7/24/2025 Medical Assistance Advisory Committee Meeting Minutes

ATTENDEES: Anthony Abrams, Morgan Baker, Valerie Barnes, Anna Barone, Daniel Bates, Ellan Baumgartner, Kara Beem, Angela Biesecker, Kara Blasiak, Brittany Blythe, Amy Boyd, Sonia Brookins, Jamie Buchenauer, David Burnett, Ashton Burrell, Jolene Calla, Nikida Capasso, Andrew Centrone, Sam Chanek, Jen Cornman, Kathy Cubit, Andrea D'Angelo, Jayden Demmy, Sam Denisco, Deanna Dijer, Barbara Dunn, Richard Edley, Carl Feldman, Nicole Fidler, Kyle Fisher, Misty Fleming, Brandy Flickinger, Nicholas Focht, Marian Frattarola-Saulino, Michelle Fowler, Craig Gimbi, Janel Gleeson, Joseph Glinka, Mark Goldstein, Candy Graham, Elise Gregory, Mike Grier, Mia Haney, Rebecca Hathaway, Brett Hayes, Teri Henning, Anthony House, Paulette Hunter, Aniam Iqbal, Jeff Iseman, Matthew Johnson, Narender Kaur, Emily Katz, Mary Kelleher, Eric Kiehl, Erik King, Daphne Knapp, Julie Korick, Sally Kozak, Hannah Kranz, Jackie Kreshock, Andrew Kunka, Tom Lacey, Rob Lattin, Marissa LaWall, Mason Lee, Anita Lewis, Eve Lickers, Dylan Lindberg, Minta Livengood, Becky Ludwick, Brinna Ludwig, Pam Machamer-Peechatka, Patty Mackavage, Kathy Makara, Juliet Marsala, Rebecca May-Cole, Andrea McCague, Nathan McClellan, Russ McDaid, Julie Mochon, Sun Moon, Denise Moore, Ted Mowatt, Kevin Mulcahy, Sameerah Newsome, Jennifer Newman, Jazmin Nixon Cartwright, Chiamaka Nnamani, Randolph Nolen, Katie Noss, Chloe Palm-Rittle, Jacqueline Penrod, Mara Perez, Rhashidah Perry-Jones, Laura Piontkowski, Barbara Piskor, Jennifer Poole, Natasha Powell, Kelly Pullen, Kyle Purchase, Janell Reagan, Ashlee Reick, Annmarie Robey, Michele Robison, Ann Roque, Pam Rotella, Margaret Rybinski, Fady Sahhar, Theresa Sayce Goldsby, Kathy Scott, Naomi Shaffer, Jim Sharp, Deborah Shoemaker, Jason Shoemaker, Caleb Sisak, Jennifer Smith, Kendra Snuffer, Jason Snyder, Paula Starnes, Kimberly Steltz, Tyush Thomas, Lindsay Townsend, Marriam Wafa, Jared Walker, Chad Wallace, Adrienne Walnoha, Nick Watsula, Lloyd Wertz, Jessica Wilkerson, Erin Wyse, Anne Yanikov, Nick Young, Gwen Zander, Becca Zelner, Starell Zoric, Kelly (Captioner)

>> ELISE GREGORY: Good morning and welcome to July edition of the Medical Assistance Advisory Committee (MAAC) meeting today. Today is Thursday, July 24, 2025. My name is Elise Gregory, a Human Service Analyst Supervisor for the Office of Medical Assistance Programs (OMAP). Before we begin the meeting, I'd like to go over some housekeeping items. This meeting is being recorded; your continued participation in this meeting is your consent to be recorded. If you do not wish to be recorded, you may end your participation in the meeting at any time. Per the federal regulations, we are required to document public attendance for meetings and organizations people represent, if applicable. Please make sure you sign the sign-in sheet located at the table in the front of room. CART (Communication Access Real-time Translation) Captioning is available and set up on the right side of the room. The captioner is documenting the discussion remotely it's important for the people to speak directly into the microphones provided and speak your name and speak slowly and clearly or the captioner may not be able to caption the conversation. Also, speak clearly into the microphone so people can hear you and for those participating in the webinar. The link for CART is in the chat for those on the webinar. In the event of an emergency, the evacuation procedures are posted on the walls next to each exit door. To help avoid disruptions please remember

all devices must have their sound turn off and microphones muted. During the public comment period the microphone will be facilitated by a team member. Please raise your hand and we will bring a microphone to you. Please state your name and the organization you represent clearly. Public comment is limited to 3 minutes per person. Representing the Department of Human Services (DHS or the Department) today from OMAP Deputy Secretary, Sally Kozak. From the Office of Income Maintenance (OIM), Director for Bureau of Policy, Carl Feldman. From the Office of Long-Term Living (OLTL), Deputy Secretary Juliet Marsala. From the Office of Developmental Programs (ODP) for the Bureau of Policy and Quality Management, Julie Mochon and from the Office of Mental Health Substance Abuse Services (OMHSAS), Deputy Secretary Jennifer Smith. If you have questions related to this meeting or need information, please visit the MAAC committee webpage and I'll pass it over to the MAAC Chair, Ms. Sonia Brookins. Yes, good morning, everyone.
>> SONIA BROOKINS: We are going to start with roll call this morning. I'm Sonia Brookins, the chair of MAAC.
>> KYLE FISHER: Good morning, Kyle Fisher with the Pennsylvania Health Law Project (PHLP) counsel with the Consumer Subcommittee (ConsumerSub).
>> CHIAMAKA NNAMANI: Chiamaka Nnamani, Pediatrician and owner of Franklin Pediatrics.
>> TED MOWATT: Ted Mowatt, Warner Associates, Member.
>> MIKE GRIER: Good morning, everyone. Mike Grier, the Pennsylvania Council on Independent Living.
>> JOE GLINKA: Apologies, Joe Glinka. First day as vice chair of the meeting I am late. Thank you. Joe Glinka, Vice Chair of MAAC and the Director of Health Choices for Highmark Wholecare. Good morning. (feedback)
>> SALLY KOZAK: Sally Kozak Deputy Secretary, with the OMAP.
>> EVE LICKERS: Eve Lickers, with the OMAP.
>> SONIA BROOKINS: On the web. [in audible]
>> DEB SHOEMAKER: Deb Shoemaker, the Fee-for-Service Subcommittee chair a representative of the Pennsylvania Psychiatric Leadership Council, which is the community psychiatry group, and also a family member. Good morning.
>> KATHY CUBIT: This is Kathy Cubit from the center for advocacy from the rights of interest for elders. I chair the LTSS (Long-Term Services and Supports) Subcommittee of the MAAC. Good morning, everyone.
>> MINTA LIVENGOOD: Minta Livengood. Co-Chair of ConsumerSub
>> RUSS MCDAID: Russ McDaid, WRMC Strategies.
>> MIA HANEY: Mia Haney, Pennsylvania Home Association (PHA).
>> RICHARD EDLEY: Richard Edley with RCPA (Rehabilitation & Community Providers Association).
>> NICHOLAS FOCHT: Sorry. Go ahead.
>> MARK GOLDSTEIN: Mark Goldstein, Pennsylvania Dental Association.
>> NICHOLAS FOCHT: Nicholas Focht, AccuCare Home Nursing.
>> NICK WATSULA: Nick Watsula, with UPMC. (feedback)
>> SONIA BROOKINS: Is that it on the web? Okay.
>> BECCA ZELNER: Greenlee Partners.
>> ADRIANA MALENA: Adriana Malena, Greenlee Partners.

>> CHLOE PALM-RIDDLE: Chloe Palm-Riddle, Greenlee Partners.
>> LLOYD WERTZ: Lloyd Wertz, Pennsylvania Psychiatric Leadership Council.
>> DEANNA DIJER: Deanna Dijer Strong Minds, Bright Futures coordinated by Children First.
>> BARBARA DUNN: Barbara Dunn Strong Minds, Bright Futures coordinated by Children First.
>> ANDREW KUNKA: Andrew Kunka, Director of Government and External Community Affairs, Community Behavioral Health in Philadelphia, Philadelphia's Behavioral Health Managed Care Organization.
>> JULIE MOCHON: Julie Mochon, ODP.
>> ROB LATTIN: Rob Lattin, Bayada Hearts Homecare.
>> MARISSA LAWALL: Marissa LaWall, PHLP.
>> BRITNEY BLISA: Britney Blisa, prosthetic user and the Law Orthotist Prosthetist with Harry J Law & Son.
>> MATT JOHNSON: Matt Johnson, Physical Therapist Hanger Clinic.
>> NATE MCCLELLAN: Nate McClellan, Office of Senator Tartaglione.
>> JEN CORNMAN: Jen Cornman, UPMC.
>> CALEB SISAK: Caleb Sisak, Bravo group.
>> JASON SYNDER: Jason Snyder with RCPA.
>> STEVEN KOZO: Steven Kozo, AmeriHealth Caritas, Keystone First.
>> JULIET MARSALA: Juliet Marsala, Deputy Secretary OLTL.
>> JEN SMITH: Jen Smith, Deputy at OMHSAS.
>> JAMIE BUCHENAUER: Jamie Buchenauer, Chief of Staff, OMAP.
>> CARL FELDMAN: Carl Feldman, Director of the Bureau of Policy within OIM.
>> MICHELE ROBISON: Michele Robison, Director of the Bureau of Fee-for-Service Programs within the OMAP.
>> LINDSAY TOWNSEND: Lindsay Townsend, Human Service Analyst Supervisor, OMAP.
>> PAM MACHAMER-PEECHATKA: Pam Machamer-Peechatka, Policy Division Director in OMAP.
>> ERIN WYSE: Erin Wyse, Human Services Analyst with OMAP.
>> ANTHONY ABRAMS: Anthony Abrams, Human Services Analyst with OMAP.
>> BRETT HAYES: Brett Hayes, Human Services Analyst with OMAP.
>> SONIA BROOKINS: Thank you all for coming. I just want to take this time out to thank Debbie Shoemaker for all she's done for this committee and all she'll continue to do. We appreciate all your service, Debbie, I just want you to know that from me.
>> DEB SHOEMAKER: Thank you, Sonia, right back at you.
>> SONIA BROOKINS: All right. Did everyone have a chance to review the minutes? If not, no corrections, can I get a motion to accept the minutes?
>> JOE GLINKA: Move to accept the minutes.
>> MIKE GRIER: Second.
>> SONIA BROOKINS: All in favor?
>> MULTIPLE SPEAKERS: Aye.
>> SONIA BROOKINS: Any abstentions? (no answer) So, moved. Thank you very much. Next is OMAP.
>> SALLY KOZAK: Ok. If I put this right mic right here can the hear me? Okay, good.

