>> ELISE GREGORY: Good morning and welcome to the May edition of the Medical Assistance Advisory Committee (MAAC) meeting. Today is Thursday, May 23, 2024. Before we begin the meeting, I'd like to go over some housekeeping items. This meeting is being recorded. Your continued participation in this meeting is your consent to be recorded. If you do not wish to be recorded, you may end your participation in the meeting at any time. CART Captioning is available for the meeting. The captioner is documenting the captions remotely so it is very important for people to talk directly, state their name, and speak slowly and clearly, otherwise they may not be able to capture the conversation. There are microphones on the table for the committee members. Please speak up so the audience members in the back can hear you. In the case of an emergency evacuation, there are procedures posted on each of the exit doors. To help avoid any disruptions, please remember all devices must have the sound turned down and microphones muted. Representing the Department of Human Services (DHS) today from the Office of Medical Assistance Programs (OMAP), Deputy Secretary Sally Kozak and the Director of Policy and Planning for CHIP (Children's Health Insurance Program) Angela Episale, and the Director of the Bureau of Policy, Analysis and Planning, Eve Lickers. From the Office of Long-Term Living (OLTL), Deputy Secretary Juliet Marsala. From the Office of Developmental Programs (ODP), Deputy Secretary Kristen Ahrens. From the Office of Mental Health and Substance Use Services (OMHSAS), Deputy Secretary Jen Smith. From the Office of Income Maintenance (OIM), Bureau of Policy, Alexis Deisenroth. And for a special presentation on children with complex needs, from the Office of the Secretary, Jonathan McVey. If you have any questions related to the meeting or need any information, please visit the MAAC committee webpage. I will now hand things over to Joe Glinka.

>> JOE GLINKA: Good morning, everybody. It has been a minute. I don't know if anybody can hear me. Good morning. It has been almost four years since we have had this many people in one room for a MAAC meeting. It has always been an honor to be part of this. People are probably wondering what he is doing here instead of Deb Shoemaker. Deb had an emergency, so I was asked to pinch hit for her. Forgive me if I make any rookie mistakes. Have we taken roll call? Ok, so why don't we start with that. My name is Joe Glinka. I'm the Director of Healthcare Choices for Highmark Wholecare and the temporary Chair of the MAAC today in Deb's absence.

>> MARY HARTLEY: Hi, I'm Mary Hartley. I am the parent of a 24-year-old on the autism spectrum. [Inaudible]. And I am the new President of the Arc of Greater Pittsburgh

>> JULIE KORICK: Good morning, I'm Julie Korick. I work with the Pennsylvania Association of Community Health Centers (PACHC).

>> TED MOWATT: Good morning, Ted Mowatt – Wanner Associates. I'm here as the Executive Director of the Pennsylvania Association for Home and Community Service Providers.

>> MIA HANEY: Mia Haney, I am the Executive Director of the Pennsylvania Home Care Association.

>> MIKE GRIER: Mike Grier, the Executive Director of Pennsylvania Council of Independent Living.

>> KYLE FISHER: Kyle Fisher, Pennsylvania Health Law Project, Counsel for the Consumer Subcommittee.
>> MINTA LIVENGOOD: Minta Livengood, Indiana County Welfare Rights. I'm co-chair of the Consumer Sub.
>> JOE GLINKA: Do we have anybody remotely that is a member of MAAC?
>> KATHY CUBIT: Hi, this is Kathy Cubit, the advocacy director at CARIE, the Center for the Advocates of the Rights and Interests of Elders and I am the co-chair of the LTSS (Long-Term Services Subcommittee) MAAC. Good morning, everyone.
>> NICK WATSULA: Nick Watsula with UPMC. Good morning, everyone.
>> MARK GOLDSTEIN: Hello, this is Mark Goldstein, Pennsylvania Dental Association.
>> JOE GLINKA: Okay, something we haven't done in a while, we will move to the room. We will have everybody introduce yourself. We will not make you stand up and take a dance, although it has been discussed up here at the table, but we will start with you.
>> NORRIS BEND: Good morning, Norris Bend, Health Partners Plan.
>> [INAUDIBLE]: Good morning, everyone. [Inaudible]
>> KATIE MOORE: Good morning, everyone, I'm Katie Moore [Inaudible].
>> LLOYD WERTZ: Thanks for the no dance thing, Joe I appreciate it. Lloyd Wertz [inaudible].
>> ANDREW KUNKA: Andrew Kunka, Community Behavioral Health of Philadelphia.
>> MINDY DUNLAP: I'm Mindy Dunlap [inaudible].
>> MEL GREENWOOD: Mel Greenwood with AmeriHealth and Keystone First. [Inaudible]
>> SAM VINESTULE: Good morning, Sam Vinestule with Cozen O' Conner.
>> ANN MARIE ROBEY: Ann Marie Robey, PA House.
>> ANDREW SINTRONE: Good morning, Andrew Sintrone, Geisinger Health Plan.
>> JULIET MARSALA: Good morning, Juliet Marsala, Deputy Secretary for the Office of Long-Term Living.
>> JEREMY YALE: Good morning, Jeremy Yale, Office of Development of Programs.
>> MONTRELL FLETCHER: Good morning. Montrell Fletcher, Executive Assistant with the Office of Long-Term Living.
>> JEFF ISEMAN: Good morning, Jeff Iseman, Pennsylvania Statewide Family Counsel, at PA SILC.
>> EMILY KATZ: Good morning. Emily Katz.
>> JEN BATES: Good morning, Jen Bates from UPMC.
>> KEITH KOZO: Keith Kozo, AmeriHealth Caritas Keystone First. [Inaudible].
>> JOE GLINKA: Have we covered the bases with the introduction?
>> RICHARD EDLEY: Joe, this is Richard Edley. I just got unmuted, but I am attending as well.
>> JOE GLINKA: Welcome. Is there anybody else that was muted and is now unmuted? [Inaudible]
>> JAMIE BUCHENAUER: Good morning, Jamie Buchenauer, Office of Medical Assistance

Programs, Chief of Staff.
>> LEXI DEISENROTH: Good morning, Lexi Deisenroth, Director of Health Services for OIM.
>> ANGELA EPISALE: Angela Episale, Director for Policy and Planning for CHIP.
>> MICHELLE ROBINSON: Good morning, Michelle Robinson, Director of the Bureau of Fee for Service Programs
>> LAINA AULETTA: Good morning, Laina Auletta, Executive Assistant in OMAP
>> GWENDOLYN ZANDER: Gwen Zander, Director of Managed Care Operations in OMAP.
>> MICHAEL NAVARRO: Michael Navarro, I work for OMAP at the Bureau of Policy, Analysis and Planning.
>> PAMELA MACHAMER-PEECHATKA: Pamela Machamer-Peechatka, Policy Chief, Bureau of Policy, Analysis and Planning.
>> BRETT HAYES: Brett Hayes, Human Service Analyst for OMAP in the Bureau of Policy, Analysis and Planning.
>> [INAUDIBLE].
>> JOE GLINKA: Did we miss anybody? [Inaudible]
>> LINDSAY TOWNSEND: My name is Lindsay Townsend. I'm with the Bureau of Policy, Analysis and Planning.
>> JOE GLINKA: And the gentleman in the back, introduce yourself.
>> [INDAUDIBLE]: [Inaudible] from Pennsylvania legislative services.
>> JOE GLINKA: Ok, I think that is everybody. Welcome again to the May edition of the MAAC. I think what we'll be doing on a quarterly basis is we will be meeting like this which is great. Otherwise, we will be meeting remotely as I understand. That could be subject to change, but it is really refreshing to see this many people in the room in these MAAC meetings. It is a great group committed to the excellence in helping the Medicaid program be all it can be. And I'm glad to be a part of it. I'm anticipating that everybody had an opportunity from the MAAC to review the April minutes. Thank you for putting those out. Do I have a motion to approve the April minutes?
>> MINTA LIVENGOOD: I will make a motion, Minta Livengood.
>> JOE GLINKA: Thank you, Minta. And a second?
>> MIA HANEY: I second, Mia Haney.
>> JOE GLINKA: Thank you, Mia. Minutes are approved. Alright, so we have a presentation today. Jonathan McVey is here with us today talking about children with complex needs. So, you have the mic. Welcome to the MAAC.
>> JONATHAN MCVEY: Can you guys hear me? There we go. Alright, good morning everybody. Thank you for having me here today. I have a lot of material to cover. And so, I think I want to focus more heavily on the substance but first I will give you a little bit of background. Next slide, please.

I work out of the secretary's office on complex needs planning. There are really two hats that I wear. One is technical assistance with a team of staff from the many program offices within the Department of Human Services - developmental programs, mental health, child welfare, Medical Assistance Programs, child development and early learning. And we work

with counties, providers, and other entities across the state. When they have a kid before them where there is a challenge that they are struggling with to find a solution, a treatment option, a residential placement or whatever it might be - a return to the family home. So, we provide technical assistance to those counties, and I am already going down in the weeds here. That is one hat that I wear. The other hat that I wear is policy and systemic change. I am trying to change the way that our systems serve children and youth and their families. Next slide please.

