Consumer Subcommittee of the MAAC
September 24, 2025

Consumers present: Sonia Brookins; Minta Livengood; Rochelle Jackson; Lauren Hatcher; Marsha White-Mathis; Meghann Luczkowski; Jayme Scali; Spencer Duffee; Bethany Pancoast.

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

DHS representatives present: Eve Lickers, OMAP Policy Director; Gwen Zander, OMAP Managed Care Bureau Director; Carl Feldman, OIM Bureau Director; Alexis Deisenroth, OIM Division Director; Randy Nolen, OLTL Bureau Director.

Attendees: Chad Rush, Anthony Abrams, Laina Auletta, Puala A Stum, James Anderson, Adrena Atkins, Royna Ayala, Maxcine Bachman, Morgan Baker, Daniel Bates, Ellan Baumgartner, Norris Benns, Angela Biesecker, Kara Blasiak, Chirstopher Bratton, Sonia Brookins, Katrina Becker, Norris Benns, Hannah Brown, Dusty Carl, Danna Casserly, Melinda Correa, Kathy Cubit, Alexis Deisenroth, Mindy Dunlap, Barbara Dunn, Mary Kate Duncan, Laila Duncan, Spencer Duffee, Ray D' Ambrosio, Julie Escobar, Carl Feldman, Kyle Fisher, Montrell Flecther, Carie Frownfelter, Kristen Figueroa, Craig Gimbi, Janel Gleeson, Candy Graham, Jamelia Graham, Erin Guay, Beverly Gillot, Elise Gregory, Mia Haney, Nicole Harris, Lauren Hatcher, Teri Henning, Matthew Hertzog, Anthony House, China Jackson, Rochelle Jackson, Breanna Jackson, Matthew Johnson, Cody Jones, Emily Katz, Daphne Knapp, Elizabeth Kuhn, Andrew Kunka, Tessa Laughman, Marissa Lawall, Ann Lawall, Mason Lee, Laura Lentz, Eve Lickers, Dylan Lindberg, Minta Livengood, Amy Lowenstein, Becky Ludwick, Brinna Ludwig, Luis Lugo, Meghann Luczkowski, Michael Luckovich, Matthew Ly, Colleen Miles, Pam Machamer-Peechatka, Scott Matlock, Teresa McDonnell, Brian MacDaid, Lauren McNaughton, Michele Minter, Stacy Mitchell, Jazmin Nixon Cartwright, Randolph Nolen, Christi O'Donnell, Jocelyn O'Donnell, Christian Oliver, Seun Onafowora, Jessica Osler, Nicole Payonk, Bethany Pancoast, Ashlee Reick, Nicole Risner, Michele Robison, Pam Rotella, Rachel Rumpff, Amanda Sagastume, Allie Samuel, Naomi Shaffer, Shahram Shamloo, Emma Schmidt, Linda Sciulli, Jayme Carreras- Scali, Howard Shehan, Megan Shellenberger, Anniyah Shelton, Jason Shoemaker, Michael Siget, Caleb Sisak, Catherine Stetler, Karen Steele, Caroline Straub, Jessica Street, Lindsay Townsend, Jill Vovakes, Katherine Watson, Sarah Weir, Tia Whitaker, Marsha Mathis-White, Jessica Wilkerson, Michael Wilknson, Erin Wyse, Nick Young, Gwen Zander, Sue Ellen Zhang, Joshua Zoppina, Starell Zoric, Francine Palm, Laura McMurray, Paulette Hunter,

The meeting was called to order at 1:00pm

>> ELISE GREGORY: Good afternoon, welcome to the September edition of the Consumer Subcommittee meeting. My name is Elise Gregory and before we begin I'd like to go over a few items: this meeting is being recorded and your continued participation is your consent to be recorded if do you not wish to be recorded you may end the participation at any time.
Per DHS policy the use of AI for note taking is not permitted. AI bots will be removed.
If you continue to experience difficulty, please send a message in the chat.
Remember keep your microphone muted if not speaking and live captioning, CART captions are available for this meeting. The link is included in the chat.
Presenters should state their names clearly before speaking to assist the captioner.
Representing DHS today is bureau director Eve Lickers. If you have questions or need additional information, visit the consumer subcommittee web page. I'll hand things over to the Chair, Ms. Sonia Brookins.
>> SONIA BROOKINS: Hi, everyone, welcome back to the Consumer Subcommittee.
We have a lot to go over we're going to start with introductions. I'm Sonia Brookins.
Kyle, take it from here.
>> KYLE FISHER: Good afternoon, everyone.
Do we have the vice chair, Minta Livengood?
We have Minta.
Do we have Lauren Hatcher?
>> Present.
>> Very good.
Do we have Jayme Scali?
Jayme is on but I'm not getting audio.
Jamie.
Do you want to try to unmute?
Do we have Bethany Pancoast?
>> Present.
>> Do we have Spencer Duffy?
Marshal White-Mathis?
We have technical difficulties for members and I expect we'll have more joining shortly.
Hopefully Jamie is on and they have had issues before.
Back to Sonia.

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

>> EVE LICKERS: Good afternoon, this is Eve Lickers; Deputy Kozak is not available to be with us today. We're going talk about a few things that the committee wanted to hear about.

The state budget. As of now, and I'm sure as everybody is watching there are no new updates on the state budget at this time for us. The commonwealth is continuing operations for all critical functions that impact the health, safety and or welfare of the citizens of Pennsylvania. And so payments to providers and to our entities will continue to be made for state and federally funded areas including health care services paid through hospitals and other health care providers and nursing facilities. Vendors with state contracts with us who continue to provide goods and services to the commonwealth agencies are able to continue submitting invoices and agencies are processing all invoices that are being received. All of the invoices that they're receiving are being held during the budget impasse and will be sent promptly to the state treasury for processing and payment after the budget is enacted.
So that is where we are now. We're all watching with great anticipation on the state and federal side and no updates on federal side. We've been watching and know that some things are happening and not happening even on the federal level. More to follow on that. More to come.

