Consumer Subcommittee of the MAAC
April 26, 2023

Consumers Present: Sonia Brookins, Marsha White-Mathis, Liz Healey, Jayme Scali, Ronel Baccus, Meghann Luczkowski.

Sonia Brookins, Chair of the Consumer Subcommittee, called the meeting to order at 1PM.

I. OMAP Report

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

Status of PHE Flexibilities & Coverage Changes

Deputy Secretary Kozak provided updates regarding the PHE, which is scheduled to end on May 11, 2023. The department will continue to provide coverage of the Covid 19 vaccine with no cost sharing. They are mandated to provide COVID vaccines, testing, and treatments through September 30, 2024.

Kyle Fisher, PHLP and Counsel to the Consumers, asked if Ms. Kozak could go over the continuation of cough and cold treatment coverage for adults. Ms. Kozak responded she has a list of coverage items she could address:

- Over-the-counter Cough and Cold medications will continue to be covered for adults this will be a permanent state plan change.
- The Department does not anticipate a change to vaccines in September 2024. She thinks the COVID 19 vaccine will become a standard recommendation.
- Over the counter home testing kits will be covered through September 2024. The department anticipates this could change after September 2024, as labs become mandated.
- COVID treatments with emergency use authorization will be covered through at least September 2024. After that the department will continue to follow federal guidance.
- The department will continue to cover masks.

Mr. Fisher noted, regarding masks, PHLP has a client who is struggling to get masks. There seems to be a lack of understanding on the MCO level as neither member services nor this person’s service coordinator were aware of the new coverage. Has the department instructed the MCO to update their member handbooks?

Ms. Kozak responded that they have made the MCOs aware, but the Department will have to provide follow-up. Ms. Kozak asked Ms. Zander to follow up with MCOs and OLTL to make sure messaging gets through to consumers.

Ms. Kozak stated the department was doing early refills of medications, but that will end and go back to previous practice. Ms. Lickers noted that this was communicated to the MCOs pharmacy departments.

Parents as Paid Caregivers

Ms. Kozak confirmed with CMS that the Department is able to continue paying parents or legally responsible relatives to provide services to individuals with authorized HHA services. What that means is personal care services will now be considered HHA services. Parents need to become HHA's through a home health agency. They need to meet all employment requirements that the agency has in place, then they will be able to provide HHA services. This tracks current practice; parents have already been employed through home health agencies. Ms. Kozak wanted to be clear: home health aide services do not provide a skilled level of care such as ventilator or G-tube care. The department is aware that they have a handful of parents who are licensed nurses, they have always been allowed to provide care.

OMAP identified just over 500 families that were using this flexibility during the pandemic. All MCOS have sent updated letters saying this option will continue past May 11th, the end of the PHE. DHS continues to work through coding for this to convert from personal care coding in EVV to home health aide services. It will be re-coded to S9122 and T1099 when we provide further guidance through a bulletin. Will be adding modifier to know it's a parent.

Deb Shoemaker, chair of the MAAC, asked for the codes to be repeated. Ms. Kozak replied, S1922 and T1019. However, the agencies will continue to use current codes until new ones are released.

Mr. Fisher thanked the department for sharing codes and that level of detail in this update. He asked OMAP to confirm that the practice that exists now is not changing, that parent currently providing care as a HHA will be able to continue providing that care. Ms. Kozak replied yes they will, as long as they are employed through an HHA and as long as they meet all requirements for employment.

Mr. Fished asked if a bulletin and/or other guidance was coming out shortly, or the time frames to expect them.

Ms. Kozak responded that there is no time frame for the MA bulletin right now, will require system change on our end. Ms. Zander confirmed a new managed care ops memo will go out

that will add a bit of language. It will clarify that the same policy applies for review of HHA requests regardless of identity of HHA (i.e., whether the aide is a parent/LRR). Ms. Zander noted that the three current Ops Memos used for guidance will be obsolete and repurposed into one Ops Memo.

Mr. Fisher noted that as they are drafting the Consumers and Counsel would be happy to review and offer comments. He also asked if there was a time frame to release the ops memo. Ms. Zander responded it is being reviewed internally and the goal is to have it out before May 11, 2023, when the PHE ends.

