4/23/2026 Medical Assistance Advisory Committee Meeting

Attendees: Sam Chanek, Corey Notarangelo, Amanda Sagastume, Anthony Abrams Caleb Bressler, Erin Wyse, Eve Lickers, Gwen Zander, Marriam Wafa, Pamela Machamer-Peechatka, Sally Kozak, Scott Matlock, Sonia Brookins, Amy Lowenstein, Carl Feldman, Catherine Stetler, David Grande, Deborah Shoemaker, Dr. Chiamaka Nnamani, Dr. Valerie Arkoosh, Jamie Buchenauer, Jeremy Yale, Joseph Glinka, Julie Korick, Juliet Marsala, Kathy Cubit, Kristin Ahrens, Kyle Fisher, Mary Hartley, Minta Livengood, Montrell Fletcher, Nicholas Focht, Nick Watsula, Nicole Harris, Richard Edley, Russ McDaid, Ted Mowatt, Paula Stum, Leesa Allen, Danielle Angel, Tiffany Angel, Laina Auletta, Anna Aupperle, Radwan Azim, Ann Bacharach, Morgan Baker, Matthew Barbee, Jennifer Barmore, Daniel Bates, Matthew Bauder, Ellan Baumgartner, Clea Bell, Karen Bennett, Angela Biesecker, Kara Blasiak, Danielle Boncella, Patricia Brady, Joshua Bridges, Joshua Bridges, Hannah Brown, Justin Burdette, Dusty Carl, Andrew Centrone, Meredith Clarke, Michelle Cohen, Kristy Cole, Andrea Costello, Kristin Crawford, Fernanda Cuadro, Cindy Dang, Scarlett Davis, Melissa Dehoff, Jayden Demmy, Bikiltu Dirbaba, Kelsey Diss, Alison Dorsey, Deborah Duch, Kathleen Dunkelberger, Mindy Dunlap, Isaac Durham, Joshua Eisner, Corinne Elliott, Tess Fagle, Nicole Feaster, Nicole Fidler, Jena Fisher, Michelle Fowler, Carrie Frownfelter, Naomi Gaspard, Leslie Gelpi, Beverly Gillot, Janel Gleeson, Nadia Glenn, Tracey Glenn, Candy Graham, Donna Greco, Noah Greenberg, Elise Gregory, Erin Griffith, Erin Guay, Heather Hallman, Genevieve Harper, Elizabeth Hassett, Helen Hawkey, Casey Hayes, Brett Hayes, Beth Hennigan, Debby Hewitt, Matthew Hurford, Jeff Iseman, Breanna Jackson, China Jackson, Vicki Lee Jessup, Matt Johnson, Jennifer Jordan, Emily Katz, Zayne Kemler, Erik King, Jim Koncos, Michael Kornhauser, Hannah Kranz, Jonathan Kratchman, Liz Lancaster, Allison Lasher, Madison Laughman, Christine Lederer, Rachel Lee-Price, Becky Ludwick, Lauren Lutman, Sun Moon, John Morales, Patty Mackavage, Jocelyn Maddox, Sandy Marcella, Mary Mastrandrea, Nicole Matrey, Captioner Max, Terri Meyer, Jim Meyer, William Miskowitz, Julie Mochon, Kate Mohr, Aliya Mollah, Karey Molnar, Kevin Mulcahy, Sameerah Newsome, Alexandra Naismith, Jazmin Nixon Cartwright, Jordan Notarangelo, Ryan Paul, Nicole Payonk, Mara Perez, Elizabeth Piazza, Beth Pickering, Corey Pleasants, Kiziann Powell, Kyle Purchase, Marie Rains, Sam Rashdan, Lakshmi Reddy, Ashlee Reick, Emily Reid, Olivia Riek, Olivia Rindfuss, Annmarie Robey, Michele Robison, Jenn Rogerd, Bradley Roland, Pam Rotella, Rachel Rumpff, Ian Russell, Robert Rutkowski, Margaret Rybinski, Brad Shopp, Fady Sahhar, Theresa Sayce-Goldsby, Jessica Sebastian, Kimberly Sgrignoli, Sean Shamloo, Michele Shaughnessy, Jason Shoemaker, Nechel Shoff, Heather Shope, Caleb Sisak, Tinnesia Snyder, Jason Snyder, Tim Sohoksy, Felicia Stehley, Caroline Straub, Marisa Swarney, Dana Tacca, William Tassone, Laura Theurer, Megan Todd, Carissa Trivelpiece, Nicole Truhe, Elise Van Pelt, Courtney Walker, Jared Walker, Pam Walz, Lauren Wechsler, Maria Welch, Diane Werksman, Lloyd Wertz, Anne Yanikov, Nick Young, Starell Zoric, Stephen Cozzo, Sam Denisco, Rebecca Hathaway, Paulette Hunter, Shani Jackson, D. L., Debra Luther, Alexandra McMahon, Stacy Mitchell, Dawn Mueseler, Jim Sharp.

>>AMANDA SAGASTUME: Good morning and welcome to the April, 2026 addition of the Medical Assistance Advisory Committee (MAAC) meeting. Today is Thursday, April 23rd. My name is Amanda Sagastume from the Bureau of Policy, Analysis, and Planning (BPAP). Before we begin the meeting, I'd 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 notetaking or for any other purpose is not permitted. AI bots in attendance of this meeting will be removed. For panelists and speakers if you're expanding 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 disruptions, please remember to keep your microphone muted if you're not speaking. Live captioning, also known as CART captions, are available for this meeting. The link is included in the chat. Presenters should state their names clearly before speaking to assist the captioner. Presenting from DHS today, Secretary Dr. Valerie Arkoosh, special advisors to the Secretary of DHS Megan Todd and Dr. David Grande. From the Office of Medical Assistance Programs (OMAP), Bureau Director of the Bureau of Data and Claims Management (BDCM), Sandy Marcella. From the Office of Mental Health and Substance Abuse Services (OMHSAS), Executive Assistant Corinne Elliot. From the Office of Long-Term Living (OLTL) Deputy Secretary Juliet Marsala. Questions or comments may be submitted in the questions tab of the webinar. If you have any questions related to this meeting or need any additional information, please visit the MAAC webpage. So I will now hand things over to the MAAC chair Sonia Brookins.
>>SONIA BROOKINS: Yes, good morning everyone. Welcome to the full MAAC this morning. My name is Sonia Brookins, I am the chair for MAAC and we're going to do roll call and then we're going to get started.
>>AMANDA SAGASTUME: OK, so Jolene Calla? Kathy Cubit?
>>KATHY CUBIT: I'm here, good morning.
>>AMANDA SAGASTUME: Richard Edley.
>>RICHARD EDLEY: I'm here, good morning.
>>AMANDA SAGASTUME: Nicholas Focht?
>>NICHOLAS FOCHT: Good morning, I'm here.
>>AMANDA SAGASTUME: Joe Glinka?
>> JOE GLINKA: Good morning, here.
>>AMANDA SAGASTUME: Dr. Mark Goldstein? Mike Grier? Mia Haney? Mary Hartley?
>>MARY HARTLEY: Here.
>>AMANDA SAGASTUME: Julie Korick?
>>JULIE KORICK: Morning, I'm here.
>> AMANDA SAGASTUME: Minta Livengood?
>>MINTA LIVENGOOD: I'm here.
>>AMANDA SAGASTUME: Russ McDaid?
>>RUSS MCDAID: Here.
>>AMANDA SAGASTUME: Ted Mowatt? Dr. Nnamani? Deb Shoemaker?
>>DEB SHOEMAKER: Good morning I'm here.
>>AMANDA SAGASTUME: Matt Seeley? Nick Watsula? And Dr. Marc Yester. Okay, you have quorum, Sonia.
>>SONIA BROOKINS: Thank you very much. Good morning and welcome Secretary

Arkoosh. I just want to say thank you for attending my meeting this morning. And we just want to talk about, for us, for this committee and other committees, that we just want to know where we stand as a process as far as the H.R.1 group and as far as what our committee here in the Consumer Subcommittee. Where can we be, instead of just listening, we want to do. And we just want to help the Department in whatever we can help with. And so that is why we call this meeting this morning. And so maybe you can give us what we need. Thank you so much. You have (inaudible).

>>DR. ARKOOSH: OK. Terrific. Well, good morning everybody and thank you so much for inviting me and some of my team to join you today. And first of all let me just say thank you for serving on this advisory committee. This work is so important and is going to become more important, certainly in the months and years ahead.

