>> ELISE GREGORY: Good morning and welcome to the June 2024 edition of the MAAC meeting. Today is Thursday, June 27th. My name is Elise Gregory. Before we begin the meeting, I'd like to go over a few 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 webinar at any time. To help avoid any disruptions, please remember to keep your microphone muted if you are not speaking. Live captioning, also known as CART captions, are available for this meeting. The link is included in the chat. Presenters should state their names clearly before speaking to assist the captioner. Representing the Department of Human Services today, from the Office of Medical Assistance Programs (OMAP), Deputy Secretary, Sally Kozak. From the Office of Long-Term Living (OLTL), Deputy Secretary, Juliet Marsala. From the Office of Mental Health and Substance Abuse Services (OMHSAS), Deputy Secretary, Jennifer Smith. From the Office of Developmental Programs (ODP), Director of the Bureau of Policy and Quality Management, Jeremy Yale. And from the Office of Income Maintenance (OIM), Director of the Bureau of Policy, Carl Feldman. Questions may be submitted in the question tab of the webinar. If you have any questions related to this meeting or need any additional information, please visit the MAAC webpage. I will now hand things over to the MAAC Chair, Deborah Shoemaker.

>> DEB SHOEMAKER: Good morning, everyone and thank you, Elise. You went down the list perfect, so I appreciate all the housekeeping items being done by you, so thank you for that. At the current time, I am the Chair of the MAAC and also the Chair of the Fee-for-Service Subcommittee. So, I will go through the list of our members that I have on here. Sonia Brookins, Vice Chair.

>> SONIA BROOKINS: Good morning.

>> DEB SHOEMAKER: Good Morning, and Jolene Calla.

>> JOLENE CALLA: Good morning, Deb. I'm here.

>> DEB SHOEMAKER: Good Morning Jolene. Kathy Cubit, Chair of the MCDSSS.

>> KATHY CUBIT: It's actually just the LTSS (Long-Term Services and Supports). And I am also the advocacy director at the Center for Advocacy for the Rights and Interests of the Elderly.

>>DEB SHOEMAKER: Thank you. Sorry I messed you and Joe up. I'm looking down the list. I apologize for that. Thanks for your hard work, I appreciate that as well. Richard Edley.

>> RICHARD EDLEY: I'm here, Deb, good morning.

>> DEB SHOEMAKER: Good morning, Richard. Joe Glinka, the Chair of the committee I already mentioned. Okay. We'll wait for Joe. Dr. Goldstein. Okay. Mike Grier.

>> MIKE GRIER: I'm here, Deb. Thanks.

>> DEB SHOEMAKER: Okay, would you like to introduce where you're from Mike?

>> MIKE GRIER: I’m from the Pennsylvania Council on Independent Living.

>> DEB SHOEMAKER: Wonderful. Thank you. Mia Haney. Okay. Mary Hartley.

>> MARY HARTLEY: Mary Hartley from the Arc of Greater Pittsburgh Achieva.

>> DEB SHOEMAKER: Okay. Thank you, Mary. Heather King. Okay. Julie Korick.

>> JULIE KORICK: Good morning, Julie Korick with the Pennsylvania Association of Community Health Centers.

>> DEB SHOEMAKER: Thank you, Julie. Minta Livengood.

>> MINTA LIVENGOOD: Minta Livengood, co-chair of the Consumer Sub.

>> DEB SHOEMAKER: Yes, along with Sonia, thank you so much. Glad to hear your voice, Minta. Russ

is on vacation. So, unless he calls in. Ted Mowatt.

>> TED MOWATT: Ted Mowatt with Warner Associates and I'm the Executive Director of the Pennsylvania Association for Home and Community-Based Service Providers.

>> DEB SHOEMAKER: Okay. Thank you, Ted. Candice Poole. Okay. Deron Shultz. Nick Watsula.

>> NICK WATSULA: Good morning, Deb. Nick Watsula here representing UPMC.

>> DBE SHOEMAKER: Yes, former Chair. Marc Yester.

>> MARC YESTER: Marc Yester, I'm a pediatrician in the Pittsburgh area, representing the American Academy of Pediatrics in the state of Pennsylvania.

>> DEB SHOEMAKER: Thank you, Dr. Yester. I think I saw - let me see if I saw her, Nancy Murray, were you on this side? Go ahead. It threw me off because Nancy's name is on. I'm- like, wait.

>> MARY HARTLEY: The invitations are going to Nancy Murray still and not me, Mary Hartley. So, we need to change that.

>> DEB SHOEMAKER: We definitely will. For sure.

>> MARY HARTLEY: Thank you.

>> DEB SHOEMAKER: And Joe, did you just come on?

>> JOE GLINKA: Yes, Joe Glinka, sorry for being late. Highmark Wholecare, Chair of the Managed Care Delivery System Subcommittee. Good morning.

>> DEB SHOEMAKER: Good morning. And former Chair. And thank you, Joe, for taking care of the meeting in May when I was unavailable for a family issue.

>> JOE GLINKA: They were big shoes to fill, Deb.

>> DEB SHOEMAKER: Well, you filled them pretty well, so thank you, I'll have to try to get back to where you were. I heard you were on time. Kyle Fisher.

>> KYLE FISHER: Good morning, Deb, Kyle Fisher with the Pennsylvania Health Law Project, council for the Consumer Subcommittee.

>> DEB SHOEMAKER: Okay, wonderful. Thank you, Kyle. Okay. As people come on, people that we've missed, if there are people on, if you want to put in the chat MAAC members to let me know and I can announce that you're here. So, I believe, Elise, we have a quorum.

>> ELISE GREGORY: Yes, we do have a quorum.

>> DEB SHOEMAKER: Perfect. So, for those of you that were at the May meeting, the minutes for the MAAC members, the minutes are attached. So, I don't know if I have to abstain per se, but since I wasn't there, I will vouch to say, I will just trust that they are correct. So if I could please have a motion to approve the minutes as they were distributed.

>> JOE GLINKA: I'll move it. So, moved.

>> DEB SHOEMAKER: Thank you, Joe.

>> MINTA LIVENGOOD: This is Minta Livengood, second.

>> DEB SHOEMAKER: Wonderful, thank you Minta. Okay, all in favor, please say aye.

>> MAAC COMMITTEE MEMBERS: Aye.

>> DEB SHOEMAKER: Okay. Any nays? Okay. All right. Then next on the agenda is the OIM update by Carl Feldman, policy director. Thank you, Carl, for coming. Do you have an update for us?

>> CARL FELDMAN: Hello, good morning. This is Carl Feldman, Director of the Bureau of Policy with the Office of Income Maintenance. Thank you, Deb, and thank you members of the MAAC. I think we will

just start by sharing the information about the unwinding's completion. I think when we met last time it was shared that we had some kind of de minimus of cases to handle statewide and at this point in time we can say the processing of all unwinding associated renewals has been completed and we're now at a steady state of kind of status quo operations for renewal processing. Things will continue to shift over the course of the next two years in particular, and that shouldn't particularly be news. But we can talk a little bit about it.

Some specific questions that I think we got was around understanding the continuation of unwinding related flexibilities and what I'll say is generally speaking CMS (Centers for Medicare & Medicaid Services) has allowed states to continue the unwinding related flexibilities that they've opted for until June of 2025. They had notice that went out maybe in May describing this extension. For Pennsylvania, that's not particularly - I guess I shouldn't say it's not particularly impactful, there's some things in here we want to continue that are meaningful, but because the number of particular flexibilities is limited, it's not a broad range we expect to have to wind down. If you remember, the biggest one that we really would like to continue indefinitely and we're waiting for guidance from CMS on, our ability to continue it indefinitely, is our ability to ex parte renew zero income cases. That's one of the things that we have an (e)(14) that will continue at least until June of 2025. Like I said, we'd really like to be able to continue that indefinitely. One of the (e)(14) waivers that we have for the MCO (Managed Care Organization) beneficiary contact update will continue indefinitely because it was included in the eligibility enrollment final rule that was issued, which is updating MCO beneficiary contact information when it's shared by the MCO. There are some specifics about how we have to go about doing that, but generally speaking that's something that will be made, or not will be, it has been made permanent by CMS and we're happy about that. We think that adds value to the Medicaid program in Pennsylvania.

And then like I said, about changes until 2026, we're operating with a mitigation strategy for our ex parte activities. This is for ex parte in combination cases. In September we'll have a system release going into place that allows us to ex parte cases that include SNAP and other benefits which is very exciting and a positive step for the program. We also will need to continue doing manual ex partes for many cases so that the ex partes are correct at the individual level, delinking in September will help us to do the combination case ex parte because it will allow us to advance renewal due dates for one program but not another, but it's not de-linked at the individual level so there's still work to be done in that space. And then also for non-MAGI cases, cases with resource limits, that's another kind of later phase update that we need to make. And generally, speaking, this mitigation is permissible by CMS until April of 2026. So that's what I mean when I say I think we're going to continue to experience changes until we get to 2026. But we did and will have a policy out the beginning of next month, which is just next week, that details our new ex parte expectations for County Assistance Offices. That'll be available through the MA Handbook, and I think is going to lead to a lot of positive developments in ex parte space which I know is of interest to the MAAC. So that's kind of where things are with the unwinding wrap-up and I think there’s a lot of positive news that we have to share.

