Consumer Subcommittee of the MAAC
February 23, 2022

Consumers present: Minta Livengood, Ronel Baccus, Jayme Scali, Meghann Luczkowski, Lauren Henderson, Marsha White-Mathis, Liz Healey, Victoria Salerno.

Laval Miller-Wilson, Counsel to the Consumer Subcommittee, called the meeting to order at 1:02pm.

I. OMAP Report

Eve Lickers, Director of the Bureau of Policy, Analysis and Planning, and Gwen Zander, Director of the OMAP Bureau of Managed Care Operations, provided the updates for OMAP.

HealthChoices Procurement

Ms. Zander noted that the Department continues to prepare for the transition to implement the re-procurement of the HealthChoices Program. The Department is targeting April 1 as a "go/no go" date based on readiness review as well as provider networks. This is also the date the Department plans to submit the 2022 HealthChoices Agreement to CMS for approval. Between April 18 and April 29, Maximus will be mailing out communications to consumers throughout the state, including both impacted and non-impacted consumers. Those communications will look different based on whether or not they are impacted by the procurement. Between May 1 and June 22, people will be able to make their enrollment decisions. The Department's target for active voluntary plan selections is 60%. Anyone who hasn't made a decision by June 22 will be auto-assigned to a plan.

The Department has convened a Communications workgroup which will meet for the first time this Monday to discuss the HealthChoices Procurement communications and publications.

Liz Healey, Consumer, noted a concern about certain groups of people for whom this plan change will be a complicated process because of their complex health needs. These people include but are not limited to people on SSI, people who are in renal failure, kids who use private duty nursing, and people who have 7 or more healthcare providers. Continuity of care for these folks will be critically important, and the Consumers feel it is important to do active outreach to these subsets of people to assist them in making an active choice and help them avoid auto-assignment. Ms. Healey urged the Department to consider how they might go about doing this outreach.

Ms. Zander stated the Department has been thinking a lot about continuity of care for high health care utilizers throughout the Procurement process. The Department has a plan in place to proactively identify those groups that will be targeted and is open to discussion about this issue during the Communications workgroup meetings.

Sally Kozak, Deputy Secretary for the Office of Medical Assistance Programs (OMAP) suggested that the Special Needs Units within the MCOs can be helpful in this process.

Mr. Miller-Wilson stated the Consumers would like to see the choice rate closer to around 80% for those special populations of high-utilizing individuals.

Meghann Luczkowski, Consumer, noted that the fallout from not making a proactive choice will be problematic for these individuals and looks forward to discussing more proactive solutions during the Communications workgroup meetings starting on Monday.

Public Health Emergency Federal Extension

The Department has not heard any official notification from HHS about extending the PHE. However, they did see a copy of the letter that the Biden Administration sent to Congress stating they plan to continue the PHE. The Department anticipates we will not have official notice from HHS closer to the April 16 date, which is the end of the current PHE. Ms. Kozak also noted that even if HHS renews the PHE, it may not be for a full 90 days. The rumor going around currently is that HHS will only do a partial extension. Ms. Kozak also noted that the Department will give 60 days' advance notice before stopping the pediatric shift nursing freeze after the end of the PHE.

Mr. Miller-Wilson noted that just over 500,000 individuals will need to be reviewed for eligibility at the end of the PHE and is interested in seeing data about those individuals' categories of MA coverage. Ms. Kozak said she can make that information available at future meetings.

COVID-19 OTC "Home" Tests

As of mid-February, Medical Assistance including all the MCOs are covering OTC home COVID-19 test kits, up to 8 tests covered per month per individual. No prescription is required. As for

individuals who have paid for OTC tests previously, to the extent they kept their receipt, they can ask the pharmacist to reimburse them and resubmit the claim to MA.

Some of the MCOs have also been hosting distribution events where they give out COVID-19 testing kits, some have options for mail-in, and some have options for homebound individuals seeking at-home tests.

Mr. Fisher noted that some consumers with primary insurance are having problems getting the tests covered. There have also been some billing code issues that have led to people not being able to get these tests at the pharmacy.

Ms. Kozak sent all the information out on the Department's listserv and released the Bulletin. Ms. Lickers stated that the Department has spoken directly to Walgreens and CVS and provided them with the bulletins. Part of the problem here is that providers are having difficulty because this is all so new. If individuals are having trouble getting tests covered, the Department would like to be made aware.

MA Coverage of Masks

Medical Assistance has not added N95 or surgical masks to their fee schedule (currently only specialized respiratory masks are covered), but they are looking at the budget implications of adding those items.

