Consumer Subcommittee of the MAAC
April 27, 2022

Consumers present: Sonia Brookins, Jayme Scali, Meghann Luczkowski, Victoria Salerno, Marsha White-Mathis, Liz Healey, Lauren Henderson.

Sonia Brookins, Chair of the Consumer Subcommittee, called the meeting to order at 1:05pm.

The February minutes were approved.

I. OMAP Report

Sally Kozak, Deputy Secretary for the Office of Medical Assistance Programs (OMAP) provided the updates for OMAP.

Public Health Emergency (PHE) Extension

Ms. Kozak began by sharing that the federal COVID-19 PHE was extended on April 12, 2022 for another 90 days. The extension took effect on April 17 and will last until July 15, 2022. Federal officials promise 60 days' notice before the end of the PHE, and the Department is honoring this promise as well.

HealthChoices Procurement

Implementation of the HealthChoices Procurement has been pushed back from July 1 to August 1, 2022. The Department continues to perform readiness reviews and examine network adequacy. They anticipate a go/no go date in the coming weeks (around May 10th when the Department's subcontractor, Maximus, needs to move forward with printing notices to go out to consumers).

The Consumers asked about the status of the work stoppage & collective bargaining agreement (CBA) provision. Ms. Kozak stated the intent behind this provision is to ensure that work stoppages do not disrupt services to consumers. The Department remains committed to ensuing adequate access to services for consumers.

Ms. Brookins noted the Consumers remain neutral on the CBA provision and would like more detail from the Department on this provision before making a decision on their position.

Laval Miller-Wilson, Counsel to the Consumer Subcommittee, asked Ms. Kozak to say more about the possibility that the start date of the Procurement might get moved again beyond August 1, as well as why it got moved in the first place. Additionally, Mr. Miller-Wilson asked if there are any zones that are holding up the statewide procurement.

Ms. Kozak stated that as new plans were moving into new areas, there were concerns with network adequacy, so the Department gave additional time so that new plans could shore up their networks. The other driver for the need for the delay was the issue with the collective bargaining agreements and the MCOs being able to obtain all necessary information from the hospitals. The Department continues to target August 1 as an implementation date, and whether there will be another extension will depend on whether networks are adequate.

Mr. Miller-Wilson asked if there are any zones that are particularly problematic as far as network adequacy? Ms. Kozak said there is not a particular zone that is the problem; new entrants into new zones needed additional time to sure up their networks.

Mr. Miller-Wilson asked if the Department expects the MCOs to enter into brand new contracts with providers with which they contract currently, e.g. a plan like Keystone First has a contract with Children's Hospital of Philadelphia (CHOP), so does the Department expect a new contract will be executed to start August 1, or can the current contract be treated as a legacy contract? Ms. Kozak stated the Department does accept legacy contracts. The Department on a routine basis reviews network adequacy and is notified by the plans if they will have a problem with contract renewal. The Department does not have a minimum timeframe for these contracts either; they are executed on an ongoing basis.

Mr. Miller-Wilson asked if the Department is aware of any changes to existing plans' hospital network providers, due to the CBA provision or otherwise? Ms. Kozak stated the Department continues to work through the CBA provision. As they continue to work through it, she may have a response, but does not have a response right now. She also highlighted that the CBA provision precludes hospitals with a work stoppage from being in a plan's network; it does not preclude the hospital from being an MA-enrolled provider. Mr. Miller-Wilson asked what other information is needed to answer the question. Ms. Kozak stated the Department continues to collect information from the plans about their provider's history of work stoppages and/or CBAs, and they have not received this information from all plans yet.

Ms. Brookins asked how many hospitals this impacts. Ms. Kozak did not have exact numbers on hand; the Department provided a list of hospital they were aware of to all the plans and they are scattered throughout the state. Ms. Kozak will send Ms. Brookins this list offline.

