

Consumer Subcommittee of the MAAC
January 21, 2026

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

PHLP representatives present: Kyle Fisher; Danny Casserly; Amy Lowenstein.

DHS representatives present: Sally Kozak, OMAP Deputy Secretary; Juliet Marsala, OLTL Deputy Secretary; Gwen Zander, OMAP Managed Care Bureau Director; Scott Cawthern, OIM Chief of Staff, Elise Gregory, Human Services Analyst Supervisor.

Special presenters: Chelsea Miller, Behavioral Health Regional Manager, Nicole Matrey, Senior Health Services Specialist and Katrina Dessino, Health Services Team Leader

*Due to technical issues, Consumer Subcommittee (ConSub) support staff were unable to access the attendee report for the January public meeting.

The meeting was called to order at 1:00pm

>> ELISE GREGORY: Good afternoon and welcome to the January edition of the consumer subcommittee meeting. Today is Wednesday, January 21st, 2026. My name is Elise Gregory. I would like to go over a few items. This meeting is recorded. Your continued participation is your consent to being recorded. You may end your participation in the webinar at any time. Also, per DHS policy, the use of artificial intelligence or AI for note taking or for any other purpose is not permitted. AI bots in attendance of meeting had be removed. For panelists and speakers, if you're experiencing audio issues, please go to the top, right corner to find the gear wheel to adjust settings to the correct microphone and speaker hardware. If you continue to experience difficulty, please send a message in the chat.

To help avoid any disruptions, keep your microphone muted if you're not speaking. Live captioning, also known as CART captions are available for the meeting.

The link is included in the chat. Presenters should state their name clearly before speaking to assist the captioner. Representing the department of human services today, from the Office of Medical Assistance Programs, deputy secretary Sally Kozak, deputy secretary Juliet Marsala and chief of staff, Scott. Chelsea Miller, Nicole Mattery, Katrina, and UPMC,

Dan Lavalley, I'm sorry if I say your last name wrong.

>> SPEAKER: That was perfect.

>> ELISE GREGORY: Questions may be submitted in the questions tab of the webinar. If you have any questions related to the meeting or need additional information, please visit the consumer subcommittee web page. I'll hand things over to the committee chair, miss Sonia Brookins.

>> SONIA BROOKINS: Yes. Good afternoon, everyone. Again, I made a mistake and I'm accountable for it, but want to say good afternoon and welcome to everyone to the consumer sub and happy new years to those I didn't say it to. On that note, you can take over.

>> SAM CHANEK: It is a rocky technology start here this afternoon.

>> KYLE FISHER: Folks just heard the chair, Ms. Brookins.

I'll go through the members of the committee. Third time is the charm. Let's start here with Bethany. Do you have audio?

>> BETHANY PANCOAST: Yes, I do, I'm here.

>> KYLE FISHER: Jayme?

>> JAYME SCALI: I'm here.

>> KYLE FISHER: Liz Healey?

>> LIZ HEALEY: I'm here, Kyle.

>> KYLE FISHER: Very good. Spencer Duffee?

>> SPENCER DUFFEE: Yes. I'm back on.

>> KYLE FISHER: All right. Thanks, Spencer, and your video is on, just so you know.

Meghann Luczkowski?

>> MEGHANN LUCZKOWSKI: Hi it is Meghann in from Philly.

>> KYLE FISHER: Rochelle Jackson?

>> ROCHELLE JACKSON: Present.

>> KYLE FISHER: Ronel Baccus?

>> RONEL BACCUS: I'm here.

>> KYLE FISHER: Do we have Marsha White-Mathis? All right. Marsha may still be coming back on. Minta Livengood? Deb Shoemaker?

>> DEB SHOEMAKER: Good afternoon.

>> KYLE FISHER: Great, thanks, Deb. Any members of the committee who I have missed? Okay. Kyle Fisher with Pennsylvania Health Law Project, counsel for the consumer subcommittee here and couple others from PHLP. Danna Casserly? And Amy? I think Amy had connection issues as well. Try one more time. Amy Lowenstein? All right. And do we have Marissa? Okay. I believe that is it for consumers and counsel. I will pass it back to you, madame chair?

>> SONIA BROOKINS: Yes. Next on the agenda is OMAP. Spencer, can you cut your camera off, please? You don't have to be on camera.

- **OMAP Report**
 - **Deputy Secretary Updates**
 - **H.R.1 Updates**

>> SALLY KOZAK: Good afternoon, everybody. We have a couple of things that folks wanted to hear about. H.R.1. I'll talk first about the impact on Medicaid eligibility, and then I'll have a little bit of an update on the state directed payments and hospital assessments, talk a little bit about the rural health transformation plan and then prior auth of GLP-1s and I think Gwen is on to talk about some health issues and I understand we have folks from Geisinger and UPMC that will talk about some of the initiatives. So let me go ahead and get started. Regarding H.R.1, I think folks have heard me and the people from The Office of Income Maintenance that SNAP is our priority. SNAP changes took effect beginning in December, December of this year or October of this year, I forget, but they're already being enacted. Once the SNAP work requirements are in place, then we will begin to focus on the Medicaid work requirements which have to be enacted by December 31st, 2026. We are using the lessons that we learned from the unwinding to help us with our SNAP work, and as we move forward with the SNAP work, we will use the lessons learned, particularly around program areas as they all come into compliance with the Medicaid work requirements.

Just, as a reminder for everybody, and again, I think folks know this, but the new Medicaid work requirements will require adults to complete 80 hours per month of community engagement or work. Community engagement can include education or community service, and those had all be conditions of eligibility. We also know that there will be some exemptions for certain adults, those that are medically frail and we are still awaiting additional guidance from CMS on how it is that they will look at that. The other part of H.R.1 that will impact Medicaid eligibility is the implementation of six month re-determinations for adults. That also has a start of December 31st of 2026. We had been working on technology changes and resource impacts to complete the redeterminations to make it easier for consumers.

We will be convening a stakeholder group for the changes and members of the MAAC will be represented on that group, and then in turn, members of the MAAC and ConSub can provide updates to the respective groups and bring the input of the subgroups to the H.R.1 stake holder group.

The planning for all of that is currently under way, and we expect more information on exactly what that work group will look like and how it will operate to be released in short-

term, so I would look for probably end of February, mid-March or so for additional information on that.

So that is the update on SNAP and Medicaid work requirements.

>> KYLE FISHER: The chair may have a comment here. I got pulled away a little by membership joining issues. I wanted to recap. It sounds like you mentioned that DHS will be convening a stake holder group that will include some members of this committee and the larger MAAC, and that more details around that will likely be released next month. Did I capture that right?

>> SALLY KOZAK: In the short-term. I would say probably more towards the end of February, mid-March. I know that conversations are ongoing, but don't quote me on that as an exact date.

>> KYLE FISHER: And you mentioned, I think I may have missed some of this as well. Technological impacts, they have raised the possibility of automating some of the exemptions with an eye towards hopefully automating some of the work requirements as well. Can you just go back over some of the tech changes, IT, landscape survey, and if it involves procurement of vendors or some of the next steps that are already happening?

>> SALLY KOZAK: Let me say this. Our IT department has been working to see how it is that we could from a systematic perspective identify individuals that could potentially be exempt from having to complete the re-determination every month. For example, people with diagnosis codes that meet the medical frailty guidance that CMS will be issuing. They're looking to also see what other information streams we're able to pull together to facilitate the making of those determinations. I don't have the specifics on that. That is probably something that we can have the IT folks come talk about. I hate to summarize for them, given that I'm not an IT techie. I know just enough to be dangerous. But they are working on it.

>> SPEAKER: Okay.

>> SONIA BROOKINS: It would be good for them to talk to us about it. When the time is right.

>> SALLY KOZAK: We'll reach out to Alicia and see if they can come, probably to the MAAC so everybody can hear it.

>> SONIA BROOKINS: That's fine.

>> SALLY KOZAK: Sure. Any other questions about the Medicaid work requirements and the SNAP requirements?

>> SONIA BROOKINS: No.

>> SALLY KOZAK: Okay. So then let me talk a little bit about the fiscal impact on hospital assessments and state directed payments for H.R. 1. I think most folks are aware that a large portion of our program is funded through assessments. We have a hospital assessment, a manage care assessment, and then we also have the Philadelphia hospital assessment, which is in particular, the funds go just to the Philadelphia hospitals.

During 2028 or beginning in 2028, through 2030, H.R.1 requires that states decrease assessment amounts to no more than 3%. All three of our assessments, the Philadelphia assessment, the managed care assessment and statewide hospital assessment are all over the threshold. So a significant financial impact, as we will not be able to raise and get federal match on existing revenues to fund these providers in the Medical Assistance Program. So we will see our revenue decrease as a result of having to decrease the amount of the assessment.

With the assessment dollars, we make payments to hospitals and other provider types, and we do this through what are known as state directed payments, meaning that we say x amount of dollars has to go to the hospitals. X has to go to whoever.

Currently, we can make a state directed payment that is up to the average commercial rate, which is, everybody knows, is above Medicare and above Medicaid. However, by 2030, we will no longer be able to make a state directed payment that is any higher than the Medicare rate. So we will begin to see a decrease in the amount of dollars that are also flowing to individual hospitals through the payments.

