Consumer Subcommittee of the MAAC

February 21, 2024

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

DHS representatives present: Sally Kozak, OMAP Deputy Secretary; Eve Lickers, OMAP Policy Director; Juliet Marsala, OLTL Deputy Secretary; Randy Nolen, OLTL Bureau Director; Tara Gilligan, HIPP Policy Manager; Alexis Deisenroth, OIM Policy.

The meeting was called to order at 1:00pm.

[Captioning]

>> The broadcast is now starting.
>> ELISE GREGORY: Welcome to the February 2024 addition of the consumer sub committing meeting. Today is Wednesday 21st. Before we begin the meeting I would 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 mute your microphone if you're not speaking. Live captioning also known as CART captioning is available for this meeting. The link is included in the chat. Participants should state names clearly before speaking to assist the captioner. Representing the Department of Human Services today from the Office of Medical Assistance Programs is Deputy Secretary Sally Kozak, Office of Long Term Living Deputy Secretary Juliet Marsala, Office of Income Maintenance director of the division of health services Alexis Deisenroth. If you have any questions related to the meeting or any information or need any information, please visit the consumers subcommittee webpage. I will now handle things over to the Consumer Subcommittee chair Sonia Brookins.
>> SONIA BROOKINS: Welcome to the consumers subcommittee meeting. We're going to get started with introductions and move forward.
>> KYLE FISHER: Thank you Ms. Brookins. I was trying to do introductions of committee members. This is Kyle Fisher, PHLP, counsel for the subcommittee. We will start with our Vice Chair. Do we have Minta Livengood? How about Marsha White-Mathis?
>> MARSHA WHITE-MATHIS: I'm here.
>> SPEAKER: Thank you Marsha. Do we have Ronel Baccus?
>> RONEL BACCUS: I'm here.
>> SPEAKER: Thank you. How about Liz Healey?
>> LIZ HEALEY: I'm here Kyle.

>> KYLE FISHER: Do we have Meghann Luczkowski? Do we have Jayme Scali? Excuse me Jayme Scali?
>> JAYME SCALI: I'm here.
>> KYLE FISHER: Do we have (Indiscernible)? Do we have Rochelle on the call? Rochelle Jackson? Victoria Gardner? Do we have any other consumers I may have missed? I think we might have some joining us a bit later. But that is it for now. Also from the health will project, do we have Danna?
>> DANNA CASSERLY: I'm here. Thank you Kyle.
>> KYLE FISHER: Do we have Amy Lowenstein?
>> AMY LOWENSTEIN: Yes, I'm here as well Kyle.
>> KYLE FISHER: It looks like we have Meghann on the call but she's on the attendee side. Can we move her over?
>> SPEAKER: Let's see. It looks like Lauren was thrown out but hopefully she can get back in.
>> KYLE FISHER: I think that is it in terms of introductions from the subcommittee side. Elise OR Sally if you want to do introductions from the department.
>> SPEAKER: I just got on.
>> SPEAKER: (Indiscernible).
>> KYLE FISHER:Excellent. Minta and Ronel are on; was Meghann Luczkowski able to come over? Are you able to unmute?
>> MEGHANN LUCKOWSKI: I'm here.

- **OMAP Report**

>> SALLY KOZAK: So good afternoon everybody. I have a couple updates I'm going to give you. And then I'm going to re-jigger the order here a little bit and say PA navigate for last and Doctor Shamloo is here but actually not scheduled to talk today. He's going to talk at MAAC tomorrow so we are not going to talk about dental today but he is on the call in case you folks have questions about it. The first up that I have for you is on transforming maternal care . A lot of folks have been asking about the opportunity that was announced by the Center for Medicare and Medicaid innovation and they announced that in September. They announced a new model for transforming maternal health, which is designed to focus on improving maternal health care for people that are enrolled in MHH. The model will support development of a whole person approach to pregnancy, childbirth and postpartum care in order to do integrated physical, mental health and social needs that someone might experience during the pregnancy.

CMS intends to select 15 state Medicaid agencies to participate in the model. Witheach agency being eligible for up to $17 million over the life of the model which is a 10 year period. The model has three main pillars. First is access to care, infrastructure and workforce capacity. The goals within that are to increase access to midwives, doulas and

perinatal community health workers. The benefits and outcomes that they are expecting to see include reduced C-sections for low risk pregnancies, shortened labor times, lower use of pain medication during birth and lower rates of postpartum anxiety and depression. The second pillar that they have is quality improvement and safety. Which will look to implement initiatives and protocols with the goal of making childbirth a safer experience and improving both the mother and baby's overall experience. Then the third pillar that they are using as the foundation for the model is whole person care delivery.
Which in doing this they really want to ensure that every mother receives care that is customized to their specific needs by supporting the development of each unique situation in a unique birth plan and this includes as I mentioned just a few seconds ago physical, behavioral as well as social. CMS will release new funding opportunities for state Medicaid agencies in spring 24 with applications being duein summer 2024. And the department is currently evaluating our interest in applying for that model. So sharing that because there's been a whole lot of questions about whether or not DHS is going to apply for the model. Questions about that?
>> SPEAKER: I don't have questions. I don't know if the members do. I would note we have our (Indiscernible) is back on on the attendee side. Members of the committee, questions regarding the maternal health model Sally just described? Am sorry. Say it one more time. When applications would be due so we can emphasize that.
>> SALLY KOZAK: Applications are due in the spring -- sorry. The application opportunity will be released in spring 2024 with the states having to apply by summer of 2024. So around March and July.
>> MARSHA WHITE-MATHIS: I have a question.
>> N/A:Sally, do we have any reason to believe the state won't go forward with this, and in questions that you know about?
>> SALLY KOZAK: I'm sorry Marsha. I'm having a hard time hearing you.
>> MARSHA WHITE-MATHIS: Can you hear me now?
>> SALLY KOZAK: That's better.
>> MARSHA WHITE-MATHIS: Do we have any reason to believe the state won't be agreeable to this new system of giving assistance with pregnant people?
>> SALLY KOZAK: I don't have any reason to believe we would be interested in it. There's been focus at all levels of the administration on how it is that we can address maternal child health, particularly maternal outcomes. I know that the women's Caucus over in the leg is also interested in this. So I think it's just where the Commonwealth ends up with that strategy as a whole. Does that answer your question Marsha?
>> MARSHA WHITE-MATHIS: Yes, it does. Thanks Sally.
>> SALLY KOZAK: Sure. If there's no questions on that, then let me move on to buprenorphine. As everybody is aware, I'm up presuming everyone's aware that buprenorphine is approved for the treatment of opioid use disorder. That's always a tongue twister for me so OU D. It can be described in physician's office and dispensed by

physicians and community pharmacies. We did that a while back so that we could increase access to OU D. Right now fentanyl is the leading cause of overdose death . We are seeing higher doses of buprenorphine are often necessary to effectively treat people who are regularly using fentanyl. As a result on February 6, 2024, the department (Indiscernible) guidelines for OU D treatment to remove the daily dose limit on oral buprenorphine so that patients can start treatment immediately with the dose that they need in order to prevent overdose and to stay in reatment. The removal of these prior authorization guidelines for oral pupa nor for an apply to both fee-for-service and managed-care. So again we lifted prior authorization for oral buprenorphine. Questions about that?
>> SONIA BROOKINS: People are using the drug. Do you have a count of how many people are using this drug?
>> SALLY KOZAK: We know how many people are being prescribed bew been orphan. I don't have that number off the top of my head but we can certainly get that for you.
>> SONIA BROOKINS: Okay.
>> SPEAKER: The center of excellence is in control of everything as far as (Indiscernible).
>> SALLY KOZAK: Those center of excellence in control of what Marsha?
>> MARSHA WHITE-MATHIS: Are they controlling the usage of the drug?
>> SALLY KOZAK: The buprenorphine has to be prescribed. Any of the centers of excellence have to use medication assisted treatment as part of their modalities in order to be a center of excellence. Yes, the centers of excellence would be writing prescriptions for buprenorphine. Does that answer your question?
>> MARSHA WHITE-MATHIS: The center of excellence would also have that number?
>> SALLY KOZAK: I'm sure they have it. I don't know if we have that information broken out by center of excellence. Is that what you are asking for?
>> MARSHA WHITE-MATHIS: Yes, that's what I was asking.
>> SALLY KOZAK: Let me see if we can get the information broken out that way. We know how many people are prescribed buprenorphine or should be able to figure it out because we get the claims data. I'll have to figure out if we can get a by center of excellence so we'll follow up on that.
>> KYLE FISHER: Quick question on this one. My recollection was prior auth was removed for Suboxone buprenorphine a number of years ago. Was that mistaken or is this a change to dosage levels or something else? (Indiscernible).
>> SALLY KOZAK: Prior auth was removed for buprenorphine up to a certain dose. If people needed a dose beyond that, and I think it was 24 mg but don't quote we on that and then they had to get prior auth for high dose buprenorphine. This essentially removes prior authorization for high dose buprenorphine and the reason we did that is because we're funding the people that are using fentanyl are requiring higher doses of buprenorphine to assist them. That removes that barrier for everybody. Does that answer your question Kyle?
>> KYLE FISHER: It does, yes.