Mr. Miller-Wilson asked how a hospital would continue to serve a MA consumer without participating in a MCO's network. Ms. Kozak stated there are MA providers who don't contract with any MCOs. Mr. Miller-Wilson asked how consumers find out that they can continue to use a certain hospital if the work stoppage prevents that hospital from participating in the plan. Ms. Kozak stated they can call the member services line or the Special Needs Unit at their plan.

Deb Shoemaker, Chair of the MAAC, asked who this new CBA provision applies to. Ms. Kozak noted the requirement is being applied to hospitals. Mr. Miller-Wilson asked if the Department has yet done an analysis of how many consumers would be impacted if this CBA provision is applied. Ms. Kozak stated the Department is working through this type of analysis.

Liz Healey, Consumer, asked if a consumer could go through their Special Needs Unit to get approval to go out of network to a hospital that is no longer in the MCO's network. Ms. Kozak stated the plans do have obligations for out-of-network care if they cannot meet the consumer's needs in-network.

Mr. Miller-Wilson noted the consumers are very much trying to understand how they will learn that a provider they're using will no longer be in-network with their MCO and how much of a burden it will be to try to continue seeing that provider. How much leeway does the Department intend to use about whether any hospital that has had a work stoppage would be excluded from this provision, i.e. might the Department be flexible and allow a hospital that has many members to be exempt from the provision for the sake of consumer access? Ms. Kozak noted the Department has the ability to waive contract provisions including the CBA provision. She also noted that all plans have processes in place for continuity of care when a hospital leaves their network, which has historically happened. The plans would be expected to handle this kind of termination the same as any other network termination. The plans would implement their outreach processes; we saw them recently do it with the closure of the Delaware County hospitals and with the closure of Hahnemann Hospital. Ms. Kozak would encourage consumers to contact their MCO if information is sent out about network providers leaving.

Mr. Miller-Wilson noted the consumers still have a lot of questions and are very concerned about consumer impact. When does the Department expect to have enough information to

make a decision? Ms. Kozak said the Department is continuing to complete the analysis and does not have a definitive date, but hopes it is soon.

Ms. Brookins asked if the HealthChoices Agreement can be amended to specify that the CBA provision applies only to hospitals? Ms. Kozak said yes, this is a change they plan to make in future contracts.

Meghann Luczkowski, Consumer, asked if outpatient specialty providers that operate in association with certain hospitals would also be impacted by the CBA provision? Ms. Kozak said the Department continues to work through this. Ms. Healey asked if the CBA provision is impacting the ability of MCOs coming into new regions to develop their networks. Ms. Kozak said no.

Pediatric Shift Nursing Prior Authorization Freeze

During the PHE, the Department waived prior authorization for pediatric shift nursing. That being said, the PHE has gone on longer than anyone anticipated, and the original freeze was put in place based on concerns the Department heard about parents not working and daycares and school being closed. Now that the schools and daycares are back open and many people are returning to the worksite, the Department is going to reinstate prior authorization of pediatric shift nursing. The Department will give 60 days' notice before this change goes into effect. The Department expects the freeze will lift around the same time as the end of the PHE (mid-July), but is open to a longer timeframe. Ms. Kozak noted she is open to considering 90 days' notice.

Kyle Fisher, Counsel for the Consumer Subcommittee, noted the concern that there will be a bottleneck if the plans were all to initiate prior authorizations for upwards of 6,000 or 7,000 families—this will be a burden on the consumers, on providers, on the home health agencies. He asked if the Department has thought about staggering the reinstatement of prior authorizations? Ms. Kozak stated many providers have been submitting prior authorizations all along; the plans have been reviewing them but not acting on decreasing the hours. She does not think this will be a significant burden on providers. In terms of the numbers, the Department is aware what the numbers look like, so they will begin having conversations with the MCOs about whether and how to stagger this implementation.

Mr. Fisher asked if, given the fact that some agencies were submitting authorizations even though it wasn't required, can there be an expectation on the plans to engage with the providers and their families to ensure a new prior authorization goes in to avoid a break in

services? Further, can there be a requirement on the plans to send written notice of a denial even if there is no prior authorization request? Ms. Kozak stated this is part of the conversation she will have with the MCOs tomorrow. The Department wants to ensure there is outreach to families before this happens, and that children receiving shift care do not fall through the cracks.

