Consumer Subcommittee of the MAAC

July 23, 2025

Consumers present: Sonia Brookins; Minta Livengood; Liz Healey; Rochelle Jackson; Marsha White-Mathis; Ronel Baccus, Spencer Duffee.

PHLP representatives present: Amy Lowenstein, Danna Casserly, Kyle Fisher

DHS representatives present: Sally Kozak, OMAP Deputy Secretary; Gwen Zander, OMAP Managed Care Bureau Director; Juliet Marsala, OLTL Deputy Secretary; Alexis Deisenroth, OIM Division Director, Randolph Nolen, OLTL

ATTENDEES: Chad Rush, Anthony Abrams, Brett Hayes, Elise Gregory, Erin Wyse, Eve Lickers, Lindsay Townsend, Pamela Machamer-Peechatka, Dr. Sean Shamloo, Jamie Buchenauer, Laina Auletta, Nicole Harris, Paula Stum, Catharine Arranz, Ronya Ayala, Wendy Bailey, Morgan Baker, Daniel Bates, Ellan Baumgartner, Katrina Becker, captioner, Kara Blasiak, Patricia Brady, David Burnett, Dusty Carl, Marcus Cater, Amy Comarnitsky, Melina Correa, Kathy Cubit, Andrea D'Angelo, Scarlett Davis, Mindy Dunlap, Barbara Dunn, Julie Escobar, Kristen Figueroa, Brandy Flickinger, Nicholas Focht, Craig Gimbi, Janel Gleeson, candy Graham, Joseph Hafer, Jerri Hall, Heather Hallman, amber Hess, Debby Hewitt, Jeff Iseman, China Jackson, Narender Kaur, Emily Katz, Erik King, Daphne Knapp, Elizabeth Kuhn, Tessa Laughman, Marissa Lawall, Mason Lee, Rachel Lee-Price, Laura Lentz, Anita Lewis, Dylan Lindberg, Brinna Ludwig, Scott Matlock, Andrea McCague, Meggie McCarthy-White, Lauren McNaughton, Shannon McVey, Denis Moore, Sameerah Newsome, Abby Narvaez, Jazmin Nixon Cartwright, Jessica Osler, Natasha Powell, Helene Pletz, Ashlee Reick, Nicole Risner, Michele Robison, Bradley Roland, Pam Rotella, Emma Schmidt, Naomi Shaffer, Esther Shaffer, Howard Shehan, Megan Shellenberger, Jason Shoemaker, Kimberly Steltz, Courtney Troyer, Katherin Watson, Jessica Wilkerson, Michael Wilkinson, Anne Yanikov, Nick Young, Starell Zoric, Paulette Hunter,

The meeting was called to order at 1:00pm

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>> ELISE GREGORY: Good afternoon, welcome to the July meeting of the Consumer Subcommittee meeting. Today is July 23, 2025. This is Elise Gregory. This is being recorded and your participation is consent to be recorded. If you don't wish to be recorded you may end participation at any time. There has been an update to the go to webinar platform for panelists and speakers. If you experience audio issues please go to the top

right corner to adjust settings to the correct microphone and speaker hardware. If you experience difficulty please send a message in the chat. To avoid disruptions please remember to keep your microphone muted if not speaking. Life captioning, also known as cart captions are available for the meeting. The link is included in the chat. Presenters should say their names clearly before speaking to assist the captioner. Representing the Department of human services today from the office of medical assistance program, deputy secretary Sally Kozak and from the Bureau of management operation, director Gwen Zander, from the offices of long-term living, Juliet Marsala and from the maintenance Bureau of policy director Carl Feldman. Questions may be submitted in the questions Todd of the webinar. If you have questions related to the meeting or getting information please visit the Consumer Subcommittee webpage. I will hand things over to the consumer subcommittee chair, Ms. Sonia Brookins.
>> SONIA BROOKINS: Thank you. Welcome back. We will begin with introductions. My name is Sonia Brookins, I am chair of the Consumer Subcommittee.
>> Thank you, Kyle Fisher from Pennsylvania Health Law Project, counsel to the consumer subcommittee. To go through committee membership I'm going to start with Ms. Livengood.
>> MINTA LIVENGOOD: Yes, I'm here.
>> KYLE FISHER: - - Do we have Rochelle Jackson?
>> ROCHELLE JACKSON: Present.
>> KYLE FISHER: Liz Healy?
>> LIZ HEALY: Present.
>> KYLE FISHER: Marsha white Mathis? Working to get on. James - -? Spencer Duffy? Lauren Hatcher? Hopefully we will have more consumers able to join and work through technology issues. I believe those are all consumers on. Do we have Dana Casserly with the - - health project? Or Amy Lowenstein?
>> AMY LOWENSTEIN: Yes, I am on.
>> DANNA CASSERLY: Sorry Kyle, I am here. This is Danna.
>> KYLE FISHER: Okay. Unless we have any other committee members on I will hand this back. Thank you.

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

>> SALLY KOZAK: Good afternoon. Going to give an update on where we are with the state budget and then I think Carl will cover budget reconciliation. In regards to the state budget, I'm sure you are aware by now that Pennsylvania General assembly has not yet enacted the 2025/2026 budget into law. The Governor continues to negotiate with leaders about how to finalize the budget for 25/26. Office of budget has put steps in place to

enable the Commonwealth to meet legal obligations to fund mandated programs and provide for the welfare of residents. Examples of essential programs where services are not impacted include medical assistance and SNAP, Medicare buy-in and childcare subsidies. That is the update I have for you on the state budget. Any questions? Okay. Let's talk about the federal budget reconciliation act. HR1 or 0B3. You may be aware there were significant changes made to the SNAP program as well as Medicaid program. I believe that oh I am will talk about snap changes so I'm going to focus on Medicaid changes. We know Medicaid is a lifesaving program that provides coverage for about 3 million Pennsylvanians including 1.3 million children. 423 individuals with a disability, 312,000 older adults and nearly 10,000 veterans. We believe that the federal cuts will take over 310,000 Pennsylvanians off of their healthcare. It will raise healthcare costs across the board. And will threaten the closure of at least 25 rural hospitals. In other words cuts to Medicaid program will have a devastating impact on the Commonwealth, its economy and residents. There were two main provisions that will cause those 310,000 individuals to lose Medicaid coverage. The first provision is the work requirement. We estimate about 200,000 individuals will lose coverage because of new work reporting requirements that, for individuals ages 19 to 64, will require them to work or engage in some kind of community service or volunteerism at least 80 hours per month. We estimate that about 110,000 citizens are at risk of losing coverage because of the hassle up twice-yearly eligibility rather than the annual prior certification. Those provisions will take effect on January 1, 2027. At this point in time there is no change to Medicaid eligibility. These two changes will take effect January 1, 2027. In making these requirements the law also imposed federal mandates on Pennsylvania without any flexibility. We estimate to redetermine eligibility every six months instead of one year the department will need to increase staff by about 500 people. That said, at an estimated cost of $37 million per year. Implementing work reporting requirements would require another staff increase of about 250 people. With an estimated cost of $18 million. It will also alter how we funds the Medicaid program with other changes rooted in HR1. Changes in provider taxes, starting in fiscal year 28/29, those are estimated to cut more than $20 billion in Medicaid funding for program over the next 10 years. For those that aren't familiar, provider taxes are funded directly to hospitals and other new critical providers. Support access to services such as emergency care, especially in communities with a higher number of Medicaid patients. Because hospitals are legally required to provide the ability to pay, stripping away Medicaid coverage will inevitably lead to greater rates of uncompensated care in emergency rooms across the Commonwealth especially in rural hospitals which rely heavily on Medicaid revenue. In turn, this will raise healthcare costs for all Pennsylvanians. Including those with insurance. There are at least 25 rural hospitals in Pennsylvania that currently operate on a deficit and are struggling to keep their doors open. This law will worsen what is

