>> KAREN LOWERY Good morning and welcome to the May edition of the MAAC (Medical Assistance Advisory Committee) meeting. Today is Thursday May 25, 2023. Before we begin, I would like to go over a few items. As a reminder this meeting is being recorded. Your continued participation in the meeting is your consent to be recorded. If you do not wish to be recorded, you may end your participation in the webinar anytime. To avoid any disruptions please remember to keep your microphone muted if you are not speaking. Representing the Department (Department of Human Services) today from the Office of Medical Assistance Programs (OMAP), Deputy Secretary Sally Kozak, from the Office of Long-Term Living (OLTL), Deputy Secretary Juliet Marsala, from the Office of Mental Health and Substance Abuse Services (OMHSAS), Medical Director Dr. Dale Adair, from the Office of Developmental Programs (ODP), Deputy Secretary Kristin Ahrens, and from the Office of Income Maintenance (OIM), Director for the Bureau of Policy, Carl Feldman. We do have a change in the agenda today. ODP will be providing their presentation first, followed by OIM. If you have any questions related to this meeting or need any additional information, please visit the MAAC webpage. I will now hand things over to the MAAC chair, Ms. Deb Shoemaker.
>> DEBORAH SHOEMAKER: Good morning, everyone. Thank you for attending our virtual May meeting. And we have a lot on our plate. I appreciate all of you who have been, you know, sticking with us all this time. So today we will go through the list of MAAC members here in attendance. First, my name is Deb Shoemaker. I am the chair of the MAAC, and I am the chair of the Fee-for-Service Subcommittee. Can we -- I think we have a member that's not muted.
>> SALLY KOZAK: Hello?
>> KAREN LOWERY: Deb did we lose you.
>> DEBORAH SHOEMAKER: And also, I -- sorry, I'm in my car and I know that my phone is all messed up. And also, I am a consultant for the Pennsylvania Psychiatric Leadership Council. I'm doing marketing and working for Recovery Insight, which is a certified peer group focused in Lancaster, Lebanon, Cumberland and Perry counties. After that, I think I have said enough. I would like to go through the role of the people who are MAAC members. First, Sonia Brookins, could you introduce yourself?
>> SONIA BROOKINS: This is Sonia Brookins, I'm a chair of the Consumer Subcommittee.
>> DEBORAH SHOEMAKER: Great meeting yesterday. Next, on the list of what I see, Jeff Bechtel.
>> JEFF BECHTEL: Good morning, Deb. Yes, my name is Jeff Bechtel. I am with the Hospital and Health System Association of Pennsylvania.
>> DEBORAH SHOEMAKER: Thank you Jeff. Next, I’m going in the order I see. Joe Glinka.
>> JOE GLINKA: Good morning, Deb. Joe Glinka Director of the HealthChoices for Highmark Wholecare and chair of Managed Care Delivery Systems Subcommittee. Good morning.
>> DEBORAH SHOEMAKER: Good morning. Julie Korick.
>> JULIE KORICK: Good morning, everyone. Julie Korick with the Pennsylvania Association of Community Health Centers.
>> DEBORAH SHOEMAKER: Wonderful, Kathy Cubit.
>> KATHY CUBIT: Hi this is Kathy Cubit from CARIE; the Center for Advocacy for the Rights and Interests of Elders and I chair the LTSSS (Long-Term Services and Supports Subcommittee) of the MAAC. Good morning, everybody.
>> DEBORAH SHOEMAKER: Good morning, Kath. Another one of our chairs. Mike Grier.
>> MIKE GRIER: Good morning, Deb. This is Mike Grier. I’m the Executive Director of the Pennsylvania Council on Independent Living and I am also the chair of the MLTSS (Managed Long-Term Service and Supports) committee.

>> DEBORAH SHOEMAKER: Great. We will try Minta again. If we can't get Minta.
>> MINTA LIVENGOOD: [inaudible]
>> DEBORAH SHOEMAKER: Okay, that was Minta. Tell me if I'm wrong, Sonia, she is a member of the Consumer Subcommittee. I forget if she has a leadership role there as well.
>> SONIA BROOKINS: She does. She is my co-chair.
>> DEBORAH SHOEMAKER: As she should be. Wonderful. Okay. Richard Edley.
>> RICHARD EDLEY: Good morning. Richard Edley, CEO of RCPA, the Rehabilitation and Community Provider Association.
>> DEBORAH SHOEMAKER: Wonderful, thank you. Russ McDaid.
>> RUSS MCDAID: Good morning. Russ McDaid. Immediate past chair of the MAAC and owner and principal of WRMc Strategies, consulting on health and human services policies.
>> DEBORAH SHOEMAKER: Great. Once a chair, always a chair, my friend. Don't forget it. Teri Henning.
>> TERI HENNING: Hi Deb, good morning. It's Teri Henning and as of this week Associate Vice President with Aviana Healthcare which I will check in with you about after the meeting, Deb.
>> DEBORAH SHOEMAKER: Wonderful. Thanks for letting me know. I would have said something else, congratulations, I'll say. Okay. Did we miss anybody, or did I miss anybody that is a member? Kyle Fisher in his ex-officio role.
>> KYLE FISHER: I'm not a member, good morning, Deb, but I am here as council to the Consumer Subcommittee.
>> MARK GOLDSTEIN: Hello, this is Mark Goldstein from the Pennsylvania Dental Association.
>> DEBORAH SHOEMAKER: Wonderful, thank you. Am I missing any additional members?
>> NICK WATSULA: This is Nick Watsula, Vice President COO (Chief Operating Officer) of UPMC (University of Pittsburgh Medical Center), good morning. Deb, I would never forget you, so I'm a little bit upset.
>> DEBORAH SHOEMAKER: I'm in the car, Nick, so that's the thing, man. I would never forget you either. You were a chair, so you are always a chair, too.
>> NICK WATSULA: I appreciate that.
>> DEBORAH SHOEMAKER: I was just excited. I wanted to say your last name right. You got it. All right. I think we now, I think we have a quorum.
>> KAREN LOWERY: Yes, Deb we do have quorum.
>> DEBORAH SHOEMAKER: Ok, since we have a quorum, I would like to bring everybody's attention, that has hopefully seen the minutes from the last meeting as they were distributed, if we have no objections, I would like to take a motion to approve minutes as they were distributed. Can I have a motion?
>> SONIA BROOKINS: I'll make a motion.
>> MINTA LIVENGOOD: Can you hear Minta Livengood again?
>> DEBORAH SHOEMAKER: Yes, we can Minta, welcome.
>> MINTA LIVENGOOD: Okay, had to go back out and come back in.
>> DEBORAH SHOEMAKER: I'm glad. Nice to hear your voice. Okay, Minta, now you can help make a motion or work with us to say that you approve the minutes.
>> MINTA LIVENGOOD: I will make a motion to accept the minutes.
>> DEBORAH SHOEMAKER: Awesome. Okay. Second from Minta. No second from Minta?
>> NICK WATSULA: We have a second, this is Nick.
>> DEBORAH SHOEMAKER: Thanks, Nick. Nothing like pulling teeth for this one today. All right. All in favor of approving minutes, please say aye.