Victoria Salerno, Consumer, noted her son is enrolled in Keystone First and relies on shift nursing. Last week, Ms. Salerno met with her son's Keystone First case manager who informed her of an internal memo at Keystone First that said as soon as the shift nursing freeze is lifted, the case managers have 60 days to re-review all shift care cases, regardless of when the authorization is set to expire. Her son, for instance, has an authorization that is not set to expire until Fall 2022 but the case manager is already asking for prior authorization documentation. Ms. Kozak said she is not aware of this policy and cannot speak to it specifically, however she is glad Keystone First is preparing proactively for the lifting of the freeze. The Department will ask Keystone First about this policy/memo.

Mr. Miller-Wilson reiterated the request that the MCOs provide notice and opportunity to appeal even in cases where there is no prior authorization request submitted. Ms. Kozak stated it has always been her intention from the get-go that the MCOs would be willing partners with the Department in ensuing that families receive appropriate notification and are assisted through their case managers and SNUs. She does not anticipate that any of the MCOs will be uncooperative with this.

Mr. Miller-Wilson noted that in May of 2021, consumers drafted and shared with the Department an Operations Memo dealing with Medical Necessity review, especially parental availability, and this Ops Memo may be a good reminder for the plans about how they should be reviewing these prior authorization requests. Ms. Kozak stated she will reiterate to the MCOs the department's commitment to coordination, communication, and assistance to family and providers.

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.

FMS Transition

The Community HealthChoices (CHC) financial management services (FMS) vendor is currently PPL but will transition to Tempus. This transition was extended to a new "Go Live" date of July 1, 2022 (from originally April 1, 2022). Tempus and the CHC MCOs' priority is getting paperwork back from common law employers (participants) and their direct care workers. As of this meeting, 70% of Common Law Employers and 73% of DCW had returned their packets. Tempus is working on improving communications and conducting training.

There was an FMS Transition Stakeholder Meeting on April 1st and the next Stakeholder meeting is scheduled for May 6th.

The Department is also working on setting up 8 in-person days where participants and/or their direct care workers can walk in and meet with someone who will help them complete their paperwork and training, as well as answer questions. These in-person days will occur in May and will be held around the state. Tempus and the CHC plans are currently working on securing locations for these sites. OLTL hopes to let people know about these opportunities soon.

OLTL is working on extending the current PPL contract for the Fee for Service program, including OBRA and Act 150. OLTL is joining ODP in their Request for Proposals for a new vendor of FMS services. The RFA was released on March 10, 2022, with proposals due April 25, 2022.

Mr. Miller-Wilson asked if OLTL is still holding to the July 1 implementation date? Ms. Buchenaeur said yes, they need to keep this deadline in place to ensure that people respond. There are roughly 6,000 people that still need to get their information into Tempus. The MCOs and Tempus will have contingency plans in place for ensure people unable to get enrolled are still able to be paid. Know that will not be at 100% by 7/1.

CHC Appeals Data

Ms. Buchenauer noted that on a quarterly basis, the CHC-MCOs report grievance activity in summary by the Grievance Type. No detailed grievance decisions data is available. The CHC-MCOs report decisions in favor of the participant for all grievances combined. Currently OLTL is exploring options for the CHC-MCOs to report the grievance decisions at the participant level which will include in favor of the participant, fully in favor of the participant, and partially in favor of the participant.

The data is collected is from two sources:

- OPS-003 DOH Complaints and Grievances Reports - This is a quarterly report on the number and status of participant complaints and grievances filed by members and is reported by the CHC-MCO to the Department of Health (DOH). For complaints and grievances, it includes the number filed, withdrawn, total number of decisions, decisions in favor of the participant, and the number pending.
- OPS-004 Complaints and Grievances Detail Reports - This is a quarterly report that details the reasons for the complaints and grievances resolved during the reporting quarter. It includes 26 complaint types and 23 grievance types, the number of decisions for which the participant was notified and the number of decisions that met or did not meet the timeliness requirements.