Good morning, nice to see everyone in person. The main topic we have today is the federal budget HR (House Resolution) 1, Reconciliation Act or some people call it OB3 (One Big Beautiful Bill Act). Before I talk about that, I just want to give an update on where we are at the state budget. As you know, the General Assembly has not enacted the 2025-2026 budget into law. The Governor's Office continues to negotiate with leaders in both the House and Senate to finalize the budget fiscal years for 2025-2026. The Office of Budget put steps in place to enable the Commonwealth (Commonwealth of Pennsylvania) to meet its legal obligations to fund certain mandated programs and provide for the health, safety and welfare of residents. Examples of programs where payments are not (inaudible) include Medical Assistance (MA), the Cash Assistance, food and drug [purchases space facilities], Medicare Parts A and B buy-in as well as childcare subsidy payments. So that's the (inaudible) most recent information I have. In terms of the Federal Reconciliation Act, we know there were significant changes made to the Medicaid Program that impact not only the individuals who are eligible for Medicaid, but also how we fund the program. There were also changes to SNAP (Supplemental Nutrition Assistance Program) Program. I not going to talk about those changes to the SNAP Program. OIM is more familiar with that than I am and Carl, I don't know if you have anything on your talking points about SNAP, if not, we'll make sure to do that at some point in time. (feedback) As far as the Medicare program.
>> (UNABLE TO VERIFY SPEAKER): Sally, there's significant feedback making it very hard to hear.
>> ELISE GREGORY: If anyone in the room has the webinar open, please mute your mics and turn your volume down on your laptop if you have it open. We are actively working on trying to fix that problem with feedback. We apologize.
>> SALLY KOZAK: Sorry about that, we'll get it fixed shortly. In terms of Medicaid, we cover over 3 million Pennsylvanians that's about 1 in every 4 Pennsylvanians. There are 1.3 million children in the Medicaid Program and 423,200 people with disabilities. About 312,000 individuals here over 65, and nearly 10,000 veterans. So that just gives you an idea of the size and breadth of the Medicaid program. Federal cuts will kick over 310,000 Pennsylvanians off their health care, which in turn will raise health care costs and threaten the closure of at least 25 rural hospitals. The cuts to Medicaid will have devastating impact on the Commonwealth and the economy and its residents. The law OB3 or HR1, includes two main provisions the Department of Human Services estimates will cause more than 310,000 Pennsylvanians to lose Medicaid coverage. The first requirement is the work requirement.
We estimate about 200,000 Pennsylvanians will lose coverage because of new work reports requirements for beneficiaries ages 19 to 64 that require them to work, attend some type of education or volunteer for at least 80 hours per month. The second requirement that was in the legislation is for 6 months redetermination. We estimate this will impact about 110,000 individuals. These individuals are at risk of losing coverage because of the hassle of twice-yearly eligibility checks rather than the prior annual recertification, which means they will have to go through the entire redetermination process again.

In addition to potentially causing over 310,000 people the loss of their health care coverage through Medicaid the law imposes unfunded federal mandates on Pennsylvania without providing any new flexibilities. So, for example, to redetermine eligibility every 6 months instead of just once a year, we estimate that we will need to increase staff by about 500 and that's an estimated cost of $37 million per year. Implementing new work requirements would require a staff increase of about 250 with an estimated cost of $18 million dollars per year. Because of cuts to the way Medicaid is funded, Pennsylvania will also be forced to alter how it funds the Medicaid program. Changes to the provider taxes that is a start in fiscal year 28-29 are estimated to cut more than $20 billion from Pennsylvania Medicaid funding over the next 10 years. For those that aren't familiar, provider taxes are the funds that go directly to the hospitals and other critical providers to support access to acute and emergency services and especially in communities that see a higher number of Medicaid recipients. So, these are our supplemental payment that is a go to our critical access hospitals. Our safety net hospitals and our rural hospitals. Because hospitals are legally required to provide care regardless of the person's ability to pay under EMTLA (Emergency Medical Treatment & Labor Act) stripping Medicaid from Pennsylvanians will lead to greater rates of uncompensated care in emergency rooms across the state, especially in rural areas which rely heavily on revenue from the Medicaid program. In turn, this uncompensated care will raise health care costs for all Pennsylvanians, including those with private health insurance.

Currently we have at least 25 rural hospitals in Pennsylvania that operated at a deficit and are struggling to keep their doors open. This fall will worsen a dire situation and the inclusion of $50 billion national funds to stabilize rural hospitals is a “drop in the bucket” compared to the devastating cuts expected to hit rural areas. When rural hospitals close, it's not just a health care crisis it's a job crisis, a delay in EM (Emergency Medical) services and a public health safety issue.

These health care cuts will reduce access to health care especially for children, older adults and veterans and working families. This will lead to delays in enrollment, increase of administrative cost for the Commonwealth, disruptions in care, increased use of uncompensated ER (Emergency Room) and inpatient hospital services, and delays in treatment for or exacerbation of conditions for things like diabetes and heart disease.

You may have heard that many of these cuts will eliminate fraud, waste, and abuse, and they will not impact individuals. The Shapiro Administration is already taking action to eliminate fraud, waste, and abuse and minimize the impact of the health care cuts and keep Pennsylvanians covered. We are working with stakeholders and advocates who help Pennsylvanian’s who will be affected to prepare for the changes and know what they need to do to do to maintain the Medicaid coverage.

Program integrity is a cornerstone of our program for years. Every Medicaid applicant in Pennsylvania must prove their citizenship or specific lawful immigration status upon submitting an application for Medicaid coverage, except in certain life-threatening emergency cases. The Department reviews every Medicaid applicant in a thorough review process that has more than 10 distinct verification checks including citizenship status. Citizenship is verified through data exchange with the federal Social Security Administration. If the lawful resident does not have a Social Security number, the Department confirms a legal status by checking the database from the Federal

Department of Homeland Security U.S. Citizenship and Immigration Services. Pennsylvania ranks number 1 nationally in the number of Medicaid fraud charges filed against bad actors and 3rd overall nationally in the number of convictions secured. This success is only possible because of the hard work and dedicated staff and the Department's Bureau of Program Integrity, which offers a comprehensive fraud prevention and detection system to preserve Medicare resources for people who need it and to reclaim taxpayer funds.
The Department plans to do direct outreach to impact the Pennsylvanians through additional mailings and emails and texts like we did in 2023-2024 with annual Medicaid eligibility checks restarted after the federal COVID-19 Public Health Emergency ended. We will produce communication material that is a can be shared broadly with partners like legislators, our managed care organizations, health care providers, advocates, community groups and other stakeholders. Our goal is to build a unified message to help Pennsylvanians understand and prepare for the changes ahead. So that is a summary of the impact of what we can expect from HR1 or OB3 in terms of Medicaid. Questions?
>> SONIA BROOKINS: Question, Go ahead.
>> JOE GLINKA: Joe Glinka, thank you for that. I heard in my travel this week in Maryland, their MAAC is highly engaged in with working with the state partner. I don't know all the details to that. Just wanted to take your temperature on that or any thoughts about having this body being in more contributory in the Department separate to work through this road mapping, implementation because there's so many of us are going to be impacted by this. Just a thought. If there aren't any thoughts right now, I would be interested in having that conversation at some point. (feedback)
>>SALLY KOZAK: I'll say this. Clearly, MAAC, you guys are our main spokesperson for our recipients and beneficiaries and the advocacy groups. So, we certainly welcome input. We hope, you know we will embrace an opportunity to collaborate with you. We will certainly outreach to other partners. But yes, absolutely. No reason that you folks should not expect that you can't work with us through this process. That includes the other Subcommittees that we have as well. I know we have OIM, Long-Term Care (LTC), OMHSAS and ODP. We all have our own Subcommittees, and we welcome the input from everybody.
>> SONIA BROOKINS: We said during the ConsumerSub that we all will welcome everyone to participate in helping the Department. So that's number 1 on our list for everyone to participate because it will affect everyone.
>> CHIAMAKA NNAMANI: Thank you very much. That was very helpful as a pediatrician and provider in a rural PA (Pennsylvania) and Franklin specifically, just wondering as a health care provider, "what we can do?" I am very Medicaid heavy so that's a large part of the population. I'm in primary care, not hospital, but wondering how we can prepare our patients for that and any additional suggestions you may have.
>> SALLY KOZAK: So, clearly, communication to the Medicaid beneficiaries is going to be extremely important so folks know what to look for in the mail and to know to respond in order to be able to maintain their eligibility. One of the things that we've come to recognize, especially during the unwind, is over the years the Department has done such a good job of destigmatizing Medicaid, which was their goal, the people now don't recognize they are on Medicaid. Instead of getting that old paper blue card that

says Medicaid, you now have a card that says UPMC or Keystone or Highmark or Geisinger or United or Health Partners. So, when you talk to people and say, where do you get your health care coverage? Oh, I get it from plan “X”, not that I get it from Medicaid. A lot of times people don't realize they are even on Medicaid. So as we move through this process, we need to make sure that people understand that their health plan, Highmark or Keystone or United is the state's MA Program, which makes it even more important they need to pay attention to the information that is coming out of the County Assistance Office (CAO). Carl, I think you guys started that pink campaign, right?
>> CARL FELDMAN: The renewals are all now in pink envelopes to stand out.
>>SALLY KOZAK: Yeah. So, we will need help from all of our partners, providers, community-based organizations, anywhere a recipient would have a point of touch to keep sending that message. Because if you are enrolled in one of these plans, you need to redetermine every 6 months. So be on the lookout and there are avenues for assistance if you need help in reading the information. But if you don't complete the information in a required time frame you potentially stand to lose eligibility. We believe that's going to be a significant barrier and that we’re going to lose about 110,000 people during that process, potentially.
>> SONIA BROOKINS: On the phone.
>> DEB SHOEMAKER: Hi, this is Deb Shoemaker. Sorry I'm not there in person, But mine is more a comment. I want to formally thank the Department. I know there are people as working as much as chair in the past and working with you for the longest time, Sally, and everyone there at your staff. You are all super dedicated and have been dedicated. We’re here sharing the mission, whether we are providers, families and whatever the case might be. I wanted to formally thank you, and again reiterate we are here to support you and to help in any way possible. We appreciate everything you do to stick your neck out for all of us as families and consumers. So, I just wanted to formally thank you for that. Let you know that we are in here with you. Anything that we can do to help we'll do it. I was joking with someone who said I will sell hoagies and do artwork if we need to do that. I wanted to thank you for all your hard work and continued hard work.
>> SALLY KOZAK: We appreciate that. Thank you, Deb.
>> RICHARD EDLEY: This is Richard, can you hear me?
>> SONIA BROOKINS: Yes.
>> RICHARD EDLEY: Okay, great. I just wanted to follow up on what Joe Glinka said earlier and really the request, Sally, and others would be if there's a way for the Commonwealth to be a bit more intentional about stakeholder involvement. Specifically in the group we have providers, consumers, families, the insurers and MCOs (managed care organizations) and others that I think could help in terms of thinking through how we do a determination process and the work requirements and rather than where all the recipients, here's how we are rolling it out and all of us in this meeting say, wait a minute, this won't work. Maybe we could be involved in a work group in a formal way and that would be my hope or recommendation and just to give the thoughts. Thank you.
>> SALLY KOZAK: Yeah, so thanks for that, Richard. Let me just say a couple things. You know, the committee has the opportunity to structure this as a working session. If

