

## 02/26/2026 Medical Assistance Advisory Committee Meeting

Attendees: Sam Chanek, Amanda Sagastume, Anthony Abrams, Elise Gregory, Erin Wyse, Eve Lickers, Gwen Zander, Pamela Machamer-Peechatka, Sally Kozak, Sonia Brookins, Amy Lowenstein, Carl Feldman, Chiamaka Nnamani, Jamie Buchenauer, Jeremy Yale, Joseph Glinka, Kathy Cubit, Kristin Ahrens, Kyle Fisher, Mark Goldstein, Mia Haney, Montrell Fletcher, Nicholas Focht, Nick Watsula, Nicole Harris, Richard Edley, Russ McDaid, Ted Mowatt, Paula A Stum, Captioner Abby, Leesa Allen, Laina Auletta, Anna Aupperle, Radwan Azim, Wendy Bailey, Morgan Baker, Valerie Barnes, Anna Barone, Cathy Barrick, Christina Bates, Daniel Bates, Clea Bell, Karen Bennett, Norris Bennis, Darryl Bergstrom, Kara Blasiak, Brooke Bowers, Caleb Bressler, Hannah Brown, Zoe Buchmann, Dusty Carl, Andrew Centrone, Cristina Codario, Michelle Choen, Kristy Cole, Mauricio Conde, Jill Ann Crouse, Cindy Dang, Scarlett Davis, Marianne DeJesus, Melissa Dehoff, Jayden Demmy, Mindy Dunlap, Isaac Durham, Nicole Fidler, Michelle Fowler, Erika Fricke, Carrie Frownfelter, Phil Galewitz, Brookelynn Gilleeny, Janel Gleeson, Nadia Glenn, Candy Graham, Alix Gustafson, Emily Hackman, Rebecca Hathaway, Beth Hennigan, Teri Henning, Amber Hess, Jeff Iseman, Breanna Jackson, Vicki Lee Jessup, Matt Johnson, Emily Katz, Zayne Kemler, Daphne Knapp, Julie Korick, Hannah Kranz, Jackie Kreshock, Tom Lacey, Liz Lancaster, Mike Lane, Madison Laughman, Tessa Laughman, Suzanne LePera-McGrother, Rachel Lee-Price, Anna Lewis, Frank Lill, Dylan Lindberg, Becky Ludwick, Tim Lyden, SUN MOON, Latoya Maddox, Sarah Martin, Scott Matlock, Courtney McCullough, Teresa McDonnell, Taylor McGilligan, Elise Mercer, Jim Meyer, Terri Meyer, Lynne Miles, Stacy Mitchell, Julie Mochon, Karey Molnar, Denise Moore, David Morales, Katy Morton, Kevin Mulcahy, Corey Notarangelo, Erica Nace, Alexandra Naismith, Jennifer Newman, Jazmin Nixon Cartwright, Christi Oliver, Nicole Payonk, Jacqueline Penrod, Rhashidah Perry-Jones, Richelle Poole, Catharine Rambler, Sam Rashdan, Janell Reagan, Ashlee Reick, Christina Reilley, Olivia Riek, Annmarie Robey, Michele Robison, Dana Roman, Ann Roque, Pam Rotella, Rachel Rumpff, Robert Rutkowski, Margaret Rybinski, Tyson Rydze, Brad Shopp, Fady Sahhar, Kimberly Sgrignoli, Megan Shaffer, Naomi Shaffer, Shahram Shamloo, Michele Shaughnessy, Jason Shoemaker, Heather Shope, Michael Siget, Caleb Sisak, Jason Snyder, Tim Sohosky, Catherine Stetler, Caroline Straub, Marisa Swarney, William Tassone, Lisa Tesler, Laura Theurer, Jared Walker, Donya Weldon, Michele Werner, Lloyd Wertz, Nick Young, Starell Zoric, Sam DeNisco, Paulette Hunter, Shani Jackson, Gina Morris, Steven Moskal, Jim Sharp, Christine Valentine, Marriam Wafa

>> ELISE GREGORY: Good morning. And welcome to the February 2026 edition of the MAAC (Medical Assistance Advisory Committee) meeting. Today is Thursday, February 26th. My name is Elise Gregory. Before we begin the meeting, I would like to go over a few items. This meeting is being recorded. Your continued participation in the meeting is your consent to be recorded. If you do not wish to be recorded, you may end your participation in the webinar at any time. Also, per DHS (Department of Human Services) policy, the use of Artificial Intelligence or AI for note taking or for any other purpose is not permitted. AI bots in attendance of the meeting will be removed. For panelists and speakers, if you are experiencing audio issues, please go to the top right corner to find the gear wheel to adjust your settings to the correct microphone and speaker hardware. If you continue to experience difficulty, please send a message in the chat. Please remember to keep your microphone muted. Live captioning, also known as CART (Communication Access Real Time Translation) captions are available in the meeting. The meeting link is included in the chat. Presenters should state their names clearly before speaking to assist the captioner. Presenting from the DHS from the Office of Medical Assistance Programs (OMAP), Deputy Secretary, Sally

Kozak. From the Office of Developmental Programs (ODP) Bureau Director, Jeremy Yale. And from the Office of Income Maintenance (OIM), Bureau Director, Carl Feldman.

Questions or comments may be submitted in the questions tab of the webinar with the question mark symbol. If you have questions related to the meeting or need any additional information, please visit the MAAC web page. If you need to contact staff, please find our account on the web page. I will hand things over to the MAAC chair, Ms. Sonia Brookins.

>> SONIA BROOKINS: Good morning, everyone. Welcome to the MAAC meeting. My name is Sonia Brookins. I'm the chair for MAAC. I'm going to turn it back over to Elise to do roll call. Thank you.

>> ELISE GREGORY: Jolene Calla?

>> ELISE GREGORY: Kathy Cubit?

>> KATHY CUBIT: Good morning. I'm here.

>> ELISE GREGORY: Good morning.

>> ELISE GREGORY: Richard Edley?

>> ELISE GREGORY: Nicholas Focht?

>> NICHOLAS FOCHT: Good morning. I'm here.

>> ELISE GREGORY: Joe Glinka?

>> ELISE GREGORY: Dr. Mark Goldstein?

>> MARK GOLDSTEIN: Good morning.

>> ELISE GREGORY: Mike Grier?

>> ELISE GREGORY: Mia Haney?

>> MIA HANEY: Good morning. I'm here.

>> ELISE GREGORY: Thank you.

>> ELISE GREGORY: Mary Hartley?

>> ELISE GREGORY: Julie Korick?

>> ELISE GREGORY: Minta Livengood?

>> ELISE GREGORY: Russ McDaid?

>> RUSS MCDAID: Good morning, here. Thank you.

>> ELISE GREGORY: Ted Mowatt?

>> TED MOWATT: I'm here. Good morning.

>> ELISE GREGORY: Good morning.

>> ELISE GREGORY: Dr. Chiamaka Nnamani?

>> ELISE GREGORY: Deborah Shoemaker?

>> ELISE GREGORY: Nick Watsula?

>> NICK WATSULA: I'm here.

>> ELISE GREGORY: Dr. Marc Yester?

>> ELISE GREGORY: And we do not have a quorum.

>> RICHARD EDLEY: You may have missed me.

>> MARY HARTLEY: This is Mary Hartley.

>> RICHARD EDLEY: And this is Richard Edley. I just joined.

>> JOE GLINKA: And Joe Glinka is on now too.

>> MARK GOLDSTEIN: Did you get me, Mark Goldstein?

>> ELISE GREGORY: Okay. I have Kathy, Richard, Nicholas Focht, Joe Glinka, Dr. Mark Goldstein, Mia Haney, Mary Hartley, Russ McDaid, Ted Mowatt, and Nick Watsula.

Is there anyone else?

NOTE: Julie Korick was also present and indicated so in the chat.

>> JOE GLINKA: Does that give us a quorum?

>> ELISE GREGORY: We now are at quorum.

>> JOE GLINKA: Okay. Is Sonia not here?

>> SONIA BROOKINS: Yes, I am. Good morning.

>> JOE GLINKA: I apologize, Madame Chair. I relinquish the gavel.

>> SONIA BROOKINS: We're fine. Thank you so much, Elise, for that. And thank you all for being here this morning. So, what we're going to do now, can I get a motion for the minutes to be accepted? Or any abstentions?

>> JOE GLINKA: Motion to approve.

>>TED MOWATT: Ted, second.