Ms. Healey thanked the department for their hard work. Ms. Brookins seconded this, she was appreciative of all the work the department does.

LIHEAP Update

Ms. Kozak stated that LIHEAP has been extended two weeks from April 28th to May 12th. The average cash benefit is $398, the crisis cash benefit $658.

Proposed Medicaid Budget, FY 2023-2024

Ms. Kozak, noted that the proposed budget is 28.2 billion, but it is still being finalized. Capitation is $23.2 million, and 83% of budget. Fee for Service is 11%, or about $3 B of the budget. CHIP is 1%, or about $339 M, of the budget. Medicare Part D is 3% of budget, about $991 M. Other spending includes Uncompensated Care, MAWD, Critical access hospitals, supplemental payments to OB/Neonatal services, and expanded coverage for women.
MATP is 1%, or about $166 M.

Mr. Fished asked re capitation line-item, what portion of the $23.2 billion is physical and what portion is behavioral. Ms. Kozak stated that the Physical Health HC line-item is $19.6 billion; the other portion is behavioral.

Mr. Fisher asked if the capitation include rate increases. Ms. Kozak noted they always budget increases, but that doesn't mean it automatically goes through. DHS negotiates actuarially sound rates, as is required.

The general fund Physical Health HealthChoices appropriation is $4.6 billion, overall increase of 26%. The reason for the increase is partially due the phase down of the enhanced match tied to the PHE continuous coverage requirements. And also to the expansion population, of which there are now 1.124 million enrollees. These are newly eligible individuals 19-64, some of whom are individuals who remained eligible only due to the public health emergency. Estimated enrollment of more than 3.1 million recipients.

The proposed budget also supports a range of enhanced quality initiatives. She talked briefly about these initiatives:

- Opioid Use Disorder (OUD) Centers of Excellence – Started 2016, moved to Managed care in 2020. Increased utilization of PCP services and ambulatory behavioral health services. Increased engagement after receiving diagnosis. Increase in number of individuals to treat OUD. Decrease in all cause ER and inpatient stays. The department feels COE's have been very successful.
- Pay for Performance (P4P) – MCOs can earn up to 2% all capitation revenue based on HEDIS & PA performance measures. Payouts based on performance relative to benchmarks and year-after-year improvements. Includes measures for perinatal and infant childcare, hypertension, diabetes. Bundled some of them together. Break out by race ethnicity and add opportunity. Timeliness of prenatal care and well child. Comprehensive diabetes care and controlling hypertension. Also require the MCOs to do a provider P4P program that provides an additional $1 PMPM. The department does review the plans prior to implementation. They have now built in focuses on dental and pediatric shift care.
- Integrated Care Planning (ICP) which started in 2016. Compensation is based on 10 quality measures. It is an exchange of information, incentive not only number of care plans done.
- Community based care management programs (CBCM) – Initiatives based in the community. Utilizes community health worker and health care agency. They have flexibility to do unique tasks.

The Consumers noted that Ms. Kozak went through a lot of quality initiatives. Related to community-based care management. Dr. Kelly has spoken about this in the past. The consumers asked that updated presentation on CBCM and P4P, especially the new provider P4P program, be slated for upcoming meetings. Mr. Brookins asked for a meeting on all quality initiatives. Not in one meeting, but future meetings. Ms. Kozak replied that the Department will be happy to provide these updates.

HCBS

Ms. Kozak next addressed the ARPA HCBS Spending Plan. For OMAP, the spending is focused on pediatric private duty nursing. All of OMAP's allocated ARPA funds went towards implementing the 21 recommendations of the pediatric work group.

Of the $54 M in overall funding, the proposed budget reflects allocations of $11.6 M to MATP, some into the RISE PA tool, and the rest into HCBS/private duty nursing. Most of these initiatives are to be paid through capitation and incorporated into the managed care contracts for 2023. Provider P4P includes both PCP and Home Health Agencies. Pediatric Shift nursing bonuses will be awarded as one time grant. Terms of grant will be through 2024, they will have to apply. MS. Kozak also noted they are paying for shadow nursing and pediatric resource centers.