already a dire situation and in conclusion a $50 billion national fund to stabilize hospitals instead of dropping - - is a drop in the bucket compared to the devastating hits to hospitals. This is not just a healthcare crisis but a job crisis, EMS related crisis in a public healthcare emergency in the making. This affects children, older adults, families leading to delays in enrollment. Increased date cost of the Commonwealth, disruptions to care, increased compensated emergency room and delayed treatment for exasperation of conditions like diabetes and heart disease. For those that follow budget negotiations, occurring at the federal level are probably hearing that what these cuts would do is weed out the program. So let me say this. We are taking actions to eliminate - - and eliminate Republican healthcare cuts and keep Pennsylvanians covered. - - prove citizenship upon application to Medicaid except in certain life-threatening emergency cases. Department reviews every applicant involving a process with 10 step verification checks and citizenship status. Citizenship is verified through data exchange with federal Social Security Administration. If a lawful resident does not have a Social Security number the department confirms legal status by checking database from the federal Department of Homeland security, U.S. citizenship and immigration services. Pennsylvania ranks number one in the Medicaid fraud charges with overall conviction secured. This is possible because of the hard work within the program integrity of the department, offering fraud prevention and preserving Medicaid resources, the people who need it for healthcare funds. We plan to direct outreach to impacted individuals to additional mailing, emails and text in 23/24 when the annual Medicaid eligibility started after the COVID-19 emergency ended. We will communicate share with partners like legislators, healthcare providers, advocates and other partners such as members of the consumer subcommittee as well as medical assistance advisory committee. We hope to build a unified message to help Pennsylvanians understand and further changes that will happening. No changes are happening now. They will begin to take effect January 1 2027. The Departement still lacks a whole lot of information about the cuts being made in HR1/OB3 to the Medicaid program. Questions about that?

>> SONIA BROOKINS: I am going to say it is sad and that we have no control over this. We don't have any control but I'm going to say that we are going to work closely with the department to figure out what needs to be done and where it needs to be done at. And we can take it from there. Anybody else on the call? You have the floor.

>> SALLY KOZAK: Let me say, we encourage everybody to continue advocacy efforts. It is potential but there is time to change these laws. We know recently at least one senator introduced legislation to undo some of the changes they made. So we would say that while we prepared to implement these changes, folks should continue advocacy.

>> SONIA BROOKINS: Okay. Okay. Thank you for that.

>> SALLY KOZAK: Sure.

>> LIZ HEALY: This is Liz, we will follow closely.
>> KYLE FISHER: I appreciate the thoroughness of that report and I think just the candor. You are not glossing over the devastating impact that we all expect this will have. A couple of questions. I want to make sure we got the numbers right. In terms of estimated coverage losses for Medicaid it was 110,000 estimated due to the twice per year, what was the estimate tied to work requirements?
>> SALLY KOZAK: 200,000. They would be 310,000 people but those are just estimates. 200,000 would be due to the work requirements and 110,000 are barriers by redetermination.
>> KYLE FISHER: I know you also talked about the cost shift and a portion of that being tied to changes to the provider assessments. Was the figure tied to cuts due to provider assessments being phased down $20 billion over 10 years? Is that correct?
>> SALLY KOZAK: Let me make sure. If talking about the effort to implement these two changes, the cost to implement work requirements,, sorry I just lost my place here.
>> KYLE FISHER: It's okay, it was a provider tax piece.
>> SALLY KOZAK: They are estimated to cut more than 20 billion over the next 10 years for Medicaid. We put out a supplemental payment to our hospital providers, particularly rural hospitals,
>> KYLE FISHER: Yes, I guess that number ties in provider assessment and state directed payments which are also going to have to change.
>> SALLY KOZAK: Correct. Primarily provider assessments, this will change over the next several years and how we can use them and disperse them out.
>> KYLE FISHER: Quick comments, we saw nonprofit providers who provide abortion services could also be impacted. We understand 2027 is the timeframe for the provisions you discussed, but it looked like this was upon enactment or very shortly afterwards. Have there been any changes to Pennsylvania's program tied to that provision?
>> SALLY KOZAK: We are waiting for additional clarification. The law says entities who provide abortion who give more than 800,000, or who get more than $800,000 in reimbursement from the Medicaid program. While they do not specifically spell out Planned Parenthood in the language we know that Planned Parenthood has gotten a Temporary Restraining Order against that.
>> SONIA BROOKINS: So speaking on that, they can't touch that as of yet? Planned Parenthood?
>> SALLY KOZAK: Yes I believe that Temporary Restraining Order was renewed. I think perhaps may be, don't quote me. It was a Temporary Restraining Order. I don't have the date that it ends.
>> SONIA BROOKINS: Sure, sure.
>> LIZ HEALY: Did that go to Pennsylvania court? Or federal court?

>> SALLY KOZAK: It was the court in which they filed that Temporary Restraining Order.
>> KYLE FISHER: That's national, Liz.
>> LIZ HEALY: Thank you.
>> SALLY KOZAK: I don't know if it's national, or Pennsylvania. We got confirmation from CMS about providing services at the time the TRO was issued.
>> KYLE FISHER: I appreciate it. I know that you mentioned circulated materials with stakeholders including consumers. As a lot of this gets built out over time obviously there is some time to operationalize guidance. The federal government on work requirements in particular. I appreciate your statement that you onboard with consumers like this committee to try and minimize the harm. Although see there's going to be huge impacts. Some of which is going to be making these policy decisions on the periphery where there are state options. How this gets done could make a huge difference and hopefully we are able to mitigate some of that harm.
>> SALLY KOZAK: You know, we found out during the public health emergency that communication was critical. I think folks may have heard the Secretary talk about how important it is that people understand that they are on Medicaid. Over the years we've had done a wonderful job of D stigmatizing those old cars and people now say oh, well, I have United health plan or UPMC or - - so people are not always clear that they are on Medicaid and so that needs to be part of that message as well so people understand Medicaid and that if they don't pay attention to the notices they get from the department that they will lose their healthcare coverage.
>> SONIA BROOKINS: I am glad to hear that. I think that's a big issue because a lot of folks don't believe they are on and so I'm glad that something will have to go out in reference to that when we get to it.
>> MINTA LIVENGOOD: This is Minta Livengood. I would like information about what age brackets it's going to be, the requirements that any changes that's going to affect different age brackets. If it is going to affect seniors, if it's going to affect one's on Medicare and Medicaid because if they get SSI sometimes they get - -. I have a lot of seniors so worried that they are going to lose their Medicaid. And so it would just be, I know you don't have all of this information right now. But just to prepare people to this is what's going to happen, this is how you are going to be required to do certain steps. And I am so glad to hear. You are so right about people not realizing they are on Medicaid when they get managed care or even the waiver program. They don't realize that it's a Medicaid program. So it's very important to make sure everybody is aware. And also how the letters are written. So the consumers can understand.
>> SALLY KOZAK: Thank you for that. The ages of individuals may be 19 to 64. I know there are some caveats around that in the office of income maintenance would probably be in a much better position to speak to that than I am. I know it will exclude people with