ARPA Spending Plan

The updates to the ARPA spending plan are regularly posted. One was posted a few weeks ago and there are no additional updates to the plan at this point. There will be a meeting with the Pediatric shift nursing workgroup to discuss plans to spend the ARPA funding.

Mr. Fisher noted the Consumers are happy to see the progress being made with the ARPA funding but have concerns about ensuring the accuracy of the missed shift data that will be used to trigger Pay for Performance payments. Ms. Healey asked if later this year the Consumers could revisit the process that will be used to verify the Ops 8 reporting by home care agencies.

HealthChoices CY 2022 Programmatic Changes

Ms. Zander noted that the plans are operating under the 2022 HealthChoices Agreement but the Department is still awaiting CMS approval of the Agreements. Once CMS approves the Agreement, it will be posted to the DHS website. Ms. Zander provided a few areas of note regarding programmatic changes in the 2022 agreement:

1. Maternal Home Visits – The Department has added language to clarify that the maternal home visiting programs need to be expansive and innovative to serve new populations and new geographies. The MCOs must be working with providers of home visiting services as well, rather than using their own MCO staff to perform the home visit. These providers don't necessarily need to be evidence-based programs, as long as they use an evidence-informed model. There is also no set number of home visits that are required; this is based on individual need.

2. Addressing Social Determinants of Health – This will be done in two ways. First, through Community-Based Care Management program, for which MCOs cannot use for their own staff beginning in 2022. They must partner with CBCM providers in the community. The second method is through Value-Based Purchasing. The targets have been raised so that MCOs work with even more community-based organizations that address social determinant of health issues.

Transition of Kids from Congregate Care Facilities

Ms. Zander reported that there are currently 211 children residing in facilities in Pennsylvania. These children are from 24 different counties in each of the HealthChoices zones except for the Northwest, with the majority of the children living in the Southeast zone. The children range in age from birth to age 20. The length of stay varies for these children, with the highest being 17 years.

There is new language in the 2022 HealthChoices Agreement that directs MCOs to develop a relationship with the Family Facilitator in their area and to do the following: 1) take a lead role in discharge planning to make sure all the resources a family would need are put in place prior to discharge, 2) oversee home visits if needed or wanted, 3) look over care plans for these children, 4) monitor the children in the facilities to determine what services are being provided and to make sure they align with the child's care plan, and 5) for any child in a facility longer than 12 months the MCOs will need to increase the effort for permanency planning, including

notifying the Department about any barriers to discharge that exist. The Department will also be monitoring the case management standards that the MCOs are using to ensure they are in alignment with the Care Management Society of America's best practices.

Ms. Kozak noted that the goal for each and every one of these children should be placement with a family or, in lieu of a family, an alternate caregiver. To make this happen, coordination needs to happen at all levels of the system.

MATP Workgroup Report

Ms. Zander stated the MATP Workgroup Report is a consensus document developed over a two-year long period by representees from OMAP, OLTL, and OMHSAS, as well as PennDOT and the Department of Aging. The goal of the group was to identify opportunities to improve the operation of MATP in Pennsylvania. The stakeholders who came together endorsed 10 different recommendations for the MATP program:

1. Increasing County Collaboration
2. Facilitating coordination between Shared Ride and MATP
1. Improving coordination between state agencies that fund MATP (DHS, PennDOT, Aging)
3. Evaluating the prospect of statewide MATP standards
4. Looking at standardization of processes across the state such as applications and needs assessments
5. Identifying the technology needs of counties
6. Establishing monthly calls with all MATP Administrators
7. Considering a hybrid service delivery model
8. Issuing RFAs for direct contract counties
9. Exploring a broker pilot in one county

The Department has decided to implement all but the last recommendation about exploring a broker pilot in one county. To implement these recommendations, the Department is working much more closely with PennDOT than ever before. They meet monthly and additionally as needed to improve coordination and relationships. They have held two MATP Administrator calls thus far. In the near future, the Department will assess the counties' formalized coordination efforts vis-à-vis other counties, and look at where they might be interested in more formalized collaboration in the future. The Department will also do research about the 19 counties that coordinate their Shared Ride and MATP programs separately.

II. OLTL Report

Jamie Buchenauer, Deputy Secretary of the Office of Long-Term Living (OLTL), provided COVID-19 and CHC updates on behalf of OLTL.