So, I'll give you a little bit of background on this initiative, give you an overview of the blueprint workgroup goals and timeline and structure, an overview of the blueprint recommendations which were published in February, and kind of the next steps for that work, and some other pieces of news regarding this overarching initiative for kids with complex needs. Next slide.

So, first I want to start with who I am talking about when I say kids with complex needs. These are children, youth, and young adults, 0 to 21, with any number of these characteristics. It could be any combination of these things. I will say that the first bullet, trauma, is resoundingly throughout, like without a doubt all of these children have experienced some form of trauma. Medical trauma, institutional trauma, developmental abuse, neglect, I want to emphasize that piece. These children and youth often have multiple and complex diagnoses across the physical health, mental health, and developmental domains. They experience diagnostic overshadowing due to their intellectual and/or autism diagnosis which means essentially, they have ID (Intellectual Disabilities) or ASD (autism spectrum disorder) and because of that, any behaviors or symptoms, something going on in the child's life is automatically or by default attributed to that ID, ASD diagnosis. As opposed to looking for other potential causes. Complex communication needs, lack of diagnostic clarity, disrupted education – there is very frequently, significantly disrupted education - limited, strained, or no natural supports - family members, community members, friends, families, those are all limited or nonexistent in some cases. As a result, they often have multiple system involvement including the Justice System, the Juvenile Justice System and have an extensive history of out of home care. So those are kids we are focused on. That is the target population for this work and who I mean when I say kids with complex needs, 0 to 21. Next slide please.

So, this work started several years ago. And one of the first visible indications of the Department working on this was the issuance of a policy bulletin from the Department in October of 2020. It was re-issued in March of 2021 with some edits to clarify a few things. And the goal of this bulletin was to provide technical assistance to counties and other local entities who are supporting these youth. The Department provides technical assistance in the form of guidance regarding licensing, funding, successful strategies from other counties or regions of the state, as well as helping them to facilitate complex needs planning meetings. As some of you may know, they can get heated. There is disagreement

on occasion and it's very challenging to navigate with so many different interests and perspectives in a large group of multisystem, supports and helpers. And then, we also provide guidance or assistance with referrals to clinical resources. Sometimes we just need an outside eye with a clinical perspective. Next slide please.

So, that is the technical assistance side of this work. That is ongoing. We do have plans to update and revise that complex case planning bulletin. We need to clarify roles and responsibilities within that bulletin and hopefully streamline it a little bit. Now, for the systemic change, policy change side of things, that will be the bulk of my presentation this morning. In December of 2022 through spring of 2023, we worked with ASERT (Autism Services, Education, Resources and Training Collaborative) through the Office of Developmental Programs to conduct a series of focus groups and surveys to better understand what is going on at the ground level. We talked to the education systems, school districts, intermediate units, and PDE (Pennsylvania Department of Education). We talked to the behavioral health managed care organizations. Families and youth were surveyed, plus any child serving system that touches these children, we reached out to and solicited their feedback. The ASERT Final Report, the culmination of those focus groups that were surveyed, is attached as an appendix to the blueprint report which again, was published in February and is available on the DHS (Department of Human Services) website. Coming out of that report were five common themes and a desired future state or a vision for where we wanted to take this work. What we hope the world will look like for these children, youth, and families in the future. The five themes are communication, services and programs, resource navigation, staffing/workforce, and trauma informed supports. You will see family engagement down at the bottom and that is because it is really threaded throughout all of those themes. These are the five areas where barriers were most prevalent. This is where we need to improve things.

So, desired future state. I'm not going to read this entire paragraph to you, but it articulates where we want to be in the future. It emphasizes individualized services and supports when they are needed. It emphasizes trauma informed work, and the bullet points are essentially how we will measure that. Have we achieved the above paragraph? Are these things occurring? And I believe this presentation is available to you too. I think that it will be shared. So, taking the five themes, the desired future state, and the information gleaned from the focus groups and surveys, we established a blueprint workgroup. The goal of this workgroup was to develop recommendations to improve the system supporting these youth and their families. We empowered the participants of this blueprint workgroup and encouraged them that nothing was off the table. Think small, think big, let's think outside of the box. We really want to support them to make recommendations which address all lines of systems of government. This workgroup kicked off last July of 2023 and concluded, really we wrapped up things in December and the report was published in February of 2024.

So, who were the members of the blueprint workgroup? Behavioral health managed care organizations, primary contractors, sorry, -- providers, counties, county administrators, so all the different systems touching these kids. Mental health, IDA (Infant Development Association), child welfare, early intervention, education, families, and hospital systems. State agencies represented were the Department Human Services, the Department of Education and the Juvenile Court Judge's Commission. And there is a complete list of the participants, the actual individuals who joined that is found in appendix E of the report. Next slide please.

So, I want to draw your attention to the first four recommendations that are in the executive summary of this report. They were pulled out from the rest of the recommendations as being very important to this work in moving it forward. The very first thing was a recommendation to conduct a systemic restructuring which focuses on prevention. Overhaul our systems, all of our child serving systems to focus on prevention. Number two is that decision-makers - local, state, federal - who are implementing any of these recommendations must solicit input from those with lived experience. The third recommendation is that a steering team is needed to carry these recommendations forward. As you'll see in the next several slides, these, so the next several slides are summaries, one sentence descriptions of what the recommendations are. The report has more details, but they are still really limited to being ideas. They are pointing folks in a direction to go in and they need more details to make them actionable or implementable. So, number three here, the steering team needs to be developed and I'm happy to report we just kicked that next step off earlier this week on Tuesday and Wednesday of this week. So, that number three, we are moving forward, and we are in process. And four is an acknowledgment of the immediate crisis. State, local and system leaders need to find solutions to implement immediately. And this is a reflection of -- some of you have seen in the news regarding child welfare, residential treatment facilities, hospitals, emergency departments - where children and youth are staying in either unlicensed settings or in inappropriate settings such as overstaying in emergency departments. And so, the recommendations as the blueprint workgroup worked through these recommendations and had these discussions, we really recognize that a lot of the work that we are coming up with, were going to take a long time to implement. They are big system-level changes. Some of them can have a direct impact right now and we can move quickly to implement them. But there are other steps that need to be taken to address those things. And I do want to give a nod to the County Commissioners Association of Pennsylvania. They also established a task force around the same time that we did, and they were focused on that immediate crisis. I believe their report was also published in February and is available on their website. And the reason why I'm mentioning that is because they were pulled in, their recommendations, their report was pulled into the blueprint workgroup, this next phase. And so we are working collaboratively with them to focus on their recommendations as well as ours and to make as coordinated as possible. Next slide, please.

There we go. Moving along, so these are the recommendations. As I stated earlier, these are really brief summations, grossly oversimplified so please take a look at the report when you have an opportunity and kind of read the rationale and what the actual recommendation is. The first one reflects the prevention aspect of this work - Amend Act 212. Really what we want to do here is increase the number of categories where families become eligible and that can be offered screening and tracking for development milestones. Right now, it is lead exposure, homelessness, NICU/PICU stays for these children. We want to expand the categories for when families are offered screening and tracking of developmental milestones from ages 0 to 3. The earlier we can identify these kids, the better off their outcomes will be. The more positive their outcomes will be. Number two, establish a single dedicated funding stream to address the developmental, physical, and mental health needs. This is really focused on the natural silos that happen as a result of these different funding streams between these different systems from the federal government down to the state level, down to the local level. This is really an attempt to kind of merge those needs under one funding stream. Three, conflicting diagnoses -- excuse me. This is taking a look at the challenges families and children experience when they go from therapist, psychiatrist, they go to a psychiatric hospital stay and come back to the community and they accumulate diagnoses and recommendations, and it can get very confusing on what they should really be doing and what kind of treatment they should be receiving. This is a look at how we can resolve that conflict. Next slide.

Develop a statewide clearinghouse of services and availability. When you look at the report you will see a nod to PA Navigate. And that is right now focused on social determinants of health but is a potential platform for what the blueprint workgroup was envisioning here with services and their availability. So, you live in Dauphin County, you need IBHS (Intensive Behavioral Health Services) services, maybe you need a home health aide in your home, you would go to this website, and you would be able to find the providers and identify their availability. Five, establish specialized workgroup with legal subject matter experts, to improve information sharing. We have privacy laws in place between the education and human services and drug and alcohol. And they do not always align, and it can make things very challenging for these multisystem - with multiple systems trying to support these children and families. They will have all of the information they need to inform their decision-making and planning efforts. So, this is an attempt to try to make information sharing a little bit easier. Six, develop guidance to counties for funding – with funding for an integrated child and family team. At the county level, county mental health, county ID/A, county child welfare, they should have an integrated team that supports these children and should be working collaboratively as much as possible. This is to develop guidance to support county efforts to do that.