Jayme Scali, Consumer, explained that her home nurse recently left after 6 years. She was a

high acuity nurse, as Jayme's daughter has a central IV line. Knowing about these pay increases, Ms. Scali asked their nurse if she had received an increase in salary. She said no, she had received no pay increases other than merit, and was resigning due to pay differentials. She had to move on. Ms. Scali also asked her agency for shadow nurse. They said the only MCO that has communicated billing for this to agencies was Keystone. Only after Ms. Scali sent agency the bulletin was the shadow nursing approved.

Ms. Kozak noted that OMAP has worked with the MCOs and they all know that shadow nursing is now part of their agreement. Parents should not have to ask for it. It should fall on agencies to provide it. The departments will circle back on agencies. We are also circling back at MCOs we did hear that some are not doing it and we want to know why. As far as pay is concerned, we did an increase that had to be passed on. It's our understanding that has been completed. As for what agencies pay individual nurses, that's outside of the Department's control. Historically, agencies have always paid less then hospitals.

Ms. Scali noted that she had full coverage. Her nurse left for a leadership role, case manager position. She noted concern that if agencies are not pushing the increases through to the nurses, the Medicaid system is only going to lose more nurses. Her family currently has no night nurse. The families are trying to retain a workforce, but the agencies aren't following through.

Ms. Kozak appreciated what was being said, but unfortunately has no satisfying answer. The department will continue to work with MCOs. They have conversations with the homecare association. There is a shortage of nurses and agencies, hospitals are out there competing. The ability to compete is sometimes constrained. The Department also sees this workforce shortage with other licensed providers and even more with direct care workers.

Ms. Brookins asked, with the nurse shortage that is going on is it because the money, the pay differences, or is it because the nurses just are not out there? Ms. Kozak stated it is a combination of a number of things. In PA, it shows there are a high number of nurses who hold an active license, but no longer practice. For instance, Ms. Kozak herself holds an active license, but has have not practiced in about 15 years. Just a lot more options for nurses. We all know PHE took its toll on direct care work force and licensed work force. It's not always about money.

Ms. Brookins asked Ms. Kozak if she thought she could go back to be being a practicing nurse. Ms. Kozak responded, she could. She would need to be refreshed but some of it is like riding a bike. Theory doesn't change, equipment does. Ms. Kozak also shared she has a sister who is a nurse anesthetist. But the stress of PHE burned her out, so she said she was done.

Ms. Healey noted, as a part of the pediatric shift care initiative OMAP had got together with stakeholders and sent a survey out to nurses, and they received interesting results. Pay and benefits were a big issue, and as we look to potential solutions, we should look to the survey as a source of information.

Ms. Kozak replied that OMAP did share the information it received with the workgroup. We recognize it's an issue with shift cases but also a department wide issue. Developmental programs, OLTL, all of the department offices continue to look at attracting and retention. The Shapiro administration is sharing thoughts on the matter and it is being looked at all levels of the administration. Hopefully, we will begin to see things that demonstrate success.

Mr. Fisher noted this is a good segue into the Governor's proposed rate increase for dental services, and asked if OMAP could unpack that proposal. Ms. Kozak stated at this time she could not. As soon as OMAP works through what it looks like the department will be happy to share details of the proposal and its budgetary impact.

II. OIM Report

Presented by Carl Feldman, OIM Policy Director.

The CHIP IT transition successfully took place over the weekend of April 15th – 16th. CHIP now lives in ECIS, within MA cascade. Mr. Feldman noted there is still much that has to be done. They are meeting with MCOs daily to work on data transfer challenges; iron out details regarding bugs and additional fixes. But OIM hopes it will bring benefits for years to come.

Unwinding Updates

This month was the first month since March of 2020 the continuous coverage not in place. State MA agency was not able to disenroll individuals March of 2020 – March of 2023, same for CHIP caseload. They did not disenroll people unless they met very specific set of exemptions. This led to large increase of Medicaid enrollees.

As of March 2023, there are 3.6 million people enrolled in MA. Continuous coverage has ended at this point. Normal renewal processing began 4/1, individuals can now be disenrolled. There is a specific way to handle renewals. All renewals will take place over 12-month unwinding period. Everyone will get a chance to update information. Coverage may be renewed automatically if they have new data on file.