>> SONIA BROOKINS: Good morning, Carl. This is Sonia Brookins. And what about the MAWD (Medical Assistance for Workers with Disabilities) cases?

>> CARL FELDMAN: Yes, I can share that, as we said last time, there are about 2,000 individuals for

whom we have mailed, who may be MAWD eligible from the unwinding period and those mailings took place in mid-May. The individuals have 30 days to respond to us. So that timeframe has passed. And then the workers have 30 days to process what's come to them. So today I can't report to you on how many individuals responded to our mailing. But at our next meeting I'll be able to tell you the feedback that we received for that.

>> SONIA BROOKINS: Okay. Thank you.

>> JOE GLINKA: Hey Carl, it's Joe Glinka. Appreciate the update. I had a couple questions. I don't know if you could -- if you have the detail. So, the processing is complete with respect to the unwinding. Is there a material backlog at all on appeals cases yet outstanding, and how many would there be?

>> CARL FELDMAN: I'm going to take a look at our unwinding webpage for that because we still have that reported in our federal reports so just bear with me, please.

>> DEB SHOEMAKER: And while you're doing that, Carl, I was waiting to see if your presentation is done. Do you have more, do you have more of your report? I just want to make sure we didn't miss anything before we started questions.

>> CARL FELDMAN: No, those were the two items that I was asked to share information about. Okay. So, Joe, for the month of May, which is the latest available federal report, which includes the fair hearing pending more than 90 days, there are 36 statewide.

>> JOE GLINKA: Okay. Thank you for that. And then one more. I just want to make sure I'm understanding correctly, you'd referenced the final rule, and the updating of member individual information to be done by the MCOs. That is going to be an item that is permissible with proper safeguards and verification processes in place, but the MCOs will be able to update member information in the state system as we make those discoveries with our members?

>> CARL FELDMAN: Well, this final rule doesn't change our process. So the process that we have now that we've been using throughout the unwinding period, and I think it goes back earlier than the unwinding period actually, will continue until we make some kind of systematic update, because as you know it involves a lot of manual back-and-forth. But the change, the final rule update, the policy difference is that we no longer need a special waiver to take what you're sending us as a piece of verified information. So, we will continue to receive what you send us, we will continue to treat it as verified as we have throughout the unwinding period, and that will continue indefinitely. And if at some point in the future, we make system updates to make the process of exchanging that information easier, that's an added bonus.

>> JOE GLINKA: Okay. Thank you.

>> DEB SHOEMAKER: Okay. Does anyone else have any questions or comments for Carl? MAAC members first. Okay, Elise, any questions in the chat?

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

>> DEB SHOEMAKER: Wonderful. Thank you. Thank you, Carl, for the hard work that your office is doing. I know that you guys are moving back to status quo or normal because I know people are starting to receive their renewals like in the normal old way, old days way. So, thank you for that hard work that you guys have been doing and we continue to look forward to updates as they're available.

>> CARL FELDMAN: Okay. Have a good morning, everyone.

>> ELISE GREGORY: We do have another question that just came in.

>> DEB SHOEMAKER: Carl, are you still there?

>> CARL FELDMAN: Yep, I'm still online.

>> ELISE GREGORY: It's from Andrew Kunka. Do you have an effective date for when you'll be accepting member address updates without the waiver?

>> CARL FELDMAN: I'm not 100% about what is being asked here, but what I'll say is that we have a system in place that we have had in place for quite a while to receive member address update information from the health plans and that process will not change and the ability to use the information without the waiver will not change. It's possible that at some point in the future we get together and determine a better way to exchange the information, but as a matter of policy, there's no change.

>> ELISE GREGORY: And just to clarify, Andrew was saying the waiver is for the MCOs.

>> CARL FELDMAN: I'm still not quite sure what's being asked.

>> DEB SHOEMAKER: That's thrown me for the loop, the MCO part as well, Carl. You're the expert.

>> ELISE GREGORY: Andrew is saying it was answered so thank you.

>> DEB SHOEMAKER: Thank you, Carl, for being willing to take a last-minute ball that was thrown into left field. So, I appreciate that.

>> CARL FELDMAN: Okay. Have a good day.

>> DEB SHOEMAKER: You too. Thank you. Elise, would you like to introduce ODP's update?

>> ELISE GREOGRY: From ODP, Jeremy Yale.

>> DEB SHOEMAKER: Perfect. Welcome, Jeremy. Nice to hear you're presenting again. It's been a little bit.

>> JEREMY YALE: Good morning, Deb. Thank you. Morning, everyone. So, I do have an update on our performance-based contracting which I can share with everyone. Just as a reminder, and I know Deputy Secretary Ahrens and I have had an opportunity to talk with MAAC members and the public at large about our plans related to performance-based contracting, but just as a quick memory jog, the office is applying for a 1915(b4) selective contracting waiver, and our current plans are directed towards residential services, and those residential services include residential habilitation, supported living, and life sharing. You can go to the next slide.

So, I think the last time we had the opportunity to meet, we talked a little bit about our public comment process. That closed on June 4th. It was open for 45 days. And through that process, we received input from the information sharing and advisory committee, we held nine public comment sessions, and we opened that up to written comments as well. By the numbers, we had 152 individual commenters. That also included some of our larger provider associations as well as individuals and families and kind of everything in between. Of those 152 commenters, we received approximately 1500 individual comments related to the proposed plan. So, to get this right, we knew that it was going to take a lot of input from the community and as evidenced here, we received the type of feedback that we were really hoping for. So, we can go to the next slide here.

So, what were the themes from the public comment session? Generally, we're identifying that stakeholders really recognize the need to address quality issues in residential services. We certainly saw some themes, and these were some of the high-volume comments that we received. And I won't get into a great level of detail but just to include them for both MAAC members and the public. Selective and clinically enhanced tiers, we had reserved that in the plan for agencies serving 10 or more. That was

certainly what we received a lot of comment on that. The competitive integrated employment standards that were included, we heard a lot of comments on that, on both sides, for positive as well as some challenges that stakeholders believed they would experience in trying to implement that. Population served average needs level and average healthcare level; we had some stipulations in that related to our enhanced, clinically enhanced tier. So, we heard a lot of feedback about that as well as primary providers being limited to needs group 1 through 3. Generally speaking, we heard that there are a lot of measures and ultimately, this is a short timeline for implementation. So again, we're in the process of finalizing all of these and really building these back into our final plan. It took a good effort to really sort and organize and critically review the comments we received. But again, we feel confident that we have made some of the changes and have responded to the public comments that we received. In particular, this last one around timeline for implementation. So, if we go to the next slide, this is an updated timeline.

We are proposing that in lieu of a review period, which we began our previous position was around beginning July, July to July 31, all of July, looking at really beginning the data collection process with providers so pushing that back in response and then also looking to notify providers that participate in this first review period by November. So, with that, also giving providers some additional time to acclimate and extending that review period out if providers choose to participate in providing information in February. So, providing some additional time to really acclimate, this will also align with the data source for calendar year 2024. That was another theme that we had heard during public comment period. And then we'd be looking to notify providers of tier assignment in May. So, we think this will give providers a little additional time to organize around these standards. I'll say that, you know, the obvious advantage is that -- obvious advantage for a provider submitting during that first review period is they'll have an additional -- if they meet the criteria for either select or clinically enhanced, they will be able to get that additional rate, which again for select is an additional 5% on top of the fee-for-service rate, and then for clinically enhanced, it sits at 8%. So, they would be able to get that for an additional six months. So, it feels like a win-win. I'm sure there will still be some challenges with implementing this, but this feels like a timeline that is responsive to the feedback that we received. So, you could go to the next slide.

Then here we have some next steps. So, July 25th, completed that preparedness summit series that we talked about the last time we updated the MAAC. This included sessions for our supports coordination organizations and our administrative entities, or counties. We received a lot of really positive feedback from our provider network as a whole about these sessions. And again, just as a reminder, this was an opportunity for us to really break down the measures related to the proposed plan and give providers an opportunity to ask more detailed questions and have the office respond to those questions as they plan for implementation. So, June 28th, we are looking to publish our adjusted timeframes and some of the additional details related to the adjustments that were made. And then we are on track for July 19th to submit the amended 1915(c) waivers and 1915(b)(4) waivers to CMS. Then with that, we would be publishing all the supporting documents which would include the performance standards, an updated implementation plan, all the provider attestations, and the provider data submission tool. That will be the tool that the office uses to collect the measure data to support the measures within the performance-based contracting plan. Then on track for January 1 to begin the performance-based

contracting. And again, this is pending CMS approval. So, things are starting to come together. So, Deb --

>> DEB SHOEMAKER: Yeah, sorry, I was trying to unmute, and my unmute was not unmuting. Thank you for the comprehensive update. Send our best to the deputy secretary. I know it's a hard time to get people on the June meeting because of the budget. So, do we have any questions for MAAC members?

>> RICHARD EDLEY: Yes, Deb, this is Richard Edley.