So, I'm going to start with a quick update about where we're at in terms of implementation in response to H.R.1 and then I'm going to turn over to Dave Grande and Megan Todd who are going to talk to you today about how we are approaching the definition of medical frailty. So as you know, we have been methodically responding to H.R.1 which of course it hasn't even been a year yet, it was just signed into law last July, in the order of the things that were going to impact Pennsylvanians. So first on that list was SNAP and we moved very quickly to respond to some quite significant changes in Pennsylvania's SNAP program that were implemented over the course of last fall. And some of those changes were related to community engagement requirements and so we worked to build IT changes and updates and consumer facing processes that would also be available when Medicaid community engagements start in January. And now that SNAP is in a good place, we are fully turning our attention to what is going to happen on January 1, 2027 when we have two things that start. Both apply to the expansion, the Medicaid expansion population and only that population. That that population is over 760,000 Pennsylvanians and so it will have a significant impact. And those two things are that individuals must redetermine eligibility every six months and there will be this requirement for community engagement. So, I'll come back to that in a second.

I also want to tell you that we have been working very closely with the governor on budget initiatives which will invest in health and help to reduce pressure on our Medicaid system. Primarily there are two things in the governor's proposed budget for 2026-2027 and they are the three initiatives that we are calling Investments in Health. So that includes a Food is Medicine program, housing initiatives for unhoused individuals in Medicaid, and a set of reentry services. So that's one of the priorities in his budget. And then the second thing is to raise the minimum wage to $15. So we've been very focused on sharing information about those two things and how they would dramatically help all the individuals that we serve through our Medicaid program.

We've also been watching enrollment trends in our program and they had been ticking down pretty steadily for a number of months now. We think we may be seeing a period of stability here, but we're keeping a very close eye on those trends as well. And of course we get constant incoming from the Centers for Medicare & Medicaid Services (CMS), constant updates to rules, I mean it's just, it's never ending. So, once we have the 26-27

budget and we know whether or not the minimum wage was raised and whether or not these three investments in health got through the budget, we have more data on our enrollment trends and our Medicaid program. We will then start to begin the work to examine what is coming next in our program.

And as you know, and as we have talked about a little bit here, we know that there are sizable cuts - if nothing changes in Washington, sizable cuts - coming to our Medicaid program. And at the earliest they would start in 2028. We are hopeful that we would be able to put off any substantial changes to the funding of our program until 2029. And some of that is going to have to do with how certain assessments end up totaling out and in conversations that we're having with CMS. So, I want to assure everybody that we have not taken any steps to date in response to H.R.1 to start making any significant changes to the program. At this point we have simply been responding to new requirements in H.R.1 as they have been rolling out.

And of course one of the biggest things that will impact all of us on January 1 is identifying individuals who do need to meet these new community engagement requirements. And a big piece of that is how is medical frailty going to be defined? So, it's been an interesting process with CMS. As you know, the law says that they are supposed to tell us by June how to define medical frailty. I think that they have come to understand that that's a very complicated task and so they have actually been reaching out some states to ask us how we think would be a good way to define medical frailty.

So, we engaged with CMS last week and we presented to them what we are going to present to you today. They told us last week that they did not see any red flags so we felt that we were ready to present to you today and we are going to go through this plan with you and then we will very much be looking for your input and your reactions back to this plan.

One of the things that you will not get today, but you will get soon, is the diagnostic codes that we will be using to help meet the definition of medical frailty. So we'll talk a little bit more about through the presentation. But we don't have those ready to share with you today, but we should have those ready to share with you within a couple of weeks, hopefully, no longer than that. So again we will – and we'll give you an easy way to give us your input back, but we are really looking to our advisory committees to use your experience, it's why you are here on these committees, to give us feedback. None of this, nothing that you're hearing today is final or set in stone in any way. And so this is just our first, very well-thought-out take, but one that is by no means finalized, so we are eager to hear your reactions to it. So, with that I'm going to turn over to Dr. Dave Grande and Megan Todd.

>>DR. GRANDE: Alright, thank you, Secretary. So good morning to all of you. Again as the Secretary shared, really appreciate the opportunity to be on your agenda today and to share how we are beginning to approach this question of defining medical frailty as one component of H.R.1 implementation. Again, as the Secretary shared, H.R.1 imposes entirely new requirements on the adult expansion population and so we are working very hard to determine how we can implement these provisions consistent with the law but at the same

time maximizing the opportunity for beneficiaries to maintain coverage.

As you may know, CMS has not issued final guidance for states. We don't know exactly how detailed that guidance will be and it is not expected until June. But we also know that we can't wait until June. So again what we are sharing today is a working draft, nothing ultimately can be truly finalized until we have that final guidance from CMS in June. So I just want to note that here. But if we can go to the next slide that would be great. So, it is worth contextualizing when we are talking about medical frailty - where does it fit into the broad contours of this law? So I just want to take a step back for a moment and just remind folks of the H.R.1 requirements. Again, you may know these already but I just want to summarize them quickly and again where medical frailty sits in this conversation.

These requirements start in January 2027. Again, only applies to the adult expansion population. And to meet the new community engagement requirements in a given month, individuals must do the following - you have to demonstrate one or a combination of the following four activities for at least 80 hours in a month or an average of 20 hours per week and so you'll see those first four bullets here - work, volunteer in the community, be in a work program or be enrolled in an educational program at least half-time. So, you can be doing any one of these activities for 80 hours a month or, again, an average of 20 hours a week, or they can be combined activities to also meet that goal. You'll see the fourth bullet is be enrolled in an educational program at least half-time. As of this point, that has not been fully defined by CMS of what half-time educational programs are, so we're waiting to hear on that. The last two bullets on here are the other way to meet the requirement, which is based on income rather than counting hours. And if someone has a monthly income that is greater than the minimum wage times 80 hours, which equates to $580, that would also meet the requirement, again without needing to count hours. Next slide.

But the law does exempt certain populations from these requirements and that's really where we're focusing today. It exempts people who are medically frail or otherwise have special medical needs, including people who are blind or disabled, have substance use disorder, have a disabling mental disorder, have a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living, or have a serious or complex medical condition. It is that last category, serious or complex medical condition, where all states have been trying to determine how much flexibility the federal government will give the states. And lastly, it's important to note that separate and distinct from that list above there are also allowances within H.R.1 for certain hardship exemptions. Such as a recent hospitalization regardless of the reason for that hospital admission. Next slide.

So, we have really approached this work with a few important principles in mind. First and foremost, we want to minimize paperwork on everyone, that includes beneficiaries, providers, caseworkers, by using existing sources of information that is not only our own design principle, but it's one that's actually called for in the law and we are fully embracing that concept. The second, we want to make information available at the time it is needed and the redetermination process. It's not just enough to have information,

it is critical that that information is available at the right time in the process to maximize the effectiveness. Third, we want to make sure we identify new health conditions or recent healthcare events that occur close to the time of redetermination. For example, someone may be hospitalized just a few weeks before a critical step in the redetermination process, so we want to use as many resources available to us to ensure we are accounting for more recent health issues or health events. And lastly this is entirely new, again to the Medicaid Program. So, we approach this work knowing we will need to innovate, evaluate and focus on continuous quality improvement to make this work better and better over time. Next slide.

If you look at the big picture, the agency is going to use as much information available as possible to minimize what is asked of the applicant. So this includes for compliance checks where records can show someone is already meeting the requirements. It can also include exemption and hardship checks where records can show someone has an exception, such as being a caregiver, recent incarceration, is medically frail, or has some other qualifying activity. And only in those instances where those two first categories do not show compliance or an exemption would an applicant need to provide information. And so our focus today is on that bolded part in the middle which is medical frailty as an exemption. Next slide.

And so, again, just to underscore, there are many factors that contribute to compliance and many potential factors that can contribute to an exemption. But everything I talk about going forward is really focused on these words, medical frailty. So, we can go to the next slide. So it's important to note that the process to assess for medical frailty may vary depending on if we are talking about someone that is renewing their Medicaid vs. someone making a new application and that is for a simple reason. Obviously when people are renewing, we will have more information available from Medicaid records to determine if someone is medically frail. This would include records of past healthcare use, documented medical conditions and potentially other MCO records. But for new applicants, while we may have some old records, it will be naturally more limited and in some cases none at all and therefore for new applicants the process may require more information being provided directly from the applicant compared to those that are renewing. I will talk more about the medical frailty process in a moment, but I do want to call out the last bullet on the right which is we are exploring the use of more real-time health information from something called the Pennsylvania Patient and Provider Network or P3N to support the process. I will talk more about that, so I won't describe it in detail now, but it may have some unique value with respect to thinking about information that could be available even for new applicants of the program. Next slide.

So, we are looking at several sources of information to minimize what you see there all the way on the right side of the slide which is an applicant needing to provide information. Everything we're doing is focused on minimizing how much is asked of the applicant. So I want to walk through these other three sources of information. But to summarize we are looking to combine information from healthcare claims, which you can think of as healthcare billing data, combining that with information from electronic health

records available through that P3N program that I just mentioned and then supplement that with other information available from managed care organizations (MCOs) from activities such as health assessments and case management. Next slide.

