Consumer Subcommittee of the MAAC

March 27, 2024

Consumers present: Sonia Brookins, Marsha White-Mathis, Minta Livengood, Liz Healey, Rochelle Jackson, Meghann Luczkowski, Jayme Scali, Lauren Hatcher, Victoria Gardner.

DHS representatives present: Sally Kozak, OMAP Deputy Secretary; Eve Lickers, OMAP Policy Director; Gwen Zander; OMAP Bureau of Managed Care Director; Carl Feldman, OIM Policy Director; Juliet Marsala, OLTL Deputy Secretary; Randy Nolen, OLTL Bureau Director.

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

[Captioning]

Introductions

>> Good afternoon. Welcome to the March 2024 edition of the consumer subcommittee. I am Elise Gregory.
This meeting is being recorded. Your participation in the meeting is your consent to be recorded. If you do not wish to be recorded, you may end your participation in the webinar at any time.
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Presenters should state their names clearly to assist the captioner.
From the Office of Medical Assistance Programs, Deputy Secretary Sally Kozak and Gwen Zander.
Deputy secretary Juliet Marsala and Randy Nolen.
And from the Office of Income Maintenance, Carl Feldman.
If you have questions related to the meeting or other information, visit the web page.
I will hand things over to consumer subcommittee chair Sonia Brookins.

>> SONIA BROOKINS: Good afternoon to everyone. We will now start the meeting with introductions. And then we will go forward. Danna?
>> Thank you, Sonia. Good afternoon, this is Danna Casserly with the Pennsylvania Health Law Project. I serve as counsel for the consumer subcommittee. I know many of you from previous meetings where I have assisted Kyle Fisher. He's out this week. I will be stepping in.
I will start with introducing the members of the subcommittee:

Our chair, Ms. Sonia Brookins?
>> Present.
>> And our vice chair, Minta Livengood? Are you able to unmute? Minta, I see you came off mute. I'm not hearing anything.
We'll come back to Minta to see what's going on with her audio.
Next, we have Marsha White-Mathis. I think you're there with Ms. Brookins?
>> I'm here. Present. Thank you.
>> Thanks, Marsha.
Rochelle Jackson?
>> Present.
>> Thanks. Lauren Henderson?
>> Liz Healey?
>> Jayme Scali.
>> Present.
>> Meghann Luczkowski.
>> Present.
>> Victoria Gardner. Sorry, folks, I got another call. My audio cut out. Is Victoria Gardner on the line?
We are expecting her. I'm checking the attendees side. Elise, could you see if she's over there? I haven't heard from her.
>> We're not seeing her yet. We'll keep looking.
>> Thank you. Appreciate it.
And finally, I believe the last consumer present is Lauren Hatcher.
>> Present.
>> Great. Any other consumers on the line that I did not announce? Okay.
And if there's any on the attendees side, we will work to bring you over to the panelist side.
Okay. So that's everyone from the consumer subcommittee.
I think we're ready to get going.
Sally or Eve or Gwen?

OMAP Report

>> SALLY KOZAK: Good afternoon. Sally Kozak here. I apologize. I had initial trouble logging on. Give me one second here.
>> SONIA BROOKINS: It's okay, Sally.
>> SALLY KOZAK: It's one of those days, Sonia.
>> SONIA BROOKINS: It is.
>> SALLY KOZAK: Okay. So the big ticket item on the agenda today of course is an update

on the 24-25 submitted budget. That's what I will give an overview on.
After that, Gwen is going to talk about hospital MCO contract negotiations and about pay for performance trends and equity incentives.

1. Budget FY 2024-2025

And if we could go to the next slide. And the next slide after that.presenting their budget separately either in afternoon or tomorrow.
This slide represents the 24-25 proposed OMAP budget. The capation is the biggest part and totals almost $23 billion. And that -- I'm sorry, $28 billion because there's 5 billion in other in there that goes into capation as well.
And that presents a 4.7% increase from over 23-24.
So what you can see in there is CHIP is at 400 million. Fee for service is 2.8 billion. Medicare part D contribution is 1.1 billion. Medical assistance transportation is at 164 million. And then we have about 637 million for other. And other appropriations include uncompensated care, academic medical centers, expanded services for women, the medical assistance for workers with disabilities, trauma centers, burn centers, critical access hospital, knee owe natal services and physician plans.
If we could move on to the next slide, please.
So as I said, the capation appropriation proposed for fiscal year 24-25 is a 6.7% increase over fiscal year 23-24. It's important to note that this capation consists of physical health, behavior health, as well as the maternity care payments we make. And physical health accounts for approximately 75% of the total capation appropriation.
And you can see here on this slide where those funds come from. So for 24-25, about 4 billion of that will come from state funds. 15 billion of that or 15.6 billion of that will come from Federal funds. And about 3.4 will come from other funds.
And the other funds include the managed care assessment, the statewide hospital assessment, as well as the ambulance intergovernmental transfer.
Overall, the funding for capation is increased because the PHE ended of May 11 of 2023. And other factors resulting in an increase utilization as well as increase in the amount of state directed payments that we make.
If we could go on to the next slide. We will talk a little bit about the fee for service appropriation. Which you can see the 2.8 billion. And this represents a 12.3% decrease from fiscal year 23-24.
Just to note there are no changes in benefits despite that decrease. It has decreased because of the impact of nonrecurring payments which totalled about $100 million.
The impact of us shifting academic medical center payments to the capation appropriation and also the shifting of the disproportionate share hospital payments into the managed care payments in anticipation of the Federal DISH allotment.