>> DEB SHOEMAKER: Go ahead.

>> RICHARD EDLEY: Hi, Jeremy. Good morning.

>> JEREMY YALE: Good morning.

>> RICHARD EDLEY: I'll have to admit, I want to take a little more time and analyze some of the changes you proposed, but I do want to say at a high level, I really appreciate it, that obviously you got feedback and are attempting to address that. So, thank you very much. I forget if I even said this, I should've gone back to minutes of the last meeting, but I just want to make it clear that from an RCPA (Rehabilitation & Community Providers Association) standpoint, and we represent a lot of IDD (Intellectual and Developmental Disability) providers. We're not against this proposal and I think that might surprise some people because I think there are members who, as you know, Jeremy, would like this not to happen. But at the highest level, again, if you're addressing quality issues, that's a good thing and if you're doing something innovative in terms of how to reinforce and pay at an alternative manner to, you know, reinforce outcomes and quality, that's a good thing. It really was exactly as you said. The timeframe, the volume, some of the detail, particularly providers really needing to put in some infrastructure and technology, and it felt like it was a race that they just couldn't get there. We certainly didn't want really good providers to be caught in the crossfire. So, appreciate that, and I know we'll have more discussion about it. My only question then is in terms of some of the other feedback, are you still looking at some of the other pieces and maybe in the next couple weeks coming out with some additional changes? Or is that sort of it? Where are we with some of the other things that were raised?

>> JEREMY YALE: Richard, on slide 4, we don't need to go back to that, but that identified those areas of high-volume comments. We really, I think addressed all of those and timing-wise, I hope to have it out by tomorrow, that announcement with the adjusted timeframes, and we plan to include some of the additional detail related to some of the other, I'll say high interest areas, that may be changing.

>> RICHARD EDLEY: Okay. Great. Thank you.

>> DEB SHOEMAKER: Any other questions for MAAC members? Okay. Do you have any questions in the chat, Elise?

>> ELISE GREGORY: Yes, we have one question right now from Janelle Gleeson. Within the timeframe for performance-based contracting, should we assume that the contract with the select vendor would be announced by the August 1st date? Or does that contract not need to be in place for the fall/winter activities?

>> JEREMY YALE: I think Janelle may be asking about our performance analysis services which is currently out with procurement through an RFP (Request for Proposal). So, if I'm understanding your question correctly, no, that does not need to be in place for us to move forward with this plan.

>> ELISE GREGORY: Janelle says thank you and we have no more questions in the chat.

>> DEB SHOEMAKER: Thank you Elise. Thank you, Jeremy, and have a good month.

>> JEREMY YALE: Thank you Deb. You as well.

>> DEB SHOEMAKER: Next on the agenda is OLTL, Deputy Secretary Marsala, are you ready to go?

>> JULIET MARSALA: I am. Can you hear me okay?

>> DEB SHOEMAKER: Yes, wonderful, thank you.

>>JULIET MARSALA: Wonderful, great. Well, I hope everyone is having a good morning. Lots to talk about today. So, if we go to the next slide, it'll show us the topics we're going to talk about. We're going to have our procurement update slide as we usually do. We're going to talk a little bit about the CHC (Community Health Choices) and OBRA waiver renewal and amendment, and some additional notices. So, let's go to the next slide and we'll go through it.

So, for the procurement updates, CHC request for application is still live. We're still in a black-out period. Any questions related to the RFA (Request for Application) needs to be sent to the following email box. And that's any questions at all that in any way could be related to or impacted by the RFA. It needs to go to that mailbox. There are no updates on the Agency with Choice procurement. It is still live. We're still in a black-out period there as well. So, I can't answer any questions related to those two items.

We have excitedly put out there for public comment our CHC waiver renewal and our OBRA waiver amendment. The renewal and the amendment are set to be effective January 1st, 2025, pending our submissions at CMS and their approval. So, for the Community HealthChoices, CMS requires that all of our waivers be renewed every five years, and that's why we're doing the renewal process for those Community HealthChoices waiver. Many of the substantive changes in Community HealthChoices also require amendments to our OBRA waiver so that we're consistent with both of our programs and we try to do that as much as possible and that is the predominant reason why we're also putting the OBRA waiver through an amendment process which is whenever we want to make changes to the OBRA waiver, we have to submit it via an amendment. So public notices were published on June 15th, in the *Pennsylvania Bulletin*. It is a 30-day public comment period for written comments. That public comment period ends on July 14th. So, you know, folks may have heard me talk about it, get ready for it, it's coming. Well, it's here. So, we welcome comments from everyone and encourage folks to submit those comments via the written comment process.

So, if you go to the next slide, I'm just going to go over some of the high-level waiver changes for folks. We're also going to do a presentation at the upcoming LTSS Subcommittee. For benefits counseling, we added the WIP-C™ (Work Incentive Practitioner certification) for providers to expand the pool of individuals who may provide the service. It's a very important service and we want to expand the network and availability and accessibility to individuals. For the employment skills development, we've added text to emphasize that sheltered workshop employment is not funded through our waivers. We wanted to make that very, very clear that any sheltered workshop activities are not to be funded through our waiver programs. These are employment programs that participate in paying workers sub-minimal wages. Under home adaptations, there's language added to better differentiate between home adaptations that are paid for through the waiver and the home adaptations that are covered via the State Plan or the HADME (Home Accessibility Durable Medical Equipment) services. So that is clarified within both of the waivers. In addition, we've proposed under the structured day habilitation services,

based on feedback received by stakeholders, to change the years of experience required for individual staff support from five years to two years to increase the pool of eligible workers to address the workforce shortages and that's been brought forward particularly by our provider community.

In addition, in the next slide, for teleservices, we have added teleservices that will allow cognitive rehabilitation therapy services and counseling services to be provided remotely. There are significant caveats to that with regards to how those services would be implemented and put forward, particularly safeguarding that it is the participants' choice that would drive it in addition to considerations with regards to not having readily accessible in-person services. We're looking to bring back chore services into our system, which consists of heavy household chores, which are necessary to maintain the functional use of the home or provide a clean, sanitary, and safe environment. The service may be authorized only when an uncleaned and cluttered living space impedes service delivery or increases the probability of injury from environmental hazard such as falls or burns. So, we are looking and seeking to bring back those chore services again based on stakeholder feedback. We're also cleaning up some of the language within the waiver renewal and amendments and we're removing language about OHCDS which is other healthcare delivery services, and the Participant Review Tool in CHC only. Both of these items are outdated information and we no longer have OHCDS available in those waivers and haven't for some time and so we're cleaning that language up. We go to the next slide.

We have some changes with regards to child abuse clearances. Really, it's just adapting and changing a particular sentence to make it clear that clearances are required for all direct care workers and service providers including service coordinators and contractors providing services in homes where children are present. We've taken out reside. It used to be reside and are just making it present. This is to increase the safety of children. Appendix G language was revised throughout regarding critical incidents to ensure the timeframes stated in the waiver and the responsibilities of entities involved in the process are accurately described. And then appendix H, under the quality improvement strategy in the Community HealthChoices waiver renewal only, there's language that's revised throughout to make it current to the processes that are currently in place. Alright, we can continue to the next slide.

There are changes to the service plans. We're adding language to reinforce that if a participant's rights in a setting need to be modified due to an assessment need, it must be documented in the person-centered service plan, and if a provider creates a treatment or service plan, that plan must be incorporated into the predominant person-centered service plan. This is based on sort of our site reviews, site visits, and also recommendations from CMS. We have come across situations whereby providers may have certain interventions in place that are not listed in someone's person centered service plan, and we want to make sure that that language is stronger and it's clear that these need to be aligned. We're reducing the timeframe of the person-centered service plan implementation in CHC only and requiring that they must be completed, developed, and implemented no later than 15 days from the date of the comprehensive needs assessment or re-assessment is completed. You see here we have the original 30 days that we're changing that down to 15 days. And then for the fair hearings in OBRA, we're changing the timeframe in which a participant may request a fair hearing and have services continue. We're extending that in our waiver from 10 days to 15 days to provide additional time for individuals to receive, review, and respond to fair hearings that they wish to pursue.

If we go to the next slide, there have been recent OLTL communications that we have published and some of these are ones I just talked about, as you can see here, we published about the public comments with regards to the waiver renewals and amendments. And if we go to the next slide, we also published an operations memo related to the need for comprehensive needs reassessment following a lapse in Medicaid long-term care eligibility. That's the Ops memo CHC 2020-01. That's posted on the public site and HealthChoices extranet. It has an issue date of May 13th, 2024. It clarifies when a comprehensive needs re-assessment is required following a lapse in Medicaid long-term care eligibility. In that revision, it also removes language referred to the Medicaid unwinding because that process is concluding. We also published the revised Home Accessibility Durable Medical Equipment HADME Ops memo, CHC 2023-07. That was revised to provide additional clarification to the managed care organizations as to what should be considered HADME and what should be a home adaptation covered through the waiver program. We go to the next slide.

