Consumer Subcommittee of the MAAC
October 26, 2022

Consumers present: Sonia Brookins, Jayme Scali, Lauren Henderson, Liz Healey, Ronel Baccus, Marsha White-Mathis.

Sonia Brookins, Chair of the Consumer Subcommittee, called the meeting to order at 1:00pm.

I. OMAP Report

Sally Kozak, Deputy Secretary for the Office of Medical Assistance Programs (OMAP), Eve Lickers, Director of the OMAP Bureau of Policy, Analysis and Planning, and Gwendolyn Zander, Director of the OMAP Bureau of Managed Care Operations, provided the updates for OMAP.

Leadership Changes

Ms. Kozak noted that Kristen Houser, Deputy Secretary for the Office of Mental Health and Substance Abuse Services (OMHSAS) left her position effective October 21, 2022. Dr. Dale Adair, currently the Chief Psychiatric Officer for OMHSAS, will be the Acting Deputy Secretary for the foreseeable future.

Public Health Emergency (PHE) Renewal

The COVID-19 federal Public Health Emergency (PHE) was renewed on October 13, 2022 for an additional 90 days. That takes the latest extension through to January 11, 2023. As they have in the past, the Biden Administration continues to express that it will provide states with at least 60 days' advance notice of the PHE ending. The 60 day timeframe for that advance notice would be around November 12, 2022. DHS is also committed to providing 60 days' advance notice so their notices about the PHE ending will begin right around November 12th, unless it is extended again. DHS will begin processing Medical Assistance renewals on the first of the month following the month the PHE ends. Thus, if the PHE ends on January 11th, MA renewals will begin on February 1st.

DHS is developing a communications plan about what this process will look like, including text messaging, written communications, and messages on the DHS website. DHS has been encouraging the MCOs to remind members they need to renew coverage. DHS is providing the MCOs with data they can use when they reach out to members (who needs to renew, who doesn't, etc). DHS has also been reminding the MCOs that since the MCOs are COMPASS Community Partners, they are able to assist members with preparing and submitting their

renewal applications, and some of them have been doing that. OMAP has also shared lessons learned from the HealthChoices re-procurement for use in the end of PHE context.

Laval Miller-Wilson, Counsel to the Consumers, noted it would be helpful to have a conversation in December about the flexibilities, beyond eligibility protections, that states were allowed during the PHE, e.g. the delivery of mental health services through telehealth. Ms. Kozak agreed with this approach and noted that the MA Bulletin previously released on telehealth services was not time-limited and will continue to be in effect past the end of the PHE.

Enrollment Assistance Program

Ms. Zander stated that RFA #16-20, which announced the Department's intention to reprocure the vendor of the physical HealthChoices enrollment assistance program, has been canceled. OMAP will continue to work with Maximus, the current vendor, until the Department can reissue the procurement. The Department is working to release the new RFA by summer of 2023.

Mr. Miller-Wilson asked about someone who has been on Medicaid and turns 65, thereby qualifying for Medicare. If they are moving into Community HealthChoices (CHC) because they are becoming a dual eligible, will they get some written communication about leaving their HealthChoices plan to go into CHC? Does the letter contain a phone number for the independent enrollment broker used for the CHC program? Does the enrollment assistance program under OMAP know about the transition from HealthChoices to CHC?

Jamie Buchenauer, Deputy Secretary for the Office of Long-Term Living (OLTL), said the letter regarding the transition to CHC should have the Independent Enrollment Broker's phone number; she would confirm this. Barry Bowman, OMAP Bureau of Managed Care Operations, stated if people are calling the enrollment assistance program asking about CHC, they will likely be referred to the independent enrollment broker for CHC. Ms. Zander noted that Maximus staff do have access to eCIS, the client information system used by the CAOs, and they can see if someone is becoming eligible for CHC in which case they would do a warm handoff to the independent enrollment broker for CHC.