So, let's dig in on that first category. And again this is talking about what you will commonly hear referred to as healthcare claims but also you can just think of it as healthcare billing data. And so these are all the records generated when healthcare providers bill the Medicaid program, mostly that's happening through our MCOs. And we do plan to analyze that information and look for medical conditions both new or recent conditions, as well as chronic conditions. Once we identify conditions from that billing data we will then compare that to the list of medical conditions that the Secretary referred to that would make someone eligible for a medical frailty exemption. We have generally taken a broad approach and built a preliminary list from the CMS chronic condition warehouse along with several other sources and have been refining that through clinical review. We are taking as broad of an approach as possible in constructing the list consistent with requirements in the law, or H.R.1. However, again, this is another area where final CMS guidance will be important. We believe CMS will allow states to designate conditions as being either permanent or chronic vs. short-term or temporary. So, some conditions may provide an exemption until just the next renewal in six months vs. other exemptions that could last longer. One important limitation that I want to call out, billing data or claims data, is that it can take several months from the time clinical care is being delivered for billing and claims data to make their way through the system. So that's something like a hospitalization that occurred last month is actually visible to us. So we have to deal with the fact that we…when we rely on billing data, don't see things in the data that happened very recently. So, that takes us to the value and the next source of data, which you can go to the next slide.

So, we are looking to supplement that billing data or claims with information from the P3N or Pennsylvania Patient and Provider Network. This is the system which is how healthcare providers in Pennsylvania exchange health information from electronic health records. And this program is near real-time live clinical exchange. And so we are looking to use P3N to identify more recent health events and diagnoses that we can't necessarily see in billing data. This could also include healthcare episodes such as a hospitalization that could provide a hardship exemption, potentially something that just happened in the last several weeks. So this would supplement healthcare billing information, not replace it, because not all providers and healthcare visits are included in what would be visible in P3N. And it doesn't always go as far back in time as billing data. So, this could be useful for certainly people who are renewing but also useful for people who are new applicants where there is no medical billing data on file in our records. Next slide.

Lastly, we are also looking to partner with our MCOs to leverage any additional health information they have beyond billing data. For example, when individuals are newly assigned to an MCO, a health risk assessment is completed and members with complex conditions are then enrolled in case management. We want to collaborate with our MCOs to leverage information they have from case management and these health assessments

to identify health issues including those that cause functional limitations and again that was in the law, called out, as people who'd be eligible for exemption as people who have disabilities that cause functional limitations and sometimes that can be hard to determine from Medicaid billing data. And so case management potentially provides valuable information in that regard. Next slide.

And then lastly some individuals will have serious or complex medical conditions or other conditions that qualify for an exemption, but we do not have administrative records demonstrating that. And it is those instances where client contact and client provided information will be an important pathway. But again our goal is to rely as much as possible on administrative information available and minimize the burden on the applicant. Next slide.

So, in summary we are very focused on doing everything we can to reduce the medical frailty paperwork burden, streamline the process for the applicant and maintain coverage consistent with H.R.1. We are taking a broad view of medical frailty which we believe is consistent with the law and called for in the law. We want to focus on all the sources of information to the extent possible to support beneficiaries. We also know again this is an entirely new requirement and process. And so we plan to approach this work, again, focusing on continuous improvement which means evaluating what is working and not working and making improvements as quickly as possible. And then lastly, as I again shared multiple times, we can't really finalize this work until we have the final CMS guidance which they are obligated to provide by June according to the law.

So everything we have as of right now is still preliminary, but hopefully gives you a sense of how we are approaching medical frailty and ensuring we do everything we can to ensure people who qualify for an exemption, receive an exemption, with the minimum amount of burden being placed on the individual themselves. So, hopefully that gives you a good sense of how we are thinking about this, but again as the Secretary mentioned we welcome input and feedback and do expect to be able to provide you that code list of diagnoses that we are thinking about in the coming weeks. Thank you.

>>SONIA BROOKINS: Do you want to go on to Megan? Or how do you want to do this? Or do you want us to feedback to you now on the committee?

>>DR. GRANDE: Megan, is there anything that you wanted to jump in and add? Or…we would certainly welcome any comments or questions from the committee.

>>DR. ARKOOSH: Yeah, we can take a few questions. And we'll make sure that we put a resource mailbox into the chat where questions can go to and again we will…thank you, Eve. Eve is on it. And then we will…we should be able to share these slides with you. I'm not exactly sure how we're going to do that, but we will figure out a way to make sure that we can share these slides with you, too.

>>SONIA BROOKINS: Okay, so we have Kathy first, then Richard. And then…go ahead.

>>KATHY CUBIT: Thanks Sonia, and thank you Dr. Arkoosh and Dr. Grande for the presentation. I have a question whether applicants, or if you're considering a process for applicants to be able to self-attest to medical frailty on the application. I don't know if you can comment on that. Thank you.

>>DR. GRANDE: Yes, we are definitely anticipating that. The process in doing so has not been fully developed yet, but that again will be an important part of that category that I mentioned of applicant provided information. And so there will be that opportunity for the applicant to do so.
>>DR. ARKOOSH: And if I could just jump in, David, this is an area where we'd love to give your feedback because when we asked CMS about that process, they really didn't have any recommendations for us other than that this information will need to be able to be audited. So, we will have to collect enough information on that self-attestation that when we get audited, which we do regularly, we will be able to show that there is some evidence, and again they have not told us what that would be, but we will have to able to be responsive to an audit, that this self-attestation is indeed truthful. So, if you all have thoughts on what that would look like without being overly burdensome for instance a person who is a caregiver for an elderly parent or child, we would love to get your input on that.
>>SONIA BROOKINS: Does anyone else have questions? Joe? You have questions?
>>JOSEPH GLINKA: I always have questions. But...I have one for here, and really do appreciate the insight. I want to come back to the Health Risk Assessment (HRA). You know, with MCOs it is required that we engage our incoming members within a 90 day period of time to do an HRA. And we, you know, by contract, by agreement, we have to make, you know, at least three attempts at that. The engagement or the connection on that, it's not 100%. You know, so would there be any, realizing the 2027 agreement is still in draft, is it...should we be on the lookout for maybe an extended period of time to engage members to have additional opportunity to obtain that information or not? Just talking on top of mind here.
>>DR. ARKOOSH: Yeah, Joe, that's a really great point and we'll take that back and discuss. I don't know that we've specifically gotten to that level of detail yet, but that's a great point for us to consider. Yeah, thank you.
>>SONIA BROOKINS: So, Secretary Arkoosh, with these slides that you got out, you know, you presented today, how long do we have to respond back? What is the time limit that we have to respond back to these slides?
>>DR. ARKOOSH: Yeah. So, we want to get you these codes, these diagnostic codes, that we'll be using. There's hundreds of them. And we want to give you a chance to look for that, to look through that. So you can start sending initial comments now through that email which would be the easiest thing for us if you are able to respond through that email. And then again I'm not exactly sure when we'll be able to have these codes formatted in a way to easily get them to you. But, that will be fairly soon. And I think Megan and Dave, what, by the end of May probably would be ideal to get your feedback? Into the month of May?
>>DR. GRANDE: Yeah I think that sounds right, and we can make sure that all lines up with timelines, but then on first reaction I think that sounds correct.
>>JOSEPH GLINKA: If I could indulge one more thing that comes top of mind is, perhaps another source of information would be some type of a letter or certification form from the applicant's physician that would serve to be as proof of medical frailty, again just a thought