>> SPEAKER: I have one more question Sally. I can't pronounce it is it (Indiscernible).
>> KYLE FISHER: Suboxone.
>> SPEAKER: You just answered my question. I wanted to know if that was used for a different audience than Suboxone.
>> SPEAKER: I believe it's just generic and brand-name.
>> SALLY KOZAK: One is generic and one is brand-name.
>> SPEAKER: That's the question I had.
>> SPEAKER: Okay Sally.
>> SALLY KOZAK: School-based services grant opportunity. I want to talk about this because again folks have been reaching out to me and asking about this. The safer communities act, which is at the federal level, has authorized $50 million in funding to be made available to states for the purpose of helping to support the expansion of services for MA eligible beneficiaries in the school setting. The notice of funding was issued on January 24, and we will be applying for that grant opportunity. The team is currently working on it . It is a competitive grant process . There will be 20 grant awards of up to $2.5 million each . Applications have to be submitted by the state agency and must demonstrate coordination with the state education department as well as stakeholder input. There is ongoing collaboration between DHS and PDE to determine what our priorities should be. And if awarded the grant, we hope to expand the providers eligible to provide... behavioral health services in schools as well as to begin to address the specific needs of our rural schools.
Just As a reminder, we currently operate the school-based access program, which does cover eligible services that are included on a child's individual education plan. So this would allow us as I just said to expand the providers that are eligible to provide behavioral mental health services. We are excited about this opportunity and hope that we end up being one of the awardees. Questions about that?
>> SONIA BROOKINS: I'm excited too. Is it possible that we can give y'all some suggestions?
>> SALLY KOZAK: Absolutely.
>> SONIA BROOKINS: Thank you so much. Kyle, can get some of us as a committee to put some suggestions together on how we can use some of those funds.
>> KYLE FISHER: I'm certainly happy to hear that department is pursuing this but also Sally your specific emphasis on mental health services and capacity. I think sorely needed.
>> SPEAKER: I think the grantis due to CMS or to whoever we're submitting it to by March. The end of March. Is that right? Any of the CPAP folks?
>> SPEAKER: It's due on March (Indiscernible).
>> SALLY KOZAK: Kyle and Sonia, the sooner we get your comments the sooner we can incorporate them and if it's easier to think about it and have a meeting our folks would be happy to set that up with you.
>> SPEAKER: Would it be helpful to have a letter of support?
>> SALLY KOZAK: I don't know if the application asks for one but if we do need one we will

be more than happy to have one from the consumer subcommittee.
>> SONIA BROOKINS: Thank you so much.
>> SALLY KOZAK: Sure. We are excited about both the maternal health grant and this one. Just to give you a couple of updates on doulas and pharmacist and community health workers. As you know, we began enrolling doulas in the MA program as of February 1. And as of February 7, we have seven certified perinatal doulas that have been enrolled in the Medical Assistance Program . Clearly our goal is to build the capacity of these doulas to ensure that we have statewide access so that we have an opportunity to add them to the state plan. Just so folks are aware, just because there are seven doulas enrolled in MA does not mean that those are the only doulas being used throughout managed care. We know that some of the managed-care organizations have been contracting with doulas for a while now. Through a variety of agencies and organizations.
We also know that there are some providers out there using them . In fact we have included them in our maternity care management requirements. What we would certainly like to see more than seven enrolled in the MA program . Utilization across the state is not limited to just those seven. As you've heard me say on March 1 we started enrolling or we will begin enrolling and paying pharmacists to perform services such as medication management, disease therapy management in settings other than the pharmacy. We have issued the bulletin on February 13, and we are hosting a -- or we hosted a training for them on February 15. So that is moving along. As far as community health workers, we know that community health workers are effective . We know that they are trusted members of the community. And that they help improve overall access to care.
So we have been engaging with the PA community health workers collaborative over the past I want to say almost 2 years now to get feedback and data on their current services that will be used to draft estate plan. And we are again looking to be able to confirm statewide accessibility with the goal of adding them to the state plan in 2025. Again just a reminder. The MCOs are required to be using community health workers as part of their community-based care management program requirements. And this will just officially add them to the state plan as we move forward. Questions about that?
>>KYLE FISHER: It's certainly good news. I think one question related to the last item . Once community health workers, assuming they are added to the state plan in 2025 or sometime after then, a main difference in terms of accessibility to consumers would be somebody could then raise their hand and say I need more assistance. I need someone to come out potentially and visit me in person to help me manage these issues. And that would be available to them in a way that the MCOs using community health workers now it's much harder to under community-based care programs? Am I understanding that correctly?
>> SALLY KOZAK: I think that those are conversations that are still ongoing about what the scope of the community health care workers are. Community health workers are focused on helping to improve access and addressing social determinants of health. I think it depends on what it is that somebody would call up and say I need help with. If they needed

help finding care, that would certainly be more of a role of the care management team within whatever managed-care organization they're enrolled in. If they're in the community health worker program and CHC program, there are service Camorra knitters that may be responsible for some of those things so I think those are all questions that still remain to be answered as to the specific role of the community health worker. Does that answer your question?
>> KYLE FISHER: Is helpful. I think I'm thinking in terms of the community-based care management programs now are typically fairly narrowly targeted. (Indiscernible) Receiving XYZ. For someone who might be interested in whatever the XYZ health worker services (Indiscernible) unless they fit into that more targeted care management program, the services aren't really available. But once it's a state plan service, there are still going to be parameters along the lines of what you're saying. But community health workers are able to assist but it would be available to all members (Indiscernible).
>> SALLY KOZAK: Yeah. Community health workers are not direct service workers. So we would not be expecting them to provide any level of care so to speak. These folks are really focus more on education, preventative education, reducing or assessing and helping to identify where to go for social needs . Less about care manager type role as we tend to traditionally think about it and clearly not a direct care worker role. But so much as a community navigator to some degree. I don't know if that helps anymore or not.
>> SPEAKER: It does. Thanks.
>> SALLY KOZAK: Other questions about any of those three? Just a quick update that we will be holding a pediatric shift nursing stakeholder call on Thursday the 29th at 2:30. Invites have been sent out I believe to all the members at the stakeholder workgroup. If there's someone who wants to attend that didn't get the invite or notice let me know. During the call we are going to be providing updates on shadow pay, family parents pay, caregivers, the patient centered medical homes, pediatric complex care resource Center, expansion of the family facilitator and we are also going to share with this group about PA Navigate.
>> LIZ HEALEY: I'm really looking forward to it. I have it on my calendar. I got an initial notice that didn't have a link and I don't think I've seen another email with a link to join yet.
>> SALLY KOZAK: Nicole just let me know that official invites will be going out tomorrow.
>> LIZ HEALEY: Perfect. Thank you.
>> SALLY KOZAK: You're welcome. Then the last thing on the agenda is PA Navigate . As folks may recall, PA Navigate is our statewide resource and referral . Folks may know it by its current name of PA navigate or they may remember the concept we called rise PA. It launched on Tuesday, January 23. Once it is fully up and running, it will be an online, closed-loop referral tool that connects Pennsylvania citizens with community-based organizations, county and state agencies and healthcare providers for referrals to community resources that can help them meet their most basic needs like food, shelter and transportation. PA Navigate allows individuals to refer themselves for services, and it