>> Aye.
>> DEBORAH SHOEMAKER: Okay. Any nays? Okay. All right then, I think that the ayes have it. Thank you, everyone. And next on the agenda, since we just discussed it, ODP is jumping over OIM from the beginning. Thank you. I'm ready to go if you're ready to go, Ms. Kristin.
>> KRISTIN AHRENS: All right. Thank you. I am ready. You can go to the next slide. I'm just going to run through a bunch of updates. There isn't anything in here we haven't prior discussed. I am just going to provide updates and happy to take questions. At the April meeting I announced that we were anticipating the closure of Polk Center's campus on May 1. We did close Polk Center's campus on May 1. We do have 27 residents that remained in one building on the campus being served by a community provider. The name of that provider is Verland services. Those 27 residents had selected Verland as their community services provider. Verland is constructing new homes for them. They received some funding through DCED (Department of Community and Economic Development) to build those new homes. Until those homes are constructed, the residents are remaining at Polk center and again in one of the buildings under Verland -- Verland is a service provider so we will keep you posted on progress there, but this is to alert you that we did officially close the campus as of May 1.
This weekend's PA Bulletin will include proposed waiver amendments for the Consolidated PFDS (Person/Family Directed Support) and Community Living waivers. It will also include proposed fee schedules for a number of different services. And I did cover these in prior meetings but just as a reminder, the proposed fee schedule will be for the community participation and transportation services we had in the Governor's budget. It included the continuation of what are currently enhanced rates that we put in place during the pandemic. So, we will be looking to make those the permanent fee schedule rates or until the next time the fee schedule is updated, but to continue those rates post November 11 so those are being published for public comment. We are including – we currently have fee schedule rates for residential services that go, needs groups 1 through 4. And then we had an exceptional needs process for people whose needs and residential services were beyond needs group 4. Since 2018 we've had the exceptional rate process in place. We have sufficient data at this point to be able to develop a needs group 5 rate. So that rate is being published as proposed in the bulletin as well.
We have a number of alternative therapies in our home and community-based waivers that includes art, music, and equine therapies. We have heard from a number of participants and therapists that it is often beneficial to conduct those in small groups. We only had rates for 1 to 1 therapy. We are including rates for up to 4 participants in a group for our music and equine therapy. Those rates will be published as proposed for comment.
We have been including prior waiver amendments. We have included some of our unwinding provisions, now that we have a firm date of November 11 for when our Appendix K flexibilities must end under the federal guidance. We are including some additional amendments for the flexibilities that we need to continue. We've got some cap exceptions for the Person/Family Directed Support waiver. We have allowed individuals to exceed the annual cap if they had pandemic or COVID-related needs. We will have to continue those through the remainder of the fiscal year and then we asked for additional time to accommodate everyone's needs. We got that built in to buy us time to continue sort of unwinding that and making sure we don't have any disruptions and services for individuals.
And then we have a number of supplemental payments that we've been making using ARPA (American Rescue Plan Act) funding that the authorization for those was approved through Appendix K amendments. Many of those payments will be made after November 11 and so we need to make sure we still have the federal authority to make those payments and draw down the federal match from

those. Then finally we've got in the Governor's budget I had shared I think it would have been the April meeting. I went through the new telehealth specialty health assessment and coordination service we will be adding to our waivers. We actually are adding them to the actual waiver amendment, so the proposed language is out there for public comment before we submit that to the federal government.

And then finally, the last meeting I went over our intent to move to selective contracting for residential services and our supports coordination. We did publish yesterday a concept paper and are asking for public feedback on the concept paper and we scheduled a number of sessions to gather that verbally. We are also taking written feedback on that concept. And we will be using all of that feedback to help us construct the actual applications that we will submit to the federal government for the 1915 (b)(4). We will be submitting two 1915 (b)(4) waivers then we will have some amendments to our 1915 (c) waivers that go with that. All of this feedback is to help us construct those. Those will also go out for public formal comment before we submit them to the federal government. Just to alert the MAAC, that did go out yesterday, beginning 45 days that we will be taking feedback from the public. And that's all I have. Happy to take questions or comments.
>> DEBORAH SHOEMAKER: Do we have any questions or comments?
>> RICHARD EDLEY: This is Richard. Good morning. First, thank you again yesterday for your presentation. It does really help to think it through each time we talk about it. I want to state for the record for the MAAC, any proposal that focuses on quality and improvement and alternative reimbursement and value-based payments, we are in favor of. I did send you a lot of questions, and we continue to have questions. It really is questions not complaints. A lot of details we won't know until later. Like what are the quality standards? What is the alternative reimbursement? That is for later discussion. I would just list two things that we will probably put in our comments to the paper that was released yesterday. The first is the continued concern about midsized, smaller providers and how can they survive under this. But rather than take the time now, honestly, we have already tossed around some ideas where we think that maybe some alternatives or ideas, we would put forth to you around that. And the second one is the timeline. I think people are still a little concerned. I mentioned at the last meeting that it is for this type of implementation seems fast, but these are things we could put in our comments and offer ideas and see what you think. So again, thank you.
>> KRISTIN ARHENS: Thank you, Richard. I appreciate that.
>> DEBORAH SHOEMAKER: Thanks, Richard. I'm sure they are very thoughtful comments. I'm sure that person will address them as she always does, very well. Any questions from MAAC members? Any questions from the audience in the chat?
>> ELISE GREGORY: We don't have any questions in that section right now.
>> DEBORAH SHOEMAKER: Wonderful. Thank you. Kristin, do you have anything else then?
>> KRISTIN AHRENS: I do not. I do have to drop off for another meeting. But if there is anything to address, I can certainly do that after the meeting and I will have to send those questions over. I apologize, I usually stay on for the whole meeting, but I can't today.
>> DEBORAH SHOEMAKER: That's okay. You are a faithful member. Okay. Thank you. Okay miss -- sorry, I'm losing my mind here. No other questions. Karen, are we going to -- is Carl on by any chance? I know he couldn't get on until 10:30. If not, I don't know if you want to move to the next presentation since we have about 10 minutes.
>> KAREN LOWERY: It doesn't look like Carl has logged in yet. If Deputy Secretary Marsala would like to present in front of OIM.

>> JULIET MARSALA: Deputy Secretary Marsala here. I'm happy to present.
>> DEBORAH SHOEMAKER: Thank you, Deputy Secretary, Ms. Juliet. Ready to go?
>> JULIET MARSALA: I am. We can pull the slides up. Great. All right. I just have OLTL updates. I wanted to talk a little bit about in lieu of services and just very briefly on the PHE unwinding from OLTL's perspective. I know you will get a lot more from OIM when they do their report. That is, they will have a lot more to provide. If we go down, I will dig into updates in the next slide.
The Community HealthChoices (CHC) request for information was released and that comment period closed on April 14. We received roughly 60 responses from provider organizations, associations, and participants and many of those provider organizations and health plans and health plan associations represent really large bodies of stakeholders. We are finalizing our review. Very close to completion. It is going through the final review process, and we are hopeful to release a summary of the comments in the very near future. Really great comments. And we will be releasing that summary very soon. We wanted to let folks know about that update.
Then if we go to the next slide, we did want to talk just briefly about the Centers for Medicare & Medicaid Services (CMS) in lieu of services for the managed care program particularly as it is, you know, in our 2023 approved agreement approved recently by CMS. We want folks to understand it a little bit. The slides are pretty technical. I'm not going through all of the technicalities. But they are a great tool for developing cost-effective and medically appropriate services. They allow for setting substitutions for Medicaid covered services within the managed care program. Wanted to cite regulation here for folks. If folks wanted to really dig in, they could. We have a responsibility if a managed care organization brings us some sort of in lieu of service idea forward, to ensure it is cost-effective and medically appropriate as a substitute for coverage services or settings already under our State Plan. I bring that up because, you know, in lieu of services, while a great tool, still has limits and how they can be developed and how they can be brought forward and proposed. They have to meet the standards that CMS provided guidance on. Also wanted to reiterate that if there is an lieu of service in place, you know, within the managed care program, if they determine they cannot require enrollees to use that in lieu of service, it is sort of voluntary on enrollees and their members. But their in lieu of service does have to ultimately be approved and authorized and also approved and authorized and identified in their managed care plan. And you know, then the managed care plan can offer that to their enrollees.
If we go to the next slide, just wanted to talk about the guidance when it came out. You can see it is quite recent. And you know, guidance came out in 2021. Providing, you know, information on additional opportunities that we could use under Medicaid and shift to how we can utilize in lieu of services to better address social determinants of health. And earlier this year, CMS issued further guidance, you know, in how we can use in lieu of services to address those health-related social needs. And within that guidance, what's really important is it introduced into new requirements for us with regards to new in lieu of services coming on-line or existing in lieu of services and how we document and report and review them. CMS introduced six principles that are critical to in lieu of services to ensure we are utilizing in lieu of services appropriately within our, in this case, Community HealthChoices program. If we go to the next slide.
I will just review them very, very quickly. Again, first principle, in lieu of services must advance objectives of Medicaid program. They must advance objectives in goals of Community HealthChoices. They cannot violate any federal rules and they are limited to services that are approvable through identified authorities and through Community HealthChoices, that's the 1915 (c) waiver. In lieu of services have to be cost-effective and the aggregate in lieu of service, have to be below 5% of the