With GLP1 up days proposed changes to the GLP1 coverage criteria.
It's already been reviewed and you're already aware the pharmacy and technology committee are recommended changes to the statewide PDL, preferred drug list and preferred guidelines for GLP one. Changes were made and sent for review and they're still, currently under review so there will not be any further discussion on GLP1s during September meeting but again, they're still under review with the governor's office and as soon as we have an update and know what's happening we'll share that with the committee. So I don't know if there are questions up until this point.
>> Not for me.
Thank you.
>> For the next update is hospital and MCO contract terminations and Gwen Zander, I saw she's on to provide updates.

- **Hospital/MCO Contract Terminations**

>> GWEN ZANDER: Good afternoon, good to be with you. Just a couple of updates this month. We previously reported on negotiations between Holy Redeemer hospital and both HealthPartners and Keystone First. I wanted to share both contracts have been extended until December 31st and negotiations are ongoing; no imminent termination there.
I wanted to mention it because we've spoken about it before if these were to expire there will be 10,741 health partners members and 6,994 keystone first members do I think the extension of those contracts is a good sign that negotiations continue and do I not expect a

termination but wanted to share that.

Another update I have is not a hospital contract. But it is one that I think will be of interest to this subcommittee. There is a facility termination October 6th coming up Health partners contract will terminate with Pediatric Specialty Care, which operates congregate care facilities around the state. This will affect all its facilities.
A total of 58 members were sent notices on August 15th, advising them of termination and outreach has been made to each residents' families to discuss options.
To date, of the 58 residents, 51 have transferred to a new MCO so they can continue to reside at the facility.
Health partners is working with the remaining residents and families to coordinate care and amake decisions about future residents or MCO enrollment.
So those are the updates very this month.
Any questions I can answer?
>> KYLE FISHER: On THE hospital termination side I believe during last meeting you mentioned contract between Lancaster General and Amerihealth expiring soon.
Any updates on that one?
>> Let me look into that one.
Just a moment.
U Penn includes Lancaster general and has been extended until March 1, 2026.
>> Good news, thank you.
>> Yes.
Do any have questions?
Is pediatric special care you know health partners has others is the remaining seven members could transfer to, potentially?
>> In the a peck.
It is a residential facility opposed to a day facility. Health partners does have other options and will depend on where they were living in what options are available to them in the region.
>> SONIA BROOKINS: I have thoughts but I'm just going to keep them to myself now.
>> I can read your mind, Ms. Brookins.
>> Thank you for your report.
>> I do have one correction to share.
The expiration date I shared for Lancaster general that was Penn Medicine contract; the Lancaster general section is extended until December 31, 2027.
They've reached a new agreement.
That piece is done.
It's only the remainder of the Penn medicine system extended out until March.

>> Okay.
>> March 1st?
2016?
>> Yes.
>> Okay.
Thanks.
>> Anyone else?
>> Aside before we proceed we have additional committee members who joined in.
Do you want to introduce yourself?
>> Spencer do you want to introduce yourself?
Are you able to unmute?
>> SPENCER DUFFEE: Yes. I'm here.
>> Excellent.
Marcia Mathis.
>> MARSHA WHITE-MATHIS: Yes. >> Can you hear me?
>> Yes.
We can.
Thank you.
>> Thank you.
>> Very good.
Minta Livengood are you able to unmute?
Are there other consumers on who haven't had a chance to introduce?
>> JAYME SCALI: Hi, Kyle, it's Jayme I'm here.
>> Thank you.
>> Are we ready for HR1 updates?
>> Yes.
>> Okay.
Awesome.
>> Spencer come off.

- **Budget Reconciliation Act (HR1) Updates**

>> EVE LICKERS: Okay.
So with regard to the budget reconciliation act or HR1, some people call it OB3, as a result that have budget bill the department is required to implement changes to SNAP benefits placing significant burdens on recipients and the case worker.
The department provided statewide trainings on the September work reporting requirements and another training is scheduled in advance of the November changes, which expand requirement to new age groups and households with dependents.

We're still waiting on additional direction from our federal partners for further guidance on implementing this part of the federal budget.
And namely, implementation of the SNAP work requirements and eligibility provisions DHS is developing an I.T. system to track work requirements and significantly increase staffing and training acapacity to meet these unfunded federal mandates and DHS is doing direct access through additional meetings and e-mails sorry.
Additional mailings and e-mails and texts like we did in 23, 24 when annual Medicaid eligibility checks restarted after the COVID-19 emergency ended so it will be similar to what we've seen, and done before.
DHS intends to work with the general assembly and other partners to help Pennsylvanians understand and prepare for changes coming.
So that those who nooed meet and qualify for benefits will be able to receive them.
We're aware of the concerns, and we're aware of many questions that people have and I'll just say, fears.
One thing we can provide to you is that DHS website, www.DHS.PA.GOV backslash, work includes work requirements for SNAP and eventually Medicare requirements will be there that go into effect in 2027 and the site is going to be updated so there is a blurb up there now and I didn't mean to overstep for OIM.
I didn't see anyone from OIM and I did want to make sure we've provided that information so if we have updates beyond that we can provide that that.
Is just information there.
I don't know if there is any questions that have you that I can possibly provide and I can probably drop that in the chat for folks I think someone had a question, looks like.
>> I think a number of questions tied to this SNAP work requirements are largely for OIM.
I don't know if you have other HR1 related updates?
>>EVE LICKERS: I do.
The rule of health transformation fund I know everyone is watching this with great anticipation. This is a grant initiative established under HR1 and it is designed to enhance the health care access quality and outcomes in our rural areas and eligibility is to apply is limited to state government so individual providers or health systems can not apply for.
This DHS is working on what that proposal will be and intend to submit the application to CMS by November 5th, 2025, and do expect that the award decisions will be back to us, from CMS by December 31, 2025.
So this we're anticipating this funding will come and support efforts to transform rural health areas across the common wealth we've received a lot of feed back, a great deal of feed back and response to request for information issued last month and we're using this input to help ensure the program is able to address the beneficiary needs and delivers practical community driven solutions to health care challenges.