Set up 90/60/30 day tome frame. 90 days, please give us updated contact info. 60 days contact letter, explaining what is going on. Making it very clear they need to return renewal, at 30 days they will receive renewal packet. CAO's will try to call and make attempts to get ahold of enrollees. Even outreach after someone is terminated. Information may be reconsidered if they miss it. Also, soft referral to Pennie.

Mr. Feldman noted that a paid media campaign has started. The unwinding dashboard is also live, with initial parts available right now. Connected to state covered link. Baseline unwinding COVID made population. Hoping it gives people a sense of scope. In months past, we shared size. Using a bucket analogy, the "Covid-maintained" populations no longer fill up. In some

point it no longer continues to fill up without emptying. It is now a static file. Previously we had separate populations, which had some duplication. Now we have combined them to a total figure of about 1.3 M, unduplicated, who are considered to be Covid-maintained.

In response to questions about dual eligibles, Mr. Feldman noted there are about 5,000 MA recipients who should have Medicare but don't. The department sent a letter to them at the end of last week. There are 165,000 folks in the maintained population who have Medicare. The department is also sending a letter to population who should be but are not enrolled in Medicare Part A/B.

The department is also putting systematic process to provide good cause for non-payment of MAWD premiums during COVID maintain period. Good cause was provided systematically on April 3rd. A reminder letter is going out for MAWD premium.

Mr. Fisher noted that he appreciated the department efforts around MAWD premiums and crediting MAWD coverage for those who would have been enrolled but for the PHE. Wanted to clarify, systematic good cause has already happened and has the crediting of coverage already happene?

Mr. Feldman answered yes, the systematic good cause has occurred. With respect to crediting individuals with MAWD coverage for purposes of Workers with Job Success eligibility, that should have happened at the beginning of April as well though he was not certain if that date was met. He would encourage people to tell the CAO case workers that they should have been in MAWD but were not, and they believe credit has been applied.

Ms. Scali noted problems she recently had with the renewal process. She received notice to be on the lookout for a renewal packet. She saw the option to complete online, so I did that since I did not receive a packet in the mail. When she started the online process, she was kicked out twice and ended up having two applications. Another issue, she found was online there was no prompt to upload documents or make corrections. So she didn't send multiple paystubs, she also couldn't update employer. Versus by mail, she can make changes and submit all documentation. She signed up for texts alerts, received a welcome message. She also received a second message that a renewal packet is on its way despite the fact that she had just renewed through Compass.

Mr. Feldman thanked her for sharing and stated she had a couple things occur. The DHS helpline is the right place to deal with systems issues, and obviously we want people to access self – serve. DHS is also doing refresh based on technical assistance from Code for America, this should help with user interface and is deploying in July. Mr. Feldman wants to note the challenges Ms. Scali identified.

Meghann Luczkowski, Consumer, noted that she had the same issues, despite considering herself tech-savvy. Using Compass was frustrating as it has no save for later function, so she would have time out and start over. Also was unable to update certain information.

Mr. Feldman asked you for more information regarding “time out” function. Ms. Luczkowski said she gave up twice and drove her paperwork to the CAO. If she walked away from the screen for too long, it would log her out. Ms. Scali noted, that her application froze the first time and when it refreshed she had to start over. The 2nd time she was kicked out.

Mr. Feldman thanked the consumers for sharing this desire for a “save” functionality. This is good feedback.

Ms. Healey, reiterated her question she asked earlier to OMAP. Using Mr. Feldman’s bucket analogy, is it too early to tell if the CAO buckets are overflowing with the increased volume? We have concerns that the CAOs will become overwhelmed and that this will lead to inappropriate cutoffs.

Mr. Feldman responded that they do feel it is too early to say. There are a lot of confounding factors, such as the IT transition for CHIP and movement of renewal dates. Because of this, think that case load indicators may not accurately reflect workload of any particular worker in the field. Expect to take until at least beginning of May before have a better sense. What OIM can say is that our call center timeliness is still fairly stable.