I wanted to give folks from the committee an update on the Change Healthcare data breach. You may have seen things come out in the news. So, the Change Healthcare processed a lot of claims. There are a lot of providers in our network that utilize Change Healthcare. There was one of our CHC MCOs where Change Healthcare was their platform. So, when the Change Healthcare data breach occurred back in February, it did have some disruption and impact to the Community HealthChoices program. So back in February, Change Healthcare identified that there was ransomware on their computer system. On March 7th, they were able to confirm a substantial quantity of data had been accessed and exfiltrated from their environment. So we went through that process, our managed care organizations did a really good job ensuring that there were alternative pathways to payment, there was a lot of education that was put out. I believe billing claims have returned to their normal trends. However, beginning June 20th, 2024, Change Healthcare will be providing notice to all of their customers, or their providers, that were impacted so that their providers can in turn share information with potentially impacted individuals. This is a requirement with data breaches, following federal requirements of notifications to individuals when their data has been accessed by bad actors. So there’s a link here from Change Healthcare that provides that notification. Change Healthcare is still investigating whose personal information may have been involved. It was a significant data breach. So, this process of notification will continue for some time.

We go to the next slide. While all of this was happening, I thought it was prudent to share and hope folks continue to share this information widely, that individuals can take their own protection actions, and these are sort of best practices ongoing. So, individuals should always be on the look-out and regularly monitor the explanation of benefits statement that they receive from their health plans, and this is everyone, not just folks in CHC. And, you know, read the statements from healthcare providers as well as regularly routinely review your bank and credit card statements, your credit reports and tax returns, and check for any unfamiliar activity. So, unfamiliar activity could be something like your Explanation of Benefits (EOB) indicate that you received a knee brace, and you never received a knee brace. That’s one example of something that may show up on an explanation of benefits that you may want to report. So, if you notice any healthcare services you did not receive listed on any explanation of benefits statement, you should contact your health plan, your doctor, your service coordinator, and if individuals notice any suspicious activity on a bank or credit card, again, contact those financial institutions, let them know so

they can flag that as potential fraud. If you are a victim of crime, certainly please contact your local law enforcement authorities and file a police report. So, these are things and protections that individuals can do at any time and wanted to make sure that was shared and out there as I provided the Change Healthcare data update. And I will pause here for any questions because that concludes our OLTL update.

>> DEB SHOEMAKER: As always, very busy, Deputy Secretary Marsala. Way too busy. I had a question about the one issue. Then I had a question about the issue you just talked about. So, if I could quick ask those questions. Some of the proposed changes you were talking about, how do they comply with the CMS recent quality updates, specifically the requirements about limiting waiting periods for mental health outpatient, mental health patients that are in the outpatient setting that are waiting for appointments?

>> JULIET MARSALA: So, under the CHC renewal, that's really predominantly looking at the home and community-based services, and what's impacted by the home and community-based services. However, to answer your question with regards to any changes in the quality requirements, we would be working to align with all of those requirements.

>> DEB SHOEMAKER: Okay. In CMS quality changes, I know it tightens up a lot of that. I know sometimes you can't control that, but I know that's the goal and something just to reinforce a little bit. So, I appreciate that update. I guess the more interesting question to me, just from a standpoint of it being OLTL and being people that we serve, the data breach that Change Healthcare had, I know that you -- and I appreciate you providing the list of things people can watch out for. Is there any onus on Change Healthcare or somewhere where I'm just thinking personally, if your ATM card gets -- if there's a data breach, your ATM card gets -- what's the word, compromised, there's always an onus on that retailer and/or like the company to kind of do free credit monitoring, things like that. Is there anything in place that's going to happen? I'm only saying this because you know OLTL, that's a lot of older adults, and I know my grandmother, when she was alive, I had to help her with a lot of things, and she was smart. So, I'm just thinking a lot of our people may not think about those kinds of things and they may not be looking at their benefits, the benefits list, and things that they get. So, I didn't know if there's anything you know of or any assistance, we can suggest giving them because they're not going to understand it until it hits them.

>> JULIET MARSALA: Yeah, so there are federal requirements that all the entities are beholden to, with regards to data breaches, and the information regarding sort of free credit monitoring is included on Change Healthcare's website and will be included in their individual notifications as well. But yes, they're beholden to provide the standard free credit report monitoring and things of that nature.

>> DEB SHOEMAKER: Wonderful. Thank you. If we can in the future -- I don't want to hold up our questions or anything, but in the future, if we can, when we're going through -- the Department is going through the process of this, can we work with ConSub or work with some of, you know, Kathy's committee, to kind of come up with some consumer information that will be helpful to put down to the level of understanding when we send out notices that it's made pretty much crystal clear so they feel at ease and I don't know, Minta, if you want to jump in or anybody from ConSub. My biggest concern is knowing that's a population, aging population that needs to be pretty hand-held and not for any reason of their own. We get older and that's what happens. I'm just encouraging that we continue to work closely with consumers and with Kathy's committee to make sure that it gets out there so people aren't

getting scared, we're not getting phone calls that are saying, hey, what happened? I didn't get this. So, I don't know if anybody -- not to belabor it. I don't know if Minta, Kathy, Sonia, if anybody wants to quick jump in, if I'm on target with what I'm saying.

>> MINTA LIVENGOOD: This is Minta. I haven't heard anybody but one of the things that I have seen when the consumers receive these letters saying that their medical has been compromised, they panic, okay. They're not sure if they should do what the paper is saying about the pre-monitoring of that because they're very concerned that eventually they would be having to pay for it. So even myself, I'm somewhat skeptical on a lot of that so you may need to reassure the consumer that this isn't something that they will be billed for later. And the other thing is a lot of them, they get these papers, and they just throw them away. And then they find that they've gotten a bill in the mail and it's, well, now what do I do? I'll just pay that, instead of calling the insurance company or calling anybody to the doctor's office or the medical supply place and say what's going on. Our older, our more mature adults, don't always question the bills, okay. They assume it's right and they pay it.

>> JULIET MARSALA: I couldn't agree more, those are concerns that are shared significantly by me, which is part of the reason why I included this topic in today's update as I have in all of our subcommittee meetings in hopes to spread the awareness. In addition, I've shared those very same concerns with Change Healthcare directly. And certainly, for all of our members and all of our community-based organizations, I do hope that we all join together to share and educate and encourage folks to really look at those piles of papers in the mail and question things that don't seem right. It's also the same for me. I get my EOBs and sometimes I'm like, oh, yeah, I know I had that appointment. But I too can brush up on my sort of best practices on how to ensure that only things that are appropriate are being processed.

>> KATHY CUBIT: This is Kathy. I just want to quickly add that there are two excellent resources for older Pennsylvanians. One is PA Medi that can help with all types of billing questions, problems. And secondly, the PA SMP or Senior Medicare Patrol, which is a federal program that helps with both Medicare and Medicaid fraud. They can help people understand those benefit statements and untangle any problems that might be created in this or other circumstances. So, there are resources available.

>> DEB SHOEMAKER: Thank you, Kathy. I know there are -- if we can put the link in, and I think maybe as a follow-up, it might be helpful to have someone from either of those groups, especially PA Medi to provide a little bit of an update, or a written update for us. But no, I appreciate that, and I know you're doing an amazing job, OLTL. You're doing it, Deputy Secretary, so I know you guys are on top of it and I appreciate that. I know Department of Aging does a wonderful job for these kinds of things as well. It's very appreciated. I just think of my personal family and think about how older adults, it's something that's near and dear to my heart, especially as I age, since I have an AARP (American Association of Retired Persons) card, I know I'm on that way down, that other end. Do we have any questions from either MAAC members or in the chat? I want to make sure we're on target, but I took us down a little bit of a hole, hopefully it was informative.

>> KATHY CUBIT: This is Kathy. I have a quick question. Thanks for all your work and your presentation, Juliet. The fact that the comment period ends on Sunday, July 14th, does that mean you'll be taking comments over the weekend? Or could you just clarify that, please? Thank you.

>> JULIET MARSALA: Yeah, absolutely. We take comments all the way through the last day, July 14th.

Yep. So, we take comments over the weekend. We won't be reading them on July 14th, but the mailbox will be open through the weekend. And that also provides time for individuals who may be working through the week but haven't had time to put their personal comments together. That 30-day time period is 30 days. So, we published it on a Saturday, and it will close on a Sunday.

>> KATHY CUBIT: Okay. Thanks again.

>> JULIET MARSALA: Yep.

>> DEB SHOEMAKER: Any other quick questions for MAAC members? Okay. Any questions in the chat, Elise?

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

>> DEB SHOEMAKER: Wonderful. Thank you again, Deputy Secretary Marsala for the informative update and we look forward to additional updates next month.

>> JULIET MARSALA: Thank you. My pleasure.

>> DEB SHOEMAKER: Next on the agenda is Deputy Secretary Jennifer Smith. Hi, Jen.

>> JEN SMITH: Hi, Deb. How are you?

>> DEB SHOEMAKER: Good. How are you?