for consideration.
>>DR. ARKOOSH: Yeah, absolutely. I mean, those very traditional ways of doing this will 100% be valid, Joe. We are trying to minimize the burden both on Medicaid recipients and on providers. And so we all know sometimes providers aren't super responsive and Dave and I say that as providers. The more that we can take that out of the loop if we can, but of course absolutely that will always be an available mechanism.
>>JOSEPH GLINKA: Thank you.
>>DR. ARKOOSH: Yeah.
>>SONIA BROOKINS: Anybody else have any questions?
>>RICHARD EDLEY: Yeah, Sonia this is Richard, I had my hand up and I just wanted to make a quick comment. Good morning everyone. Just to step back for a second. I really appreciate the presentation and what I've been reminding everyone is that obviously DHS has the best of intent here. I mean, you're trying to do this well and you are under a lot of pressure and I appreciate particularly Slide 4 on the Implementation Principles. And words are important. Hearing you say how much you welcome input and feedback means a lot. And I just wanted sort of go back to the original issue, I think that there was a lot of rumblings at the MAAC and some of the other groups that I think today is a good way to sort of start off a new process and a new relationship with the stakeholder groups. I think when the workgroup was initially created - and I'm on it, so I'm saying this just from what I'm hearing from my colleagues – that there wasn't a lot of transparency, I heard that word a lot, that how was it chosen, why is it chosen and how often is the meeting? What's going on here? There seemed to be a lot of concern. But then second, related to that was that there seem to be some, sort of, tripping earlier, early on about is this a workgroup that you are looking for feedback or is it, the quote was, this is simply a report out. And hearing you today, I always thought it was a matter of semantics. I mean yes, you are reporting out, but yes you are also taking feedback, so whether we call it a work group or not, it's the concept. And so I look forward that today is sort of the start of a new way of doing it and maybe people will feel a lot better about the value of their input. That's my main comment.
>>DR. ARKOOSH: Thank you, Richard.
>>SONIA BROOKINS: Alright. Deb Shoemaker?
>>DR. ARKOOSH: Hey folks, I am so very sorry, but I have a 10:30 AM meeting so I am going to have to hop. I think Dave and Megan might be able to stay on a little bit longer, I know Sally is on, so if there's anything else that needs to come back to me they'll be sure to get it to me. But thank you all so much for your time I really appreciate it today and I'm sure we will be seeing each other, you know, many times over this next year. So, take care, everybody.
>>SONIA BROOKINS: Thank you. Thank you so much.
>>DR. ARKOOSH: You bet.
>>SONIA BROOKINS: Alright. Deb?
>>DEB SHOEMAKER: Well, I wanted to say to Secretary Arkoosh while she was on thank you and she's welcome anytime, but you can take that back! One of the questions, and I know that we've talked about H.R.1 implementation at some point, I don't know if Catherine will

be talking about it, but one of the things that has come up that I don't know, when you're talking about this situation is what I call transitional age youth. So Dr. Grande I don't know, like when we're looking at these definitions, you know, I'm going to give you a personal example, my daughter has just turned 18, she's ready to go to college. And I was wondering how some of these requirements and how CMS may be developing education and how that requirement works and part of that, as well, I was talking about when Joe just talked about traditional letters and things like that, there's times when especially people who have mental health, you know, concerns. And I'll be curious on the medical frailty when it says about what definitions they consider whether it is SMI or whatever the case may be. But, how people who are going to be in college, how they are going to determine that for things such as medical frailty, work requirements and things like that. I'm just checking to see if it CMS is taking any look at that? How they're going to work on that, because we do have a lot of people who obviously, that 18 to 19-year-old, I mean I just saw it recently in emergency room where there's a lot of confusion when somebody just turns 18, do they go...they're no longer in the pediatric world, they are in the adult world, but they're in an unsure world so I wasn't sure if there was any guidance on that specifically.
>>DR. GRANDE: A great question, resonates a lot with me having a similarly aged child where I can vouch for the fact that it's very confusing when your child turns 18 what changes and what doesn't change. I think that there is going to be a lot of work to be done around how we get information out to everyone and this group hopefully can provide some good input in that regard, because I don't think CMS is going to be a driver of pushing out information. I think they are really kicking that to the states. I think educational programs in particular and whether they qualify for an exemption and how to automate the use of information about enrollment and educational programs is something that requires a lot of data systems to talk to one another that haven't had a reason to talk to one another in the past. So again, these are about these very new requirements in Medicaid and having systems that need to be stood up that haven't been before. I know that CMS is trying to provide states with some potential electronic sources of information and one of those may be around enrollment educational programs. But, a lot of that is very preliminary right now. So I think just to take a step back I think they're both incredible needs around thinking about how to get information out to all types of people in different life circumstances around what these new requirements are and who they apply to and how they can report information if they will need to report information. And then the second thing is how do we leverage as much data as possible and whether or not we can be able to pull educational information into this process I think would be incredibly valuable that there is work to be done to make that a reality.
>>DEBORAH SHOEMAKER: Thank you, then I guess we will do it together!
>>DR. GRANDE: Sounds great to me!
>>SONIA BROOKINS: Any more questions, anything in the chat? I hear none, there's no questions, anybody else?
>>AMANDA SAGASTUME: Sonia, there are a few questions in the chat.
>>SONIA BROOKINS: OK.

>>AMANDA SAGASTUME: I'll read…we'll get through what we can. So one from Christine Lederer. Will this process be similar for people with intellectual disabilities? Will you pull on similar status sources so the burden doesn't fall on the individuals to provide documentation?
>>DR. GRANDE: Yeah, I think if someone, again, is in the adult expansion population and so again all of this is just for that population, then yes we would definitely be drawing on all these information sources.
>> AMANDA SAGASTUME: OK, from Janel Gleeson. I think you said that states will have flexibility in determining short vs. long-term diagnosis in the applicant's medical record, can you talk more about what kind of look back we expect from CMS or even a look forward for certain diagnoses that should always be considered permanent?
>>DR. GRANDE: Yes, Megan I don't know if you want to speak to this, again it's an area where we've gotten some verbal statements from CMS, but not confirmation yet on how temporary vs. permanent will be applied to the redetermination process, but I think we have some hope about what that would look like and Megan – do you want to speak to that?
>>MEGAN TODD: Yeah, I mean not a lot to add. There's a lot of uncertainty. We've heard that there will be a distinction between these temporary vs. permanent conditions, but not a lot about how we define one vs. the other or if there will be different look back periods for determining one vs. the other. So, more to come there. And we're kind of right now trying to think about lots of different possibilities that may come to pass. But, still don't know.
>>DR. GRANDE: What we've definitely heard is that for some conditions, they will need to be reevaluated. Like ones that are not clearly permanent will need to be revalidated through this process when someone comes up at 6 months while others could carry forward for at least 12 months. Whether or not some conditions need to be reevaluated beyond 12 months, I think that is where there is some uncertainty at this point from CMS. But, I would anticipate that will be in some of the final guidance that we see in June.
>>AMANDA SAGASTUME: And then we have one more question here from Matt Johnson. Our healthcare specialty related to orthotics and prosthetics, we work extensively as part of the care teams for those having physical, ADL disabilities. Would our interdisciplinary assessments help establish medical frailty?
>>DR. GRANDE: So, we are open to hearing about any and all information that could be leveraged in this process and so I would be eager to hear more about that and how we could potentially leverage it. As part of that third data source I mentioned, working with MCOs as we want to have a roll up our sleeves conversations with the MCOs about all of the things that they learn about folks and the different ways that they do and how we can pull that into this process and so we know, again, as we mentioned earlier those health risk assessments in case management, but if there are other ways in which information is gleaned on certain populations, and we can incorporate that in the process, we would welcome a conversation about that.
>>AMANDA SAGASTUME: And then just a last one from Naomi Gaspard. In reference to the

list of diagnostic codes, just confirming you'll accept comments and suggestions until the end of May. Can organizations and people outside the MAAC weigh-in as well?
>>DR. GRANDE: That's a great question. I mean, I know that what we're…I guess that's one we can follow-up on what that process will look like. Certainly the MAAC is who we're primarily turning to of course to get feedback. Beyond that what that will look like I think is something that we can follow up on.
>>AMANDA SAGASTUME: Okay, thank you and that is all the comments in the chat right now Sonia.
>>SONIA BROOKINS: Alright thank you for that. No one else has any questions for them.
>>JOSEPH GLINKA: Madame Chair, can I indulge one more time?
>>SONIA BROOKINS: Sure!
>>JOSEPH GLINKA: Thank you. So this is probably my limit Dr. Grande, he'll shut me off after this, but just to put it on the radar, I mean, if we are looking at the chronic impermanent upon initial determination, and then there is perhaps a little bit of a relaxation on that at the redetermination in 6 months, I think messaging is going to be very, very critical for consumers to understand, you know, when they go through this the next time what they do and don't have to do. You know messaging with respect to this whole initiative is going to be critical, because you've got cohort of 760,000 that are going to be impacted and you've got the balance of 2.3 million+ that aren't impacted by this and we are trying to make sure we're managing expectations over there as well as far as business as usual. So it's going to be critical that that messaging is appropriate and timely and accurate. So, just making that suggestion.
>>DR. GRANDE: Yeah, I couldn't agree more. I mean, these requirements are complex, they're complex in how they apply to the adult expansion population. I think they're complex for individuals knowing whether sometimes if they are even in the adult expansion population and this is relevant to them or not relevant to them. And then if people have exemptions with varying time frames. So it is an enormous communication challenge, so I take your point and again hope that we can be as all hands on deck as possible with all stakeholders in terms of thinking about how to get this information out to all the Medicaid beneficiaries who need it.
>>JOSEPH GLINKA: Thank you.
>>SONIA BROOKINS: Absolutely. We look forward to working with the Department on these slides and see what we can do to make a difference. Help someone. Everyone. So, we look forward with this. Anyone else have anything to say before we move on?
>>DEBORAH SHOEMAKER: Just one addition to what you just said Joe, this is Deb Shoemaker again. Is that as you do the communication, keep in mind in the Consumer Subcommittee that we want to be a part of that discussion and I know that we always hammer home about that so that the language is something that is easy to understand and that we make sure that there is not confusion for consumers and the people that we serve.
>>SONIA BROOKINS: I think they got that, Deb.
>>DR. GRANDE: Thank you.
>>SONIA BROOKINS: All right, thank you. Moving on to…thank you both, thank you very

