Consumer Subcommittee of the MAAC
December 7, 2022

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

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) and Gwendolyn Zander, Director of the OMAP Bureau of Managed Care Operations, provided the updates for OMAP.

Public Health Emergency Update

The Biden Administration has been renewing the PHE in 90-day increments, Ms. Kozak reported. The current Public Health Emergency (PHE) is set to expire January 11, 2023. CMS has committed to states that they will give 60 days' advance notice of the end of the PHE, which would have been in mid-October 2022. Since we did not hear from CMS in October, we anticipate the PHE will be renewed beyond January 11, 2023. If they renew for another 90 days, the end-date of that PHE will be April 11, 2023. Until such time as the PHE ends, Medicaid continuous coverage eligibility protections will continue. DHS has been doing redeterminations throughout the PHE but has not been ending coverage for those who no longer qualify. Starting on May 1, 2023, if the PHE were to end in April, DHS would resume terminations of Medicaid coverage for those who no longer qualify.

CMS has encouraged DHS to allow sufficient time for unwinding of the PHE. The 1135 Waiver flexibilities will end when the PHE expires without a transition period. There are some exceptions for those flexibilities that were provided under the Appendix K waiver, which allow a six month runoff period after the PHE ends.

Electronic Visit Verification (EVV) Good Faith Waiver

DHS has been implementing EVV for a while now. A good faith waiver for home health services was approved on October 28, 2022. EVV must now be in place by January 1, 2024. DHS is doing additional work around this, and additional communications will be forthcoming.

Pediatric Shift Nursing Initiative

Ms. Kozak reported that the pediatric shift nursing medical home funding has already been put into the HealthChoices Agreement. It will become effective once the Agreement is approved by

CMS. A Pay for Performance program will roll out in 2023 for home health services. Ongoing conversations around the Pediatric Resource Centers are happening. DHS assumes these will be active by late summer or early fall of 2023. Additionally, payments for shadow nursing and the shift nursing rate increases have also been put into the Managed Care rates for 2023.

Shift Nursing Prior Authorization

Ms. Zander stated that DHS is hearing that the reinstatement of prior authorization for shift care services is going well in the physical HealthChoices program. Today, with AmeriHealth and Keystone First both returning to prior authorization of these services, all MCOs have returned to prior authorizing these services. DHS is aware of one MCO having trouble keeping up with the volume of cases due for renewal, but that MCO has brought on additional staffing to clear the backlog and they are prioritizing new requests for authorization.

Kyle Fisher, counsel to the Consumers, noted that the Pennsylvania Health Law Project has been pleasantly surprised by how smoothly the reinstatement has gone and thanked OMAP for ensuring that the MCO with a backlog was continuing to meet the timeframe requirements for processing new requests.

Liz Healey, Consumer, noted that the MCO with the large backlog requires prior authorization every 3 months, whereas most other MCOs require reauthorization every 6 months. It is a lot of work for physicians and home health companies to have to do these authorizations every 3 months, and not doing it so often could help with the backlog. Is DHS open to suggesting all plans authorize on a six month basis? Ms. Kozak replied DHS cannot tell the MCOs the timeframe within which they need to do prior authorizations. The MCOs are fully capitated and responsible for managing utilization. However, Ms. Kozak had a conversation with this MCO and the MCO reports they are looking into whether the 3-month prior authorization schedule is the best use of their resources.

Laval Miller-Wilson, Counsel to the Consumers, asked how many children are receiving shift care services in MA FFS. Dan DeLellis, MA FFS Bureau Director, replied that, on average, there are roughly 200 children per month receiving shift care services.

Parents as Caregivers

Ms. Kozak stated that DHS, historically, has not been able to pay legally responsible relatives to provide personal care services, such as helping with bathing, feeding and hygiene. However, during the COVID PHE, that restriction was waived so DHS was able to pay parents and other legally responsible relatives for providing personal care. That flexibility will not continue past the PHE. CMS does not have the authority to extend this flexibility beyond the PHE. DHS has

been having conversations with the MCOs to determine how many families will be impacted by the loss of this flexibility. At this time, they have identified 414 families who are utilizing this flexibility. This number will rise as some plans that have not been tracking this report back.

Ms. Kozak stated she has always been an advocate for allowing parents to be paid caregivers. To this end, DHS has been working to identify what options may be available to continue this process and will continue to keep consumers updated on any progress made here.

Ms. Healey noted that the Imagine Different Coalition has been looking into this practice. They were surprised that CMS took the position that home health aide services cannot be shift services, since the federal regulations do not state this and the prohibition on parents as paid caregivers does not apply home health aide services. Ms. Healey hopes DHS will explore this more with CMS.

Ms. Healey would like DHS to provide updated data on the frequency of open or missed shift care shifts. Unfilled shift data brings greater urgency to the issue of parents as paid caregivers when parents need to forego employment in order to care for their children. It should not be the default that parents must give up work if they cannot find shift care workers.