program capitation. We have to evaluate that. But there needs to be rate certification that goes with that. And we have to be able to explain and prove how those in lieu of services are cost-effective. I wanted to point that out for folks. We go to the next slide.
With medically appropriate, this is how it has to be described, the name of the service, definition of each of the in lieu of services, they need to identify which service or setting in lieu of services substituting within the State Plan. It is not sort of an open and broad we can do it in lieu of service, there needs to be a correlation to the State Plan. If you are looking at therapies, they are providing sort of enhanced therapies. That is, it has to be correlated to what do the therapies look like in the State Plan and how are you substituting that. For example, if you are looking at well can we utilize assisted living facilities to substitute for nursing home setting you would have to explicitly state assisted living facility and bringing that service definition on-line as a means to replace setting or certain services at nursing facility level. Something like that. So just to again reiterate, there are guard rails to how in lieu of services are developed, authorized, and are monitored. Number 4, which is critically important, which is in lieu of services must preserve enrollees' rights and protections, so you cannot force a member to be required to use in lieu of service. It is a choice. If you have an in lieu of service that is available for a targeted population, anyone within that targeted population should have opportunity so you can't deny someone that would otherwise be appropriate for that in lieu of service. And in lieu of services must also still follow all of the member rights to file appeals and grievances with regards to denial or receipt of the in lieu of service. So that is a critical element I wanted to make sure that was reviewed.
And then if we go to the next slide, principles 5 and 6, in lieu of services are subject to monitoring and oversight like any other service. They are also subject to retrospective evaluation, and you have the details of that. And while we are encouraged and excited and we do have in lieu of service language in the 2023-24 agreement, we did want to make sure that folks kind of had that framework understanding of what in lieu of services are and sort of what the guard rails may be with how they are developed. It is not necessarily a fast development. There is a lot of thoughtfulness that managed care organizations will have to think about as they are thinking about how they may wish to utilize this tool, in lieu of services, to innovate or tailor services and supports to best meet individuals under the Community HealthChoices program. Okay.
And we wanted to recap the PHE unwinding. Bring to the group here. Which I know OIM will talk about in-depth. But we also wanted to share that each and every one of the managed care organizations have been working hard to make sure members are educated about the Medicaid unwinding. They have sent out text messages, emails, supports coordinators have been connecting with members and so there is really a huge effort in the Office of Long-Term Living. Not just under CHC, but all of our programs to ensure that folks are aware of the Medicaid renewal requirements. I will leave it at that. And have the information here because I know OIM will be speaking more to this. Any questions?
>> KATHY CUBIT: Hi this is Kathy Cubit. Thank you for your presentation. I have a question about the in lieu of services. Could you comment or talk a little bit about how the home and community-based settings rule will factor into the approval of applications and monitoring of in lieu of services for alternatives to nursing home settings?
>> JULIET MARSALA: Yeah, so all in lieu of services do have to align with the CMS final settings rule. So that is something that will be evaluated as part of services. It may be that if folks are looking at alternatives to nursing facility settings, OLTL would have to consider whether or not an alternative setting is subject to heighten scrutiny or whether it meets the requirements of the final settings rules as outlined by CMS.

>> KATHY CUBIT: Thank you.

>> JULIET MARSALA: You're welcome.

>> DEBORAH SHOEMAKER: Any other questions from the committee for Deputy Secretary Marsala? Wow. Any questions from the audience or the chat?

>> TERI HENNING: Hey Deb, this is Teri. Can I ask a question?

>> DEBORAH SHOEMAKER: You can always jump in, Teri.

>> TERI HENNING: I was wondering if you could speak to the Department plans or discussions or engagement with external stakeholders on proposed HCBS (home and community-based services) rule that CMS has published.

>> JULIET MARSALA: I know from OLTL's perspective what we have shared with our stakeholders and have talked about in public meetings and is that OLTL is very happy to hear from our stakeholders about their views with regards to recommendations with regards to the recent CMS guidance that's been issued and open comment period that is closing after 60 days. And we have received some comments and thoughts with regards those. Our team has been collecting and developing our thoughts and I know we as an entire Department will come together to discuss those and providing a response that we do intend to respond and provide comments as a whole Department. But I will let Sally add to that.

>> SALLY KOZAK: Teri, thank you for that. That is one of the items on my agenda to make sure that folks are aware that the various rules have been released and as Juliet said, let folks know we welcome comments and feedback. We are working internally as a department to prepare our responses. Thank you for bringing that up.

>> TERI HENNING: Thanks Juliet and Sally. Deb I wonder if we can maybe have a discussion at the MAAC level about this issue. I think there is still time at the next meeting.

>> DEBORAH SHOEMAKER: Yes, June. We can still do that. Internally we have our steering committee call in a couple weeks or you can send it to me. Why don't you send it to me by e-mail, and I will make sure we address it on the next meeting.

>> TERI HENNING: Thanks.

>> DEBORAH SHOEMAKER: No problem. Any other questions? Thank you for jumping in there too, Sally. It wasn't your presentation, was it. Any other questions that we have either in the chat, Elise, or for members before we see if Carl is on?

>> ELISE GREGORY: There are no more questions in the chat.

>> DEBORAH SHOEMAKER: Last call for MAAC members. Kyle do you have any questions or were they addressed yesterday?

>> KYLE FISHER: I do not. Thank you, Deb.,

>> DEBORAH SHOEMAKER: Okay. Thank you, Deputy Secretary Marsala. We will see you next month.

>> JULIET MARSALA: Thank you.

>> DEBORAH SHOEMAKER: Thank you. Okay, do we have Carl?

>> CARL FELDMAN: Hi, good morning. Can you hear me?

>> DEBORAH SHOEMAKER: Yes, good morning, Carl.

>> CARL FELDMAN: Okay. I am going to share some information this morning about some updates that we have made to our webpage that can give you a lot of information about what is going on in the unwinding. That is our unwinding data tracker. That is a tool we have developed to try and see what is taking place with the Medicaid population and specifically the COVID maintained population at the individual level. It's got cross tabs and data visualizations down to county and zip code. Not exactly age, but child or not, which we think is something that people are very interested in. And we intend to make

sure that is updated monthly. There is some additional information on there about the entirety of the Medicaid population in detailing additional enrollments, churn over time, people who leave and then come back, but the detail level is really focused on the maintained population. We believe that pool of people are the ones most disconnected from the eligibility process and because we intend to make available the reports that are provided to CMS that are also at the individual level but for the entirety of the population statewide. We also wanted to share information about what happens after an eligibility determination is made. In some ways it hasn't changed but we added new outreach mechanisms to the process that were not there before. Households have always received a notice on the status of their eligibility after the caseworker has reviewed their case. And that includes appeal rights for them, but that also includes some new contact. If you go to the next slide.

The new outreach that we are doing is going -- it is actually two outreaches. Possibly three. So normally, as I said, you will receive a notice indicating what occurred with your eligibility after we reviewed it. If you are ineligible and you do everything and give us your information on your income, we are going to do a handoff to Pennie, our state-based exchange. That was not available before. They are able to use the information you provided to show that you might be eligible for subsidized coverage on the exchange. And there is a process by which you are given everything that you need to claim those subsidies for marketplace insurance.

There is also a response set up for people who don't return the renewal to, I guess, do less of a warm handoff to Pennie and also inform people about their ability to potentially return to Medicaid because if they didn't return renewal maybe there is something going on in their life and they just missed it but they can come right back on and we will open them to the date of closure, should they provide everything that we need. And Pennie is also doing outreach to those people, and they have set up tools to do that. I believe they have a dial-in campaign put together for that purpose. They were talking about putting together a texting campaign and mailing is a part of it too. That was not something we did before. We certainly didn't have Pennie available before. But it is a lot of additional back-end activity that we hope will continue to drive down the rate of procedural closures and loss of coverage at every point in the process. Next slide.