That's why we see the decrease there. Not because it's a cut in service.
You can see for the fee for service budget, $601 million comes from State. 1.9 billion is in Federal funds. And 344 million is from other. And again, the others represent the Philadelphia hospital assessment, the statewide hospital assessment, the FQHC alternate payment methodology and the intergovernmental transfer. And the hospital intergovernmental transfer as well. Just to note transfer is only for the second half of '23 and the first half of '24.
If we can go to the next slide, please.
So MATP, medical assistance transportation program. The allocation is $165 million. This is a 3.8% decrease from fiscal year 23-24.
However, that is also an increase in state funding of MATP. It went from 71 to 73. And it was the Federal funding that decreased. That was because the PHE ended in May and we have the wind down of the enhanced map which shifts everything to state funds.
There was an increase in state and we are projecting an increase in the number of trips for 24-25.
The 4 million extra that actually is on here -- I'm sorry, 4 million in the state funds includes the lottery funds as well.
Then the CHIP appropriation. The CHIP appropriation for fiscal year 24-25 is 400 million. This represents an increase of 15.5% approximately over calendar year 23-24.
Again, the funding increased because we anticipate a projected increase in eligible children for fiscal year 24-25. We anticipate CHIP enrollment at about 174,000. Which is an increase of about 28,000 over 23-24.
And just as a reminder to folks, right before the COVID public health emergency, CHIP did experience its all-time high enrollment of slightly over 120,000 kids and was anticipated to start growing then but didn't. Again, because kids shifted from CHIP into Medicaid.
The other funds on this slide that help fund the CHIP appropriation include the MCO assessment and the vision services donation, which is our vision to learn initiative.
And then here's the break down of the total funds for all of the other programs I talked about. So you can see that MAWD went up by 13.6%. The physician practice plans went up slightly.
Hospital burn centers, critical access, OB NICU, trauma centers, academic medical centers, expanded services for women -- well, that went down a little bit. But uncompensated care, those all went up just slightly.
And the next slide.
For the 24-25 budget, we do have some mandated increases. And the mandated increase is going to be to the dental services. And those will begin January 1st, 2025. The MCOs will implement a uniformed percentage increase to payments for the dental services to dentists under contract to provide services to MA recipients and who are participating in the MA program. That will be done through a minimum fee schedule and there will be 31

codes that have been identified in the legislation as well that will see those rate increases. So this year, I know in past years, I have given you a lengthy all kind of numbers. I tried to slim it down a little bit this year into what I hope made it a little bit more easy to interpret. So with that, happy to answer questions that folks might have about the OMAP budget.
>> DANNA CASSERLY: Thank you, Sally. And I want to pause and let the folks know that Victoria Gardner did join. She is in the attendees side and needs to be moved other. Thank you.
Sally, thank you for the budget piece. We were happy to see the information about the dental rate increases, especially. And heard the secretary talk through the pieces that are already put into place.
>> DANNA CASSERLY: We noticed you didn't mention this, but we noticed there was an increased reimbursement rate for emergency medical services in the MA line item.
Can you confirm what the services encompass? What that line item means?
>> SALLY KOZAK: That was legislatively mandated to do an increase for ambulance services. We needed to submit a SPA for it. The SPA has been submitted. And since this is the 24-25 budget, Eve, you want to talk to that?
>> EVE LICKERS: Yes. So we had issued a public notice at the end of last year advising that based on -- and I'm trying to think if it was last year, that there would be an increase to the ambulance transportation fees. It wasn't legislation.
So we had issued a public notice at the end of last year, beginning of this year saying that we were increasing it and subject to a Federal approval.
So we have submitted a state plan amendment for those increases. And it is currently still under review with CMS at this point in time.
And we -- I'm just looking and pulling it up right now as to what the date is that we have to hear back from them by May 5th. If it's approved, we will go back and reprocess the claims we received from January 1st until that point in time. And then that will make the providers fee for service.
The MCOs will also be going back to January 1st and making the providers -- to pay the difference between what they received and what the rate was published as.
We did issue a second public notice adjusting a couple of the fees because we were using also because some people may have seen a second public notice. We were using the fees for the rest of PA with our first public notice. The second public notice, we had actually increased, I believe it was three of those rates to the highest rate, which was the Philadelphia. I believe that was the Philadelphia rate.
So that was explained in the public notice as well.
I'm not sure if you have any questions.
>> DANNA CASSERLY: That's really helpful. Thank you. That's good to hear about access in terms of those services.
>> EVE LICKERS: And also, it includes -- historically, we have paid for ambulance ground

transportation mileage after the first 20 miles. So that legislation also provides us to be able to pay for all loaded miles. So that was also included in the state plan amendment as well.
>> DANNA CASSERLY: Thanks, Eve.
Sonia, did you have a question?
>> SONIA BROOKINS: I wanted to make sure I was hearing it right. So all this is accounted for just for ambulance only? Ambulance only?
>> SALLY KOZAK: Correct.
>> SONIA BROOKINS: Okay. I wanted to make sure I heard it right. There's things going on with the computers. I'm making sure I heard you.
>> SALLY KOZAK: You asked about the dental benefits. I can send you the complete list of it. But essentially, they are the codes that focus on oral evaluations, periodic comprehensive, intraoral. They focus on adult and child application of fluoride and sealants. And there are two filling-based codes and crown codes in there. And tooth removal. I can make sure you get the full list of them. That's not a problem. They're spelled out in legislation. We will send them to you.
>> DANNA CASSERLY: Wonderful. Thank you, Sally. Appreciate it.
>> LIZ HEALEY: Sally. This is Liz Healey. I think you gave the number, but I didn't catch it. Can you tell me what the change in enrollment has been since the -- well, I guess since the unwinding began. And maybe that's a question for Carl. But I was wondering whether the number in this budget is greater or smaller than the number of covered lives in the last budget.
>> SALLY KOZAK: What I have in here is the CHIP number. I don't have the adult number. So that's a question for OIM. So I don't know if Carl is on the agenda later today. If not, we can certainly find that out for you.
>> LIZ HEALEY: Okay. Thank you.
>> SALLY KOZAK: Sure.
>> DANNA CASSERLY: Thanks, Sally. I don't know that there are other questions about the budget piece. Appreciate that.
>> SONIA BROOKINS: Okay. Anything else?