much. Moving on to workgroup follow-up discussions, do we have any updates? And we got conditions of qualifications exempt for community engagement requirements? Anyone?
>>JOSEPH GLINKA: Sonia, this is Joe, yeah I…from the Managed Care Delivery System Subcommittee (MCDSS) I know we're going to have quite a list and resource for consideration in the H.R.1 workgroup. There will be material items of input as well as probably a number of questions as well, because the MCDSS will be bringing forth both the physical and behavioral health perspectives in the next H.R.1 implementation group. So, you know, I share that to the extent that it is helpful.
>>SONIA BROOKINS: All right, thank you so much for that, Joe. And I have that, thank you. Okay, no questions? Okay, Sally? OMAP update.
>>SALLY KOZAK: Yeah, so we actually have Sandy Marcella to talk about some updates that we've made to our Medicaid Management Information System (MMIS) which people know as PROMISe. She's going to talk about the rollout and then we also have some updates on the new prior authorization system which we are calling Qualitrac®. So Sandy, are you on to go ahead and give your presentation? Do we not have Sandy on?
>>AMANDA SAGASTUME: Sandy, you are unmuted, I don't know…we cannot hear you. You might want to go to the gear tab and make sure that you are on the right microphone?
>>SALLY KOZAK: While Sandy works on that, do we have Allison?
>>ALLISON LASHER: Yes, this is Allison, I'm here.
>>SALLY KOZAK: Allison, were you going to give a Qualitrac® update?
>>ALLISON LASHER: Yes, we were going to talk about the provider…
(MULTIPLE SPEAKERS)
>>SALLY KOZAK: Yeah, go ahead then.
>>ALLISON LASHER: Sure, we can do that. So, in front of you you'll see the statewide rollout plan that we put together for the provider portal and it is spread across eight waves or phases in which we invite or target specific provider types and specialties. And we offer an initial kickoff communication to those providers and then a specific onboarding process and that includes an initial training that is virtual and then a follow-up training for any issues or questions they have as they progress through the registration and prepare to be able to use the portal. So, we have targeted specific provider types and specialties as I mentioned. Based on their volume that they submitted last year we used the counts there to determine which were the higher and which were the lower volume providers. So, we started with the lower volume so that we could iron out any kinks in the processes and make sure as to not overwhelm the infrastructure, the support and the program offices by starting with some lower accounts and moving to those types that have higher counts, higher volumes. So you will see on page 1 here that the first six waves are laid out and if you click over to page 2 you will see wave seven and eight where we target the outpatient and inpatient acute hospitals at the end of the waves and below that you will see a link to the landing page. If we have time, can we go ahead and click on that link? Is it not going to – okay, if it is not working we can show you later, but that link will be in the slides and shows you what information has been laid out for the providers so they can understand both the

rollout schedule and there are FAQs to help them get orientated to the registration and onboarding process as far as, or including, contact information for who they can request assistance.
Are there any questions?
>>AMANDA SAGASTUME: Allison, sorry, we were unable to open it up on the web browser so we will put that link into the chat as well, so that everyone can look at it on their computer.
https://www.pa.gov/agencies/dhs/resources/for-providers/prior-authorization-portal
>>KYLE FISHER: Allison one question here, Kyle Fisher with the Health Law Project. If we could go back a slide, I just wanted to make sure I'm understanding. This is enrolling, phasing in enrollment of different provider types into the new electronic prior auth system that Medical Assistance (MA) fee-for-service is using, did I understand that right?
>>ALLISON LASHER: Correct.
>>KYLE FISHER: Okay. And so, that new system, this new Qualitrac® system, has been, sort of, live for some time, you're sort of phasing in the provider types. The distinction between phase one and three here - private duty - is that just (inaudible) for the first rollout phase and then the third, home health services? Would that be home health aides etc.? The remaining agency types?
>>ALLISON LASHER: Exactly.
>>KYLE FISHER: Okay, thank you.
>>ALLISON LASHER: Yes. And those review type descriptions are included on that landing page that we just mentioned. You'll see a pulldown that describes the rollout waves and schedule and right beneath that you will see another pulldown that has review type descriptions, and it will clarify for the providers which is being targeted in each of the waves. Any other questions?
>>SONIA BROOKINS: Anything in the chat? Okay.
>>AMANDA SAGASTUME: Yes, there is one question in the chat. Once a provider type is onboarded, are they required to use the portal exclusively?
>>ALLISON LASHER: At this time, it is not mandated and the current options that providers might be using such as fax or phone are still available.
>>SALLY KOZAK: So this is Sally, let me just add a piece to that. We would strongly encourage all providers to begin using the provider portal as the various groups are onboarded. I am not sure if folks are aware, but CMS has recently released some communications that they will be drafting proposed rules about mandatory electronic prior authorization. So, those providers that use the portal now as we launch it will be in better position as those changes start to become permanent under Medicare and Medicaid.
>>ALLISON LASHER: Thank you, Sally.
>>SALLY KOZAK: You're welcome.
>>SONIA BROOKINS: Anyone else have any questions for the rollout? Okay. Thank you for that.
>>AMANDA SAGASTUME: We are still having an issue with Sandy Marcella being able to unmute…

>>SALLY KOZAK: Okay, well then, you know what, I'll go ahead and do Sandy's presentation for her. And she can later tell me everything I forgot to say. So, do we have a slide up on the MMIS modernization? I know that we only have the one slide. Next one please. Okay, there we go, thank you. So, MMIS, or as PROMISe as people knows it, has been in need of an update for a number of years now and I think folks know that we had originally started down a path of procurement that was diverted a little bit and took us a little bit longer to get restarted. So the restart of the modernization project started in 2022 and the goal of the project is to actually take all the functionality that is in PROMISe and carve it up into system modules. And just so folks know, the reason that we need to be able to do that is one, CMS has said that states have to go to this modular design but even more importantly, the system that we have right now is kind of a linear system and to make a change to one piece of it requires that you make changes the whole way down that line. And so as we begin to carve out the separate modules it allows us to be more flexible and more nimble as we respond to the changing environment and the changing needs of the different components of this system. So, we started in 2022 and we are on a path where we believe that our new system will be completely updated by the end of 2029. So prior authorization was one of the systems that we had to change. We call that Qualitrac® now. We just had the presentation about it being live and how the statewide rollout is beginning. The folks that helped pilot it with us have found the automated process to be much more efficient than the old process. In fact we have heard from some providers that it has significantly eased their workflows and has allowed us to make more timely decisions and in a more expeditious manner.

We removed ID cards that were coming out of PROMISe over to the Office of Income Maintenance (OIM) which again adds efficiency and streamlines that process. We are currently working on the Electronic Visit Verification (EVV) replacement module and HHAeXchange, which some folks may be familiar with as they were already using it, is replacing Sandata, and that project began July 1 of 2025 and we expect that it will probably be right around 18 months or so until that change over totally happens. Provider management module, which I know over the years has been a little bit of a source of perhaps discontent for the provider community in that in order to enroll if you practice at five different locations you essentially have to enroll five times. We will be streamlining that so that a provider enrolls once and can list all of their locations on one application. It will allow them to more easily update their applications, and it will provide for our staff a level of automation that we currently do not have as we process provider enrollments. We are currently finalizing that contract. Once it is finalized, work will begin on that and that will be the second module that will go live and again I think the date for that is probably right around mid-2028 or so.

And then the last big section of the PROMISe system that we will be changing is the Claims, Financial and Federal Reporting module. And again that's the system, the core component of our systems, that processes all the claims that we pay. It takes in the Encounter and claims information that we receive from the MCOs and it is also the system that we get all of our federal financial reporting from. That procurement is currently in

process. I don't have a date as to when that will begin, but again we expect that that will be completed, implementation of it will be completed, by the end of 2029 which means that we will then have a brand-new MMIS. So we are excited about that. I think a lot of people on the outside don't necessarily think about all the components that have to happen as we operate the program, but at the end of the day we see from the Qualitrac® that they are beginning to see the improvements. We know they will see improvements as we go with the HHAeXchange and they will also begin to see improvements as we move to the Provider Management Module, making it easier and more efficient to do business with our Medicaid program. Questions about any of that?
>>SONIA BROOKINS: No questions.
>>AMANDA SAGASTUME: And there are no questions in the chat.
>>SALLY KOZAK: Okay, I think that is it for OMAP then.
>>SONIA BROOKINS: Thank you very much, Sally.
>>SALLY KOZAK: You're welcome.
>>SONIA BROOKINS: Thank you both, thank you both. All right. Moving on – who do we having next? Okay - Jen Smith – OMHSAS.
>>CORINNE ELLIOT: Hi, good morning everybody. Unfortunately, Deputy Secretary Jen Smith cannot be here this morning, but I here for her instead. My name is Corinne Elliot, I'm the Executive Assistant and I'm here to go over the 988 update as well as the regulatory update. Next slide, please.