We are happy to talk about more general questions about the unwinding or these slides. I will open up myself up to questions now.

>> DEBORAH SHOEMAKER: Carl, I want to thank you for your constant information. And thanks, Scott, as well. Your department is doing a wonderful job. I know everyone has questions about reporting and things like that. And I can tell you from a personal experience, you guys are doing a wonderful job. For my daughter, she is on because of some of her needs, I've gotten two text messages and phone call already. You guys are doing amazing. And if you don't answer those, then you know, you can't really ignore it. So hopefully this will be a good outreach. I appreciate that information about Pennie. That is just my public thanks. Are there any questions from the members?

>> MINTA LIVENGOOD: This is Minta Livengood.

>> DEBORAH SHOEMAKER: Go ahead, Minta.

>> MINTA LIVENGOOD: Okay. I have a question. As you are doing the re-evaluations of clients, are you taking time before you send them off to Pennie, are you taking time to see if they are eligible for MAWD (Medical Assistance for Workers with Disabilities)? Because I had someone do re-evaluation and at the time, he would have been ineligible for Medicaid, but he would have been eligible for MAWD, and they didn't do that. They just said he was no longer eligible for Medicaid and his situation had changed. We solved that problem because his income dropped. Okay. But there's going to be other ones out there

that are going to be MAWD eligible because they are working but not making over the guidelines for MAWD that they could possibly qualify to purchase because of health issues. I'm reaching out about that question.

>> CARL FELDMAN: Thank you for asking about that. Sorry for the person who experienced it. That is a challenge. I can tell you that our direction is very clear that individuals should be evaluated for MAWD. Our policy about the redeterminations during unwinding period has a whole section just to speak about MAWD and Workers with Job Success. But what I know and what some of you also know is that MAWD, because it has a premium involves an additional step in the eligibility determination process, because we don't want to automatically put someone into that category if they are not interested in paying the premium for the coverage. We are hoping to make system changes in the future that will kind of make that process more efficient, easier for the worker and clearer for the client. But we think when something like that happens, that kind of system challenge, not an error or bug or anything like that, but just design challenge, is what is often the culprit.

>> MINTA LIVENGOOD: That is where the notice, something to look at notice, that you could put on there. You may qualify for MAWD, and it is a 5% of your income. I don't think it has gone up. That you would pay to qualify for MAWD. But this does not identify any options. It just says, if you don't agree with this decision, you can appeal it. But unless the person knows anything about the MAWD program, they're just going to assume there's no help out there.

>> DEBORAH SHOEMAKER: Thank you, Minta, that is important. And that was a question that I think that I had before is resources and things. I'm glad there is Pennie and a warm handoff, much more than in the past. I assume, and Carl, you can tell me if I'm wrong. I assume that Pennie, things and MAWD and other things, one thing you said here, people in the process can find out if they can requalify and they can get back on quickly. Are there additional resources or any, I don't want to say financial incentives, but is there anything that the Department is able to help people or moving over assistance for those who do not make or would no longer qualify for Medicaid but have to do Pennie. I know it is confusing. Pennie can be confusing for people if they don't understand it and making sure they get the options that are most appropriate for them that will give them as close to the same coverage as Medicaid without having to pay a lot because there are still people who obviously, if they were Medicaid population, they are still working hard to make ends meet, and we don't want them to fall through the cracks.

>> CARL FELDMAN: I'm not in the best position to talk extensively about how Pennie handles their connections for the former Medicaid recipients. I would encourage this group to engage with Pennie. I'm sure they would be happy to come here and talk about what they are
doing once they receive the information and what that outreach is like. You can see on our dashboard the number of referrals to Pennie that have been made based on the maintained population and the CMS report I think also has a section on that. I would just encourage this group to connect with Pennie. I know they would be happy to talk.

>> DEBORAH SHOEMAKER: That's on my list along with Teri's. Any questions from MAAC members? If not, I will ask Elise if there are any additional questions. Thank you, Carl. I know you have been doing hard work and I appreciate that.

>> JOE GLINKA: Deb, this is Joe Glinka, I do have a question.

>> DEBORAH SHOEMAKER: Go ahead Joe.

>> JOE GLINKA: Carl, thank you for the update and if I am misunderstood, please I know you will correct me on this. Is it possible for the MCOs on the 834 files we receive to get information relative to our members who have been referred to Pennie and/or CHIP?
>> CARL FELDMAN: That's a question I haven't heard before. I'm not sure if it is something the Department hasn't heard before, so I think it is something we have to discuss. Any changes to 834 files can be somewhat of an undertaking. I'm not in a position to say yes or no but I appreciate you asking about it.
>> JOE GLINKA: If there are any possibilities or realities to that, that would be helpful. I certainly understand where you are coming from. Thank you.
>> DEBORAH SHOEMAKER: Kathy, did you get your question answered? Kathy Cubit, that you had previously?
>> KATHY CUBIT: Yeah, this is Kathy. I don't have any questions. I do appreciate all of the work the Department is doing, and I know it is a huge task and I appreciate all you are doing. Thank you.
>> DEBORAH SHOEMAKER: Okay, Kyle? I don't want to belabor but I want to make sure everyone has the chance to answer the questions. The health unwinding is one of the top things right now.
>> KYLE FISHER: I don't have questions. I know Carl spent some time with the consumers yesterday answering their questions. Thank you.
>> DEBORAH SHOEMAKER: Okay. Last call for questions. Alright, thank you Carl. I am sure that we will be talking to you and Scott on many occasions' thanks for your availability.
>> CARL FELDMAN: Thank you for your time and thank you to the members. Continue to use the stakeholder toolkit we have available on the site. That information does not go stale. It is a twelve-month process, and we are just at the beginning of it. Have a good day.
>> DEBORAH SHOEMAKER: Thank you. Next up is OMHSAS. Aare you ready Dr. Dale Adair?
>> DR. DALE ADAIR: Yes, I left another meeting to make sure I was here on time, so I am here.
>> DEBORAH SHOEMAKER: Thanks Dale I appreciate that.
>> DR. DALE ADAIR: I always appreciate the opportunity to come and speak to this group, particularly during May as May is Mental Health Awareness Month. I know you are all aware of that but always want to point that out during this month. I'm going to provide you with a couple updates. We are going to start with the Behavioral Health Commission. There are two bills that are looking to enact legislation that then would get money out that the Behavioral Health Commission report recommended. There is House Bill 849 which is Representative Schlossberg's bill, and its companion Senate Bill is 605 which I believe is Senator Collett. On Tuesday, the House of Health and Human Services Committee voted House Bill 849 successfully out of committee. It came out with a 21-0 vote. There will most likely be some movement for the movement on it, although I can't tell you exactly when it actually hit the floor. I don't remember if we talked specifically because the recommendations from the Behavioral Health Commission are not word for word in legislation. But I would just say that there are three broad groups. Obviously, workforce and legislation put $34 million into legislation and workforce, criminal justice and public safety, $25.5 million, and for strengthening and expanding mental health services and supports, $40 million. The way the legislation is written, it utilizes several different agencies to help get the money out. And there were some amendments to 849 when it came out of committee, for it to get out of committee, and one of those amendments involved applicant eligibility under the Department of Labor Workforce grant program. There are some reporting obligations for the funding of some recipients. There are also additional eligible behavioral health service settings under the Department of Health loan payment programs. I think when we look at the agencies that would be involved in helping