In addition, CMS has added conditions to the payments that are different than what they currently have in place. We now have to require -- we are now required, sorry, to tie these directed payments back to provider measures that show improvements, and these have to be very specific. Currently, we can use measures like improve access to care or maintain access to care. Going forward, we're going to have to say improve access to care by increasing the number of providers participating in the program by 10%, as an example. There is a little bit different set of requirements around what the quality tie backs have to look like. In addition, if we do not make the improvement promised, they could take back the funding that we made to providers. So that really changes the way that we will have to do our state directed payments.

At the end of the day, what this all means is that the H.R.1 changes mean that there will be less funding available for the Medicaid programs in the future. Folks frequently ask me what that means in terms of dollars, and I will say that we continue to evaluate that. I do not have any specific dollar amounts for you at this time. It will really depend on where we're at the the time that all of these changes take place.

Questions about that before I talk about the rural health transformation plan?

>> DEB SHOEMAKER: Hi, Sally, this is Deb. Thanks for all of your hard work. I appreciate it.

>> SALLY KOZAK: You're welcome.

>> DEB SHOEMAKER: I know you can't give us an amount, but, like, at the current time, how much above 3% are we?

>> SALLY KOZAK: I don't have the exact numbers on me. And I should, because everybody always asks me that question. Our hospital assessment is right around 5.2, 5.3%. I think the Philadelphia assessment is just a little bit higher, and I'm not sure about the MCO assessment, so at least with the hospital assessment, you can see we're going to go from 5

down to 3, so that is at least a 2% decrease, so that is a nice little --

>> DEB SHOEMAKER: Right. It is significant, especially when you're going to talk about the next topic where rural health hospitals already had, I remember, I think a percentage before that there were over 20 hospitals already in trouble before, you know, a risk of closure before H.R.1 went into effect. So obviously we want to help you as much as we can, but that is a significant issue. So I'm sure we will want to talk about ways in how we can assist in trying to fill gaps and concerns about the next budget, but we'll see how that shakes out. Thank you for your hard work. I wanted to get an idea. 2% is too much. 1% is too much.

>> SONIA BROOKINS: On this note, and I know, it is sad, but we know you have to -- we all are in this. This is not a thing that you want to do. This is something that is happening. But, on that note, with all of these decreases, that means it will be hospitals can decrease care. I know we don't want that, but I think with these kind of cuts, that is what is going to wind up happening. I hope not, but that is what I think. That is what is happening with the cuts.

>> SALLY KOZAK: I think there is a whole set of reactions that will happen as a result of the changes in eligibility and the changes in funding, and I think you've heard various folks from the administration talk about this and say this. As people lose eligibility, they're going to not seek care. They're going to wait until they get really sick and end up in the emergency room or in the hospital.

Clearly with EMTALA laws, we know the hospitals are going to at least treat and stabilize people. We know that we will see increases in uncompensated care and that is not just on the Medicaid side of the program. That will be for the non-Medicaid population that is having difficulty purchasing healthcare as a whole.

We know that as hospitals provide more and more uncompensated care that even those hospitals that are right now in, you know, at least stable financial condition are going to face financial hardships. And so we know that they're going to be extreme disruptions to our healthcare system. It is not just in Pennsylvania although that is clearly where our focus is. It is going to be a national problem.

>> SONIA BROOKINS: Sure. Sure. Okay.

>> KYLE FISHER: I appreciate you highlighting the state directed payments and the provider assessments. I think you had shared an earlier meeting, an estimate of roughly \$20 billion over ten years as the H.R.1 impact in lost revenues for the state Medicaid program, and I think that estimate was largely tied to the provider assessment hold harmless threshold being reduced. CMS issued new guidance, I think in November, on provider taxes. Is DHS budgeting, is it revisiting that \$20 billion number to potentially make changes based on the more recent guidance?

>> SALLY KOZAK: I have to be honest, I'm not sure what you're talking about with the \$20 billion. Our program is right around \$18 billion. The hospital assessment funds about 2 billion. Maybe that is what you're talking about.

>> KYLE FISHER: When you shared the estimates, the H.R.1 estimates of a loss of 310,000 enrollees coverage wise with the work requirements. At that same time, you shared the \$20 billion estimate in terms of lost funding, federal funding, I think possibly also assessment dollars as a result of this threshold reduction. That is the reference. An average of \$2 billion a year.

>> SALLY KOZAK: I think I know what you're talking about now. Those were the very, very early, and very preliminary, back of the neck, and so to speak, math at the time all of this was being introduced as to what the potential impact to the commonwealth could be. Those were not officially calculated numbers, so to speak. We were waiting on the specifics. That is the potential that could be happening within the commonwealth. As I said earlier, we, I mean, clearly we look at it, and we're having internal conversations about it, but to say the exact number is going to be x is going to be difficult until we see what happens going forward. And until we see additional guidance from CMS. We're expecting additional guidance around exemptions for eligibility, particularly around the medical population. We're expecting additional guidance to come out around assessments, they had said, perhaps in June and we're waiting for additional guidance to come out around state directed payments.

>> KYLE FISHER: Okay. And I guess, despite waiting for the additional guidance, it sounds like conversations are already well underway with sort of, for instance, the IT team, and evaluating the state's capacity and the need to make tech infrastructure changes to be able to implement all of this before this rolls out.

>> SALLY KOZAK: Our focus has been on SNAP, again, because that had to happen first. Our next focus will be on the Medicaid eligibility, and the coming changes. Again, the financial changes that happened don't begin happening until 2028, so we still have time to do that work. We could do a whole lot of work right now and the environment can change tomorrow. So as we move forward, we are being thoughtful, and clearly trying to be anticipatory and still being efficient with the way we're approaching this. We have limited resources, as you know, and we can spend a lot of time spinning our wheels, and we have heard that other states are out there with all of these, you know, estimates and, you know, we have chosen to be sequential and methodical.

>> KYLE FISHER: I appreciate that. I guess the one last question I had, going to I think pretty undeniable reality that the budget is getting tighter as the provider tax changes are implemented over the next couple of years, as the department is considering policy decisions in response to that, changes to potentially optional service categories, eligibility groups, are some of those considerations or discussions going to be shared with the stake holder work group you mentioned a few minutes ago for discussion and feed back?

>> SALLY KOZAK: Absolutely. That will be the focus of the stake holder group to help the department make those types of decisions. And I think folks have heard the Secretary say this in conversations. These will be very difficult conversations in terms of the impacts to

the program and how it is that we address them and how it is that we continue to ensure that the individuals that need these services are able to continue to receive them. So definitely, the stake holder group will be part of those conversations.

>> KYLE FISHER: Glad to hear that. Thank you.

>> SALLY KOZAK: Sure. Okay. Well, then, let me give you an update. I think we're supposed to be on slide four or slide five right about now. About the Rural Health Transformation Program. CMS, in December, December 30th, I got the email. Was awarded 193 million plus a few extra dollars in federal funding for the first year. Just the first year, and approved five year rural health transformation plan. The goal of CMS in establishing this money and granting it out was to help states foster innovation and improve access to essential health services in rural communities that we know definitely are going to be most impacted by the federal spending cuts to the Medicaid program.

So as we know, H.R. 1 or H.R. 1 established the RHTP in a reconciliation bill, and it awarded \$50 million nationwide to support rural health, just so folks, as a reminder, this is not a Medicaid-funded project. It is just a federal grant program. However, with the approved funding, we will work with some established economic development entities through our regional care collaboratives, which will help us guide the rural health projects in funding for the regions. If folks are not aware, and I think folks may have heard me say this. At the time we applied for the grant, Pennsylvania was in a really good position. When the Shapiro administration came in, we were at the beginning of the wind down of the Rural Health Program, and so we took that opportunity to begin to talk about what is next, and so through a series of meetings, there were a number of regional collaboratives that were developed that are focusing specifically on the rural health needs in the rural communities. Those initially started out with just conversations with the hospitals, and they have since expanded to a wide array of individuals within the impacted communities, including commissioners, some of our legislators, businesses, the hospitals, county entities. So we were already in already in a good spot.

As a result of that, we will use the initial funding to establish rapid response stabilization grants to support work that was already happening in the local communities. So, in other words, shovel-ready projects.

The funding is renewable over five years, and so we will have an opportunity to secure additional funding based on program performance and how well we do at getting the money out the door, and this initiative, which is a grant initiative, is being led by our Office of Policy Development within the Department of Human Services, although the programs funded could be cross departmental. We were excited to hear that we got \$193 million. Any questions about that? While it seems that we got less than other states on a per capita basis, we did pretty well.

>> SONIA BROOKINS: Wonderful.

>> DEB SHOEMAKER: I have a quick question. This is Deb. Sorry. Just curious, because I

have been following, but haven't been following previous to this grant funding. When you said there is already rural health, like, hubs or places already regional, how many are there already? Do you know?

>> SALLY KOZAK: Just so you know, regional can include multiple counties in multiple hospitals. I'm aware of three main ones, but there may be some sub ones. Eve, can you have somebody put the website to our Rural Health Transformation Plan in there? The rural health plan we submitted to the feds is online.

>> SPEAKER: I've read it, but I have to look again.