Things that emerged from feed back that we receive included and improving maternity care in rural areas and how to enhance behavioral health services and access to care, improve access to dental services, work force development around unlicensed providers such as community health workers and dualas we have certified home health aids, dental hiejennists and others and licensed providers include obstetric and trained physician assistants and psychologists and LCSWs and how to leverage technology as telemedicine, telemonitoring and EHR, electronic health records.
And connectivity.
Maternal health related apps and deploying mobile health units.
These are great ideas and we're looking at how to utilize these suggestions to develop this plan.
A key component is the expansion and strengthening of the rural health care work force to ensure sufficient capacity is there to meet needs of rural populations we know in providers are often closing doors and there is some scarcity amongst providers in area areas as well as looking at transportation issues and things that rural areas face.
So we're looking at how we can develop this plan to address how to utilize training, and work force vemment for licensed an unlicensed providers so application if you don't see details when this comes out it's going to be written so I think what we're going to see and did see that with a recent proposal we have had done related to 1115 it was more broad and then, as things developed, then you're going into the more specific ideas and, initiatives so that is what we'll be expecting to see with a short turn around, we really have to you know get what we can together and make sure that we get it submitted into CMS timely so they can have time to review, ask questions and respond to us.
So I don't know if there are any questions on that one.
>> I don't know that they are. I think you've covered much of what we'd discussed.
Someone is jumping in.
Please.
Go ahead.
>> There was a question how do we educate folks on the work requirement processes and is there packets or information we can reenforce?
>> I think more information will come on that.
I think one of the first places is the DHS website.
I think as this develops, OIM will probably provide additional guidance on the best way to educate I think MCU will, I imagine they'd be partnering with us to provide that information, as well as them being able to contact the department.
So.
I think that is a great question.
And I think that we're all working on what steps will be for communicating and educating

folks I think there is more still to come and we'll take that back to make sure that is addressed how can providers and how can various areas where beneficiaries are engaging how they can help to support education efforts.
Thank you for that question.
>> KYLE FISHER: During the last meeting I believe spoke and shared the 20 billion figure over ten years.
Do you have additional information to unpacking that estimate?
When it's expected to hit?
What exactly it includes?
>> EVE LICKERS: I do have information and will say I'm in the expert on provider taxes so I did phone a friend.
So we have Michelle on who will be able to answer questions of the information I provide and didn't get to the core of what you're asking.
>> We did take back your questions and for each class you asked what are the provider tax percentages for each of net profit. The current provider tax percentages by class are, for inpatient hospital it is 5.04%, for outpatient hospital services it is 2.87%, for the MCO assessment, the rate is 5.13%. We are working on a strategic path forward. We can see as I mentioned there is still a movement and uncertainties on federal levels so it's not clear kind of where we're going to end up at this point.
And we're waiting for additional communications from CMS.
So until we receive that we're going to have unanswered questions.
We're still in that wait and see.
So until we get that definitive information it's going to be difficult for us to provide definitive information.
>> I appreciate you answering those questions and appreciate there is ambiguity here, there is another question maybe you, or Michelle, could answer.
Related to aspect of state related questions there is question around whether current state directed payments are not grand fathered so you can have grace period before they'd have to be altered to with reduced down.
Do you know the answer to that?
>> I believe there had been information about that.
I'll defer to Michelle.
She's the expert on this directive payment.
>> MICHELE MINTER: Hi, Kyle, it's Michelle.
>> Hi.
>> So at this time, we believe that our state directed payments will be grand fathered in. However we haven't submitted to CMS for 2026 so of course that is not 100% confirmed until we submit them and receive confirmation back, we'll let you know.

At this point, we do believe they'll be grand fathered in.
>> That is good news, hopefully.
>> Agree.
>> I don't know if committee members have, I know this goes into the weeds and thank you.
>> Thank you.
And next piece is the home accessibility durable medical equipment and we have folks from the bureau fee for service programs that are on Michelle Robinson and Francine I'll let them take this particular area.

- **Home Accessibility DME (HADME) (FFS MA)**

>> MICHELE ROBINSON: Good afternoon.
Can you hear me?
I was having system issues joining.
>> We can, Michelle, please.
>> Thank you.
So.
Good afternoon everyone.
So I was asked to provide some data updates on home accessible durable medical equipment.
We refer to it as HADME here.
I was asked how many have been received for January 1, 2023. How many had been approved and of those how many have been installed?
To date we've received 39 requests of those 12 were approved so remaining 27 were not approved.
And I'll provide a breakdown of those. So eight of those were denied administratively.
Top reasons for this was that the provider was not enrolled in PA medical assistance.
The request included incorrect provider type and or incorrect procedure code and modifier combination was submitted.
Remaining 19 denied as additional information was needed to determine medical necessity.
Of those we're able to confirm four were installed, with the caveat here that once we approve an item we do not follow up to determine if it was installed or not.
We determine service was approved and however did go through of those 12 and to confirm a paid claim was made for four of the services.
>> SONIA BROOKINS: So what happened to other folks?
>> We do not have a paid claim in this system.
It could be they're still -- we don't know.

Without reaching out to the vendor, the -- we don't know.
When we approve a service it's approved from our perspective and we don't follow up to determine if it was received or not received.
>> So.
Michelle who do the following up?
If y'all don't do it, who do?
Is it MCO?
I'm just trying to figure out.
Who do the follow up?
>> We reviewed service and determine if it was medically necessary and approve it.
We tell the provider prescriber and member, this was approved.
That is how we and how operations works vm awe prove service if intention is you expect us to reach out on every request that is unrealistic.
I understand you're concerned about the other eight.
>> Can I just say this to you?
I don't expect to you do that.
I expect for someone to follow up to see if this work is being done.
Because remember, you're putting out money.
That is stuff supposed to be done.
So if I was put out money for a job, I want to know if that job is being done so I have to do follow up to find out if that is not done, why it's not done?
Somebody should be checking to make sure and you're not putting money out just to put money out.
That is all I'm saying.
>> Okay.
>> If.
>> Carl can I just respond real quick?
>> Of course.
Yes.
>> Sonia.
I appreciate that and I completely understand.
I want to let you know we're not giving out money until we receive a claim from the provider.
So no money is being issued but from your perspective if approved is it being completed?
A agree with you.
We're not sending out money.
No money is being sent out.
>> KYLE FISHER: I think the process is unusual here. There is not a fee schedule rate right?