>> SONIA BROOKINS: So, moved. So next on the agenda is H.R.1 (House Resolution 1) update, work group update.

>> SALLY KOZAK: Good morning, everybody. This is Sally. I know folks can't see me, but you can hear me. I want to give a brief update on the H.R.1 workgroup. So, the workgroup is going to be made up of representatives from the MAAC and subcommittees of the MAAC, as well as other advisory committees that we have here within the Department. And there will also be representatives from other organizations. I believe that those notices have gone out to the various groups. Once the work group starts to meet, they will meet every two months. And then they will begin to meet monthly starting in the fall. The expectation is that the workgroup representatives will serve as liaison with the larger groups that they represent. However, we will still be providing updates to the larger groups throughout the process as well. So that means that from time to time, I will be updating the MAAC or your representative, your liaison, I should say, will also be providing updates to the entire group as well. The workgroup topics will include four primary areas: Progress on H.R.1 implementation; Listening to major concerns from representatives related to the H.R.1 implementation; Coordination on public engagement and information sharing; And then sharing feedback on policy and implementation strategies specific to H.R.1. So, kind of in a nutshell, that's the update that I have on the H.R.1 workgroup.

Any questions?

>> JOE GLINKA: Sally, it's Joe. I don't think there's any slide that has it. Can you repeat the four priority areas for the work group? I apologize.

>> SALLY KOZAK: Sure, I can do that. Do we have a slide on that, Elise?

>> JOE GLINKA: If there is --

>> ELISE GREGORY: No. We just had the talking point.

>> SALLY KOZAK: Okay. I will be happy to repeat them. They will also be put into the meeting minutes. Yeah. So, the workgroup topics will include, and there is four of them. Progress updates on H.R.1 implementation. So that's the first one. Listening to major concerns from the representatives on the workgroup related to the HR implementation. That's number two.

Coordination on public engagement and information sharing. So that's topic three.

And then the last topic is sharing feedback on policy and implementation strategies specific to H.R.1.

>> JOE GLINKA: Okay.

>> MARY HARTLEY: Sally, this is Mary Hartley. Is there a way that we can bring concerns to that group if we're not included on this subgroup?

>> SALLY KOZAK: Yeah. So, what I would suggest to you is that you go ahead and bring those concerns to your representative from the group. Or you can always share directly with the Department. Although I would encourage you to use your representatives. So, I'm not sure who the MAAC representative is. Catherine, do you have that information? Or Sonia?

>> SONIA BROOKINS: It's Richard Edley and Kathy Cubit.

>> SALLY KOZAK: Okay. Yeah, I would encourage you to share your feedback with them.

>> MARY HARTLEY: Thank you.

>> SALLY KOZAK: Sure.

>>JOE GLINKA: I would also say I would submit that if anybody attends the MAAC subcommittee

meetings, the MAAC subcommittees have been asked to provide two representatives from each of them. So, there will be discussions on our agendas with respect to this process to provide feedback, for lack of a better term, to the ambassadors, if you will, into this process to help inform it as well from each respective subcommittee. So, to the degree that's helpful to anybody in the meeting today, that's another opportunity to share information.

>> SONIA BROOKINS: Any information that you have that you want to share, inform me, Joe, or Richard or Kathy Cubit just so that we could bring it back, your point of views. Everybody has a say so because we're all in this together. Thank you. Anyone else? Thank you for your update, Sally. I appreciate it.

>> SALLY KOZAK: Thanks, everybody.

>> SONIA BROOKINS: Next is ODP. Jeremy?

>> KRISTIN AHRENS: Hi. I am not Jeremy. Yeah, I am Kristin Ahrens, Deputy Secretary. I originally had a conflict, so I asked Jeremy to cover it. My conflict resolved so I am here.

>> SONIA BROOKINS: Thank you so much.

>> KRISTIN AHRENS: My pleasure. It sounds like we have got an hour to do an overview of the Office of Developmental Programs. All right. We can go ahead to the next slide. I will walk you through everything from ODP's mission and sort of foundational values, which we refer to as Everyday Lives. Walk you through our home and community-based services (HCBS) structure. How we implement all of that in terms of our community partners. We'll walk through eligibility criteria, PUNS (Prioritization of Urgency of Need for Services), which is how we manage our waiting list and some information on the waiting list itself and do a little bit of highlighting four of our current big initiatives that we have in play here. All right. So go ahead to the next slide. And the next one.

Our formal mission is to support Pennsylvanians with developmental disabilities and their families. One of the things that is somewhat unique about the ODP is the extent to which families are critically engaged always in this Medicaid program. You will see that threaded throughout and that is to achieve greater independence, choice, and opportunity in their lives.

Next slide.

And one of the things I think that's also really important to understand about the ODP is a long history of very strong engagement with stakeholders. I think one of the, again, there's a lot of things unique about the population that ODP serves. And one of them is in terms of advocacy. In the case of intellectual disability, autism, developmental disability, you have people that were typically born with or acquired a disability at a very young age. And that is a lifelong disability typically requiring lifelong support. So, you have family engagement. Education advocates tend to drift off after kids graduate from school. We have very historically, in addition to individuals with disabilities and just some phenomenal advocacy over the years, some very, very strong family advocates who have between self-advocates and our family advocates have very much shaped what our service system has looked like over the years. ODP has our advisory council called the Information Sharing and Advisory Committee (ISAC). And it is made up of, we have about 40, a little over 40 people on our advisory committee. Almost entirely organizational representation. So, we have asked for across stakeholder groups. So, this is self-advocates, families, advocates, provider associations. We have got our health care quality units, which you will hear about. We have our university partners on there. We have got our county partners, supports coordination. We have got rural family representation, Latino family representation. So, we have a big group of stakeholders to engage. And we expect that the plans that come out of ISAC are not just for what ODP is doing, but broader what other stakeholder groups are also doing in terms of advancing the mission of Everyday Lives, which I will talk about in a second.

But importantly, our advisory committee is made up, it is greater than 51% individuals with disabilities or family members. Our ISAC does serve as our quality council. So, they do spend a lot

of time looking at data and assisting us in sort of looking at what direction we want to take and what our strategies are. We have two subcommittees. One on housing and one on provider performance review. All right. Next slide.

One of the things I have said as the Deputy for the ODP is we're blessed at the ODP, I shared with you the formal mission up on the DHS website, but when we really think about our mission and vision, it simplifies into two words. And that is an absolute gift. Anyone who does work trying to do missions and visions for cooperations, government, whatever it is, get it simple so people can remember it. Ours is Everyday Lives and the concept here and this has been our concept and the driving vision for our system for over 30 years at this point, adopted by stakeholders, they adopted this in the '90s, is Everyday Lives. Meaning that, our vision is that individuals with disabilities live everyday lives like any other Pennsylvanian. They work, play, and worship in communities across Pennsylvania and our job is to figure out how to support them to do just that.

And so, ISAC in an effort to make sure that Everyday Lives are real for everyone that comes through our door, developed 14 different recommendations. Actually, this occurred in a very formal planning process with 260 people over the course of about a year. Kind of narrowed this down to 14 different recommendations that span from making sure that everyone has an effective way to communicate. About 30% of people that are supported by ODP do not use words to talk. So, we need some other kind of formal communication system. You can see employment is on here. We have a high focus on making sure that people have an opportunity to live in community settings versus institutional settings. Focus on opportunities for participating in community integrated activities in the community. But quite a span of recommendations and with these, to make this come alive, that stakeholder group, we publish strategies. We work through and come up with a strategy for every one of these recommendations. There's a whole set of things that ODP is doing that other stakeholder, stakeholder groups might be doing to try to make this come alive. That is all published. Actually, we can put the link here in the chat for you if you want to see those strategies. And then because it's our quality council, ISAC also has helped identify how do we know if this is working? How do we know that we are actually supporting people to be experiencing integrated time in their communities? So, we use what's called the National Core Indicators. We also expand the sample of that. It's a quality of life and satisfaction with services survey that is done in person. We have a large sample. That's one of the measures that we use a lot to establish whether or not we are meeting. So actual participant beneficiary experience of the service system to tell us whether the strategies that we have identified to prominent health and wellness are working or not. But that's ISAC's job. We look at that and publish a report every year. We can also pop that in the chat so you can see the extent of work that is done toward this. All right. Next slide.

I have kind of gotten into this a little bit. One of the things, again, there are some real unique and distinct things about the population that ODP serves. I have shared that family piece of the engagement. And the critical nature of family, pretty unique. And you will see that as I describe where people are served. Basics of who comes to us for support is people with all ages with an intellectual disability, an autism or developmental disability through age 8. That was to pick up where we know there are gaps in diagnosis of autism prior to age 8.