>> SALLY KOZAK: That has more detail in it. It also has the five areas that we chose to focus on, and they included maternal health, behavioral health, work force development, transportation, I think, and I always forget what the fifth one is, but it is out there on the website.

>> DEB SHOEMAKER: Okay. And when you said about the meetings that they have, how much, do you know, what consumer involvement is involved? I know you talked about businesses and other things, because I'm sure that we're always -- anybody on our work, on the committee, subcommittee would be willing to assist, depending on the area. I'm curious, since, again, I'm getting up to speed on the rural stuff. I was focusing on other stuff like what kind of consumer involvement has been in the meetings.

>> SALLY KOZAK: Let me say this. As we talk about rural health, we don't just talk about Medicaid. I mean, it is commercial population. It is Medicare population. It is the Medicaid population. It is the uninsured population. So, yes, all of those meetings were open to the public to attend. How much or how many members of the public and what constituency, I don't have that information, but we can go back and ask that question.

>> DEB SHOEMAKER: Okay. Thank you. This is related to some work that Lisa Davis has done.

>> SALLY KOZAK: I don't have that answer, Deb.

>> DEB SHOEMAKER: Okay. It is okay. I can find out. Thank you.

>> SALLY KOZAK: Sure.

>> LIZ HEALEY: This is Liz Healy. When you talk about shovel-ready, I assume you're using that as a metaphor and that these funds primarily would not be used for construction of new facilities. Is that right?

>> SALLY KOZAK: There were limitations to the grant by CMS on how the money can be used in terms of the hospitals, particularly around hospital infrastructure, so there were restrictions on that. However, when I say shovel-ready, I mean initiatives that were ready to go, and I'll give you an example. We were aware that there are some organizations out there where maternity access is less than it should be have said, oh, we can do what they call a mom mobile or a mobile maternity unit. We're ready to go. We just need the funding for the actual vehicle. So they have a plan. It is things like that where people are ready to go.

It is just that they need money. So shovel ready is not tied to the facility.

>> LIZ HEALEY: Thanks, Sally.

>> SALLY KOZAK: Yeah. Maybe I need to find another term to describe it.

>> SONIA BROOKINS: I understood it.

>> SALLY KOZAK: Particularly with the first year, we have a deadline on how fast we have to get the money out. That is why I say we're looking for those initiatives that are ready to go on day one.

>> SONIA BROOKINS: Right.

- **GLP-1 Coverage Changes**

>> SALLY KOZAK: So let me talk about GLP-1s. As everybody knows, effective 1/1/26, Medicaid program was no longer covering GLP-1s for the treatment of obesity. As a reminder, we covered it for diabetes and other medically accepted indications and we do have Prior Authorization requirements in place. All individuals that were using a GLP-1 as of January 1st were required to have a new Prior Authorization in place regardless of current or past approval status. There was no grandfathering of existing approvals. We did, the one exception to that is the EPSDT, which children under the age of 21, because they get all medically necessary services regardless of whether or not it is a covered benefit under our state plan. We did send notices to individuals that were on it and the managed care MCOs also sent notices to individuals that were on the GLP-1s telling them all of this.

We have informed the physical health manage care plans about the reminder for EPSDT and that they had to continue to provide all medically necessary services to children under the age of 21, so we did reiterate that, and Kyle, I know you had a question about that as we were going through the process.

We issued a bulletin on November 24th advising providers of the changes as well as the revision to the prior auth guidelines. A Public Notice was published on December 27th announcing that GLP-1s will no longer be covered for the treatment of obesity, and we also submitted a State Plan Amendment to CMS on 12/30/25 to update the coverage of GLP-1s, and that is currently with CMS for review.

Just to give you some idea of where we are in terms of appeals or complaints, and this is through the first full week of January. We had a total of 1112 appeals that were filed. Of these, 68 were for members under the age of 21, and the remaining 1,044 were for adults. Over 900 of those were filed as complaints appealing the initial notice indicating that current authorizations would be ended, and the remainder were grievances of subsequent denials of new requests for Prior Authorization. So we have been looking at the data as well as pulling sample cases to ensure that the coverage of the drugs is being appropriately

provided during the time that the appeal has been filed and until it goes through the process.

So that is where we are in terms of GLP-1s.

>> SONIA BROOKINS: Okay.

>> SALLY KOZAK: Questions?

>> SONIA BROOKINS: Who wants to go first?

>> KYLE FISHER: We did have a good amount of conversation on this earlier this morning, and I appreciate you confirming here, clarifying again that EPSDT exception and the obligation on the part of the MCOs to provide the services where medically necessary even where prescribed for weight loss purposes for the young adults under age 21.

Just sort of unpacking of the other information you provided and I think we have feedback in terms of what we learned about MCO practice on the ground. One other item I wanted to touch on first was the general EPSDT guidance or obligation. I know we had some talk previously about an EPSDT bulletin. Is the department going to be reissuing or issuing an updated EPSDT bulletin generally so that there is written guidance to refer to by providers or the MCOs?

>> SALLY KOZAK: You know, we can reissue the old bulletin. It will not contain anything particular to GLP-1s, but it will say that children get all medically necessary services regardless of whether or not it is a covered benefit. Eve, correct me if I'm wrong. I believe that is what the previous bulletin said.

>> EVE LICKERS: Yes.

>> SALLY KOZAK: We can certainly reissue it again.

>> EVE LICKERS: And we're actually looking at that right now and also in the context of some of the new areas that CMS is looking at, so we want to make sure that when we come out of the gate that we have -- that we have hit all of the areas that we need to, but it is certainly something that we're researching and looking at right now. Thank you.

>> SONIA BROOKINS: Let me just say this. That is fine, well, and good, but I'm going to say this, because I don't want to call these folks out. So what I'm going to do is, Sally, and whoever you need, that let's have a conversation with y'all first because we have some more information that we did not share with you, so I don't want to call the MCOs out right now, but once I talk to you, and whoever else, and then we can go from there, because I think that you saying one thing, you know, and they're doing, you know, what they think they're doing, and right now I just need to talk to you and whoever else, Kyle, and whoever else that you have on the team with that is dealing with this so that we can tell you what we got and then we can go from there and then y'all can make the recommendation, because I don't want to call them out because I can, but I don't want to put them on blast. That is what I want. I want from that. That is what I want.

>> SALLY KOZAK: Okay Laina would be on the listening side. So we'll have somebody reach out to set that meeting up.

>> KYLE FISHER: And I think that makes sense. We can share some notices or at least redacted notices before that to show you what we're seeing on the ground as well.

>> SALLY KOZAK: Sonia, in the next two weeks?

>> SONIA BROOKINS: That is fine.

>> SALLY KOZAK: We'll set that up. She is pinging me right now telling me she heard it.

>> SONIA BROOKINS: Tell her thank you. All right.

>> ELISE GREGORY: We have a question. Does the GLP-1 -- apply to CHIP?

>> SALLY KOZAK: No. Is Nicole on?

>> SPEAKER: I'm here.

>> SALLY KOZAK: The CHIP plans were not covering GLP-1s to begin with for obesity, right?

>> SPEAKER: I'm having a hard time hearing you with my network.

>> SALLY KOZAK: I said the CHIP plans were not covering GLP-1s for obesity to begin with, correct?

>> NICOLE HARRIS: You're correct.

>> SALLY KOZAK: Yeah. So, no, it does not apply to CHIP. Just as a reminder for folks, our CHIP program, while it is subject to some of the same rules as Medicaid because we have a free CHIP component to it, it also operates as a commercial program. Pennsylvania is one, I think, of three states that operates their program as a hybrid. Somewhere between Medicaid and somewhere between commercial, and as a reminder, because we operate our program that way, there is no child in Pennsylvania that is not eligible for CHIP. And so for that reason, there are slightly different sets of coverage requirements and so that is why the CHIP MCOs were not covering GLP-1s to begin with.

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

>> SALLY KOZAK: Does that answer the question? I apologize, I forget who asked it.

>> DEB SHOEMAKER: Plus, this is Deb, plus, if my mind serves me correctly, there is a difference between CHIP goes to 18 and EPSDT goes to 21. So there is a difference there, too. Just to keep in mind.

>> SONIA BROOKINS: Thank you for that.

>> SALLY KOZAK: Sure.

>> SONIA BROOKINS: Is that all you have for us, Sally, for today?

>> SALLY KOZAK: That's it. I have a slide here that says break for OIM report, and then I also have a slide here that says Gwen will talk about health choices issues. So I'll let people smarter than me --

>> SONIA BROOKINS: Thank you. I appreciate you, Sally. Thank you.

>> SALLY KOZAK: Thank you, Sonia.

- **OIM Report**
 - **Mail Issue & Delayed Notices**

>> SONIA BROOKINS: OIM? Scott?

>> SCOTT CAWTHERN: Can you hear me all right?

>> SONIA BROOKINS: Yes, how are you?

>> SCOTT CAWTHERN: I'm doing well. I hope everyone else is doing well as we brace for what ever might come this weekend on snow fall for the moment. I'll be happy to talk through the OIM update based on the questions that we received specifically related to the mail issue that we experienced throughout the month of November into early December.

So first bullet point asks about the status of mail delays described in the Philadelphia Enquirer impacting 1.7 million pieces of DHS mails.