We have the department agreeing with this consumer ... fee-for-service MA agrees that it is medically necessary for this person to have a chair lift or vertical platform lift and we're seeing two thirds of those approvals, for whatever reason, not translating to consumer getting that ramp or left or chair glide they need.
So I guess what we'd like to do is try to parse out why.
I do hear you, Michelle saying we're not routinely then reaching out to the vendor or doctor.
So there is a further negotiation of rates right?
There is a piece that has to be agreyed on.
Can you speak more so to how that process works?
And timing for installations would those be in the works or dating back to 2023.
>> MICHELE ROBINSON: So there are multiple questions.
>> I'm try to go back to question one. With that.
The first ask. So you're correct, yes. These are program exceptions.
All program exceptions come on that MA97 form.
Requested information that needs to be submitted is published in our MA bulletin and provided a provider quick tip.
Information we do request is nothing different that be what we ask for any other program exception. The challenge we're running into is with the actual vendors that they don't fill out the, they don't fill it out or only partially fill it out.
More challenging are waiver providers some have been helping the provider complete information on MA97 and supporting information however, not all service coordinators are as robust in assisting as others.
My team goes above and beyond and help get information so a determination can be made.
So once we get that information and physician reviewer determines it's medically necessary then, information shared with our sister agency are working on rate setting within 24 hours of receiving request from my team.
To determine rates, BFM (Bureau of Fiscal Management) requests a detailed cost of materials from the supplier. This quote are analyzed and unallowable items are removed.
Final rates then discussed with the director.
Providers are notified of the approved rate and once the provider agrees they share that rate with my team.
Time frame depends how quickly quotes are received and, if enough detail is provided in the quote and a rate can be agreed to.
So quote should include acquisition costs, labor costs and delivery costs, permit costs to get the information needed it takes rounds of back and forth and most cases will submit quote with just one line and price.
Not breakdown what is needed so.

One thing BFM has done is that they're communicating with providers so there is an understanding of the rate set and what is allowable and needed to be removed and they're coming to an agreement.
Once my team receives that rate we add it to the notice and batch those overnight so they'll good out next day to the vendor and prescriber.
So this is a lot of work. The challenge is getting information in to make a determination.
We have three recent requests that provider submitted everything as requested and needed and items were installed within six months so the process works it's just getting information to have a time of installation.
>> Maybe there is a due for service process.
There is some recognition and negotiating or discussing the appropriate rate directly with the vendor how recently did that happen?
>> I'd have to go and ask Michelle.
>> Michelle Minter: Hi. I'm on the line.
So I would say this happened within the last year to last six months.
And this is so that providers coming back to avoid and we just deal with provider and they understand what the rate is and if they have questions I talked to them directly actually and explain to them based on the quote you sent you asked for X amount and I had to remove things like I can't pay for meals for your team.
I can't pay for their lodging and those cannot be included and I had to remove them.
They understand that and to a point of agreement and share approved rate and I hope that helps.
>> I think it does.
I guess there is mention of three requests being installed is that three of the four?
That was reported initially?
>> Yes.
Those are included in the four.
>> AMY LOWENSTEIN: This is Amy.
Thank you for that explanation and details about the rates are determined I had a question so four that were approved were actually installed? Out of 12 approved?
Does that mean we have rates agreed upon that?
Is that medical necessity?
>> Those are all approved rates.
>> Okay.
So it's those 12 and they have had negotiations on this?
>> Correct.
>> Okay.
I'm glad to hear process is improving I've spoken to vendors and this is over a year ago.

Who had been doing this?
In it was through waiver in the past. And a number said they were not comfortable working anymore because it's too difficult a process and overly itemized.
And so we have had heard from concerned people.
Almost all people here are people in ODP waivers so it is a concern what we're hearing is that it's easier to work with managed care than fee for service.
Do you, have you thought about speaking with MCOs?
Which seem to be stream lined?
>> MICHELE ROBINSON: As you know MCO have greater flexibility.
We have what is in MAB. Is this same information.
And when this is rule out, bureau of managed care operations and fee for service worked hand in hand so we'd have a mirrored process going into this.
>> I am hearing that is not similar but speaks to flexibility.
It's only 39 requests.
I'm in the sure why there is a low number.
But.
It with many of them being denied administratively.
Can I ask you.
Are those unique?
>> Yes.
12 approved and 27 denied.
>> Okay.
>> People who are, other thing is that there people are not able to find providers that will work with them.
Does fee for service have a list that it knows.
>> Can I step back?
We can confirm we're installed if that is finding a claim and promise is that doesn't mean other eight weren't installed all we know from looking in promise is that there is four claims submitted.
>> And I'm concerned and I see that.
With the other 19 that were denied for medical necessity has there been follow up with them to see if there is going to be a resubmission or whether or not they need help finding a correct provider or helping them with enrollment in Medicaid?
>> So if you're asking about provider availability yes, initially there was accepting fee for service beneficiaries since that is no longer an issue we have a sufficient provider list to install.
Is that available?
Yes.

Fran and her team have that list and for those individuals that haven't issued they work with them and that is not providers do we follow up after a denial?
No.
We do not.
>> This is helpful and I'm glad to hear there has been improvement.
And we have had a case that went through I asked because we're talking about people who have very high needs in almost exclusively if not exclusively in ODP.
To help facilitate it.
So that recipients can get ac ises to services and understanding how you can work with a home modification for things that needed to be done in addition to support that.
It seems like there might be collaboration here.
>> I can share.
Fran and testimony have gone step by step.
With coordinators step by step and what needs to be submitted but we're willing to help.
>> That is why I'm thinking about a collaboration.
There is maybe ODP and supports coordinators might need more training in how to assist people they're supporting.
And understanding of them.
Any other questions?
>> I don't.
I do appreciate you digging in the data and walking us through process and hearing our concerns, and progress there have been changes and figuring out rates so hopefully that will continue and Sonia if you're open it maybe we can circle back and look at the data on this a year, or so from now to see if that is born out some of the data.
>> Okay.
>> No problem.
>> Thank you.
>> If you have questions, feel free to reach out.
I mean that is what we're here to do.
>> Thank you.
>> Thank you.
Appreciate.
Next is OIM.