to get the funds out, DHS, Department of Labor and Industry, Department of Health, Department of Drug and Alcohol Programs, and PCCD (Pennsylvania Commission on Crime and Delinquency). I think I have them all. But anyway, in order to get $100 million out in the legislation, would require that the money is obligated by July 1 of 2024. Then it had to be spent by -- sorry, by December 31 of 2026. The other piece of this, and this was recommended by the Behavioral Health Commission, is the need to have a study done that would then look to where the money went and then the impact of the money. DHS would have to submit a report addressing the impact of the money. That's where that legislation is. I have not heard movement on the Senate side. But anyway, that is what is going on with House Bill 849. If you want me to go to the end and take questions in general.
>> DEBORAH SHOEMAKER: Whatever you prefer, Dale.
>> DR. DALE ADAIR: I'm happy either way. Why don't I just go ahead, then.
>> DEBORAH SHOEMAKER: Go ahead.
>> DR. DALE ADAIR: So CCBHC, Certified Community Behavioral Health Clinics, you all know that there has been -- since we left the demonstration, there have been a number of questions about whether or not we would re-enter the demonstration. We have always said that we would continue to assess, and we have always been involved in conversations with both CMS and SAMHSA (Substance Abuse and Mental Health Services Administration). CMS has recently released -- I'm losing track of time, whether it was last week or the week before -- but recently released proposed guidelines for the prospective payment. And with this they have a comment period and comments are due next Friday, June 2. We have had an opportunity to review the proposed changes. And quite honestly, I think that the proposed changes are reflective of the fact that CMS has listened to Pennsylvania's concerns, but now we have to really see what the final decision will end up being. So will they end up putting out the guidance consistent with the proposed or based on comments that will come in and will they make other changes. We do expect to send in some comments to the proposal and what we have been doing when people have asked questions about the proposals. We also want to make clear that, you know, they are seeking public comment. Anyone can submit comments, but we will be submitting our own comments. Next slide.
>> DEBORAH SHOEMAKER: Before you do the next slide, since you can do it whenever you want, quick question so I don't forget, using my speaker privilege, what are some of the changes that you think for the CCBHC exchange, what is specific to PA or things, since it’s long and people can comment, what to look out for?
>> DR. DALE ADAIR: One of the sticking points for us was with the PPS (Prospective Payment System) rate, right? That is part of their last major question. And you know, when we started in 2017, we went with the PPS1 rate which is a daily rate and really there is -- that created limitations and issues for us and we moved, and when we left the demonstration and started the ICWCs (Integrated Community Wellness Centers) we moved to a monthly rate. The way it was set up from the beginning, the monthly rate in the demonstration requires you to do a special population. There are restrictions that would be burdensome for us and has actually been burdensome to other states within the demonstration. And you know, these were part of the conversations that we had with CMS. Because they did a number of interviews, in general, with states and they did some specific interviews with us. They are adding, or proposing to add, two additional PPS rates. But they have removed the requirement of doing specialized population. They have made it optional. So that was our big sticking point.
>> DEBORAH SHOEMAKER: Thank you. And for PPS is paid per service. Right?
>> DR. DALE ADAIR: Well not exactly. Prospective payment schedule.

>> DEBORAH SHOEMAKER: Oh, sorry. I make up my own words. Alright. Any other questions, since I make up my own, to ask Dale then. But thank you. That's good to know. We definitely want the CCHBC to be around.
>> DR. DALE ADAIR: That's all right. I think it is actually the last slide. So just want to make everyone aware. This was brought up yesterday. In May, OMHSAS released two bulletins. The first is, mental health emergency services, which addresses when the 120-hour clock starts -- sorry, for some reason I'm having trouble talking today. But they clarify expectations when someone is involuntarily committed. This is a bulletin. I can't remember when clarification originally came out. But there have been at least two, if not three, revisions to this bulletin. And really the effort is to follow what the statute actually says although there have been questions raised as to the statute and what is being practiced. And you know, the Department’s stance is our guidance has to follow the statute, the existing statute. So that is out there and has, as I said, been released recently, revised and released. And the second thing is, the bulletin in regard to Act 32 of 2022 which confidentiality and attempting to align with HIPAA, the Health Insurance Portability and Accountability Act of 1996. Act 32 and Act 33. Act 33 applied to DDAP; Act 32 applies to DHS. Act 32 requires the Department to put out regulations. We have put out the bulletin so people will know what the expectations are around confidentiality and what to allow, what not to allow. We will be beginning work to amend Chapter 5100 to align with Act 32 as per our requirement by the Act. Those are the two bulletins I wanted to make you aware of. I think that's the last slide.
>> KAREN LOWERY: It is.
>> DEBORAH SHOEMAKER: Okay. I do have one question. And I will ask other MAAC members. For the 302 or the bulletin on emergency services, will there be training planned for members, like judicial members and all the counties and others to ensure that everybody is on the same page and that there is consistency across the Commonwealth? I know that's been an issue with 302s, there’s always a different interpretation whether it is from mental health review officers or others. To make sure that everyone is on the same page or it’s just going to be another one of those bulletins that you talked about where it is not very clear. Because this law is clear as mud.
>> DR. DALE ADAIR: Deb, you are right that there are and has always been different interpretations. You will recall, I don't remember what year it was, but we did do some training to try and get everybody on the same page. There does need to be some further training. We have had conversations about how to move that forward.
>> DEBORAH SHOEMAKER: I know when I was involved, I was involved in a couple of them. It was difficult. I won't belabor the issue, but one place you might want to look because of my involvement is reaching out to PCCD. I know they do trainings. They have mental and justice advisory committee and victim services and other committees over there. Where I did assist them in doing, a couple years ago, in doing training that was online for just about mental health and some of the process. You know, it might be a place to start. As long as we can keep everybody on the same page, because I know that's been a discussion from the moment that it is, and we want 302s to be the least restrictive alternative for everyone. But that would be helpful. You have your work cut out for you always on this issue.
>> DR. DALE ADAIR: You are absolutely correct.
>> DEBORAH SHOEMAKER: Do any members have questions for Dr. Adair?
>> RICHARD EDLEY: This is Richard. A couple of comments. Going back to the slide on the BH Commission and so forth. We just spoke in that, Dale. This is really more for the rest of the MAAC. That the legislation for the BH Commission money, we did submit an RCPA letter of support for that and

continue to meet with legislators really urging that their action be taken. We are cautiously optimistic. And then on the CCBHC piece we have been supportive of your analysis to get back to it. And also, I'm very hopeful. We know there is more to come on it but I'm happy to see where it is headed. Again, thank you.

>> DEBORAH SHOEMAKER: Anyone else? Joe, Kyle? Anything else before I ask Elise if there are any questions in the chat?

>> ELISE GREGORY: There are no questions in the chat at this time.

>> DEBORAH SHOEMAKER: Anyone else from membership? Okay. If not, just my own plug, my own personal plug, if you have any opportunity, please, please, please advocate for the Behavioral Health Commission funding. It is so important because it hits across the whole span. Like Dale said. Education, you know, and education, law enforcement across the board. If we had our way we would like an ongoing commission, but we need the funds. If there is an opportunity to talk to your legislators. If you need more information, don't hesitate to contact me or any consumer group or any group. I'm sure Richard or others would be more than willing to talk to you about it. That's my own personal plug. Not an official MAAC position. That's my- position. Using my own thought process. Next, thank you, Dale. I appreciate it.

>> DR. DALE ADAIR: Thank you for the opportunity.

>> DEBORAH SHOEMAKER: Next, I think you're up, Sally.

>> SALLY KOZAK: Thank you, Deb. Good morning, everybody. I just have a few updates I will give you. And I'm going to start from the bottom up on this slide that should be up on the screen. A little bit earlier, we were asked about the new CMS rules and Juliet talked about the process and I just want to provide some additional information. The rules were released on May 3rd by CMS. Final comments are due back to CMS by July 3rd. The two rules focus on ensuring access to MA services and Medicaid and CHIP manage care access, finance, and quality. Both of these rules are proposing significant changes that are aimed at improving access to and the quality of Medicaid services. The ensuring access rule proposes to fund requirements on medical care advisory committee. And the beneficiary advisory group. It includes requirements for Home and Community-Based Services including home and community-based services reporting requirements as well as standard quality measure set. It includes new requirements of documentation of access to care and service payment rates. And more specifically, payment requirements to Medicare. The second rule, the MA and CHIP managed care access, finance, and quality, establishes requirements for enrollee experience surveys, appointment wait time standards, secret shopper surveys, provider payment analysis, website transparency, state directed payments, medical loss ratio standards, in lieu of services, quality assessments and performance improvement as well as quality rating systems. At a very high level those are the areas that the proposed rules would have impacts on. Again, a reminder that comments are due to CMS on July 3rd. The Department has been working internally across the effected program offices which are ODP, OLTL, OMHSAS, and OMAP to coordinate our comments. As Juliet said earlier and as I said, we welcome your input, however I want to let people know that we are nearing the end of collecting and gathering our internal comments. That is because we have an internal review process that they go through before they are finalized for submission to CMS. If you submit your comments to us or have comments that you would like us to include, I suggest that you get that to us in the next week or so. I appreciate that is rather short notice. These rules came at the last minute and did not give more than a 60-day period for review. Given that your feedback might not make it to our comments, I would encourage you and your organizations to submit comments to CMS as well. Questions about any of that? That was a lot.