The mailings and text messages affected recipients were sent and the staff had been going through case reopenings, reviews, and taking action as necessary to ensure that the budgets are processed and are correct. If we don't receive anything after the text

messaging and mailing and contact with the recipient, we are taking action to close if the recipient hasn't provided us the information that we need to establish continued eligibility.

The next bullet point was provide an over view of the CAO actions for consumers that did not receive proper notice before the MA or CHIP benefits were stopped or reduced. When the mail vendor issue was discovered, OIM directed cases to remain open. The cases were granted the deadline extension of a month to required materials. For those affected cases that were closed before the direction was issued, we directed workers to reopen the case and review to determine if outstanding documentation had been provided. If it had not and the person was no longer eligible in the case that was closed with appropriated advance notice and doing this also reset the timeframes for the cases.

The next bullet asked about how many MA and CHIP -- go ahead.

>> SONIA BROOKINS: Sorry. So how many people from the 1.7, how many people actually got -- how many in the back log. Do you have them numbers or you don't?

>> SCOTT CAWTHERN: I don't have the numbers because mixed in with all of the mail was just about everything that we send. So there could be renewal packet, SAR requests, late and incomplete SAR requests it could be a pending verification request for an application or renewal. So there was really a mixed bag of just about everything we touch that had, to some degree, an impact.

>> SONIA BROOKINS: So what about the ones that, let me, what about the ones that took the information and they still did not -- they still cut them off? I don't know why, but I'm just saying to you, what about those ones that took it in and they still didn't get -- they didn't get the benefits?

>> SCOTT CAWTHERN: We would need to take a look and see if those cases -- that should be exceedingly infrequent that someone would bring their information in and then we not take -- and then the county themselves not take action. Certainly if you have specific examples where someone said, look, I took everything in, we would want to take a look at

those and do a review, and make any necessary corrections.

>> SONIA BROOKINS: Okay. I'll make sure you get the information. It is from another county, but we'll make sure. So Minta, you make sure you give us that information so we can get it over to Scott. Okay. Go ahead, Scott. Thank you.

>> SCOTT CAWTHERN: Absolutely. Anything that you have like that, we'll take and take a look at it. Based on the mailings, we had specific mailings that we sent to recipients trying to give them an over view of what happened, what recourse they could take and what actions we were taking to try and mitigate the disruption that was caused by the third party mail vendor.

>> SCOTT CAWTHERN: Scott, if I can jump in.

It is Kyle. I appreciate all of the action the department has taken to sort of mitigate this problem after you discovered the vendor failure here. Appreciate for instance that you have directed the counties to restore all of these MA budgets where maybe there was a termination notice that went out during this time period. I guess two questions for you. We have had client cases that seemed to predate that November 3rd date that is in the info memo. It seems like the department viewed this as mailings between November 3rd and December 3rd, so where we have client cases with individuals reporting not getting a mailing, that might be from late October. Should we be raising those to your attention, someone else's? We think impacted by this vendor issue, but not necessarily within the parameters of the info memo?

>> SCOTT CAWTHERN: We would certainly want to take a look at anything that you have as an example and see what we could do to try and, you know, work with the recipient to mitigate any potential impact that might have occurred.

We are working with the November 3rd to December 3rd because that was the timeframe we had through the mail vendor. A myriad of things could have happened prior to that in the run up to October 3rd. I can't speak to whether it was a mail vendor issue. Could have been delayed in the post office. There is a lot that factors in. Again, we're working with what the, you know, was provided to us through DGS and their contact with the third party vendor. But certainly, any examples of that, we would want to take a look at and see what we could do, if there is anything we can do to try to assist the recipient.

>> KYLE FISHER: Thank you for that. The second one, going to the action that CAOs are restoring the budgets and in our own cases, the Health Law Project, we saw variability on how quickly that happened and Minta has raised cases out of Indiana county where there are some that possibly have not been restored. Is there a deadline -- is the expectation from the leadership that the county should have completed that activity by now?

>> SCOTT CAWTHERN: We're still -- depending on the county and the volume of work that is going through there and the ability of our processing centers to jump in and assist the larger counties, the Lehigh area, Philadelphia, Allegheny, so I think the expectation for OIM, and this address is one of the questions that was put on the agenda. This is an exclusively

manual activity that we're going through. We're projecting that we should be finished with this by the end of January, and so, and because it is a manual process, it requires 100 % case worker review involvement and data entry to correct or assist recipients who have been impacted by the delayed mail issue.

So we are continuing to chip away at that. Again, our goal, and this was part of my update coming up here, that we should be completed by the end of January.

>> AMY LOWENSTEIN: This is Amy. Thank you for the update and also the clarification on the number of the third date. We probably had three or four people who had notices dated October 23rd or 24th who suddenly got them mid-December, so we have worked those cases out. We can share them, but is DHS doing anything to see whether this really predates November 3rd to maybe look at case closures that had earlier dates, earlier mail dates?

>> SCOTT CAWTHERN: I can check with our team, but, you know, certainly as I said, a little earlier. If you're seeing those, you know, numbers, in cases where they have a date, late October that weren't post marked or anything like that, we would certainly want to take a look at those. You know, we can't speak to whether or not that there was any kind of, you know, run up where things started to slow down with a vendor. Again, we're working with what DGS provided to us as a date of November 3rd when they realized the issue and the span and worked with the vendor. To kind of outline the issue that was experienced.

>> SONIA BROOKINS: So Scott, okay. Amy, just get that stuff to Scott and then we can go from there. They might have to go back. Let's just get him what he needs to get for now and if they have to go back, they have to go back if they have more cases. If they have any old cases, they have to fix it.

>> SCOTT CAWTHERN: We will certainly take a look at that, and look at each one on its own to see, you know, what we can do.

>> SONIA BROOKINS: Okay. Anyone else have any questions for Scott?

>> ELISE GREGORY: We have one question from Jeff. Since the USPS changed guidance from post marks in December, are they making adjustments to the programs for notices and appeals?

>> SCOTT CAWTHERN: Yeah. That is a great question. At this time, we're not factoring that in. We need to kind of understand exactly what the impact is to our mail and the processes that we go through with, you know, the dating rules that we use whenever something, you know, a notice is created, the time it goes through our new third party presort vendor, and then until it is handed to the post office.

It is my understanding that when it goes through the presort vendor, and again, this is arm's length of understanding everything that happens to a piece of paper or an envelope whenever it is stamped and processed and ready to be put into the custody of the U.S. Postal Service that when we run it through the mail meter, that essentially serves as the post mark, so it is not that the post office affixes another post mark to it. I think that, and

again, it is my understanding that for someone who puts a stamp on an envelope and hands it to the post office, that used to be date stamped or cancelled when it first went into U.S. Postal Service custody, but those rules have been adjusted by the post office in terms of what date they're putting on it. But we can check and see, and certainly we're taking a look at, you know, this new process that the postal service has and wanting to make sure we understand the impact to the mail that we send.

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

>> SCOTT CAWTHERN: Sure.

>> ELISE GREGORY: There are no more questions in the chat. Jeff said thank you, Scott.

>> SONIA BROOKINS: Anybody have any more questions for Scott? Okay. Thank you so much, Scott. And we appreciate it, and hope for you to get back to us with the numbers. Appreciate you.

>> SCOTT CAWTHERN: Thank you very much. Have a great day.

>> SONIA BROOKINS: Okay. Gwen, you're up. Sorry about the lateness.

>> SPEAKER: No problem. Are you able to hear me?

>> SONIA BROOKINS: Yes.

- **HealthChoices Issues**

- **MCO Initiatives: Geisinger & UPMC**

>> GWEN ZANDER: All right. I think first up, actually, I'm passing the microphone to Geisinger to give their presentation for you all this month.

>> SONIA BROOKINS: Sure.

>> CHELSEA MILLER: Wonderful. Thank you. This is Chelsea Miller. Good afternoon. Thank you for giving us the time today to share an update on Geisinger Health Plans to support healthier communities through the comprehensive social needs strategy. I want to make sure everyone can hear me okay?

>> SONIA BROOKINS: Sure. We hear you.

>> CHELSEA MILLER: Thank you. I am Chelsea Miller. I'm a manager over seeing our social needs resource hub, and I'm joined today by Nicole and Katrina who will also be speaking to you about our mission and the work that we have under way. So at the heart of the mission is a simple commitment to identify the social factors that influence health and to connect members to trusted community resources and provide ongoing support to ensure those connections are meaningful and effective.

Supporting health and well being of communities that we serve has always been a cornerstone for Geisinger. Our efforts continue to grow through partnerships, expanded member support, and innovative tools that help us better identify and meet the needs across our service area. We're delighted to share more today the partnerships, the impact

work that we're doing to create -- from your membership and communities across the region.

If we can move to the next slide. As we're talking about the commitment to supporting the Medicaid members, I want to highlight the progress that we have made together in addressing health-related social needs. I'm sorry. If you can back up one slide for me. To date, we have completed nearly 897,000 screenings.

Which means almost 897,000 opportunities to hear directly from the members about challenges that they're facing, so things like food insecurity, housing instability, transportation barriers, and more. Our screenings help us to better understand what is impacting our members beyond just their medical care. And with that, we've built 61 formalized partnerships with the community-based organizations across Pennsylvania to help address the needs around housing, food, and those SDOH needs. These partnerships provide food support, housing services, transportation resources and other types of assistance for our members, and since the needs are real for many individuals in our communities, our partnerships help us be more responsive and provide meaningful support.