>> JEN SMITH: Good. Happy to be here. You can go ahead and flip to the next slide. So, I'll start with just a quick update on the Behavioral Health Council. We have, to date, had seven meetings as a council. Each of those meetings has been focused on a different area of the behavioral health system. The meeting that we held in June was focused on the crisis system and we heard presentations from my office, from folks at the county, from folks that work in providers and those that offer different forms of crisis services. It was very informative. I think it definitely highlighted some areas for the council to dig a little bit deeper into in terms of how we can support the crisis system long-term knowing that there are so many benefits to the health system at large for standing up good crisis services and really to the health and wellbeing of Pennsylvanians. So, we're continuing to meet monthly as a council in addition to the council meeting monthly, the advisory committee also is meeting monthly where they are hearing the same presentations and discussing the same types of topics. There is a goal to have a report generated with some high-level recommendations within the next several months. So, the council will be working their way through reviewing that plan and those recommendations. It is my understanding that at some point before the report is officially finalized and published that there will be a public comment period so to speak, where the report is available for public consumption and we're able to get feedback from folks on what those recommendations are. So that being said, I know there are many folks that join these MAAC meetings who had desired to be part of the council or part of the advisory committee and may not have been selected because they had to keep the numbers manageable. Dr. Chris Finelo, who is the Executive Director of the council, is very willing to meet with folks, to get emails from folks about additional feedback and information that you want to make sure the council has access to. So, trying to solicit as much feedback as possible, even before those recommendations are developed but wanted you to know also that once the initial report is developed, there will be an opportunity for folks in the public, including MAAC members, to have the opportunity to read that and weigh in on it. So, like I said, you can expect that several months from now. It will be by the end of the calendar year that that will be available for review. So, I'll keep providing you some of these quick updates but if you're really focused

on it, make sure you pay attention in the coming months for an announcement around the ability to review and comment on that report.

Next, I'll jump into some policy updates. So, we have the psychiatric rehabilitation services, these are our chapter 5230 regulations. The final draft of those regulations has been sent to the governor's office. We're expecting the final form of those regulations sent to IRRC (Independent Regulatory Review Commission) by September. So, we're hopeful we'll be on the calendar for IRRC's September commission meeting for a vote on those regulations. As a little bit of a reminder, these are services that are currently paid through as an in lieu of service, and CMS has recently released a number of final rules which was alluded to a few moments ago. In part of those final rules, CMS has now indicated there is a cap on the amount or the percentage of spend that can be on in lieu of services. And that cap is enforceable by each specific program of the Medicaid program. So, for example, physical health has to abide by that cap. Behavioral health has to abide by that cap. CHC has to abide by that cap. Unfortunately for behavioral health, Pennsylvania has been well-known to widely use the in lieu of services option in order to cover a number of different services and these psychiatric rehab services was one of those services that we paid for through that mechanism. So given the fact that we are currently above the percentage cap that CMS has now set for us, we are working with CMS and working with our partners to figure out how we get ourselves below that cap. And one of the ways to do that is to bring some of those services that we are paying as in lieu of services into the Medicaid State Plan. And that's exactly what we're doing with these psych rehab services. So, we are currently working on that draft State Plan Amendment (SPA). Our goal is to have that SPA to CMS by the end of summer. That will kickstart some back and forth between Pennsylvania and CMS to get that refined and hopefully approved. So, that was part of the impetus behind getting these regulations published and getting the services into the Medicaid State Plan was so that we can be in compliance with the CMS final rule as it relates to those in lieu of services. So, that's one regulatory package that we've got underway.

If you move to the next slide, I'll talk about a second package that we have underway, which is our PRTF regulations. That stands for Psychiatric Residential Treatment Facilities. These are currently in the Commonwealth's executive review process. We believe that the 30-day comment period for these regulations will probably begin sometime in late summer. The Children's Bureau at that point will be holding some webinars for stakeholders to talk through the major changes and what's to be expected. There really shouldn't be any big surprises though. These regulations have been in the works for quite some time and have involved a really significant amount of stakeholder input, involvement, and constant engagement. So, there's not going to be any surprises in those regs. I think the webinars will be more of a refresher for folks because for some people that had participated in the drafting and development of these, it's probably been quite some time since that had occurred because this process generally takes a lot longer than any of us would like it to. So, we'll get dates out soon for those webinars, if this is a topic of interest for you, make sure that you join us for one of those webinars and have the opportunity to ask any questions you might have or provide feedback. The other thing I wanted to mention related to these regulations, interesting timing, if you hadn't seen it, there was a recent US Senate Committee on Finance report issued related to residential treatment facilities. I think it was just within the last two weeks. We included the link here in the PowerPoint for you. It's a very interesting report. It highlights specifically

four providers who operate in a multitude of states across the nation and talks about some real deficiencies related to these facilities that treat children. And some of the names of the facilities will sound familiar to you because they do in fact operate here in Pennsylvania, and they are some providers that have in fact had some deficiencies from us as it relates to our licensing process which of course is public information. You can find those reports on our website. So, I think the importance of having these PRTF regs finalized and begun to be implemented is even more important based on what has been published in this report. So, you know, what it does is allows us to strengthen some things like the clinical standards that are required within these facilities.

So, you know, while it is adding additional regulations that aren't currently enforced, it's an important part of our system to ensure that the health and safety of these children are protected while they're in our care. So timing is just interesting on that. Check out the report if you haven't done so already. It's not on the slide, but I'll just briefly mention a third package of regs that we have working is our crisis regulations. There's two regs that are part of that package. One is more programmatic, the other is payment related. Those are still within the DHS review and approval process but are really close to the end of that process and should soon be moving out to review by the other Commonwealth entities that are required to review regulations. So, we've got a lot of reg packages moving out of OMHSAS. They've been in the works for a long time. But most of them are sort of headed toward the end of the process. That's good news. And that means we'll be able to focus on some new regulatory updates or creation of new regs once we get those crossed off the list.

And then last but not least for an update, just wanted to make folks aware, the PA support and referral hotline, this is a hotline that was created I believe during the pandemic where individuals could call and talk to someone if they were struggling, if they were looking for resources. We have been funding that line since the pandemic in addition to funding our 988 call centers and what we decided was it didn't really make sense to have two separate state related hotlines. So, we are transitioning that support and referral hotline to 988 services effective July 1. So just so folks know, callers have been receiving a message for the last two months essentially saying that this line is going to be going away and directing them to call either 988 or their local crisis number. Many counties still operate their own local crisis call centers. Starting July 1, when the line is actually no longer functional, callers will still receive a message for at least a month or so directing them to call 988 or their local crisis number. So, most of the callers that are using this particular support and referral hotline are regular callers, they're people who call either on a weekly or sometimes a daily basis into this hotline. Usually just looking for someone to talk to. So, they've had lots of opportunity, there's been lots of messaging to them about the fact that this hotline, this number specifically is not going to be operational anymore, but they can still call 988 and get the same level of service that they would have calling the support and referral hotline. So just wanted to make folks aware of that in case you hear anything about folks not being able to access services or resources. Please make sure you're just referring them to 988 or to a local crisis number. And that was all I had for today, Deb.

>> DEB SHOEMAKER: That's all? That's a lot. Thank you for the hard work of the office. I know some of these regs you've been talking about are a long time coming. So, thank you for that. Then the budget to tackle next. So, I think there's a lot going on, I think. I'm looking to see, are there any questions from

MAAC members?

>> RICHARD EDLEY: Deb, this is Richard Edley.

>> DEB SHOEMAKER: Go ahead.

>> RICHARD EDLEY: Hello, Jen. I actually have a question that we didn't address, just sort of a separate issue. More and more we've been hearing from both providers, BH-MCOs and primary contractors, about the impact of the unwinding disenrollment post-COVID. That the numbers appear to be a bit larger than expected and perhaps disproportionate, that healthier people are being more disenrolled and those more in need are remaining. Now it is a very live issue you weren't necessarily prepared for so I'm not asking what you're going to do about it, I mean, that may be for a future meeting, unless you want to, it's really more a question of I'm hearing that anecdotally. Is that what you're seeing? Are those correct assumptions perhaps and have to be addressed? So, it's really more of what are the facts maybe behind that?

>> JEN SMITH: Yeah, thanks for bringing that up, Richard. We too are hearing similar things, although not widespread. We're hearing it from some limited organizations. So, we are working, and when I say we, I'm really talking about the entire HealthChoices program. So, this includes physical health, behavioral health, and CHC. We've been working with Mercer to take a look at the data that's being used, to work with some of the organizations that are telling us about these discrepancies they're seeing, and we've been having meetings trying to sort through some of those things. So, I think it's pretty early yet for us to really comment on whether we agree with what we're hearing or whether we see something different. The other challenge is, and I think you know this specifically, Richard, there's a lot of cyclical nature to some of these rate discussions and reimbursements. So, historically we have seen lower numbers in the first quarter reports, which at this point is all we have seen coming in from the organization. So, we want to be really careful that we're not getting too excited based on one quarter's worth of information, but really taking a look at what's happening then into the second quarter. And of course, there are opportunities for us to do mid-year rate adjustments if in fact we see that need arising. So that's certainly an option that's on the table. But at this point we're still in the process of really looking at the data that we have, and we are using versus the data that the organizations who are reporting these losses are using. So that's kind of where we stand. We are aware of it though.

>> RICHARD EDLEY: I appreciate that. I'm sure there will be a lot more discussion about it. Thank you.