Catalog and assess types of peer supports available now and then develop an integrated family peer specialist role. I'm happy to report that I know this work is already occurring

within the Department and elsewhere. And so, this recommendation was really an acknowledgment of the importance of supporting these families navigating these really complex systems. Navigating complex insurance, navigating the different treatment regimens needed, provider requirements, all of that. Eight, establish a workgroup to develop tools and an assessment that chronicles a child and family's life, a biopsychosocial profile. Each system has a different way of doing this, with different goals in mind. The blueprint workgroup said that we need one tool, one assessment that does that for everyone. So that no matter what system you are in, that caseworker, social worker, whoever has training in this tool and can create this profile and hand it to the family and they don't have to keep telling the story over and over again. It also enables the clinicians and providers with a complete picture of the family. Nine, develop a unified and proactive approach to transitions for youth. This was a nod to - when people hear the word transition you think of oh, 18 going into the adult system or 21 going into the adult system or transitioning from an RTF (Residential Treatment Facility) back to the community. This is more than that. This is about you get a new therapist. You go to a new dentist. Maybe you go to a different unit in the same residential treatment facility. These are all really big transitions for these kids. When you think about having a young child, you always try to talk to him and say in five minutes we are going to go upstairs and brush your teeth. You prepare them for that. This is a nod to a closer look at creating a more unified and proactive approach to transitions, big and small. Next slide.

Ten, we cannot do any of this work without taking a look at staffing and workforce recruitment and retention. And so, the blueprint workgroup felt it was imperative that we take a closer look at our workforce and how we are recruiting and retaining staff. This is not just dollars; this is also about quality. How are we supervising those staff, how are we supporting those staff, and how are we training them, bringing them into the human services field. This isn't child welfare only; this isn't only mental health. This is really a ground-level recommendation to build our workforce. Eleven, establish a workgroup to create greater uniformity between insurers. This is a nod to the many different insurance products out there and the different policies, processes and forms that insurers use. This is private and public insurance and trying to find a way to make it as uniformed as possible, so it is easier for families and providers and systems to navigate. Twelve, find a better balance for provider credentialing. This is an acknowledgment that we actually have to have provider credentialing. It is critical to the safety and quality of the services these providers are rendering. However, we also need to make it easier for providers to prove that they are qualified to render the service they are doing. Do we want them to spend their time filling out many different forms, answering phone calls from different insurance companies? Or do we want them to do the work that they were trained to do. The blueprint workgroup felt that was really important to find a better balance there.

Thirteen, examine rules and policies regarding funding flexibilities for teaming and bundled rates. In the Office of Child Development and Early Learning world there is a rate available

for providers to bill for a full hour of their time, a teaming rate. So even though they may have only "participated" (air quotes) or spoke for five minutes or 10 minutes, they get to bill for the entire hour. This is a recommendation to look at that for other systems, 0 to 21. So, examine the rules and policies regarding that to see if there's any flexibility elsewhere. Fourteen, conduct a comprehensive needs and gaps analysis. This is an attempt to look at what is happening at the ground level, where are the services throughout the state by county, by region, by behavioral managed care organization, child welfare system, and where are the needs? We need to take a closer look at that. And fifteen is, create a multidisciplinary team of professionals for treatment in the community. This is a direct service, this is one of those things that could have a more direct, immediate impact on kids. In the adult serving system there is a service called dual-diagnosis treatment team and it is, for lack of a better word, a kind of a SWAT team of clinicians, therapists, psychiatrists, and nurses. And they come into whatever the community-based setting is for the adult, and they try to prevent any future hospitalizations. They come in, they support the provider that is already there and work with them and the individual and -- they leave when things have settled down, whatever that may look like. The blueprint workgroup felt it was important to look at something similar for children and youth. There are similar things in existence but perhaps not quite the same parallel as dual-diagnosis treatment team.

Sixteen is, increase the flexibility and scope of family based mental health services. The blueprint workgroup took a look at family based mental health services and, in their experience, it appeared as though children and youth who would benefit from family based mental health services are not able to access it when they need it. So, I am thinking of younger children who would benefit. They are living in the community with their family. They are on that grey area of being at risk for institutionalization, being sent to a residential treatment facility. But for whatever reason they do not access family based. So, blueprint workgroup felt it was necessary to take a look at that service and see if there is any flexibility to increase the scope of it. Seventeen, develop uniform standards to make Pennsylvania a healing centered state. We all know that there has been a lot of work done in the trauma field and informed awareness practices across the state. And this blueprint workgroup said we need to create uniform standards that are applicable across all systems and across all providers so that we are using the same terminology, the same definitions and that it is being applied appropriately. Eighteen, training for judges in the juvenile justice system and child welfare system on the practical application of trauma informed principles. So this is -- we can be trauma informed, we can be trauma aware, but how do you actually apply those things in the work that you do, how do you apply those in the court room? And so, this is a look at how we can develop training from that lens. Next slide.

So next steps, as I mentioned we kicked off this week, Tuesday and Wednesday of this week with a multidisciplinary, multi-professional, multi-system group of internal and external stakeholders. The goal of this workgroup is to look at each one of these recommendations individually and build out the details of the recommendations so that

we can then present it to leadership and make it as actionable as possible and ideally implement them. The first step in that is trying to prioritize those recommendations. We are working through those details with the steering team. I am not able to report out on that yet, we are still deciding that with the steering team. But some criteria that we are looking at is whether it is going to be a short-term, midterm, long-term effort. IT systems for example, are a big lift. They take a lot of time, and it is expensive. Policy, regulatory or statutory changes, those can take time. And then, easily achieved versus heavier lift. There are obviously different reasons why something might be easier to implement. It might be easier for the Department to issue a policy statement and then follow that up down the road with regulatory changes. Direct impact versus indirect impact. Are these recommendations going to directly impact and have positive outcomes for these children and youth? Or is it more indirect, like provider credentialing, that is more of like an administrative and efficiency kind of thing and not going to directly impact the outcomes for these children and youth, but it will help. Next slide.

In other news, I also want to share very briefly the Pediatric Capacity Building Institute (CBI). The Department -- this is separate from the blueprint work group. This is something that the Department has launched. and we have had an Adult Capacity Building Institute for dually-diagnosed individuals going on I think seven or eight years. Highly successful. So, we are re-creating that but from the pediatric lens for youth with complex needs. This is an annual in-depth educational experience for participants. Two days per month. We kicked off in January and we are concluding the first CBI in September. The curriculum includes topics on child development, trauma, vicarious trauma, cross system knowledge and multisystem planning, prevention, communication, etc. It's increasing the clinical and administrative capacity of all of the different child service systems supporting these children. All right, that concludes my presentation. I forgot to mention the audience for the Pediatric Capacity Building Institute is the same group of child-serving systems that participate in the blueprint. Behavioral managed care organizations, county administrators, system of care coordinators, hospitals, providers, educators in the room as well. It is very diverse group of members. So, I don't know if we have time for questions or –

>> JOE GLINKA: We are a little bit behind. [Inaudible] We can truncate subcommittee reports and so forth. I like starting off the MAAC meeting with a nice area and light topic. This is supporting a big plan, big goals. You know, just an observation – representing, being the Chair of the Managed Care Subcommittee and working for a physical health plan and as a part of a community that is really committed as well. Within the parameters of our system, we have three distinct systems, and we are trying to get to that. I noticed that in the system partners, physical health MCOs (Managed Care Organizations) were not represented in that conversation. We would like to be, in the interest of working with kids. 50% percent of the overall denominator in this Commonwealth and Medicaid are kids and they are members of our plans. So, to the extent that is helpful, we would like to be a part of that conversation moving forward in solutions. Again, within the parameters we have.

The provider credentialing, there is a big conversation going on with that right now. The Department, the Pennsylvania Insurance Department as well as Department of Health, are all involved with trying to get to the future state where we can have a unified credentialing process that's going to transcend all insurance domains. That is a big discussion that is underway. Anyway, I will stop there. MAAC members, any questions, comments?
>> MINTA LIVENGOOD: As you are in the process of helping children, are you looking at any way to have the system – and any way to work with the PCPs (Primary Care Physicians) - to be able to connect with the mental health and children and youth to better serve these children so they don't go to the doctors and present one problem and they give this child something that isn't going to interact well with the child's behavior. With medication, all of that. That is the area that is very touchy because we don't want the mental health connecting with the physical health, but they do need this documentation to know what the diagnosis is. So, they might be giving the child something that maybe the psychiatrist has already prescribed something different to help this child. So, this is an area in which children and adults, it seems to be -- an area which they cannot intervene with one another. It's really nice when you go to the hospital and your PCP knows all of your specialists that you have already seen. So, they are not standing there saying okay, "what is your child or what is your adult issues?" So, and believe me, parents will get in there and it's like ok, I know he has this issue but...what and forget something and if you get the hospital and in the emergency room and you get a different doctor, they want your history and parents, if they got more than one child it is very hard to remember what each child is doing. It really is important to intervene for the PCPs to connect with the mental health.
>> JOE GLINKA: I could not agree more, [Inaudible] and Jonathan too, [inaudible) one of the assets we have within the HealthChoices program is called the TIPS (Telephonic Psychiatric Consultation Service) program. That is something that may be able to be leveraged as well because when a child presents at the PCP and there is a situation there, the PCP has a TIPS team they can reach out to and counsel. You may be able to speak more politically about this than I, but maybe 97, 98 percent of the time there is a connection within 30 minutes in order to get that child connected on the behavioral health side of things and to get them into some type of treatment regimen or -- [Inaudible]. That program has been in place for quite some time, and I actually think we are looking to expand that program. So, again, to dovetail off of what Minta is talking about, that is an asset I think needs to be leveraged.
>> JONATHAN MCVEY: Absolutely. So, I believe it is mentioned somewhere in the blueprint report that the TIPS program, specifically with the technical assistance we provided at the county level, that is always on our radar in terms of working with the county and other planning entities and providers. If a child is returning to the community, making sure that we are connected with the PCP and folks are aware of who that is and in doing doc-to-doc consults as needed, as appropriate.
>> MIA HANEY: Thank you, Jonathan. I appreciate this work and was involved a little bit with the tail end of this process and thank you. I think it is really wise to have one assessment tool. That is something that I can't reiterate more and potentially even to have that as children become adults, that they can opt-in to continue to have their case sort of in the