>> DEBORAH SHOEMAKER: I think you're good.
>> SALLY KOZAK: Okay, continuing up the page, instead of down the page, as folks may know, back in December I want to say, we issued a bulletin advising organizations that we were going to carve some very expensive high-cost drugs out of applicability for 340B. We did that because these are -- they are million-dollar drugs that manufacturers have approached us with an interest in value-based purchasing arrangements with the state. As part of that bulletin, we reiterated that we do not recognize contract pharmacies in the 340B program. We appreciate this caused some consternation for some of the 340B entities. We agreed to convene work groups, which we held a series of them. I think it was the series of six meetings as well as individual meetings with various associations and other parties interested in 340B. We issued a draft bulletin for comment. The comment period on that is closed and I want to let people know that all of the comments and our feedback have been posted to the MAAC website as well as to the LISTSERV. We continue to address the issue and we anticipate that there may be some additional clarifications forthcoming. But just wanted to let folks know that those are out there.

Provider enrollment backlog and processing updates, I know that over the past several months we have acknowledged that there was a significant backlog in provider applications both new applications and revalidations. Since Secretary Arkoosh has come on board, we have dedicated additional resources to helping to clear up that backlog. As of today, all of the applications that were in the backlog on the date that the new administration got sworn in have been completed and processed. We continue to streamline our processes. We continue to dedicate resources to it. And folks should be seeing improvements in the timeframes for approval of completed applications. I just wanted to share with folks that we continue our commitment to improving the provider enrollment process.

And then the last update that I have is on Street Medicine because folks have been asking about this. Street Medicine services, include those that can be provided by a health care professional where the medical equipment and supplies are portable and that can be rendered to MA beneficiaries experiencing unsheltered homelessness in their lived environment. We are including the services on the MA fee schedule. We anticipate that it will be in the next month or two that folks will see the bulletin come out notifying them that this has been added. And I also want to let folks know that we are adding these services in a phased-in approach. The first phase will allow for physicians, certified nurse midwives, registered nurse practitioners, physician assistants and psychologists for children under the age of 21 to provide these street medicine services. As we continue to phase in, we will be looking to add other provider types including paramedics and EMTs (emergency medical technician) to be able to provide these services. It is going to take additional work with how we classify providers in our State Plan to be able to do that for them. We are viewing these services the same as any service that a provider would provide in their office. It is just now that they are offering these services in a different location. Which is why we expect that we will see additional provider types being added to that as we move forward. That is everything on my list of updates for the committee. Any questions or anything else that folks wanted information on that I did not have on my list?
>> JOE GLINKA: Sally, it is Joe Glinka. I have a question.
>> SALLY KOZAK: Sure.
>> JOE GLINKA: Thanks for that update, especially on the Street Medicine. I want to make sure I have this right. The update for the fee schedule, that's happening this month?
>> SALLY KOZAK: The bulletin will be coming out probably in the next month or two.

>> JOE GLINKA: Okay. And then the --
>> SALLY KOZAK: Sorry.
>> JOE GLINKA: Sorry. The bulletin would also include the detail with respect to the provider types that will be phased in I would imagine, right?
>> SALLY KOZAK: Yeah. We are not adding new provider types. Not new provider types. Not a new service. It is really a new service location. The location being the street so to speak.
>> JOE GLINKA: Okay. Thank you.
>> SALLY KOZAK: Sure.
>> TERI HENNING: Hi, Sally, it's Teri again how are you? I wonder if you can share any updates on the timing, sort of where in the process the paid family care giver bulletin or guidance might be within the Department?
>> SALLY KOZAK: You're talking about the paying parents?
>> TERI HENNING: Yes.
>> SALLY KOZAK: Eve can fill me in on that. Eve, I thought I saw the bulletin. I thought it went out or maybe not.
>> EVE LICKERS: It has not gone out. Because this will be a public notice and a bulletin. We are working on some final touches to it before it goes into the final stages of review. We would expect that it probably will not be out until probably the beginning of July. And remember, those changes will be effective at the beginning of August.
>> TERI HENNING: Thank you.
>> EVE LICKERS: Sure.
>> SALLY KOZAK: Ops memo, that has gone out to plans, Teri.
>> TERI HENNING: Thanks.
>> SALLY KOZAK: Congratulations on your new position, by the way.
>> TERI HENNING: Thanks again.
>> JULIE KORICK: Hi, Sally, this is Julie Korick with PACHC. I wanted to give some comments on the 340B program.
>> SALLY KOZAK: Sure
>> JULIE KORICK: So PACHC did submit comments and concerns. One of the concerns was the timeline start of July 1, 2023. That is very short to implement any new model. We are requesting a delay because there are ongoing discussions, and you know covered entities will have to set up processes and negotiate with contract pharmacies. There is a lot of work that will be done, including notifying patients who may be impacted by any change. We would suggest including the details in a bulletin and allowing at least three months after the bulletin to implement. At least three months. That's a large concern right now. Lastly, I do want to say that PACHC appreciates the addition of language in the 2024 MCO contract to prohibit the MCO and any subcontractor from reducing 340B drug [inaudible] payments. Thank you for that.
>> SALLY KOZAK: You're welcome. And I did reach out to your folks and let them know that we are happy to have additional conversations about the timeframes and I think we have included some of that in our comments. In our response to the comments, that we are happy to engage in additional feedback conversation on that.
>> JULIE KORICK: Thank you
>> SALLY KOZAK: Sure

>> DEBORAH SHOEMAKER: Sally I have a question. I figured I would jump in before there are others. How is OMAP deciding how it will measure the appointment waiting times as part of the CMS proposed rulemaking. Do you know what I am saying, how will the service delays be measured?
>> SALLY KOZAK: Yes, the proposed rule has some parameters for how states have to do that. At this time, we are just reviewing the comments for potential impact on us. Clearly, the rules give states opportunity or time to phase in these requirements. Deb, I don't have an answer for you on how we would do that. And we won't know for sure that we even have to do it until these become final rules. And it is a little bit premature for us to decide how we do it at this point.
>> DEBORAH SHOEMAKER: I'm sure and it's just a request. Yyou are always so thorough with giving information. I'm sure as you drill down and figure out what you need to do, you will make sure that we know, providers and others that have to deal with some of those reporting requirements, you will let us know.
>> SALLY KOZAK: Absolutely, if and when the rules are finalized, we will certainly keep all of our stakeholders apprised of how those changes will impact the program.
>> DEBORAH SHOEMAKER: You are always good about that. That's what I figured. And if I didn't ask Consumer Sub would ask so we're good.
>> SALLY KOZAK: Sure, no problem.
>> DEBORAH SHOEMAKER: Any other questions from MAAC members or any questions, Elise, from the chat?
>> ELISE GREGORY: Yes, there is one question in the chat from Melinda Eberhart. For Street Medicine, are home medical equipment suppliers included in the service location along with the provider types mentioned today.
>> SALLY KOZAK: Currently the only providers included that will be in the bulletin that will be issued for street medicine are the provider types I listed today. Having said that, this is just phase 1. We will be phasing in additional providers, and we have been having conversations about what that would look like for medical suppliers. The short answer is going forward most likely. Anything else?
>> ELISE GREGORY: Melinda says thank you. There are no more questions in the chat.
>> SALLY KOZAK: Okay then great. Before Deb, I turn it back over to you, hey Minta, I want to give you a shout out. I'm a western PA girl, and I know exactly what yins means.
>> MINTA LIVENGOOD: Thank you.
>> SALLY KOZAK: I lived down south for a while and they always used to ask me, how many yins does it take to make a y'all.
>> MINTA LIVENGOOD: That's a good one.
>> DEBORAH SHOEMAKER: So how many does it, now that you brought it up?
>> SALLY KOZAK: I never figured it out because they didn't like the Yankee nurse.
>> DEBORAH SHOEMAKER: We like the Yankee nurse. We will keep you.
>> SALLY KOZAK: With that, Deb, I am going to turn it back over to you.
>> DEBORAH SHOEMAKER: Wonderful. If we put the agenda up, I believe right now we are into all of the updates. For the Consumer Sub, who is giving the report? Minta or Sonia or Kyle? Or a little of everybody?
>> KYLE FISHER: This is Kyle. I will take the lead here and I guess Sonia and Minta will jump in if I miss anything or take over if you want to. We heard from four offices. The Consumer Subcommittee met yesterday. Some of the topics discussed were discussed already this morning. I will only highlight a few that weren't covered earlier this morning. With the OMAP report we heard a bit more discussion