So tools like neighborly are helping us take work even further. Neighborly makes it easier for our teams and members to find trusted, local resources quickly, and had helps streamline the referrals that we're making for our members and help to check our outcomes for individuals as well.

If you want to go onto the next slide. One of the things we like to pay close attention to is around our screening, so from the screenings we've completed we've learned 31% of the GHP family members share that they would like help connecting to community resources. The top needs that members tell us about are employment, transportation, and food, and these are the things that most affect the day-to-day life and they are also -- they also have a big impact on our health. Hearing directly from the members about the needs helps us guide our work and it also tells us where to focus our efforts and where we need to strengthen our partnerships in the community to help better support our members. I'm going to hand it over to Nicole, and have her speak to how we are connecting members to resources.

>> NICOLE MATREY: Good afternoon, everyone. My name is Nicole Matrey. I'm a senior health services specialist here at Geisinger. I'll highlight how we connect members to essential resources that support the overall health and well being. We focus and identify the social needs early and linking the members to the resources. As we're thinking about identification, we're thinking about social needs screening, conversation, and clinical touch points to work to understand those barriers our members face that could be food insecurity, housing concerns, or access to basic resources.

To support this, we use neighborly, our statewide resourcing referral platform.

It is a way our members and care teams can find resources right where they live, making

the connections more timely. Food access is a critical part of health and here at Geisinger, we have a large portfolio of supportive services that are going assist our members in need. Thinking about those different programs we offer, they look like mobile food pantries operating across seven counties in rural communities. Also, thinking about SNAP application assistance with community partners, helping members access long-term food support.

We also offer fresh food pharmacies, which is a food as medicine approach that assists our members managing diabetes, providing fresh, healthy food options to them. And then lastly, thinking about home delivery boxes, making it easier for the members to access food when they need it the most.

Stable housing is also a foundation of good health and we partner with community-based organizations to help our members stay housed through access to shelters, utility assistance and rent support. Through partnerships with over 26 housing providers across the state, we support our members facing housing instability and work towards that long-term stability. This slide really shows how we connect our members to practical and every day resources through our integrated channels with Neighborly. If you can go to the next slide, please.

Looking at transportation it is often a critical barrier to care, and here at Geisinger and Neighborly, our members and care teams have access to over 470 up to date transportation programs making it easier for them to get transportation to their appointments and other needs. We assist members with enrolling in transportation benefits such as MATP, ensuring they can attend medical appointments and essential services and the 4ride has supported 43,000 rides since 2018, members members get care when they need it.

Transitioning to work force, employment and education are key drivers of health. Neighborly connects our members to work force resources including GED programs, job training and professional clothing support. We refer members to GED works which is a virtual program providing tools, testing and personalized advising needed to earn the GED. The program is available in English and Spanish, making it accessible to more members. Lastly, maternal resources are really important and we accomplish that through strong community partnerships. Maternal social and needs support includes access to preand postpartum care, diapers and resources all available through Neighborly. In 2025, Geisinger collaborated with community-based organizations to host baby showers and diaper distribution initiatives. It helped meet immediate needs and providing healthy outcomes. By connecting members to transportation employment, maternal and food resources, we reduce barriers and support healthier families and communities. I'm going to turn it over to Kat to talk about the health and wellness offerings. Thank you.

>> SPEAKER: Thanks, Nicole. Good afternoon, everyone, I'm the health services team lead for the Medicaid and CHIP health and wellness team. And today I want to talk about some

of the health and wellness benefits that our members have access to, so we have regionally-based staff who attend several different events out in the community, collaborate rating with community-based organizations to offer things such as health education, health screenings, variety of different programming, and then also providing assistance with, you know, navigation. We are addressing the social needs and during the interactions, able to help to connect members back to other health plan services and resources we have for them. You'll see a few of the things I mentioned.

The educational presentation, we have a comprehensive library of seminars focusing on nutrition, fitness, general health education, sports safety, a variety of topics that our team offers and presents at things, locations like community-based organizations, public settings, so local libraries, and we also do them within the schools as well. We have digital resources for members, so they have access to unlimited resources on our on demand library that range from things as webinars. There is hand outs on there. There is some short task things that they can do on there as well, and it is a platform that features well being resources and other behavior change tools.

Like I mentioned, we offer health screenings at those events that we're going to, so we offer screenings ranging from body mass index to hand grip strength, blood pressure screenings, usually really popular one and these are, like I mentioned, at the community events that we're attending and also other locations as well. We might set up at a community-based organization during a food pick up time and offer that screening to individuals that are coming through.

We also offer evidence-based programming to adult takes are 18 and older. I listed the four evidence-based programs that our team offers. Freedom From Smoking, you can probably guess it is a smoking cessation program developed by the American Lung Association. We have the life Style Reboot Program. That is through the CDC and for individuals who have prediabetes. Our Live Your Best Life program, also one, more focused on individuals with chronic diseases, so it could be chronic pain, chronic asthma, could include diabetes as well. And then your live your Best Life With Diabetes, the sister program to the Live Your Best Life, but this focuses on individuals who have diabetes for that program.

We also offer programming for children, so we have the healthy kids programs that are hands on, very fun, interactive with the kids. We do provide those on site, and we have done them virtually, and we range from topics on hand hygiene, which became really big during Covid and still continues to be a popular topic that schools and Headstart wants our kids to provide and dental health as well.

And additionally, we have our life style management, our health coaches available, again, for those individuals 18 and older to just help them build those healthy habits and support them on whatever their individual wellness journey is. So it could be weight management. It could be tobacco cessation, stress reduction, so we have individuals that are trained and certified to help those that want to walk through that journey and have that little bit of extra

support. So like I mentioned, you can find our team in a variety of locations, libraries, head start in schools, community-based organizations we work with. It could be health fairs, YMCAs, community baby showers and we offer digital and virtual programming as well. You can see the number you can call into if you're interested in learning more or I put the QR code if you have a mobile device, if it is easier to scan and you can find any of the upcoming events that our team is holding. And with that, I will pass it back over to Chelsea. You can advance to the next slide, please.

>> CHELSEA MILLER: Thank you, Kat. So as we were talking about our strategy for addressing health-related social needs is built on four pillars. We identify, connect, and then support and follow up. So really using embedded universal screenings to help support and follow up. So the health flows have embedded social health-related screenings. Our clinical settings and self navigation tools which allow for screenings to be completed. Once the screening has been completed, we are able to connect members and individuals through Neighborly to trusted community resources, which have been shared, and then there is support and follow up. We provide assistance to ensure that gaps are closed and that closed loop connection is secured. Next slide, please.

To make sure we're connecting members to the right resources, we use three main pathways. So we have our care management support and you heard from Katrina and her team and how they assist. We have community health workers, interventions through Neighborly that can support. We have calls and resources through emails. There is also the clinical care connection, so we have social needs screenings that are done in the hospital setting and the out patient clinical setting. And then we also have those self-navigation tools. So self-screenings have been available in Neighborly and continue to be available where we can provide that personalized resource results for the member to self-navigate and see self-navigation options.

Next slide, please. Our impact, we want to see increased identification of health-related social needs and stronger connection to resources. So our next steps include expanding self-navigation options, refining our referral pathways and strengthening partnerships to broaden resource access. Ultimately, our goal is to make it easier for our members to get the help that they need for their health-related social needs.

And I appreciate your time, and thank you for having us.

>> SONIA BROOKINS: Thank you so much. I do appreciate all that Geisinger do for the clients that they represent. So I thank you all for that, for that program. Okay. Next?

>> DAN LAVALLEE: Ready to go. I appreciate it. You know, I'm still a little chilly, Sally, but it is a beautiful day in the neighborhood. I even have my trolley here, you know, because any time we get to talk about pathways to work, it warms my heart, let me tell you. But just so grateful to be here. My name is Dan LaVallee. I have been at UPMC for 11 years, I work on the community engagement team and I work on a program we'll talk about today. Many of you on the line have helped us build this, and you know, we want to give a quick update on