>> JEN SMITH: Yeah.

>> DEB SHOEMAKER: Thank you, Jen, for the answer. I know I agree that I'm sure Carl will tell you, now everybody is being added to the discussions, be anxious to see how this falls into place with new people needing assistance but I know you guys will handle it. So, no problem. Any other questions from the MAAC? Okay. Any questions in the chat, Elise?

>> ELISE GREGORY: No question in the chat. It does look like Ted posted in the chat when will MPC (Mental Health Planning Council) meeting schedule be posted?

>> JEN SMITH: I'm assuming mental health planning council? Is that what the MPC -- I'm not familiar with that acronym. Sorry, Ted.

>> TED MOWATT: Yeah, that's what I was asking.

>> JEN SMITH: Are you looking for, I think the schedule is out for the remainder of 2024.

>> TED MOWATT: No, just through the last meeting of the '23-24 cycle.

>> JEN SMITH: I'll make sure to send it to you.

>> KENDRA SNUFFER: This is Kendra. I can make sure Ted you get that. I can also send them to Lindsay or Elise after this and make sure everybody has the dates for the '24-25 cycle, because the '23-24 just ended, or will end in a couple days here.

>> TED MOWATT Right. Okay. Thank you.

>> DEB SHOEMAKER: Thank you, Kendra. Any other questions from the chat or from the MAAC? Last chance. Okay. Thank you, Deputy Secretary Smith, and Kendra. Have a good month. We'll hear from you next. I'm sure we'll hear from you before next month. But we'll hear -- because there's always something going on in OMHSAS. Thank you. Have a great day. Thank you.

>> JEN SMITH: Thanks. You too, Deb.

>> DEB SHOEMAKER: Thank you. Okay. Deputy Secretary Kozak, OMAP update.

>> SALLY KOZAK: So, good morning, everybody. I just have a couple quick updates then there's going to be a presentation on our new Qualitrac system. Final rules, folks have asked when we'll have some additional information about the impact to the program. We are still reviewing those. We're meeting on a regular basis, and we hope that we'll have an update ready by late summer. Of course, we are aware that there are portions of the final rules that will have an impact on our stakeholder advisory committee. So, the MAAC. So, we will keep you updated on all of that. The MATP (Medical Assistance Transportation Program) study, this is still going through internal review, and it's waiting approval for release by PennDOT. So, we don't have an exact date on that, but as soon as it's released, we will let you know and do some additional presentation here to the MAAC on it.

Then the last update that I have before the presentation on Qualitrac is the school-based services grant. It was announced yesterday that Pennsylvania was one of 18 states that got the technical assistance grant. It is $2.5 million. The grant period is from July 1st of this year through June 30th of 2027. We'll get $500,000 in the first year and $1 million each subsequent year after. The purpose of the grant is to help states in enhancing our efforts to connect more children to healthcare services with a particular focus on mental health services. We will be working with the Department of Education in developing a plan for how it is that we move forward. The grant will actually be managed by us in cooperation with the Department of Education's Bureau of Special Education. So just wanted to share that since that news had been released yesterday. So, unless there's any questions on those three topics, I'm going to go ahead and let the folks proceed with the Qualitrac presentation.

>> DEB SHOEMAKER: I say go ahead, Deputy Secretary Kozak. It's too fresh and don't have many answers.

>> SALLY KOZAK: Okay. Then I think it's Dale that's presenting, correct? Dale Flor?

>> ELISE GREGORY: We're seeing that Dale's mic is open but we're not hearing you, Dale.

>> SALLY KOZAK: Dale, we're still not hearing you.

>> DEB SHOEMAKER: While we're waiting, do you have anything else to report -- oh, I think we have him.

>> DALE FLOR: Okay. Can you guys hear me now?

>> DEB SHOEMAKER: Yes.

>> DALE FLOR: Sorry about that. Alright. So, thank you for having me. My name is Dale Flor. I'm a

delivery leader in the Bureau of Data and Claims Management. My team is responsible for initially or essentially managing the delivery of our technical strategic initiatives. So, what I'm going to provide an update on today is what we call our PAU, prior authorization and utilization release 2. Back in the fall of 2023, we implemented the first phase, which was a case management aspect. Phase 2 of this is to move our existing prior authorization capabilities from the legacy system to a new, I'll say web-based, cloud enabled module called Qualitrac that's presented to us by the vendor Telligen. Essentially the premise of this is to support or to align with the CMS directives to modularize the different aspects or capabilities in your infrastructure. So, this is just the next one that we were in the process of doing. One of the things, one of the key capabilities, and I'm not going to read each of the bullets here, but one of the key capabilities that I think is very important is the current prior implementation process is very manual. We have internal users answering phones, entering authorization requests for the various services across the different business areas. They can enter fax, paper, and with the new implementation of the modern module, we're going to have a better handle and better metrics and visibility on all the different requests or authorizations that are being entered into or being used to support our claims processing aspect. Next slide, please.

One of the other capabilities that the modern platform also allows is workflow management and task management capabilities that just don't simply exist in the legacy system today. So as these new requests come in, oftentimes they get routed and need to go to different levels of approval, they need to go to other areas for certain input. They also have other stages in their lifecycle, if you will, where additional information is required throughout the lifecycle. One of the other key aspects that this implementation is going to provide to the providers is a portal, a provider portal so that the providers can ultimately submit the prior authorization request on their own. To do some self-service instead of having to pick up the phone, call the business, and have them manually enter those authorizations. And providers will be able to do that themselves. They're going to get better visibility on the status of the request they have submitted. If they enroll and have access to the portal, all of that correspondence that could be required for the different services will be handled via the portal in a real-time manner. There's chat, email capabilities, if there's additional information or documentation that's required, the providers, or their administrators that designate can actually upload and attach those attachments via the portal. Again, to streamline the process and provide that central repository if you will for all the correspondence. Next slide, please.

So, this is just a high-level timeframe. So, everybody kind of gets a visual of where we are. Our go-live is scheduled for the evening of October 24th. So essentially for our internal users that handle these requests today, on the morning of Friday, October 25th, they're going to be entering all new authorization requests regardless of vehicle of transmission. So, we'll still allow paper. We'll still allow fax, phone calls. But essentially on October 25th, all new authorization requests are going to be entered into the new Qualitrac system. So, you can kind of see here there's a run-out period in the orange to the right of that. The next key milestone that's more significant to our provider community is scheduled on December 16th. They will get communication and information on how to register for the new provider portal and they'll be able to begin that process from then into 2025. Those are really the key two milestones that we're tracking to.

If you go to the next slide, you'll kind of, see how we have the project broken down, just so everybody is aware of all the different activities that are going on. You can see on the dashboard here; this is probably about a week old. That particular point we had I'll say a rather significant change request that needed to be accounted for and added to the schedule. We've since brought that through our change control process and that has been added. That was specifically to handle the pharmacy request, the pharmacy work is coming in a little bit later phase. Still before go-live, just from a development and testing perspective. You can kind of see, we've met with the different business areas. We've gathered their requirements. So, the requirement phase is essentially completed at this particular point. We're actively in the various stages of communication we're also currently working with our internal business leads to make sure that they're getting the visibility and access to the changes that are going to be implemented into the action. So, some of that training has begun with the business leads. Then we're at I'll say a critical junction as far as communication because we're also going to be pushing out internal communications to the rest of the staff to help manage expectations as far as what they can expect and the timing of when training is going to occur and when we're going to bring them onboard to start working with them so they can get familiar with the new processes and the new application. In parallel to that, we have communications drafted to our external parties as well. We've reviewed those internally and we're working on the exact timeframe, probably within the next I'll say two or three weeks is probably where we're at before we start pushing communication out through the various channels, bulletins, emails, websites, that sort of thing, to our external provider community. So, they'll be becoming aware in the next couple of weeks that this change and the provider portal is going to be something that's going to be presented to them later this year. So, like I said, the key I'll say junction that we're at right now is we've got enough confidence in our development activities, in the capabilities that we're going to start communicating and managing those expectations. Not only to the internal staff, but the external community as well.

We are well underway, if you will, in testing. If you can kind of think about the complexity of this, we're not changing anything from a claims adjudication perspective but the new system will have to communicate with the existing claims engine, so there's multiple vendors in play here, so my team is responsible for the oversight and managing those deliverables for each of those vendors to make sure everything is getting done, tested, and implemented within the timeframes to support the October 25th and then again the December 16th dates for the provider portal. We've also begun moving down on this graph here, we are well on our way onboard to work through the details of our implementation plan. So, this is the detailed plan that will be kind of a playbook, if this, then that sort of thing, with exact timeframes or windows in which communications or tasks need to be done at go-live. Then we've also started working through any mitigation strategies that we may need to execute depending on if there's any defects or if there are capabilities that aren't working exactly the way we need it. Those mitigation strategies, we're currently in the process of building those out, so that if any work arounds need to be accommodated or implemented, we're putting that proactive approach around that decision-making now so that we're ready when we get closer to that go-live date.