Ms. Healey asked if there were repercussions for consumers if staff fall behind? Mr. Feldman replied, no, MA does not have automatic closure. They need to make eligibility determinations appropriately. DHS has authorized overtime and OIM can move work around and to processing centers. DHS does not think additional things need to be done yet.

MS. Brookins noted there was a systems glitch last week that was fixed relatively quickly in 3 days. The Consumers look forward to hearing more in May on outcomes.

III. OLTL Report

Deputy Secretary Juliet Marsala presented for OLTL.

Deputy Secretary Updates

Deputy Secretary Marsala introduced herself to the Subcommittee and briefly discussed her background and experience. She noted that she is honored to be joining the OLTL team.

Ms. Marsala spent 15 years in Commonwealth as an LTSS provider and as an advocate at the Centers for Independent Living. Ms. Marsala stated she is very excited to be in this role and working in partnership with the Consumers. Her goal is to continuously improve services. This is only week two in the position for her; she is of course still adjusting to role.

CMS has now reviewed and approved the CHC Agreement and rates for 2023. Ms. Marsala noted her appreciation for OLTL policy director Jenn Hale and her team. The CHC RFI (Request for Information) comment period closed 4/14. There were around 60 responses from wide

variety of stakeholders; It was really wonderful to see the number of comments. A. OLTL is reviewing comments now and will preparing themes. OLTL does share all comments due to stakeholders who provide personal information, they want the comments to be a safe space.

Ms. Marsala also noted a Nursing Home Transition (NHT) training announcement. There is a vendor that was selected, PCIL. PCIL will provide trainings moving forward and OLT is looking forward to working with them.

Ms. Brookins welcomed Ms. Marsala to the committee, thanked her for attending so early in her tenure, and noted she is looking forward to working together.

Reduction Review Project
Presented by Randy Nolan, Director at OLTL. The consumers welcomed Mr. Nolan back following his recent leave.

Mr. Nolan explained that about a year ago OLTL started the reduction review project to look at the CHC-MCOs reduction of services. They were also reviewing all the assessment pieces and notes. All three CHC-MCOs had issues. They followed up on issues and data that had to be corrected.

OLTL did another round of all 3 CHC-MCOs pulled records and report of all changes. They looked at non-voluntarily reductions; "plan driven" decisions. OLTL pulled 60 cases from September and October from each of the MCO's. That was our target goal. Worked with our medical director and nurses in house to do reviews. Once that was completed, they had an internal meeting to discuss results. They also had individual meetings with the CHC-MCOs and asked for feedback. These were the results:

- UPMC – Our sample size was 58, out of the 60 cases we pulled. OLTL found the reductions and notices were appropriate. Especially around informal support and other services. UPMC was asked and complied with at discontinuing non-quarter-hour increments.

- PHW – provided a smaller sample size, 54, as there were duplicates. OLTL did find some inappropriate reductions. OLTL requested additional info for 6 cases, 4 were deemed inappropriate. They are doing additional education and training. At this point, we are not doing continuous monitoring. But they did have marked improvement, so OLTL feels the earlier trainings were effective.

- AmeriHealth/Keystone – They provided only 46 of 60 cases. There was inconsistency in Ops 21 report. Worked with them to correct reporting. OLTL requested additional information for 8 cases, and after review, all 8 case reductions were found to be inappropriate. Because of this high level of inappropriate reductions, OLTL has

instructed Keystone to pull another round of cases from January/February 2023. They are pulling a total of 68 cases, from all 5 regions, and will submit all appropriate documentation for those cases. OLTL and Dr. Appel's team is in the process of reviewing to determine if there was improvement.

Mr. Nolan noted that they continue to monitor all of the CHC MCOs on a monthly basis.

Ms. Healey stated then when she did the math, it comes out to almost 20% of cases reviewed for AmeriHealth/Keystone were not done properly. This is highly concerning, and she asked whether OLTL is going back to look at all the other reductions that took place at the time to ensure they were appropriate. Corrective action should be put in place.

Mr. Nolan agreed that there is a concern. That is why they pulled new sample of 68 cases to determine if there is improvement. They have done a lot of training and meetings. If they find same kind of result, if they are at 17%, 18%, 25% deemed to be inappriate, OLTL will take further action which will probably include CAP. Whether it does a retroactive review to look at all the other people is one of the options on the table. They will discuss internally.