where we're at, but then also an ask of you to keep sharing this in the community. We will go anywhere, anytime when we're talking about pathways to work and a life changing career for the community members. We wouldn't have this program without the departments years ago. With the Medicaid Work Support Program that we, of course, wanted to build, but I had no idea we would get to this point where we hired 10,000 of our own members since 2021, just a beautiful day. I remember I wanted one, you know? And if there had been just one, I probably wouldn't be here talking about this program, but a couple of things that we try to do. What we heard of course then, as many of our other plans heart in the same way, and of course, right in the middle of the pandemic, our friends and neighbors were losing jobs. One in three people right here in Pittsburgh and many other neighborhoods were filing jobless claims. That is so wild to me. That is an unbelievable number if you think about the people we have on the call today. So for us, realizing at the time, of course, large Medicaid population, and then of course, a broader UPMC, largest non-governmental employer in the commonwealth. So we had an opportunity here. So what was clear to me, and we had heard out in the community that of course, while we were out doing health and wellness, we weren't always out helping people finding careers and it was an opportunity for us. I took that feedback deeply, and so that is why we built this team that we have. Kind of the first thing that we did was build a team of dream makers. We call them early in the career, HR members of our team that go out and talk to anybody, anytime. Of course, we love supporting our members, but it is anybody who has a barrier to work, to help navigate into careers and using skills. So the first picture on the left is a dear friend of mine, she is a member of ours. One of the first hires that we had in this program, and it helped us so much. She had such unbelievable customer service skills, and she was, you know, working nights in retail, minimum wage, you know? And wanted to get into a different career, and a different life. I think for us, we realized, you know, if you think about it, not everybody is calling the health plan and saying, thank you so much, and hanging up. It is a hard conversation sometimes where people are at a vulnerable time. So we need to define people who had the skills to be with people in challenging times and help them navigate their care journey. She has been on our wonderful team, promoted a number of times and I think some day will be a pharmacist. One of her jobs during the pandemic, especially, was calling high rises to make sure that our members had their medication. There is no more important job than what she did. That was all about job skills and navigation. And then we learned, and this was new to me, it has been a great journey. I appreciate the team at OIM and DHS overall and the partnership with labor and industry, and how it has worked in the commonwealth, we were able to realize that partnering with work force investment boards was the way to go. The individuals on Medicaid or any type of public assistance are eligible, you know, for training support and other programs, and we needed to build the pipelines. So the middle, you know, picture that we had is Michelle. She is wonderful. Went through a program we

call Freedom House, some of you may know the legacy of. Recently featured in an episode on the Pitt. I haven't watched the whole thing. I did see that one.

What was new to me is that in the '60s here, emergency medical service was developed right here, when really at the time it was so challenging to help people in an emergent need and that program became nationally recognized but came into cities and howl they trained EMT techs which is obviously important. We realize that we needed to restart that program, and not just for EMTs, but for all types of workers in the community, whether it is community health worker, a patient care technician or nursing staff in the hospital. All people that could be trained, you know, on trauma and how to care for people at the most challenging, especially with what was happening.

And again, this one for us was the beginning of how we partnered with the work force boards and how to build a model that we can scale across the commonwealth. We're about to hit the five year anniversary. We expanded the program we were grateful to have Sally and others join us. It is just the beginning, but it is an important piece of the model on how we think we can do this at a larger scale by partnernering with the work force system. We were attempted to, you know, talk in the same words. I always tell this, the WIOA program, at the beginning, work force said WIOA. I thought it was a human being. I kept waiting to meet WIOA and I learned the acronym and ever since, we have been able to build something special.

We also focus of course, on, you know, a number of other programs, whether it is supporting veterans of anybody who has had any type of barrier to work, we want to be able to bring hope and join together to do this. You can head to the next slide.

I think one of the cool things that we have tried to do here, you know, I have a few photos on the next slide; also how we talk about and how we support our students. Many are members of Medicaid, CHIP, of course, especially, and a number of our higher need areas. We feel like we got it right here. Again, something we have heard is we need to do better job expanding into schools, and especially in neighborhoods with high population of our membership on Medicaid and CHIP. That is what we tried to do here. We're trying to develop a model we can replicate to other places. We had a large career event with some very, very exciting opportunities and shadowing again in ways that we can go and work with the work force boards, get the message out there and make sure we're doing this in the right manner. We're grateful for secretary walker to be there and I can't say enough on how the agencies worked together to help us build out some of the programs and make the difference that we see for the members. That was the number one thing. How can we help people get into life sustaining wage jobs that we know will be better help for a family, an individual. Doesn't always work, and sometimes it is challenging, but we're trying to continue to build this. So my ask of you all, I promise I will stop you in 30 seconds. We want to continue to make this better. I personally, and our team will go anywhere, anytime to talk to one person or 1,000 about jobs and how we can do this a bit better.

So if there is any organization, we have hundreds of partnerships with the career links, other agencies that support overall in the community to develop referral pipelines into careers. It is pathways to work at UPMC @EDU. Come to us any time and we're hopeful for the future here. Even with some of the challenges and what is coming down the pike in the first part of the conversation today. I remain so hopeful for the work because of leadership of so many of you.

That is -- that is it for me. Happy to take any questions or happy to talk to anybody another time. I'll put my information in the chat.

>> SALLY KOZAK: No. I was just going to say, I don't have any questions for you, but I just want to say I'm so thankful that you guys don't let a good contract requirement go to waste.

>> DAN LAVALLEE: Bless you, Sally.

>> SONIA BROOKINS: I just want to say thank you for the program and helping folks get employed, stay employed. I do appreciate that program for that. Keep people employed. So thank you for the good work that you're doing with the program.

>> DAN LAVALLEE: Thank you very much. We'll keep it going. Happy to talk to anyone, anytime.

>> SONIA BROOKINS: Thank you so much. All right.

>> SPEAKER: Thanks, Dan.

>> SONIA BROOKINS: All right, now. Okay. Gwen. That was good.

- **Pediatric Shift Care - Staffing & Shadow Nursing Updates**

>> GWEN ZANDER: I will take us to this month's iteration of update. We have the data for you all. We can move onto the next slide. I'll try to keep it high level today and just call out the biggest points here that I want you all to be aware of. We were asked to provide a comparison between 2024 and 2025 and just kind of show what has changed in terms of the number of people receiving shift care, both skilled nursing and home health aide services, and then also the shift rate. On this slide, you're going to see the total number of health choices members that are receiving shift care, and that includes both home health aide and skilled nursing has increased by about 48%, which is a really note worthy number from a grand total of 8,479 in February of 2024 all the way to 12,589 in November of 2025. I also just want to note that at the same time, between February of '24 and November of '25, the total health choices population actually declined by 10%, so that just makes it kind of even more strikingly increases in utilization. While the overall enrollment in the program has declined. Really, the shift care increase is driven by the increase in the number of members that are receiving home health aid services.

The number of members receiving skilled nurse services increased very little and we'll look in the next slides at some of the break down there. On the next slide here, this is just

breaking out, again, the same timeframe that we showed, February of 2024 and then we can look at November of 2024, and then a year later, November of 2025, and you can see that those numbers in yellow are home health aid and those in green are skilled nursing where you're seeing the small increases in skilled nursing, but big increases for home health aid services.

The next two slides, I probably won't spend much time looking at, but they're there for anyone who would like to look in more detail month by month, broken out by MCO. You'll have access to those slides. I think we can go through them for now. One more, and then that will take us to the next one where we've got a chart here.

This is just showing differently, you know, the home health aid services only, and it is by MCO showing you throughout the course of 2025. You can see the steady climb, and you can see where the majority of those members are enrolled, which MCO they are enrolled in. And then finally, before I get into the missed shift rates, the last chart that we have on the next slide here, this is just the data showing skilled nursing and that is, again, broken out month by month and MCO by MCO, so for anyone interested in looking at the nitty gritty details, that is a good slide for you.

The next slide here, this is where we start talking about missed shifts. So I've got two of the slides. One is for home health aide services, the one we're looking at right now, and then eventually when we move to the next slide, that will show skilled nursing, but for right now, on home health aide, overall, the missed shift rate has declined between November of 2024 and November of 2025, a small decrease, but 2.5%, give or take. All MCOs saw a decline in the missed shift rate, and this is one of those situations where a decline is a good thing, because we are measuring missed shifts, so if you have fewer missed shifts, that means that you have more covered shifts, so that is a good thing. You can see the MCOs that are operating in more rural areas where there are fewer providers tend to have higher rates, while those with the majority of the members in urban or suburb areas tend to have lower rates of missed shifts.

That is to be expected, just by the nature of supply of providers. I will also note, if you're looking at this, you are probably noticing the big spike there in the blue from United Healthcare. I wanted to note that because they operate in the southeast zone and they have comparatively a small number of shift workers when you compare them to the other MCOs, that means the numbers can really swing a lot from month to month just from, you know, a few cases or even one really high need member case, when there are changes in the unstaffed hours, they can change a lot. That looks drastic, but I don't view that actually as a cause for concern. It is just kind of the nature of the numbers that we're looking at here.

I'll also note that this data, as well as the next slide, they're based on the report which is an operations report that DHS collects from the MCOs and the MCOs gather the information from the agencies, the shift care agencies themselves. That means, you know, any time

you're passing papers from one person to the next, you're going to have varying degree of reliability and accuracy of data, so we know that there are some limitations to this data. We're working really hard to look at some changes that we can make to the reporting process to get us to more consistent and reliable data that is maybe less labor intensive and time consuming both for the people reporting it and those of us that are analyzing it. We'll keep working on that and hopefully be able to show you some dash boards and regular reports in the future. We're really excited about some of that work. For now, we do it manually, which means we sometimes identify errors, and if we do ever identify any errors, we'll send the correction to the members of this subcommittee.

Finally, the last slide here, again, this is looking at missed shift rates, this is for skilled nursing. Similarly, we saw a decline in the missed shift rate. This time about 2.7% between November of '24 and November of '25, so this was, again, a good thing. You know, a modest decline, but it is a decline, and that is something that we are excited about and hope to continue to see. So I will stop there with shift care and open up for questions.

>> KYLE FISHER: Just a question, I think, going to definitions here. The last version of the missed shift data that the department shared had much higher missed or unfilled shifts for both nursing and home health aide services. So I guess, just to classify. The missed shifts reported here, does that mean unfilled shifts for any reason or are you reporting something else out?