- **OIM Report**
    - **Budget Reconciliation Act (HR1) Work Requirements**

>> CARL FELDMAN: This is Carl. Can you hear me all right?
>> Yes.

>> Lexie you're on the line as well?
>> LEXI DEISENROTH: I am. Can you hear me?
>> Yes.
>> Okay.
Great.
>> Right good afternoon.
Consumer subcommittee.
So.
I'm looking at the agenda that was presented to us.
And the request that was made was some discussion on the HR1 changes that are facing snap program and work requirement components.
Lexie and I are on the call today. I'm Carl Feldman director of policy for OIM -- we make eligibility for SNAP and Medicaid program we're going to try to do this in chronological order, so to speak.
I'll talk about the snap items and then, we'll hand it off to Lexie and I'm sure there will be questions we want to work through.
It's starting chronologically we'll talk about SNAP and SNAP time limits.
They've been known as ABAWD work rules, we're moving towards a change in that for reasons I'll get into so snap program has work rules and they're 18-54 and under rules you can, if you're in that category of recipient you can only 73 months of a benefit within a three-year period unless you become exempt from the rule, or, you participate in employment and training or education and community service for 20 hours per week or 80 hours a month.
Those rules were changed by HR1 and include two major ones: first and what we're experiencing now is a change in the geographic waivers stemming from economic hardship.
Which is talk about lack of employment or high rate of employment in a typical jurisdiction, typically counties and as a result of this new, higher threshold, parts of the state that qualified for a waiver from these SNAP limits any longer do. So September 1st snap limits that were waived in much of the state are no longer waived.
And so that is a result of HR1 and second major change related to snap time limits is that this is to be applied, these time limits, to individuals aged from 54 to 64 and also, this is why I was saying we'd wish to no longer designate this is able bodied adults without dependents, we'll need to determine a different term for it.
It will need to include households with children over 13 in the population to whom time limit rules apply. And those new rules begin on November 1st.
Existing recipients of snap exempt due to having an exemption when made eligible for snap will keep that exemption until the next renewal due date and phase into those new rules if

they continue to be.
The important thing to note is that statewide, time limits have resumed and then, November 1st, these rules apply to a broader group of people at that upper age threshold which has been increased, and households with children. And I'm going to ask Lexie to talk about the Medicaid community requirements which will come into effect in 2027 I'd just say the primary focus is on the appropriate management and implementation of the new snap eligibility requirement. It is a major change we have to manage correctly.
Lexi?
>> LEXI DEISENROTH: Thank you,Carl.
So examining the Medicaid community engagement requirements - as they're called in the law - work requirements we can refer them these must be implemented first of January, 2027 and the law does give states an option to request an extension up to two years and we'll keep an eye on additional things coming from HHS to what that entails and what they look to be granting for those.
Applicable individuals for community engagement are adults that are 19 to 64 and enrolled in expansion Medicaid group and so the requirement can be met by working, at least 80 hours a month, community services, and participation in a work program are part of that as well for 80 hours and could do a combination of those activities.
Another way is also to be someone 80 times that is the hourly wage can count and seasonal workers with average monthly income over the previous six months is and aside from that same group of individuals can meet an exemption to requirement so if there is an exempt person they do not need to meet the requirement.
So someone that is pregnant or in the postpartum period meets the exemption.
Former foster youth and foster youth meet exemption.
Veterans with disabilities. Medically frail - we expect to hear more about this from HHS secretary to further define this group, and individuals that are blind or disabled defined by Social Security act and individuals in AUD treatment or SUD treatment and meeting work requirements for TANF or SNAP programs. Meets an exemption there is an question about how Medicaid and staff requirements can work together.
This one of the places. If an individual is a parent are care taker of a child or individual with a disability. If an individual is entitled to or enroll had in Medicare part A or B they're considered exempt and incarcerated individuals are considered exempt.
There is an option to allow for short term hardship events, which includes individuals out of community medical care for complex positions there are verification standards individuals must meet.
These community engagement requirements must be completed at application and renewal and we do have option to verify more frequently within their own policies.
And required to use an ex parte process, meaning to look at what we have on hand to

determine if applicants or enrollees before outreach an individual so if we can get it, we won't ask someone else to send it in F.is part of our verification.
There are procedures too, requirements so states have to conduct advanced outreach for awareness of requirements three months prior to eligibility taking effect, so for example if we're to start with individual in the month of January of 2027 when the law goes into effect means advanced outreach will need to occur in October 2026.
States must provide a notice of non-compliance and members not compliant within 30 days and provide courage during 30 days to verify compliance or exempted status. So those are the initial overview.
I'll pause for just a moment.
>> There are questions on the list around what we're doing and what you'd like us to cover. I expect maybe now is a good time to open it up to the consumer subcommittee to see how they want to proceed in discussion.
>> We went over some of this and appreciate you covering it as well.
I know you have a list of questions we've laid out.
But I'll pause in case they do.
>> CARL FELDMAN: I'm going to jump to ones that have direct responses.
On alignment with the work requirements for Medicaid and snap, Congress handled the provisions separately and we can't see there is an extensive effort put into the alignment of requirements and Lexie mentioned that would enable it for someone who has Medicaid requirement to be meeting as well and that is a helpful area of overlap but it doesn't mean they're fundamentally different but at the outset that is now how they're designed.
Lexie.
Can you talk about the data sources that we use to verify information?
>> LEXI DEISENROTH: Sure.
So we have several exchanges and so some more commonly known data exchanges are found through DLI.
Department of labor and industry.
So from them we get quarterly wage data as well as unemployment compensation data we have a connection to talks.
Referred to as a work number that comes to us through the federal government at the federal data services hub.
We receive data connection to Social Security administration for verification of RSDI and SSI income.
We have a connection to our internal child support system.
We have a few sources we use for income information.
New hire information is something we also get from department of labor and industry.
And we do get information from Pennsylvania department of revenue for lottery.