disabilities but I don't know them off the top of my head.
>> KYLE FISHER: Thank you Sally and Minta Livengood. There will be exclusions and exemptions. The work requirement on the whole applies only to the expansion category. Anyone who is eligible, someone who has Medicare as well as Medicaid wouldn't be impacted when it goes into effect.
>> LIZ HEALY: Sally, I was really pleased to hear you saying that the value of consumers and participating in the past, I think when consumers participated on figuring out the role out for the determination after the federal health emergency really was critically important in having that go relatively smoothly and I would really encourage as the administration begins to consider how they are going to implement some of these changes where they have some choice and implementation. That would be really critically important to have consumers participate in those discussions around determining how to implement what would be the least harmful way to implement.
>> SALLY KOZAK: Absolutely, we will have consumers and stakeholders involved. Eve just sent me a quick list of people that will not be subject to work requirements and so pregnant women, or an exemption. Individuals under the age of 19 or over the age of 64. Individuals enrolled in Medicaid part a or B. Foster youth and former foster youth, veterans, members of a tribe that have greater disability. Medically frail, individuals participating in OUD or AUD treatment program that has provisions to it. People already in compliance with work requirements under the SNAP programs. Individuals with a dependent child 13 years of age or under or at any age with a disability.
>> KYLE FISHER: Sally, Kyle. Sorry, go ahead. My last question, Sally, if you can speak to this is rural health transportation fund which I understand has applications due from the state, and to be approved by the federal government before the end of this calendar year.
>> SALLY KOZAK: I don't have any information. I'm sorry. We can take a look and get back to you on that.
>> KYLE FISHER: Thank you. Any members of the committee have questions?
>> SONIA BROOKINS: No, we can move forward.
>> SALLY KOZAK: As we continue to move forward we are happy to have the conversations to answer questions, I know it was a lot of information. I expect if we move forward people will come up with more questions. The next update from me is the pharmacy GLP-1 update. Approval has not been granted for the committee's recommendations for prior authorization or the preferred checklist status of the GLP-1. Once approved we will issue an MA bulletin - so no new news on that one. Next on the agenda is dental BLE process and our chief dental officer I believe is presenting that.

- **Dental BLE Process**

>> DR. SEAN SHAMLOO: Yes thank you. I will be providing an update regarding the ops

memo issued June 25, 2025. Titled dental benefit limit exception process clarification. This operations memorandum applies to HealthChoices as well as Community HealthChoices. The memo was issued to clarify requirements of the bulletin issued originally in 2011 which limited adult dental benefit. And Medical assistance bulletin zero – eight – 21 – 08 issued in 2021 which streamlined the BLE process for certain underlying health conditions. This recently issued ops memo clearly states that a member qualifies for a BLE if they have one or more of five health conditions. Those conditions are diabetes, coronary artery disease or risk factors for the disease. Cancer of the face, neck and throat not including stage 0 or one, noninvasive skin cancers, intellectual disability and current pregnancy including postpartum period. The ops memo emphasizes if the MCO receives a BLE request it must review the member's claim history and document presence of any of the five conditions. If the MCO is able to find the information in claims history, they are not required to submit any medical records or documentation. They are also not able to dispute whether the condition or its severity warrants a BLE. Now if there isn't such evidence in claim history then in that case the member is required to submit additional medical records to document the existence of the condition or conditions if they were not furnished with the submission of the form. Very important to note that approval of a BLE does not mean automatic approval of the requested procedure. But if the procedure is deemed medically necessary and appropriate based on the MCO clinical review process MCO must approve the originally submitted procedure authorization request. MCO's cannot deny BLE requests on the basis of admissions, errors and incomplete information on the submitted BLE form that can be corrected with any data available to the MCOs within their internal systems. In this case the MCO must make a reasonable effort to find the information and if they are not able to at that point they must reach out to the provider to obtain that missing information or correct any errors on the form. Another important point that the MCO cannot substitute an alternative or less costly treatment such as an extraction for the procedure being requested. If the originally submitted procedure is deemed to be medically necessary and clinically appropriate. The only time in MCO can approve an alternative procedure is if that originally submitted procedure with the BLE is determined and appropriate for clinical review. An MA bulletin was currently issued to provide revised form MA 549 attached to this operations memorandum when issued. The revised BLE form has additional guidance and fields including a list of the five qualifying conditions mentioned earlier. To clarify and simplify the process for providers. MCO's have been notified that they should use this revised fee for service form as a model or template for their own BLE forms. Along with the operations memorandum we included a flowchart that provides further guidance for the MCO's on the BLE review process and how approval and denial should be granted. That concludes my update for the operations memorandum. If there are questions I am happy to take those.

>> KYLE FISHER: I appreciate you coming on the meeting today and giving us the update.
>> DR. SEAN SHAMLOO: Absolutely.
>> KYLE FISHER: You may be aware, the streamlined process for dental benefit limit exception, the guidance and the process of operationalizing among all MCO's goes back a number of years preceding your tenure with the department. But it has been a challenge over the years to see this operationalized consistently. Among MCOs. We really appreciate that the department has taken the additional step, issuing guidance in the form. Thank you for your efforts and to Gwen, Randy and their teams. Really making this streamlined process a reality. To realize the reality of the streamlined process for members across the board throughout these managed-care programs. With this guidance and the updated form, are these changes effective now or is there a date in the future that the MCOs are expected to be in compliance?
>> DR. SEAN SHAMLOO: Yes as of the date of issuance, June 25, 2025 MCO's are required to adhere to guidance provided in the operations memorandum. To begin using the new form or our form as a template for their new forms. Which they will submit to us for review and approval.
>> KYLE FISHER: Great. Referencing guidance to the plans being asked to submit a list of the diagnosis codes considered a sort of - - for the five conditions of the streamlined process. Can you speak about what the department is doing?
>> DR. SEAN SHAMLOO: Yes, we have asked MCO souk comply with the list. We have done in a collaborative nature through PAMCO or other operations but they are required to submit those codes to us for review and approval before they can use those to identify conditions in claims history.
>> SONIA BROOKINS: Good afternoon. Thank you for that. You said something that I need you to walk me through. You said they approved but they are not approved? They are approved but need to be approved? That doesn't mean they are approved? Help me understand the process.
>> DR. SEAN SHAMLOO: Sure. Are you speaking about BLE requests itself, Sonia Brookins?
>> SONIA BROOKINS: Yes.
>> DR. SEAN SHAMLOO: There are two components when a request comes in. The first is the exception request which comes in the form of this request. The form submitted with the requests to render a procedure for a beneficiary. If a beneficiary has one of those five conditions mentioned through claims history review at the MCO level that member qualifies for a benefit limited exception approval. So that BLE has been approved at that point, that has been shown to be part of that individual's claimed history. At that point whatever procedure is being requested, a crown, a root canal, periodontal work, any category of services under BLE review at that point they go on to be clinically reviewed for

medical necessity. So if the procedure is deemed to be clinically appropriate, a standard of dentistry, then it should be approved for that beneficiary.
>> SONIA BROOKINS: What happens in an emergency? In those conditions they still would have to wait?
>> DR. SEAN SHAMLOO: No. In an emergency situation there is an opportunity for retrospective submission of a BLE request. Let's say a member is presenting to the dental office and need a root canal on an emergency basis. The provider is able to go ahead and render that service and submit a retrospective BLE request. In that case. The same guidance applies as far as the review process is concerned.
>> SONIA BROOKINS: Okay. Thank you.
>> DR. SEAN SHAMLOO: You're welcome. Any other questions for me?
>> KYLE FISHER: Not for me, Dr. Shamloo, we look forward to seeing what the data shows in terms of BLE approval and denial rates. We've periodically gotten that data from OMAP and look forward to seeing if this new guidance in BLE form makes any measurable impact in these approvals going forward. Thank you again.
>> DR. SEAN SHAMLOO: Likewise, thank you.
>> SONIA BROOKINS: Appreciate it. Anybody else? Okay. Thank you. Next?