you would like, it does not have to be a forum where I come and talk at you. It doesn't have to be a forum where the other deputies come and talk at you. You can structure it into a working group. It's your committee, and as I said, we appreciate, and we want the input. I don't want to speak for the other deputies, but I'll guess maybe they would be open to this type of suggestions for some of their subcommittees as well. So, I think there are a lot of avenues for people to participate via the recognized committee that is we have. The Department is always open to receiving written suggestions, written I get letters, so please feel free to send me letters with what you think the communication needs to be. We also have some other committees that meet regularly. So those are avenues. If you think those there are additional opportunities and additional avenue, please suggest those to us. But I encourage to everybody to use the current avenues we have in place.
>> SONIA BROOKINS: Anyone else on the phone? Joe, then Andrew and Lloyd.
>> ANDREW KUNKA: Thank you Andrew from Community Behavioral Health and our Senior Director of Communication and Government Affairs is joining us by phone, Rashida Perry-Jones. We appreciate this update. It was very thorough with all the numbers, and I think all of us, including the Behavioral Health Care Managed Organizations are trying to think about the impacts and the numbers. We know that everything is very fluid. We are waiting for guidance from CMS (Centers for Medicare & Medicaid Services) and there are so many moving parts. I just wanted to ask a few questions and you may or may not know.
So we know the only report we've seen so far released from the Governor. Some of the numbers sounded very similar was released when the House Bill came out based on the provision of the House version of the Bill, which subsequently changed with the Senate version that was ultimately passed. I just wanted to ask like if the numbers that you gave like what the primary source is? And if there's any expectation that updated numbers or if these numbers are updated will be released at the statewide level as well as the county level? Because we know the Governor's report included county level estimates on loss. If we are expecting anything like that.
Also, if there's any sort of timeline around what this captures. I think many of us have seen the Governor's report and I wasn't sure, you know, is this was over the course of the full act implementation. The act is implemented up to what, I think 2035, some provisions. We are looking at a 10-year course, but we know the majority of these eligibility provisions are going in the end of basically January 1, 2027 and then the provider tax provision, you know, over that 3-year base period. But if you could provide context on the sources. Maybe the time period of this particular estimates are and if there in fact will be additional estimates and information provided to help the Medicaid Assistance stakeholder community plan and respond to this significant change in the program?
>> SALLY KOZAK: Yeah. Thank you for that. The numbers that I gave you were based on the current numbers of individuals enrolled in the program and based on our experience public health emergency timeline and our experience. (inaudible)
>> SALLY KOZAK: I would say this (inaudible) during the course of the legislation, I don't want people to think we weren't doing analysis, but we were using our resources officially. So instead of spending a lot of time doing analysis on some kind of change today and a different number came out tomorrow and a different number came out

tomorrow. We waited until everything was actually enacted before we started doing some of that. So, we are working on those analysis. As the information becomes available, we will share it with people.
I will also share with you that even though the bill has been finalized we know there's been legislation introduced to at least repeal some of what was in the bill. CMS has also not issued guidance on how they will implement some of these things. So, until we get the absolute final it's hard for us to say this is the actual impact. We don't want to create a lot of panic by throwing numbers out there that were wrong. The numbers I gave you today we are confident based on past experience, but we need to continue to look as we go forward. We will share that as it becomes available. I will also say this, if you go to our webpage our data statistics and research, we have all kind of information out there that goes down to the district level, county level, state level. You can roll it all up. The information that's out there the charts and graphs and all the data books are user friendly. I mean, I went out there and figured out what my local representative district looked like. So, I would encourage you to check there. That information is continuously updated.
>> ANDREW KUNKA: So, with this information presented today from the Governor's latest report or from the unwinding numbers?
>> SALLY KOZAK: No, the numbers were based on our experience.
>> ANDREW KUNKA: So, it was based on that. But the numbers today were based on the Department’s experience from the unwinding?
>> SALLY KOZAK: They are based on the current numbers and how we calculated them. Based on our experience from the [overlapping speakers]
>> ANDREW KUNKA: They are based on the current, what we know as current legislation that was ultimately passed?
>> SALLY KOZAK: Yes.
>> ANDREW KUNKA: Okay, okay. I appreciate that clarification.
>>LLOYD WERTZ: Psychiatric Leadership Council and I'm so proud that Andrew asked the very question that I was about to pose. That's good news. I did have a backup though, (laughter) I know it's shocking. Is it OMAP still planning on going forward with the RFP (Request for Proposal) for the MMIS (Medicaid Management Information System)? Is that still in process?
>> SALLY KOZAK: The MMIS has been in process for some time. I'm more than happy at some point in time to do a whole presentation on that but we have gone to a modular approach. There are about 8 modules, if I'm not mistaken. We have already reprocured and are implementing about the modules already.
>> LLOYD WERTZ: Thank you very much.
>> SALLY KOZAK: Sure.
>> SONIA BROOKINS: Anyone else?
>>JOE GLINKA: I appreciate Richard chiming in on what I mentioned before. Although I represent an organization who operates in the OMAP space, putting this hat on, these changes are going to impact all HealthChoices Programs and this body has representation from the planned side, advocate, systems side, and so forth. So, Sally, really appreciate the suggestion. Maybe we take one of these sessions or more and use it as a working session, considering the intellectual capital housed within this committee. The other thing too and this is part of maybe an advocacy effort. If gap in coverage is

not just a gap in coverage. A gap in coverage is a gap in care. A gap in care is going to lead to exacerbated conditions that when a person finally comes back onto their respective plan now it's the plan's responsibility as long with the provider partners to address issues that were exacerbated during that process and may be more costly involved to solve for. So, there's a lot at stake in this conversation. Which is going to transcend over a 10-year period of time, depending on what other legislation might be. I just want to offer that commentary in case you find it helpful
>> SALLY KOZAK: Thank you.
>> SONIA BROOKINS: Thank you. What we'll do is get together as an executive committee and a work committee. Yes?
>> DEB SHOEMAKER: Sonia, this is Deb. Quick question. It’s not a quick question but relatable. When you said, Sally that you could do a presentation. Because and this is somewhat piggybacking on Joe's but not really. Joe they were talking about the people that are going to lose their care and other things. I know we had the presentations on the housing and some other things which would be more crucial, all the social determinants, people are losing their coverage. But it would be really helpful to get a better sense on how we can have some of those services or support services if they are still going to be funded and some things that I know unfortunately. I don't want to take time to do that, but I know certain things are not mandated like dental and other things that are important, but do they fall by the wayside since they are not mandated coverages? But I agree that anything that we can do to have information about housing and have information on all the thing that is a need to happen for people on a normal basis who are going to have an additional barrier to that, including job finding a job when they can't even afford their rent or prescriptions. So, I do again, I commended you for all the hard work and we are here to work with you. I think any information we can get in these presentations about the other services or maybe services that people aren't aware of that they can finally take advantage of because they need too.
>> SALLY KOZAK: Yea, No. Absolutely. We'll be happy to do that.
>> SONIA BROOKINS: Okay, we have to move on, I know this stuff is very important and I know it's a little late so I'm letting this go on because this is very important to all of us. Next on the agenda is Carl.
>> SALLY KOZAK: Let me just real quick GLP-1 (Glucagon-like Peptide), the prior authorization criteria is in review. When they get approved, we will make sure that everybody is made aware.
>> CARL FELDMAN: Hello, good morning. This is Carl Feldman, Director of the Bureau of Policy within the OIM and I'm happy to be here with you today in Harrisburg. Maybe a good time to go over that information that Sally alluded to regarding the SNAP components of the HR1, One Big Beautiful Bill Act, whatever we are supposed to call it now. Let me see. I have it, yes, thank you. Give me a moment here, please.
As was mentioned there's significant impact to the SNAP Program that cannot be denied. I think much of what was said prior to the passage of the bill can largely be reiterated as mentioned earlier it changed somewhat over the various version that is a came through the Senate and was ultimately passed into law. In Pennsylvania we have about 2 million people who receive SNAP. SNAP is the most effective anti-hunger program in the nation. It is the work of the food bank and pantries although we feel this is a critical component of the social safety net too. We provided $366.8 million in

benefits in December of 2024 alone and overall there is expected to be a significant reduction to the SNAP program as a result of the law.
So, the first thing that is worth mentioning is the final version of the law passed into effect, although not effective immediately a change in the way that administrative funding is apportioned to the SNAP Program. We had a 50/50 state federal match for administrative cost for a very, very long time. This law changes that from 50/50 to 75/25. 75% of the cost is borne by the state and 25% of the cost is borne by the Federal Government. That's administrative costs. There's also cost sharing on the benefit side, which is new. The SNAP Program is 100% federally funded in its benefits. It actually functions a little bit like a credit system. But now the states will be on a somewhat convoluted sliding scale, cost share structure for those benefits.So, for states with an error rate, payment errors are when someone is overpaid. When someone is underpaid. When someone is paid when they shouldn't be. When someone didn't get a benefit when they should have or possibly procedural errors that are head made in the case which is a common occurrence. Which we don't like to see happen. It doesn't impact the payment and is certainly not necessarily fraud. When it's over 6%, the states shoulder some of that costs. So, that's really never been the case before. Pennsylvania's error rate from 2024 was 10.76% which improved 6 percentage points of the previous error rate of 2023.The cost shift is supposed to take effect in 2027-2028 and based on the 2026 SNAP error rate. To give you a sense what that accounts for it's over $660 million annually. So, a large, large portion of funds and that's beyond the admin funding piece that we talked about. Together when you put it all together, we are looking at a potential cost of Pennsylvania taxpayers of $785 million dollars and you may have seen the Governor's statement that we cannot back fill those costs. This is new costs out of whole cost. So, this is going to have a big impact on retailers. Probably we're estimating around 10,000 grocers and retailers are going to feel this and the SNAP is a huge producer if for economy, it generates over $474 million in grocery wages, more than 12 thousand grocery industry positions all around the state, where a Big Act state no small part. That's the upfront cost I think we can expect and there's so much to say about the eligibility changes that we haven't even touched yet. I think I'll leave it there to talk about the SNAP component from the top.
>> MIKE GRIER: This $785 million is annual figure?
>> CARL FELDMAN: That's admin and cost share if we were faced with both of them.
>> KYLE FISHER: Beginning 27-28?
>> CARL FELDMAN: Yes.
>> KYLE FISHER: Thank you.
(FEEDBACK)
>>SONIA BROOKINS: Any questions for Carl?
>> CARL FELDMAN: If no, I can speak about some of the general processing information I share here with all of you. I'll share that for the month of May, the most recent available month we have information on our average day's process for Medicaid was 12.7 days and that's no change from the previous month. Same waiver was 17.7 days, that's about 1 day longer than the previous month. LTC was 18.6 days, which is one day longer than the previous month.
Then to look at timeliness, completing these reviews in 30 days. Medicaid was at 99.5% rate statewide, which is the same as it was in April, waiver at 99.1% statewide, which is