2. MCO/Hospital Contract Terminations

>> DANNA CASSERLY: I think the next item we wanted to discuss, if you're ready, if you have updates about the hospital terminations. And I don't know if Gwen is on. She had been sharing some of this information.
>> GWENDOLYN ZANDER: Hi, thanks. Happy to give this update.
As far as MCO and hospital contract terminations go, there is only one that we are aware of on the horizon right now that we're tracking very closely. And that is the contract between

keystone first and the Children's Hospital of Philadelphia, CHOP.
I want to be really clear and say there is no intention between the two parties to allow that contract to terminate. They are negotiating and they hope to come to terms and be able to continue that contract.
But it does have an expiration date of June 30th, 2024, which means that we are approximately 90 days out, three months out from that termination date.
The Children's Hospital has sent communications to the keystone First patients advising them of this. Keystone First is not required to send notifications to their members until 30 days in advance.
Like I said at the beginning, they are negotiating and they hope to come to terms.
So any questions on Keystone or CHOP?
>> SONIA BROOKINS: Yeah. I have questions. How are you?
>> GWENDOLYN ZANDER: I'm well. How are you?
>> SONIA BROOKINS: I'm good. I just hope that this -- that they do come to a happy ending. We're talking about a whole lot of children.
>> GWENDOLYN ZANDER: It is many children. You are correct.
>> SONIA BROOKINS: I understand that CHOP put something out. For me looking in the window, it seemed that CHOP put something out before Keystone put something out. And people are scared.
So I don't know why they did it. They probably had a good reason why they did it. I just think that when you do stuff like that, people should be aware of these things that's going to happen before something like that comes out. Because people are really scared about this.
And I'm just hoping that they come to a happy medium. I really do. Because we will have a problem if they don't.
>> GWENDOLYN ZANDER: We certainly join you, Sonia. And there were about 140,000 individuals that received that outreach. And that is the Keystone First members who have received services from CHOP within the last two years. So like you said, that is a lot of children.
You're also correct that CHOP did send those communications out before Keystone First sent anything out. The reason provided to us is because CHOP is currently scheduling into July and beyond. So they felt it was the right time to tell their patients about this. But I can certainly understand that it's generating concern. And we wish that the communications had been coordinated. And more than anything, we wish that the notifications never had to go out. We wish for the contract.
But that is the situation that we're in right now.
I will point out that CHOP is in network with every other MCO in the southeast zone.
>> SALLY KOZAK: Yeah, Sonia, just to share with you, we met with CHOP. And we encouraged them to find an alternate route and not to do this. As you know, though, we

have no authority over the hospitals to prevent them from doing anything.
As Gwen said, we understand the reasoning, they were scheduling out. But we expressed our concern over member confusion and the impact it would have on those families.
>> DANNA CASSERLY: Thank you, Sally. I would add too, I think the silver lining is that it seems like the communication that CHOP sent out was pretty clear in terms of the guidance and also seems very accurate.
So the project has not heard from many families, as many as we expected to hear from who are nervous about this or unsure of what to do. I think it could be attributable to the strength of the communication.
I just want to pause so we can let other folks in and we will go to your question. We do have consumers that when the call dropped got put to the attendees side. Lauren Hatcher is on by phone and a few other folks as well.
Is there anyone what could be monitoring that to bring them over so they can contribute to the discussion?
>> ELISE GREGORY: Sam, are you able to do anything with the phone? I'm not seeing them.
>> SAM CHANEK: Which phone are you talking about?
>> DANNA CASSERLY: You need the phone numbers? I can give you them quick for Lauren Hatcher, she's 412-216.
>> SAM CHANEK: Do they need to dial in?
>> DANNA CASSERLY: They are dialed in. They're joined by phone.
And Victoria Gardner is the second.
Meghann, I'm sorry, Elise, I think Meghann from the consumers was going to reach out to try to handle this. I'm sorry I caused the discussion. I just want to make sure these folks come in.
>> ELISE GREGORY: Yes, I did see that from Meghann. Unfortunately, Sam is going to have to be the one to pull that over. Thank you.
>> DANNA CASSERLY: Thanks, Sam.
Okay. Marsha, did you want to ask a question? Sonia or Marsha, are you still on?
>> The question is to Sally. Sally was in communication with CHOP. So the question, Sally, is since CHOP and Keystone are still at the bargaining table and they're still trying to work something out, did you foresee how it would make the consumer panic? This is about the children, the children coverages. That's a lot of children.
And I just think it was so unfair for CHOP to do that and make people panic and it wasn't time yet. They had time better they got to that point.
If you were in communication with them, did you not foresee that if they put out a communication the way people would be reacting?
>> SALLY KOZAK: Marsha, I mean, our conversation with them was very Cordial. I was forceful in our position and concern around consumers.
Again, unfortunately, I have no authority to tell any individual hospital that they're not