Mr. Fisher, thanked Mr. Nolan for OLTL time and effort in this obviously important area. He ask whether the MCOs – for the cases found to have been reduced inappropriatedly – have been instructed to restore the hours at issue. Mr. Nolan was not certain; OLTL will follow up with a response.

Mr. Fisher also asked whether OLTL, in doing its reviews, is requesting the assessment prior to the assessment the MCO used for the reduction. Put differently, is OLTL looking to see if there has been any change – such as an improvement in a person's condition or change in their social supports – that might justify a decrease in services? Mr. Nolan stated what OLTL looks at is current documentation that led to reduction. They have not gone back and looked at prior assessments. We have had discussion about that.

Mr. Fisher noted that PHLP routinely sees clients whose health has not improved, it has often even gotten worse, and their MCO has reduced their PAS hours. The reductions notices of course don't specify any change. Without that explanation, for an MCO to say based on your assessment, X number of hours can meet your needs – when the same assessment resulted in far more hours the year before – is arbitrary and, for clients, completely unsatisfying.

Mr. Nolan noted that he completely agreed, it is unsatisfying. It is not sufficient for a notice to just say an assessment shows your needs can be met with X hours. If they had multiple assessments with same answers, and the CHC-MCO reduces hours that is not a good explanation. It has been a task for OLTL to look at these assessments over time.

Ms. Brookins encouraged the Mr. Nolan to look at more reductions for all the MCOs, including UPMC. Mr. Nolan reports they do look at cases every month. HCBS, dental, physical health, they are at least sampling every month and taking a look. UPMC has no issues following this

particular review, but they are not ignoring them. There can always be issues.

Mr. Fisher stated it sounds like these cases were all pulled from Ops 21 report. You also mentioned separate reporting. A concern with the Ops 21 is that it is not capturing reductions that are appealed timely. That subset of cases, for auditing purposes, should be reviewed too. Mr. Nolan noted they also use QM/UM 7 reports, which captures reductions and denials across all services. The Ops 21 report does not capture reductions appealed where the benefit stay in place right away, but it does capture the data when there is a final appeal decision maybe two or three months later. But they can go back and pull that case.

Mr. Fisher asked if OLTL are looking at PCPS goals in the service plan, and how they relate to the need for PAS. General goals, and not just the clinical rationale. Mr. Nolan reported Yes, when we look at cases, we are pulling everything related to the case. Including the InterRAI, SC notes, PCSP. If there is an issue surrounding community integration, we are looking at it.

Proposed Long-Term Living Budget, FY 2023-2024
Dan Sharar, presented for OLTL.

Mr. Sharar shared the highlights of the proposed budget. Total funding of OLTL is proposed at $15.B, of which CHC at $14.4B, LTC managed care at $399M; and LTL Appropriated $232M (this includes the OBRA waiver and Act 150; small portion NF through FSS). OLTL Total funding decrease $312M. This is mostly federal funding, enhanced FMAP, and well as COVID-related payments to providers – Act 54 and 24 last two fiscal years. Regular FMAP rate increases to 54.12%. The budget supports actuarially sound capitation rates that continues to support nursing facility staffing efforts.

Long term care/managed care/life program – There is one total line on this slide, doesn't add up. That was a mistake. Total funding for 2023-24 should say $399 million in the budget request. They are projecting increased enrollment.

Mr. Sharar added that the DHS budget book is now available on the website.
Executive budget – Continuing budget in CHC appropriation. 23-24 fiscal year, numbers are different from DHS budget book. Right around the same 476 million figure. Question regarding rate assumptions increases – we have capitation rates that will be revisited during the course of the budget year. We don't know what final rates will be at this point.

Mr. Fisher stated a lot was just covered and recognized we were over time. But wanted to ask, regarding assuming enrollment accrued. Mr. Sharar confirmed his question is what was assumed enrollment change for budgeted figures: we assumed an increase of about 1.5%.
Mr. Fisher asked if they have a NFI vs NFCE breakdown. Mr. Sharar responded not at the moment. Ms. Brookins thanked OLTL for the presentation.

The meeting was adjourned at 3:16 PM.