the same as it was in April. LTC at 97.3% statewide, which is down 1% from April. I have some information on a compliment fill as well. I can give you this information statewide and Philadelphia and Allegheny are our two largest jurisdictions. Statewide we're at 92% compliment fill. In the city of Philadelphia we are at 80% and Allegheny County we're at 89%. I believe it was asked yesterday, just generally gives us sense of what the trend has been. The trend is not positive at this current point in time. We had 425 vacancies in May and we have 524 as of last Monday. There's fluctuation based on the time of the year when people choose to leave Commonwealth Service, when people choose to leave positions for reasons we don't really know but it seems to follow this trend. If you are asking us what's this trend at this current point in time it's not necessarily the best trajectory.
>> JOE GLINKA: Carl a question. You mentioned earlier in a meeting potentially 750 people would be brought upon for work requirements and the redetermination, and then what about these vacancies? Does it also have to be filled in addition to the new complements that is happening?
>> CARL FELDMAN: (inaudible) I mean, we operate hoping to fill all the vacancies that we have. I'm sure all the agencies do that and so the estimate on how many additional workers it would take to do this, that would be above and beyond what we have now. I don't think anybody here can say anything. Those of us from the Commonwealth about whether that's going to be possible. I think the point in making that claim is that we have done the analysis to try and figure out, well, how much work does it take to do some of these things and quantify what that amount is and the number is what we provided you. But I think everyone knows it just means it's a lot of work. We only have the staff that we have. It's not yet clear how that delta will be resolved.
>> SONIA BROOKINS: Anyone on the phone have any questions for Carl?
>> KATHY CUBIT: This is Kathy. I'm curious if you estimated your IT (Information Technology) costs. To make changes in the system that will be needed to meet the new requirements.
>> CARL FELDMAN: Thank you, Kathy. Yes, we are starting to do some of that analysis because you may know there's some components of the law that come into effect, technically immediately but from a functional standpoint they say October. I can't eliminate exactly what those costs will be but safe to say put it all together. All the significant changes, which being they are mandates we must do them. It's a lot of money. It's an enormous amount of money. It displaces other things we may otherwise wish to spend our limited resources doing. But Congress makes the law of the land.
>> SONIA BROOKINS: Before you give it to Andrew, How…when do you know…when do these cuts start? This year or next year?
>> CARL FELDMAN: There are elements of the law that come into effect immediately. But from a functional standpoint they don't take effect until September-October time frame. These are mostly on the SNAP side. Those are the ones that are most immediate from what I'm watching. The MA/SNAP eligibility component. I'm sure the IMAC (Income Maintenance Advisory Committee) will also be interested in talk about that.
>> SONIA BROOKINS: Ok, Thank you.
>> ANDREW KUNKA: Thank you, Sonia. I have a couple clarifying questions and thank you for that update. If I heard correctly the staffing vacancy rate in Philadelphia is at

80%. Does that mean it's 80% filled.
>> CARL FELDMAN: 80% filled.
>> ANDREW KUNKA: Okay, and I wanted to make sure I got this right. I believe last time you said it's 85%. Is there a reduction?
>> CARL FELDMAN: Our trend is not positive.
>> ANDREW KUNKA: Okay, so there's no reduction. I wanted to ask to reiterate the processing rates. I think you spoke about like the 99%, 30-day processing rate. So, I wanted to make sure I didn't know if there were different processing rates provide by county, or if you could repeat the 30-day processing?
>> CARL FELDMAN: Sure, I'll share that. The percentage of Medicaid applications completed within 30 days which is our standard at 99.5% statewide, which is the same as it was in the month of April. These are more May waiver at 99.1% which is the same as it was in April and long-term care was at 97.3% which is down 1% from April.
>> ANDREW KUNKA: Thank you so much.
>> SONIA BROOKINS: Anyone else?
>> CARL FELDMAN: Yes, I believe I received some requests to talk about some of the ways in which our notices are issued to people. Specifically, we gotten some very helpful example notices from PHLP indicating that people on CHC (Community HealthChoices) receiving notice that appears to be contradictory. What we can say is that we think there's some system activity that's driving these notices. We can't really detail further what that is and what would be required to alter it. We are still doing the research associated with that but we also know that the notices included, include also the accurate notice and necessary appeal rights associated with that notice. So, we are taking it seriously. We are doing our due diligence. We are trying to identify why these are going out and what triggers that and what it might take to change that. But we're not really able to detail what that is at this time.
>> KYLE FISHER: Carl, if I could comment there. We appreciate the conversation from yesterday's Consumer Subcommittee on this topic. Appreciate that OIM is working with the contractor to try and identify what is generating these notices. I think for purposes of broader dissemination it's important to realize some subset of non-MAGI (Modified Adjusted Gross Income) population in our experience has been entirely CHC participants ability notices. Multiple eligibility notices, one which says you continue to qualify for Medicaid but a managed care plan is changing. The other says, and you are getting these at the same time, you are no longer qualified, for whatever reason, income. They're flatly inconsistent and contradictory. The Department is trying to identify what is causing this so they can fix it but it's confusing for participants who get these notices. Some in our experiences have chosen to rely on the optimistic notice. It's sort a personality test of sorts. Half full, half empty, which one is these is accurate for clients who have not appealed those notices they're losing coverage despite having received a notice that says you continue to qualify for Medicaid. So, I think as a public service announcement of sorts if you have a client, participate or members of the health plan getting multiple notices. They should not take the optimistic view. They should assume the determination notice is the accurate one. Because that is in fact what is happening to their benefit. So, a lot of Departments are working to fix this, individuals who don't aggree with that determination should be careful to file the appeal in the time frame to not lose benefits.

>> CARL FELDMAN: The examples on what we have seen the termination of notice is accurate. I think we would say any time anyone receives information that appears to be contradictory, just call us. I understand that's not always the easiest thing to do. Our call center wait times over the course of last month have gone in the right direction. I think that we hope that will continue. But that would be my first suggestion to anyone who says well I got a notice one day that said, my plan ended but my Medicaid continues and maybe a week later I get a notice saying I'm not eligible. If that appears odd, they should call.
>> SONIA BROOKINS: In any the event they call and can't get through, you know how the offices are in Philadelphia, then what?
>> CARL FELDMAN: Well in Philadelphia, I think we have a lot of people who are able to approach a district office in-person. We are going to try and resolve that on the spot. We do the best we can to do that, I wouldn't advise everybody walk in the door. The phone is probably the more helpful way to do it. But the customer service center a lot of people still think to this day you need to call your CAO for something like this. The Customer Service Center has everything they need to give you good information about what is going on. They should call the Customer Service Center. I don't have the phone number in front of me. I feel like I should have it memorized by now and you may recall there's a separate phone number for the office in Philadelphia but that's the first call I would make.
>> CHIAMAKA NNAMANI: Piggybacking off that. You mentioned fairly, how about because I haven't seen one. So, when they get notices does the notice include call this if you remember for further questions or whatever, if they are not sure? I'm in rural PA. A lot of patients are not as educated. Some may not even comprehend. So how simple is the letter? How can they make next steps based on whatever the letter says?
>> CARL FELDMAN: The letter does include our customer service call line. They usually include the county system call line and I don't want to say they can't call a CAO but it's often harder to get a hold of someone at the CAO because a lot of processes are getting done there. I also won’t claim the notices aren't the easiest thing in the world to understand. We endeavor to continue to try to make them better but the phone number they need is on that piece of paper.
>> SONIA BROOKINS: Anything else?
>> CARL FELDMAN: I was asked to bring some information about income disregards for eligibility notices as well another notice component. This was brought to us by PHLP and MAAC by PHLP. I think what I surmised is PHLP is looking for eligibility notice to more fully detail the exact income threshold for eligibility on each notice. I would say that we do detail the eligibility threshold. The deduction being referred to as a 5% deduction, that occurs in certain eligibility determinations just does not present as a deduction for all eligibility determinations. It also doesn't reflect the income eligibility threshold. It is a deduction from that threshold. When it is put into effect it is included on the notice and again, maybe the notice could more discretely identify that particular item, but it is there, its present but It’s not always applicable to every eligibility determination.
>> KYLE FISHER: We had a fairly lengthy conversation about this yesterday. I won't rehash it. We appreciate you are looking into it. We can talk more offline. I think from a participant standpoint, and this is more of a consumer recommendation of the