Ms. Kozak stated she fully appreciates how complex this issue is and she is adamant that DHS find a way to resolve this. She is very concerned about losing the current flexibility to allow parents to be paid caregivers given the workforce shortage, which is much more acute now than at the beginning of the pandemic. She anticipates we will see more vacancies in shift coverage as the parents as paid caregiver flexibility ends.

Mr. Fisher noted that the Consumers and counsel remain confused over CMS' interpretation of the applicable regulations. The relevant regulation applies to personal care services, but there is a distinction between home health aide and personal care services. We are aware of no federal authority requiring home health aide services to be part time or intermittent, which we understand is the rationale for why these services have been interpreted to be personal care services. Are these conversations ongoing with CMS? Ms. Kozak said yes and noted this discussion will be a lengthy back-and-forth with CMS. Our structure of providing this service only through home health agencies is something DHS has noted. Ms. Lickers noted DHS is meeting with CMS later this month to discuss this topic.

Ms. Brookins expressed confidence that DHS would find a way to allow the flexibilities to continue, and Ms. Healey noted the Consumers are happy to continue to support DHS externally on this issue.

MCO/Hospital Contract Terminations

AmeriHealth/Keystone has completed negotiations with Einstein and Jefferson Hospitals. These new contracts are evergreen, which means they automatically renew unless a party terminates.

The Delaware County Memorial Hospital has closed. There were physical HealthChoices members impacted by this closure; they have received notice of the closing and have been assisted by their MCOs to find alternative in-network care.

Moses Taylor Hospital will be merging certain lines of business with the Regional Hospital of Scranton.

United's contract with Temple University Hospital continues to be negotiated. It had been extended into February 203. There is a potential for just over 7,000 members to be affected if this contract were to terminate, however negotiations are ongoing, and DHS hopes for an extension or a full-blown contract.

Value Based Purchasing (VBP)

Ms. Zander reported that the HealthChoices Agreement imposes an overall Value-Based Purchasing (VBP) requirement that is equal to the percentage of overall dollars the MCO receives from DHS that they need to put into VBP arrangements with healthcare providers. This percentage has risen from 7.5% in 2017 to 50% in 2022. Within VBP requirements, there are different strategies the MCO can use: some are low-risk, some are medium-risk, and some are high-risk. At least 50% of the of the 50% threshold in 2022 must be from any combination of high- and medium-risk strategies. The VBP threshold has been 50% of the medical capitation since 2020. With the pandemic, DHS knew that plans and providers did not have the bandwidth enter into new VBP agreements and instead used the time as an opportunity to see how the program is performing or progressing over time.

In 2021, DHS started requiring the MCOs to work with Community Based Organizations (CBOs) to provide services that meet Social Determinants of Health needs. There are two ways MCOs can do this: they can contract directly with the CBO, or the MCO can have a contract with a provider, like a health system, who then subcontracts with the CBO. DHS requires the MCOs to incorporate relationships with CBOs in their VBP arrangements. CBOs must address at least one of the following Social Determinants of Health (SDOH): childcare access and affordability, clothing, employment, financial strain, food insecurity, housing instability/homelessness, transportation, or utilities. Examples of CBOs who have received funding through VBP include Manna, Benefits Data Trust, Philabundance, Sanctuary Farm, and Broad Street Ministries.

Challenges in this area identified so far have to do with CBO bandwidth to serve more clients, stressors like staffing shortages from the pandemic, data sharing & IT challenges, and the challenge of getting MCOs and CBOs to speak each others' languages.

Ms. Zander explained a handful of models of VBP. First, Performance Based Contracting is a low-risk, fee-for-service style contract where the provider bills the MCO for the service they rendered, but there is opportunity for an additional performance-related payment where the provider gets a bonus or incentive, or even a penalty imposed. The MCO and provider agree to a target or goal and if they meet that target or goal, they get an incentive payout. If they do not meet the goal, they do not get an incentive payment and may even need to pay a penalty.

Shared Savings is another VBP arrangement that is considered medium risk. This is where the MCO and provider set a target price for a service, and if the cost of services comes in below the target price, the MCO and provider share in the savings. With a similar VBP arrangement known as Shared Risk, if the cost of services is greater than the target price, the MCO and provider share in the cost of the extra.

Another VBP arrangement is Bundle Payments. An example is the maternity bundle, where all services provided to a pregnant person throughout their pregnancy are covered by a bundled payment rate. The provider and MCO agree on a payment rate. If the provider is able to provide the service for less than the agreed-upon rate, they get to keep the extra.

The last VBP model is the Global Payment model. This is similar to the bundled payments model, but rather than being for a discreet episode for an individual person, these are payments for an entire population. An example is the rural health model, where the MCO may give a hospital system a set amount of money to cover all members who go to that hospital.

There are three required VBP models in the HealthChoices Agreement. They include: 1) the Maternity Care Bundled Payment, where the PH-MCO must pay Network Providers who elect to partake in the Maternity Care Bundled Payment as specified by the Department; 2) the Patient Centered Medical Home (PCMH), where PH-MCOs must include requirements defined in Exhibit DDD to be qualified as a PCMH. Payments listed must be categorized as a payment strategy that include quality benchmarks, with incentives or penalties or both; and 3) the Rural Health Model, where PH-MCOs that pay more the $500K to a hospital participating in the PA Rural Health Model must offer to pay in the form of a global budget as established by the current Technical Specifications for Rural Hospital Global Budget as published by the Rural

Health Redesign Center. Participating hospitals are excluded from bundled payment arrangements.