HealthChoices Implementation

Ms. Zander stated that, since going live with the HealthChoices physical health reprocurement on September 1, 2022, DHS continues to monitor requests for expedited transfers or enrollment. They are also keeping an eye on any complaints received from consumers or providers. To date, the Department has not identified any program-wide problems.

Ms. Zander presented data on the number of individuals who requested a transfer from one MCO to another since the 9/1/22 transition: 22,858 health plan transfer requests were processed during the month of September 2022. Of those, 13,917 (61%) were from a new MCO in the region (702 transfers to a new MCO plan and 13,215 to a legacy plan), and 8,941 (39%) plan transfers were from a legacy MCO (1,365 transfers to a new MCO plan and 7,576 to a legacy plan). The Department received a total of 97 expedited plan transfer requests between September 1, 2022 and October 21, 2022. The top five reasons plan transfers were requested included: 1) prefers nonparticipating doctor or hospital (15,115); 2) prefers another MCO's benefits (1,859); 3) doctor left plan (867); (4) PCP recommendation (631); and 5) can't stay with current nonparticipating doctor for treatment (507).

At this point, all impacted consumers should have received their new MCO member ID cards and new member packets. Consumers should be hearing from their new MCO, who will complete a new member assessment, in the next 30 days.

Liz Healey, Consumer, asked if it is possible to look at people who had been identified as being high utilizers and who had gotten additional outreach from the enrollment assistance program to see if they had a higher rate of active choice during the reprocurement process. Ms. Zander said the Department would need to look into this question; it would likely require an ad hoc and labor-intensive report from Maximus.

Shift Nursing Prior Authorization

Ms. Zander stated that on July 26, 2022, the Department released a Managed Care Operations Memorandum reflecting that effective November 1, 2022 the physical health MCOs can reinstate the shift care prior authorization requirements that were in place prior to the COVID-19 pandemic. This impacts skilled nursing and home health aide services for kids under 21.

As of today, all plans except two have sent notices to their members informing them of the upcoming reinstatement of prior authorization. These letters should be received around now and should also state the end-date of the member's current authorization, even if the end-date is not for a few months still. Two plans (Keystone First and AmeriHealth Caritas) have decided to push these re-authorizations back to December 1, 2022. Keystone and AmeriHealth have not yet sent letters to their members, but they will do so prior to December 1. Ms. Zander believes these Keystone and AmeriHealth letters will start going out as early as next week.

In response to a Consumer request, Ms. Zander stated that the Department will connect with Keystone and AmeriHealth's Special Needs Units (SNU) to discuss performing affirmative

telephonic outreach to members who have authorizations coming due in December, given the busy time of year.

Per the Ops Memo, the MCOs should not re-review all shift care authorizations at once; they must stagger re-authorizations based on the end-date of the child's current authorization.

Kyle Fisher, Counsel for the Consumers, asked if there have been any conversations with the Bureau of Hearings and Appeals (BHA) regarding the likely increase in appeals after November due to the reinstatement of prior authorization requirements. Ms. Zander said yes, the Department has been in contact with BHA about this and have provided BHA with projections about the number of consumers who may be going through the appeal (fair hearing) process once the prior authorization requirements are reinstated.

Mr. Fisher asked if there has been any conversation with the MCOs around their ability to handle an influx of internal grievances when the reinstatement of prior authorization happens. Ms. Zander said yes, the MCOs are prepared for that.

Mr. Fisher asked if an authorization is expiring and the MCO has not yet received a packet from the provider to continue the authorization, what steps is the MCO supposed to take before stopping services? Ms. Zander stated that, per the Ops Memo, the MCO is required to make telephonic outreach to the member's family as well as to the provider to alert them to the need for a new authorization packet prior to sending a notice about any reduction in services. That outreach must take place at least 10 days prior to the expiration of the current authorization.

MCO/Hospital Contract Termination

Ms. Zander presented the following updates regarding potential MCO and Hospital/Provider contract terminations.