allowed to do that.
>> MARSHA WHITE-MATHIS: But you did know they were going to do it before they did it? 140,000 letters that were going to go out.
>> SALLY KOZAK: They notified us of their intent which is why we had the conversation. And Gwen, they notified you and provided you the notice?
>> GWENDOLYN ZANDER: They notified me the morning it went out but did not provide an advance copy.
>> MARSHA WHITE-MATHIS: That was my question. Morning is not advance notice. Thank you guys. I just needed to understand why we was getting all those calls and all this concern. But you just found out this morning. That's not really advance notice. Thank you.
>> SALLY KOZAK: Sure.
>> MEGHANN LUCZKOWSKI: Hey, this is Meghann from the consumer sub. And just to be clear, that messaging came through by text from CHOP. There are consumers that are panicking. And we understand the Department doesn't really have the ability to say one way or the other if a provider can do that.
Just if thinking ahead moving forward, and I know we can't really say anything definitive right now because they haven't come to an agreement, but as the consumers are growing concerned and we're trying to get everybody to hold tight and see what happens, is there some information the Department might want to say we're definitely sharing the continuity of care options, that enroll will be there for consumers to change if they need to. Is there anything the Department would recommend or that they could share with us that might put consumers at ease or that you would hope that they know now?
>> SALLY KOZAK: We have processes in place to address all of the questions that you just answered at the point in time that our managed care organizations officially notify us that a provider is being terminated from their network for whatever reason.
We do not put those policies and procedures in effect in anticipation. We believe that the time frame we have is sufficient to allow all of that information to go out.
Again, this was not the MCOs or the Department's action. This was CHOP's action.
>> MEGHANN LUCZKOWSKI: Yeah. And we understand that. I think we're just making sure that we have whatever information the Department would suggest that we give consumers to put their minds at ease. Just the procedures, I guess, it's probably what we're already telling people.
>> DANNA CASSERLY: I think the piece about the other hospitals is a big one. All the other MCOs. CHOP does contract with all the other MCOs.
>> SALLY KOZAK: People will still have the continuity of care provisions. They will still have the opportunity to change. So even if they wait until there is an official action, they will still have adequate time for all of that.
>> MEGHANN LUCZKOWSKI: Yeah. That's what we're trying to line out for everybody so they can see they won't fall off a cliff. There's provisions in place to make sure that people

have time to make decisions. Our concern is always for those particularly medically complex individuals who have so many providers that are in different places. Some might be CHOP, some might be another hospitals, there's nursing agencies. And trying to get that to fit into the next and go down the line doesn't always work out.
But again, we're all going to be really hopeful. And we'll keep in touch.
>> DANNA CASSERLY: Gwen and Sally, thank you. Realizing that nothing is final, we appreciate the update on it. And just keeping folks in the loop. We will look forward to more updates. And just to confirm, it sounds like the 60-day notice that is required for Keystone to present the Department with the notification, correct? End of March?
>> GWENDOLYN ZANDER: 90 days is when Keystone will send the final notice to the department. And 30 days is when their communications to members.
>> DANNA CASSERLY: Right. Thank you.
>> GWENDOLYN ZANDER: And those communications will include answers to all of those questions that Meghann just asked. The majority of that information is currently on the CHOP FAQ website they sent out via text. I know you have seen. Some of that information is there. But all of it will be in the communications that go out from Keystone, if they have to go out. If they don't reach terms before then.
>> DANNA CASSERLY: Okay. Thank you. I agree the CHOP website is a good reference for what to be thinking about to get prepared.
>> SONIA BROOKINS: This is Sonia Brookins again. I appreciate Sally and Gwen, the Department. But I think I know how to fix this problem. Y'all might not want to hear it. I'm going to say it.
>> SALLY KOZAK: Always happen to hear what you have to say.
>> SONIA BROOKINS: I think we can eliminate the problem if y'all give them a raise. And this probably won't even be going on. I think that's what it's all about in a sense. I'm just saying. Just being honest.
>> DANNA CASSERLY: Thank you, Sonia.
All right. Do we have other updates from the Department? The computer and phone stuff got me a little sidetracked. Back to the agenda.
>> GWENDOLYN ZANDER: That is the only hospital MCO contract. I have the presentation regarding the pay for performance program as well.
>> DANNA CASSERLY: Great. So we want to hear pay for performance, right? I know it's been carried over a few months. We're good to go forward with that.
>> SONIA BROOKINS: Thank you.

3. Pay for Performance Trends & Equity Incentives

>> GWENDOLYN ZANDER: All right. So before I really dive into the content here, I want to just offer kind of an overview of what the pay for performance program even is. And I will

say that this is some complex and technical material. I'm absolutely going to do my best to make it straight forward and common sense. But please interrupt me if something isn't making sense or you need to go back over something. It's pretty detailed.
So the pay for performance program, P for P for short. This is really a program where we give bonus incentive dollars to the MCOs for achieving good outcomes and for having high quality care for their members.
It's kind of the cherry on top of the funding that they receive from us through capitation. There's just an opportunity for them to make some additional money. You can think of it as you get a good report card and you can get a free slice of pizza at Pizza Hut or something like that. It's the reward.
The purpose of the P4P program is to make sure that the payments we're giving to MCOs are aligned with the quality of care, the health outcomes, the access to care they're providing for their members. And how efficient they are in operating their programs.
So this is a form of value-based purchasing. It's a low risk form. It's meant to make sure the money we pay the MCOs is a lined with quality, access, and efficiency.
So on the next slide, we'll start to talk a little bit here about how this program works.
So in order to set up a P4P program, you have to have what we call quality measures. These are just ways that we measure the care and the outcomes of that care to the MCOs are paying for.
We do this through claims data primarily. So there are national sets of measures that we rely on. The most popular one is called HEDIS. That's something that health plans all across the country use. They're standard measures so that we can look at all different kinds of outcomes.
Sometimes we develop our own measures. We call them PA performance measures. That's when there's not a national measure that gets at the thing that we want to be paying attention to and tracking and incentivizing.
And we also have a measure related to the maternal home visiting program. All of them, like I said, they're quality indicators that show how well our MCOs are doing basically.
Now the way that the P4P model is set up, there are a lot of different ways for the MCOs to earn these incentives. One way is through benchmarks and goals. So for those national measures, the organization that develops those measures sets -- they release information every year about different benchmarks that compares an MCO's performance against their peers and other health plans. So maybe you do better than 50% of plans. Or maybe you do better than 75% or 90%. Goals are for when we don't have a benchmark because it's not one of the national measures.
There's incremental improvement. Maybe you didn't hit a benchmark or goal, but you did better than last year. Or maybe you're at the 95% percentile and performing better than just about everyone. At that point, it's tough to be better when you're already the best. But you can still get incentives for improving.