And we do serve children with medically complex conditions as well. So, this is children who are dependent on technology.

The level of care, unlike CHC (Community HealthChoices), which you are probably more familiar with, the level of care for CHC is nursing facility, clinically eligible. Individuals in our program must be eligible for an intermediate care facility. That generally means they have that diagnosis of intellectual disability or developmental disability, autism and then they have substantial functional limitations in at least three areas of major life activity. So, self-care, communication, learning, and mobility. And one of the kinds of two primary characteristics in terms of what we see that does,

again, sort of set aside this population from other populations is the primary deficits do tend to be around communication and learning cognitive executive functioning. So, to that end, there is a significant need for supervision and safety-related support. As I said, we are birth to death in terms of our eligibility, and we do have some 1-year-olds in our program and I think I just saw we had a 98-year-old. So, we do really, truly have quite a life span of services here.

The other thing that is notable is that people who come to us for support are typically going to need lifelong services for basic health and safety. Essentially life sustaining support. If they do not have assistance and support, they are at grave and immediate risk in terms of different health and safety areas. People come to us to support improved function; habilitation is most of our services are aimed at habilitation. So, either acquiring a skill or maintaining a skill or improving a skill that someone has. We have a heavy focus on integration. As I'm guessing most MAAC members know, there is a long history of very, very significant and pervasive segregation for people with intellectual disabilities, autism, development disabilities. Our services have a heavy focus trying to ensure that people have opportunities for integrated services. And then obviously to support people to be as independent as possible and to provide for that everyday life, that quality of life. Next slide.

And I am actually, if MAAC members have questions as we're going, I am happy to take them if you are putting them, I'm not even sure I can see them in the chat. But I don't have a problem taking questions as we go here.

Basics for our office. ODP serves, we currently have about 62,000 individuals enrolled for services. Just went over kind of what that looks like. And the array of services that people may get through our office, and these are in the order of how many people are receiving them.

So, we have the most people coming to us are getting some kind of Medicaid HCBS. We have 42,000 people enrolled in a home and community-based waiver. The next, and we do have a significant waiting list, and for people who are on the waiting list or don't need any more intensive HCBS, they are going to be receiving Medicaid Targeted Supports Management. So, through our State Plan, ODP has Targeted Supports Management for people with intellectual disability, autism, and children with medically complex conditions. We have about 17,000 people who are not otherwise receiving HCBS, but they are getting some targeted case management or supports management. We do have people who are receiving services through base or state funded. So, we do have a cohort. Most people known to us are Medicaid eligible. So probably 98% or so of individuals in our program enrolled in our program are Medicaid eligible and they are receiving either targeted supports management in HCBS or services in an ICF (Intermediate Care Facility). We have some people who are not Medicaid eligible for whatever reason, they will receive base funded or state funded case management. And then our counties have, and these are historical allocations, so there is definite disparity in terms of how much counties have. Our counties do have some funding that they can use for HCBS for people who aren't eligible or for unique services that may not, that aren't Medicaid-funded services but will solve a problem.

And lastly, we do still have intermediate care facilities in Pennsylvania. There are some states who no longer have intermediate care facilities. We're not one of them. We do have two state-operated facilities, one in Selingsgrove and one in Evansburg Serve about 400 people and then we have about 140 privately operated facilities serving about 1500 people.

Next slide.

And that is, again, Medicaid funded.

Next slide.

So how our office looks in terms of administering those programs. You can see I have got the ISAC reporting right to the top here in terms of advising the direction that we take.

I have got a medical director, Dr. Greg Cherpes and Chief of Staff is Tawanda Jackson.

And we have five bureaus. So, our Bureau of Community Programs oversees the operations for

the three IDA (Intellectual and Disability and Autism) waivers: Consolidated, Community Living and P/FDS (Person/Family Directed Support Waiver). We have a bureau and under that, we have regional offices, field offices that then work with our county partners, those areas to administer the waiver.

Our Bureau of Supports for Autism and Special Populations oversees the administration of the Adult Autism Waiver. And we have an adult community autism program, which is a small managed care program that serves 200 people in four counties. Then our Bureau of State Operated Facilities, which oversees those two state-operated facilities at Selingsgrove and Evansburg and supports the operations for the intermediate care, the privately operated facilities. We do, because we fund it, we have engagement there. We are not the surveyors for the intermediate care facilities. But we do provide programmatic support for them and have an ICF (Intermediate Care Facility) task force that meets quarterly to be over different issues that are relevant for the group of ICF operators. We have our Bureau of Policy and Quality Management, which is Jeremy Yale, who you're familiar with because he has presented it to MAAC, on behalf of us many times. And then our Bureau of Financial Management and Programs Support, overseeing all of the data analytics and our budget and payment for we are a \$7 billion agency annually, when you add up all of the HCBS, the ICFs, all of our programming, we are \$7 billion a year.

All right. Next slide.

And then when you're talking about the IDD (Intellectual and Developmental Disability) system in Pennsylvania or anywhere else, one of the things that is really important is to understand a little bit of the history and how the service system has changed over the years. I mentioned at the front end that one of the core things that we are focused on is always ensuring that people have opportunities to receive services in integrated settings. And they have opportunities to live those everyday lives in the community that they have chosen in the Commonwealth. And that comes from a long history of institutionalization. It really was until the mid '60s, and Pennsylvania was definitely ahead of the curve nationally here, where for anyone who needed support beyond what their family could provide for them, the only place to do that was in an institutional setting and our public institutions in 1966, we had 13,600 people living in state-operated facilities. We had about 1,500 living in privately-operated facilities and we really didn't have community services. And again, this was a time where there was starting to be more public attention as to the conditions in these facilities.

So, in Pennsylvania in 1966, our General Assembly passed the MH/ID (Mental Health/Intellectual Disability) Act which really created that county-based community program. That was the beginning of it. You come to 1982, now you've got Medicaid waivers, and you can see the chart here is really just showing Medicaid services, we're paying an ICFs. That's the blue line and you can see that steady downward trend. And you can see this very strong upward trend in terms of serving people in community settings through home and community-based waivers that really kicked up in the middle to late '90s as Pennsylvania launched our consolidated waiver, expanded that Statewide, introduced the person and family-directed waiver. And then you can see how the enrollment of numbers of people really expands at that point.

So today, well, last fiscal year, we were down to 413 people in our state-operated facilities. 1,500 in private institutions and at the time, we had just shy of 59,000 people receiving some kind of community service.

Next slide.

The other in addition to thinking about just the downward trajectory of institutional care as the only option for people, the upward trend of people receiving services in the community, another important thing to understand is just how many of those individuals are receiving care in a family home and that is represented on these bars by the blue portion. So, you can see a very high percentage of individuals in Pennsylvania receive services in family homes. And I think you can

see just from the data jumping around that isn't people, actually changes in people where you have got the big jumps. That's the way that this national group has collected data or how it's been reported. But I think what you can see here is very consistently from the 2000s, we have been providing quite a bit of HCBS in Pennsylvania in family homes. And then the other thing that you can see here, and this is something that I think, again, Pennsylvania can be pretty proud of, is the next biggest bar in these graphs is for people living in group setting of one to six. We have had since the early 2000s a restriction for our licensed homes where we provide a service called residential habilitation. So, when you think group home and services of a group home, that's residential habilitation in a licensed community home and that is our really primary model for people who need that 24/7. We currently have just shy of 6,000 licensed homes that serve between 1 and 4 people in the Commonwealth. And by this graph, you can kind of see that gray bar, fairly sizable gray bar at the bottom. That is really the primary model and the black bar, which is those large facilities, has just continued to decline over time, including last year, we closed Woodhaven, which was a privately operated ICF that was actually once was a facility owned by the Commonwealth years ago. We closed that, that had about 70 people at the time that we began that closure. So, we have continued to do that.

All right. Next slide.

So, in the context, and I know you have had hopefully an opportunity to see the Secretary's budget briefing after the Governor's budget. Just to kind of highlight where ODP is within the DHS budget. This is state funded. We have the Governor requested \$3.82 billion for fiscal year 26-27 for us to operate those programs. And again, when you translate, add the Federal funds into that piece, that takes us to about a \$7 billion program. So, within the context of DHS, pretty sizable.

Next slide. And next one.