- **Hospital/MCO Contract Terminations**

>> GWEN ZANDER: This is Glenn Zander to present pediatric shift care data on prior authorizations. I think we have slides we can move on to. I will warn you there is a lot and I'm not going to spend time on each and every slide. Nor am I going to dig into each and every number. These slides have been provided to the subcommittee members and as always I'm happy to meet if anybody would like to dig in deeply in a separate meeting. The next slide just gives us the disclaimers about the different data that's going to be presented and it's important to keep in mind there are limitations to the data we are working with but it is the best available data that we are presenting to you. We can move on to the next slide where the first thing we are showing is the way that the number of individuals receiving shift care including skilled nursing and home health services has increased. I think the big take away from the slide is not the total number of members receiving shift care services has grown steadily month by month. Over the last two years which is when we begin allowing for legally responsible relatives to be paid as home health aides taking care of their children. You can see month over month those numbers for MCO's continue to increase. This is a trend we are keeping an eye on. On the next slide we are showing that you can see the proportion of members served by each MCO receiving shift care services. It has been relatively stable over the last year or so. However, I want to note that there are

37 percent more HealthChoices members receiving shift care now than February 2024. There has been significant growth in the utilization of the service however, distribution across MCO's while not directly proportionate to their present of membership across the program has remained relatively consistent. Speaking of that point, moving onto the next slide, this is where we look at the proportion of membership each MCO has of the full program and looking at the proportion of individuals receiving shift care services that MCO covers. There is a couple highlighted where you can see that an MCO has a smaller proportion of members in a particular zone but a higher percentage of those receiving shift care services. Geisinger, in particular, stands out as covering a disproportionate number of individuals receiving shift care services as well as Keystone first in the southeast zone.

Looking at the next slide, this is where we get into some of the denial rates. For context we are looking at skilled nursing and we are going to look at home health aide separately. We are starting with skilled nursing. This is a comparison between 2023 and 2024. What we are seeing is denial rates for these services are decreasing. Decreased from 2023 to 2024. More of these requests are being approved than they were previously. This is for skilled nursing. Looking at the next slide, we are getting into grievances for skilled nursing. And so this one is difficult to look up but I think it's important to pay attention to the colors you're seeing. And really, the gray category which is the appellate category shows you when there was a denial, how many of those denials for which a grievance was filed were upheld and it was determined that the denial was appropriate you can see the blue is what was overturned, orange was a partial return and then yellow, a small proportion are the ones that either subsequently were approved by the plan that had previously denied it or the grievance was withdrawn during the appeal. So is the context of the appeal. You can see what those those filing rates look like look like and what was overhauled versus what was overturned. Next slide. Looking at this one, this just gives you the actual numbers that substantiate the graph that we were looking at only previous slide. On the next one we are looking at these prior authorization appeals and overturned rates by MCO. For 2024, this is again, the raw data. What we have highlighted in yellow, these are any places where there was a variation from the median rate program wide. That was plus or -10 percent. So you can see that there are some MCO's that have a noteworthy rate of overturns. Amerihealth, hi Mark and UPMC - - volume is extremely low and so if there were any requested compared to 100 requests then 100 percent looking out the percentage might not be the only thing to look at. That is some background data that sheds light on the slide we were looking at previously. On the next slide we are going to start talking about home health aide services.
>> KYLE FISHER: Can I ask a question?
>> GWEN ZANDER: Please go ahead, Kyle.

>> KYLE FISHER: I don't see column headers on this slide. Are we are looking at prior authorization and then appeals by type?
>> GWEN ZANDER: We will get this corrected for column headers but it is at different points in the process. The first kind of collection of columns is related to the prior authorization requested itself. Then you move into the grievance and different phases of grievances. So we will get this reissued with corrections.
>> KYLE FISHER: Yeah, apologies that we missed that on earlier iterations.
>> GWEN ZANDER: No problem. It's the same column headers that you're going to see on the final slide that I'm going to talk about so if while you are waiting to get these corrected you can see which ones are prior authorization, grievances, external reviews and fair hearings. Those are the categories and then you'll be able to see which ones go with which.
>> KYLE FISHER: Perfect. Thank you.
>> GWEN ZANDER: Thanks for that, Kyle and apologies but just two more slides previous to this one that I wanted to look at. One is, if we can go backwards. Apologies for the out of order here. Looking at, there we go. This one. Home health and prior authorization denial rates. What we are seeing is these requests are overall across the program being denied less. However, there are some MCO's denying more of these requests. And we've highlighted in yellow which MCO's we have seen a noteworthy change. Keystone first and AmeriHealth visa plans are denying more of these than previously where we see an increase with United. A small increase with UPMC across the program relatively stable. You are seeing a lot of variation between plans and what's happening with denial rates for home health aide services. The next one, yes, go ahead.
>> SONIA BROOKINS: How are you doing? I'm just trying to figure out, is there a reason they are denying? Did they give you a reason? Why is it so high?
>> GWEN ZANDER: We do get reasons for the denials. They very case-by-case. We wonder if it's going to look differently and so we do have staff on the team who go through and audit denials to make sure they are appropriate and considering clinical and nonclinical information in that decision. But it is tough to say overall what the reasons are just because these cases are so unique. Any instance where we are seeing an appropriate denials or denials where MCO's are looking at information that they should not be looking at or they are looking at it in a different way than what the department has instructed. We have issued corrective action plans for MCO's to make sure they come into compliance with guidance for how to review request for services.
>> SONIA BROOKINS: Thank you.
>> LIZ HEALY: This is Liz Healy. I want to make sure I understand. The data we see is on initial request for shift care services for nursing and home health. These are not redeterminations?

>> GWEN ZANDER: They are for any requests. Including redeterminations.
>> LIZ HEALY: So this includes those losing services because of denial?
>> GWEN ZANDER: Correct.
>> DANNA CASSERLY: Do these numbers include full denials or partial denials? I think that was Meghann's question last time.
>> GWEN ZANDER: I can double check how we define denials. Let me double check and respond in chat or I will come off of mute to clarify. I don't want to give the wrong answer.
>> DANNA CASSERLY: Okay thank you so much.
>> GWEN ZANDER: Thank you.
>> KYLE FISHER: Last comment, I know there are more slides. On the last piece under auditing denials in the work your team has done to ensure it's appropriate, I think it's borne out the data so I want to pause and give thanks and kudos to you and your team for the work you've done in issuing the guidance and training and MCO's. Your willingness to look at cases where patterns of cases where a plan may have been applying a rule in a way other than intended or applying a practice that's a contradiction to the departments guidance. We appreciate that. And I think it's fairly clear in the data here that it has had a positive impact with these services. Thank you.
>> GWEN ZANDER: Thanks, Kyle. I appreciate that. We have work to do. But we've laid the groundwork and now it's just monitoring. Danna, going back to your question, someone confirmed that if partial denial is counted as denial for the slides purposes. This is anything other than actually approved as requested is shown as a denial.
>> DANNA CASSERLY: Very helpful. Thanks for clarifying.
>> GWEN ZANDER: Of course. Just a couple of things to look at. One is going into the next slide where we are looking at outcomes in terms of grievances. What the overturned rates were. Here you are looking at the colors of the different blocks to see which ones were upheld. On this slide those are blue. Dark blue. Anything overturned is lighter blue. Partial returns are green. Then either withdrawn or dismissed because it was resolved in one way or another, those are read. You can see that most are upheld but when you combine over returns and partial returns there is a good number of those that happened during the grievance levels. To me and says there is work that needs to be done to make sure MCO's make the correct decision in the first place. It also says to consumers, file those grievances so you get a decent chance at having a different outcome as a result of the additional layer of review. This is the overall chart. Our final slide goes into the background data that substantiates what you just saw on the previous slide where we have highlighted anything varying from the median. You have some where it is significantly higher from the median in terms of was approved or denied and what was overturned. Noteworthy here, Geisinger, they really do approve requests received and I don't really have over returns on grievances. Then you'll see some differences also with AmeriHealth