All right, so 988 suicide and crisis lifeline. Last month we had 13,870 calls that were routed to the Pennsylvania call centers in March. 12,392 answered in state, 89.3% answer call rate. We had over, we had 8,321 texts and chats routed to the PA call centers in March. 822 were answered in state at a 9.9% answer rate. Funding and capacity remain the primary concern for 988. Chat and text continues to see rapid growth and demand with no additional funding to support the module. Pennsylvania again registered an in-state answer rate under 10%. Voice metrics continued a slow decline due to the lack of funding and capacity while volume reached an all-time high of 13,870 in March. OMHSAS is working on securing funding through the Rural Health Transformation Program (RHTP) to support 988 for capacity and public awareness. The Substance Abuse and Mental Health Services Administration (SAMHA) grant opportunity forecast was delayed again and we're now looking for May 2026, given lead time for application, review, award, procurement, Pennsylvania's 988 centers may be going without funding starting in October of 2026 due to delays. With the current grant ending, there is currently no 988 funding beyond September of this year, so we're really looking forward to that grant opportunity as well as the RHTP. Next slide.

Alright, now we are going to go into some regulatory updates. For crisis regulation and licensing, OMHSAS has made significant progress on processing 950 comments and making changes to the package based on the comments received. Listening sessions will be held starting June of 2026 to give a high-level overview of the changes planned for the final form regulation package to receive stakeholder input. That will need to go back through DHS and the Governor's office to review. Hopefully (inaudible) ready by

the Independent Regulatory Review Commission (IRRC) in spring of 2027. Crisis regulations regarding payments, that has moved forward to the Governor's office for review and then it will go to the Office of the Attorney General (OAG). Tentatively hoping to have the regulations out for public comment by the end of summer of 2026.

5100 confidentiality regulations - the final form package is now in DHS review. After that it will go to the Governor's office. No OAG on final form, they see after IRRC, not before unlike proposed where they see it pre-IRRC. Tentatively planning for a fall 2027 IRRC. Next slide.

Psychiatric Residential Treatment Facilities (PRTF) regulations, the final form package is now in DHS review. The deadline to have the final form package to IRRC is November 2027. Some other things that are on hold due to staffing shortages: 1223 Drug & Alcohol payment regulations as well as inpatient regulations. We're going to get to those as quickly as we can. And that is all the updates from OMHSAS.

>>SONIA BROOKINS: Any questions?

>>JOSEPH GLINKA: Sonia, I have a question.

>>SONIA BROOKINS: Sure!

>>JOSEPH GLINKA: So, if we could go back I think I saw an 89.3% of the calls incoming were captured at the state level and I think there's a spill over to the federal side to this, right? As far as those calls?

>>CORINNE ELLIOT: I believe so, that is correct.

>>JOSEPH GLINKA: So I'm just curious, is it safe to assume that they get prompt attention as well even though they are being directed to an overflow?

>>CORINNE ELLIOT: We certainly hope so, but we do not oversee those sites in particular, but we would imagine so if they call it over.

>>JOSEPH GLINKA: Okay.

>>SONIA BROOKINS: Anyone else? Any questions in that chat?

>>AMANDA SAGASTUME: There are no questions in the chat at this time.

>>SONIA BROOKINS: Thank you so much, Connie, I do appreciate it.

>>KYLE FISHER: Sonia, if I can…

>>SONIA BROOKINS: Sure!

>>KYLE FISHER: …raise a question seeing that we are a little ahead of schedule, if we still have Sally or Sandy on regarding the MMIS update…?

>>SONIA BROOKINS: But we finished with Connie, right?

>>KYLE FISHER: Oh yes, OMHSAS, I don't have a question for OMHSAS. Thank you.

>>SONIA BROOKINS: Thank you so much Connie, appreciate you.

>>AMANDA SAGASTUME: Sandy is not still on. I do see Sally, I'm not sure if she's available.

>>SONIA BROOKINS: Alright, well maybe we can send her something Kyle.

>>KYLE FISHER: Sure. Well, Sally, one question to pose if you are on and available going back to the provider portals and the provider use of PROMISe to verify enrollment, I know there's been conversation in the context of H.R.1 and the upcoming community engagement requirements around providers having insight into which of their patients are in the MAGI adult expansion groups. So just questions related to whether that information

is still going to be available or could be added to the provider portals, the PROMISe portals, so that doctors and other providers can see which of their patients need to be aware that they are impacted by these new work requirements. But I might have missed the window on that, and we can return to it with Sally or others in the department when there's a chance. Thanks Sonia.
>>AMANDA SAGASTUME: Yeah, we can forward your question to them.
>>SONIA BROOKINS: Thank you so much. Next up, OLTL update.
>>MONTRELL FLETCHER: Good morning, everyone. Juliet was hoping to be here to provide the update, so if she joins in enough time, then I will pass it off to her, but for the sake of time I will go ahead and get us started. My name is Montrell Fletcher, I'm the Executive Assistant to the Deputy Secretary in OLTL. So I will be providing the OLTL updates today. Here you have our agenda which will cover the procurement updates. We'll talk about the new executive order, expanding protections that the governor just signed and some recent OLTL communications. So, if we go to the next slide.

Here we have our usual slide. I do want to make note that the courts recently rendered a decision on the Community Health Choices (CHC) Procurement and at this point in time the decision canceled the award, but it did not cancel the Request for Application (RFA), so at this point in time we are currently evaluating the court's decision. And as it stands we are still asking for individuals who have questions regarding the RFA to send those to the resource account (RA-pwrfaquestions@pa.gov). So at this point we are business as usual operating under the current MCOs until we have further understanding of the court's decision. Next slide.

Alright, so this is something that we are excited to announce. On April 15, Governor Josh Schapiro signed three executive orders to strengthen the rights and protections of Pennsylvanians with disabilities. These orders reaffirm the Commonwealth's disability nondiscrimination policy and by doing so it rescinded and replaced the executive order 2002-5, protecting the rights, dignity, and privacy of people with disabilities. That was the first order that was signed. The second order rescinded the 2006-09 as well as 2016-03 and established a Governor's Advisory Commission on people with disabilities which is going to consist of up to 30 volunteer members who will be appointed by the governor. I am sure more information will be shared once that advisory committee gets underway. And then the last executive order that was signed rescinded 1997-2 and it reestablished the Developmental Disabilities Council. And if we move to the next slide.

Just wanted to provide a communication from the Department of Health (DOH) that OLTL lifted up via its ListServ that DOH, their COVID-19 response team is distributing High-Efficiency Particulate Air purifiers or HEPA for short, to schools, early childcare facilities, long-term care facilities, government offices that are open to the public and nonprofit organizations to reduce the spread of COVID-19 and other respiratory illnesses. These devices are being provided at no cost to the eligible facilities and it comes with a two year replacement filter for optional use and so if anyone is interested in receiving those purifiers or have any questions, you can reach out to DOH's COVID-19 response team and the email is RA-DHCOVIDMITIGATION@PA.GOV or you can reach out to Paul Foster at 717-

547-3179. And the deadline for this initiative is Friday, April 24. I believe Juliet has joined us and I will pass it off to her for the remainder of the OLTL portion.
>>JULIET MARSALA: Good morning, everyone. I apologize I am out of the office attending a summit today and I am glad that we are able to connect. If we can go to the next slide. Okay, great. Thanks Montrell for going over all of the updates. I imagine you also provided information on the CHC/RFA court decision and how we are evaluating that decision and we are still in an active RFA blackout period because the RFA was not canceled, just the award portion was.