around parents as paid caregivers issue that Sally alluded to a minute ago, including discussion around the ability of that option to continue post pandemic or past the end of the public health emergency which ended earlier this month. The consumers commended the Department, including Deputy Secretary Kozak, Gwen Zander, and their teams, for all the work they have done to extend that flexibility and to allow parents or legally responsible relatives who are providing home health aide services to continue to do that, now that the PHE ended. And honestly, the direct care worker shortage shows little signs of evading. While this is not a solution to the ongoing shortage problem, it does help that we know it is already being used by at least 500 families. We heard more about the recently issued managed care ops memo, guidance from OMAP and discussing prior auth in general for home health aide services. And in response to a question around how quickly OMAP expects MCOs to comply with this new guidance, Sally was clear in saying immediately and consumers and council appreciate the guidance is new, but this practice isn't.
One other issue we heard a report on is dental benefit limit exception (BLE) data. Sally gave an explanation of the history of a streamlined process that OMAP implemented for dental BLEs and limited exceptions in 2021. This streamlined process applies for consumers with certain diagnoses including pregnancy and largely disability and diabetes and where that is the case, claims records and diagnosis codes for medical claims can be used to allow the dental process to move much faster without the need for the consumer to prove that diagnosis and submit any other medical records for prior auth review under the dental landscape process.
And Gwen Zander walked us through data from the MCOs on BLE submissions over the last two calendar years 2021 and 2022, BLE line-item submissions, and also approval rates. One very positive outlier the data showed was Highmark Wholecare, which has implemented some backend system changes where its medical and dental sides talk and those dental BLEs are processed and able to identify whether the member has again five conditions that are part of this streamlined process. As a result, Highmark's approval rates dramatically increased. In calendar year 2022, they went from a BLE approval rate of basically 5 to 21% to over two-thirds, over of 66%, three straight quarters. Highmark has gotten this right. Unfortunately, other MCOs have not seen appreciable increase in approval rates. They are flat. Even since the new streamline process was put into place. Flat at less than one-fifth approval rate, 17% or less. One take away from that conversation, it is clear the Department is going to be working very closely with other MCOs to fix whatever implementation problems they are having and maybe getting medical information or diagnosis codes to their mental benefit managers so that the rest of the HealthChoices population can realize the promise of the new streamlines process. Shout out to Joe Glinka there and his implementation team.
We also had a presentation from OMHSAS and Deputy Secretary Jen Smith continuing the conversation on network adequacy and workforce shortages on the behavioral health side. Jen walked us through this new Medicaid Enterprise Management tool, the MEM. It may not be so new, but OMHSAS is connecting to it and utilizing it to better monitor the behavioral health provider networks. She also walked us through some steps to increase usage of secret shopper surveys to ensure accuracy of those reported networks and voting out a new reporting framework to monitor provider wait times. One of the things we highlighted was the difficulty not only of knowing what agencies are in particular BH-MCO (behavioral health managed care organization) networks, but knowing whether those provider agencies actually have staff. Do they have capacity? There is a list of agencies for consumers to reach out to. It does not do any good if agencies in network providers don't have staff to send out to someone's home or the ability to take them on as new patients.

Last item I will note is a report from the Office of Long-Term Living and Deputy Secretary Marsala around a problem with wheelchair repairs and delays in DME (durable medical equipment) vendors getting the parts they need to repair DME, like wheelchairs in particular, in a timely fashion. The consumers raised up a number of anecdotal cases where participants and CHC have been waiting for a year or sometimes for a year plus for repairs to occur and difficulty in getting loaner chairs from their vendor while this happens. The Deputy noted a number of complications in this space, including not just the supply chain delays, but also around warranty issues, coordination of coverage types for participants who are dually eligible, with Medicare often covering some of the same services. But despite those challenges, the Deputy assured the committee that OLTL is coordinating with the MCOs on the particular cases raised and also looking at this across the board and asking CHC MCOs to ensure participants needs are being met and service coordinators are doing what they should to monitor when a covered service isn't being provided and helping coordinate with Medicare benefits where that is necessary. I think that's all I had. Sonia or Minta, anything you want to add to that recap?
>> SONIA BROOKINS: No, you did a good job. Thank you so much.
>> KYLE FISHER: I'm happy to take questions from yins or y'all. Or whoever else might have questions.
>> RICHARD EDLEY: This is Richard. I wanted to thank you for the update on the network adequacy on the behavioral health side. I am happy that OMHSAS is on their radar. Probably like a lot of people on this committee, I will get calls frequently, friends of friends, neighbors, or relatives, whoever it is, in need of services asking me for help. I personally can say that I've gone down the list and realized it is not that easy to find a provider available. Even though have you a network, supposedly being sent out on a list. Particularly the case with psychiatry. I don't have the solution either because it is yet another version of the workforce issue, we have with all of human services, but again I just appreciate that update.
>> DEBORAH SHOEMAKER: Thanks, Richard. I know Deputy Secretary Smith and the slides, if you haven't seen the slides, you can get them from Consumer Sub off the website. It does have good information. It does have split out. It was a very good update yesterday. But I hear you. If there are no other questions, I will go to my update.
Like stated previously I am the chair for the Fee-for-Service Delivery System Subcommittee. We have recently, we as in our subcommittee, and Fee-for-Service itself, recently had a change in the Director, which was Michelle Robinson. She was at our last meeting, the 10th of May. We started around 10:00 like normal. Virtual attendance. Did our normal housekeeping items. Then new Director of the program, Michelle Robinson introduced herself. Provided an overview of her service being a nurse and working with consumers and others. Some updates we talked are probably not much different than some of the ones we talked about here. Fortunately, as of late, last year or so, the staff made it much more Fee-for-Service specific.
We talked about public health emergency had talked about the same standard updates we get from OIM and other places and talked about reinforcing things that Sally always mentioned about what is continued to be covered like labs and other things. And that was the first meeting, I believe, that I got information about the dashboard for OIM. There were conversations about what would be on that dashboard, monthly. Some of the conversation was about the CMS reporting and when it will be available to get information. I know that we are looking forward to more information about that. And there was a note which now we are past the deadline. When it is a nice day, we forget. But Director Robinson reminded us about that time about LIHEAP (Low Income Home Energy Assistance Program)