committee and not just PHLP. It would be beneficial if the notes were clearer in terms of the relevant income threshold is with the 5% MAGI disregard as well. As they are now, I think it's misleading. Again, we can have more conversations later.
>> MATT JOHNSON: Matt Johnson from Hanger Clinic. Just a suggestion for the work group mentioned. Many of us are providers in the room and these patients and family will come to us to help them navigate. So, I think there's a vehicle to have providers help navigate the eligibility process and direct. We are vested in the community and vested to help these individuals out. They often look to our teams to help them understand and process it. So just a suggestion to make that part of the working group. We are happy to take part of it. We see patients regularly.
>> JOE GLINKA: That's a great suggestion. During the unwinding a number of MCOs were working with their providers to provide renewal information to the provider self and their outreach efforts to help in that encounter where you can say to that patient, hey, I see you come up with a renewal and place a reminder to them to prompt them to go through the eligibility process. I think that we are going to probably have to revisit a number of things deployed in the unwinding a little different context. But I think there were a lot of things that we found out during that process that could be helpful because it's getting information to people is one thing. But also prompting them to act in a timely manner so that we don't get to the gaps in coverage. We certainly can talk more about that offline. But I'm all on board with that.
>> SONIA BROOKINS: Anything else?
>> CARL FELDMAN: No, I don't.
>> SONIA BROOKINS: Thank you so much. Appreciate it. (feedback)
>> ELISE GREGORY: We are still having feedback issues so if your mic is open and you are not speaking, please turn it off. (feedback)
>> JULIET MARSALA: Good morning, everyone. Juliet Marsala the OLTL and I know we are a little behind schedule, so I'll be brief. If we go to the next slide, you are familiar with the agenda. We are going to go over just a couple things today. Our procurement updates, The InterRAI (Inter-Resident Assessment Instrument) and the nursing facility rate information and a couple updates. I'm certainly happy to answer any questions that folks might have. If we go to the next slide there are no new news on CHC so I think we can skip this; the procurement remains in a stay. I was pleased to hear about folk's discussions regarding utilizing committees for working on being involved with different changes and things of that nature. So, I'll give a nod to the LTSS Subcommittee because they are going to be involved in our InterRAI update. Can we move to the next slide on there?
So, the InterRAI upgrade evaluation the OLTL is kicking this off. So, it's in early stages of work planning. The InterRAI is used for the comprehensive assessment that informs person centered service planning within the community hearing loss choices LTSS services, so that's home and community-based services. Certain sub questions of the InterRAI, which is an internationally normed assessment tool is also used for our functional eligibility determination process. When participants are evaluated for eligibility into these LTSS programs. We used the 9.1.2 version since inception of CHC, which was back in 2018. Version 10 of the assessment tool was released in 2021. At that point in time the OLTL determined it was not the right time for us to move from 9.1.2 to the version 10 for numerous reasons. However, at this point in time, we feel the time is right

to move to the new tool. One of those reasons is because the 9.1.2 tool will be sunsetted with the InterRAI organization and no longer supported. We feel it's really important to have a tool that is continually supported and validated ongoing. So, we've begun to evaluate and prepare to upgrade to the 9.1.2 version to the 10 version. We anticipate we are going to be doing a lot of this work over the course of this next year with the hope of an implementation of July 1 of next year.
Again, very, very early stages, participants and advocates will be included in the work process and in that work planning. We have asked through the LTSS Subcommittee that participants and advocates who want to be part of those work groups as they get scheduled and get formed raise their hands and let us know, very pleased we had numerous volunteers for those work groups that will happen. So, the LTSS Subcommittee will be working very closely with the OLTL in this upgrade evaluation and implementation. We do not expect there to be functional eligibility determination changes that are material as part of this process. We want to honor the incredible amount of work that occurred when we set up the functional eligibility determination. It is our goal to kind of maintain that moving forward. So just wanted to provide that. We go to the next slide.
Also wanted to share with the MAAC that we had a significant change in the data element portion of our nursing facility cost methodology and reimbursement. So, on June 26, we provided testimony to the Independent Regulatory Review Commission also known as IRRC to address that change in the regulation from changing the data element from the RUG or the Resource Utilization Group to the payment driven payment model or PDPM (Patient Driven Payment Model). This is significant because the RUG will no longer be supported by CMS. They moved to PDPM. This is essential in the case mixed calculations for nursing facility populations that then feed into the nursing facility or rate setting process. The RUG classifies participants into groups based on their care requirements that allow for a more resource accurate resource allocation when we think about rates to ensure that nursing facilities are payments are tied into the complexities of the nursing facility residents they serve. The PDPM considered each participant's unique circumstances and addresses the acuity and aims to reimburse just what that individual needs. It's a different way that CMS set up these data elements to address sort of the acuity of populations served. So, since they are no longer supporting the RUG that would mean the RUG is not updated year over year. They have moved to the PDPM. So now too we are moving to incorporate the PDPM data element. Everything else on that structure remains the same. We wanted to make sure that folks knew that we made this change and the reasons for it.
As we talk about redeterminations, I know this training happened earlier this week. I'm still going to highlight it because I think the PA ABLE Savings Program for individuals with disabilities is going to be a critical importance for individuals. So, I do want to highlight that the OLTL routinely putting out training on the PA ABLE Savings Program. Go to the next slide. There we go. All right.
So, this is an example of information in a we push out through our Listserv in the OLTL. We do it with the intention for providers, community-based organizers, our service coordinators, it's our hope they then pick up this information and then spread it into the hands. So that individuals and communities know these resources are available. I'm going to make a plug if folks haven't signed up for the OLTL Listserv. It's important you

do so now because this is where we are going to push out a lot of information that we then hope gets expanded by our community members and providers to keep up-to-date with what is happening with LTSS Subcommittee.
We go to the next slide. All right for our sister agency the Department of Aging, we wanted to share this announcement related to the PA CareKit. The Office of Long-Term Living has worked closely and always worked closely with the Department of Aging. The PA CareKit is a collection of tools and resources and information that addresses key challenges in the caregiver journey. It's part of the Aging Our Way PA Master Plan on Aging. Where the Department of Aging was tasked with creating a dynamic interactive and comprehensive caregiver toolkit that will address key challenges faced on the informal unpaid caregivers. And we know there are millions of informal unpaid caregivers. I'm one of them. I expect everyone will also raise their hand as well. It provides practical solutions to support their entire caregiving journey. We pushed it out on our Listserv on June 2nd. So, there's additional information there on the PA CareKit, which includes a shareable one-page flyer that our community partners can also share and distribute. In addition, if you google "PA CareKit" and "aging" it should come up on your browser search page and also, the Department of Aging will be coming to the LTSS Subcommittee on August 6th to do a presentation and a walk through of that toolkit. So, I wanted to raise that here and invite everyone to join the LTSS Subcommittee meeting if you had an interest or had any additional questions. Keeping it short and sweet and opening it for any questions folks may have.
>> SONIA BROOKINS: Questions on the phone? Any questions on the phone? Hearing none, thank you very much.
>> JOE GLINKA: I have a question. Forgive the naivety of this question but I'm going to ask, InterRAI upgrade version 10 was out 4 years ago. Is there a version 11 at all in the pipeline that might make sense to go? I'm just asking.
>> JULIET MARSALA: Not that we are aware of. I think one of the benefits of us waiting is there were several upgrades and versions of 9.1.2 to 10 that we get to skip. So, there isn't an 11 that's rolling out that we are aware of at this point in time. I imagine there'll be different versions and upgrades of the 10. But at this point, I don't think waiting would be beneficial to wait for an 11.
>> SONIA BROOKINS: Thank you very much.
>> JULIET MARSALA: Thank you.
>> SONIA BROOKINS: ODP.
>> JULIE MOCHON: Good morning, everyone, my name is Julie Mochon the Director for the Policy of Innovation for the Policy of Programs and filling in for Deputy Secretary Ahrens. I'll try to be as brief as possible. Next slide. Some updates are regarding some amendments that will be effective January 1, 2026. We recently had those amendments out for public comment. About 140 people and organizations commented on the waiver. So, we appreciate anyone who commented because it's so critical to creating the best service system that we possibly can. So, some changes that we made based on public comment are we originally proposed there would be different tiers for our supports coordination organizations, who provide our supports coordination service or case management if that's a term that people are more familiar with. Based on public comment that all supports coordination organizations should offer the same service the same quality. Because everybody must have a supports coordinator (SC). We agree

and so, there’s are no longer tiers. All supports coordination organizations will have to have meet the same performance measures. Those will be phased in over time because there was a lot of anxiety, heartburn from the public about there were a lot of proposed measures and a lot of them were new. So, we will like this first year, this current year, they will be more of capacity building on the supports coordination organizations understanding their numbers, their baseline numbers. Then next year we would have expectations for the supports coordination organizations to increase these numbers from their baseline. In future years based on that data that we are getting we would set a state benchmark, then we would expect the supports coordination organizations to meet those benchmarks.

We also originally had proposed that supports coordination organizations would submit their documentation in August and September. Once again, quick. It's all new. We still, we are, you will see in later slides; we haven't published the final performance measures yet based on public comment. So, we did delay and push that submission period back to October 1st through November 1st to give them more time to prepare.

Next slide.

Then some other major changes to performance-based contracting. Based on the tier system we also had tiered rates for supports coordination organizations. So now that there are no tiers, all supports coordination organizations will transition to monthly case rates and no longer will have a 15-minute unit rate. Those payments, there'll be different payments based on the program targeted support management, which is people who are not enrolled in a waiver. They are usually on the waiting list. They are eligible for MA and there'll be two different tiers. There really is a lot of variation in people who received targeted support management, where some people get two visits from a SC a year and others who are talking to their SC weekly, monthly, those things. So, you'll see standard targeted support management and then that's one rate, intensive targeted supports management, and then our person family support waiver. When we look at the utilization, they were very similar. The community living and the consolidated waiver haves a yet different monthly rate. We didn't operate the two monthly and the 15-minute rate system because we heard from supports coordination organizations how it will it is to build a billing system. Let alone one that can handle two different rates, and the rate could differ from you could be in one tier one year and a different tier a different year and have different rates from year-to-year. So, we want we wanted to avoid those complications for supports coordination organizations.

The final major change we are making for supports coordination is we are adding a qualification standard for associate SCs and certain tasks they can complete. There are general college credit hours and experience requirements for SCs but we do know there are tasks that can be done by people outside of those requirements that we are going to build a different tier. It will kind of create a pathway for people to gain that experience. So once again this is just it's more of an outcome focused approach so the supports coordination organization is responsible for the individual assistance outcomes and the system will allow flexibility for how for supports coordination organizations to figure out how the work is completed and achieve that quality and those outcomes.

Next slide.

Then our next steps and this is where I am at full-time right now is we are submitting documents to the CMS in late July, which is now. So, by the end of this month, because

there's still several documents in process, we will submit the Targeted Support Management State Plan. The 1915(b)(4) that's the selective contracting waiver that allows us to do the outcome payments and allow us to kind of close the front door for new supports coordination organizations and then corresponding a 1915(b)(4) waiver doesn't exist on its own. It connects to the Consolidated, Community Living, and the Family Directed Support waivers. All of those will be submitted to CMS. We will publish, so those are kind of high level then all detail the documents will go. We have a webpage on my ODP dedicated to this. So, there'll be an implementation guide similar to what we did with residential services last year. There will be a toolkit and where you pay for performance structure. We will have training and technical assistance forums for supports coordination organizations starting next week on July 28th. We do have a performance analysis services vendor building the system that supports coordination organizations will use to submit their data and documentation in October through November 1st. Then, because that monthly rate payment changes and that's a huge change for supports coordination organizations. That's why it's not effective until July of next year. We want to bring together a work group of our supports coordination organizations to help us understand all of the ramifications and all of the impacts and what guidance we need to give and help we need to give to help supports coordination organizations make that change.