>> GWEN ZANDER: No. These are only for two different reason codes that we capture. Nurse unavailable or unable to staff. Those are the two codes that indicate some kind of limitation on the staffing agency's part. There are some other codes that could be for example, a child is hospitalized or that a family chose to defer or decline their hours for some reason or another. This is just showing the ones where either the agency could not find a nurse or home health aide to work the case or the one that was assigned is not available for some reason. So it is a more limited subset. I will say, you know, like I said, with all of the limitations of the data that we capture, the reason codes are one area that it is very difficult for the department to verify the reason code that is submitted. I guess I'll just say take it with a grain of salt.

>> GWEN ZANDER: Sure. I think for that reason, it would be useful, and maybe in slides you're putting out. If you can share the underlying full data set, I know there is interest in that on the part of the committee members. And I think that is possibly what we have gotten before.

>> MEGHANN LUCZKOWSKI: Yeah. This is Meghann. I think without being able to see the corresponding code, particularly the ones where parents have cancelled the shift to see if there is an increase there, while a decrease in other ones, I don't know if we're able to really feel out what the changes are.

>> GWEN ZANDER: Sure. Sounds good. We'll work on following up with all reason codes.

>> SONIA BROOKINS: And then any other questions for the sake of time? When we get the

codes, we can send our response to the questions we need from Gwen.

>> SPEAKER: Yeah, yeah.

>> SONIA BROOKINS: Okay.

>> KYLE FISHER: The only other question I had for you, sorry, Gwen, and this may be something that can also be when you share the data otherwise. I know we have seen some sort of state-wide weighted average. That would be useful if you have that. I know looking at the missed shifts by MCOs, some of the plans have far more members receiving the service than others, so to the extent that you have it.

>> GWEN ZANDER: We will take some notes and get you some more raw data.

>> SCOTT MATLOCK: This is Scott Matlock, I will note that the red line is the average

>> GWEN ZANDER: Thank you, Scott. If you're looking right there on this, for example, we have weighted average in there, and we can look to include, yes, there is, up in the health choices, total is almost the center line and the chart above, but we'll just make sure that is clear in all of data that we provide.

>> KYLE FISHER: I know time is short. But I'm seeing a bunch of text here. All of the data is coming from reports, it is coming from agencies.

>> GWEN ZANDER: Correct.

>> KYLE FISHER: So for families with children there is not an agency assigned, is the state able to fold that data in at all? Do you have any sense of how big of an issue that is?

>> GWEN ZANDER: Yeah, so it is not just agencies that contribute to OPS, they contribute to reason codes and hours that were covered, but any child that has been open authorization for shift care is included in the OPS report, even if an agency has not yet been identified to staff the case.

>> SONIA BROOKINS: Okay. Any other questions?

>> KYLE FISHER: Thanks very much, Gwen.

○ **Hospital/MCO Contract Terminations**

>> GWEN ZANDER: I think the last thing I have for you is our standard monthly update on some upcoming hospital and MCO contract terminations.

I've got some tough news about closures this month that I'm sorry to report. The first is that Warren General Hospital abruptly closed the labor and delivery unit earlier this month. There are 663 impacts members across all MCOs that received notifications about the closure directing them to alternative places for them to deliver their babies. Some of the alternatives include UPMC Chataqua, 20 miles away from the hospital that closed. Allegheny Health Network St. Vincent, is 62 miles away and another is 67 miles away. So this is a pretty rural area, which means that there are not so many options very close by. Commonwealth officials are working with the hospital to see if there are resources that

could be directed to Warren General that would allow them to reopen that unit. It was a staffing issue that was cited as the reason for the closure. So perhaps that will be reopened, but as of this time, Warren General L and D unit is closed.

Similarly, I would say that Lifecycle Wellness and Birth Center in the Eastern part of state is in Bryn Mawr. They will discontinue deliveries in February and discontinue at the end of March. MCOs are evaluating the number of members that will be impacted but this is one of only a handful of free-standing birth centers that operate in Pennsylvania.

Next up is Tower Health, the holding company that owns several hospitals in the Eastern half of the state. They are currently engaged in a restructuring plan that has resulted in the closure of several units in different hospitals. At Pottstown Hospital, they have closed the ICU, endoscopy, cancer institute and out patient rehab. At Phoenixville hospital, they have closed the rehab center and Reading Hospital they closed the bariatric surgery center. Notices have been sent out. That was Keystone 727, United 680, Geisinger 313, Highmark, 153, health partners, 98, and UPMC, 59. So the closures or discontinuations have impacted a fair amount of people on the Eastern part of state.

Finally, my update is that Holy Redeemer continues the negotiations with Keystone First and HealthPartners. I've reported on this every month for awhile. The contract is not expected to terminate and likely will be renewed again. I do mention it because large numbers have impacted members and it continues to be renewed on, like, a month to month basis, but, again, continued extended so likely not to terminate.

Any questions? I know I just said a lot very quickly.

>> SONIA BROOKINS: That was a lot. But --

>> SPEAKER: It was a lot, Gwen. I guess the only piece, and I do want to save them some time. I don't know if they will have a lot to report out. Going back to the labor and delivery closures.

>> LIZ HEALEY: This is Liz, and I had a question about the labor and delivery closure up in Warren. Is the Warren hospital an independent hospital or is it affiliated with a healthcare system?

>> GWEN ZANDER: I will have to check on that one. I believe it is independent still but let me see what I can find.

>> LIZ HEALEY: Okay. Thank you.

>> GWEN ZANDER: My understanding is that it is an independent hospital.

>> SPEAKER: I agree.

>> SPEAKER: I'm not seeing any affiliation with a system.

>> SONIA BROOKINS: I take it if the hospital would close, the rest of the hospitals that we're doing everything that we need to do to make sure the folks get to where they need to be.

>> SPEAKER: They're affiliated.

>> SPEAKER: Huh?

>> GWEN ZANDER: Yes, that is part -- the notices that get sent out when services are being discontinued somewhere, part of the notice is identifying alternative resources for members to seek care elsewhere in network.

>> SONIA BROOKINS: That's fine. Thank you. Thank you, Gwen.

>> KYLE FISHER: My only question to Sally, this ties back into the state-directed payments you were talking about earlier. Is that still an option the department has when talking to hospitals about what types of supports Medicaid program the state can offer to help prop up the labor and delivery units that, for whatever reason, seem to be closing left and right?

>> SALLY KOZAK: Let me say a couple of things about state-directed payments. State-directed payments are funded through the hospital assessments, and it is very difficult, given that all hospitals play into the assessment to say only certainly hospitals can get enhanced payments, and so as we submit our state-directed payments, we focus on utilization at each hospital, so there would have to be some very special, particular payments in terms of a state-directed payment to go to a hospital purely for maternity care. We have options for that through the Hospital Quality Improvement Program, but again, those can target certain initiatives. For example, we have the OUDED so that hospitals that refer people with opioid use disorder that come into the emergency department can earn quality incentive payments, so we have the ability to do that, but again, they're very broad-based. And so it is possible that I could theoretically develop a type of maternity improvement payment, but that would have to target any hospital that has a birth. So that is a very long answer to your question, Kyle, that the answer is it is extremely complicated to direct the payment in that manner.

>> KYLE FISHER: It is helpful to hear. Thanks.

>> GWEN ZANDER: I wanted to add, Liz, to your question, it appears that Warren General does have an affiliation with Allegheny Health Network.

>> SONIA BROOKINS: All right. Anyone else? Thank you, Gwen. We appreciate it. We appreciate you.

>> GWEN ZANDER: Thank you.

>> SONIA BROOKINS: All right. Okay. OLTL.

- **OLTL Report**
 - **Deputy Secretary Updates**
 - **PAS Hours Staffing Data**

>> JULIET MARSALA: Hi, good afternoon. I heard Kyle say I didn't have to talk for very long, so I'm going to keep it brief. Just kidding.

All right. It is good to be with you this afternoon. I hope everyone is watching the weather and will be well-prepared for this weekend come what may. I do hope everyone stays safe

and takes some time to prepare for the winter storm.

If we go to the next slide, folks, as Kyle mentioned, a short agenda. We go to the next slide, folks are familiar with this slide. There have been no changes to this slide. We are still in a stay. All activities related to the RFA have ceased. We have no time line. I wish we had a magic ball but we do not and CHC is operating under the current Managed Care Organizations until further notice. Randy is here with me if there are additional questions. If we go to the next slide, there were questions from this committee related to OLTL being able to report out on personal assistance services hours that were authorized in the service plan prior to an authorization being in the system to assess those gaps. I know we have missed shift reports for once an agency has accepted services and missed shifts going on wards, but there is a gap between the service plan and the agency assignment. We are working on getting those reporting capabilities, and so we are hoping and anticipating that we would be able to get those reports shared with us through HHA Exchange Reporting or via a report that we manually develop and request and expect each of the MCOs to complete, so that work is ongoing. We don't have that reporting capability at this time.