We also have benchmark bonus bundles. This is where we take several different measures together that are kind of related to one another and we offer even an additional incentive when you perform well on all of those measures together.
We have our health equity program, when I will talk about. And as I mentioned, maternal home visiting as well.
That's how the program is structured.
On the next slide, there's a list of all of the different measures that we are incentivizing or that we were incentivizing for 2023.
So you can see each of these measures here. I won't read them. We are going to go through each of them. And you will note that any of these measures that have the little number one next to them, that means they are also incentivized in the health equity program.
Next slide.
Controlling high blood pressure. We look at the percentage of adults 18 to 85 who have hypertension or high blood pressure diagnosis, but whose blood pressure was adequately controlled.
So obviously, you would want to see 100%. Everybody with hypertension would have the hypertension well controlled. That's what we hope for. Of course that's not the case.
But year over year, we have seen great improvements in the measure and have seen more people with hypertension getting that under control.
This is a sign that the incentives we're paying are working. It's driving better outcomes.
Now we can move to the next measure.
We can actually -- sorry, it looks like this is the full slide deck, which I had intended to send one where we were only going to go through a few slides. So I will tell you to keep going through a bunch of slides. Here we go.
Hb A1c. This is a measure where we're looking at people with diabetes. This is how we control how well diabetes is being treated and being managed.
So here we're looking for adults 18 to 75 whose diabetes is poorly controlled. For this measure, a lower rate is better performance because you would want to see that 0% of people who have diabetes are poorly controlled. You want everyone to be well controlled.
In this case, when you're seeing the decrease, that's a good thing. We want the number to go down. Again, we think that this is successful.
So we can go through a few more slides until we get to the next bar chart. There we go.
This is planned all cause readmissions. This is when someone is in the hospital and then they get discharged from the hospital, they get to go home. But then for some reason, whatever reason, they wind up getting readmitted and go back to the hospital. That's not a good thing. We don't want to see people going back into the hospital after they were released.
So over the last three years, we saw the weighted average decreasing, which is better

performance -- excuse me, sorry. I'm looking at the wrong notes.
But we have seen the average decreasing. But yes, this is a better performance because the lower rate is also better for this measure. You want fewer people that are getting readmitted after they were discharged.
So again, good outcomes here.
So I think we can move along to the timeliness of prenatal care. There we go.
So this shows the percentage of deliveries. So these are actual babies born. We look backwards and look to see did the pregnant person have a prenatal visit during their first trimester?
So we obviously want to see lots of people having prenatal care during their first trimester. We did see a drop off in 2023, which is a bit concerning. What I do want to point out to you is that even though this looks like a really big drop off, if you look at the actual percentages, it's really small. So in 2021, we were at 88.93. Went up to 88.97. That's great. Dropped down to 88.74. While it was a drop off and we are concerned about that and we're going to keep focusing on it, it wasn't major. It was a quarter of a percent less than that.
So we can move on to the next one. Here we have post partum care. So the prenatal care we just looked at was looking backwards to see who had a prenatal visit. Now we're looking after the delivery to see who had a post-partum visit to receive follow-up care between 7 and 84 days after the delivery.
Great results here. Seeing the numbers go up in the right direction. That's what we want to see.
Next slide. There we go.
Annual dental visit. This is for children. So I want to point out that it's ages 2 to 20 years. In the Medicaid program, we count anyone under age 21 as a child.
This is where we're looking to see more kids having those annual dental visits. We're making some progress, but we definitely still have room to improve. We're kind of climbing out of the drop off that we saw during the early pandemic years and trying to climb back to where we once were. It's an improvement. But we need to stay focused on this one. It's still too low of a number for 63% of kids to be having an annual dental visit. You want that to be 100%. We will keep focusing on this one.
Next. Thanks.
So this one is the asthma medication ratio. This is for people who have asthma who actually have an inhaler. So you obviously want people to have their controller medication. Maybe it's not an inhaler. I think most of them are. But you would want to see everybody who has asthma actually being in possession of an inhaler or a controller medication.
So for this one, we like what we're seeing. Again, here are the increases. We're going to keep going until we get close to 100%.
Next one.
These are well child visits in the first 15 months of life. So we definitely want kids to be