Keystone First and AmeriHealth Caritas' contacts with Thomas Jefferson and Einstein continue to be extended on a month-to-month basis. All parties are hopeful that a new contract will be executed. If the negotiations fall through and the contracts end, 380 AmeriHealth members and just over 322,000 Keystone members will be impacted for Jefferson; 127 AmeriHealth members and just over 162,000 Keystone members will be impacted for Einstein.

Keystone First's contract with Penn Medicine was due to expire on 12/31/22. In the last month, the parties have reached an agreement that is "evergreen," meaning it will automatically renew on January 1st of each year unless one party terminates. Ms. Zander recognizes that there were mailings to Penn Medicine patients advising that they would not see Keystone patients as of

January 1, 2023. The Department is not sure why the providers mailed these letters to their patients, and regrets that these letters went out to consumers and will be keeping an eye out for any requests for an expedited transfer in the event that a Penn patient reached out to Maximus to be assigned to a different plan than Keystone First based on this misinformation.

Ms. Brookins asked how many consumers received these letters. Ms. Zander does not know because the mailing was not sanctioned by Penn leadership and thus has not been tracked.

The following additional plans and providers have termination dates coming up within the next 60 days:

- HealthPartners is currently mailing notices to just under 8,000 members that will be impacted by the fact that Patient First Urgent Care Centers will no longer be in network as of November 25th;
- AmeriHealth's contract with Medline Industries will end on November 30th and notices have been sent to 67 members; and
- Keystone and AmeriHealth's contract with the Crozer Health System is set to expire on December 31st, but the parties are in negotiations currently. This closure, if effective, would impact 56 AmeriHealth members and 78,080 Keystone First members.

MATP Referrals Guidance

The Department's OMAP staff met with MATP administrators this morning to explain some of the forthcoming changes to the MATP referral process. The Department has made some changes to the MATP referral process after getting feedback that it was confusing and not streamlined enough. A single referral form has been created that will be used by all parties, including the MATP administrators, the County Assistance Offices (CAOs), and the MCOs. The new guidance (Operations Memoranda) should be posted to the DHS website, along with the new referral form, tomorrow.

Mr. Fisher and Ms. Brookins thanked the Department for including consumer input in this process.

II. OLTL Report

Jamie Buchenauer, Deputy Secretary for the Office of Long-Term Living (OLTL), delivered updates on behalf of OLTL.

Proposed 2023 Waiver Amendments

OLTL is working on the amendments to its Community HealthChoices (CHC) and OBRA waivers. At the MLTSS subcommittee of the MAAC, OLTL presented on the changes they are implementing for 2023 to both the CHC and OBRA waivers. These amendments go through a public notice process and are set to be released for a 30-day public comment period on November 5th. The proposed changes are set to take effect April 1, 2023.

Act 54 Funding

Ms. Buchenauer noted that funding for long term care services, as outlined in Act 54 of 2022, is available to healthcare providers who offer COVID-19 services. These payments should be forthcoming in November.

CHC Appeals Data

Complaints

Ms. Buchenauer provided CHC appeals data. She noted that during Quarter 1 of 2022, the three CHC-MCOs received 957 complaints (318/33% in UPMC; 134/14% in PA Health and Wellness; and 505/53% in AmeriHealth Caritas/Keystone First).

The following is a breakdown of the top reasons members filed complaints in each CHC-MCO during Quarter 1 of 2022:

- AmeriHealth/Keystone
    - CHC-MCO Service and Administration – 230/38.1%
    - Quality of Care or Service – 182/30.2%
    - Payment Issues - 54/9.0%
    - Coverage of Services – 44/7.3%
    - Not Covered due to Benefit Limits – 33/5.5%
- PA Health and Wellness
    - Other LTSS – 122/91.0%
    - Quality of Care or Service – 9/6.7%
    - Not Covered Due to Benefit Limits – 3/2.2%
- UPMC
    - Quality of Care or Service – 104/41.1%
    - CHC-MCO Service and Administration - 92/36.4%
    - Access & Availability - 43/17.0%
    - Coverage of Services - 9/3.6%