works because that transition is particularly challenging on multiple systems. The one thing that I just can't stress enough, this would be amazing, if you walked in and services were sort of there. Right? Often times we don't know what we don't know as parents. We do not even understand the disability. We do not understand the issues. We do not know why our child is behaving in a certain way or experiencing certain medical issues. That sort of single point of contact piece is also really critical. Even a helpline. That is what we do as advocates. We give PA, [Inaudible], to families that do not even have a clue how to navigate the system. So, navigation is important but also single point of contact - here is a place you can go and get an answer and get to somebody else. And lastly, I just want to say I still want to see some sunshine around finding out, getting feedback from the broader community. Especially, as you develop these particulars, you know, in sections maybe, so it is not so overwhelming. Would this have worked for you? What else can we do to improve systems? Because there are so many silos, and it is so different for every situation and many of us who have been through these systems understand what the challenges are but also how to solve them. Thanks.
>> JOE GLINKA: Any other questions, comments from MAAC? All right, we are running a little bit behind. Do we have anything in the chat as far as questions from our audience?
>> ELISE GREGORY: There are no questions in the chat.
>> JOE GLINKA: No questions. Anybody have a question here in the room? Lloyd?
>> LLOYD WERTZ: It seems to me that you are addressing a number of issues that are really huge. And the one I just can't get around is workforce. There seems to be a number of issues that people have raised and lifted about workforce, and we just can't get our hands on that and without that, we have a popcorn thing here. You really can't make stuff happen without folks in the workforce. I wonder how much focus you anticipate being able to have on that one overarching problem.
>> JONATHAN MCVEY: Well, the steering team, over the past few days has really focused on that issue and the goal here is, we have the C CAP task force is present and they made that a priority of theirs as well. And I think the goal here is that we have so many different systems involved [inaudible] we have specific and concrete ideas. Obviously, we need to catalog what else is going on in the state because I know there are a lot of other efforts that are occurring right now. Umm, but to pick and choose the things that we think will most directly impact this target population within the vision that we've outlined. So, we have to work through that. There are some concrete ideas. I think that this steering team wants to prioritize it and then it's going to be a matter of taking those ideas to leadership.
>> LLOYD WERTZ: There are a whole bunch of feet out there that are willing to pound the ground to help and support this. We just need to know how and when and where.
>> JOE GLINKA: One last question and then we will move on.
>> MARY HARTLEY: Can you just expand on, I know that there – the goal is to have this be its own funding source – how this effort will collaborate or interwork with the existing funding streams that support children that are in the same bucket.
>> JONATHAN MCVEY: We are not able to articulate that at this point. Are you referring to the single dedicated funding stream? That has not been tackled yet. That is the next phase

of this workgroup. They're going to take all of these recommendations between the blueprint workgroup and prioritize the ones that they believe are the most important to them and their perspectives and then start working through them. And so, I am not able to answer that question at this time with what that would look like. It really depends on so many different variables. Are we talking state funds, are we talking Medicaid, --
>> JOE GLINKA: Okay, we're going to stop there. Jonathan, to the extent that it's helpful, and nothing's ready for presentation right now, but the Managed Care subcommittee is tackling two things. One is providing capacity. [Inaudible]. And then complex care in the other workgroup. So, as we move forward this year, there may be some recommendations coming forth from the MCDSS (Managed Care Delivery System Subcommittee) that may be helpful. Just to let you know that we're working on that.
>> JONATHAN MCVEY: I've been engaged with them a little bit, the MCDSS. Excellent. Thank you.
>> JOE GLINKA: So, we started the meeting a little bit late. Then we went over but that was quite the discussion and is very important. So now we're going to ask everybody to speak 500 words per minute, 750 words per minute. Next on our agenda, we have Carl Feldman from OIM. In Carl's stead we have Alexis Deisenroth.
>> ALEXIS DEISENROTH: I do not look like Carl Feldman. [laughing] Good morning, everyone. I'm Lexi Deisenroth and I am the Director of the Division of Health Services for the Office of Income Maintenance. Thank you very much. I'm happy to be here for Carl who sends his regrets. He's at a Mass Care [inaudible]. We appreciate the opportunity to speak. I will keep it short and sweet. So, I think a lot of this group has asked us to provide an unwinding update. So, I think I will jump in that the Office of Income Maintenance is the eligibility portion of Medicaid. When we are looking at Medicaid and CHIP for the unwinding, we are almost done. Our unwinding period, our last month of renewals are March renewals which we are finishing up any backlog of those renewals processing now. We are happy to say we started at around 3.7 - 3.6 million individuals to review for Medicaid over the course of 12 months and we are now under 5,000. So, that is a huge step for OIM and for the Commonwealth to be able to say that we were able to take a look at each person at an individual level to review their Medicaid eligibility and their CHIP eligibility for the unwinding.

One thing that is important as we go through some of the system changes that we will need to do from unwinding, none of the logic for the COVID maintained population – meaning the logic that was keeping those people open – will be removed from our system until every single renewal has been processed. We are adamant that we are keeping people open for the amount of time until they have a full review of their benefits. So, we have a ton of policy and procedural transitions happening based on the timing. Some policy that needs to return to pre-pandemic policy, some policies that have shifted for eligibility in the course of the pandemic and then into the unwind. And then some things that we hope will become permanent policy or become more clear and permanent policy over the course of review of some of the recently released CMS final rules. So, I think just to

review for this group because I know there's been a little bit of interaction, specifically with our MCO group, we have some (e)(14) waivers in place for the unwind. Two of those waivers are – CMS recently extended the end date for those waivers. They were extended from December of 2024 to June of 2025. The waiver that is most significant for this group is the waiver of MCO coordination and receipt of verified information from MCO's that we can consider verified eligibility. I think we're looking forward to hearing CMS's decision on whether or not they are going to make that a permanent change for us. But, until we do, they continue to expand those waivers, so we are happy to take them. The other waiver that has been extended that Pennsylvania is interested in is the zero-income waiver. That is if you have zero income on our system versus zero income on our data exchanges, we're able to renew that case without asking for additional verification if there is nothing else critical for eligibility purposes. And that is the general update on (e)(14) waivers.

And then the final flexibility I think that I want to make sure that we outlined today, is that we are going to do lots of incremental change over the next two years. Or at least until April 2026 in regard to how we process ex-parte renewals, meaning, do we need to ask for verification from an individual to process their case? Or can we actually just go ahead and process with the information that we have on hand, in comparison with what we have available in data sources to the Commonwealth. So, that is something we will be taking incremental approaches to. CMS clarified for us later last year that renewals need to be done at an individual level, and our system, along with 30 other states in the US (United States) were doing it at the household level. So, we are in the process of shifting our systems and our policies to come into compliance by the CMS deadline of 24 months post unwind which [inaudible] to April 2026. Those are my larger scale unwinding updates. So, if you have any thoughts or questions for me. That's the nitty gritty.
>> MARY HARTLEY: Do you have any kind of – in the COMPASS system - that is still largely used, correct? And you still have the app? Push notifications through that system in other words, messaging out to the public, not just having people sign in.
>> ALEXIS DEISENROTH: Yeah, I do not know that the COMPASS mobile app does push notifications right now but that is something that -- we always perk our ears up and brought up in conversation [inaudible] I can check with what the status is of that. There might be what we call a change request entered for something for a future enhancement, and just not sure where that is.
>> MARY HARTLEY: Just to add to that, as a parent, one time I got cut off from services. I would love to get served like you get with a bill if you miss a bill, like a yellow notice or red notice. Not just like you are cut off. I think maybe for the individuals who may not know there may be additional mail [Inaudible]
>> ALEXIS DEISENROTH: Our Comms Department, I think there has been some conversation. I know that different states used different tactics during the unwind. I think we did examine that during the unwinding, and I think there was a very big supply chain issue at the time for different things like colored paper, colored envelopes, or the ability to print in colored ink. That was a challenge. I know that is something we are constantly