getting their well child visit during their first year and three months. There's a lot of well child visits that you have to go to when you're a baby. So we're looking at who is actually having six of those visits within 15 months.
Again, good results here going up. But we're going to keep going until we get to 100%.
Next slide.
Child and adolescent well care. This is similar to what we just looked at with the well child visits, but just an older age group. Age 3 to 21. Every kid should be going at least one time for a well child visit during the year.
So these rates are definitely lower than what we just saw with those visits in the first 15 months. So we really need to keep focusing on this. We have made a little bit of an improvement over last year. But we need to keep going. Really every kid should be receiving a comprehensive visit every year they're covered by Medicaid. So folks should be getting those services.
All right. Next slide.
This one is lead screening. This is kids who are two years old, whether they had a blood lead test to check whether they have lead exposure. We know that exposure to lead can cause all kinds of different complications, including developmental challenges. So we want to be screening. This is really important.
We have had some kind of mixed results over the years. It dropped off a little bit. Starting to climb back up. This tells us this is a measure we need to continue to watch.
We got pretty good performance here in the 80s. Again, it should be every child who is having one of these blood screenings.
Next slide.
These are developmental screenings within the first three years. And so these are screenings where kids are being evaluated for developmental, behavioral, and social delays using a standardized screening. Within their first three years.
So we're seeing these numbers going up. Again, this is good. And just to reiterate when we see these numbers going up, what it tells us that the incentives we're paying are working. So we definitely want to keep focusing on this one as well.
Next slide.
All right. We can actually go back a couple of slides since we made our way out of the bar graphs. If we can go back to the one that says MCO P4P benchmark bundles at the top. Thank you.
I mentioned earlier that the benchmark bonus bundles, this is where we take a few measures that are kind of related to each other and we incentivize them all together. We have a Peri natal and infant bundle. This is obviously a population that we're really focused on in this program. We cover a lot of babies, and we cover a lot of people giving birth to babies. So we want to make sure that we're having good prenatal, post-partum, and well child care.

And then we have another one for child and adolescent well care. So the lead screenings and the child and adolescent well care visits. We bundle them together. Even if you did well on each of those measures individually and got those bonuses as I described in the last few slides, you can get an even bigger bonus if you're doing well on all of these things together.
Next slide.
So these are just some results that you can kind of see how things are going. You can break down the bundles. This is the Peri natal and infant bundle. It's kind of a complex formula. I won't spend too much time going through that. But you can see we look at each of the measures and see how the plan performed against each of those measures. And you have to have three of those green check marks to get the bonus. So even if you only have two green check marks and one of those little yellow star bursts, you were close, but you need all three of the green check marks to get the bonus pay outs. You can see how those went for the plans.
And the next slide. Keep going.
One more.
This one is the child and adolescent well care bundle results. Again, you can see here that everybody did really well on this bundle.
So just to let you know. When we see that everyone is doing well, we need to raise the bar a little bit and either make it harder to get that bonus incentive or we need to think about what measures we're focusing on. Maybe look at this and say we're doing a great job, let's focus on something new. My team looks at these and see if we need to make it harder to earn the bundles to have the best outcomes they can.
And we can keep going to the P4P health equity slide.
So this is a relatively new component of the program. This is where we look at a few measures where we noticed black health choices members were having poorer outcomes than white health choices measures. Everybody should have the same great outcomes regardless of race or ethnicity. We wanted to focus on some of the measures where we saw the biggest disparities. We want to focus on closing the gap. Getting the MCOs to get the outcomes close to the same, regardless of race or ethnicity.
This is one of the incremental improvement things we have. We're looking for them to close the gap.
There are a few measures we focused on. Five of them.
If we keep going, we will get to a chart with some red and green. Keep going. There's one that has all of them together. There we go.
So this is just looking at how the MCOs did with closing those gaps. High blood pressure, diabetes control, post partum care, prenatal care, and well child visit. Those are where we noticed the biggest disparities. We're looking for the MCOs to close the gap. And you can see if they have had success so far in doing that.
The ones who have had success, we will push them to continue the success. The ones that

haven't had success yet, we will keep pushing them as well to close those gaps.
We will move on to the maternity home visiting program.
So again, this is a relatively new addition to the program. You all may be familiar with this. This is an initiative where all pregnant and post-partum families have access to in-home, home visiting service that are evidence informed or evidence based for first time or at risk parents or caregivers, anyone who is not receiving home visiting services through the office of child development and early learning.
These home visits are really important so we want to incentivize the MCOs to make sure the members receive the visits.
We have seen a slow ramp up initially in getting the visits to increase. We're looking to see those continue to increase over time.
On the next slide, I think what we get to here is you can see kind of what the results were. Like I said, this is still pretty early, pretty new. We're going to keep incentivizing to see these increase.
We can go to the next slide.
These are the measures that we're going to be looking at for 2024. Not a whole lot of changes from last year. We think we still have work to do with these measures. So we're going to keep focusing on them.
I think the biggest difference is that one of our dental measures had a change in name and a change in specification. But otherwise, we're going to keep at what we're doing. We're looking for some bigger changes probably in 2025 where we can look at where we have had those successes and start to either push further or focus on other measures where we haven't seen success yet and start incentivizing those.
I think that's all I really wanted to present today. Like I said, I know it's dense. And it's a lot. There were a ton of slides. But I'm happy to take any questions you have. Or I'm happy to be quiet and allow you to move on with your agenda.
>> DANNA CASSERLY: Thank you. Go ahead, Sonia.
>> SONIA BROOKINS: One, that was excellent. I appreciate the slides. But what I can do is the questions that I have, I can get it to Danna and we can get it to you. But all in all, I appreciate the slides and you communicating that to us well. I don't know about anybody else.
>> LIZ HEALEY: This is Liz Healey. And Gwen, I had a question. I remember when the last time we looked at this which I think maybe was two years ago, what you were giving us was the average of the number of people who were now meeting the standard that you had established. And it wasn't broken down by MCO.
And I think I remember last time that there were some MCOs that in some of the areas were consistently low. And it's hard to see that with these averages.
Are you seeing that the lowest performers are improving? Are they getting close? Or is it just that the average as a whole has gone up?