IRS data is received with exchange through the income and Social Security earnings do come through there and we receive systems known as Paris.
Those are the main data sources we use to verify income.
>> One question is around snap implementation, who is time limited, and I can share that there were 82,000 people became time limited on Sept 1st and another 34,000 people to be starting on October 1st. Plus a small number who became time limited this summer which is fairly small number in total and exceptions are documented when receiving information on them and I don't have the number of people who are receiving an exemption at this time to share with you.
I think you've asked us if we use claims information to automate those exemptions, it's something that probably has value for snap and we do have interest in. We did send individuals with time clocks that went to 130,000 and we hope those will be returned they're returned to county systems offices all over the state and so we can't know without looking into each specific case if the 558 form being returned is the reason the person is receiving that exemption.
You asked if exemptions can be reported through compass or calling CFC and the answer to both is yes.
You asked if we'll be tracking when SNAP and Medicaid is closed as a result of non-compliance that is information we'll be looking to gather.
The first point in time we expect that will occur will be in December because that will be the largest cohort whose time clock initiated ending September 1st.
>> I appreciate you walking us through so much.
>> SONIA BROOKINS: To ask Do you know as of today how many was the determined to forms?
>> We don't know how many people returned the forms and likely can determine how many people are except but it's not something we can connect to mailing that went out because it isn't tracked at that level of detail.
What is important as you'd like to know how many people have an exception and that is the information we can share with you.
We just don't have it for you today.
>> Thank you for that.
>> KYLE FISHER: We've talked about we want people to continue receiving them and new requirements are putting tremendous burdens on recipients to provide forms and get medical exception documents and to mail these out. One thing we discussed is the department's ability to automate some of these and, it would be useful to hear if you're contemplating and have interest in using claims data or its vendors have process these over time.
But. Sorry. Back up a little. Numbers you gave us out of 2 million I believe you said 82,000?

>> Yes.
Which is encouraging given it's a fairly small percentage. Do you have similar numbers for Medicare populations there?
>> CARL FELDMAN: Our priority are snap changes and we don't have information to share about what hypothetical regime would require and how many people that would affect.
>> And I can appreciate why the department is focusing on snap at this point.
Another question is state agency decision points understanding these can with made now. Have those decisions been paid?
>> We haven't made any decisions about what the community programming program will look like.
I'll just say our leadership agrees with you.
This is something we have to do we, want to do it in a way that requires the least amount of administrative burden on ourselves and client. It's a guiding principle, not necessarily a policy decision.
>> I appreciate that.
We spent time and I believe I heard you say snap recipients can call summer service center and use COMPASS to indicate there is a way to indicate as well?
>> They'll use a case notes in COMPASS and can send a photograph of the questionnaire there is no integrated questionnaire in compass though application or renewal form does ask questions which would inform the outcome of potential for an exception so on many occasions simply calling can be enough.
>> Do any members have questions here?
>> It's just a lot going on and that we have to take in.
We have to work together and be there for people we serve.
>> I'll direct this group to the web page set up on snap changes and are attempting to put information on that is useful to recipients.
It has a good set of FAQs and a set of documents and also documents they can use to indicate they may be exempt by hope to have a tool kit in the near future so people can have messages that are pre determined that we're working towards getting as much as possible available on that web page certainly by November 1st deadline.
>> One other piece going to a similar theme here of putting out materials and mailings going out this committee can help do user testing and we appreciate the work and certainly want to be of assistance however we can.
>> Thank you.

- **Eligibility Notices**

>> CARL FELDMAN: Unless there is more to be said I wanted to talk about the second item on the agenda, multiple eligibility notices being mailed that may be contradictory.

Direction has been given to suppress that notice to ensure it does not go out. We recognize it is confusing, and if someone receives a notice that indicates eligibility will be discontinued we encourage them to follow directions and appeal it.
>> KYLE FISHER: Related question here and we appreciate you working with vendors if I'm understanding you correctly there are instructions is there a time frame for changing the system problem of these going out in the first place?
>> We're working on it but at this time I can't say about when that will take place.
>> They're working on it, Kyle.
>> Thank you.
Anyone else got anything for Carl or Lexi?
Thank you for your time.
Thank you for your patience.
>> Thank you.
A.
>> I expect we'll be talking about this more.
>> Yes.
>> Thanks everybody.
>> Have a good one.

- **OLTL Report**
    - **Deputy Secretary Updates**
    - **Trigger Event Assessment Timeframes**

>> You may be muted.
>> Randy we can see your mic is unmuted but it's not working.
>> Are you trying to say Randy doesn't want to talk to us?
>> His microphone is open if you want to check the gear wheel in settings to Mick sure the correct microphone is synced up?
Is there anyone else from the office of long term living?

>> MONTRELL FLETCHER: Can you hear me?
Yes.
>> I don't know if Randy is doing this on purpose I'll punt in the meantime while he gets set up.
>> Okay.
>> Next slide, please.
So today we have a couple updates I know the most of which is going to be CHC appeals data.
So we'll kind of move ahead and then jump into that discussion so next slide.