and UPMC as well. I know this is a lot of data. I feel every time we present on this topic we are getting closer and closer to understanding one another better in terms of what data is helpful to you. What you want to know from us and helping us communicate clearly what we are keeping an eye on. So Kyle, just as you thanked us, I'd like to thank you and consumerism and finessing this reporting on an ongoing basis as a matter of course in making sure you all have this data whenever you want or need it. So maybe you can devote meeting time to whatever other topics interest you but always happy to come back and talk about this at any time. I think that's all I've got. We will take any questions you have.
>> LIZ HEALY: Liz Healy again. These numbers include redetermination-you say your staff are reviewing the, to determine whether decisions are appropriate. Are they taking into consideration that a child was eligible before and has been determined not eligible now? And that requires a higher standard of review. That they have to be able to show that something has changed in the child's condition that something is no longer eligible.
>> GWEN ZANDER: Yes, MCOs must provide their justification for what they thought was previously necessary no longer is.
>> LIZ HEALY: Thank you.
>> SONIA BROOKINS: Anyone else?
>> KYLE FISHER: No questions from me. Thank you again for your willingness to present this data with as much detail as you have. And as often as you have. I look forward to the next version. Very happy to hear that your team has supporting capabilities and dashboards. Much of a manual lift in terms of presenting.
>> GWEN ZANDER: We will keep working on getting things automated and aesthetically appealing. In terms of conclusions we can reach. So we will work on presenting this data in a meaningful way. It's a bit of a pet project now.
>> SONIA BROOKINS: Thank you so much for all you do. We appreciate it.
>> GWEN ZANDER: Happy to do it. The next item on the agenda as well if we are ready to move to the MCO and hospital contract terminations, I fortunately don't have too many things for you. I think the biggest one is keystone first has reached agreement with University of Pennsylvania system, including Doylestown Hospital as well. The current contract termination date is now March 1 2026. We are very relieved that is not a termination happening but we will continue to monitor negotiations closely. Because there would be a total of - has been extended to March 1 of the upcoming year. That was great news I wanted to share. There are a couple of other items updates on hospital closures that we have discussed previously. One was Suburban community Hospital in Montgomery County. They did close their acute care hospital effective July 1 a couple of weeks ago. They have now begun transitioning to only serving, only providing behavioral health services. That happened as of July 1. The other one was Heritage Valley Kennedy Hospital. Closed on June 30. A total of 2485 members were impacted by that closure.

Health plans covering those members have been working with those numbers to make sure they are transitioning their care to other hospitals still open and in network. The next update I want to offer is that HealthPartners and Keystone First continue to negotiate with Holy Redeemer. No termination is expected however there is a current termination date. That date is October 31, 2025. There are 10,741 health partners, members that would be impacted. And 7,063 keystone members that would be impacted if contracts are not renewed or extended. Notices would need to be sent mid-September but continue to negotiate in earnest. Last I have are AmeriHealth is negotiating with Lancaster General; current contract termination of September 30. If notices need to go out that would be August 30th. Let's a large number of members – 21,000. A final update, this is not MCO hospital but an important closure I want to mention. Rite-Aid pharmacies across the Commonwealth are slated to close as a result of bankruptcy proceedings. So MCO's have been hard at work trying to alert their members who currently have their prescriptions through right aid to find alternate pharmacies or other pharmacy delivery options that will be available in the future. There are hundreds of RiteAid across Pennsylvania slated to close at different dates as a result of bankruptcy proceedings. This is a big loss for the program and for Pennsylvania. We are doing the best we can to transition to other available options. Any questions from the subcommittee? Regarding these different contract negotiations or closures? - -
>> KYLE FISHER: Go ahead, sorry.
>> SONIA BROOKINS: I would like to know, do you know how many people service Rite Aid?
>> GWEN ZANDER: I will have to get that number for you.
>> SONIA BROOKINS: Thank you. Go ahead, Kyle.
>> KYLE FISHER: I was going to say I second the good news comment regarding UPenn and Keystone. A relief even if it's only another five months or so. You mentioned the AmeriHealth contract affecting - - members. What facility?
>> GWEN ZANDER: Lancaster General.
>> KYLE FISHER: Termination date?
>> GWEN ZANDER: I just closed my notes on that.
>> SONIA BROOKINS: October?
>> GWEN ZANDER: Sounds correct. Sorry, I shouldn't have closed that document.
>> KYLE FISHER: That's all right. [Multiple speakers] Celebrating prematurely that I was finished but - -
>> GWEN ZANDER: September 30. Notices would need to go out August 14.
>> SONIA BROOKINS: We hope not but. Okay. Anybody else have anything for Gwen? Okay, thank you very much. As always. Thank you. Next on the agenda is OLT L. Juliet?

- **OLTL Report**

- **Deputy Secretary Updates**
- **InterRAI Evaluation**

>> JULIET MARSALA: Good afternoon. Can everyone hear me?
>> SONIA BROOKINS: Yes.
>> JULIET MARSALA: Thank you. Hope everyone's having a good afternoon. Presenting for the office of long-term living update. Go to the next slide. Have a couple of agenda items. We will talk about general updates, I will present on the - - Randy will talk about the trigger event assessment timeframe and answer questions there. Then we will wrap up with recent OLT L communications. If we can go to the next slide. We have no updates on the community health choices RFA. Still remains in the same status as before. If we go to the next slide. For the InterRAI evaluation the office of long-term living is working with various entities and stakeholders to move and evaluate moving from the InterRAI 9.12 version to the 10.0 version. We have a group coming together to take a look at that and wanted to add that to this announcement so that folks know we are beginning this work. InterRAI is the internationally formed homecare assessment tool within our HealthChoices program for the purposes of ensuring clinical and medical requirements for services within a comprehensive service plan. The InterRAI version 10 that we are moving towards was first implemented in 2021. At that time for a variety of reasons we made the decision not to move from the 9.12 version to the 10 version or any of the versions in between but at this point the InterRAI is going to be moving to no longer support version 9.12. And so at this point in time we will look to do the work to move to the updated version 10. So again, at the beginning of this work we will be likely looking to work on this over the course of the next 12 months. Hoping to look for implementation July 2026. Part of that is looking to map the differences between 9.12 and 10 to determine if there are questions that need to be added or adopted. We are evaluating potential impact and eligibility of the FPD. We are not anticipating any significant impacts at this time. But we are looking at those questions. We added a question, one has been removed from version 10, etc. looking at those things. An additional significant working with information and technology team and the managed care organizations, updates from 9.12 version to the 10 version will have an impact on IT systems which have been automated and designed within various MCO's and our own state information technology systems. Work groups will be formed, teams will be formed. Right now we are in the middle of work planning to plan out the whole working phase to go from the nine version to the 10 version. This is predominantly focused on systems, changes, tools but not assessments, the intent of the assessment or things of that nature. Part of that is looking to pull a InterRAI workgroup that will include participants and advocates. Our focus is because this is an LTS as project to rely and work with the LTS as subcommittee. And participants and advocates within the LTS as subcommittee who work

very closely with the work we do in the LTS S group. Interested in working in a workgroup please send an email to our Millan IPA.gov. I will pause to see if there are any questions before handing it over to Randy to talk about trigger event assessments. And timelines.
>> LIZ HEALY: Would it be possible for the person sharing the screen to decrease the size of their document? We are not seeing the entire slide. We are losing the top and bottom of it.
>> KYLE FISHER: Liz, there is a way that you can scroll out. It's on the right hand side of your screen.
>> LIZ HEALY: Thanks, Kyle. That's helping.
>> JULIET MARSALA: Okay. If we go to the next slide I will hand it over to Randy to talk about the trigger event and timeframe.
>> SONIA BROOKINS: Thank you.