>> GWENDOLYN ZANDER: First I will say that you will see in the full slide deck which will be distributed to membership if it wasn't already, you will see those MCO by MCO breakouts. I just didn't spend the time on them during the presentation today. But you have that information available to you if you want to dig in.
But we are seeing some improvements. There certainly are some plans that continue to perform lower than their peers. But we have seen some good improvements in those plans as well. And it's also a little bit difficult to track performance in the program right now year over year given the effect of the reprocurement in 2022. With changes zones of operation, you're no longer comparing apples to apples year over year. They have different populations they're taking care of. It's a little bit difficult to answer that question right now. But overall, we're seeing improvements. It varies measure by measure. I would encourage you to look at those plan to plan comparisons in the full slide deck as well.
>> LIZ HEALEY: Thank you.
>> DANNA CASSERLY: Thanks. It sounds like some of the consumers may have other questions. They want to sit with the information and follow up with you.
We appreciate the time and the Department's efforts to make sure the program is as equitable as possible. This is exciting work.
I believe that's it for OMAP. Is there anything else we haven't addressed yet that you want to mention before we move on?
>> SALLY KOZAK: I'm good unless there's questions from members of the committee that they want in follow up.
>> SONIA BROOKINS: No, we're good. I'm good. Everybody good?
>> SALLY KOZAK: Okay.
>> SONIA BROOKINS: Thank you, Sally.
>> DANNA CASSERLY: Thank you very much.
All right. Next up, we have OIM. We're a little ahead of schedule on the agenda, which is good news. Do we have OIM, Carl on ready to present? Or anyone else from OIM?
>> ELISE GREGORY: I did not see him join yet.
>> DANNA CASSERLY: Okay. I think we're expecting Carl. Is there anyone else on from OIM that may be presenting in his place?
Okay.
Sonia, do you want to wait or OIM? Maybe change the order? I know Juliet Marsala is on but not slated to talk until a bit later. I don't know, Juliet, if you're available to switch with OIM while we wait to figure out if they're coming.
>> SONIA BROOKINS: I'm good with it.
>> DANNA CASSERLY: Okay. Is Juliet on?
>> JULIET MARSALA: Randy and I are both on and happy to adjust.
>> DANNA CASSERLY: Thank you. Thank you for doing that. Appreciate it.
So for the OIM folks, we can switch. If Carl does join, we will move him later closer to 2:30.

Thank you. Juliet and Randy, thanks for joining us and being flexible.

OLTL Report

>> JULIET MARSALA: You're welcome. Okay. So we just have a few updates. I do have one update I'm adding last minute because it's sort of hot off the presses. So I may take a little bit of that ten minute extra time.

1. Deputy Sectary Updates

If we go to the next slide, we have the standard where we are with the procurement updates and list so that you have that handy.
And we will have time to talk about the annual waiver determinations.
If we go to the next slide and then the next slide. Again, there hasn't been any status changes on agency with choice, community health choices, and the independent enrollment broker is still in the final process. So I wanted to let you know where those were at.
And then I just wanted to share I'm very excited to share that our participant self-directed work group has concluded their work. You may have heard me talk about this work group in past meetings. It is a group of approximately 40 individuals that were asked to kind of do a deep dive in our participant self-direction model to see how we can improve that model and support participants in choosing, understanding, and participating in the participant self-direction model, which is for folks who may not be aware the model whereby participants are the employers of their own direct care workers. And so participants have full control over who they hire, wage allocations within the rate provided, training, scheduling, those sorts of things. So it's really an empowering model.
This group got together and have been working diligently for several months and looking at the process, looking how points along the system can be improved, going through pain points and human centered design exercises and activities, such as journey mapping of a participant's experience, of the direct care worker's experience. It included affinity mapping where folks could share their ideas and really look at where their common thoughts were, where there might be differing thoughts. It's a really engaging process.
In addition, there was a survey that went out as part of that process that had over 1,000 responses back.
So it's come together into a final report that includes recommendations. So those are recommendations that OLTL will be looking at to see where we can make impact as we think about strengthening that program moving forward.
So that report will be posted. I don't know the timeline on that posting. I know there's still some website design and elements that are still in play. As soon as we can post it and

share it, we will. Because that was incredible work from this group. The group included participants, it included direct care workers, it included service coordinators, included representation from all three MCOs. And the FMS vendors. I just wanted to share that.
>> DANNA CASSERLY: Thank you, Juliet. Sorry, we had some background noise there.
>> JULIET MARSALA: That's okay. I didn't know if someone was asking a question.
I can pause there for questions if you would like.
>> DANNA CASSERLY: Yeah. That would be great. That's great news to hear. Does anyone on the committee have questions or comments for Juliet?
Okay. We'll look forward to hearing more about the findings from that group. It sounds like a good dynamic process happened. So we'll anticipate future updates on that. Thank you.

2. Annual Waiver Redeterminations

>> JULIET MARSALA: Absolutely.
And so then we'll go into the next topic. Continuing the discussions of the annual waiver redeterminations. We do have Randy Nolan on the line who is going to present out this information as his team is working I think the closest with it. So Randy?
>> This is Randy Nolen, I'm the Director of the Bureau of Coordinated Services with OLTL. We have talked at several meetings about this. I will go over the update information on the annual waiver redetermination, the functional side of things.
Next slide.
>> DANNA CASSERLY: Thanks, Randy. Welcome.
>> RANDY: Some of the ongoing efforts we have got in place is we're working with the organizations to identify issues with the process. This includes the analysis to identify issues that they're finding with the assessment process. And retraining the service coordinators on the inter-RAI as necessary.
Some of the focus is on individuals with traumatic brain injuries and cognitive issues, dementias, and other progressive related diseases.
We want the MCOs and we have asked them to retrain the SCs to understand individuals that have these conditions may be good when the assessment is done. But throughout the rest of the day, they have problems functioning.
So we want them to take a look at in a day of what the participant does instead of just a snapshot of an hour during the assessment.
So there's emphasis on that and looking at that type of thing.
Working with family members to make sure that they're providing input as part of the person-centered planning team.
And for those individuals that are in -- work with the staff. And getting an understanding from the staff what participants are capable of doing.
We have also put an emphasis on the SCs looking at past inter-RAIs to make sure that