So how we operate these programs is, you know, I've described we have our HCBS, our targeted supports management, our intermediate care facilities and our office maintains the four home and community-based waivers, Consolidated Community Living, P/FDS, and Adult Autism Waiver. We have the budget authority for that. We also license day facilities and we license both those community living homes. We also license life sharing homes. We license many of the facilities that we are also funding services in. We have program regulations and we have licensing regulations. We have aligned those over the years so that kind of the primary areas that are important at an individual level, medication administration, individual plan, incident management and there's a fourth area that I'm going to forget. Those are all in alignment across our licensing and our funding of program chapters. We delegate for our HCBS. We delegate about half of our Federally required waiver administration functions to our county partners under operating agreements as administrative entities on behalf of the Commonwealth. As I noted, the MH/ID act of '66 created community-based ID programs. We really expand the scope of what counties do by these operating agreements and delegating them to administer due portions of that waiver administration on our behalf. So, our counties do eligibility. They look at that level of care, that responsibility falls on them. They have all kinds of responsibilities in terms of incident management and risk management and provider oversight at a local level. They are also the ones that review and authorize services in individual support plans. We have got 48 county or county-joiners who we have operating agreements with. Then we have the supports coordination. Everyone who is eligible for ODP services has a supports coordinator (SC), whether that is funded if they don't have Medicaid through the county or it's through targeted supports management or through the waiver. But everyone has a case manager or SC. And they are tasked with person-centered planning. Their three main functions are with planning, coordination, and monitoring. So, we really rely on SC's to not only support individuals to develop a person-centered plan to ideally ensure that they are living that everyday life in their community, wrapping community supports around them in the context of family for many individuals. And then looking at a very large array of HCBS designed to

support them to live those everyday lives.

We also, as I noted in terms of our population, we have a highly vulnerable population. Most of the people that come to us need support most of the time. People are very vulnerable to abuse and neglect. And so, the extent to which we monitor for risk for individuals is pretty extensive. Very much cooked into what SC's are doing when they are coming out to monitor individuals both for health and safety risks, but also to ensure that the services identified in their plan are actually being delivered as designed. Then we have the last kind of big group in terms of how our service system is structured is the home and community-based providers who are qualified and enrolled to provide services and they render those HCBS. All of this to drive the key folks in this, which are the individuals and in many cases, the families that are involved with them. This is where the support team is focused. This is where that person-centered planning is really critical. Everyone who is registered and enrolled for ODP services has an individual support plan. Whether or not they have access to a home and community-based waiver, they may have a plan that has very little in it beyond they've got some case management and maybe some connection to community resources. Then it is really critical that people have service satisfaction and that is where we have the national core indicators, our independent monitoring for quality to be constantly evaluating the quality-of-life factors and the service satisfaction for people.

All right. Next one.

We at ODP adopted something called Life Course back in 2016. And Life Course is really a framework. It comes with this great set of tools that are very easy to use for individuals and families and their teams. At the end of the day, this is actually something that's been endorsed by the World Health Organization because it's anticipatory planning. And because ODP serves population that has disabilities, typically lifelong, it's really important that we have anticipatory planning throughout that life span. So that we can anticipate for the 5-year-old who has autism that there may be some real challenges as that child is approaching puberty and how are we going to support that child, how are we going to support that family? What additional supports might need to be in place. We know that's going to happen. Right? So, let's anticipate these things. How do we set high expectations for youth, again, in the context of family if we are expecting that child with a disability is going to work and so going to have significant relationships as an adult, what are we doing, when that child is 3, 4, 5, 6, 7? We know what school is doing. How do we also make sure that those expectations are building up those skills and those experiences. So as that youth is aging out, that is a natural progression, right? Is the child engaging in some kind of household chores like other kids and learning those skills and being expected to have those kinds of responsibilities? Again, completely geared, individualized toward that child. But this is the idea of Life Course that we have been trying to embed in our system. One of the things that we're really proud of and we actually just received some national recognition from the national group that's been putting out and creating tools related to Life Course is we have a partnership with the Pennsylvania Department of Education (PDE) and the Office of Vocational Rehab (OVR). We have \$13 million grant that the three departments are working on aimed at competitive integrated employment and transitioning people from sub minimum wage employment to competitive integrated employment. The core of that we have built in Life Course. We have another \$5 million grant with PDE and the OVR aimed at even the younger group. So, starting at age 10, what are we doing to build up the expectation and skills and support for employment for youth with disabilities starting at that young age. Life Course is such a natural fit for this. So, this is something that has been embraced and embedded within OVR and PDE is doing the same. So really nice, shared framework, shared language that's pretty easy across systems.

All right. Next slide. One more.

The basics of our waivers. This is a pretty good resource for folks. For the ID/A (Intellectual Disabilities and Autism) waivers, which when I say that, I'm referring to consolidated person family,

community living. Again, these are all ages and you have got the numbers here. So, we have got about 20,000 people enrolled in consolidated. We have 13,000 enrolled in P/FDS and about 9,000 in community living as of the end of this last fiscal year. The Adult Autism Waiver, the eligibility is a little bit different. That is adult only, 21 and older, and that doesn't include medically complex. It includes you have to have autism. You don't have to have an intellectual disability. If you have an intellectual disability and not autism, you're not going to qualify. So, autism for adults, we have about 750 individuals in that program.

Next slide.

And I can't see if there are questions, I can't see them in the chat. But again, I am happy to address them. Some distinctions in terms of the waivers. We do have two waivers that have annual funding caps and two that do not. So, the consolidated and Adult Autism Waiver do not have any annual funding cap on them. The P/FDS and Community Living each have a cap on them. So, the P/FDS is capped at \$47,000 per year. There are a couple of services that are excluded, three services actually that are excluded from that calculation. And the Community Living Waiver is \$97,000 cap per year. The only service excluded from that cap is Supports Coordination. Next slide.

We have ODP's waivers, the three ID/A waivers are aligned in terms of the services available. The only real distinction there is that the only place that a person would be able, their budget would essentially afford for them to be able to purchase a residential service, a 24/7 residential service, is in the Consolidated Waiver. The Community Living Waiver, someone could get supported living and life sharing. But it's pretty limited in terms of the affordability based on need there. So for a 24/7 residential service, that's pretty much happening in the Consolidated. Otherwise, the services are the same and they are largely aligned in the Adult Autism Waiver. But there are some distinctions there still. But we have probably about 40 different services. This is everything from those residential services to respite care, there is family consultation. They're not all listed here. So, you've have some of the primary ones, but not all of them.

We have assisted with technology, home and vehicle modifications, shift nursing, that one is not available in the autism waiver. We have community participation, which is sometimes known as dayhab and behavioral support. All kinds of therapies, including art, music, and equine therapies that are built in our waivers in addition to more traditional ones. Essentially, we have tried benefits counseling is another one related to those employment services. I really tried to have an array of services that account for supporting individuals in community settings and making sure that their families also have the support that they need.

Next slide. One more.

>> KYLE FISHER: One quick question, if I may. Could you repeat the piece about housing? We always hear from families, particularly older adults caring for an individual in a waiver worried about their ability to continue doing that with housing concerns for their adult child. I think you mentioned Reshab (Residential Habilitation) and life sharing are clearly covered by community living P/FDS by sort of the budget constraints there. Could you unpack that a little more? Please.

>> KRISTIN AHRENS: Sure. Let me start with there are three residential services where there is a provider agency that has responsibility for 24/7 care for someone in a residential setting.

So, there's supported living, life sharing, and residential habilitation. P/FDS does not offer any of those. Under life sharing, for life sharing in the Community Living Waiver and supported living, our rates are acuity based. So, the greater acuity of support need, so the higher somebody's support needs are, the more paid support they're going to need. They are not likely to be able to get life sharing or supported living in the Community Living Waiver. There are some people that can and by all means, they should. But for the most part, anyone who is needing provider-managed owned or operated residential care is going to be in the Consolidated Waiver. So, all three of those are soundly in the consolidated. I think we have out of the 9,000 people in Community Living, we have

less than 100 who are receiving a residential service in that waiver.

Does that help?

>> KYLE FISHER: Ok, yeah. Thanks.

>> KRISTIN AHERNS: All right. Next one. I will give you a little bit more of the technical. I have been describing kind of who we serve. But very specifically our eligibility and this is determined by the county. Our system does not go through the IEB (Independent Enrollment Broker), which many of you might be familiar with through CHC. For ODP, this goes back to the Act of '66. Our counties are still the ones who are determining eligibility. And so, individuals go to their county MHID (Mental Health-Intellectual and Developmental Disabilities) office who determines their eligibility for services. And that eligibility is all of this has to occur before age 22 because we are a Developmental Disabilities Program. That's all of our, you know, the way we are authorized federally, that's what's in the Act. So, the disability has to occur before age 22. You got have to have that diagnosis of either intellectual disability or autism. For the medically complex, I want to say it's three major bodily function systems, technology dependent, and you have to have some level of need of nursing. Very specific criteria for the medically complex condition, again, has to be under 22 for that.