Future VBP initiatives by DHS include assessing the value in VBP for Medicaid consumers and the MCOs, encouraging increasingly complex arrangements between MCOs and providers, providing clarity and direction for CBO arrangements, and developing more consistency across program offices.

Mr. Fisher noted he was encouraged to hear DHS was beginning to monitor the performance of the VBP initiative and asked if the Consumers could be involved in this evaluation and the development of future VBP models. He noted that finding consumer who have been part of a VBP model could be difficult however, insofar as there are no requirements for providers or MCOs to disclose them to consumers. This is especially concerning with the higher risk models where providers have financial incentives to withhold more expensive care. If the gatekeeper role has shifted from an MCO to a person's doctor, that needs to be made transparent.

Ms. Brookins stated that Consumers want to hear more about how health outcomes have been impacted by VBP. Ms. Zander noted these points are well taken and said OMAP is happy to have continued conversations with consumers.

Mr. Miller-Wilson noted that the shared savings model does not necessarily fit for non-profit CBOs. Ms. Zander replied that providers often serve as the intermediary between MCOs and CBOs, and providers take on the task of determined whether there have been shared savings/risk.

Medical Assistance Transportation Program (MATP)

The Operations Memoranda that detail the new MATP referral process have been issued and are available on the DHS website. There is a single form that will now be used for all MATP referrals among MCOs, County Assistance Offices (CAOs), and MATP Administrators. This is an effort to streamline this process and make referrals consistent.

Additionally, Ms. Zander reviewed utilization data from the MATP program. Pre-pandemic, i.e. in 2019, there were 6.8 million MATP trips, and there were just over 1 million mileage reimbursement requests. In 2020 this number dropped off significantly with the pandemic. In 2020, there were just over 3.2 million trips, and the number of mileage reimbursements declined but not as significantly from just over 1 million to about 640,000. The numbers remained pretty low in 2021 though they went up a bit; in 2021 there were 3.3 million MATP

trips and 706,000 mileage reimbursement requests. Only 2 quarters of data is available for 2022. So far there have been over 2 million MATP trips this year.

MATP agencies continue to report driver shortages. DHS is using some of the ARPA HCBS dollars to provide driver incentive payments for the MATP program.

Marsha White-Mathis, consumer, asked if MATP ridership declining would show as a financial surplus to the department, i.e. where does that unspent money go? Ms. Zander said when funds go unexpended, they return to the general fund for the Commonwealth. The funds cannot be used for anything except what they are appropriated for.

Mr. Miller-Wilson noted it is not surprising that mileage reimbursement requests have been steadily increasing since 2020. Mr. Miller-Wilson asked if the Department has any way to measure mileage reimbursement other than by spend. Additionally, he asked what the per-mile rate is for MATP. Ms. Zander stated the current reimbursement rate is 25 cents per mile, which was recently increased.

II. OLTL Report

Jen Hale from the Office of Long-Term Living (OLTL) Bureau of Policy delivered updates on behalf of OLTL.

Appendix K Flexibilities & Comprehensive Needs Assessments

Ms. Hale provided a high-level overview of the flexibilities allowed under Appendix K. This information is also available on the COVID section of the DHS website. In January 2021 OLTL submitted to CMS an amendment to Appendix K for the CHC and OBRA Waivers extending the effective date and allowing some flexibilities to continue until six months after the end of the federal public health emergency (PHE), or another date determined by OLTL. Ms. Hale described the range of flexibilities, which include the ability to perform remote level of care and comprehensive needs assessments.

At this time, OLTL intends to end the Appendix K flexibilities on April 1, 2023, but would like stakeholder feedback about that date from this subcommittee. If the April 1 date holds, OLTL will look to release materials about the end of the flexibilities in January.

Ms. Hale then provided data on face-to-face versus telephonic needs assessments in CHC. In November 2022, 38.2 % of AmeriHealth/Keystone's assessments were completed telephonically vs. 61.8% completed face-to-face. 51% of PA Health and Wellness' assessments

were completed telephonically vs. 49% face-to-face. 29.8% of UPMC's assessments were completed telephonically vs. 70% face-to-face.

Ms. Brookins stated that it is time for needs assessments to go back to face to face. The Consumers have hear a lot of complaints about telephonic assessments and participants not even being given the option of a in-person assessment. Returning to all face to face is overdue.

Mr. Miller-Wilson expressed concern over how many assessments are still taking place telephonically. He stated the consumers will need to review the proposed date and have time to discuss and consider it before providing feedback on the other flexibilities.

Ms. Brookins and the Consumers thanked all of the DHS staff present and involved with the Subcommittee for all of their work on behalf of the program and wished everyone a Merry Christmas and happy holidays.

The meeting was adjourned at 2:49 PM.