I'm just getting back.
But from what I understand there have been no updates to the procurement.
CHC procurement so we don't have any updates and are continuing to ask people if they have questions to submit them to the RFA account on the screen.
Next slide.
So I believe the committee had questions around trigger events and assessment time frames I want to report out that MCOs have 14 days upon learning of an event that meets criteria that 14 days is to complete assessment and does not include notice to participate and those have been made a two-business day notice is required and I see you're unmuted I don't know if there is anything you want to add to that.
If not we can move to next slide.
>> KYLE FISHER: If we can pause, my recollection is that the contract says up to 14 days, and expeditiously as health or circumstances require, and that MCOs can with and should be doing assessments or issuing a temporary authorization until they're able to do that assessment. Is that accurate?
>> From what I understand.
Yes.
Randy if you have additional feed back.
We're going to make a best attempt to get the assessments completed but those are the standards we try to stay within those as much as we can but at the least we know that 14 daytime frame is in place that doesn't keep us from completing the work earlier, if we can.
>> Just looking at this language and I see there is outer boundary of 14 days MCOs can do sooner but I'm going back to expiration as required under certain circumstances you know have you an urgent situation to submit are the plans not expected to move quickly.
Minta.
I don't know if you're on now.
The decision there might have been confusion from the last meeting.
About reporting during last meeting MCO decision after assess many was supposed to be made two business days. Here I'm seeing a 15 business day deadline for the plan decision.
So they have an assess many before or after.
Are you saying participants might have to wait that long after a trigger event and assessment? And during that time do you not expect MCOs to authorize temporary services?
>> Kyle, unfortunately I'm going to have to table this.
I wasn't in that previous discussion so I'm in the sure and it looks like Randy is having issues coming online.
So I hate to kind of kick the can down the road but I just don't have those answers today.
>> Understand.

Thank you, Montrell.
>> Are you going to go forward?
What are we doing?
Waiting on Randy?
>> Let's keep this on the table.
And I know a large chunk of the discussion is going to be appeals data.
Let's transition over to that and we can keep this on the books for next month.
>> Can you hear me now?
>> Yes.
I can hear you now.
>> You guys can hear me?
>> Yes.
We can hear you Randy.
How are you?

>> RANDY NOLEN: I hate automation. I don't get along well with technology.
I don't know what is going on with my computer I have had meetings all day and mics have been working until now this wasn't an attempt to set up Montrel since he just came back.
He came from leave and you put him on the spot.
>> I appreciate you jumping in there, Montrel.
>> No problem.
>> As far as trigger assessments we do have information in the agreement of time line.
Those are general time lines but do discuss and encourage to provide responses and looking at putting services into place on an interim basis until they get a full trigger assessment done if they've got someone in the hospital and they're needs charged so there is some means for the MCOs to change services in these situations.
>> KYLE FISHER: Appreciate it. This is one to be circled back to.
I do think Minta had to leave.
During earlier meeting we discussed, and you saw this in the case example, there's a concern that these trigger assessments are not happening quickly so could OLTL clarify this? That is the last piece around the expectation for plans to issue temporary authorizations if not able to decide in a quick basis.
>> RANDY NOLEN: So we are talking to our policy folks in regards of how we want to clarify this. Whether ops memo or clarification. In the event of a trigger issue they need to react and get services into place.
Individuals will have an opportunity to get into the hospital and work with them and staff to make sure services are appropriate when they get home.
MCOs don't always know if a participant went into the hospital.

A lot of times Medicare is the primary payer and that is who the hospital deals with so this is something we can discuss and I'll continue to work with policy and see how we want to clarify this so there is some process in place for MCO to follow.
>> Appreciate that.
Thank you.
Is that everything on this slide?
Are there other questions on trigger events?
This follow up written guidance is the last thing we had on this topic.
>> Okay.
>> No.
>> AMY LOWENSTEIN: It says it can take 15 days for PCSP to be finalized in our experience there is not much that gets changed but the time tends to get taken is there a reason? Would it be possible to shorten that time frame?
>> RANDY NOLEN: We've discussed that for future agreements and any changes will be in 27 agreement. But we can have discussions about that.
If there is little or nothing that changes it should not take 15 days to review.
When they're looking to add services it may take longer they should be able to turn these things over quicker so we can look as we go forward.
But.
Certainly.
You know.
Again, as we do clarification you have to move it along.
>> Thank you.
>> Thank you.
14 days is a little bit too long okay?
That is wonderful.
>> You can move on.
>> Next slide.
>> This is still trigger events we'll move to next slide.
What we're going to do now is have a little discussion about 2024 community health choices participant grievances and fair hearings and external review numbers I'm going to turn this over to Colleen Miles and Brian McDay.

- **CHC Appeals Data**

>> COLLEEN MILES: Good afternoon, it's my pleasure to be-to-present our 2024 community health choices participant grievances fair hearings and external review data. My name is Colleen Miles for OLTL and work behind the scenes compiling data reported and I'm going walk through data and we can go to the next slide.

Just to start with basic information to begin with grievances and just discuss what constitutes a grievance and in shorts is a request for recreation of a decision when there is a denial based on medical necessity sdp effectiveness of service.
Next slide, please it is important to know who can file a grievance.
This should be done within 60 days to deny a request either fully or in part in the next slide.
We'll begin reporting our data with statewide grievances.
And, calendar year 2024 statewide, we did see a 6.9 increase which is on track with prior year grievances and reflective of our enrollment data.
RPTT is a way to calculatation that allows compare sons across and we can see here, we're on track.
Next slide, please personal assistance services is thes number one grievance filed by participants.
We call this PAS services and PAS is one of the most utilized services for CHC and is due to reductions in or denial of hours and following slides will demonstrate consistency across all three CHC, MCOs statewide and as you saw with mirror health, PAS is the top grievance issue for Pennsylvania health and wellness and next slide.
Next slide and we see that is 91% being pass related.
>> I don't know if it's possible to go back per 10,000 slides.
There is a fair amount on this.
This is OLTL and we see second line and then, UPMC.
Can you explain what variance columns mean again?
>> So is a percentage difference and it is our PTT between each calendar year.
Each of these line is a unique number so our rate used for grievances is OLTL distinct count logic enrollment counts so these are counts for when a participant is active if that is kind of what you're looking for, we have to take each line in, and of itself.
>> This is helpful to air grievances.
Is that --.
>> Yes.
They had a reduction in grievances to 507.5 I'll ask there is a bit of a lag on the data.
And miss Mathis has a question.
>> MARSHA WHITE-MATHIS: Can you hear me?
>> Yes.
Just fine.
Thank you.
>> This is just in my head, does this show if there is a call to complain, because someone does show up to fill the hours, for example?
>> This is different and I wanted to explain a denial of services.
That is when your service coordinator asks for a service to be approved and CHC, MCO