- **Trigger Event Assessment Timeframes**

>> RANDY NOLEN: This is Randy, from the office of long-term living. I wanted to go through some questions that came up from the last meeting. We did have some discussion with MCO's and got some answers for them. The first question that came up was to the CHC plans have policies in place for addressing urgent situations? And following responses. AmeriHealth, Keystone does not have a policy in place does not address but service coordinators are trained on how to address urgent situations which includes reaching out to the SC and utilization management leadership to request a temporary increase in services while scheduling completing new trigger assessment. The assigned SC is not available to complete trigger assessment, another SC or supervisor would be assigned to ensure the assessment is done. They would put emergency step in place until they get the trigger assessment done. PH W, again, does have a policy in place for addressing certain situations. Requirements regarding urgent situations are defined in policies. And service coordination oversight plan. Reviewed by OLT L. Some of the call what they do is similar to what AmeriHealth does. Put services in place and ensure that. UPMC doesn't have a specific policy in place but, I think they just sent me something. If I'm able to find it. What they sent in was that following deadlines with trigger assessments were done. And they will put services in place also. All three MCO's will work on emergency situations, get services in place and get trigger assessments done. So the next slide. A question that came up was Ken CHC plans assess people in the hospital prior to discharge? All three of them, AmeriHealth, Keystone can assess participants in hospital prior to discharge. Service coordinators are trained on how to address urgent situations which includes reaching out to leadership to request temporary increases and they will work on getting assessments done either in the hospital or when the person gets home. When necessary

pH W will have SC is going to hospital and assess additional needs of the individual may have. Work with the care team and discharge plan team to address needs. For planned hospitalizations, they will ensure a plan is in place for the time that the individual leaves. If someone knows they're going to get a hip replacement done they will work on getting services in place for that individual for temporary time to provide additional services for their needs due to hip replacement surgery. UPMC can assess participants in hospital prior to discharge. As long as they set it up with the hospital and work with them. If not they will completely assessment when people get home. They will have the opportunity to work with the care team to get into the hospital and address the individual to meet their needs. Next slide.
>> MINTA LIVENGOOD: Kyle? Not Kyle. Randy. This is Minta Livengood.
>> RANDY NOLEN: Hi.
>> MINTA LIVENGOOD: How are you?
>> RANDY NOLEN: Good.
>> MINTA LIVENGOOD: Back to your slide, about a month ago, UPMC did not have the means in place for them to show up at the hospital, do prior assessment and see if you get increased hours. It took them by reaching out it took them an extra four or five days after the person was released. Then it took them two weeks to okay an extra five hours. So we need to stay top of that because a month or so ago that was not in place. That they could not come to the hospital, do the assessment, figure out that they may need temporary extra hours. So if you need more specifics on the case I can give you that later. But if that was not done, they may just come up with this?
>> RANDY NOLEN: For all MCO's, processes have been in place for a while. I don't know why the situation did occur. If you send me specification information I can work to try to figure it out. MCO's are trying to work more effectively with the hospitals and Medicare players so they know when people are in the hospital. So they don't know when people are in the hospital because either the family did not notify them or the agency didn't. That is something we continue to work on and try to gather better data. An up-to-date data where people are admitted to the hospital. Sometimes that is an issue. Sometimes the hospital discharge planners may not know the MCO's. When they reach out to the MCO so they are trying to educate on those issues so that cases are not missed. But even when home it should not of taken weeks to get additional services. [Multiple speakers]
>> MINTA LIVENGOOD: I want to say, Randy, the social worker addressed it and so did the consumer and it just was not, it seemed like not to be a very major issue. But it took too long for somebody that chose not, I will say this. Chose not to go to rehabilitation place. They chose to go home and even though a social worker reached out to MCO it still took about three weeks until they got extra - - approved.
>> RANDY NOLEN: If you send me that information I will follow up.

>> SONIA BROOKINS: Randy, I think Minta Livengood didn't want to come out and say it. Overall it just took too long. If this was in place for any other health plan then they need to stand on it. It shouldn't take this long. I don't care what plan it was. I just think that you just need to get the case but just overall, just watch this because of people are in the hospital and they are contacting them and they are not being responsive, that's right there, enough.
>> RANDY NOLEN: I agree and I know three MCO's are on call today hearing the message.
>> SONIA BROOKINS: Okay. [Multiple speakers]
>> MINTA LIVENGOOD: That's what I was trying to say. They need to stay on top of this.
>> SONIA BROOKINS: Okay Randy. Thank you.
>> RANDY NOLEN: We will certainly keep monitoring it. The next question was on the next slide, do plans report how long it takes between a trigger event assessment and a decision? CHC agreement provides information that a trigger event occurs, MCO must complete reassessment as quickly as possible in accordance with circumstances of the individual and health status and needs. In no case is more than 14 days after the occurrence following a trigger event that they should be putting new services into place. The person centered service plan. We require that they do this in the 14 days and then another day or two to put the updates to the person centered service plan to put that out. That's in the agreement. Next slide.
>> KYLE FISHER: Sorry, Randy. Before you go on, I appreciate you highlighting that. I guess the question was going to how long does it actually take? How long is the average assessment from the time that they are requested? A situation where a person asks for in the hospital and it wasn't done until four or five days post discharge. Are the MCOs tracking that time and reporting it to OLTL?
>> RANDY NOLEN: We do have operation reports that this is tracked. Something that we monitor. I would have to check the reports but I don't think there's a problem right now in making it in 14 days but again, when issues come up, get some in excess, then it's two weeks until they get out there and get them assessed. Those are red flag issues that we will continue to follow.
>> AMY LOWENSTEIN: Looking at language from the CHC agreement, when you say following assessment and updates to the service plan, how long does it take to update the person centered service plan before that? Before the clock starts on the two business days?
>> RANDY NOLEN: Once the assessments done they should be updating the service plan in two days.
>> AMY LOWENSTEIN: Okay I got - -
>> RANDY NOLEN: if the plan is done that it should be - -
>> AMY LOWENSTEIN: - - Than the decision is issued.

>> RANDY NOLEN: After the service plan as well as the two day period.
>> AMY LOWENSTEIN: That's what has to be done in two days and a decision issued at the same time basically?
>> RANDY NOLEN: Right.
>> AMY LOWENSTEIN: Okay thank you.
>> KYLE FISHER: Sorry, I don't mean to be dense, so the two days are running at the same time? Not stacking? I have an assessment now, and it's not two days until I get a service plan, and another to until decision?
>> RANDY NOLEN: The assessment is done today, they have two days to get it through their system and a service plan update.
>> KYLE FISHER: How does that factor into authorizations?
>> RANDY NOLEN: That's part of the process. Service coordinator UM - -
>> KYLE FISHER: So if I have an assessment today then within two business days by the end of the day Friday I should have an updated service plan and prior authorization decision on additional waiver services requested?
>> RANDY NOLEN: Yes.
>> KYLE FISHER: Got it. Thank you.
>> SONIA BROOKINS: That is what supposed to happen. That should happen. Right Randy?
>> RANDY NOLEN: Yes, that's within the agreement. Yes.
>> SONIA BROOKINS: Thank you. Anymore for Randy?
>> RANDY NOLEN: I think there's another slide. There is another question about you plans provide temporary authorizations when trigger events occur? AmeriHealth, yes. They allow temporary authorization to allow for assessment to be completed by SC. Until the assessment is done. Same with pH W, temporary authorizations when a trigger event occurs. And UPMC can provide temporary services in limited instances when the need is identified. That is a situation where someone is coming to the hospital, they had surgery, they have increased hours but the trigger event assessment cannot be done until the day they get home or the day after. They will put services in place, do the trigger assessments and move from there. They will temporarily put services in place. Question is what is OLTL expectation based on CHC MCO making a decision following hospital discharge trigger assessment? Expectations are based on the agreement. If trigger event occurs MCO must complete reassessment as quickly as possible in accordance with the circumstances of the individual. Both status and health needs. But in no case more than 14 days. Sooner than 14 days but nothing should be longer than 14 days. And then they have the two day period. To improve things and get the person centered plan changed and authorization in the system. That's language holding that they are required to hold to the agreement. Okay. Next slide. I think we are back to Juliet.