- Other LTSS - 3/1.2%

Mr. Fisher asked how "Other LTSS" is defined in this data set. Ms. Buchenauer said this is a general catch-all for other LTSS services and supports. She would need to pull a definition for this term and get back to us. The following is a breakdown of the top reasons consumers filed complaints across all 3 CHC-MCOs during Quarter 1 of 2022:

- CHC-MCO Service and Administration – 322/32.5%
- Quality of Care or Service – 295/29.8%
- Complaints - Other (LTSS) – 156/15.8%
- Access & Availability 64 6.5% Payment Issues – 56/5.7%

Regarding complaints timeliness requirements, each CHC-MCO must reach a decision and notify the participant in 30 days or less or 44 days or less for complaints where the participant requests a 14-day extension. During Quarter 1 of 2022, 100% of AmeriHealth/Keystone's complaints were timely; 98.5% of PA Health and Wellness' complaints were timely; and 98% of UPMC's complaints were timely. Across the state, 99.2% of complaints were decided timely.

Of the complaints filed in Quarter 1 of 2022, 1% of AmeriHealth/Keystone's complaints were decided in favor of the participant; 0% of PHW's complaints were decided in favor of the participant; 0.4% of UPMC's complaints were decided in favor of the participant; and statewide, 0.7% of complaints were decided in favor of the participant.

Amy Lowenstein, Counsel to the Consumers, asked how "in favor of the participant" means in the complaint context. Ms. Buchenauer stated this means that the MCO is taking action to remedy what the participant complained about. Ms. Lowenstein also asked for a list of the complaint types and how the CHC-MCOs are asked to report complaints that receive one vs two levels of internal review, noting that under federal law some complaints are adverse benefit determinations that can have only one level of complaint review before a fair hearing option is made available.

<u>Grievances</u>

During Quarter 1 of 2022, the three CHC-MCOs received 1,884 grievances (332 in UPMC; 513 in PA Health and Wellness; and 1,039 in AmeriHealth Caritas/Keystone First).

The following is a breakdown of the most common service types of grievances decided by each CHC-MCO during Quarter 1 of 2022:

- AmeriHealth/Keystone
    - Personal Assistance Services (PAS) - 1,152/83.2%
    - Pharmacy - 79/5.7%
    - Dental - 62/4.5%
    - Durable Medical Equipment (DME) - 57/4.1%
    - Adaptations/Modifications – 29/2.1%
- PA Health and Wellness
    - Personal Assistance Services (PAS) – 683/92.2%
    - Adaptations/Modifications – 25/3.4%
    - Pharmacy – 14/1.9%
    - Durable Medical Equipment (DME) – 11/1.5%
    - Dental – 7/0.9%
- UPMC
    - Personal Assistance Services (PAS) – 223/71.2%
    - Dental - 30/9.6%
    - Adaptations/Modifications - 27/8.6%
    - Pharmacy - 18/5.8%
    - Durable Medical Equipment (DME) - 14/4.5%

The following is a breakdown of the top reasons consumers filed grievances across all 3 CHC-MCOs during Quarter 1 of 2022:

- Personal Assistance Services (PAS) - 2,058/84.4%
- Pharmacy – 111/4.6%
- Dental – 99/4.1%
- Durable Medical Equipment (DME) – 82/3.4%
- Adaptations/Modifications – 81/3.3%

Regarding the grievance timeliness requirement, the CHC-MCOs must reach a decision on the grievance and notify the participant in 30 days or less or 44 days or less for grievances where the participant requests a 14-day extension. During Quarter 1 of 2022, 99.8% of AmeriHealth's/Keystone's grievances were decided timely; 95.9% of PA Health and Wellness' grievances were decided timely; and 100% of UPMC's grievances were decided timely. Statewide, 98.7% of grievances were decided timely.