I am also here today to present a request to the esteemed members of the MAAC Committee with regards to an ask on behalf of the Long Term Services and Supports (LTSS) Subcommittee and to present a potential motion for the MAAC Committee members to hopefully adopt and consider putting forward and voting on as part of the committee. So, the LTSS subcommittee bylaws currently state that the chair of the LTSS subcommittee is also to serve as the MAAC committee member representative and part of the executive team. And while the bylaws also identify that the chair is able to identify a proxy as needed, that proxy does not maintain voting rights per the bylaws. However, it is one of my goals and has been for a very long time to promote and ensure that there are opportunities for leadership for individuals with lived experiences and people who receive services from LTSS and really desire to have them serve in leadership roles on the LTSS Subcommittee and be the voice that drives the advisory capacity of that committee as it informs OLTL. So, given this and given the nature of the population we serve and the duties required of the LTSS subcommittee Chair, we are asking the MAAC to hopefully support us in piloting a flexibility over this next year to allow the LTSS Subcommittee Chair to delegate the LTSS Vice Chair to serve as a long-term delegate to the MAAC committee and serve with the full privileges of voting rights that is afforded to the LTSS Chair. We believe this is going to be beneficial both to the MAAC and the LTSS subcommittee, continuing the strengthened coordination between the two. And should this pilot work well, we may request a future sort of adoption of it permanently in our bylaws. So, we have consulted with (inaudible) legal teams, in the bylaws and had some preliminary discussions and were advised that, you know, a motion passed by the MAAC in an official meeting would allow for this flexibility to be adopted in the interim at the LTSS subcommittee. So, I would like to put this request forward to the MAAC and appreciate your consideration of this request and hope this could be a motion presented by or adopted by a MAAC committee member for a vote today. Thank you. Any questions? Happy to answer them.
>>SONIA BROOKINS: Deb, you have your hand up.
>>DEBORAH SHOEMAKER: Yes, I just have a question because I know this is...I mean this is setting a precedent and I was just curious if there was any particular reason, and of course I am looking from a consumer family standpoint, anyone with lived experience I think is critical. But, is there any particular reason why the Vice Chair then, when there was a vacancy why the Vice Chair would not be moving to Chair of the LTSS and then that Chair, then she would, he or she - I said she because I know who it is – but he or she in the future would then be able to automatically have those privileges. Just asking, because I'm not

sure. I know like I said, I of course I am the chair for Fee-For-Service (FFS) and we are in a different situation. I mean, I'm thinking of Joe and the importance of Joe being the Chair of the MCDSS and then coming as a, you know, as a member of Executive Committee of MAAC and then moving forward. I just didn't know if there was any particular reason why you are looking to adopt this, I know you said flexibility, but I was just wondering if there's…yeah…the reason.
>>JULIET MARSALA: Very good questions. So in thinking about this quite a bit, and you know in recent experiences and building on sort of experiences over my career, we look at the Chair position as a position with, you know, primary responsibility, secondary responsibility is a big scope of where the support and doing the agendas and topics and things of that nature. And all the efforts that require to be had on top of individuals' other daily responsibilities, it can be a lot. And, you know, sort of depending on someone's circumstances - it could be for medical reasons or other reasons, there may be a need to have support. If we look to the rehabilitation field of employment for people with disabilities, this kind of falls very clearly under one of the best practices for consideration which is kind of a job share and job sharing has been sort of proven to increase accessibility and opportunity for people with disabilities wherever they are and however, you know, sort of their health or disability may manifest. Some people have good times, some people don't. So instead of asking a Chair who's got valuable information, expertise, and contributions to step down anytime that there might be an issue that might be longer-term, we would like the flexibility to contemplate alternatives to helping support that person continue to succeed and continue to be a leading voice for the LTSS population as the advisory member. So it's sort of changing an all or nothing to broader options for people with disabilities to serve. And in the longer run it may also encourage other individuals with lived experience and disabilities to contemplate taking up these leadership roles.
>>SONIA BROOKINS: So, you're asking us for a vote today on this?
>>JULIET MARSALA: For the next year to pilot this as a flexibility and then we can consider whether or not this is something we might want to put forward as a permanent flexibility within the bylaws.
>>SONIA BROOKINS: Okay, committee. Does anybody have any objections or before…?
>>DEBORAH SHOEMAKER: This is Deb again and I'm not…I'm sorry if I sound like I am being a hard ass about this and sorry - but, just in, I'm just thinking of the people we had in the past who did LTSS…Kathy, Mike Grier, others. They have done…and I am a Chair and I know my Chair might not be as active as Joe's, but the one thing that I feel with the subcommittees that makes it strong besides having the people (inaudible) up to the staff committee is the staff of DHS. You know I, I know, I could not do FFS without Gina and, you know, in the past, you know, Dan and some other people and they help develop the agenda and work with us and said a lot of the things and not just Gina, but some other people who have done FFS but I'm just citing Gina because Gina's fabulous and I don't want to lose her. So, but at the end of the day I guess I am just concerned about setting a precedent, because you know the whole role of consumers is key and now I, maybe I am

missing something and maybe your Vice Chair doesn't feel that they don't want to step into a full Chair position and maybe the Chair does not want to come to the other part. I can't speak for that because I'm not part of that subcommittee, but I just wanted - I'm just concerned as we are setting a precedent that we never had to do in the past, so if I am being a little tough on it I just want to make sure we're walking through the motions, because we have to change the guidelines and things like that, so I apologize…
>>JULIET MARSALA: Well, we don't have to change the bylaws now which is why it is being put forward as a pilot flexibility over the course of the next year so we can evaluate and see how it works. Again, the main value of this is really to promote and expand opportunities for people with disability. If you look back at the LTSS subcommittee and the number of times a person with a disability or user of service has led it, it has not been the majority of the time. So, I think and hope this would help expand that. The other piece to kind of recognize that it is sort of best practices in other positions, but the piece here is in the bylaws, if the Chair cannot attend the LTSS subcommittee has no voting rights. So this is allowing for the Vice Chair as a delegate to preserve the voting rights. The Chair can send a proxy today, whenever needed, but it does not allow for that voting right. So that really is the key to this flexibility request and I do appreciate the questions, Deb, I really do. You know (inaudible) some considerations in motion we should absolutely take the time to consider them and ask those questions, so I appreciate those questions.
>>SONIA BROOKINS: Okay. So, I guess I'm going to have to make a nomination for the Vice Chair for the OLTL who is Pam Walz, is that correct?
>>PAM WALZ: Yes, I'm Pam Walz, I'm the Vice Chair of the LTSS, I'm here.
>>SONIA BROOKINS: Yes. Could we have a motion to accept her for this pilot program?
>>KATHY CUBIT: This is Kathy Cubit and as former Chair I am pleased to put forward this motion for the pilot as Juliet described.
>>SONIA BROOKINS: Can I get a second or motion?
>>DEBORAH SHOEMAKER: This is Deb, I'll do a second, and just so you know Pam, I have the full faith and confidence in you. It was nothing to do with you. I wanted you to be the chair. So that has nothing to do with you just so I'm clarifying that, but I will make a second!
>>SONIA BROOKINS: Okay.
>>PAM WALZ: I completely get that. Thank you!
>>SONIA BROOKINS: So it's been first and second. Can all in favor say aye?
>>MULTIPLE SPEAKERS: Aye.
>>SONIA BROOKINS: In abstensions…so moved. Pam Walz, welcome to the full MAAC for this pilot program. We look forward to working with you again.
>>PAM WALZ: All right, thank you so much.
>>JULIET MARSALA: Thank you, Chair Sonia and all the members of the MAAC for your support. I am also at the question stage of the OLTL so if there's any questions for me, I'd be happy to answer them.
>>SONIA BROOKINS: Yes, if we have any more questions we will get them to you. Okay? Thank you so much.
>>JULIET MARSALA: Thank you. I appreciate you. Have a great day.