In addition to the diagnosis, the individual also has to have the substantial adaptive skill deficits in three areas and they have to meet the level of need for intermediate care facilities. They got to have the diagnosis, got to have adaptive deficits, and would otherwise receive those services in an intermediate care facility. So very parallel to how CHC works. You're eligible for a nursing facility and you get the services in the community. Exact same parallel structure here. It's just a different type of facility. It's not a nursing facility; it's an intermediate care facility.

And the last piece is Medicaid eligibility. And one of the things that I think is great about Pennsylvania and our Medicaid benefit for HCBS, this is true of CHC and ODP, we allow for people enrolled in our waivers, we allow up to 300% of the Federal benefit level as income to still maintain Medicaid eligibility. So that's different Medicaid eligibility than straight Medicaid eligibility for people not enrolled in HCBS.

Next slide.

So, the other important things, MAAC has heard me talk about the waiting list. Our program is the only Medicaid Program that maintains a waiting list for enrollment. This is not a waiting list for a provider or access to a particular service. This is a waiting list for enrollment in a home and community-based waiver. This is historic. When our program, when Pennsylvania started offering HCBS for individuals with intellectual disabilities and autism, we have always had a waiting list. So, you can see this is a little more than a 10-year look back. The top line is the overall trend line. We have had as many as 15,000 people on a waiting list for services. We are down to today under 12,000. We're about 11,500 with the December data. The bottom lines here are just to give you a sense of how many people come in for needing service each month and how many people we're enrolling each month. You can see the trend lines are fairly steady in terms of people coming in. We got a blip related to the pandemic when we didn't see people coming into the system for a while there. And the need most certainly picked up here, but this is a real distinction for ODP's services compared to other Medicaid services in the Commonwealth.

Next slide.

We manage our waiting list for the ID/A waivers by urgency of need. So, we have an instrument that we have used for more than 20 years. We have modified it. We just actually released earlier this week a new modification to it that has a little more sensitivity to help us manage enrolling people who have the most direct need the most quickly. And so, we distinguish between emergency, meaning people need services immediately or within six months, to people who need services six months to two years, to people who we're in a planning phase for. They don't need anything immediately, but they know they will and they want to be on the radar for that. So, they

are two to five years out in a planning category. We are very focused right now in this emergency category for adults. I will talk about that a little bit when I talk about our initiatives.

Next slide.

I think I can anticipate the next one is the multiyear program growth strategy. I know MAAC has heard about the waiting list and that we launched this multiyear program growth strategy. The Shapiro Administration has I think looked at this issue of the waiting list and particularly at the issue with adults on the waiting list. We've long had public policy in Pennsylvania that said if you're an older Pennsylvanian, you're a Pennsylvanian with a physical disability at 21, you will be enrolled. We used to have a slew of waivers. Now we're down to OBRA (Omnibus Budget Reconciliation Act) and CHC. But you're 21, you're going to move and you will need the services; you are going to be enrolled. We have not maintained waiting lists with the exception of one year during the Rendell Administration for one of the waivers for part of the year. ODP is different. And so, we have adults who are 21 and not enrolled, or older, and not enrolled in a waiver.

So, our focus has been in 2018, we said every graduating student will be offered a waiver. And we have been able to do that. We were able to manage within our resources to make sure that every graduating student was offered a waiver. We took our learning from that and said we are going to expand that to the entire adult population in the emergency list and Governor Shapiro committed in the budget that year and then this year some really significant increases to capacity in our budget to do that. The other piece that came with that is we are managing those resources differently. So, we have authored our agreements with the counties, and we are essentially doing a management to budget versus a number of slots, and we are certain that we will be able to serve more people that way. We have with this new approach; we have actually reduced the waiting list by 31% since Governor Shapiro announced this in February of 2024. Which is absolutely remarkable. We have never had that kind of a decrease in the adult emergency waiting list.

So, we're really pleased with that and very aggressively trying to tackle this to ensure that when students turn 21, for the folks that are adults, when they have a need, that we are able to very quickly enroll them.

Next slide.

Another initiative that I know MAAC has heard us talk about is we moved to performance-based contracting arrangements starting last year, July of '25/July of '26 in order to address pretty significant issues within our system. From sustainability, making sure that, I just shared the extent of the waiting list, we're very much a system of haves and have nots. We have 11,000 people waiting, and then we have got some very expensive service models that we are overly reliant on. So, we have got performance-based contracting is really aimed at making sure we have the clinical capacity to address the need for people coming to us now. It is aimed at trying to professionalize our workforce and making sure that we are stabilizing our workforce, that we have got better recruitment and retention. And that individuals have access as we're enrolling all of the people from the waiting list and the service, they have the services to get. So really trying to address our access issues within the system, particularly in the residential habilitation space.

Next slide.

So, we moved, again, as I said, January 1, 2025, we moved residential, you can go to the next one, Erin. We moved residential services, so that's the residential habilitation, those are the licensed homes, one to four people. Our life-sharing model, also called shared living. Provider managed is where someone is living with a family and family is defined by the person but living in a family setting. And then supported living. So, somebody living in their own place, but a provider has 24/7 responsibility for their support. Moved all of that January 1, 2025. We moved supports coordination January 1, 2026, to a performance-based contracting arrangement with us.

Go ahead to the next slide.

This is where we know, CHC is a 1915(c) waiver, which is a Home and Community Based waiver, that runs concurrently with the 1915(b)4, which is how you manage it. In this case, ODP has a (b)4 that we actually manage ourselves. So, we are instead of having managed care organization (MCO) do that, an MCO, ODP is doing that management. And the reason that we moved to a (b)4 concurrent with our 1915(c) is it allowed us to set new performance standards. So, all of the contracted providers, residential or supports coordination, now have to meet established performance standards. So, we can really drive some quality and some practice. We can also through a (b)4 use alternative payment methodologies. So, we can start paying for outcomes instead of just for units of service. So, we have a methodology for supports coordination that we think will support this improvement in quality. We have enhanced rates that are part of this for residential. There's residential rate add-ons for higher performance. And we have pay for performance opportunities for both supports coordination and residential.

Next one. I'm trying to make sure we have a couple of minutes here.

We have a supportive housing pilot that we started. So, there were funds, there's a restrictive fund established in Fiscal Code where any savings that we have from either closure of a state-operated facility or reduction in cost or sale of a property that was once a state center goes into this fund and the fund can be used for housing, waiting list, or direct support professional quality initiatives. Our ISAC said we want to do a housing pilot. So, we have a little housing pilot that has had incredible success in terms of addressing the need for housing and making sure people have whatever support they need around that. So, this is not licensed homes. This is people living in their own places who need some kind of housing subsidy to do that. And so far to date, we have seen just tremendous savings for people that have transitioned from residential habilitation, so they're living in licensed community home receiving 24/7 residential habilitation from a provider. We are seeing an average savings of \$75,000 per person for those individuals who have transitioned to these models. So really great outcomes. The DD (Developmental Disabilities) council will be issuing a report. They're doing the experiential report for individuals who have been using the supportive housing pilot. So that will nicely couple with some of the other financial outcomes that we're seeing related to this. All right. Next slide.

And then the last thing I just want to share with MAAC is ODP, our population, has a lot of unique features to it. Our service providers, all of our system partners, there is a lot of specialty service provisions that has to occur. And as a result of that, we are very much at ODP in the business of creating and delivering training and technical assistance. So, we have got some really nice materials for pretty much everyone in the stakeholder groups. The easiest way for people who are trying to get a basic understanding of our system, we have a really nice resource called the Gold Book that's featured here. It was written for individuals and families. So, it tries to simplify our very complicated system. And then we have contracts with health care quality units. ODP and OMAP worked together to launch the Pediatric Complex Care Resource Centers available for families and individuals and professionals to better support kids with medically complex conditions. We have some groups that are very engaged in advocacy who also do a lot of networking and mentoring for our population. A self-advocate group and a family group. Go ahead to the next one. Is that the last one? We have a bunch of universities, that might be the last slide. Yeah. We have partnerships with Temple to provide additional training and technical assistance. Drexel through the autism service education resource training (ASERT) centers. So, lots and lots of materials that we put out. The ASERTs create things like social stories for every imaginable scenario. So, when COVID was occurring, we lean on them to help create materials during COVID so people with autism could understand social distancing and the new protocols going on. They're very much at the ready to help us with anything like that. I left one minute for questions. I am happy to stay on. But I apologize.