Ms. Buchenauer shared the following data with the Subcommittee:

Plan	***CY2021 Grievances Received (All Grievances)***	***CY2021 PAS Grievance Decisions***	***CY2021 % Decisions in Favor of Participant (All Grievances)***
AHC/KF	6,470	6,430	19%
UPMC	2,628	2,658	33%
PHW	6,176	6,306	13%

Amy Lowenstein, counsel, asked if OLTL is looking at outlier plans when evaluating this data? One CHC-MCO had 32% of its population file a grievance; the other two had only 9-11% of their member file a grievance last year. Ms. Buchenauer said OLTL does evaluate the number of grievances by the number of participants in the HCBS program. The Department is also awaiting 2022 data and they expect to see a leveling-out of the data.

Mr. Miller-Wilson asked when the 2022 data will be available. Ms. Buchenauer said they will have data from the first quarter of 2022 available in May. Ms. Brookins asked if this data could be brought to the May Consumer Subcommittee meeting. Ms. Buchenauer said June is more likely because the data is not due to OLTL until May 18th.

III. OIM Report

PHE Unwinding

Carl Feldman, DHS Policy, presented updates on the unwinding of the federal PHE. The Department has been working on an analysis to try to determine how many people in the Medicaid system are currently being held as eligible even though they no longer meet the requirements. As of April 17, 2022, 497,345 people have a "COVID flag", which means at some point that case was maintained as eligible when they were otherwise ineligible. Of that pool, there are 330,047 individuals who only have a COVID flag but have not missed a renewal. They think the 330,047 are more likely to be found ineligible after the PHE expires. There are 444,604 people who are overdue on their renewals, which means OIM does not know the status of their eligibility. There are some who have a COVID flag and are overdue on their renewals. This creates a total population of 941,949 people, or 650,000 approximate cases.

OIM can segment this data in a number of ways, including at the case level to provide context on category and/or age. They are developing a report to be able to provide this data by plan to all the MCOs.

Mr. Fisher asked if OIM can share this data on an individual member level so that a particular MCO knows which population their member falls into. OIM is capable of segmenting the data at this level and he believes OIM will be able to share this information with the plans and is still evaluating whether to do so.

Ms. Brookins asked when this information will be shared with the plans. Mr. Feldman said it will be as soon as it is segmented in the way it needs to be so that they are sharing only that plan's members.

Mr. Feldman also noted that OIM has launched a website pertaining to the end of the PHE. It is still being worked on and improved. The URL is www.dhs.pa.gov/PHE. On this site they intend to share information the plans can use to share information with their plans, as well as information for entities that help people complete MA renewals. Mr. Feldman noted OIM will more formally be seeking feedback on the website.

Mr. Fisher asked if OIM intends to use contact information from the MCOs to update individuals' case files without hearing from the individual directly. Mr. Feldman said they are interested in this approach and have had a lot of discussions about how they could make this

work, but they have not yet made a decision on this. Ms. Brookins encouraged OIM to act on this available flexibility.

Mr. Fisher asked how cases will be prioritized for renewal in the 6 months after the PHE ends. Mr. Feldman said OIM has not come to a decision on this yet. OIM's goal is to appropriately distribute the workload over the 6 months to ensure that everyone has a fair opportunity to be renewed.

Mr. Fisher asked if OIM will provide individual information about the category (flag, flag and no renewal) to MCOs. Mr. Feldman stated that OIM starting out by sharing figures with the MCOs and having conversations about sharing at the personally identifiable level, but needs to complete internal discussions about how that will be shared. Mr. Fisher strongly recommended that it be shared at that level given that 900,000 is more than plans are likely to be able to do targeted outreach to. This will allow the plans to determine who to focus resources on.

Mr. Miller-Wilson noted the Department has created a small working group as subcommittee of IMAC that has a date on the books in the next week or so to get into a communications outreach discussion.

The meeting was adjourned at 3:10 PM.