>>SONIA BROOKINS: All right, you do the same. Next on the agenda is minutes, but before I - let's just do the minutes and then after that I will go into what I need to go into. Can I get a vote on the minutes? To accept the minutes? (Inaudible)
>>JOSEPH GLINKA: Moved to approve.
>>SONIA BROOKINS: May I get a second?
>>DEBORAH SHOEMAKER: Second, Deb.
>>SONIA BROOKINS: All in favor.
>>MULTIPLE SPEAKERS: Aye.
>>SONIA BROOKINS: So moved, the minutes is accepted for March. We are going to go into old and new business but before that I would like to say something in reference to Russ McDaid. His mother passed away and for this committee we did not – I had an opportunity to say it, but for this committee, on behalf of this committee I just want to send our condolences out to Russ McDaid on the passing of his mom and her legacy. I just want to say I'm truly sorry and I understand. I know what you're going through, so we just...
>>RUSS MCDAID: Yeah, I - thank you Sonia. And I recognize that you do. I had the pleasure and privilege of working with your mom early on both as a member of the DHS staff and then as a stakeholder, so understand that really appreciate those kind words. Thank you.
>>SONIA BROOKINS: Thank you. So, much appreciated. Okay, old and new business, okay, Eve, you are up.
>>EVE LICKERS: Okay, thank you and good morning everyone. Since the last meeting it looks like we've had four bulletins that have been issued. The first one is bulletin number 01-26-50. And it is the "Prior Authorization Guidelines for Removable Premolded Arch Supports" so this is issuing guidelines for these items and it was issued on March 30th also effective on March 30th. Another bulletin that was issued also on March 30th and effective on March 30th was Bulletin 01-26-51 and that is for the "Prior Authorization Guidelines for the Thoracic Lumbar Sacral Orthoses", also I think more commonly referred to as TLSO for providers that are in that area. The third bulletin issued on March 30th and effective on March 30th is Bulletin 01-26-53, again another prior authorization bulletin and this is for sickle cell anemia agents under the pharmacy services area and so this is the guidelines for prior authorization for that. On April 8th, we issued Bulletin 01-26-52 which was also effective on April 8th and it is for the "Prior Authorization Guidelines for Pediatric Adaptive Seating Equipment" and these guidelines just to reinforce our in preparation for part of our Qualitrac® implementation initiative. So, this is making sure that these things are out and so that as we implement and rollout Qualitrac® that providers will have these guidelines at the ready for them. So, thank you. That is what we have for this month. These are available on the Department's website on the DHS Bulletin search but also, and much easier, on What's New at OMAP. Thank you.
>>SONIA BROOKINS: Thank you Eve. Oh, we have time for the subcommittee reports. Kyle Fisher, Consumer Sub!
>>KYLE FISHER: Okay, a surprise here, thank you Sonia. Consumer Subcommittee met yesterday, we heard a number of updates, I will focus on promising updates from Gwen Zander and the OMAP team monitoring the managed care plans in terms of provision of

GLP-1 medications for members under age 21 under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, so work is underway there and it sounds like progress in ensuring those EPSDT reviews are happening and members under 21 who continue to need GLP-1 for weight loss purposes are able to access them. We also heard a really interesting presentation from Dr. Appel from OLTL tied to OLTL's women's health initiative and a number of approaches that managed care plans within CHC are taking to reduce things like fall prevention efforts and other efforts addressing behavioral health and other conditions on the OLTL side, so we heard a lot of positive information there and saw some data indicating that repeat falls are declining as a result of those efforts. We also heard a presentation from OIM tied to the work it is doing to prepare for implementation of H.R.1. OIM shared some really good data on populations within the adult MAGI group that it already knows will be exempt based on either having income over that $580 a month threshold or already sort of known as compliant or exempt based on having a known disability such as Social Security or caring for someone in their home or a child under the age of 13. So we received data on that. OIM is also developing materials like the outreach letters that will go to the MAGI population and a screening exemption form which it plans to share with the Consumer Subcommittee next month for review and feedback. I think I hit the main points, Sonia, if you or Minta have anything to supplement please do.
>>SONIA BROOKINS: No.
>>MINTA LIVENGOOD: I do not.
>>SONIA BROOKINS: Thanks, Kyle. Our next meeting is May 27 and we welcome you all. Fee-for-service, Deb?
>>DEBORAH SHOEMAKER: Hi, this is Deb, I'm also a member of ConSub and the one potential reaccommodation maybe for the MAAC is the presentation from Doctor Appel about women's health and some of the initiatives they have going on, sometime may be if interest to the MAAC. I thought it was extremely informative so I think that may be something that might be worth it some point. I know that we are talking about H.R.1 and some of those things, but to have OLTL bring him over as part of a presentation. But for the FFS delivery system subcommittee, we have not met since February. We are having a meeting I believe next Monday if I remember for members who want to express issues to put on the agenda. Our meeting will be on the sixth. If you have any questions, you can send them to myself or to Gina. And also for those who do work in the FFS realm to let you know that Michele Robinson has retired, or will be retiring, I forget her official date. So just to let you know that we thank her for her service. That is all I have for FFS.
>>SONIA BROOKINS: Okay, thank you, Deb. LTSS?
>>PAM WALZ: Hi, this is Pam Walz and as I sort of settle in I will come with a more detailed report for next month. But, at - we met on April 1 and the main thing on the agenda was a review of the 2025 CAHPS survey results, that's the Home and Community Based Services (HCBS) Consumer Assessment of Healthcare Provides and Services (CAHPS) surveys that are done annually to ask participants in the CHC HCBS programs how their experience is. So we had a presentation from the Department on that and then some discussion with the three CHC MCOs and particularly you know some areas that we are really hoping to - not

just hoping, we are expecting to see improvement on in the next year, particularly around community engagement and consumers ability to get out into the community. The other thing that we've had a fair amount of discussion about is wanting to make the LTSS more of a group that really actively provides feedback and engages with the Department on providing input and feedback rather than being primarily a place to get reports. So that is something that we are actively working on, shaping our agenda to achieve. Thanks.
>>SONIA BROOKINS: Thank you. Joe? Managed Care Delivery Systems Subcommittee (MCDSS)?
>>JOSEPH GLINKA: Thank you, Sonia. First of all, a couple things. Pam, welcome to the MAAC under the pilot. And based on your comments, if there's any ideas that we can provide at the MCDSS, we have taken a posture trying to be more proactive if you will in delivering ideas rather than just being a reporting entity and if there's anything we can do to help with that, please let us know.
>>PAM WALZ: Okay, that's great, thanks.
>>JOSEPH GLINKA: Next thing, I had a question probably for Sonia with respect to the pilot, is that effective today for a year? I don't know if we (inaudible).
>>SONIA BROOKINS: Yes, it's effective today for a whole year.
>>JOSEPH GLINKA: Okay, and then with respect…not to mess up our agenda, but I noticed that we did not – we're we going to revisit the MAAC as an advisory, doing more of a working advisory group or are we going to save that for another meeting?
>>SONIA BROOKINS: You want to do it at this meeting? Because that is what we need to find out if we want to do it before the meeting at 9:30 to meet or have it from 9-10 before we go into our meeting because we didn't talk about that because we're meeting today.
>>JOSEPH GLINKA: Yeah, if it's not on the agenda today, then we can perhaps save it for our next meeting. I didn't, like I said, want to mess up our agenda for today. Cause I think it's been a very good discussion. Okay, so onto the MCDSS, we did meet April 9th, a couple things just wanted to make our listeners here aware. Right now the OMAP is requesting information from the physical health MCOs with respect to the draft 27 HealthChoices Agreement (Agreement). This is an opportunity to offer constructive input into help shaping what that draft Agreement will look like that would be released later on in the summer, probably toward June-ish. (Inaudible) Plans will then have the opportunity to make again suggested edits based on the language that is provided, eventually getting to that final Agreement that everybody signs off on toward the end of the year. I believe the deadline for that input is tomorrow to the Department. Also, during our meeting, the Department talked about seeking input from the MCOs with respect to the data sets other than encounter data that can be helpful in for instance medical frailty determinations that we just spoke of earlier today, health risk assessments came up in a conversation and so there will be more to come on that, but certainly the MCOs want to be helpful to whatever way they can in making sure that anybody who is truly qualified or meeting medical frailty, meeting the community engagement requirements to truly remain on the plan so there is no gaps in coverage and thus gaps in care.

One of the other things we have been working on is transparency with respect to

the value-based purchasing (VBP) arrangements with providers and plans, providing some additional clarity for consumers to truly understand objectives, motivations and really mechanics on how these various models work. And so we are hopefully finalizing a resource and an educational resource that will be socialized to determine down the road. But, deadline for comments based on what we discussed in the 4/9 meeting is tomorrow as well. The goal is to take whatever draft we have in advance that on to the consumers for additional deliberation so that we can, you know, get closer to the finish line come the June 11 meeting which is what we are scheduled to meet again. So, the stages that we are following in this VBP transparency conversation if you will is one, let's get a credible resource that is accurate and understandable and digestible so that consumers truly understand what these arrangements are and then we will get into a conversation as far as disclosure at the encounter itself and what the guardrails may be within that situation (inaudible). I will stop there and see if there's any questions and again our next meeting is on June 11.
>>SONIA BROOKINS: Any questions for Joe? Anything in the chat?
>>AMANDA SAGASTUME: No, there is nothing in the chat.
>>SONIA BROOKINS: Okay. Thank you all again. Thank you all. Our next meeting is May 28 at the 10 o'clock hour. Again, we do appreciate all input and so if anybody has any questions or anything that they want to say they can go to the ListServ or give it to anyone that is attending on the MAAC committee. Thank you all. Can I get a meeting to adjourn?
>>MINTA LIVENGOOD: This is Minta Livengood, I make a motion to adjourn.
>>SONIA BROOKINS: Second?
>>JOSEPH GLINKA: Second.
>>SONIA BROOKINS: All in favor?
>>MULTIPLE SPEAKERS: Aye.
>>SONIA BROOKINS: So moved. Everyone be safe. Alright.