>> SONIA BROOKINS: Deputy Kristin, I want to say I commend you for this report and overview. I

know a little, but I didn't know that much. So, I appreciate all that you and your staff have done and putting into doing this. I know it ain't easy. And I want you to know that we as a group commend you on the work that you have done.

>> KRISTIN AHRENS: Thank you.

>> SONIA BROOKINS: Anybody else have anything to say?

>> JOE GLINKA: It's Joe Glinka. Kristin, thank you. This has been an education, to say the least. And probably long overdue, in my opinion. I had a couple of questions. Forgive the naivety of the questions. If it's something you covered, forgive me. I'm looking at slide 11. And I see a portion of homes or settings that were unknown in terms of size. And then from 14 on, it seems like that's been mitigated. What was done to help eliminate that unknown factor? That's one question I had as far as what ODP was doing. And from 2017 on, I see that the overall cohort had decreased materially. Does that have something to do with the implementation of CHC?

>> KRISTIN AHRENS: It doesn't, Joe. Yeah. So, this is, we pulled these data from a national information research group that has been doing this for decades. As you can see. I think they even may have started before '98. They have been collecting this data for years. They have made changes in definitions. So, I suspect that the unknown was because either ODP didn't, you know, we weren't doing something well in terms of what we submitted, or a data definition changed and so we couldn't reply to the request for data collection. But a lot of those are those big jumps are more noise in terms of how they collected the data or how they were defining what they were collecting. So yeah. We still have, it is accurate in terms of the kind of home and community-based services, the settings they are collecting, that is pretty accurate. They just, it's data collection.

>> JOE GLINKA: Okay.

>> KRISTIN AHRENS: Yeah. If this helps, we have got about 15,000 people that receive some kind of residential service. So that's the supporting living, life sharing, or Reshab. Out of 42,000 people. The remainder of those live in their own home or in family homes. Most of them are in family homes.

>> JOE GLINKA: Okay. I appreciate that. Thank you.

>> KRISTIN AHRENS: Yep.

>> MARY HARTLEY: This is Mary Hartley. I'm sorry, I'm on the phone. If anybody else's hand is up, please take them before me. So, Kristin, thank you so much. Of course, I'm pretty familiar with your system and participate on the ISAC. I appreciate you doing a download for everybody on the MAAC today. I have a more general question, and it was actually great to hear this all-in context. Especially the conversation about getting people into their own homes, which is part of that housing pilot. And how that not only obviously includes people in the community in their own homes making their own choices, but it also reduces the cost of the Department. We know the same about employment, for instance. And students are included more in school. They're looking for employment in real jobs, not in a set aside segregated setting. And that does reduce costs over time. I wonder if you can suggest any changes that you have been seeing in the past couple of years that really point to how inclusion for kids in school and your work with the Department is sort of leading to less reliance on systems, but less need for the more expensive programs.

>> KRISTIN AHRENS: So, Mary, I would love to be able to tell you that I could demonstrate that at this point. But I can't. So, for a few reasons. One, our supported living model is very new. Our pilot for supportive housing has great success in the ten counties it's in, but we don't have it Statewide. And I think part of the, one of our big emphases in performance-based contracting, and supports coordination very soon, like right now this next year, they can receive pay for performance if they have reduced the number of people receiving residential services versus nonresidential. So, we are putting a lot of pressure on our supports coordination to get better at helping people use all of that whole other package we have to support people in their own homes or in their family homes more effectively rather than just looking to that residential as the solution. We also are really

applying a lot of pressure, well, it's pressure and incentives for our residential providers to look at who am I currently serving. Can some of them be served in a less restrictive, less staff intensive, less expensive model like life sharing or supported living? There are good incentives built into performance-based contracting for residential providers to do that. We've seen a nice expansion of providers offering now life sharing and supported living to try to do that. I think it's too early to say that we have good data because we didn't even have access to some of these services before. So, we have really built out the services to support people more effectively in different types of settings.

>> MARY HARTLEY: Thank you. I will follow up with you in more detail. I appreciate it.

>> SONIA BROOKINS: Anyone else have questions for Deputy Ahrens? What about in the chat?

>> ELISE GREGORY: Yes. We have quite a few.

>> ELISE GREGORY: From Lloyd Wertz, what is the expected level of impact, slash, damage anticipated to ODP programming due to the H.R.1 implementation?

>> KRISTIN AHRENS: I think the question was just what are we expecting in terms of H.R.1? Yes?

>> ELISE GREGORY: Yes.

>> KRISTIN AHRENS: Yeah. So, Medicaid is an ecosystem and I, I think it's pretty early to say. The Department has shared that we are anticipating a \$20 billion loss that begins in 2028 through the ten-year period for the H.R.1 implementation that is \$20 billion less in revenue coming to the Commonwealth for the Medicaid Program. It is hard to imagine that amount of loss not having impacts across the entire ecosystem. But I think at this point, it's pretty early to say. I do, Sally started with the H.R.1 workgroup, and I think these are the kinds of things that the H.R.1 workgroup will be looking at. But I think this is H.R.1 or not, ODP had a sustainability problem to begin with, which is where we started, we introduced the concept of performance-based contracting back in 2023 to start working with stakeholders on this concept with a real eye to sustainability and trying to make sure related to workforce, related to budget, related to making sure people have options for least restrictive settings that we get better at supporting people in non-residential settings.

>> ELISE GREGORY: The next question is from Lynn Miles. Is there a time limit on starting to receive services after becoming eligible for the waiver? In other words, do people lose eligibility if they don't start using services in a certain number of days?

>> KRISTIN AHRENS: I believe and actually Jeremy is on. I believe people are supposed to receive services within 45 days of enrollment in the waiver. Now, that's not to say we don't when there are circumstances preventing someone receiving the services that we don't have leeway around that.

>> JEREMY YALE: Good morning, Kristin. Just to confirm, 45 days is that window. But that individual would not necessarily lose their eligibility, per se. We would just, the team would work to identify what that barrier is to service delivery and work to eliminate them.

>> KRISTIN AHRENS: Thank you, Jeremy.

>> ELISE GREGORY: Is the 11,000 people on the waiting list for residential habilitation space?

>> KRISTIN AHRENS: No, no. Not necessarily. The individuals are waiting for enrollment in a waiver. So, they do not have access to any HCBS under the consolidated community living or P/FDS because they are waiting to be enrolled in a waiver. In terms of the needs of that group, our data is, there are questions about how solid the data is. There are quite a few of those individuals that have indicated that they need support residentially, whether that could be through a housing pilot or through supported living or residential habilitation, I can't tell you because the way we collect the data doesn't give us that discrete level of information.

>> ELISE GREGORY: From Ashley, is there a plan to extend the program once the ID/A supportive housing ends?

>> KRISTIN AHRENS: It is dependent on funding. At this point, I think the results that we are seeing are pretty compelling. The funding that is available for that is through the HCBS augmentation fund, which is limited in funding. So, our ability to expand it is limited by available funding.

>> ELISE GREGORY: Those are all the questions we had.

>> SONIA BROOKINS: Thank you, again, Deputy Ahrens. I really appreciate it. I do. We commend you for all the work. Thank you.

>> KRISTIN AHRENS: My pleasure. Thank you.

>> SONIA BROOKINS: All right. Next on the agenda is OIM, Carl Feldman.

>> CARL FELDMAN: Hello. Good morning. Can you hear me, okay?

>> SONIA BROOKINS: Yes. Good morning.

>> CARL FELDMAN: Good to be with you today. I have information to share on some of the items that you asked about. I will start with an update that was provided to me from the Bureau of Operations. So, we're a little time ways off from a kind of a nice, neat overlay, but I can tell you that in April 22nd, so April of 2024, we were at Statewide complement fill of 91% Allegheny, so District 5, or Area 5, sorry, was at 84% and Philadelphia, Area 1, at 82% and that was 2024. So 2025, Statewide in April, we were at 93%. So ticked up marginally from the previous year. Area 5 was at 89%. So pretty sizable increase in Area 5 and Philadelphia was at 85%. So, kind of around the margins. And then as of 2026, clearly, we're not in April, so we're giving you the most recent available. Statewide, we're at 92%. So, kind of neither here nor there relative to last year. Marginally down, Area 5 is at 86% and Philadelphia is at 87%. So, you can see we're kind of hovering around the same range from 2024 to 2025 to 2026 at this time of the year kind of in the upper 80s, lower 90s and it's over these past three years somewhat held steady. Is there more you would like me to talk about related to that?