Then next slide, outside of performance based contracting we did also propose some additional changes. Some of them mostly we received positive feedback support for the changes. So, benefits counseling can be billed when the individuals, when working with the individual's representative payee that will go through right now it's just only if the individual is present, they can bill. So, this will open that up and expand it. Assistive technology there's a $10,000 lifetime limit that will be removed. The Community Living and Person-Family Directed Support waivers won't have a limit because there are annual limits on all services in those waivers. The Consolidated waiver doesn't have annual limit on all services so there'll be a $3,000 annual limit but an exception process we call it a variance process for people who need more than $3,000 a year. We also had changes to participant-directed services that will give safeguard the individual's health and wellbeing, and that will go through one of the changes -- next slide. That we did receive a lot of public comment on.

So, we made changes as a result of that public comment. Community participation support, in-home community support and companion are three of our top-used services. When we are out, and we are hearing from individuals and families they're also the service that people have the most difficulty finding providers to render those services for them and provide all needed services. So, we propose the providers of those services for serve a minimum of five people every year we did reduce that based on concerns we were hearing during public comment to three and then next slide because it's easier to try to explain it through a clarification. So new providers that would enroll after the waiver becomes effective in January, they would until have the following fiscal year to meet that standard. So, if they enrolled to provide one of the services in February of 2026. They would have until June 30 of 2027. So that means, they would have to meet that requirement no later than June 30 of 2027. So, it gives providers time and then providers, current providers currently enrolled to render these services, they would have through fiscal year 2026-2027. So that means the standard would be met no later than

June 30th of 2027. Also, we also clarify because there was confusion that if the provider renders any services under that same master provider index number, the MPI number, those will be counted. So if a provider was rendering residential services to four people but they only render community participation support to one person because that one person couldn't find a provider for some reason or they needed a specialized provider of that service, that provider would meet that requirement because they are serving four people through residential even though it's one through community participation support. So, these are all, that's it for the ODP. We can take questions.
>> SONIA BROOKINS: Anybody on the phone have questions?
>> RICHARD EDLEY: This is Richard Edley. Julie, I have two questions for you. One is very specific one. I apologize if you said it and I missed it, but with the supports coordination contracting a few SCs contacted me saying they've been in presentations where they heard or implied or whatever that in the future, date unknown, contracting with ODP would only occur with those SCs in the select the higher level. That if you are a primary SC in the future, you would not necessarily be contracted with. Is that official? Is that really out there? Or is that just being floated as some ideas? Where are you with that? I have not heard that with residential at all, even hypothetically so just your thoughts.
>> JULIE MOCHON: That's the first time I heard that. So, as you heard, we are getting rid of the tiers so there'll not be a primary and a select tier. All supports coordination organizations will have to meet the same measures. At least the first year, unless a supports coordination organization doesn't submit data and documentation at all, supports coordination organizations will be given a chance to correct any measures they are not able to meet at first. So, no. That is…I have not heard that.
>> RICHARD EDLEY: Okay, thank you.
>> JULIE MOCHON: I have not heard that.
>> RICHARD EDLEY: Okay, I will make sure that people understand. The other one is bigger and maybe sort of unfair but it's just a general question and really for the entire MAAC and group. What we've been saying seeing lately is obviously we get a lot of information out about the impact of the HR1. What I keep reminding everyone is regardless how we feel personally or as a MAAC or as an organization, we are a microcosm of the state. Meaning, when I present, you present anything, half the audience could very well be supporters of this of the HR1, supporters of the Trump Administration, Republican, or whatever we want to say. So, it's important to be objective and factual.
When it comes to the IDD (Intellectual and Development Disabilities) system, I've been getting emails like that from people in the field saying why is everyone being so negative? There's no direct impact on this population. Unlike behavioral health like you could say the Medicaid expansions and other things are direct hits this population is exempted. What I tried to set is even if that's true, all of these possible and indirect effects in terms of administrative costs and all the thing that is a Sally talked about earlier could have an impact on this population. Plus, the IDD population is not an entitlement. So, I'm not saying anyone is proposing this, but if there's going to be changing in cut this is a population potentially at risk. My question is, has ODP put out any document about that? Sort of explaining like okay we get it. It's an exempt population but here's how the impact would happen within this system. So, we could

help educate people and be just very objective about it.
>> JULIE MOCHON: Yeah, thank you for that question. So, we have not put out anything yet but we are planning to put out information. So, the information is being developed and kind of I think at the Department level and then as that goes out then we will be able to develop materials as well. Explaining what you just explained so well, Richard, for our specific for people served by the ODP.
>> RICHARD EDLEY: Ok. Thanks, and again as in in the discussion earlier, if we could be of any help whether the MAAC or RCPA or whatever, be glad to. I think it's important we don't catastrophize, but we need the information out there to educate people.
SONIA BROOKINS: Thank you so much.
>> MIA HANEY: This is Mia with the Pennsylvania Homecare Association and the PAHCBS (Pennsylvania Association of Home and Community Based Services Providers) Association. I have a question for clarification purposes. I'm hearing you say there'll not be a differentiation between the tiers, and everyone is meeting the same standards. But we are still referring to the submission that will now be due in October as the tier determination submission. Is that the submission specifically to see where they land in regard to the benchmarks? And will you be renaming that tier assessment given the fact we are not talking about tiers anymore?
>> JULIE MOCHON: Thank you for catching that. I'm so close to yet. You know how you get too close to see clear clearly? I didn't even notice it still said tiered determination period. So, thank you, we will update that in all our presentations going forward. So, and I should also say because on previous slide, our forums are really starting next week. For supports coordination organizations, we did talk with their executive level staff, or I think on Monday of this week. But that was the first time they kind of even heard this information. So, this is still all extremely new for supports coordination organizations. So that's why those forums that are starting next Monday will also be critical so more of the staff with the supports coordination organizations can hear it, but thank you for catching that.
>> MIA HANEY: So that would be a benchmarking assessment? Is that what that is essentially trying to achieve?
>> JULIE MOCHON: Yeah. It's a data and documentation submission period for the performance measures. I'm not sure what our name -- what we are going to call it but, yes.
>> Mia Haney: Okay, and the length to join those forums that are starting next week, where can those be found?
>> JULIE MOCHON: Those were sent out on the supports coordination organization Listserv. We should have put them up on my ODP webpage that was part of the presentation. If we haven't, I'll go back and recommend that be added now, today, if possible.
>> MIA HANEY: Okay, I know you did reference a work group. Is there still opportunity for supports coordination to join a work group if they have not yet?
>> JULIE MOCHON: I believe the work group has already been selected. So -- but if you have interest, you could submit an email to the performance based contracting mailbox, which I don't have with me right at this moment, I don't have access to it but there should be once again on my ODP website there should be an email address. So, feel free if there's interest in emailing but I do believe that work group is already

formed.
>> MIA HANEY: Thank you very much for your help. Appreciate it.
>> SONIA BROOKINS: Anyone else? Thank you so much, appreciate it.
>> JEN SMITH: Good morning, so first, I would like to say that we took the liberty of renaming this committee to a council. I'm sorry about that, I don't know, I think we were using a template from another deck. I realized this this morning like now I'm questioning what's the name of this group is it a committee or a council? It's a committee. So, my apologies for calling you council, committee members. All right; you can flip to the next slide.
So, I have a couple of updates to share. The first is around our ICWC Program, ICWC, which stands for Integrated Community Wellness Centers. I'll try to do a better job of spelling that out in the future for folks not up-to-speed on our state acronyms. This is Pennsylvania-specific created a number of years ago on the heels of a CMS demonstration project that we participated in that was their CCBHC model which is the Ceritied Community Behavioral Health Clinics model. We were part of a cohort of states that was part of the first demonstration. We were in that demonstration for a year or so. Realized that it seemed we could replicate that model but in a better way in Pennsylvania without being part of the demonstration. We pulled out of that demonstration and renamed it because we can't call it the same thing as the demonstration process, hence the ICWC acronym and have been operating it as a specifically Pennsylvania-specific model since. In 2025-2026, we will have a number of improvements we are working on.
We are looking at improving the monitoring process for the ICWC. So, some things to do on our end to reduce the administrative burden both on our part as well as the providers that are offering these services. We learned a lot in the years that we've been doing this now and think we have more efficient ways to be able to collect what we need to collect and ensure that the providers are doing what we need them to do. We are also going to be looking at updating and/or creating some new policies and procedures based on best practices. Now that the demonstration has been in effect for a number of years and our model has been in effect for a number of years, we have some experience, and we have better data and research nationally to say what's the best model for these types of services. We'll also be doing our best to align the policies and procedures with the CCBHC model, so we are not headed down two separate paths. We are also going to put a focus on providing technical assistance to these providers specifically as it relates to the changes that we are making around the monitoring processes and the new policies. We are going to take a good look at the data collection and reporting aspects. Ensure that really what we are collecting is useful information that it really is giving us a sense of the effectiveness to program and the outcomes of the individuals that are being seen. When you initially create a program, you go into it thinking I want all the data. All the data will tell us a story; I have to be careful how I move. I think we found some data being collected is maybe not very helpful for us in determining the effectiveness of the programs. Maybe there are some new data elements that would be more helpful.
So, we'll be working with those providers during the fiscal year to work through those four areas of improvement. In terms of a path forward, I think I probably presented to this committee, not council, many months ago, that we had been looking at creating a

State Plan service for these particular providers. And that was at a point where we were under a prior federal administration and that administration was working to develop some template language for states to use to create a State Plan service. We waited patiently for that language to be released, then there was an administration change. So, a lot of uncertainty around the future of that program from a federal perspective. So, we have not seen that language just yet. We have been working with some other states to look at the language they've been using and giving some thought to how that might work in Pennsylvania. The real, tough, pause for us has come as it relates to a budgetary situation. When we create a State Plan service, any provider that meets the criteria of providing that service then, you know, would need to be reimbursed for providing those services. Right now, we have a limited set of ICWCs. If we create a State Plan service, there may be a large number of providers who would be interested in meeting that criteria and providing the service. While that may be helpful in terms of serves capacity and communities, financially, if we don't have the budget to accomplish paying those providers, we are not really doing anybody a service. So, this is as Sally mentioned a fairly tight state budget year. And so, I don't know that additional budgetary needs are going to be something that we can consider for the current fiscal year. So, we need to do some planning about what that means for the ICWC Programs. Whether it means if we can continue down a path that could mean expansion of those services. If so, how will we fund them in a sustainable way?