OLTL 2022 Priorities

In 2022, OLTL will focus on the following priorities:

1. Value Based Purchasing
2. ARPA Funding
3. FMS Transition
4. Nursing Home Funding Issues
5. Agency with Choice (a participant-directed model)
6. Direct Care Worker Support
7. Support for BHSL

Mr. Miller-Wilson asked, with regard to the nursing home funding issues, if Pennsylvania has enough nursing home beds. Ms. Buchenauer said pre-COVID, the state did have enough nursing home beds available. Now, there is an adequate number of licensed beds and Medicaid beds, but the issue is that nursing homes have taken some of their beds offline or closed them due to staffing shortages. The Governor's budget allocates funding especially for the new DOH staffing requirements.

FMS Transition

OLTL has decided to delay the effective date of the transition of financial management services (FMS) from PPL to Tempus from April 1, 2022 to July 1, 2022. This took place after getting a lot of feedback from stakeholders including consumers and providers. As of now, 52% common law employers and 46% of direct care workers have returned their packets to Tempus. There is much work to be done before implementation on July 1, including communications from Tempus and trainings for consumers and providers. OLTL is in the process of setting up an email inbox for additional questions about the Tempus transition.

OLTL is joining with ODP to issue a Request for Proposals for a new FMS vendorfor the OBRA and Act 150 programs. Since OLTL will not have time to get a new vendor by July 1, PPL's contract will be extended.

Mr. Miller-Wilson asked about materials being sent to consumers and providers in alternate languages where those consumers or providers speak a language other than English. Ms. Buchenauer says Tempus is working on translating the materials.

ARPA Spending Plan

Enhanced payment rates in the CHC and OBRA waivers started on January 1, 2022. This raised the personal assistance service (PAS) payment rates. OLTL is also working on strengthening the workforce payments and payments for adult day service providers. The first round of payments are going out today. Providers must return their attestations to the Department in order to receive these payments.

The HCBS Quality Improvement Grant is aimed at improving the services available under to HCBS participants under the CHC and OBRA waivers to address social determinants of health, purchase remote support technology, development of and payment for enhanced training, and purchase and implement new technology for electronic verification.

Community HealthChoices - Appeals Data

OLTL has begun to address grievance outcomes by service type and grievance outcomes distinguished between “fully favorable” and “partially favorable”. DHS is holding internal discussions regarding grievance report changes required under the upcoming CMS MCPAR requirements. After the DHS discussions conclude, OLTL will need to address identified CHC OPS report revisions with the CHC plans and give them adequate time as prescribed in the contract agreement to apply the report revisions. The first MCPAP report is due in about 18 months (mid 2023). OLTL wants to be able to track a case from grievance through completion of the fair hearing process and struggles to do that now.

Mr. Fisher asked if OLTL could provide data about adverse benefit determinations, rather than appeal data at this time. Ms. Buchenauer says they only collect data when there is a change to the service plan, and the data they collected did not readily show whether the person filed for a grievance or fair hearing. This is something that OLTL is looking into.

Home Accessibility DME

All CHC-MCOs have had their home accessibility DME policies approved. These policies are effective retroactive to the effective date specified in the State Plan Amendment. At the Home Adaptation and DME Advisory Committee, concerns were raised and are being addressed regarding approvals contingent on the consumer doing prep or other modifications necessary to accommodate the HA/DME. For example, if a retaining wall is needed for a vertical platform lift, then this may need to be a home modification if the person is receiving HCBS.

Ms. Lowenstein raised the concern that some CHC-MCOs are denying requests for home adaptations based on the need for contingent improvements, rather than offering a contingent approval, and Consumers expect to see this same thing happen on the home accessibility DME side. Ms. Kozak noted that she and OLTL are interested in hearing these examples. Ms. Lickers added that the bulletin language allows for a "plan to obtain" necessary improvements.

Additionally, before CHC-MCOs will approve any home accessibility DME, safety must be assessed before installation. For example, if the supporting area and stairs are unsafe for a stair glide, then it cannot be installed.

Fee for Service Specialty Pharmacy Program

Terri Cathers, Pharmacy Director for the Bureau of Fee for Service Programs, provided an update on the Department's Fee for Service Specialty Pharmacy Program, which operates as a 1915(b) Freedom of Choice Waiver. There are two preferred specialty pharmacies currently—Accredo and ChartWell. The Department has decided to exercise an agreement renewal with ChartWell, and to not to exercise an agreement renewal with Accredo based on certain performance issues. ChartWell is prepared to meet the specialty pharmacy needs of all Fee for Service enrollees across the state. An MA provider bulletin was issued on February 9, 2022 with an effective date of July 1, 2022. Currently there are about 125 Fee for Service beneficiaries who will need to transition from Acredo to ChartWell. The Department does not expect any service interruptions. ChartWell will outreach to providers on March 1 to obtain new prescriptions for consumers currently using Acredo.

The meeting was adjourned at 3:05 PM.