helps facilitate greater connection and communication between healthcare providers in the organizations that we serve and the shared populations that we serve.
It is connected to physicians offices and health systems, so the system will allow healthcare providers to assess an individual's needs as well during a visit or during an emergency department visit or inpatient stay even that they can then also be referred out. We will be collecting some basic data from it that will help us in our business partners to better understand the health and social needs service of the citizens of Pennsylvania and to identify service gaps or opportunities for better support. Just so folks know, it is still in the process of being up and operational. Even though it launched on the 23rd . The secretary intended the launch down in Lancaster if I remember correctly. The Association is community engagement manager is beginning to reach out to people. Community-based organizations and others to join the network and to begin to finalize some of the work flow procedures that people have been asking about.
So it is statewide, but it will still take a little bit of time until everybody is onboarded and using it. Questions about that?
>> KYLE FISHER: Sally one quick question. The underlying -- I know there have been discussions around (Indiscernible) is this an entity we would've known by another name prior to becoming PA Navigate?
>> SALLY KOZAK: It's called Findhelp. I believe that they were formerly Aunt Bertha . Just as a reminder, and for folks, we granted this out to our HIO's health insurance organizations . We did that with ARPA funds so it is actually the HIOs that solicited for and are contracting with the vendor and that is (Indiscernible). I think it used to be called PA Navigate. This is really the department has really handed this off to our vendors now for implementation and ongoing management. There are number of stakeholder boards and groups and clearly the department is represented on them as well. Does that answer your question Kyle?
>> KYLE FISHER: It does. I know earlier iterations of this have been run primarily as Medicaid MCOs . It sounds like that's no longer the place but they will be connected in in the same way as healthcare providers and CBOs and if I understood you correctly individual consumers Medicaid or otherwise will be able to use this tool as well. And self refer.
>> SALLY KOZAK: If you go to our webpage PA Navigate you can find the link to the tool for somebody in the community to use. The MCO's will be connected to PA Navigate so yes, that information will be shared with them as well. Some of them may continue to choose to use their own systems in terms of what assessments that they use. But they will be able to connect and we require that they connect to find help. Or PA Navigate I should say. Martin is not available today but he's going to be doing a demonstration I believe were talking about it in more detail tomorrow. He does it much more justice than I ever could. Any additional questions?
>> KYLE FISHER: I don't think so. Thank you Sally.

>> SALLY KOZAK: The only other thing I have real quick is the MATP transportation study update. And the study update is that that still underway I believe . Someone asked for an update on it so when it's finalized we will certainly provide you a more detailed update.
>> SPEAKER: Thank you Sally.
>> SALLY KOZAK: You're welcome. I think that's it for me.
>> SONIA BROOKINS: Next on the agenda is HIPP .
>> SPEAKER: I just got a message fromKaren Gilligan that she kicked off the meeting and was restarting her computer so she might be joining us later.
>> KYLE FISHER: Sonia do you want to (Indiscernible).
>> SONIA BROOKINS: Not a problem.
>> SPEAKER: (Indiscernible).

- **OLTL Report**
    - **CHC Employment Supports**
    - **Annual Waiver Redeterminations**

>> JULIET MARSALA: Good to be here. Juliet Marsala, Deputy Secretary of the Office of Long Term Living. Just our general updates we are going to talk about procurement updates, about our priorities for OLTL in 2024 and topics of interest of the annual waiver determinations which I will hand over to Randy and then Community HealthChoices employment supports updates and some data there. We'll skip ahead two slide. Back one. There are no updates on agency with choice that can be shared at this time. For everyone's awareness if you are not already aware, Community HealthChoices RFA was posted to the e-marketplace on January 30, 2024. It is live. All questions regarding the RFA and its content should be directed to procurement via the resource account RA-PW RFA questions@PA.gov.
Myself and the OLTL staff will not be answering any questions related to procurement...Last the with our procurement updates the independent enrollment broker contract has been signed by maximus who is the awardee and is effective January 1, 2024. I think it's at the very, very tail end of the signatory process. It might've been completed by this point. And Randy and others of the old TLT have been working with Maximus to implement the provisions of the contract which includes some additional planned participant beneficiary supports. Excited about that work to move forward now that the contract is in ce. If we go to the next slide, OLTL priorities for 2024. I just want to bring a cascade of things down and then add where OLTL is at.
Following Some of these taglines should be familiar for folks. Following our governors interesting getting stuff done or his GST attitude we are certainly bracing as the OLTL team. If you had the pleasure of hearing Secretary speak on numerous occasions she talks about getting upstream. Addressing the situation as it is today and the services needed today but also keeping an eye on getting upstream to the root of issues and causes so that we can

have a multipronged approach. We are certainly embracing getting upstream for OLTL. The third point of our triangle of approaches getting back to basics. So that we can pursue excellence now that we are getting through the public health emergency, the official public health emergency has ended. The COVID timeframe caused OLTL along with many other programs to drop everything, pivoted and address the public health emergency.
As it emerged. And so at this point, it is time for OTLT get back to those basics, to the years of stabilization and improvement and final implementation stages of CHC that are critically important that were somewhat paused during the PAT so that's why getting back to basics is really important for us and that third point of the triangle and how we're moving forward. What you see on this slide, what does that mean? Unpacking that getting back to basics again really strengthening person-centered values and approaches within the program . Increasing the participant voice at all levels. Ensuring a trauma informed approach as you heard in past meetings. All of our OLTL staff received trauma training from our good friends over at . Increasing participant education and independence and there ...And more opportunities to really have them in that driver and central position driving their care and being in charge of their person-centered planning process.
Also Focusing on continually addressing health equity and disparities, improving quality and outcomes and increasing our adoption and implementation of evidence-based and evidence emerging practices . Ensuring that whole person approach is occurring within the OLTL systems. Strengthening the emergency backup planning and incorporating everything we've learned through the PAT making sure those are strong and solid for each of our participants who we serve. And improving service delivery at all points, community integration at all points and the participant experience and reviewing the results of our recent caps survey. There are areas of improvement that we need to focus on and get up to speed to higher marks where we like to see those improvements.
This is our focus. There is room for innovation. But truly we need to make sure that our foundation and core are very strong. Which they are but really pausing to take a look at that after we've been sprinting a marathon that was the public health emergency. I can stop there for questions or we can move forward.
>> SONIA BROOKINS: You can move forward.
>> JULIET MARSALA: I'm going to hand things over to Randy to share updates and the data requested for the annual waiver determination. Randy?
>> RANDY NOLEN: I guess I'm (Indiscernible) pleasure to be with you today and go over some stuff about the re- determinations onto the next slide. For those of you that don't know me I'm the director of the (Indiscernible) integrated services so part of my role as overseeing Community HealthChoices program the life program and anything participant facing which is part of this waiver redetermination process. What we took a look at is every year by regulation we have to ensure that or do a redetermination functional redetermination to make sure people are still eligible on the functional side to the program. So we look at whether they are still NFC versus and FI. From NFC versus and FI.

From April 24, 2023 through January 2024, the number of nurse facility and ineligible individuals there's some data here that we requested and it came back as and FI our next step is to request a physician certification and then once that's done there's a process after that.
During That time period we sent out 9314 requests for physician certifications . We received 4495 back which is about 54% I believe. Out of those 4495 that we received them back, they went through medical directory review process and then once they were determined to be and FI, we sent out 3,122 ineligibility notices to participants . The reason why there's a 1300+ difference in that number is the rest of the cases are still pending with CAO's to be updated in the record. After the 3122 eligibility notices were sent out we had 1849 appeals . Therefore 569 people did not appeal . Out of those numbers, what we are doing with the folks that didn't appeal, we have sent out lists to the MCO's, the three MCO's and we've asked them to contact these individuals to determine why they didn't appeal. Either they were fine and understand being NFI or they didn't understand the appeal process or there was some other issue. We're collecting that data right now from the MCO's as we do this outreach . There may be individuals that we need to assist with MPO's or were made to do new assessments on them but we will have some (Indiscernible) with those individuals that did not have an opportunity to appeal.
>> KYLE FISHER: If I can jump in just on clarifying just some of the numbers here. The 3100 notices that went out . That's out of the 4495 physician certs that would received, but the entirety of that (Indiscernible) medical directory review team find some of those to be NFCE?
>> SPEAKER: Yeah, they did. Some of them were NFCE. Like I said there's 3122 notices that were sent out. The difference between the 3122 and the 1849, those are the notices that went out and the CEOs hadn't sent notices out yet. When they come back into the system, when they are and NFI, we send the letters over to the CAOs to put on the record if the person is ineligible. Once that's done then we send out the notice to participants of we're still pending close to 1300 cases with the CAO's right now.
>> KYLE FISHER: I guess this is where I want to make sure I'm understanding this correctly. The notices that went out is the 3122. Those are notices actually sent by the CAO's? OLTL sent to the CAOs like this is the 1768. Take action on these cases and they did for over 3000. 1800 participants received those notices and filed an appeal. So it looks like 1200+ did not appeal. If I'm understanding this right.
>> RANDY NOLEN: They are still pending in some of those were NFCE .
>> KYLE FISHER: I don't know if that would be the difference between the 4495 and the 3422.
>> JULIET MARSALA: I can step in here Kyle. These numbers aren't in logical order. They are moving pieces through the appeals process. They are point in time counts so some may be pending and still being within the timeframe to respond to an appeal notice. Some may have been an FCD. So it sounds to me that you're looking for the math to work out exactly.