looking. [Inaudible]
>> MARY HARTLEY: Because we do see families who get cut off and then we have to try to get them back on right away, maybe – I mean, pretty serious issues. So, if there is a way to do that more generally.
>> JOE GLINKA: It's been previously reported in the MAAC that OIM will be moving to an automated approach or a system upgrade in September. Will that be helpful in individual evaluation, or will that accelerate the time frame for Pennsylvania in that incremental process you mentioned?
>> ALEXIS DEISENROTH: It is part of the process. [Inaudible] In September we do look for some updates to assist us in bringing us to the next step. I think what we will see in September is more of getting more households to go through the process. And then, incremental change, post-September will take us to an individual level.
>> JOE GLINKA: Thank you, any questions from the MAAC? The audience? Okay. Thank you.
>> ALEXIS DEISENROTH: Thank you for your time.
>> JOE GLINKA: Thank you. Next on our agenda we have Kristen Ahrens from ODP. Okay, Jeremy. You're on deck.
>> JEREMY YALE: Good morning, everyone. Thank you, Joe. Representing Deputy Secretary Ahrens, she unfortunately had another commitment. I have a couple of slides here. I just want to give the MAAC three updates today. One on performance-based contracting (PBC), an update on the CMS settings rule and also some good news toward the end around our midyear capacity initiative to address the waiting list. If we could go to the next slide here.

So, I know Deputy Secretary Ahrens has reported out on previous MAAC work-related performance-based contracting. So just a quick recap, on April 20th the Office of Developmental Programs put out for public comment for 45 days several pieces of information that are included in the performance-based contracting plan. The first was more comprehensive overview of the implementation of this strategy. The other one was the 1915(b)(4) waiver application, which is new for the office. It would be a complement to our existing three 1915(c) waivers. We have some non-related performance-based contracting amendments that are out for proposal and there are a series of proposed rates. We can go to the next slide.

So, the public comment process has been robust. We have had, I believe nine public comment sessions. We have heard from all of our stakeholders. We have held special sessions for individuals and families, really trying to aim our providers and giving us their best feedback. We anticipate seeing a majority of our feedback come in written form. Some details on this slide, if you are interested in providing public comment, we are still open until June 4th, midnight or 11:59 pm. If you are so inclined to send that email, there is an RA account listed there. If you prefer to send that in vernacular snail mail, Julie Mochon is the lead for that. So, we will go to the next slide.

How is ODP helping providers prepare for this? It is a large change for the orientation for

residential services. It is widely being deemed as necessary and needed. So, one of the things that we have done in addition to the publications I just referenced, we have also taken each of the measures and standards that are part of the performance-based contracting and composed them into a preparedness tool. Those tools are really directed towards residential providers, giving them some quick reference and resources to break down what these new requirements are and how they may impact their organization and the like. In addition to that, if you have this slide deck, I included the links in there as well to both a workbook as well as the evaluation tool. In addition to that we are hosting four sessions coming up on June 3rd, 10th, 12th, and the 20th. Each of these are going to be a different session, they are not repeat sessions. Each session is dedicated to taking a component of the plan and the specific measures and really helping unpack each of them and taking some time to really delve into that. Additionally, beginning in September, we plan to begin providing quarterly meetings, provider forums around this topic. Go to the next slide here.

Quick update on the Home and Community-Based Settings rule. Again, a revisited topic for the MAAC. You may recall CMS conducted an on-site visit on the week of February 26th. During that visit, they were testing the Department's compliance with the Home and Community-Based Settings rule. So, they were looking at things like person centered planning, having conversations with our supports coordinators and direct support professionals, interviewing individuals, count on particular sites. We have worked very collaboratively with the Office of Long-Term Living, Deputy Secretary Marsala and her staff on this. Recently, on May 13th, our Assistant Director received a letter from CMS and we are currently taking a look at those results and working very closely with the Department and OLTL.

And then lastly, a bit of good news. Back in February 2024, the governor announced a strategy to address the Office of Developmental Program's waiting list. At that time Governor Shapiro ordered the release of 1,250 Community Living waiver spots and 400 Consolidated waiver spots. This in and of itself was a very big initiative compared to even some of the things that legislators have funded in previous years. So, having this as a midyear was really fantastic in addressing the needs of individuals and families. So, as of May 20th, some progress on that. Of those 1250, 870 individuals have been successfully enrolled in the Community Living waiver and 310 individuals in the Consolidated waiver. That concludes my updates.
>> JOE GLINKA: Thank you very much, Jeremy. Appreciate that. Questions for ODP?
>> RICHAR EDLEY: Joe, this is Richard Edley, can you hear me?
>> JOE GLINKA: Absolutely, go ahead.
>> RICHARD EDLEY: Hi Jeremy. Just a quick comment and then one question. As you know, I attended several of the public comment sessions and spoke and I'm sure I can take the time to review all that. But, in essence what we said is that we can support the program in terms of focus on quality, which is always important and certainly performance-based

contracting. And alternative reimbursement strategies are far superior to Fee-for-Service. It is really just the enormity of the change, timing, the need for more detail and so we offered some potential solutions that we hope you will look at of how you can implement it and maybe a little bit of a softer start. But the question I have is, my concern in the last meeting was and one of the meetings was when it was an individual and family session. And I couldn't help but think you had people commenting, but how many people, how many individuals and families really knew about those public comment sessions. I know about it because of my role, and I bet they saw a lot of families out there who really have no idea what is happening, and this is a big change. I am not even saying it is all negative, but if things shift in the provider network, and there are consolidations, we could all say - maybe that's even better for the system, but families should know about it. So, my question to you is, are there going to be any additional outreaches to families - mailings, anything like that - to make sure people know about it and if not, would you at least take it back and consider it? Thank you.
>> JEREMY YALE: Thank you for the question and comment, Richard. It is of concern because there are a lot of changes, and we know we are moving at a good pace. Because it is so critical at this point looking at some of the challenges that the system is facing with sustainability and common things, right. Complex care. Workforce issues. We certainly will take that back Richard. I had the opportunity just this week to not necessarily publicize but engage with Speaking for Ourselves, a self-advocacy group, and heard directly from families there as well. So, I think there are other avenues that we are able to take. We also lean into our partners like Mary Hartley sitting at the table and all of her great advocacy work. You know, the Arc of Pennsylvania and some of our other family advocate groups. Thank you.
>> RICHARD EDLEY: Thank you, Jeremy.
>> JOE GLINKA: Question from the in-person audience?
>> ANN MARIE ROBEY: Hi, Annmarie Robey with PA House. I was just wondering, I think it would be helpful to do some more legislative outreach. We did have an informational meeting in the Human Services Committee in the House which was very helpful but there were still a lot of questions and I know that the members were going to receive inquiries in their district offices, and it will help us navigate responses to that. So, if you could do some outreach in some way, whether webinar or a meeting, I think that would be very helpful.
>> JEREMY YALE: Thank you for that feedback. We will certainly take that back.
>> JOE GLINKA: Absolutely. Do we have any questions in the chat?
>> ELISE GREGORY: There are no questions in the chat.
>> JOE GLINKA: Ok, for the sake of brevity [inaudible] Jeremy, thank you very much. We will move on. Juliet Marsala is next with the Office of Long-Term Living update.
>> JULIET MARSALA: All right, good morning, everyone. Juliet Marsala. I always appreciate when ODP goes first because then our presentation is shorter. [Inaudible]. If we go forward, just a couple of things to touch on today. Again, you're probably used to my disclaimer slide but then we will just talk about some stuff at the federal level and, [Inaudible] Next slide.

My disclaimer slide. Community HealthChoices - we are in a blackout period. We will not answer any questions. There is an email resource account if there are questions that are related to that RFA (Request for Application). The independent enrollment broker RFA has been finalized. Final signatures are still in the routing process. Maximus was the vendor selected to continue the independent enrollment broker services. Our staff is working with them to review and implement the additional contract and we will have more updates for that when that is finalized. There are no updates that can be shared with regards to agency with choice. That is also in a blackout period. That concludes my disclaimer slide.

Alright so, for OLTL and we will talk more about this, it is very high-level for us. Very significant changes in final rule, about federal level, Medicare and Medicaid services that will impact the Office of Long-Term Living. Working with OMAP and DHS on a whole as we dive into them deeply. It is going to take a long time to go through them so, please bear with us. We certainly will communicate out selectively from DHS as we finalize those reviews and the impacts for us for OLTL. From CMS in particular we are looking at the nursing home staffing standards, the Ensuring Access to Medicaid services, particularly for the Fee-for-Service system, and the Medicare and CHIP Managed Care Access, Finance, and Quality. So more to come on that.