does a review and determines appropriate amount of hours if any will be approved.
What you're discussing will be considered complaint an individual with approved services but, service care worker is not attending them appropriately.
In that case participant would need to take initiative to reach out to their CHC-MCO and ask to file a complaint that would prompt that to look into why they're not getting services as approved does that answer your question?
>> It does and thanks for straightening it out.
>> It's okay.
It's a lot.
That is okay.
>> Thank you.
>> Sure.
>> Any other questions regarding this particular slide?
>> No.
Thank you.
>> I believe where we're leaving off was moving on to slide nine.
Sorry.
Mistaken.
Slide ten.
Okay.
So.
Now we're going to move to grievance decisions if a grievance results in a full or partial overturn of a previously issued denial, it's considered to be resolved in favor of the participant.
In calendar year 2024, the year date decided in favor of participant was 21.7%. If not fully or partially overturned grievance is considered to be resolved in favor of the CHC-MCO so in calendar year 2024 the year to state were 78.3% are we on the same slide?
I'm on slide 13.
>> We're on track that is perfect.
CHC waiver measure tracks and trends number and percentage of grievances resolved within required time frames.
Time frames for grievances to be resolved are 30 days or less. Or, in the case of a request or extension 44 days or less.
And all CHC exceeded the bench mark.
And if there is no questions we can move to next slide.
And fair hearings are a type of external review conducted by an administrative law judge and external review is like a fair hearing conducted by independent review entity an participants have a right to request both when a grievance is not fully in their favor and can

with conducted consecutively or concurrently F there are no questions we can move to next slide.
Okay.
So.
In 2024, we had 2138 state fair hearing requests.
And sometimes, what happens is CHC-MCO reach an agreement or may reconsider their decision to go forward with the state fair hearing and in these instances request may be withdrawn by the participant so in 2024 there are 1030 requests withdrawn prior to hearing state date scheduled and that leaves with us next slide.
So this slide then is how many decisions were made and there decisions reached statewide and if we move onto the next slide in 2024, 54 or 18.9% of the cases were decided in favor of the participant.
One more slide down, please.
And in 2024 there were 232 -- or 81% of the state hearing stations made in favor of CHC-MCO.
Do I have questions before moving into external reviews?
So in 2024 there were 3402 external reviewed decisions reached.
Next slide.
915 decided in favor of the participant.
Next slide.
2487 or 73% decided in favor of CHC-MCO.
And our last slide here a questions regarding information I've presented today.
>> That is a lot of information it might take time to digest some of this.
There was one slide if there is time.
>> Sure.
>> Do you mind going back?
>> Go ahead, go ahead.
>> I believe it's slide 19 on the slide deck here.
Did woe have a chance to go over this?
>> It might have.
Let me just find that.
>> Grievance decisions can be made in favor of the CHMCO meaning it did not result in approval of requested service and can be partially in favor of the for days pant which means it resulted in full approval of requested service if you look at the slide 11,492 grievances were decided in favor of the CHC-MCO.
And do you have questions about this slide?
>> I do appreciate you covering it.
We have had discussion around parsing out that distinction so it's useful to see that and

understanding how well participants are faring and I'm sure we'll spend more time on it.
I am not sure if members have questions?
>> I think for us I think what it was a lot that we have to digest I think that we should come back if we go back and if we have questions we can send them.
That would be best for us.
Yes and feel free.
I don't know if you're able to provide information on how to reach out to me with questions?
>> We'd go through normal staff.
Thank you..
>> I'm sorry I wasn't sure this is my first time presenting to this group.
>> We appreciate you coming on to give us this information.
>> Thank you.
>> We'll probably have you back.
Look forward to that.
>> I look forward to it as well.
And I enjoyed talking with you.
>> Thank you.
And anyone else have questions?
>> Thank you.
Thank you.
>> Thanks again.
Anyone else have any for our great friend Randy?
>> RANDY NOLEN: There are communications we wanted to highlight.
Concerns with increase in COVID-19 cases we released a LISTSRV there is a sharp increase in positive tests in PA.
And current vaccine does protect against the variants and department of health encourages people to get the vaccine and if you have any questions we gave contact number for health department we're seeing a marked increase at this point.
Next communication is about a foundational leadership in HTPS certificate program.
This is an announcement from states in the university of North Carolina to create a first of it's kind online training program to support our work force.
It's a course to give accreditation for work they do.
It's online.
Self paced should take two hours a week and ten weeks long.
Participants will learn about population utilizing services.
Organization for writing services and variety of funding so it's a good educational course.
That is available outthere.
Next list SRV on federal on electronic payments recipients of electronic benefits SDI, SSI

and railroad or veteran benefits no longer getting paper checks.
The beneficiarys so if you know they need to make sure they sign off to make sure they get their payments. There are a few exceptions.
Anyone over 94 is going to be rare and federal government is making everything electric now.
People can use direct deposit to get their income.
And they can use a direct express card.
This is people need to make sure they get that completed.
What is needed to get smoke alarms.
American Red Cross is looking for volunteers to by calling the number.
That is online.
So this is a good way to get smoke alarms.
October is national disability employment awareness month.
And this is just awareness created in 1945 and to challenge any stereo types in the work place.
Strategies to build a more inclusive society.
Encouraging dialogue among policy members trying to influence policy changes.
And during this month this is a good month.
Last slide talks about web sites.
There is a couple videos out there you can see about national disability employment awareness month there is one on department of labor.
YouTube and more information about national disability employment awareness website.
Good information for people to follow up if they have a desire to look at that and have questions.
That brings me to the end of the presentation.
Again I apologize for my audio problems I'm going to have to figure out what is going on.
Thank you if if you have questions I'm here.
You guys know how to get a hold of me.
>> Thank you.
We do appreciate you.
Do we have new or old business?
>> I think so.
>> We don't?
>> I think we do not.
>> SONIA BROOKINS: Okay.
Thank you for that.
I want to thank you all for being on this call.
We might see you next month if not we'll be virtual again but don't know.

As of now we won't be so we don't know.
Thank you.