That's not going to be the case with these numbers.
>> KYLE FISHER: Just making sure I'm understanding what's being(Indiscernible) because the math doesn't quite add up . I guess I'm not fully understanding the concept. We have the PCs receive back of that 9000+ figure . When the PC comes back if it indicates that the person is still NCF the and the doctors opinion then the medical director (Indiscernible) some subset of those the medical director is finding that person still qualifies so they are not sending and FI ineligibility . Or in between step before them CAO. And that's data that OLTL has. You've given us that in the past in October. That something in future slides here or am I misunderstanding.
>> AMY LOWENSTEIN: This is Amy. I looked at the slides ahead of time. There's a later slide that says there were 4070 cases sent to the CAO's . So it seems like -- I think it's the next slide.
>> SONIA BROOKINS: On this slide then. In the meantime, I want to ask a question. What has happened to the folks that's waiting for the CAO office to communicate with the OLTL. Is they still being serviced? What are they doing?
>> SPEAKER: They are getting services until they get the loader of notification that they are no longer eligible.
>> SONIA BROOKINS: If they are not eligible then what?
>> RANDY NOLEN: Once they get the letter that they are not eligible then they have appeal rights to appeal the decision.
>> SONIA BROOKINS: Okay. After appeal if they still don't then what? That's what I'm asking. What comes next?
>> RANDY NOLEN: If they go to appeal and they are still considered and FI then services will be (Indiscernible).
>> SONIA BROOKINS: This is me. If you give me a number of 9000 folks and then you add all the rest of the numbers they do not add up and what you're saying is that they are not supposed out of?
>> RANDY NOLEN: No. Because some of the cases are still in process. Some of them are still pending information coming in. So the numbers don't 100% add up. But to Amy's point this slide says we said 4070 1768 to the County Assistance Office. Out of that 4070, they had processed 3122 or 83 so we still have a number of 800 most 900 that have not been processed by the CAL so people are still getting services until they are processed. Out of the 3120 individuals who God letters telling them they were and FI (Indiscernible) have sent in...83% of the individuals did send it in but the other 17% of individuals that didn't send in an appeal those are the ones we are having MCO's outreach to.
>> SONIA BROOKINS: Gotcha. Thank you for that.
>> KYLE FISHER: This is helpful. I think it definitely clarifies part of what I was asking about earlier. One follow-up question here. The number of folks who have not filed an appeal . The difference between the two numbers on this slide is less than --
>> SPEAKER: 257.

>> KYLE FISHER: It's a different number than what we saw on the first slide.
>> AMY LOWENSTEIN: The number appeal this different as well. It's a difference of about 1000. It looks like there might be some just with the number appealed and the number who didn't appeal. The 3122 is consistent but the other numbers I think is what's not making sense to us.
>> RANDY NOLEN: (Indiscernible) Can we go back I think two slides? These are snapshots in time. I'll take a look at it . On this slide we say 800 1849 appeals received. I'll take a look at that. I know that the list that I sent out to the MCO's had the 569 individuals on them. Where there might've been 568 but it's off by one. But I know that the list I sent out to them a week ago had this number on it. That did not appeal.
>> SONIA BROOKINS: The 569 folks that you sent to the MCO's and if it comes back that they cannot reach them, then what? That's what my (Indiscernible) because they could be anywhere. That's what I'm trying to say.
>> RANDY NOLEN: If they come back that they are unable to reach them, the MCO's have mechanisms in place that they have to do three phone calls to individuals at different times and different days of the week. To try to locate them. If they cannot, then there's two other steps they can do. They can do a drop by visit, and if they are unsuccessful without then they send out and unable to reach letter to the individual. So there's a mobile attempts to contact the individual.
>> SONIA BROOKINS: Okay.
>> AMY LOWENSTEIN: This is Amy again for the recording. Were you able to figure out whether the 569 people are all still enrolled in the MCO, whether there's others who have appealed who are just no longer enrolled?
>> RANDY NOLEN: No. I'm still waiting for that data to come back from the MCO. I just sent that to them the middle of last week so I'm still waiting for the data to come back from them . They are either going to tell me the person is no longer enrolled with them and they are unable to locate them and then we'll take the next step from there but I'm waiting for information from the MCO's.
>> SONIA BROOKINS: Randy, did you did them get line or are you just waiting? Did you give them a month or three weeks? How did you --
>> SPEAKER: (Indiscernible) I believe is the deadline I gave him.
>> SONIA BROOKINS: Thank you for that. Anything else anyone?
>> KYLE FISHER: We have some more slides coming up.
>> RANDY NOLEN: This slide shows we refreshed data for nursing facility ineligible from October to December 2023. We did it by month by MCO so you can see that Amerihealth Keystone they went NFI of 280, 314, to 215 last month. PHW went from 115 in October and are down to 53 in January. UPMC was at a high in October of 445 and are down to 217. Our number of total NFIs that came in based on the FED assessment October were 840 – you can see as we've talked and done some retraining of the SEs and put some other processes in place and went from 840 and done some retraining of the SEs and put some other

processes in place and went from 840 in October to 727 in November down to 510 and December and down to 485 in January. We're seeing a decrease in the number of NFIs that are coming in based on the assessments. Some of that is due to the fact that they are through a lot of their assessments but it's also retraining that we've been doing and the closer look that they are doing on these assessments. Then the second part of that chart is the medical director review.

It shows the total number of assessments that were done by each MCO over a period of time . Total we did about 120,000+ assessments. Out of that number 118,000+ were NFC and 9,800 were NFI . We're running about 92% of the assessments are coming back as NFCEso we will continue to monitor that number.

In January, medical director review staff reviewed 260 cases and found that 74 of those were NFCE. We're putting two things into place as we move forward in February. First is that we are asking the MCO's on any case that comes back as NFI that they must upload the full interRAI and all service coordinator notes that went into that assessment into a doc you share file that our medical director review team has access to. That way they have more documentation to look at as they are doing the MVR review. The other thing is that we have a team that reviews these.

We Obviously have the medical director Doctor Appel but we have a number of nurses that also review these cases. For the next 30 days Doctor Appel is going to be reviewing 100% of them just so he's looking at the documentation coming in to see if we need to change anything else with that process we are expecting to see probably some differences coming through . The difference is prior to us making a change in the process, the other thing the medical director review team had to look at was the snapshot of the InterRAI that related to the FED questions and the PC that came in. Now they are going to a full InterRAI so they can see the whole picture of the person and have the service coordinator note so they can see what the service coordinator was documenting when they were out doing the assessment and they'll have the PC. So we are hoping with some work, robust documentation for them to review, we will probably see some more cases coming as NFCE from medical director review because we have better documentation for them to look at.

>> KYLE FISHER: One quick question. You discussed some of the MDR changes during last meeting as well. The January stats we see there with 28% of the cases reviewed . We found that MDR basically the termination being overturned . Did the MDR team have any additional material at that time or when were these changes (Indiscernible).

>> RANDY NOLEN: The changes for the additional material came in Monday. For January, they had a heightened awareness that we were looking at these. But with more data coming in, they did have opportunities to go back and question the MCO's on some of these questions which led to some of the decisions being NFCE additional documentation just coming in (Indiscernible) .

>> KYLE FISHER: I guess additional conversation and opportunity that might account for the 28% figure versus I think it was a 2% return rate back in October for that (Indiscernible).