If we go to the next slide, we also want to talk about the federal level, particularly for the Office of Long-Term Living, the first ever Final rule with regards to Adult Protective Services was released May 7th I believe. It established the first ever regulations for adult protective services nationally. So, that came out of the United States Department of Health and Human Services in particular their demonstration for community living. So, what this does is it provides some consistency across all of the states with regards to definitions for adult protective services, expectations, coordination efforts, things of that nature. My team is going through those as well in partnership with the Department of Aging because as you know, in Pennsylvania we have a bifurcated system. We have older adult protective services and adult protective services within the Department of Human Services providing services to the end of adult, 18-59 and there is a lot of coordination between us and the Department of Aging, so we are both looking at these regulations and our different systems. Within the final rule, ACL (Administration for Community Living) aims to support the national network and deliver adult protective services with the ultimate goal of better meeting the needs of adults who experience or are at risk of maltreatment, and self-neglect. Very important as we will be talking about this more as we kind of work through all of those new points and clarifications.

In addition, really impacting the Office of Long-Term Living and many other services, any services, so, our provider networks, community-based organizations etc. that receive funding through the Department of Health and Human Services. They have strengthened the Rehabilitation Act of 1973, Section 504 to issue a final rule with strengths and protections against disability discrimination. This comes out of the Department of Health

and Human Services Office for Civil Rights. It really discusses and prohibits discrimination on the basis of disability. And it looks at advancing equity and service access for people with disabilities and bolsters protection for people with disabilities. It addresses, clarifies very important expectations for medical treatment and access, accessible medical devices, communication requirements, accessibility of websites and mobile applications. This goes for any organization or agency within our system. I did want to raise that up for folks.

And lastly, I did want to give an update on the HCBS wage rate setting. It is important for folks to be aware of you know from previous meetings with the Office of Long-Term Living is undergoing a Home and Community-based Services rate study for a particular service area. Our personal assistant services, our residential habilitation services, our supported employment services and our adult daily living services and structured habilitation services. We are unable to [inaudible] but those are the ones that were identified as most critical and had the most stakeholder interest and significant impact on populations that we serve. What is important for this group and what I want to highlight is that we are grateful for the LTSS chairs and their partnership and having us take up quite a bit of time in the upcoming LTSS subcommittee to go over and engage on the HCBS wage study process, updates etc. So, it will be a very exciting summer to engage with the LTSS subcommittee [inaudible]. In June we will have a kickoff presentation on the HCBS wage studies. Also, in June it is our intention to have a provider stakeholder session diving into the assumptions related to that rate study. There will be a mid-project update in the July LTSS subcommittee, and we will be finalizing the report in August and doing a final presentation at the LTSS subcommittee in September. So, if you do not have the hold the dates for the LTSS subcommittee meetings, this is my plug for that. And that is all I have.
>> JOE GLINKA: That is a lot.
>> JULIET MARSALA: Great.
>> JOE GLINKA: Thank you for the update. Do we have questions from the MAAC?
>> TED MOWATT: Hi Juliet, do you anticipate any legislative changes coming as a result of either the APS (Adult Protective Services) or the 504 rules or is it just [Inaudible]
>> JULIET MARSALA: So, there may need to be some legislative changes. It is [too early] Likely, there might be, some alignment, [Inaudible] Things of that nature and structure. [Inaudible] and regulations. Certainly, some education across the border.
>> TED MOWATT: Okay, thank you.
>> MARY HARTLEY: Hi Juliet. Wanted to ask [Inaudible] about APS. I noticed that on the chart Pennsylvania, [Inaudible] $580,000 for that service. Do you have any more fundraising results [Inaudible] legislative.
>> JULIET MARSALA: [Inaudible]. There's a history of making changes at the federal level. Not at this time. Certainly, we would be hopeful.
>> [INAUDIBLE]
>> MARY HARTLEY: The bigger question is, do you just look at sort of the landscape of what they're going to ask before [Inaudible]
>> JOE GLINKA: Any other questions from the MAAC? Anybody remotely on the MAAC?

Anything in the chat? Last call for anybody in the room. One question. Lloyd?
>> LLOYD WERTZ: You were really, really good at providing people in the audience to add commentary and helping us. I served on that committee and I'm happy to see that. I have a question about your one slide. On the first federal rule it was noted as proposed, is that true?
>> JULIET MARSALA: No, it is finalized.
>> LLOYD WERTZ: Okay, thanks.
>> JULIET MARSALA: Things happen quickly. [Inaudible]
>> JOE GLINKA: Thank you. Appreciate it. We are about 16 minutes behind according to my calculations. We have a couple more departmental updates. OMHSAS? Welcome aboard.
>> JENNIFER SMITH: All right, I only have one slide. That should make it easier. Those that don't know me, I am Jen Smith, Deputy Secretary for the Office of Mental Health and Substance Abuse Services. I want to start on a really positive note by reminding everyone that May is mental health awareness month and a comment that there have been so many wonderful community events all across the state. We have been able to see courthouses lit up in green and posters along streets and communities. I wanted to say thank you to this group and the folks on the phone who are a part of that awareness. You can't underestimate the importance of talking about and celebrating the fact that there is hope for recovery for mental illness and it is a really, really important month for us to seize that opportunity. So, thanks to those that participated in those events.

The second update is around the Behavioral Health Council. This was the council that was established through executive order back in late 2023. There is an actual council and then an advisory committee and I know some of the folks here in the room and/or on the phone are part of that advisory committee. The work is continuing. We meet monthly as a group, either in person or virtually and each month there is sort of a different topic that we address. This past week the topic of discussion was around licensure and regulation. You can imagine that was a very detailed conversation. I have found the conversations to be very fruitful. I think that there are really good conversations, discussions, recommendations already coming out of these meetings. I think we've had six now as a group. So just to give an idea of what is expected to come next, we are anticipating that a report will be issued from that counsel and hopefully in the fall. So, probably later fall as opposed to early fall, given that we are already almost in June, and we still have a few topics that we really need to get to the Council before the report is developed. The goal would be to put that report out for somewhat of a public comment period. I think that's not really formal and probably not that formal but to publicize it and expect that folks would give us feedback on it. And the reason, rational behind that is the fact that when you form a Council, you can only have so many people to make it an effective group. If you have too many people in the room the conversations are hard. But we do not want to dismiss the opinions, the viewpoints, the suggestions of people from all across the state. So, you will see something to look at closer to late fall. And then, once that report has been put out and we have received comment on it and made whatever revisions are necessary, the next step

for that council is to begin the action plan to implement the recommendations associated with the report. That will sort of be part two of the council's responsibility.

A quick update on our 988 suicide and crisis lifeline. So, currently we have 12 call centers that operate in the state of Pennsylvania receiving 988 calls, text, and chats. In the month of April, we received 9,364 calls. In one month, just in Pennsylvania. And that was up about a thousand calls from the month prior. So, in one month we jumped 1000 calls. Comparing to last year at this time, it's up about 2,300 calls. The SAMSAS (Substance Abuse and Mental Health Services Administration) goal for every state is to achieve a 90 percent answer rate through their call centers. For a couple months we were right on that 90 percent and this past month we did slip back down to 89 percent, likely due to that pretty big jump in volume, a thousand calls per month is a pretty big increase. However, we do have two new call centers that are in the process of onboarding right now. That is really good news. That means once those two are up and running we will be able to take a look at the bandwidth in each of those call centers and appropriately kind of distribute where calls are going so we can ease some of the burden on the centers that are really struggling to keep the answer rate up.

The 2023-24 Leadership Fellows Academy; this was a first here in Pennsylvania. We hosted this Academy which was actually started by individuals from the University of North Carolina. They have been operating a similar program in a handful of other states. And this was an opportunity for folks in the field working in behavioral health in sort of mid-level leadership positions. We really wanted to gain experience, exposure, and refine their leadership capabilities. This is a way of the state contributing to building up our community-based organizations, supporting leadership in those roles, building folks to be kind of the next generation of leaders in those communities. We give preference to individuals who have lived experience that applied for that experience. We selected 14 individuals from, I do not know exactly how many applied, but I think it was near 100. We had lots of interest. We were able to refine that and chose 14 individuals who graduated last week from that program. And I had the opportunity to hear each of them present for a few minutes about what their challenges were, what their expectations were headed into the program, and then their key breakthrough. They had to present to the group about what was most impactful to them. I just wanted to raise it to this group to remind everybody the importance of building up the next generation of leadership in human services. It's really important for folks like us that have been doing this work for a long time, but it is also important to recognize that we can't do the work forever and that there are folks that are going to eventually have to take the torch from us and we want to make sure that we are giving them all of the skills and resources that they need to do that effectively. This is a really wonderful program, hoping we can continue offering it in the future.