I mentioned also that the training is well underway. If you kind of think about where we are in that previous slide with the timelines, as our delivery activities wrap up over the summer, we'll be working

with our internal users to make sure they're comfortable in that September and October timeframe and then in parallel to that in that September - October timeframe, we'll be pushing out invitations and hosting forums so that the provider community can join those sessions and get trained on how the new portal experience is going to be, look and feel for them. And they'll have an education also provided to them as far as, again, keep in mind, today they don't necessarily, at least for DHS, or their interaction for Medicaid for the state of Pennsylvania, they're used to calling or submitting paper or faxes. In the future -- or they'll have an opportunity, I'm not going to say they have to, we're not going to mandate that they have to use the portal but that will be another vehicle for them if they want to take the self-service approach. So, a part of that communication and training, we'll be managing those expectations with them so that they understand what required fields, what kind of documentation, all of those steps will be clear for them as far as what they need to do to submit those authorizations via the provider portal.

Then lastly here, the main point I want to make around certification, we are working closely with CMS to make sure they understand when and what it is that we're doing. From an operational readiness perspective, they also want to make sure we've done our due diligence in making sure we've trained and prepared our internal users because that will be one of the key metrics that they're going to be looking at and trying to watch for us is the movement of this work eventually over time from our internal staff and the manual burden that that has on the different business areas today to moving that work to the self-service model where providers can initiate those requests for themselves. We have a host of metrics that we've provided to CMS. We met with them a couple weeks ago. As part of that session we provided them an update on where we were with the implementation and then we have a number of steps. Over the next year and milestones that we'll be working closely with CMS to ensure that we get the appropriate funding and we're doing everything that we told them, evidence to support the metrics that we're going to be tracking based on the agreement that we have with CMS. Like I said, I wasn't going to read every single bullet in here. I'm pressed for time. But any questions? That's basically what I wanted to do was provide an update to this forum to make sure everybody's aware of what's coming and kind of where we're at.

>> DEB SHOEMAKER: Thank you, Dale. Actually, I was fortunate, I'm going to say as a disclaimer, I was fortunate to hear this first from Fee-for-Service sub. We asked Dale to come at our meeting in May I believe. So, I appreciate the update since then. So, you're moving and shaking way beyond even in a month what we talked about.

>> DALE FLOR: The light is at the end of the tunnel.

>> DEB SHOEMAKER: That's right. You see a good result. So that's good. Any questions from MAAC members? Okay. Any questions in the chat?

>> ELISE GREGORY: Yes, we have a question from Andrew Kunka. Will the new Qualitrac utilization management solution system be used or can be accessed by MCOs or is it just for Fee-for-Service?

>> DALE FLOR: It will be for MCOs as well. Yep.

>> ELISE GREGORY: And from Nicole Payonk, has there been any consideration to include other services beyond mental health as part of the grant? I'm assuming they mean the school-based access grant.

>> EVE LICKERS: This is Eve. Sally had to step away for another meeting. But yes, behavioral health is

obviously a part of it, but we're also looking at other services as well, physical health services. Hope that helps.

>> JOE GLINKA: Deb, it's Joe Glinka. I do have a question if I may.

>> DEB SHOEMAKER: Go ahead.

>> JOE GLINKA: This is back to Dale, appreciate the presentation. I was intrigued by the provider enrollment piece that I believe is coming in mid-December as part of this new system. What comes top of mind in terms of additional efficiencies in that respect for provider enrollment in the Medicaid program?

>> EVE LICKERS: I'm going to see if we can unmute Michele Robison. Michele Robison who's the Director from the Bureau of Fee-for-Service. She muted herself. But if she would like to address the question, that would be great.

>> MICHELE ROBISON: I'm sorry, Joe, can you repeat it?

>> JOE GLINKA: No. No, I'm just kidding. So, with respect to provider enrollment, which I understand is part of the transition to the new web-based system that won't take place until mid-December if I'm looking at the information correctly, new efficiencies with respect to provider enrollment in terms of timing or anything like that that you can comment with the new program that we can look forward to. Because that enrollment is obviously critical in the credentialing effort.

>> MICHELE ROBISON: I think we're confusing the word provider enrollment. The enrollment that's in December is just for this new prior authorization system. It's not overall provider enrollment. That's a whole different topic. So, the December 15th date is providers being able to enroll and be able to enter a prior authorization request into the new Qualitrac system for Fee-for-Service.

>> JOE GLINKA: Big difference. Okay. Thank you for that clarification.

>> MICHELE ROBISON: Yes, you're welcome. And I just want to clarify, this is for Fee-for-Service only, not managed care. The managed care organizations will continue processes as they currently are. This process here is just for Fee-for-Service.

>> JOE GLINKA: Thank you for that.

>> MICHELE ROBISON: You're welcome.

>> DEB SHOEMAKER: Thanks, Michele, my fearless leader of Fee-for-Service. We're fortunate to have Michele at all of our Fee-for-Service meetings. I'm glad she could answer that question. Any other questions from either MAAC members or in the chat? Last call. Okay. Thank you, Dale. Eve, I assume Deputy Secretary Kozak doesn't have anything else in her report.

>> EVE LICKERS: No, ma'am. That was everything that we had for you today.

>> DEB SHOEMAKER: Okay. For Consumer Sub, Kyle, are you giving the report?

>> KYLE FISHER: I can, yes. Thank you, Deb. And certainly, our Chair Sonia or Vice-Chair Minta can supplement this if they'd like. I'll limit the report here to two of the updates we received. The Consumer Subcommittee met yesterday. I'll focus on two updates we haven't discussed already this morning. From the Office of Medical Assistance Programs, we discussed some of the recent activity around hospital contracts with the physical health MCOs and in particular we talked about the Children's Hospital of Philadelphia (CHOP) which did come to an agreement at the end of last month just before Keystone AmeriHealth would've needed to mail notices to the roughly 125,000 members that would've been impacted. So certainly, a relief that Keystone and CHOP came to an agreement there and notices weren't

mailed. Also, obviously unfortunate that the negotiation process was so public and so many families were concerned about being able to continue their care, many of whom changed MCOs prior to that agreement being reached, hopefully they realize they can change back if they so choose. Deputy Secretary Kozak also shared that the agreement between Temple Hospital and Keystone AmeriHealth is set to expire at the end of July. Keystone would have to mail notices to its members by the end of this month which is really the end of this week. If a new agreement or extension is not reached. This is another one that would have a huge impact, an estimated 190,000 members of Keystone AmeriHealth's would be impacted by this termination. It sounds like DHS is optimistic the parties are going to reach at least an extension that gives them additional time to negotiate. If the termination goes through, it is good news that two or three other managed care plans in the southeast also contract with Temple so those impacted families could change their plans to remain with their current providers.

The second update I wanted to touch on was the report from Deputy Secretary Marsala from the Office of Long-Term Living. We touched on a number of topics. OLTL presented updated appeals data for CHC for the calendar year 2023, which consumers and council are still digesting. We also talked a bit about service coordination. Consumers have provided some feedback around continuing concerns and challenges with service coordinators not being responsive, participants not being aware of who their service coordinator actually is and participants not being given a choice of service coordination. The deputy spoke about continuing to work with the CHC-MCOs to ensure they're making efforts to address all of these topics including trying to meet the preferences of a participant such as if they want to work with the service coordinator who is male or female or someone who is comfortable with their particular religion. They're also working with the MCOs on making sure they're putting processes or systems in place to reinforce that they need to be responsive to outreach from participants. The contract requires a two-business day turnaround, in response to requests from participants. The Deputy Secretary talked about practices such as leaving a refrigerator magnet with the service coordinator's name and contact information on it so that participants know who their service coordinator is. And in terms of choice, they also -- she highlighted that participants have the right to interview a service coordinator prior to selecting. So, it's something that I think has not been disseminated information. It's not widely known. So certainly, appreciate her highlighting that.

The last piece I'll update here is a programmatic change that OLTL clarified, confirmed they will be adopting, and this was a consumer recommendation. As of 2025, CHC contract will require the MCOs to identify a change in a person's condition or circumstances or previous mistake in an authorization before they reduce an existing service. So that's a change that was recently implemented on the HealthChoices side. I'm certainly pleased to hear that it will be implemented beginning next year for the CHC program as well. That's everything I wanted to cover. I don't know, Sonia, or Minta if there was anything else you wanted to highlight. If not, I'm happy to take questions if there's time.

>> DEB SHOEMAKER: Okay, ladies, do you have anything to add to Kyle's presentation? Sonia? Minta? Okay. Any quick questions for Kyle? Okay. Thank you, Kyle, for the hard work. You guys meet on the 24th right before the next meeting next month.

>> KYLE FISHER: That's right. Thank you.

>> DEB SHOEMAKER: Thank you. Fee-for-Service Delivery System Subcommittee, we did not meet. We

met last month. So, our next meeting is August 7th. LTSSS, Kathy.