>> AMY LOWENSTEIN: This is Amy at PHLP. For the medical director review, are they also reviewing what services a person was receiving? So that they can get a sense of how many hours of personal care? We had a client who is getting cognitive rehab, which would be relevant to some of the cognitive questions on the inter-REI .
>> RANDY NOLEN: They are getting the information the service coordinator knows. I did not ask for the PCSP to be sent in but they are looking at what's recommended in the service coordinator notes.
>> AMY LOWENSTEIN: Just an observation . I can see that the numbers are changing going down, but it does still appear that UPMC has a pretty large share -- percent of the NFI determinations despite them having a lower market share. Their market share is about 23% in looking at these numbers they are 45, 40% of the NFI determinations.
>> RANDY NOLEN: Yes. We have a lot of discussion with UPMC about this. They are doing a lot of retraining . They have found that they had a number of staff were trained directly by the University of Michigan the number of service coordinator's and they had found that that percentage or that group of service coordinator's were probably finding more NFIs or doing assessments that led to more NFI's than the rest of the SC population so they've done retraining around but to make sure that everybody was doing InterRAIs the same way that they were looking at the questions and the instructional works for the InterRAI in the same manner. So it was just a matter of how some staff were trained different than other staff so they are doing a coordinated effort to retrain all of their staff. That's why we see I think the drop in numbers that we have . Obviously their drop in numbers have been a lot more intense than the other two MCO's.
They Dropped 50% in their NFI from October to January. So did TH WCAC AmeriHealth did not drop. They dropped about 20% .
>> SONIA BROOKOINS: Randy, wouldn't it be fair to say that they need to train retrain all of them not just UPMC?
>> RANDY NOLEN: UPMC is doing new training. (Indiscernible) We had a lot of discussions about some of the cases were a lot of the cases that were brought to our attention are individuals who have brain injuries or dementia or some other type of cognitive issues, especially early onset cognitive issues. So we had a lot of discussion and retraining around those areas. Just the fact that you have to look at a person at more than just an hour or two hours you're with them doing an assessment. You have to get an understanding of how their abilities and behaviors are throughout the day. Maybe they're good at 10 o'clock in the morning but at 5 o'clock in the afternoon they become very disoriented because it's been a long day and they are tired. So they're wandering and unable to cure themselves. Along the way we instituted that they've got to look over time. They've also got if somebody's in a program like a (Indiscernible) program they've got to talk to staff to get an understanding of what the individual (Indiscernible). We've had a number of participants in the programs tell us with brain injuries, there's sometimes that we are profoundly functional and perfectly capable of doing whatever. But three hours from now I'm so wiped

out I can't do anything for myself. So we had a lot of discussion with the MCO's about training around that and making sure that they are taking that into consideration . There's been some focused training on that so there's a lot of retraining and upgrade of training going on from the SEs.
>> SONIA BROOKINS: Randy I appreciate that because you have some most vulnerable folks out here and as you say I could be alright in an hour or two in the next two or three hours some just out of it. I agree that there are training doing more training and just not letting it go the way that it was done. So I do appreciate that.
>> AMY: I want to clarify to make sure I heard you right. You were saying the people who had actually been trained by intra-RAI were finding more people and FI than the people who weren't trained by intra-RAI?
>> RANDY: They were trained more towards the inter-RAI manual. We said the manual is the piece you have to look at and if there's any questions or anything related to the InterRAI but you also have to look at the individual when you're out there with them. It just can't be a black-and-white situation . They have to be out and be able to evaluate a person over a period of time. Evaluating somebody for a day and they really had a good day, you may go back in there tomorrow and do an assessment and find a whole different person. We had a lot of discussions with the MCO's and understanding that they have to do more than just a snapshot in time . They have to really look at a period of time on the person. That was kind of the difference. The manual really trains more towards a snapshot in time. We had a lot of discussion about the fact that you have to look at a person over more than an hour or two hour period.
>> SONIA BROOKINS: Not only that. You have to look at a person in lifetime. If you're going to assess me then assess me . Don't just think because him sitting there and I'm talking to you -- you have to spend more time than an hour. My point. And not go just by the manual. If I go into her room and I'm there with the client, I can just observe and see what's really going on around me. It doesn't take a rocket scientist to see that. All I'm saying is these coordinator's need to go in there and they need to do their job. They need to assess these folks and really see what's going on with these folks because we have with these folks because we have some 66 folks out here.
>> RANDY: We can talk a lot about the need. Get back to face-to-face assessments because it gives the ability for these coordinator's to actually observe somebody. If somebody says I can make my own meals I can do this I can do that in the service coordinator will say show me how you eat your meal. What would you do (Indiscernible) steak or hamburger. They should be able to do follow-up with that now that they're back in person so I think we will see some improvement because of that.
>> SONIA BROOKINS: Okay.
>> MARSHA WHITE-MATHIS: Randy can you hear me? This is Marsha. I was with a client yesterday . A client that's been my client for years. I said to her cub are you here by yourself? She said (Indiscernible) . I said you don't have a caregiver? She said not right now.

I said we have 56 hours. How many hours did he cut you? 20. Why didn't you contact me? She said because I think I can do it -- what they say I can do and I said what did you eat for breakfast? I had some cookies. I said you're diabetic. Where you eating cookies? She said they were right here. What did you eat for dinner last night? Sardines. Why did you use eat sardines? Did you have a vegetable or starch? She says no. I had a can. I didn't have (Indiscernible). I said when they -- did you tell them? I told them that I was wanted to be able to do this for myself and this is a person who speaks good English and she had (Indiscernible) issues. Look at your medical records. Didn't they see how long you've been on the caretakers and everything and she said yes. I just gave out as an example of someone who along with what the MCO did cut their hours and she thought she was okay but I was sitting there with her going over her rent rebate paperwork and she was not okay. I just wanted to give an example of someone who had a face-to-face and she still was not okay.
>> SONIA BROOKINS: You have a question Ronell?
>> RONEL BACCUS: I have a question. Because I had an assessment December 4 and the first 20 minutes we argued and she left. She did an assessment and she filled it out. She didn't ask me none of those questions. And I did not get a notice . Just fill out to appeal. I asked for service coordinator and I did not know that whatever she did with the paperwork Aaron told me to agree with the assessment and all the stuff you put in there was not true. It was not being said. We did not go over my medications or anything like that. I'm just saying the assessment should last longer than 20 minutes because she did not ask me questions. We argued . She told me I needed a power of attorney and I told her I do not need a power of attorney. My daughter is (Indiscernible) and the whole time. Then she said she'd been here for two hours when she wasn't. She was here at 10 o'clock. 1025 she was out the door. My question is how long is the assessment supposed to be?
>> RANDY: It depends. A good thorough assessment to go through everything probably an hour and a half to two hours. Some can be longer depending on the conversation that occurs. I agree you are not going to be doing a full assessment in 20 minutes. (Indiscernible).
>> RONEL BACCUS: I'm with UPMC.
>> RANDY: (Indiscernible) And ask about it?
>> RONEL BACCUS: Yes, sir.
>> RANDY: I will do that.
>> SONIA BROOKINS: Anyone else?
>> RANDY: You said you requested a new SC?
>> RONEL BACCUS: Yes, I did.
>> SPEAKER: Lauren Hatcher's hand is raised. I'm not sure if she's able to unmute.
>> LAUREN HATCHER: Can anybody hear me? Hi Randy. My name is Lauren Hatcher . I'm new to the consumer subcommittee . It's really nice to talk to you today. I would just like to echo everything that everyone is saying on multiple levels. I work with people with

disabilities and I've done these assessments with people where the NFI called the functional availability assessment says that they are completely independent with everything and they call me and they say (Indiscernible) 20 minutes. I have one individual that was completely bedbound and his hours got cut from 56 hours per week to seven hours per week. There's been multiple instances of that. Service coordinators are going into people's homes, but they are still not doing their job appropriately and that needs to be echoed again from somebody else.
>> RANDY: Thank you.
>> SPEAKER: Sonia, did you want to table the employment presentation? This was a very important discussion and thank you Randy for the presentation. I just wanted to check in before we went forward.
>> SPEAKER: I think there might be more slides on the waiver of redetermination issue.
>> SONIA BROOKINS: You want to finish the slides? Y'all want to finish the slides or what?
>> RANDY NOLEN: This shows me -- you about the medical director review and the other physician certification is not returned within 60 days currently then in the past what we've done is we didn't get a PC back within 60 days the person was made NFI. We change that process about three months ago and are currently asking Aging Well to do new assessments on these individuals. So far, we've identified over 5000 people that needed new assessment done because we did not get the PC back in. They've been able to assess about 1300 so far . Probably since the second week in January . They started redoing the assessments. Out of those 1300 that they reassessed a little over 1000 or 78% have been back into the NFCE. The others have come back as NFI. We do have a number of individuals that could not be reached or refuse the assessment. What's happening with those is I've asked the MCO's to reach out to the individuals to make sure the address and phone numbers are up-to-date and to explain the importance of them answering the calls when the AAA calls to do the assessment. I've asked them to talk to individuals that have refused so that they understand that if they do not do the FED they are going to be found NFI and are going to lose their LTSS services so it's important for them to do the Fed. So they are working on those cases right now for us. We send them out I think every two weeks we're sending the updated list out to them. To the MCO's based on what the (Indiscernible) is doing. As you can see 1300 assessments and about seven or eight weeks in at this point . With the whole 5000 done obviously it's going to take probably another couple months to get all those done. Now the good thing is if the PC didn't come back on there's no decision made on them and they are continuing to get services. Even if we don't get them reassessed until April through this process, they are still getting services up until their assessment and if they are found NFC they continue to get services.
That's will we are at with aging well process.
>> KYLE FISHER: The 1300 assessments are these only in the context of individuals who did not have a PC determined?
>> RANDY: This 5067 number are all individuals that did not get a PC back within 60 days so