And then last but not least, a handful of policy related updates. We continue to chip away at some telehealth related issues. There is a number of components to addressing

telehealth in the behavioral health space. Specifically, we are looking at some legislative fixes that would give us the ability to allow for expanded telehealth services. Those on the mental health side and substance use disorder side. We also simultaneously have to pursue some state plan amendments to make that happen effectively. There is a lot of moving components related to that. We are also looking at creating a guidance document within the mental health space that by program or by licensed activity, would give guidance around what telehealth should look like for those particular programs because we get asked a lot by providers what can we do, what can't we do, what should we do, and it is kind of a moving target. A lot has changed since 2020. And frankly, there is not a ton of research out there about what is the right thing based on research. But what we do know is data that we have collected, that other states have collected, in terms of some pieces that we know, certainly work or don't work. We are looking to create a guidance document that would not be regulatory in nature, just a guidance kind of indicating a place that providers could go to get a sense for what that state believes are appropriate of telehealth services based on those different levels of care and the populations being served. We are in the process of that, and we are working closely with the state of New York. They put out a very similar document not too long ago so we're having some conversations with them about some logic behind some of the decisions they made and trying to compare what we had and what they had and using them as a good sounding board as we develop that.

The next one is the Certified Community Behavioral Health Clinic demonstration (CCBHC). I put this on just for you, Richard. I hope you're listening. We get asked a lot about whether Pennsylvania plans to rejoin that demonstration. I think the last time I talked with you all about this I said we had back and forth with CMS, and we were waiting for some answers from them regarding those questions. We did get answers to all of the questions we had posed just recently, and we have come up with a recommendation that now needs to be vetted by the rest of DHS to make sure we all agree for a path forward. By our next MAAC meeting I should have a decision to officially share with you on the direction that Pennsylvania is headed. What I will say, and I have said this before, is that regardless of what the decision is, whether to rejoin the demonstration or not, we do intend to expand capacity. So, whether that is expanding within the CCBHC model or whether that's expanding the existing integrated community wellness centers. Either way, we believe in the model and a lot of the decision is coming down to some of the logistics and financial impacts, and frankly the impacts to the entities themselves. You know, ones that were originally CCBHC and then we transitioned to a different model and we're talking about transitioning back. There is some cost associated with doing that and some time and effort. So, I will have a decision for you though by the next MAAC meeting.

And last but not least, just wanted to let folks know that we are pursuing how we will incorporate certified recovery specialists into the state plan. Those are peers in a substance use disorder space they are called certified recovery specialists. Most cases those services are currently paid for as In-Lieu of Services (ILOS). There has been a movement by CMS,

particularly targeted in Pennsylvania for us to shift away from using ILOS quite so much. So, this is an opportunity for us to take a look at generating an in-plan service for these care supports. However, I will say it is a lot more complicated than simply amending the plan to make that happen. And the reason is that there are some requirements imposed by CMS in order for them to be in-plan services that would be very difficult for the field to currently adhere to those requirements. And so, what we don't want to do is limit the use of these services because we are making them Medicaid reimbursable. I mean the whole point of making them reimbursable is to have them used more widely. We are taking a cheerful approach to this to make sure that we are trying to account for ways that we are ensuring the continuation of the services in all the settings that they are currently occurring in. Trying to cause the least amount of negative impact to the field. So that is why it is going to take a little bit longer. It feels like we have been on this for a while, and I did not want you all to think 'why is it taking you 6 months now talking about this.' It's because there is a lot of challenges behind that. We really want to make sure we are not disrupting the services that are being provided to individuals. That is all I had.

>> JOE GLINKA: Thank you. Any questions from the MAAC? Comments?

>> MINTA LIVENGOOD: Just one, if they switched to get switched to Medicaid, would you see some of the peer specialists now not qualified to do that position?

>> JENNIFER SMITH: No. So, in order to deliver peer services, you already have to have a certification. That is a requirement regardless. The challenge with moving it through the in-plan service is that you now have to have a licensed professional sort of approving or authorizing the use of those services. And that is not currently a requirement in the way that we reimburse their services. So, when you think about the ways or settings in which services are used, if it is used in a clinical setting, that authorization by a licensed practitioner is probably not a big deal because they probably have a licensed practitioner. But if you think about it in the way we use peers for like, outreach and engagement activities where it is a community-based organization that's using these peers to kind of get out into the community; less likely that they would have a clinical individual on staff. So, the peers themselves are still being certified the same way and still the same criteria to receive that certification, it is just a matter of how their services are able to be paid for. Does that make sense?

>> MINTA LIVENGOOD: I just would hate to see that decrease because it is helpful. It keeps people out of the hospital. You know what I mean. When there is somebody there able to work one-on-one with the person.

>> JENNIFER SMITH: Definitely.

>> KYLE FISHER: To follow up on that, Jen. ILOS [Inaudible] Are these services broadly available throughout the Commonwealth? [Inaudible]

>> JENNIFER SMITH: Um, I mean yes, the services are available broadly. I would say that the ways in which they are used and paid for vary significantly across the Commonwealth. In some cases, they are paid for with managed-care funds. Some cases they are paid for with reinvestment dollars. Sometimes their funded through counties. Sometimes it is through federal block grant dollars. It might even be through state dollars. It kind of depends on what program is being funded as to how those services are reflected as part of typically another program. I know that is not an easy answer. But it is the reality.

>> JOE GLINKA: Any questions from MAAC members that are remote?
>> RICHARD EDLEY: This is Richard, I have to at least acknowledge the shout out, Jen, thank you. I have a cold today so I could not make it there in person but the news on the CCBHC has brightened my day. Thank you.
>> JOE GLINKA: We will take one more question. Andrew, I think you had a question.
>> ANDREW KUNKA: I'm Andrew Kunka for Behavioral Health in Philadelphia. Thank you for the update. I was wondering if there is any research or ideas that may be what was driving up the crisis call center rates. I didn't know if there was any sort of timeline on the telehealth work that you are doing. Just both of those things are really interesting for the BH-MCOs (Behavioral Health Managed Care Organizations). And again, excellent update so thank you for that.
>> JENNIFER SMITH: The question around what we would expect is driving the influx of 988 calls could be a number of things. 988 is a nationwide number and so the federal government will also pay for ad campaigns to promote. We also know that counties are promoting it more, but I will say that we are investigating it and we have heard that there was somewhat of a decline in the use of the substance use disorder Get Help Now hotline. So, we were wondering if there was sort of a switch of folks shying away from using the substance use disorder hotline in favor of calling the 988. We don't know yet if that is a correlation. If it is a correlation, we are not sure what the reason is. Is it because they in fact do have broader behavioral health issues and so 988 was a more appropriate phone call? Is it because 988 is more well-advertised? Is it because they feel they get better services? Those are all things we have to dig into but first we have to figure out if there was in fact, a correlation between those changes just within the last month.

And what was your next question? Oh Telehealth. As I mentioned, we're looking for some legislative help to create some relief to the dreaded formal discussion. If you don't know what I am talking about, don't ask. You don't want to know the intricacies of it. If you do know, you are the ones that are laughing about it. We are hoping that maybe this legislative session might get some resolution to that legislative component but that is not preventing us from moving forward with the other things which include drafting some state plan amendments to create a mobile substance use disorder type service. I do not have a firm answer for you.
>> ANDREW KUNKA: Appreciate it. Thank you so much.
>> JOE GLINKA: Thank you. Alright so, we are behind. It has been a great discussion. We know OMAP update's coming. I want to be fair to Sally and the Department. So, I will ask MAAC as far as subcommittee reports, would the MAAC be amenable to having subcommittee chairs submit their reports as a part of the MAAC report up in minutes and writing? It's just a question. Ok, alright. Sally?
>> SALLY KOZAK: Thank you. We just have two updates for you. Angela Episale from our Office of CHIP is going to give an update on some work that has been going on there and then I have a brief update on the final rule [inaudible].
>> ANGELA EPISALE: Hi everybody, it is great to be here. Again, I am the Division Director

for Policy and Planning in CHIP. We wanted to talk to you about what is going on with continuous eligibility and start with a little bit of background. On September 29th, CMS issued a state official SHO (State Health Official) letter indicating changes to CE (continuous eligibility), that went into effect on January 1st. A child's eligibility previous to January 1st, there were a limited number of exceptions and now there are a few fewer. Before January 1st, the only way you could interrupt a child's continued eligibility period would be if the child attains age 19, if the child or the representative requested a voluntary termination of eligibility, they ceased to be a resident of the state, we determined that eligibility was erroneously granted, they were deceased, they became eligible for Medicaid, if they failed to pay their initial premium, if they failed to pay the ongoing premium, or if they had other insurance. Next slide please.

As of January 1st, there is no more exception for failure to pay premiums and no more exception for private health insurance. What does that mean exactly for CHIP families? No adverse action can be taken during the eligibility period for other insurance or for lack of paying premiums. An adverse action for income can only be taken at application or renewal and within the eligibility period, if other insurance is obtained or discovered, CHIP becomes the payor of last resort. So, the idea is that once we know that child wants our services, we want to keep them within their benefits for their full 12 months.