Of the grievances filed in Quarter 1 of 2022, 12.9% of AmeriHealth/Keystone's complaints were decided in favor of the participant; 12.5% of PHW's complaints were decided in favor of the participant; 15.8% of UPMC's complaints were decided in favor of the participant; and statewide, 13.2% of complaints were decided in favor of the participant.

External Review/Fair Hearing

Across the state, there were 285 state fair hearing requests resolved during Quarter 1 of 2022 (166 from AmeriHealth/Keystone members; 99 from PHW members; and 20 from UPMC members). Of these, 8 fair hearings were decided in favor of the participant (5 in AmeriHealth/Keystone; 2 in PHW; 1 in UPMC); 130 were decided in favor of the MCO (92 for AmeriHealth/Keystone; 24 for PHW; and 14 for UPMC); and 101 fair hearings were withdrawn before a decision (19 in AmeriHealth/Keystone; 73 in PHW; and 9 in UPMC).

Of the total number of external review requests resolved during Quarter 1 of 2022, 69 were decided in favor of the participant (53 in AmeriHealth/Keystone; 11 in PHW; and 5 in UPMC), and 360 were decided in favor of the MCO (208 in AmeriHealth/Keystone; 119 in PHW; and 33 in UPMC).

Mr. Fisher noted that the abysmal success rate of CHC participants at fair hearing could be misleading. Both stipulated settlements and favorable external review decisions likely show up in this data as "fair hearing withdrawn." Nonetheless, for only eight hearings to have been decided in favor of the participant is highly concerning.

Mr. Miller-Wilson asked about the timing of the data from Quarter 2 of 2022. Ms. Buchenauer stated OLTL will have this data by mid-November, at which time they will review and analyze the data. It was delayed because of changes made to the reports. They may have the data ready by the December meeting.

Direct Care Worker (DCW) Workforce Shortages

Ms. Buchenauer stated that OLTL is working on changes to the OPS 23 report to capture services authorizations where no agency is assigned. Regarding the ad hoc reports requested from the MCOs earlier, the plans are working on those and monitoring their cases but do not yet have data to share. The plans are monitoring these issues through a variety of ways, including EVV compliance and the percentage of authorized hours vs utilization (which all three plans report has been increasing). The percentage of authorized hours being used normally ranged about 85%; it is now trending in the 90% range.

The CHC-MCOs are monitoring cases to ensure participants are getting the services as outlined on their Person-Centered Service Plan (PCSP). The following are the actions each CHC-MCO is taking:

- PA Health and Wellness: Review reports on the provider looking at EVV compliance, % of missed shifts vs. utilization. Missed shift reporting prompting outreach and provider re-assignment as well as provider outreach. Using EVV utilization and critical incident reporting
- AmeriHealth/Keystone: Monitoring via HHA eXchange authorized hours vs. missed visits, prompting Service Coordinator (SC) outreach as well as Health and Safety. Tracks total number of authorized hours and a number of shifts provided compared to the number of participant canceled, hospitalized and unable to staff shifts.
- UPMC: Automated service authorization follow up tasks prompt the SC to outreach and follow up to check statuses in time period after services are authorized and prompt SC if 5 consecutive shifts are missed – for follow up with the participant. They also monitor HHA (EVV).

The consumers have asked if OLTL is tracking whether the ARPA funding rate increase for DCWs has improved PAS staffing levels overall. Ms. Buchenauer stated that the American Rescue Plan Act (ARPA) Funding Reporting Portal was sent on September 29, 2022. For providers receiving Strengthening the Workforce Funding (PAS, Residential Habilitation and CI) and funding for Adult Day Services, the report includes the number of employees Hired as a result of Strengthening Workforce Payment/adult day, and the number of employees gained (+) or lost (-) since December 31, 2021. OLTL is asking for data on the workforce, such as the total number of employees, total number of full-time employees, gender breakdown, and the average age of the workforce. The first quarterly report with this information is due to OLTL on November 30, 2022.

The meeting was adjourned at 3:02 PM.