>> SONIA BROOKINS: No.

>> CARL FELDMAN: I guess I would say when I look closer at it too, Philadelphia back in 2024 was at 82%. Being able to go from 85 to 87 shows pretty consistent upward trend. Whereas Allegheny is a little more stable, Statewide, it's a little more stable. So at least for Area 1, which is of course a major portion of our total case load, the trend is pretty good.

All right. I will talk now about some of the questions posed to OIM around SNAP (Supplemental Nutrition Assistance Program). So, I will read what was shared with us. There's an interest in hearing more about SNAP enrollment levels as a result of SNAP PEERS (Public Employment and Reemployment Rights) work rules and information about the SNAP error rate changes under H.R.1 and just general information about things we believe we have learned from the implementation of these peer work rules. I will start with just talking about overall enrollment levels. I have information about this for SNAP and for Medicaid. SNAP, both SNAP and MA (Medical Assistance) enrollment are declining. MA is a 2.6% decline year over year, and SNAP is down 10% year over year. So, both programs on somewhat of a decline from the previous year. I don't think that that's terribly surprising given the long tail of the unwinding, given the overall changes to the national political environment and what that might be telling to applicants or recipients. And then in particular in SNAP, I can't say that we're terribly surprised to see a decline as well because of PEER SNAP work rules. SNAP work rules are not new to the SNAP Program. There are new things about the H.R.1 changes that make them more widespread than they have ever been before.

In 2016 when the American Reinvestment Recovery Act (ARRC) rules around SNAP work requirements ended and we returned to SNAP work rules in much of the state, unfortunately, it's the case that many people did not continue in their eligibility beyond the three months of benefits that they're entitled to without an exemption or meeting compliance standards. And that is something we see kind of replicated now. People use their three months and unfortunately, some

people walk away. Some people return, but overall, I think we shared yesterday that there were between SNAP eligibility losses due to clock exhaustion in December and January, somewhere approximately around 80,000 recipients who are no longer receiving SNAP.

The work rule implementation in terms of what have we learned about this just required new efforts from us to find and identify populations. This is a big change for many parts of the state. While work rules themselves are not new, Philadelphia, of course, largest portion of the Commonwealth never had work rules imposed upon it up until this Federal law change. So, clients have to become familiar with that. Workers need to become familiar with that. It is completely novel for them, despite this being a long-term part of policy, people know that while that's in the policy, it has never applied to them before. And we took the time to update the policy as best we could to train the staff. But it's not an easy thing to do. And we think that despite our best efforts to communicate with people about these changes, some people did not come forward to self-disclose exemptions. We put a lot of effort into trying to find people who we can tell based on the data that we have available are entitled to an exemption based on their homelessness status, based on their participation in drug treatment, based on their receipt of unemployment compensation, and based on just direct correspondence with them through our mailings that indicate what exemptions might be available to them. But I can't say all this without saying that the speed at which we were required to change these rules significantly hinders our ability to help. Because the work that we did to try and identify these recipients who would otherwise be exempt was very manually intensive. We do not have a sophisticated mechanism that will sift through the information available to us and rise that to the top and allow us to just seamlessly apply the results of those searches to everyone to whom we found the information. It's really manual effort in doing list comparisons and then list dissemination to the workers to do re-coding. And unfortunately, there's not really anything that can be done about that. But we know that it's important and that's why we put the effort in. Are there questions that people have about that process? That change?

>> SONIA BROOKINS: Anything in the chat?

>> ELISE GREGORY: No questions in the chat at this time.

>> JOE GLINKA: I do have a question. Carl, it's Joe Glinka, again, forgive the naivety of this question on the SNAP eligibility determination in the context of work rules, is there a cadence of six months that will be applicable for those on expansion in that context as it will be on Medicaid eligibility determination?

>> CARL FELDMAN: Can I re-ask your question? Are you asking us if the certification periods will align for the SNAP and the expansion population of MA recipients?

>> JOE GLINKA: Yeah. That's a better way of putting it. Thanks for rephrasing that.

>> CARL FELDMAN: That's okay. It is possible for the certification periods to align. But it's not definite that that would happen. I think more times than not; it probably would not happen. In the Medicaid Program, up until, of course, the changes that will take effect in January 1 of 2027, individuals were primarily entitled to a 12-month certification period. Expansion individuals were and then effective 1/1/27, those expansion individuals will go down to six-month eligibility period. The SNAP Program has a number of different certification period assignments based on household circumstances and the shortest of those is actually three months and SNAP PEERS in particular are assigned the three-month certification period. We do this so that we can have greater contact with the household in order to determine if they have an exemption. And a lot of the time that comes out of a conversation from the interview. There are individuals receiving SNAP, including some SNAP PEERS who have a six-month certification period. There are some that have a 12-month certification period. And there are some with a 36-month certification period. So, my general opinion is that for the most part, the certification period at SNAP and the eligibility period for the Medicaid expansion population will probably not align neatly. We make every effort to try and align them, but the policy just does not really support that.

>> JOE GLINKA: I appreciate the education on that. Thank you very much.

>> CARL FELDMAN: Actually, to go beyond that, we have been thinking a lot about that question because it's likely the case that the majority of our SNAP recipients have a 12-month certification period and the majority of them are enrolled in simplified reporting, as if they get a SAR (Semi-Annual Reporting) form at six months. It's likely the case that if the certification periods are, not certification periods, the renewal period is aligned, the Medicaid expansion recipient will get a renewal at the same time they get a SNAP SAR. And we've been talk about what could be done to make these forms basically the same to try and align them. But I can say thus far in our policy exploration, we have not been able to identify a way to kind of combine that paperwork, for lack of a better term. And I should add, though, that today, people, when this happens, though it's less common, they get both forms. They get a renewal on the Medicaid side and a SAR. So, it would be nice to be able to find a way to make these be one document, but our exploration of it so far has not come up with any successes.

>> JOE GLINKA: I appreciate that and one more question. Do we have any line of sight into what proportion of the expansion population is qualified for SNAP?

>> CARL FELDMAN: I don't have the figure in front of me. So, I will get back to you about that. I can say that when we had some of these conversations two years ago during the unwinding, I think it was about 60%. But I think it's time to do a refresh.

>> JOE GLINKA: Thank you.

>> ELISE GREGORY: We have a question from Lloyd Wertz. Can you share the impact of the unmailed letters that were not sent out at the end of last year and the impact to beneficiaries?

>> CARL FELDMAN: Well, I guess I would start by saying that the letters were in fact mailed. They were just received a month late and I didn't come prepared to talk about that today. So, I don't have a lot of figures that I shared at the last MAAC meeting around this. But I can just say as a directional and a policy matter, what we did for Medicaid recipients for whom we identified was affected by the issue, if they had not yet closed, we held open their eligibility in order to give them 30 days to return what was mailed to them. If they had already closed, we ordered re-opening and review of the case to see if we received what we requested. And then if we did not, we took action based on the outcome of that review.

>> KYLE FISHER: Carl, this is Kyle. I appreciate you sharing that even where individuals on SNAP had not reached out to request exemptions, County Assistance Office (CAO), OIM did its own review of things, like homelessness status, participation in drug treatment.

Can you unpack that latter piece in particular, the extent to which you were able to use something like drug treatment, how OIM was identifying that and using that information, and I guess efforts to expand that in the short term, if there are any?

>> CARL FELDMAN: Yeah. It was of interest by the MAAC, the Consumer Subcommittee (ConSub), other folks that we talk with about the SNAP Program and SNAP PEERS that we identify people who may be exempt from PEERS rules from the requirements to use Medicaid claims to find people. And I think that's been of interest for many years. I remember discussing this with the MAAC in, gosh, I think 2016. And what I can say is that we were able to, in particular, use Medicaid claims to identify people in drug treatment. And proceed with an exemption based on that information before the end of, I guess what I would call the first major cohort eligibility period end before the end of December. In terms of our ability to replicate that, that is challenging and we have not made a commitment to do anything additional. We feel that the SNAP regulations are very supportive of the action that we have taken, specifically for people who are participating in drug treatment. It's less clear. We feel that we have support for SNAP regulations for other particular circumstances. And then in addition to that, it's extremely manually intensive to make these changes. Our goal in taking this step is to identify the people who meet these criteria and then because they are coded in such a way that reflects that in their future eligibility

determinations as a SNAP PEER through the SNAP interview will continue to have a discussion with them about their exemption status.