The last slide please. So, what is Pennsylvania CHIP doing? We have been working with our managed care organizations and advocates in order to create a letter template to share with families. It is very important to us to focus on education. Although we want to keep children open in their benefits, we do recognize that some folks don't know that if they stop paying their premiums, their benefits aren't going to stop. And some people have been doing that, especially single moms like me, I've been there. So, when you don't pay your bill, you think it is going to stop, you move on with your day. You don't want to spend a few hours on the telephone. We want to protect our families from things like that. If they intended to have their benefits end, we want them to know that they need to withdraw from their benefits and let us know so these won't keep building up on them. We held an in-person meeting with our managed care organizations to review the changes. We have a letter and FAQ (Frequently Asked Questions) document ready to go out to the families. We talked to advocates yesterday. We are going to make sure some have it [inaudible]. We have manual processes in place right now to protect families, but we are working to complete system changes for that. Recently, we shared a proposed state plan amendment to CMS for informal review before [Inaudible] to make sure states do understand our processes for all of this and are ready to approach things when we [inaudible]. So we are really trying to make sure that everybody's family, managed care organizations, advocates, everybody's on board with knowing we do want to protect our children and have them covered by their benefits but if there is some reason that family doesn't want to have those premiums stacking up, if they assumed that when they got their other insurance, this would be canceled [inaudible] in the past, we want them to know that those won't happen

anymore and what their rights are to make their choices. We are going to skip our last slide. I will pause if there are any questions.
>> SALLY KOZAK: Angela, can you clarify for me, I know I always have things in my head. This rule only applies to those [inaudible] cost children [inaudible]. Because the full cost is operated a little bit differently and not subject to the [inaudible].
>> ANGELA EPISALE: Absolutely and that is a great call out. Thank you. Full cost CHIP is not regulated by the federal government. That is something we offer to our communities so that people can get the health insurance that they need for their children. So, we don't have to adapt to that program every time there is a change from the federal government. The families who are in our full cost program, go with what they want, where they are, and we are not trying to change anything for them at this time. Those educational materials do make that clear, so they are not confused and worried about [inaudible]. We do want to make sure that people know that full cost CHIP will stay how it is. That is a Pennsylvania product that we are very proud to share it in the way it is. Our other families and the subgroups in free CHIP, we want to make sure that they are staying [Inaudible]
>> KYLE FISHER: So, a manual process until the system changes occurs, when is that expected?
>> ANGELA EPISALE: We are looking at that, I think most of our system changes really are more towards like 2025, beginning in that timeframe. We are really working with the managed care organizations. Like I said, there is a lot going on behind the scenes [inaudible]. It's just going to get a lot easier for us after those system changes go and hopefully there won't be a big change for our families and they won't recognize that what we're doing to make it work.
>> SALLY KOZAK: Yeah Kyle, the systems changes that we need to have happen impact what OIM needs to have happen in the changes that they have on the record. So, those will all happen at the same time. The process we have in place right now is one that we've been using for a while. So, [Inaudible] We have some trial and error. [Inaudible]. But we have now smoothed it out.
>> JOE GLINKA: I do not have CHIP responsibility. But, in just looking at, no adverse action for non-payment of premium, [Inaudible] What proportion of the overall CHIP denominator falls into that bucket? I would imagine that the insurers basically have an issue with that because in the reference to try to collect payment and they may not get paid. [Inaudible].
>> ANGELA EPISALE: So, the question is how many people we think that this might affect who don't [inaudible],
>> JOE GLINKA: I mean, how large of an issue within the CHIP program would this be and how much noise are you hearing from plans?
>> ANGELA EPISALE: We are so fortunate with our relationship with our managed organizations. It's been very collaborative. We had concerns because we want to protect our families. We don't want to force people to be going into debt and the managed care organizations, we want to keep them wanting to provide services. So, we have just been so fortunate that they have been working with us. I don't have that number off hand as far as the percentage. I know it has come up.

>> SALLY KOZAK: It is a small percentage.
>> JOE GLINKA: The bulk of this time, they are a group of kids in free CHIP.
>> SALLY KOZAK: It's a small percentage of the population and that would've been the group that got involved in the 90-day lockout period which [Inaudible] because they didn't pay for any of it. And that number was very small, we are talking literally in the 150,000 [Inaudible] program every year, maybe less than 100 or so, if I remember the last number, that never paid the premium and ended up in that lockout period. There are at any point in time of course, families that are in somewhat level of arrears, but our managed care plans, Angela has said, we are very fortunate in that they are very [inaudible] in ensuring all of our CHIP families maintain access to coverages, so they have been very flexible in working with them with a payment plan. We don't anticipate that is going to change.
>> JOE GLINKA: If a family is unable to pay, is there some type of outreach to see if maybe they qualify for HealthChoices?
>> SALLY KOZAK: Oh absolutely, the managed care plans have contracts with those individuals. They can call them at any time and talk about their change in situation. So yes, that does happen.
>> ANGELA EPISALE: Particularly if somebody is not paying [inaudible] and if it will continue to happen.
>> JOE GLINKA: Any other questions from MAAC members, in-person or remotely? Any questions from the audience? Okay, Sally.
>> SALLY KOZAK: The last piece I have on the agenda is just a really quick update regarding the set of three final rules that came out I guess earlier or late last month. It was the Home and Community-Based Services, the Access, Quality, and Eligibility rules that came out. We said that we will get back to you as we speed through this. We are still reading through them. As I heard yesterday there was only 1095 pages. [Inaudible]. And then after that we have another set of 100 pages, the frequently asked questions and clarifications. We have formed the internal workgroups that actually begin meeting next week to begin to wade through all of the information and sort of start to project plan, [Inaudible]. We know, because we have seen the draft of them when they were proposed, we know that there will be impacts in particular to the structure of the MAAC and the Consumer Sub and other committees and so as we move forward in evaluating what that looks like we will be including folks from this group in those conversations. Probably sometime more towards the end of summer, we will come back to you with our overview of changes and what it all means for our program. Is there a meeting in July or August? We have a meeting in July. I don't think we are going to make July, so probably September we will have a follow up for you. Just wanted to update everybody on where we are with that.
>> JOE GLINKA: Is there anything else?
>> SALLY KOZAK: I think that is everything from us. [Inaudible]
>> JOE GLINKA: We are almost there. Thank you for that. Eve, as far as subcommittee report outs, do they submit those to you?
>> EVE LICKERS: You can send those actually to the RA account. [Inaudible].
>> JOE GLINKA: Ok great. So that RA account [Inaudible]. So that gets us to bulletins.

>> EVE LICKERS: Good morning, everyone. So, we have one bulletin that was issued since the last meeting. It is MA Bulletin 99-24-02, Medical Assistance Program Fee Schedule Revisions. Please take a look at this. There were a number of updates related to – a few codes that were added to the fee schedule, but we have a lot of revisions that were, [Inaudible]. That was issued at the end of April, on April 29th, effective that same day. So, you will definitely want to take a look at that. [Inaudible]. Just to give you a heads up, we are finalizing our 2024 HCPCS communications [inaudible]. That should be coming out by the end of May and if not, it will be in June. [Inaudible]. So, if you looked at the ListServ, you also saw that we had drug utilization review board documents, and I am not sure if anybody had any comments or questions. If not -- [Inaudible] RA account [Inaudible]
>> JOE GLINKA: Thank you, Eve. I would just drive everybody's attention with respect to subcommittees, is to pay attention to when their next meeting dates are. They are on the agenda. I know a number of you attend those meetings regularly and we appreciate the contributions you make and your attendance in those meetings. Do we have any old or new business for the MAAC now that we are back on time. Yes, Jeff?
>> JEFF ISEMAN: This is Jeff from Pennsylvania Transportation Alliance. This is a future request. Can we get an update on what is going on as far as MATP, (Medical Assistance Transportation Program) I understand that the Medical Assistance Transportation Program is having to update policies and procedures related to what CMS is requiring of the states. [Inaudible] particularly with like managed care and maybe some practices? So, that'd be great.
>> SALLY KOZAK: Sure, absolutely we can schedule an update either in the next meeting, the June meeting or in the July meeting.
>> JOE GLINKA: We did have somebody in our April meeting talk about that from the Transportation Alliance, but I think it would be good for others to hear that too.
>> SALLY KOZAK: No, yeah absolutely we can put that on the agenda.
>> JOE GLINKA: Thank you, Jeff. Yes, Lloyd.
>> LLOYD WERTZ: How would one access electronic copies of the presentations that were offered today? As part of the presenter's PowerPoints?
>> SALLY KOZAK: The documents are available on the DHS website, on the MAAC listserv. All the documents will be there.
>> LLOYD WERTZ: Will be but not yet. [Inaudible]
>> SALLY KOZAK: I think they're also available on the MAAC page. [Inaudible]
>> MICHAEL NAVARRO: If anyone wants a copy right now, I have a few extra copies here.
>> LLOYD WERTZ: Ok, thank you.
>> JOE GLINKA: Or you can subscribe for $199.99. [laughing]. Anything else? Old or new business? All right, I appreciate everybody's participation. Do I have a motion to adjourn?
>> MINTA LIVENGOOD: This is Minta Livengood, I will make a motion to adjourn.
>> JOE GLINKA: Thank you, Minta. Do I have a second?
>> MARY HARTLEY: I'll second, Mary.
>> JOE GLINKA: Mary, thank you. Thank you everybody. We'll see you in person in another quarter and we will be remote next month, June 27th by webinar.