>> KATHY CUBIT: Thanks, Deb. The LTSS Subcommittee met in person and remotely on June 5th. Deputy Secretary Marsala provided OLTL updates as shared today. There will be a presentation and discussion about the CHC and OBRA waiver renewals at our meeting next week and all are welcome to join us. She also provided an overview of the Living Independence for the Elderly or LIFE program. Nationally the program is known as the Program of All-inclusive Care for the Elderly or PACE program. It's a fully integrated optional managed care program. LIFE offers services in an adult day center providing primary healthcare, therapy, socialization, and other services. The program began in Pennsylvania in 1998 and serves about 8,000 people across 54 counties. OLTL hopes to address challenges in operating LIFE in some rural areas with the goal of having LIFE available state-wide.

Each of the three CHC-MCOs presented information about how they support both CHC, home and community-based services, or HCBS (Home and Community Based Services) waiver and nursing facility participants during annual renewal process and when a participant receives notice of loss of eligibility during redetermination. The top priority expressed by the plans is to support participants in maintaining eligibility, but they also all provide support should a participant receive a termination notice. Much effort is dedicated to training staff and on outreach and education efforts to participants. CHC plans provide support as needed both for the clinical and financial components of eligibility. And I'll condense this to say the MCO shared one reason for the higher-than-expected rates for nursing home participants is attributed to guardians not providing needed documentation.

Staff from Mercer provided an overview of its home and community-based services rate and wage study for OLTL including goals and the timeline for stakeholder engagement. Mercer will evaluate the following service categories in this rate study, adult day, residential habilitation, personal assistance, structured day habilitation, and employment and training services. The LTSS Subcommittee will hear a progress report at July's meeting and Mercer expects to present the rate study results at September's meeting. As always, there were two open forum times during the meeting for public comment. The next LTSS Subcommittee meeting will be both remote and in person at 333 Market Street Tower on the first floor Honor Suite in Harrisburg next Tuesday, July 2nd, from 10:00 to 1:00. All are welcome. And I'm happy to answer any questions. Thank you.

>> DEB SHOEMAKER: Thank you, Kathy. I know your committee is always busy as well. So, thanks for the hard work there. Does anyone have any questions for Kathy? Okay. Thank you. Last but not least, Joe Glinka, MCDSS.

>> JOE GLINKA: Thanks, Deb. Had to get myself off mute. We met June 13th and a number of the items that were covered in this meeting were touched on in our meeting. One of the things we did get an update on briefly was the MyOMHSAS update, an online resource modeled after what ODP has. We were informed the training platform went live in the middle of May, May 16th to be exact. It's available to anyone who wants to browse, but you need to register and log in to dive deeper into what the resource can provide. So great development in OMHSAS as far as additional insight into what's going on there.

We did get an OMAP update as we always do with respect to the newly eligible population which we heard from Carl today that the unwinding is basically completed. OMAP's work done by the Department, but the population of the newly eligible groups run 752,000 per our meeting, if you're keeping track at

home, that population was around 678,000 pre-COVID. So, if you do the math, it represents probably about a 3% annual growth which would probably be in line with normal growth had the pandemic not occurred. So, the number of applications continues to increase dramatically over the same period as last year. I'm talking about a period of April 29th to May 24th where there was an 18.3% increase in the applications submitted to the Department for eligibility over the same period last year. That total represents about 84,000 apps in all being submitted for that period of time. As Sally pointed out, final rule deliberations continue to go underway. More details to come as far as what that will look like when the rubber hits the road so to speak. We did get a brief update on the Department's efforts to update its website and revisions to come. It will embrace additional transparency, easier navigation, it will be a more generous supply of quality data among other enhancements to look forward to when that website enhancement happens. We were not given a timeframe on that.

We did have a brief discussion on additional providers coming into the Medical Assistance space. We have previously talked about doulas and there's been frankly a slow uptake with respect to doula providers in the Medicaid space. Moving forward, we anticipate that will pick up momentum. Pharmacists are our new provider type within the space. That uptake has been a bit brisker, so to speak. As of the date of our meeting, we had 250 pharmacists enrolled serving over 300 different locations in the Medicaid program. The provider type to look forward to is the Community Health Workers, we've heard in previous meetings here, probably no later than in year 2026, as shared in our meeting. A lot of work goes into that in terms of scope, service definitions, and so forth. So, we'll continue to keep the group updated as we get more details on how that evolves.

Then we got updates from our respective work groups if you will. Those of you familiar, MCDSS has taken on a couple projects. We've divided the subcommittee into two work groups. That being complex care coordination as well as provider capacity. At the MCDSS meeting we did get updates from both of those work groups and in terms of process, those respective work groups will do their good work, report to the MCDSS. When we finally get to a finished state or final product if you will, in each one of those work groups, the findings of those work groups and what they want to bring to bear to the MAAC level will be discerned over by the MCDSS before it gets to MAAC and its level of discernment for recommendation to the Department. Target for finished products in both of those work groups, we're looking at the end of the year. There's a lot of good work being done. Then in the interim periods, when MCDSS does not meet, the workgroup is meeting in the provider capacity group in particular, there are three different teams that have been created in order to get out the provider domains they're looking to tackle. So, the provider workgroup forum is an opportunity to share ideas with respect to what's going on with provider capacity, similar to what's happening in complex care. But we are making progress. And looking forward to sharing more about that. Deb, when we finally get to bringing that workgroup information to the MAAC, we're going to need some time on the calendar. Just sowing that seed now. More to come. But we'll need to have some, a realistic period of time, portion of this agenda to really discuss those items when they're brought to bear.

>> DEB SHOEMAKER: Good. We would appreciate that, Joe. If you could give us like a month's heads up, that will be great.

>> JOE GLINKA: We'll do that. So, the work groups, like I said, are meeting in between. Our next

MCDSS meeting is not until September 12th. Historically, we wouldn't meet in August anyway. But again, in the interim the work groups and their respective team members will be meeting. I'll stop there. If there's any questions, I'm more than happy to answer it.

>> DEB SHOEMAKER: Okay. Any quick questions? Okay. Eve. MA bulletins, pharmacy documents, What's New?

>> EVE LICKERS: Yes, ma'am. Good afternoon—well we still have a couple minutes so good morning, everyone. We had three bulletins that were issued since the last meeting. And the first one is MA bulletin 99-24-03 and that was the 2024 HCPCS Updates, Fee Schedule Adjustments, and Other Procedure Code Changes issued on May 28th and also effective on that same day. MA bulletin 01-24-06, Updates to the Family Planning Services Program Fee Schedule, also issued on May 28th, effective on May 28th, that was a bulletin that made updates to the Family Planning Services Program which is our State Plan option for Family Planning services, formally known as Select Plan for women. Those code changes were based on changes that stem from the 2024 HCPCS changes. So, MA bulletin 27-24-03, that's the 2024 Medical Assistance Program Dental Fee Schedule Update and that was issued on June 5th and effective back to May 28th, also changes based on the 2024 HCPCS implementation. So, these bulletins can be found on the Department's website on the updated bulletin search page which is still probably maybe a little bit challenging but also much, much better than what we've been kind of struggling with for the last several years. But again, the What's New at OMAP page is still up and available and a quick reference point for finding all of the communications from OMAP. And I think that's all I have for you.

>> DEB SHOEMAKER: Thank you. Old or new business. MAAC members? Okay. One new business. Go ahead.

>> MIA HANEY: This is Mia Haney from the Pennsylvania Home Care Association. I had a question. We had seen an ODP announcement about an enterprise licensing system and upon further investigation it looks like this has been deliberated on for a couple of years now across multiple departments including those on today's call. We're curious how this impacts or if this impacts incident reporting across the EIM (Enterprise Information Management) system that's currently used in home and community-based services and if it would also impact the Department of Health incident reporting system and somehow find efficiencies between those two reporting systems.

>> DEB SHOEMAKER: Can someone from DHS answer that question? If not, we'll get back to you, Mia.

>> EVE LICKERS: I'm not sure if there's someone on the call that can answer that at this point, so we may need to take that back. If you could submit that in writing to us, I think that would assist us as well.

>> DEB SHOEMAKER: Will the chat suffice, Eve?

>> EVE LICKERS: Yes, and that's what I mean. If you could drop it in the chat, that would be great.

>> MIA HANEY: Will do. Thank you.

>> EVE LICKERS: That will have your contact information and we can make sure we get you a response.

>> DEB SHOEMAKER: Okay. Thank you. Being the noon hour, I will take a motion to adjourn. But before I do that, at the bottom as you can see, our attempt this year is to at least get closer to being back to normal if we use the normal word anymore, but we have been trying to get at least quarterly in-person meetings, so the next meeting in July is scheduled to be in person. It is in the same location as before which I believe is the Keystone Building. I might be wrong. Let me know if I'm wrong, Elise. So,

you'll get more information but plan to attend in person if you are able. And then remember, August we take a break. So, if I could take a motion to adjourn.

>> MINTA LIVENGOOD: This is Minta Livengood. I make the motion to adjourn.

>> DEB SHOEMAKER: Thank you, Minta. Second?

>> TED MOWATT: Ted, second.

>> DEB SHOEMAKER: Thanks, Ted. All in favor. I will take it. All in favor?

>> MAAC COMMITTEE MEMBERS: Aye.

>> DEB SHOEMAKER: All right. Thank you, everyone. Have a wonderful rest of your month and we'll see you next month hopefully in person.

>> EVE LICKERS: Thank you. Take care.