In terms of a Four Walls update for those not familiar. Well, I think you know what Four Walls are but specifically, when I say "Four Walls" we are talking a particular Medicare payment provision that requires for behavioral health clinic services that either the provider of the service or the recipient of the service will be located within the four walls of the clinic. That requirement has been in place for many, many, many years. During the federal public health emergency that requirement was waivered. Meaning that both providers and recipients of the services could be located essentially anywhere. Most often times it was from their home. When the federal public health emergency ended, the federal government no longer had an option to waive that federal Medicaid payment requirement. So not just Pennsylvania but states nationwide were in a difficult position because their providers had gotten used to a new model of service delivery and accepted a patient load based on the ability to deliver those services outside of the clinic. Now found ourselves all of a sudden not in compliance with that role. CMS at that time was aware of the predicament that put everyone in and certainly decide not to want to encourage cutting off service for individuals that needed healthcare services. They basically said states do your best to work towards a solution. We've been doing that in Pennsylvania. There are two pieces to the solution for us. One of those pieces was the submission and approval of a State Plan Amendment that gives an exception to behavioral health clinics. That same submission also requested an exception to some physical health rural clinics that was all part of one submission to CMS. Submitted that the last day of March, it was approved June 26th with a retroactive date of January 1, 2025. So, hurray. Small victory there. Big victory.

The other piece, however, is that we have some state level Medicaid regulations that are still problematic for us. There are two ways to solve a regulatory issue. One is to go through the normal regulatory process. I see smiles around the table because if you are familiar with that process, you know it is not a fast one. The other solution would be to

use statute or law to make those changes. In this particular case, the changes were fairly straight forward. It's sort of the removal of a sentence or two that would fix the problem. So, we went the path of advocating for some statutory change. Had some success in the House, it was passed almost unanimously and was moved to the Senate. At this point, that bill is still sitting in the Senate in committee waiting for consideration. So, we are very hopeful. There's been a lot of advocacy from folks and organizations in this room. If that's something that interests you, feel free to call your Senators and let them know that we really need this last piece of the puzzle to come into compliance with these requirements. To allow providers to continue offering this kind of telehealth service and for recipients to be able to receive that in their homes. So that's a very important piece that's still remains outstanding. Next slide, please. This is my last slide.

In other regulatory news, we have two really big regulatory packages making their way through the process. The first I'm going to touch on is our crisis intervention services. There's two pieces associated with our crisis regulation intervention package. One is kind of service and program licensure focused, and the other is payment focused. The payment package is following behind. So, the one that I'm talking about here is that service program licensure piece that is currently with the office of attorney general, which is one of the last stops before it gets to the IRRC and that's out for initial consideration. So, it will be put out for public comment. As soon as it is out, we will send a message in our Listserv to let people know. We are highly encouraging anyone and everyone to review those regulations and provide comments to us. They very are closely aligned with SAMHSA (Substance Abuse and Mental Health Services Administration) guidelines. That's wonderful and a good starting point and benchmark but we want to make sure they are realistic for implementation here in Pennsylvania because we want a good, robust crisis system but we also want one that is a exists and that means making sure we are not setting the minimum so high we can't get providers able to be licensed and offering the services.

The other package we have moving is our psychiatric residential treatment services or PRTF regulations. Those are put out for public comment under the first consideration. We completed a series of webinars with individuals from the public, providers, Managed care organizations and Counties, etc. receiving feedback on that. We are in the process of making updates to those regulations. Once those updates are made they will make our way through the second round of review and ultimately, to IRRC. Then there'll be a hearing for the IRRC to vote whether those regs were approved or not.

A quick update on the 988 suicide and crisis lifeline. I also give you statistic, we were hovering around the 10,000 mark for calls coming in each month. In June we saw that jump significantly to almost 12,000 calls in the month of June. We are maintaining our answer rate above the 90% benchmark that SAMHSA set. They have applauded Pennsylvania in a number of settings for having achieved that and consistently maintained it for well over a year now. So that's really good news. The not-so-great news around 988 is the federal administration announced, I don't know, maybe a month ago now, the removal of what we refer to as option 3, from the call menu. So, when you call 988, it gives you a menu of options before you are actually connected with a voice. Option 3 when you used to call that number was an option for individuals' youth specifically with LGBTQIA+ (Lesbian Gay Bisexual Transgender Queer Intersex

Asexual+) needs. It would connect them directly to a call center that had individuals specifically trained to help individuals in need part of that population. So, the bad news is that is no longer an option on the main menu. The good news is that Pennsylvania, among many other states, have been working on solutions to ensure that that service is still accept accessible for individuals calling. Instead of having a menu option they'll reach one of our 14 call centers in Pennsylvania. If the individual who answers the phone doesn't have expertise themselves they can directly warm line connect to the same call center that had been answering the call under option 3 previously, which is The Trevor Project. A long-term solution for us is to have individuals in each call center trained specifically to address this population and its needs so we don't have to refer it out. But that's definitely a longer-term solution for us. Last but not least for me, in terms of updates, two staffing updates.
One is that we have hired a chief psychiatric officer who will be starting with us in October. Dr. Julie Graziane currently employed at PPI (Pennsylvania Psychiatric Institute) in Harrisburg. So just down the street in a way and she has a great deal of education, training and experience in addressing the adult and geriatric populations, specifically in community psychiatry settings. So, she will be a wonderful addition to our team. Definitely her expertise will lend well to the 7 facilities that we have the responsibility of running our 6 state psychiatric hospitals and our LTC facilities. Second, many knew the name Phil Mader he was working in the Commonwealth for over thirty-seven years. He was the Director of Community and Hospital Operations and he retired within the last two weeks. So, his replacement is Paul Minnick. Paul comes to us with a wonderful wealth of experience. He got his start in behavioral health as a psychiatric nurse. Worked his way through many positions in behavioral health systems. Ultimately, was a CEO of some hospital and health systems and worked on the insurance side of things and both in Pennsylvania and in New Jersey. He decided to really come back to why he got into this field in the first place, which was to work with people who have mental illness. He wanted to have an impact on people more directly. So, we were fortunate to have someone with his experience take on this role and decide even though he's nearer the end of his career than the start of his career he's really energized about seeing how he can revitalize or state hospital system. That's all I had for today.
>> SONIA BROOKINS: Thank you, any questions? Anyone on the phone?
>> DEB SHOEMAKER: Yes, I have a comment and a question. Hi, Jen.
>> JEN SMITH: Hi.
>> DEB SHOWMAKER: This is Deb Shoemaker.
>> JEN SMITH: Hi.
>> DEB SHOEMAKER: Hi, this is Deb. The first comment is I'm so excited about Dr. Graziane, if you don't know her, she's a fierce advocate for community psychiatry and community behavioral health and for peers, families and consumers. It's very exciting. I can't wait for her to get moving with you. She'll fit in perfect, with you, Jen, I think as you probably already know. My question is related to 988. I know this is my little pet project, so Jen you know I was going to ask it. But one is, is there a way to and I know it's a I'm uncertain and not so nice political climate right now. Is there a way for us to be able to let consumers know that our state is still welcoming and friendly to our colleagues at LGBTQIA+ friends and families? Because I know I heard it many places where people of course hear the news and they are extremely concerned and you

know, with the suicide rates and other things. But they know they can still access that service here in Pennsylvania in a way that doesn't get you in trouble if there's anything we can say to say, hey it's still a warm hand off and two, are you still working on the text message opportunity? Because I know it's probably utilized a lot.
>> JEN SMITH: There were a bunch of questions rolled up in there, I'll do my best to answer them all. I'll touch base with our communication team around messaging. I know there had been some interest initially when this was announced by the federal government. I don't know where that landed and to be honest I'm not closely following our agency social media page to know if we actually put something out or didn't. Let me check in with them about the status of what those communications might look like. Aside from that, there probably is a minimum a Listserv announcement that we could put out there OMHSAS just making sure that folks know the ability of 988 services for any and all populations. I'm sure we can do something but I'm not sure what the something is without touching base with the comms folks.
Related to the text and chat. We are continuing to invest resources in ensuring there's adequate staffing and training for those staffing in our call centers to receive and respond to the text and chat features. There's actually a separate platform that has to be used when responding to the text and chats, which is separate from the voice system. Not all of our 988 call centers have the platform to be able to answer texts and chat and that's one of the challenges for us for a while we only had one center doing all of that for Pennsylvania. Which didn't mean that any texts and chats went unanswered it just when they would roll to the nationally established call center. So, folks answering it may not be as familiar with Pennsylvania specific resources and such. We've been working on investing resources to get more call centers on board with that platform and able to provide the service. Our numbers are increasing but still not nearly where we would like to see them be. Hopefully the federal funding for 988 continues. You know, that is one big risk for Pennsylvania that we don't have another sustainable mechanism at this point to fund our 988 call centers. We've been relying on that federal funding. We've not heard it's in jeopardy. So, I don't want to get everyone panicked. We have not heard there would be any reductions or changes to it, but you just don't know sometimes until it happens. It's really important that Pennsylvania focus over the next year on getting a sustainable solution to that. There's been some legislation proposed in previous years that would add a small fee to cell phone bills to help support. That's a really great way to do it. Some other states have utilized tax revenue from hospital systems. Some of them created separate state line items in their budgets. There it's whole myriad of options states are using to fund these, but we are a little bit behind the 8 ball in making sure that we have a sustainable funding source for these centers. So, something will we'll need to work on and perhaps with partnership with folks in this room, that would be helpful.
>> DEB SHOEMAKER: Thank you, Jen, I appreciate you and you know, anything we can do to help we will, that's extremely important. 988 in this time is one of the most important, but you know that's my little pet project, so I can't really say anything else.
>> EVE LICKERS: I'm not going to ask you a question. I just wanted to say thanks for all the work that you and OMHSAS have done with 988. There some really interesting places you can find where people need 988. Couple weeks ago, I happened to get in my vehicle and the trucker channel was on in my vehicle, because my husband is a