And we did talk about enhanced Personal Assistance Services reporting capabilities as a topic of discussion in the direct care Worker Network Adequacy workgroup because we share interest in adequate reporting for personal services. The work group has worked really hard on that. They have looked at different ways to more accurately report network adequacy within the personal assistance system, and that report and those findings and recommendations and sort of that path forward is currently under administrative review to determine sort of next steps in the feasibility of the next step to those changes that we might make to that network adequacy work group.

>> SONIA BROOKINS: Can I ask a question?

>> JULIET MARSALA: Of course.

>> SONIA BROOKINS: Do you know when you'll have some sort of data in reference to the direct care work?

>> JULIET MARSALA: I do not have a timeline for that at this moment in time, but certainly can circle back and see what we can have for a timeline. But I don't. I don't have a firm timeline right now, and I don't want to sort of over promise something.

>> SONIA BROOKINS: Okay. No problem.

>> JULIET MARSALA: No. Good question. So that is the PAS staffing update. However, I did want to share some general information and data about PAS. We had a request to look at PAS personal assistance services utilization year over year for the past three complete years, so I did have that data available that I thought would be of interest to the consumer sub Maac. If you would like me to, I can take a few minutes to walk through it and certainly share the data with the committee, but I tend to like walking through the data set so you can understand how we laid it out and what you're looking at. Is that something the

committee would like me to move forward with?

>> SONIA BROOKINS: I think that we can do that next month, Kyle, but I guess in March.

>> KYLE FISHER: Sonia, the only thing I will say is we have another 13 minutes or so, and nothing else on the agenda after Juliet's presentation. So I don't know --

>> SONIA BROOKINS: Okay. Let's do it.

>> JULIET MARSALA: Okay. Now I have to get it back up again. I just closed it out. Give me one second. I will get that up so that I can be prepped to share.

>> SONIA BROOKINS: I thought she had more stuff for us. That is why I said next. I'm sorry.

>> SPEAKER: That is all right.

>> KYLE FISHER: I think it is a good time to plug that there will not be a February consumer subcommittee meeting. That is being cancelled, so for folks on the call, the consumers will meet again, Sonia, is it March 24th?

>> SONIA BROOKINS: Yes.

>> SPEAKER: It will be the March meeting in person.

>> JULIET MARSALA: All right. Okay. I have the file opening up. And then I just need to share my screen.

>> SONIA BROOKINS: You're doing good. All right.

>> JULIET MARSALA: So what you see here is an excel spread sheet. It is a little large so I will go through different parts of it. So what we have and how this is set up so you know when you take a look at it, at the bottom of the spread sheet, there are four tabs. One that says logic read me, so that kind of gives you some updates on, you know, notes about the data, so it is always good to take a look at that so you can kind of get a little bit about the background, and then in the other three tabs, you'll see, we have it broken out by the three main waiver programs, OBRA and CHC. I'll walk through CHC. So you guys get a sense of what you're going to be receiving. And certainly we'll answer questions. So we have in this data set of CHC, we have looked at the personal assistance service data under two models, so there are two ways to kind of ask the question. What is the utilization of personal assistance services, and so we looked at it two ways. Model one, the first one you're seeing here, you'll see it in three years, 2022, 2023, and 2024. These are the calendar years. You'll see it broken out three three ways. Agency only, participant self direction and both models together. That is how you're looking at the chunks of data by kind of section and by year.

In this first model, we looked at participants who utilize personal assistance service hours. We looked at it by day. If you looked at any day that someone was using services, on average, how many hours of service would they use in one day? Right? They may only use hours on Monday and Tuesday and Wednesday and have informal supports for Thursday, Friday, Saturday, Sunday, so this is kind of looking at average time in a day window. Okay? So what we saw here, we look at both the average, and as you know, in the average, there could be outliers that kind of push an average up or down, so we also looked at the

median, and kind of for folks, the median is kind of like the middle number of all of the numbers, if you rank them all, the median is the middle number, so it is sort of the number that comes up most frequently. So there are two ways to look at it. An average and a median. It will give you a good sense of some of the clear data.

So when we look at the data year over year, if we're looking at how many hours on average does a participant use in a one day look, we see that statewide, year over year, the number didn't change very much if you look at the median in 2022, it was 7.97 for the agency model, and in 2024 it is up a little bit at 8 hours on average a day.

When you look at participant self-direction, you see a little bit more of a utilization increase from 2022 and it was -- the median was about 8.04 hours a day, and in 2024, you see that increased up to 8.58. Certainly the participant self-direction model is a lot smaller than populations a lot smaller than the agency model. When you look at the data together, there hasn't been much change in terms of per day usage. Looking at 2022 at 7.98 hours median to 2024 where you have been 8 hours median.

That is one way it look at the data. It is, like, when someone is using services in a day, how many hours in that one day are they using? So it looks like folks are using, typically, an eight hour shift on the days that they are using services.

Now, there is another way to look at personal assistance services.

The numbers will be drastically different, because this is going to look at the total number of hours that someone uses in an average day if you're looking at sort of dividing it by all of the days in the year, okay? So if you take all of the utilized hours that someone has authorized in their plan and you average it out over the days of the year, 365 days or 366 days if is a leap year, you'll get sort of the utilization per person kind of on average over the year.

And so you'll see here, from these numbers, it does sort of look like it goes up a little bit in that utilization, so statewide you'll see that back in 2022 we have the median being 5.95 hours per person on average, and in 2024, we see that go up slightly to 6.42 hours. That is the agency model. You see a similar trend in participant self direction, 5.63 hours back in 2022, and that has gone up to 6.36 hours. So it is kind of saying on average, over the years, the utilization on average per person has gone up a little less than an hour when you look at average across the days.

When you look at both models together, you see that same trend, again, participant self-direction is a much smaller population, so we would tend to not see too much of a difference when we combine them both together. So you'll see back in 2022 on average, a participant was utilizing 5.2 hours, and in 2024, the utilization has gone up to, on average, 6 hours and 42 -- 6.42 hours. So we just thought this would be a good indication for folks. I know folks wanted to kind of know about PAS utilization, so we had done this analysis and wanted to share it. As I said, we have it for CHC, you can see the same numbers in OBRA, because OBRA is a much smaller program, you'll see that we had to redact some data, and

that is where you see the stars of the data on here, I'm sorry. I should have zoomed in a little bit more. So you will see, there is asterisks in certain regions because we have the data also by zone. And some of the regions have less than 11 participants so for the sake of privacy, we redact the numbers.

And that is the same thing for ACT150. We believe this has been sent around to the committee. We welcome, you know, you can take a look at the numbers. If you find them of interest, we've certainly found them of interest, and you can see how the utilization changes via program, via zone, and by model. So I'll pause there if there are any questions.

>> LIZ HEALEY: This is Liz Healy. I had one question. You talked about the third column being the number of hours that they utilized. Is that another way of saying that is the number of hours that they were able to get staffed for the service that they needed?

>> JULIET MARSALA: That's correct. This is based on utilization.

>> LIZ HEALEY: And do you have numbers that would show us what was the number of hours they were authorized for?

>> JULIET MARSALA: That is the report we're working on.

>> SPEAKER: Okay. Thank you.

>> SPEAKER: Yup.

>> SONIA BROOKINS: Juliet, you said something about the stars data that you have there. You have stars because of what?

>> JULIET MARSALA: So the stars right here, like, right here that you can see here, these, that is the suppression of data. That is indicating, when we have a zone or data element that is ten persons or less, we have to suppress the two lowest data points because sort of CMS, Medicaid data sharing rules, you know, that is kind of the threshold. If we think we're reporting out on ten persons or less, you could potentially figure out who those ten people are in that zone and so we want to protect their privacy.

>> SONIA BROOKINS: Oh. I'm glad you told me that. I just didn't know that. Okay.

>> JULIET MARSALA: Yeah. So when we're sharing any data or Medicaid --

>> SONIA BROOKINS: We wouldn't be able to check it, but somebody else looking at this would be able to check it. Is that what you're saying?

>> JULIET MARSALA: Yeah. If someone in a health plan knew that they had ten people, they would know we were talking about just all of their ten people or if in the northwest there was an agency that served, like, nine people and when he data on ten, they could figure whout, you know, they could deduce data that potentially could identify folks.

>> SONIA BROOKINS: I thought they would know that anyway because they're their numbers. I understand that. I know you have to jump off.

>> JULIET MARSALA: CMS protection rules.

That is all it is.

>> SONIA BROOKINS: All right. No problem. All right. Thank you. Anybody have any questions? Anybody else? Anybody have any questions for Juliet? All right. Thank you so

much, Juliet. We appreciate it. Appreciate it. All right.

>> SPEAKER: Stay safe.

>> SONIA BROOKINS: All right. Old and new business?

>> SPEAKER: I don't believe we have any.

>> SONIA BROOKINS: All right. And can I get a motion to end this meeting? I want to thank everybody that is on this call and thank you, again, for the little accidents that I had earlier, but I appreciate it. So on that note, can I get a motion to adjourn the meeting?

>> SPEAKER: Motion Deb Shoemaker.

>> SONIA BROOKINS: A second?

>> SPEAKER: Meghann will second.

>> SONIA BROOKINS: All in favor?

>> SPEAKER: Aye

>> SONIA BROOKINS: So moved. Once again, thank everybody for being on the call. Thank you so much. Appreciate it. We'll see you all in March. There is no meeting in February. We will have a full meeting then. Thank you.