>> SONIA BROOKINS: So, Carl, 80,000 people that you said are no longer eligible, is it they're not eligible because they dropped off?

>> CARL FELDMAN: Yes. That reflects people's, what we call PEER clock, we used to call it the ABAWD (Able-Bodied Adults Without Dependents) clock. If you recall, there's three months in which you're entitled to SNAP eligibility within a 36-month period if you are a PEER. And we tick the clock for every month in which you receive SNAP benefits without being in compliance or exempt from that requirement. The figure I shared reflects the total number of people whose PEER clock was exhausted in both December and January. So, these are people who we believe left their eligibility specifically because they were not compliant and they didn't meet the exemption.

>> SONIA BROOKINS: Thank you for that. Anyone else have questions for him? For Carl? You have one more overview?

>> CARL FELDMAN: Yes. I can speak about eCIS (Electronic Client Information System) and some of the IT (Information Technology) Runway items. So, I think the key question here is about an understanding of when community engagement requirements and other H.R.1 activities will be made a component of the eCIS system or eligibility system. That's certainly a key question because, as I said on our last call, today our eligibility system does not include these requirements. This is new functionality that must be created and put into that system. I can't share an exact date, but I can say that there will be a fall release sometime in the fall that will be inclusive of community engagement requirement changes, that will be inclusive of non-citizen Medicaid eligibility changes. That will be inclusive of retroactive eligibility Medicaid changes. I should say that, in six-month eligibility determinations for the Medicaid expansion group, I should say that the things that take effect on 1/1/27 will still take effect on 1/1/27 just because we have a system release to deploy the system and does not mean we will implement any of these changes early. We do not intend to implement any of the changes early. We just have to make sure that we get the functionality in the eligibility system in time to be able to take action according to these new Federal rules. So, we were asked more I think about that time frame and I will just reiterate that of those changes, the earlier one is the MA non-citizen eligibility change which takes effect for the start of a new Federal fiscal year. We were also asked if there is a way to automate SNAP PEER exemptions on the basis of MA category. And what I can say is that we're definitely considering changes to SNAP PEER exemption processes in so far as they are tied into Medicaid community eligibility requirement rules. So, we're spending a lot of time thinking about how those two things work together.

>> [Interruption on call / Person muted]

So, I will reiterate on the request around triggering a SNAP PEER exemption based on an MA category. I can share that our discovery work so far in the policy unit is really around attempting to see what can be aligned for SNAP PEER exemptions and MA community engagement rules. You asked us if there are examples of eCIS using integrated or imported data from other DHS systems. We do have 11 different data exchanges that we use right now. Most of these sources of information at the moment are from other Federal or State agencies, such as Social Security Administration, the DOH (Department of Health), the Department of Labor and Industry. I think that just reading into the question and knowing the interests of this group, a lot of this is really a question about our ability to use data that we might have through medical claims through health information exchange, and we are very interested in that. We don't currently have a mechanism by which that information becomes a component of the eCIS eligibility system. So, it's definitely something we are thinking about, but as a matter of facts about how our eligibility functions today, it's not something that we can do. We were asked about how we provide member renewal dates in

our enrollment files to the MCOs and the 834 file. I believe that the eligibility period is a component of the 834 file. So, I believe that that is information that they have available to them. It was a large source of discussion and education during the unwinding period. And we were also asked if there would be the ability to add a notice of noncompliance to the enrollment file. I think this is really what's being referenced here as the 834 file and what goes back and forth from DHS to our MCOs, so they can have all the information they need about MA recipients so that the physical health and behavioral health MCOs could do targeted outreach to the members to say what we have identified is you're not compliant and should come into compliance. I can't say what it would take to change the 834 file to include information such as this. But we appreciate your thoughts on things that may be useful and it will be made a component of what we have to consider when we get to determinations about what needs to change in the 834 file, if at all.

>> JOE GLINKA: Hey, Carl. This is Joe Glinka from the physical health MCO standpoint, if there's anything that that community can do to align with OIM and partner, we would be more than happy to do that. We care about the members that we serve and reliable food source and the ability to pay for it is essential in trying to address a person's overall health status. So, if there's anything that we can be helpful on, we're at your disposal, I would say.

>> SONIA BROOKINS: Kathy?

>> CARL FELDMAN: I appreciate that. I want to share a little bit of information about how the non-compliance, I guess you could say, would work for pretty much all states. I don't think this is new information. The way that Medicaid community engagement requirements are to function is that the state is required to look at the prior month for the application to see if the person met one of the indications that they have been, I guess, doing community engagement and the notice of at that point there wouldn't so this is at an application. So, this is that application that they're not already enrolled. So that I think is a little bit of a challenge for MCO to get involved in and at the recertification, what we're looking for is any occurrence within the last six months and the notice of noncompliance would occur at the point which we send a renewal, if we have to send a renewal because we can't ex parte them. So, I think that's kind of the space that we would be working within. Just to give you some sense of where the potential for opportunity is.

>> SONIA BROOKINS: Thank you for that information. Kathy, you had your hand up.

>> KATHY CUBIT: Thanks. Quick question. Does any of your systems checks with particularly with others within the state agency, are you able to identify family caregivers, including unpaid family caregivers?

>> CARL FELDMAN: The eCIS eligibility system today doesn't provide any information about that, except for kind of some small cohort of people who are, I can't remember what it's called. It's a component of ACA (Affordable Care Act) eligibility. It's not what I think you're getting at, which is that if something is paid to provide pass hours through CHC, no, there is not something available to indicate that to us. And as we go through the various exceptions and exclusions to community engagement requirements, it's a part of what we'll have to consider.

>> KATHY CUBIT: Thank you for that. And I'm also thinking about all the unpaid family caregivers that may be identified through various care plans through waivers, as well as through aging's options program, et cetera. But thank you.

>> CARL FELDMAN: Thank you for bringing that up. I would say nationally, this is one of a couple of the exemptions and exclusions where there is, I will say, less information generally available from which to draw.

>> SONIA BROOKINS: Anyone else have any questions for Carl? Hearing none. Thank you again, Carl. We appreciate it.

>> CARL FELDMAN: Have a good day.

>> SONIA BROOKINS: Thank you. Next, old or new business? Okay. Hearing none. Eve? You're up.

>> EVE LICKERS: Hi. How are you?

>> SONIA BROOKINS: I'm good.

>> EVE LICKERS: We have had five bulletins issued since the last meeting all related to prior authorization. So last year on June 24th, we had issued a bulletin to advise providers of changes to all InterQual to the Milliman Care Guidelines, referred to as MCG. We have been using the InterQual guidelines since as early as 1993. So, this was a little change for us. But the prior authorization bulletins that we have been issuing recently are for those services or items where there are no MCG guidelines, but we would like to provide guidelines for Prior Authorization. So out of those bulletins, we issued a bulletin on January 29th for the Prior Authorization Guidelines for Manual Hospital Beds and Accessories. Also, on the 29th, we issued a Prior Authorization bulletin for the Face and Ear Prosthesis. On February 4th, we issued two bulletins related to Prior Authorization for Lower Extremity Prosthesis and Breast and Nipple Prosthesis. And the last bulletin on February 6th, the Tracheostomy and Speaking Involve and Voice Prosthetic Devices. So those bulletins can be found on the Department's what's new at OMAP web page or the bulletin search web page. We do have other Prior Authorization bulletins that will be issued in the near future. Hopefully, we'll be rounding that out pretty quickly here. But also, in addition to the bulletin, there are updated handbook pages for providers to use for the Prior Authorization. So, thanks very much. We'll talk to you next month about it.

>> SONIA BROOKINS: Thank you so much. Before I adjourn, I want to thank everybody that's on this call today. I also want to let everybody know that next month, we are in person. March 26th at the Keystone Building, the Forest Room. So, I appreciate all of that. Can I have a motion to adjourn the meeting?

>> JOE GLINKA: Move to adjourn.

>> UNABLE TO VERIFY SPEAKER: I second that.

>> UNABLE TO VERIFY SPEAKER: Second.

>> SONIA BROOKINS: All in favor?

>> COMMITTEE MEMBERS: I

>> SONIA BROOKINS: Thank you very much. Everybody continue to stay safe. Thank you.

>> EVE LICKERS: Look forward to seeing you all next month in person. Take care.