would like to clarify her question about kids being sent out of state was regarding residential treatment facilities. We can forward to that to OMHSAS. Not on the call right now.
>> SONIA: Okay. Noted.
>> ELISE: Angela corrected it's the 1915© HCBS, HC BS waivers.
>> Thank you for sharing that. Before okay.
>> KYLE: Before we break, Sonia, we may want to notify the audience our next meeting is scheduled to be in person but may switch to virtual depending on the outcome of the state.
>> SONIA: The budget. Sure. That's it? Old and new business, any old or new business? Okay. All right then I want to thank everyone on this call. I appreciate all of the feedback and questions and everything. Just want us to be aware that the next couple of weeks we will hear what we need to hear. We just need to stay focused for our people that - - and I need a motion to adjourn the meeting.
>> EVE LICKERS: Real quick, sorry to interrupt, I just wanted to circle back on something we had talked about. The pending budget. It's unclear as to whether or not it will be passed at that point in time. Would the July meeting be scheduled to be in person if the state budget is not passed untimely, or by that, we will just say timely. The July meeting may need to be adjusted to be a webinar meeting or there may be some limited travel at that point. So if this occurs and there is any changes that need to be made it will be done through a sunshine notice and we will also update the consumer subcommittee website as well. Obviously we will be working with you all as well.
>> SONIA: Okay thank you. Can I have a motion for the meeting to be adjourned?
>> I make a motion.
>> I second.
>> SONIA: So moved. Everyone have a wonderful day.