trucker. Right, I'm like that channel's on again, good lord, you know and so what was on was a guy talking to a driver from PA who needed somebody to talk too. So I call number on the radio, and I told the guy, call 988, you know anytime 24 hours a day it's confidential. Hey, can I get you on the line and I talked to this guy about the 988 and encouraging other drivers across the nation to utilize this, not because they feel like they want they want to jump off the truck or a building, but they need somebody to talk to. They drive 24 hours a day throughout the day and night and a lot of the drivers that are not company drivers are truly alone. They don't have CB radios anymore and they are not interacting a lot so it's critical that they access these services that can connect them to services in their own state. So, thank you for your work on that.
>> JEN SMITH: You heard it here, Eve Lickers, 988 for the truckers. (LAUGHING)
>> SONIA BROOKINS: Anyone have questions for Jen please? Go ahead.
>> LLYOD WERTZ: Thank you, Lloyd with Psychiatric Leadership Council. Do you have an estimate of the number of providers who are duly licensed, DDAP (Department of Drug and Alcohol Programs) and OMHSAS who are looking forward to having the dual licensure or are opting out?
>> JEN SMITH: We don't have a sense of that yet. So, for folks not familiar with what Lloyd is talking about, for any providers that have a DDAP license and a OMHSAS license. So, they provide co-occurring services. We just announced that we are offering an opportunity for them to participate in a dual licensure process. Meaning both of our agencies would collaborate on what that licensure date would be, and they would only get one site visit per year from both agency agencies. There would be a process for them to upload the documentation for them prior to the visit to reduce the time we are onsite. We would come together and the licenses would be dated for the same period of time, which is why this is voluntary because right now most of those license cycles don't core correspond. Their DDAP license might run from July to July, but the OMHSAS license is from September to September. So, we have to do some work to sync those up and figure out how the close the gaps between there. But we're just in the process of reaching out individually to each one of those providers to talk through what this would mean and to gauge their interest and really build a list and a plan for what would that look like. I don't have a sense for how many are willing to participate, but as soon as we know, we would be happy to share that.
>> LLOYD WERTZ: Thank you.
>> KYLE FISHER: Jen, you mentioned there was a significant uptick in calls to 988 in June. Does OMHSAS have a sense what was driving that?
>> JENNIFER SMITH: I don't. I will ask our team. We have a team both at OMHSAS and at the Thomas Jefferson University who help us administer some of these calls and with the call centers. I'll ask them if they noted anything specific. The other thing I should mention around 988, we're still in the very early stages, but we are working to build a public dashboard that will depict the calls coming in month over month. The call centers receiving the calls. The text and chat numbers. What demographic information we have about the calls. So remember, you know, not everybody provides the same level of detail when they call in and you know, it's not a requirement for us to provide they tell us these things. We'll provide what we have, but I think it would be helpful for folks to go on at any time and see what that trend is looking like. I'll definitely follow up and see if there's anything notable, we can see from the data.

>> SONIA BROOKINS: That’s it, any more questions? Thank you very much, appreciate you.
>> JEN SMITH: Thank you.
>> SONIA BROOKINS: This is new on the agenda, but we have to do it. Public comments.
>> ELISE GREGORY: We do have any public comments that came on the webinar that I can share.
>> SONIA BROOKINS: Sure.
>> ELISE GREGORY: Okay. The first two are from Paulette Hunter I think having one card is helpful and having it state Medicaid. This is the only way for individuals to remember they are on Medicaid. The next comment from Paulette, my sister died, and my mother is having a hard time. I was going to give her the 988 number but after calling the line myself I was concerned the first sentence states the term suicide. Because the line mentions it seems to plant the seed in your brain. Is there a way we could please not mention suicide and only mention Mental Health Crisis on the help line? The next comment from Becky Ludwick from PA Partnership. There are a number of different implementation dates. It would be helpful to understand DHS plan or one where they are needed to changes alert the public on changes coming down from the road. We’re eager to help as advocates especially informing families. There's a question from Anthony House, will or could DHS be will willing to share some templated messaging with partners to pass along to enrollees about them being enrolled in Medicaid. Clear consistent messaging will be critical. The last one is from Jackie Kreshock. Any update about the inpatient psychiatric hospital regulations? I know the work group has been formed but have not heard anything more about it after the survey.
>> SONIA BROOKINS: Okay. We'll move to the next ConsumerSub reports.
>> KYLE FISHER: I'll start with the ConsumerSub. Oh. We should actually cut short. Do you want to do them or how do you want to do it, Sonia? I think we could submit relevant updates to the ConsumerSub via email. I didn't realize it was actually noon now.
>> SONIA BROOKINS: We can do that.
>> KYLE FISHER: I don't know if the Department has other critical updates in terms of bulletins or pharmacy docs. (inaudible) Then we'll lose access to the CART Captioning here.
>> ELISE GREGORY: The broadcast is still going for a bit, but yeah.
>> SONIA BROOKINS: Do we have old or new business? If not, can we have a motion for adjourning this meeting, please?
>> MINTA LIVENGOOD: This is Minta, I make a motion to adjourn.
>> DEB SHOEMAKER: Second, and reminder we don't have a meeting in August. This is Deb Shoemaker.
>>SONIA BROOKINS: Yes, Deb, we do not have a meeting in August. So, we will see everyone in September. Thank you very much. Thank you. Thank you so much.

July 2025 Long-Term Services and Supports (LTSS) Medical Assistance Advisory Committee (MAAC) Meeting Report

The LTSS MAAC Subcommittee met in person and via webinar on July 2, 2025.

In addition to the updates shared today, Deputy Secretary Marsala announced the release of the final House Resolution 165 report of the Legislative Budget and Finance Committee's study of the effect of home and community-based services workforce shortages on commonwealth-supported Medicaid waiver programs, Lottery-funded Area Agencies on Aging programs, and Act 150 services. The report was published in June 2025 and can be found on the Legislative Budget and Finance Committee's website at https://www.palbfc.gov/Resources/Documents/Reports/800.pdf. Pennsylvania has joined the National Council of State Boards of Nursing's Nurse Licensure Compact (NLC). Effective June 27, 2025, nurses with a valid multistate license from a NLC participating state may enroll with Pennsylvania Medical Assistance without obtaining a separate license from the Pennsylvania Department of State. As part of Aging Our Way, PA, the Pennsylvania Department of Aging is conducting an evaluation of the PA Link to inform the design of a strategic plan to improve and redesign the program to better serve consumers. The public comment period ends on July 28, 2025. Finally, Deputy Secretary Marsala shared several recent OLTL communications including a new Medicaid application phone option that started on June 16, 2025, through the PA Consumer Service Center for LTC and home and community-based services applicants. Individuals can call 1-866-550-4355 to apply for Medicaid. Questions regarding this initiative can be directed to the DHS Helpline at 800-692-7462.

Each of the three CHC MCOs presented information about their respective support strategies for behavioral health. All the plans incorporated responses to questions submitted by the Committee in advance such as information related to how the mental and behavioral health needs of participants living in nursing homes are addressed, service coordinator training, suicide prevention and interventions, and information sharing between the CHC and Behavioral Health (BH) MCOs. While there are still issues accessing Medicare behavioral health encounter or utilization data for those also enrolled in original Medicare, the CHC and BH MCOs continue to monitor the accessibility of BH encounter and/or utilization data for these participants.

On July 18, 2025, the Subcommittee sent a letter to Governor Shapiro and copied various legislators including the four Appropriations Chairs and Chairs of the committee of jurisdiction in each chamber as well as key DHS and MAAC leadership. The letter describes the urgent need to include funding to increase Medicaid personal assistance services (PAS) rates in this fiscal year's budget. The impact of low PAS rates is an issue commonly raised at meetings and is addressed in various reports such as the Mercer rate study. Like the letter the Committee sent to Secretary Kennedy, this advocacy effort falls outside of the normal work of the MAAC and OLTL was not involved in drafting the letter. You may email Kathy Cubit at cubit@carie.org to request a copy of the letter.

As always, there were two open forum times for public comments.

The next LTSS Subcommittee meeting will be held on August 6, 2025, from 10 AM to 1 PM both via webinar and in person at the Forest Room in the Commonwealth Keystone Building at 400 North Street Harrisburg. All are welcome to join us.

July 2025 Consumer Subcommittee (MAAC) Meeting Report

The Consumer Subcommittee met virtually on July 23, 2025.

The Consumers heard reports from three program offices:

From OMAP, Chief Dental Officer Dr. Shaun Shamloo, discussed the issuance of a new MCO Operations Memo on the dental Benefit Limit Exception (BLE) process. DHS also issues a new BLE request form that lists the five conditions – diabetes, Intellectual disability, pregnancy, coronary artery disease diagnosis or risk factors, and cancer of the throat, face, or neck – that, DHS clarified, meet the BLE standard under the streamlined BLE process. If any of these conditions are verified through claims data or documentation, the MCO cannot inquire further into whether the BLE standard is met or how the condition impacts dental need, and should then review the medical necessity of the dental procedure being requested. The Consumers applauded OMAP for issuing this new guidance and are hopeful that the next round of dental BLE data from the MCOs will show a more consistent implementation of the streamlined process.

Also from OMAP, Gwen Zander presented CY 2023 and 2024 prior authorization and appeal data for pediatric shift care services. Despite an increase in the number of children receiving HHA and shift nursing services, the data show a decline, program wide, in shift care denials by the MCOs in 2024. The Consumers and counsel thanked the bureau of managed care team for their efforts to ensure the MCOs comply with the contract and department guidance and approve medically necessary services.

From OLTL, Randy Nolen discussed CHC MCO policies and timeframes in the CHC Agreement regarding how quickly a plan must (1) complete a Trigger Event assessment and then (2) approve or deny any requested change in waiver services. The Consumers highlighted a recent experience where a participant was refused an assessment prior to hospital discharge, had the assessment two days after discharge, and then had to wait over a week before any additional PAS hours were approved. OLTL confirmed that service coordinators should conduct a trigger assessment as soon as possible based on the person's needs, but no longer than 14 days, and that the service plan should be updated _and_ a UM decision made within 2 business days after the assessment. All three CHC-MCOs reported that they can do needs assessments in a hospital prior to discharge, and that they can provide temporary authorizations.

From OIM, Alexis Deisenroth provided the latest metrics on CAO processing MA/HCBS/LTC applications and confirmed a systems issue in which some consumers are being mailed contradictory notices. OIM is working with Deloitte to identify what is

triggering the errant mailing, which appears to be only mailed to a subset of non-MAGI consumers. A timeframe for fixing the systems issue is unclear and involves balancing mandatory changes and other priorities on the IT runway. An interim solution could involve manual caseworker activity, such as suppressing the second mailing, once the trigger is identified. In the meantime, participants who receive two eligibility notices stating opposite messages – you continue to qualify, and you no longer qualify – should know that the termination notice is the accurate one. And should appeal quickly if they do not want what termination to take effect.

The next Consumer Subcommittee meeting will be held on September 23, 2025, from 1-3 PM via webinar.