>> JULIET MARSALA: All right. Thank you, Randy. Just a couple of communications. We want to highlight Pennsylvania achieving a better life experience, the able savings program webinar is happening today. We wanted to have that included. I think it's a fold over from other slides. But really wanted to take time to highlight the ABLE savings program because it's very beneficial to individuals being served by the office of long-term living. And other programs. And highlight looking at financial eligibility. It is absolutely a tool and a resource for many individuals with disabilities and their families. A tax-free way to save a wide variety of disability expenses. Including important benefits. If we go to the next slide we wanted to highlight our sister agencies, the Pennsylvania Department of aging and celebrate their launching of the Pennsylvania care kit which is a collection of tools and information resources to address key challenges in the caregiver journey. This was part of the aging our way PA master plan. And the Pennsylvania Department of aging was tasked with creating dynamic and interactive and comprehensive kit to address key challenges by formal caregivers and provide solutions and resources to support their entire caregiving journey. So OLT L listserv release June 2, 2025 provides additional information on the Pennsylvania care kit. Includes a shareable one page flyer so we hope folks can help us get that word out and share that valuable resource. Widely. And also wanted to give a highlight that Pennsylvania Department of aging has been invited to provide a demo of the Pennsylvania care kit of the long-term services and supports two LT SS meeting August 6, 2025 if you want to learn more and see and interactive overview of the Pennsylvania care kit. I believe that's all the slides we have but let's go to the next and answer any questions folks might have.
>> SONIA BROOKINS: Questions, anyone?
>> KYLE FISHER: None from me. Thank you, Juliet.
>> JULIET MARSALA: Thank you, have a great day.
>> SONIA BROOKINS: Do the same. Thank you. Next on the agenda, OIM.

- **OIM Report**
    - **County Assistance Office (CAO) Operations**
    - **Eligibility Notices**

>> ALEXIS DEISENROTH: - - Carl was not able to be here today. I received agenda items and can walk through the first one which is the County assistance office of operations. I think one of the main reports that we do at this meeting is to walk through the different metrics for timely application processing and average process so I'm prepared to do that for Bureau of operations. Most recent information I have is for the month of May. Average days to process in the month of May. For MA applications, looking at 12.7 days. Which was no change for the month of April. For the waiver, 17.7 days. I think that's up one day

from the month of April. For long-term care, 18.6 days which is one day. Those are the average days of processing for the month of May. Looking at other statistics. Medicaid was at 99.5 percent completed in 30 days in the month of May. The same as the month of April. Waiver was at 99.1 percent completed in 30 days in May which was also the same as April. Long-term care was at 97.3 percent. Timely in 30 days in the month of May which was down one percent from April. Does anybody need me to repeat any of that?
>> KYLE FISHER: It's Kyle, good news. Across the board. First average days of processing for MA, 99.5%?
>> ALEXIS DEISENROTH: 99.5%. Timely and within 30 days for the month of May.
>> KYLE FISHER: Thank you.
>> SONIA BROOKINS: That's good. Have you, will I don't know if you, have you had consideration of what's going to happen when you look at this nice bill that they said they passed? How much is going to be more work put in for the workers there? Because I know that they are working that. So are they considering getting more people in? Or how is it going to affect the workers.
>> ALEXIS DEISENROTH: I love to say I'm the person to answer that, there's many downstream impacts and considerations about what's going to happen for workers but I don't know that I'm prepared to get into that today as we are furthering analysis and kind of working out all of that information with all of our different bureaus to determine those impacts. I'm sure there's going to be lots of conversation on that so I appreciate you raising the ceiling and please know that it is on the top of our list to understand.
>> SONIA BROOKINS: Thank you for that.
>> ALEXIS DEISENROTH: You got it.
>> SONIA BROOKINS: Anyone else?
>> ALEXIS DEISENROTH: I do have some further statistics. I think that there is some CEO staffing complement usually reviewed. I do have that available for Allegheny and Philadelphia councils and statewide. Our staffing for our complement filled for Philadelphia is currently 80 percent. For Allegheny County we are currently at 89 percent. And statewide statistic is 92 percent. In our complement filled statewide.
>> KYLE FISHER: Thank you for that. How has that been trending the last few months?
>> ALEXIS DEISENROTH: I don't have that in front of me. I can follow up with that, Kyle.
>> KYLE FISHER: If you are able to. Thank you.
>> ALEXIS DEISENROTH: No problem. Okay. Taking a look at what's next on our agenda, there were a few things submitted for eligibility notices. I know that there were some follow-up from the June eye meeting that was requested and there were some notices that were sent to our team over in policy to take a look at. From the understanding of the notices, what I can see here are two different notice inquiries. I want to make sure that I first have that right. The first sounds like the notices we have, two different notices that are

going to individuals the same day. One explains that a person is no longer enrolled in community HealthChoices or a HealthChoices plan. And it says that, I think a separate notice that goes along that says they are not eligible for MA. I think there is some language on the notice that talks about their enrollments in HealthChoices plan and that includes something to the effect that MA will continue. We are taking a look at this. We will create extensively but I think we are in the process of looking at it with our tech vendor a little more in depth. This is the first issue. The sending of the 'no longer enrolled in a plan notice' that kind of includes language about your MA will continue, that's being triggered in eCIS for an unknown reason. We are working with Deloitte to figure out why they are sending that notice. We are still narrowing down the affected population and I know that was something we were trying to narrow in on. We have narrowed it to a subset of non-MAGI but I don't know that we can go further at this point. As far as when the issue has started we are still looking into that. This is the first report of these dual notices in the circumstances. I do want everyone to know that we are still reviewing, still trying to understand the exact triggering of what's happening with the scenario. That is just very much on our radar and we are going to have continuing conversation on it. That is what I understand, the first noticed issue to report. The second, I thought we did have some examples to look at but when I looked back we did not. MA requested examples of an instance and I will read from - - receiving notice that they no longer qualify because circumstances have changed. I think this notice was something brought up because the reason for eligibility may have been different than what was stated is what was reported. I couldn't find anything of a known issue. Within our team. If there are any examples that can be provided and if I missed it I apologize. The examples I think I received in preview from that eye meeting were all surrounded to the two notices. If there is possibility of sending on additional information for that issue I'm happy to look further into it.
>> AMY LOWENSTEIN: I shared a bunch of notices like that. A more recent one, three of them when they went for their hearing the judge refused to hear the income issue because they said it was related to medical eligibility. It was temporarily resolved but CAOs don't know why it was issued. I will send that on, I just got those yesterday. Something we shared in the past as well. We had seen it a lot with people on the waiver but this one was not. I can look back on that as well. The one from last year.
>> ALEXIS DEISENROTH: I apologize if there weren't follow-ups to circumstances. We usually get those quickly but happy to take another one.
>> AMY LOWENSTEIN: I will send these over today, I will try today. The other, the first issue with folks getting notice. Sometimes with denials, sometimes a couple of days before or denial, you continue to - - it is pretty confusing for participants who receive that. They are not sure what to do especially when they come out of order. I shared with you a client who didn't understand they needed to appeal because they knew they had submitted