being extended because there was still a little bit of funding but at this point, I think it is probably at capacity.
The last couple of things we talked about really related to workforce and one perennial thing on our meetings is talking about the 180-day claim exception. And we have talked about policy updates. But 180-day claim exception. We thanked China Jackson and her group for doing so well with getting it up to speed. And we asked about workforce and if there was any way we could assist in making sure that they got more workers because I know as probably everyone, not just at DHS, but around pulling from all different places and trying to mention that DHS is very good at when you need to put focus on one place, if you don't have workers, everybody attracts to that spot. We asked formally if there was a way for us to assist in allocating or not allocating but soliciting in advocating for more workers for DHS or specifically for that area. And we were told that, like everywhere else the same problems exist. The Department of General Services controls the allocations. We formally mentioned that we are willing to assist in any way we can, and it was appreciated. With no other additional information to report, because our meetings are chalked full of information, our next meeting will be August 9 and next is November 8.
I'm not sure if anybody has any other specific questions for me. Thanks to my members and everything. We have a wonderful subcommittee. I'm very pleased to be able to share that. Next LTSSS. Ready, Kath?
>> KATHY CUBIT: Yes. Hi, Deb. We did not meet this month. But our meeting, as stated, is on June 13 remotely between 10:00 and 1:00. We welcome everyone to join. Thank you. We hope everyone has great holiday weekend.
>> DEBORAH SHOEMAKER: Thank you. Thanks for that reminder, too, Kath. Okay. Next, Joe.
>> JOE GLINKA: Thank you. We met on May 11. I want to say thank you to Kyle for your kind remarks with respect to Highmark Wholecare. Dr. Theilan apologizes for the technical difficulties connecting to the meeting but certainly is available for discussions down the road, just wanted to share that. In the meeting, one of the things that we always cover is the expansion population or the newly eligible group within Pennsylvania Medicaid. And the current population, as of May 11, in that group was 1,121,669. The applications over the four-week period of time leading up to that was up 4.2%. However, number of applications was down 4% or 4,000 apps prior to the last month of this year. For those of you who value that information, I wanted to share that with you.
Also discussed with respect to shadow nursing, which became effective 1/1/23, all of the MCOs are accepting claims for the new code associated with shadow nursing and those claims are to be paid retro back to 1/1/23, that is one of the items discussed, but sharing that with the larger group here.
As Sally walked us through the notice for proposed rulemaking, you know, DHS has focus on, as well as managed care community, to see what that pathway looks like moving forward, and once all comments are received. But one of the things that covered in our meeting with respect to a number of items considering that Pennsylvania has a very mature managed care program when it comes to Medicaid. Though there are a number of changes proposed in this rulemaking process, being Pennsylvania has been in the managed care environment for so long, there are items with respect to wait time standards where changes may not be described as all that great. But there will be changes. That with respect to surveying for feedback from enrollees in the program there are already vehicles in place at the Department. The annual member experience survey, which is part of this rulemaking process has already been deployed in Pennsylvania. The webpage for public transparency, PA HealthChoices already has a webpage available. Kudos to Pennsylvania and the Department for being forward-thinking in a

number of areas where we're further down the tracks then maybe perhaps some other states are. So again, we went through the items of that rule making process. I won't be repetitive. But our next meeting is June 8 at 10:00. I will stop there to see if there are additional questions. I would also wish everybody happy Memorial Day weekend.
>> DEBORAH SHOEMAKER: Any questions for Joe? Okay. Last but not least, Michael Grier.
>> MICHAEL GRIER: I'm ready, Deb, thank you. The MLTSS meeting, they met earlier in the month and we had the Office of Long-Term care updates with Deputy Secretary Juliet Marsala. She provided brief updates on Community HealthChoices reprocurement request. And in the information, she relayed that the comment period closed and that OLTL is in the process of reviewing just like you heard today. Talked about flexibilities of Appendix K and COVID-19 federal emergency. She also provided us with a proposed budget which included a budget breakdown for CHC, Long-Term Living and Living Independence for the Elderly, the LIFE program. We also had a presentation from Kevin Hancock about Pennsylvania's Master Plan for Aging and Disabilities. It is a state-led strategic planning resource to assist states in transforming infrastructure and coordination of services for older adults and disability populations. Kevin highlighted the development of this plan will include all levels of government for input regarding goals, opportunities, and challenges and Kevin welcomed input from the MLTSS committee.
We also went over the HCBS consumer assessment of health care providers and systems survey for 2023. Representatives from each of the CHC MCOs shared presentations about strategies and initiatives that they are putting in place for future HCBS survey results, as well as participant experience through a CHC MCOs plans of action. These improvements focused on strengthening outreach and increasing awareness among their participants, providers, and staff. Our upcoming meeting is next week, June 1st, and will be held in person at the Education Honor Suite at 333 Market Street in Harrisburg with remote streaming as an option. I will take any questions if anyone has any.
>> DEBORAH SHOEMAKER: Any questions for Mike?
>> RICHARD EDLEY: Mike, this is Richard. Not a question but I'm happy you brought up the Kevin Hancock MPAD (Master Plan for Aging and Disabilities). I met with Kevin earlier this week and it is a pretty substantial initiative. Deb, I just wanted to point out that we are focused on Medicaid in this committee but even though this plan goes beyond Medicaid, it can impact a lot of people being served. We might want to have Kevin coming into this larger committee at some point to present on what it looks like and what the process is. As you mentioned, Mike, there is a lot of stakeholder feedback involvement listening sessions that you name it. I believe he is in Scranton announcing the unveiling of the program today.
>> DEBORAH SHOEMAKER: Well Kevin Hancock is always welcome here. That may be something to put on, you know, put on our list. Thank you.
>> MICHAEL GRIER: I know he wanted to go to subcommittees, and I assume he would be approaching you too, Deb. But he wanted to get to subcommittees first.
>> DEBORAH SHOEMAKER: Good. Kevin is always welcome. He is one person that talks even faster than me which is hard to believe. If we don't have anything else, thanks to all subcommittee chairs and members for your hard work. Eve, MA bulletins and pharmacy documents?
>> EVE LICKERS: Good afternoon. Or not yet. Good morning still. We did not have any bulletins issued over this period. However, we have a few Provider Quick Tips that I did want to make note of for everyone to check out. There was Quick Tip #263 which updated important news that an electronic submission process for Office of Medical Assistance Programs, Fee-for-Service and the Office of Long-

Term Living and long-term care 180-day exception requests and other claims requiring documentation is available in the PROMISe portal. That is exciting news. And then also we had Quick Tip #233 which is updated. During the COVID-19 public health emergency there was a waiver of prudent pay requirements. And so, we just wanted to make sure that providers are aware that the waiver of prudent pay did not end on May 11 with the ending of the public health emergency. It is still in place and will remain in effect until further notice. There will be an actual MA provider bulletin that will go out advising providers of the change. There is also Quick Tip #230 related to the ability of pharmacies to override early refill alerts for medications, particularly related to those medications for COVID-19. But pharmacies at this point in time, effective May 12, dispensing pharmacies may no longer override the DUR (drug utilization review) alert for early refills at the pharmacy point of sale in response to COVID-19. Those, although quick tips, are still important for providers. More to come in the next month. Remember to look at What is New at OMAP on the Department of Human Services website for the upcoming communications and thank you. Have great Memorial Day.
>> DEBORAH SHOEMAKER: Thank you. And when you said pharmacy, I was waiting to, I think at some point, a brief update that was given at Consumer Sub yesterday, wouldn't hurt for us to remind us about, not five-day emergency supply. Terri called it temporary. I think she called it temporary supply. I mean a reminder about rules regarding temporary supply of medications or that early or five-day supply so that may be something to talk about as well at some point. But is there any new business or old business that we are aware of that should be brought up at this time? Okay. Anyone at DHS? Anything that you remember that is on our list? Okay. Alright. I will second and third everyone saying have a wonderful holiday over the long weekend. For those of you who have a pool, like when we were kids, the pool opened the day of Memorial Day. Not before Memorial Day. If you have it, get it ready. I would like to take a motion, put it on the record, 9 minutes early. Knock on wood, may not happen for a while.
>> MINTA LIVENGOOD: Motion by Minta Livengood.
>> DEBORAH SHOEMAKER: Second by Minta for motion to adjourn.
>> JULIE KORICK: Second, Julie Korick.
>> DEBORAH SHOEMAKER: It is always a good day when Minta is on the call. All in favor of adjourning.
>> Aye.
>> DEBORAH SHOEMAKER: Alright. I assume there is no nays. Have a wonderful day. Enjoy your time with your loved ones of choice and enjoy your time here at the rest of this month. See you in a couple weeks. Take care.