about 1300 is a subset of that 5000.
>> KYLE: I'm wondering about the aging well outcomes for the 1800 who appealed or received determination now experiencing (Indiscernible) also had assessments in the home to resolve these appeals. Do you know the outcomes of those have been?
>> RANDY: They are not included in this data here. This is just from the ones that came back in. I don't know if we have any (Indiscernible) data on here (Indiscernible) let me see what the next slide is.
We are ready talked about. I'll have to see if we have Aging Well data back on these individual so I can check on that.
>> AMY: If 78% of people who had an NFI determination are being found to actually be NFCE by aging well, is there any reason to believe that there wouldn't be similar outcomes for the 4000 people who did have a physician cert returned and 1768 sent to the County?
>> RANDY: Not going to speculate on the number that would be. It's possible it would be the same outcome. This is part of a larger discussion we've been having with the MDR review process and what we can do to improve that moving forward. Obviously as we saw before we have a lot of things tied up with the waiver that tells us certain things that we have to do . By waiver and by regulations. A PC is what we require as part of our waiver that we justify that we're going to check responsibility determination with MCF so if we were to change that it would require massive changes to our waiver. There's also the issues with resources. Understanding that we're asking the network right now AAA network right now to do an additional 5000 assessments as soon as they can. Not only are we looking at resources to do that. We're looking at a substantial financial investment in paying aging well to redo these assessments where normally they would just go through a physician certification process.
The Reason why we've made some changes to go this direction would be the Fed's when we don't get the PC back in just because the numbers were somewhat higher than we expected so as we went through the functional redetermination process we did not expect the numbers to be up in the six or 7000 range or more. That we've seen. The hope is that once we're done through this process where people are redetermined financially and functionally that these numbers will go down and it'll be a much more manageable system through the PC process . That's kind of where we're working right now as far as moving forward. Now if we move forward and this additional information that comes in with the MVR process and we are still not getting some of the figures that we expect and some of the outcomes that we expect that we look at that next step and do we need to change the whole process meaning that we change the waiver we change everything. But to do that, we want to make sure that we've exhausted our current process and trying to improve it to make it work in what's best for the program and the participants.
>> JULIET MARSALA: Thank you Randy. I thought it would be best for Randy to present because they've been working diligently focused on the (Indiscernible) and the changes so it would be best to present on the details of where we're at today.

>> SONIA BROOKINS: Are we still presenting more stuff from OLT?
>> JULIET MARSALA: I don't know. I know that you have other presenters from the other departments to present so I'm happy to revisit the employment support support said our next meeting. However you want to move forward. I know we've taken up quite a bit of time today.
>> SONIA BROOKINS: Kyle, do we want to move this next month?
>> KYLE FISHER: It's your call Sonia. I feel like we've had some discussions already about the employment supports. We've not gotten through that conversation and we also had HIPP on deck and OIM as well.
>> SONIA BROOKINS: That's fine. We can revisit this. Can I request Julie and Sally and Randy, can I get a meeting. It doesn't have to be today. Not a long meeting. (Indiscernible).
>> SPEAKER: On which issue?
>> SONIA BROOKINS: I want to have a conversation. I have some thoughts and I just need them to hear me.
>>SALLY KOZAK: Sonia, who would you like to meet with just make sure I'm clear? I know you asked for me and Randy.
>> SONIA BROOKINS: Randy and Juliet too.
>> SPEAKER: Randy, can I leave that to you and your folks to set up?
>> RANDY: Juliet can we have Chrissy set that up?
>> JULIET MARSALA: Absolutely.
>> SPEAKER: There you go Sonia.
>> SONIA BROOKINS: Thank you. Appreciate that.
>> KYLE FISHER: It sounds like we are shelving employment supports. If we have (Indiscernible) on we can move into the (Indiscernible) thank you Juliet, thank you Randy.
>> SPEAKER: Terra is on but is she self muted?

- **HIPP Program**

>> TARA GILLIGAN: Yes, I'm here.
>> KYLE FISHER: Thanks for your patience. I'm glad you were able to get back in the meeting. Whenever you are ready.
>> TARA GILLIGAN: What would you like? How would you like it to go?
>> KYLE FISHER: If you want to give a brief overview of the HIPP program we discussed at the pre-meeting. I know we provided dparticular questions. We can (Indiscernible).
>> TARA GILLIGAN: The hip program just a quick overview was created in 1992 in Pennsylvania due to federal legislation to require which requires states to adopt programs to identify cases where enrollment of a Medicaid recipient in new and employer group health plan would be cost-effective to save taxpayer dollars. On MA program expenditures. Working with employers HIPP ...Individual medical assistance households and enrolls cost-effective families into the HIPP program. We purchased employment related group health

insurance for the employee and/or their dependence based upon the cost . We reimburse the employee share of the premium . We currently have about over 31,000 MA recipients within the over 14,000 cases that are enrolled in HIPP. Our specialists enroll an average of 500 cases or a thousand recipients per cycle which saves Pennsylvania roughly around $136 million. Some of the questions I got was waiver recipients that are enrolled in or eligible for 24 and yes, we do look at waiver recipients . Not CHC waiver due to the funding . But other waivers we do look into the eligibility for HIPP. Medicare recipients are not eligible for HIPP.

Our -- I know there was questions about our disenrollment basis and what we do is when we find out that an employee or when we find out that the recipients aren't eligible for the employer insurance, we would disenroll them from HIPP like if the job terminates or something like that. If someone becomes not eligible for medical assistance or we have a child that turns 26 and can't be on the benefits anymore, we enroll with a 30 day notice so that recipients can remove themselves from their employer insurance if they wish. We said discontinuous notices that explain that and that that he can take two employers to disenroll from benefits. I know there's a question about enrollment services and getting back into managed care once they are not eligible for HIPP anymore. Our process is automatic so if today you find out that the employer benefits are no longer active either the end of this month or the middle of the month or prior months, what would happen is we would remove you from HIPP but because of the dating rules and when that opens the managed care would open automatically for March 1.

That's not enough time for our system to send something to enrollment services and for them to send out a package so I know that that's the timeline thing which HIPP has no control over either.

>> KYLE FISHER: If I can jump in. Thank you for the overview and I think you hit on a couple of the questions that consumers had. I guess going back, what triggers HIPP enrollment, or someone receiving a HIPP application?

>> TARA GILLIGAN: They are sent automatically from the County Assistance Office when the case worker enters that there's employment or that there was employment or is employment and there's benefits available . That triggers our application to be generated. We don't have knowledge of that case until the clients actually send back the application to our program. I know there were different triggers sometimes. I'm not sure. We are not on that end of it at the CAO. I know some recipients have received HIPP applications who are not employed or have never been employed and there's (Indiscernible) they call and our staff just tells them that that's fine. They are not eligible for HIPP and they don't have to worry about sending an application back.

>> KYLE FISHER: That's helpful. One of the concerns that initiated this conversation is something members who received HIPP packets with the normal language saying they had to return this and these are members who are on Medicare or CHC waiver or folks who were actually excluded from trend 24 the concern is especially if someone's on waiver if