everything for their renewal or thought they had. So they thought it was a mix up. Is DHS going to make people whole don't appeal by reinstating them and issuing a proper notice that doesn't have confusing information?
>> ALEXIS DEISENROTH: Because we are still looking at this, from what I can tell, Amy, when I look at all of the cases we have reviewed, the correct MA closure notice for these eligible individuals, what is sent in these cases. There are, there were appropriate due process time frames. I'm not prepared to say today that we are going to reopen these individuals. Think we still have some looking here but from what I can tell of the cases we have reviewed, the correct notice did go out.
>> AMY LOWENSTEIN: That's correct. But a separate notice went out saying they continued to be eligible. So there is a conflict between those two notices.
>> SONIA BROOKINS: Amy, what you should do is send her what you have so then you can discuss.
>> AMY LOWENSTEIN: Okay. I'm just trying to understand generally because I think there's a lot of people impacted. We see so many of those notices.
>> ALEXIS DEISENROTH: Yeah, I'm happy to follow up Amy. We can continue to have the conversation for sure.
>> KYLE FISHER: Appreciate you taking this back and working on identifying a system issue. With Deloitte to try to identify what is triggering. Can you speak a little bit to the timeframe? When do you think this might be resolved? I realize you haven't quite gone to the solution phase, but. What are your expectations at this stage?
>> ALEXIS DEISENROTH: So we walked through a certain process once an issue is identified. And then once the solution were proposed idea of a solution as we walked through regular systems process. In separate meetings. I think generally those meetings occur quickly. In terms of when a systematic fix can be implemented to correct. That is not something I have an available timeline for but the more that we are able to dig in and I am hopeful that soon we will have some sort of available caseworker solution to be able to correct an interim process. I will continue to follow-up as we walk further through the correction process and investigation process but this is certainly ongoing. But a regular process, I want to say that the issue is already up for discussion on our meeting early next week.
>> KYLE FISHER: Okay, I'm not sure I followed you there entirely.
>> ALEXIS DEISENROTH: I'm sorry.
>> KYLE FISHER: It's okay.
>> ALEXIS DEISENROTH: - - Sometimes.
>> KYLE FISHER: I know the system changes. There is typically a runway. It's not quick. Sometimes it is expensive but you mentioned caseworker solutions. Would that be something like a worker suppressing the second contradictory and inaccurate notice?

>> ALEXIS DEISENROTH: I think that's what we are looking at in that particular situation. I would have to see what the group comes up with as they walk through that process will be. But off the top of my head and unofficially, that is something we would probably pursue as we walk through those conversations internally.
>> KYLE FISHER: And timeframe for systems change? If you know what the fix is. Best case scenario for how soon that might happen?
>> ALEXIS DEISENROTH: It's that sliding scale. We have a lot of mandatory changes coming up so if there is a viable temporary fix that's able to be done by a caseworker to solution this then it would have to, system implementations would be prioritized. Based on complexity and availability in a runway.
>> KYLE FISHER: Okay, thank you.
>> ALEXIS DEISENROTH: Thank you.
>> SONIA BROOKINS: Do you have anything else for us today?
>> ALEXIS DEISENROTH: I do have a topic brought forward to discuss the five percent disregard. Being entered on a notice. I think the ask from the group, if I am reading through correctly was a recommendation to review any notices stopping or denying coverage for a -- category that that be changed to include the five percent disregard. I did read through this. The five percent disregard is only applicable to the Magi computations when reviewing eligibility at the highest income limit for somebody. And it varies among eligibility groups. I think what is difficult sometimes in verbalizing the five percent disregard on notice is well, there's a lot of different things. But the disregard itself doesn't give us the ability to change the income limit on the notice to make it higher inappropriate situations. We've got to keep the income limit the same in those circumstances. But maybe show it as a deduction and show those computations where it's needed to establish eligibility. I think CMS has given us a few examples of statements to explain the income limit and deductions and I think we have used those as our models in noticing. But they do not include itemization and deduction. I remember when the concept rolled out it was really tough to wrap around in terms of caseworkers and doing the manual computations because it's not really based on that percentage of a person's income. The 100 percent FPL. That's tough to convey some of the time. So I am interested to hear what some thoughts or what you're proposing to see may be on a notice that would make this concept clear to individuals as to what that five percent deduction is. And what it would apply or not apply. The guardrails are pretty tough sometimes to make that clear. So if there are thoughts on that we are very open to hear it.
>> KYLE FISHER: Lexi, I appreciate you engaging. I think part of our struggle is just the context of people losing their Magi coverage or being denied. I think the five percent is sort of irrelevant. It would be necessary for eligibility and seeing notices includes 133 percent of real life or person that qualified, there could be up to the 1800 figure that you saw. It

seems like the five percent wouldn't necessarily apply and we are confused about - - the income threshold without the extra five percent. Or even sort of listing the five percent is a deduction that applies automatically for anyone who needs it. So where we have seen the five percent is it sort of is only in demand. It's if we know how the deduction is applied to that person's - - which the vast majority of applicants and recipients - -.
>> ALEXIS DEISENROTH: I think that's where it's hard to figure out how to show an individual that the disregard is there. But what is it and how does it matter for one it could or cannot be eligible. The income limit comparing against 133 would have to have the income limit applicable loan there. We could show that by percent of deduction but I think what you may be alluding to and just let me know if I'm right. It is make it more clear that that would be applied in a certain circumstance or not. I'm trying to make the connection of how to make that identifiable and understandable I think for somebody as they are considering whether they need to reapply or understand how close they were to the limit to say hey, I am right there. That's the tough part I'm coming up against.
>> KYLE FISHER: Take a quick hypothetical. If I'm a single individual between 18 and 65 from Medicaid working a low-wage job, and I make $1802 dollars a month and I apply for Medicaid. Right now I am getting a denial notice that says the income limit is $1735. That's 133 percent. 1735. In this hypothetical making 1802. In reality there is no reference for - - present district. With the five percent district which the department would apply, adding that in, - - Kyle, you don't qualify here because you make $1802. That's telling me I am two dollars over a period not - -. That's a huge difference if I have any ability to adjust my income so I can establish. From our vantage point ideally that notice would say the limit is $1800.
>> ALEXIS DEISENROTH: I do think we are required to have that as the limit. I would have to double check that but the FPL is a required item to have on notice. Being able to verbalize that deduction of five percent as opposed to a tack onto the notice. I understand the communication. CMS, I think raising the limit in those circumstances could bring. But it changes what we are required to put on the notice as limit for the MA individual. If there is another thought to how you would verbalize that as a deduction, in a way that stands out more than maybe what the current table shows. Then we could certainly look further to that end.
>> KYLE FISHER: I appreciate you looking into it. We can look more with CMS guidance to see if there are suggestions that we think would be an improvement of current notice.
>> ALEXIS DEISENROTH: Yeah, I did look through their thoughts on how to kind of walk through some of that. And I couldn't find anything so if you have thoughts or if you see something I am happy and open to talk about it.
>> KYLE FISHER: Thank you.
>> ALEXIS DEISENROTH: Thanks everybody for your time. If there is anything else I'm

happy to take them back.
>> SONIA BROOKINS: Thank you for your time. Does anyone have questions for Alexis? Hearing none, thank you so much. Appreciate it. We will be in touch.
>> ALEXIS DEISENROTH: I appreciate it. Thank you.
>> SONIA BROOKINS: Do we have any old or new business?
>> KYLE FISHER: I don't believe so.
>> SONIA BROOKINS: Well, I would like to thank everyone on this call for being on this call. We look forward to more conversation with the state and can I have a motion to adjourn this meeting?
>> MINTA LIVENGOOD: I make a motion to adjourn this meeting.
>> SONIA BROOKINS: All in favor? I thank everyone for being on the call. I appreciate it. Thank you.