they know their employer cost of insurance doesn't provide (Indiscernible) Medicaid fee-for-service it's not going to provide those waiver services because it's apart from just the administrative burden in addition to the staff processing the form. Also acknowledging that the system design sounds like it's outside of your wheelhouse as well. But for others on the call might have some control over this? Recommend if possible that the logic be changed so that folks who are not eligible to be enrolled in.
>> RANDY: Are receiving HIPP applications it sound like that would be a change to (Indiscernible). What is the system that would trigger the mailing?
>> TARA GILLIGAN: That would be eCIS.
>> KYLE FISHER: The second piece you touched on as well and client and service experience here disenrollment and the program is no longer cost-effective (Indiscernible) standpoint. There's actually there's two pieces. The lag between this disenrollment from HIPP and the ability to be enrolled into a health choices plan but also lack of information provided to families being transferred from one program to another. If someone is choosing a plan from the initial fee-for-service window (Indiscernible) brochure that gets (Indiscernible). To make a plan choice. A couple of recent examples we've had families disenrolled from HIPP who received no information and I'm wondering if that's not another system design element that could be improved?
>> TARA GILLIGAN: We would be very willing to discuss it with the other departments and see what we can do for our time frames. Unfortunately, because the case is no longer cost-effective, there could be reasons because it could be because the employer insurance had open enrollment and the cost increased or something along those lines. We give them the 30 day notice but I'm not sure where the enrollment services would be able to get that information to send out a packet ahead of time because our HIPP plan code is a ESAsin the system like the managed care would be. Oh yeah, we would be open to it, definitely open to discussions about that so we can streamline that a little better. Part of the consumer subcommittee. I actually was recently.
>> JAYME SCALI: In my particular situation, my husband's employer-based insurance plan runs from 6/1 to 5/31. I didn't receive any notification that we were no longer cost-effective until November 17 and I was told that that's the day it was postmarked. I received it after Thanksgiving. Telling me that as of December 31 we would be placed into managed care organization. But then I had no sorry I have a little one in the background. I received no packet or what to do. Basically I just called the number on the paper that I received and started asking more questions. That's when I found out that my determination that I was no longer going to be enrolled in HIPP actually was done back in May. Why didn't I receive notification sooner? If HIPP determined I was no longer cost-effective, that would've been great and I should've been able to have enough time to have a packet sent out.
>> TARA GILLIGAN: If it was because of the cost of the benefits changing at open enrollment then you should have been notified as soon as sometimes the employers don't get that information back to us but that's not that long. Usually it's a few weeks until that's

back. So I would have to look into your case to see why you were determined basically in the middle of your plan year.
>> JAYME SCALI: The other part that was hard for me to navigate was I called and they told me managed care because I'm involved in the subcommittee and am pretty well versed on what's offered in Pennsylvania and what my kids would benefit from I wanted to elect Keystone First so when I would call to try to make that election before December 31 I was told I couldn't because my kids were in fee-for-service and they were still part of this program. Then January 2 I called and one of them was moved but one of them was in and then I was actually automatically enrolled in health partners when the whole time since I got that communication up until December 31 I was trying to elect Keystone First.
>> TARA GILLIGAN: I'm going to look into that because I know that the managed care, they can't enroll you as input in the codes that you're in there in Ecis because our codes are in there but if we can find a way to communicate that yes your case was closing and they are able to pick you up before it gets closed and you get put in something else you don't want, I'll look into that and reach out and see who I can talk to about that type of situation.
>> JAYME SCALI: Thank you. Lastly to mention I know you are giving 30 days and maybe that's what suggested within the realm of acceptable. But it is a hardship for a family to go from there is a financial burden that goes into it as well. If I had known in May that come December 31 we would no longer be eligible for the program, that would've been different. But it's a hardship. In our particular families case it's $500. Sorry. It's a $500 difference a month that we automatically had to acclimate to which luckily we were able to do that but I worry that other families, 30 days just isn't enough time. For them to be able to adjust their budgets.
>> TARA GILLIGAN: Right. That's why in our discontinuous notice we recommend bringing the discontinuous notice and going to the employer and dropping the primary insurance so that the recipients would still have medical assistance only but wouldn't have that cost at play anymore.
>> JAYME SCALI: That is beneficial only if -- in our case my children it's my two children out of three are the recipients. So dropping the primary insurance was offered as an option but it wouldn't have change the cost because I still have a child that is not eligible for medical assistance that we need to maintain. So the cost is the same.
>> KYLE FISHER: (Indiscernible) Mentioned 500 new enrollees into HIPP monthly -- is it 500 families or budgets and 1000 recipients you said?
>> SPEAKER: That's the number of households.
>> KYLE FISHER: Roughly how many are disenrolled?
>> TARA GILLIGAN: I don't have that in front of me. Since the COVID unwinding it's been higher than normal. Medical assistance was remaining open for the past couple years for those who wouldn't be eligible for MA anymore. Our amounts have been a lot higher. For the past I think the unwinding started last spring. Since then our disenrollments have been much higher because over the pandemic we weren't disenrolling anybody at all.

>> KYLE FISHER: How many of those disenrollments are around for ratio of individuals like Jayme who is was found no longer cost-effective?
>> TARA GILLIGAN: The majority of are no longer MA eligible.
>> SALLY KOZAK: I apologize. We are beginning to run very much behind. I'm sure that we can have Tara come back again and answer any additional questions that you might have about HIPP. I'm not sure who it was that Tara was speaking with about the cost and the issues she experienced. But if we have her name and contact information Tara can certainly reach out to her as well and finish that conversation if need be.
>> SONIA BROOKINS: I agree with you Sally. Yes, we can give her information.
>> SALLY KOZAK: I just want to be sensitive of the time. I know OEM needs to go and many folks need to jump at three.
>> SONIA BROOKINS: I agree Sally.
>> KYLE FISHER: You answered all the questions I had so thank you for joining us.
>> SONIA BROOKINS: Thank you so much. Next is OIM.

- **OIM Report**
    - **Unwinding Updates**
    - **HCBS & MAWD**

>> SPEAKER: This is Lexi . Can you hear me?
>> ALEXIS DEISENROTH: I'm Director of the division of health services over here in OIM. Carl Feldman sends his regrets. He is on vacation this week. So I'm not going to feel bad for him. Taking a look at some of the updates that we wanted to provide I know that there were some very mindful points sent to us to address within this meeting . I just want to walk through some of those first of which is the unwinding updates. I know that our new unwinding data for the month of January is available on our website now. You'll be able to take a look at the unwinding data tracker . Our federal reports which I'll reference later here when we talk about some of the appeals information and the final unwinding monthly renewal outcomes are all available on those sections of the website and I can post some links in the chat. If you're unfamiliar with our website and federal reporting intrastate reporting it's a great place to look for unwinding data and see how things are going. Within our processing and moving through the unwinding. Again our newest data for the month of January is available now. Taking a look at some of the updates for programmatic and data. One of the things -- our first start. This is a pretty significant month for us in Pennsylvania when it comes to the unwinding. This is the last month where unwinding renewals are starting to initiate with renewal dates in March 2024. Our mailings are going out now for those renewals and this is the last month of unwinding renewals.
It's Just significant. I know it's been a long and hard road for all of us through the preparation, the implementation and just the efforts for continuous improvement throughout this whole process. This was unprecedented. So I just wanted to take a quick moment to thank everybody on this call for your partnership and the shared goal to keep

Pennsylvanians covered through the unwinding process because it has been and continues to be an interesting and important road for us to walk together. We've come really far and it feels good to be rounding that bend into this homestretch. First and foremost, a big thank you as we continue to work to close out the unwinding.
>> KYLE FISHER: Thank you to OIM . You and the team and Carl over there at OIM. We share your enthusiasm and excitement that's there a light at the end of the tunnel.
>> ALEXIS DEISENROTH: Right. We really, really appreciate that. Acknowledgment. We're looking forward to how DHS continues to assess what we can do to learn the lessons . There's a lot that we can do to alleviate some of the renewal process for some by increasing ex parte rate. I know this is top of mind for a lot of us as we start to work on this just based on our own understanding of exparte and making sure that people can have the opportunity to renew potentially without having to get a renewal in the mail. Working to increase those exparte rates for individuals on Medicaid and CHIP is really top of mind. Part of this effort that we look forward to is continuing to evaluate the recommendations and I think I talked a little bit maybe last month about just some of our engagement with code for America.
We spent some time looking forward to six weeks stint working with code for America on the month of November and December. We came away with some recommendations from them and shared thoughts of things that we could do for exparte. I hope by next meeting we should be able to give a little bit more into the things that we are looking and examining to implement in an incremental level . The items to improve that exparte rate given our current systems runway and parties within that runway and to do that within the timeline given by CMS. I don't know if we've discussed that timeline. CMS issued some guidance in September, August September last year and asked for states to come into compliance with that guidance within 24 months of the end of the unwind.
Currently We are operating on a mitigation plan for that . That's our end goal to ensure that we're coming into compliance within that timeframe for increasing exparte, ensuring that people are getting the opportunity to renew ahead of the renewal going out and at an individual level as opposed to a household level. We are mostly examining that and we hope to be able to put into place both policy and systems impacts to increase that rate. But I'm going to work with Carl to see if there is additional information we can provide at our next meeting regarding anything that we're getting closer to potential implementation or in plans to implement. I just wanted to T that part of that up and I'll pause for a second because I know that was a lot. Are there any questions?
To Keep moving and let me know to pause and we will go ahead and take e questions. We -- some of you may know that we had another project for exparte reinstatements based on the guidance issued from CMS . CMS had indicated that households needed to be evaluated for exparte at an individual level as opposed to the household level. And for that reason, we did a close look at any individuals that potentially could have been eligible at an individual level, and then we went back and reinstated them. I know that there's some

progress that we have yet to discuss I think in terms of notifying people if they have been impacted. Let's talk about the prospective group. Some individuals needed prospective reinstatement and some needed retro and some needed both. Let's talk about the prospective group. Prospective notices, people were notified if they were opened backup going forward and when that action was taken, that's when the notices were mailed.
That action was taken in the final quarter of last year. And those notices have gone out. So the prospective is done. In terms of retro notices, we have an estimated mail date for those notices of this Friday. I'll pause there if we have any thoughts or questions to that. But the noticing should be complete and all fingers crossed going into next week.
>> KYLE FISHER: I guess if you don't mind reminding us of the figures. I know there are a number of individuals identified before that already returned to Medicaid so I'm imagining the perspective notices that were mailed is a much smaller number (Indiscernible) do you have those handy?
>> ALEXIS DEISENROTH: I do not have them available right at this moment. I will pull them and report back to this group.
>> KYLE FISHER: Thank you.
>> ALEXIS DEISENROTH: Thank you. I think the next space that was requested just to get a general understanding on was hearings and appeals. The agenda item that came through was we understand that fair hearings through BHA have been increasingly delayed due to unwinding volume. How many Medicaid appeals are pending for 90+ days? I will say that the newest data from the month of January is available now on the website, and again all tried to get a link posted to the chat . They are available in a federal reports on the DHS website so January 24 is available now and the January report showed 653 appeals over 90 days. The second question in regard to appeals is what is the status of E 14 waiver regarding appeal processing timelines? Currently DHS is still evaluating that waiver. We met with CMS to discuss some noticing challenges and have sought some feedback from other states that have implemented the waiver.
For additional feedback on how to alleviate some of the similar challenges to noticing. And if implemented, use of that waiver would require coverage restoration for individuals with an appeal pending. Those are all steps that we continue to walk through and examine as we continue to evaluate the waiver.
>> KYLE FISHER: Is there any deadline on making that determination from DHS?
>> ALEXIS DEISENROTH: I do not have a deadline that I can share from my preview today, but I can check back on that as well.
>> KYLE FISHER: Are you able to elaborate on what you mean by noticing issues? (Indiscernible).
>> ALEXIS DEISENROTH: There's a lot of timing issues with being able to make some systematic changes and being able to get appropriate noticing to individuals as described as needed by CMS. The specific issue that I think we're facing is the ability to change the current eligibility notice at every determination . I think the complexity, you'd think that

changing a line in a notice wouldn't be as difficult as it is. Let me -- the specific ask of CMS is to remove old language that indicates recoupment could happen for MA as the result of an appeal. That language isn't abundantly clear on our current notice so we worked to take a look at that and see what our options are to be able to change that. Our notices are sent out I think in English, Spanish in the next top five languages. Translations for secondary languages are and next stop authentication of those languages are a following step. Then our final step to being able to change is implementation through systematic means.
Trying To find efficiency in that update is a little bit of a challenge. So we are continuing to work through the steps while we continue to evaluate the waiver.
>> KYLE FISHER: Thanks for sharing that.
>> SONIA BROOKINS: Thank you for that.
>> ALEXIS DEISENROTH: I do have some questions presented here for HCBS and MAWD I want to be mindful of time though. Kyle and Sonya, if you want to take a lead in what you'd like me to walk through here unless you just want me to walk through the whole kit and caboodle.
>> KYLE FISHER: If you don't mind I know last month you'd identified or mentioned identified about 75 individuals who were targeted outreach to updates on that cohort. Have they been reenrolled?
>> ALEXIS DEISENROTH: Sure. Let's take a look . I'm going to break it into two groups . We had sent a group of 26 individuals over to the operations bureau to review the eligibility for MAWD. Of those 26 the results were that eight of those had been reopened or are in the process of reopening in MAWD or HCBS. Six were not interested in MAWD or ineligible for MAWD or found eligible for other categories. And then 12 that's who we hadn't heard back from. We were waiting on a response to the letter we sent from those individuals. If you remember the process was to give them a call and then if we could not reach those individuals by phone, we were going to mail them a letter. There are 12 of that 26 group outstanding. That's the first group that all review. The next group is about 50 individuals, and we did not send those to operations. The reason for that is our folks over here at MA policy took a look at that group.
We were able to either tell by review of what was going on in the case or narrative that they were either ineligible for MAWD by one means or another, they were not interested in MAWD when reviewed in processing that original application. Or they had already been reconsidered or reopened in MAWD prior to sending that over to operations. I have to see if we have exact numbers for that group because I know that you were asking me how many have reenrolled into the HCBS waiver through MAWD or otherwise. So I want to see if we have some of those more definitive (Indiscernible) and I know someone in my group is seeing if we can identify if we have those specifics. In terms of who we were unable to reach there were only about 12 of that group that -- or 12 of that group that we were unable to reach and had sent the letter and are waiting back to hear from them.
>> SONIA BROOKINS: How long will you wait? After they send the letters out? How long will

you be waiting for response from the client?
>> ALEXIS DEISENROTH: I think the letters did ask for a response in 30 days . I think we are getting pretty close if we haven't hit that timeframe already. Anybody at any point -- the letters that we did send indicated that anybody could call at any time to be reviewed and apply for MAWD. That's just something we always want to make sure that people are aware of in our communications. There might be a wish on a timeframe for this initial activity that we sent on these 75. But at any point, we want to make sure that it is clear that MAWD is an available category at any time someone wants to be reviewed.
>> SONIA BROOKINS: Thank you for that.
>> LAUREN HATCHER: Hello. Can anybody hear me? Real quick my name is Lauren Hatcher. I don't know if I just missed this but we were talking in this forum about adding MAWD into the database system so that the workers at the county don't have to manually calculate everything and it just goes in what everybody else is and (Indiscernible) so they only have to go through it with a fine tooth comb . Also I've had experiences with the statewide hotline where they don't really know what MAWD is. So training really needs to be amped up there. That's personally and professionally . That's all I had to say. MAWD is wonderful program. I wish more people know about it and knew how to use it. So that's all.
>> ALEXIS DEISENROTH: Thank you Lauren. I appreciate that. I think we do have a change request out there to have MAWD added to the cascade but it's currently not able to be prioritized in the current system availability. It's something we are always thinking of because of the efficiencies that we could gain from potentially adding that to our cascade. We're going to continue to look at that and we appreciate you continuing to raise that.
>> LAUREN HATCHER: Thank you.
>> SONIA BROOKINS: I know this is not the meeting for that, but I would like you to go back and let them know that the line that -- what's the line?
>> ALEXIS DEISENROTH: Customer service center?
>> SONIA BROOKINS: Yes, the customer service center. We have a lot of problems . The line is not being answered. I'm just telling you. I know this is probably not the first time you've heard it. Or is it?
>> ALEXIS DEISENROTH: Throughout the unwinding of course there's been some ebbs and flows of CSC volume . I can certainly relay that to the Bureau of operations but that's coming through this group as feedback back to our customer service. I do want to say I'm not sure what we'll see going into post unwinding if some of that will maybe calm down a bit. But we hope to see some improvements on our customer service center and we are always looking for different ways to improve and change and ensure that those calls are being answered because they are so very important so thanks for bringing that up Sonya.
>> SONIA BROOKINS: I do appreciate it. Thank you. Anything else? Anybody?
>> AMY: I just have a quick clarifying question. You said the group that Bureau of operations review that there were some eligible and other categories. Can you explain what that means? Were they on the waiver already?

>> ALEXIS DEISENROTH: I'd have to look at the spreadsheet so let me mark that for follow-up Amy. I want to make sure that I'm getting back to you with the appropriate information. I think it was Act 150, but I want to take a closer look to see where those are landing.
>> AMY: Okay, thank you.
>> SONIA BROOKINS: Anything further sake of order?
>> KYLE FISHER: Not for me Sonia. We appreciate your time.
>> ALEXIS DEISENROTH: Thanks everybody. I appreciate that.
>> SONIA BROOKINS: Thank you for your time. I want to say thank you to all the committees that represent us today. We appreciate your service. And all that you do for the people that you serve. Can I have a motion to adjourn the meeting?
>> MEGHANN LUCKOWSKI: Our motion to adjourn.
>> LIZ HEALEY: L second that.
>> SONIA BROOKINS: Thank you so much and have a safe rest of the week.
(End Of Session)