they're comparing a person over time. If they have had two inter-RAIs that show a person needs extensive assistance and now suddenly they just need supervision, they need to look at it and justify the supervision answer. Same way they need to justify what's going on with the person's needs that now all of a sudden, they need maximum assist. So it works both ways. They need to use those historical tools to help them out as they're moving forward. That's some of the emphasis we're putting on with the MCOs.
We are also working with them if there's differences between the feds for them to take a look at the fed versus the inter-RAI and walk through the cases there's a lot of work at the MCO level to try to improve the process.
Next slide.
And here are some figures for our redeterminations. This are a number of participants who were assessed NFI by the MCO. And as you can see the time periods through May of '23 through January of '24. February data should be in soon.
As you can see, when you look at the months of May, June, July, all 1600, 1700 people coming back as NFI.
And the numbers started to come down to 1,000 in August. 755 in September. 840 in October. 727 in November. So they were similar.
And then in December and January, we're seeing some marked decrease on the number of NFI cases from down to 510 and 485 in January.
And as you can see, PHW has around 50. And both UPMC and AmeriHealth has just a little over 200.
So the hope is that as we get through these assessments and reassessments that occurred in the unwinding period, that we'll start to see the numbers level off. And hopefully, this type of thing will not be as much of an issue as we move forward. But we are working with these individuals even as they're identified at this point.
And we're working with Aging Well to implement a few things to address the redetermination process.
On individuals that were found NFI through the inter-RAI assessment. And when somebody is found to be NFI, we have the MCO requesting new physician certification from the PCP. In a lot of cases, we're not getting that PCP back, or that PC back. Probably about 40% of the cases are within that 60-daytime frame.
In the past, if we didn't receive the PC, we were automatically taking people off the program as NFI.
Since this number was so large, we put a process in place that Aging Well would do new FEDs on these individuals.
So we sent Aging Well probably over 4,500 cases to review. They have done about 1,400 FEDs as of a month ago. So it's probably closer to 1,700 FEDs at this point in time. They are getting through the backlog to see these individuals and do the FED.
Other FEDs that were done of this 1,370 done, 1,072 were not received. Then 22% NFI.

And there was also a couple of other groups of people that Aging Well couldn't reach or they refused the assessment.
So we're working with the MCOs on those individuals that came back as NFI to help them out and make sure that they understand their appeal rights and they can appeal the services.
We also have the MCOs reaching out to those individuals that either refused the new assessment to explain to them if they don't have the assessment done, they can lose their services. And also to follow up on the people that triple A was unable to get ahold of. So we're working through that to close the loop on that.
>> DANNA CASSERLY: Thanks, Randy. Can I jump in with a question to clarify the data? I recall the 78% piece from the February meeting. 78% of the reassessed folks were found NFCE. Is that still the most recent data you have of the 78%? Or do you have updated outcomes of those?
>> RANDY: This is the most updated data I have. We should have new data hopefully in the next week to update this.
>> DANNA CASSERLY: Okay. I just want to clarify what we're comparing. Thank you.
>> RANDY: So we're working to close the loop to reach out to the individuals to assist them. We have a number of people that came back as NFI that did not file an appeal. So we have the MCOs reaching out to them to see if it was an issue that they didn't understand how to file an appeal. Or if some other circumstance or if they didn't want to file an appeal and all right with the decision.
So we are working through those cases also with the MCOs.
>> DANNA CASSERLY: Okay. Great. I think unless the consumers have questions about the Aging Well reassessments, there was interest definitely in going through the medical director review piece. And then I think at the end, we would like to get time to talk through the terminations who didn't appeal.
>> SONIA BROOKINS: I have a question.
>> DANNA CASSERLY: Go ahead
>> MARSHA WHITE-MATHIS: This is Marsha. Does that mean the client walks away? Just accepts no care? Or are they doing something? I don't understand that. Can you help me understand that?
>> If they're refusing the assessment, the only people of information we have is the inter-RAI to list them as NFI. So I'm asking the MCOs to reach out to the individuals and explain this is what we have right now. The reason for the new FED is to look at the opportunity of you possibly staying on the program. And so we're having the MCOs explain that to the individuals.
Now I don't know -- I have to go back and look at the data. The MCOs are working on this stuff now of those 129 that refused, how many of them decided to take the assessment. Or to answer Aging Well and get it set up. So we're doing education with those individuals.

If we still refuse to do the assessment, they're acknowledging the MCOs told them to and they're acknowledging the fact that they are going to lose LTSS
>> MARSHA WHITE-MATHIS: Okay. My other question is about the 28 the participants you were unable to reach. Are any of those 289 still getting services? If you can't reach them, they're not getting help?
>> If they have services in place, they're continuing to get them. That's the one thing throughout this process. Until we make a final determination on the status, all of these 4500 people are still getting their services.
So the 289, it may be they didn't answer the phone because they didn't recognize the phone number from the AAA. So we have the MCOs reaching out to them to say look, this is the phone number that's going to be calling you. Or you can call them or we'll help you call them to set up the assessment.
What we have done in the past if we have unable to reach consumers, the MCOs are required to make at least three phone attempts at different times of the day to reach them. If they can't do that, they go out and do a popup visit. And try to talk with them. And they also send a letter to them asking them to respond back. So we do have a mechanism in place when we have individuals that are unable to reach.
And the MCO is taking a look at the person is getting services now, say they're getting past services, the MCO is calling the agency and saying when the worker is out there, can you call us with the individual so that we can set this up. So we're doing a lot of things to make sure we're reaching out to all of the participants.
>> MARSHA WHITE-MATHIS: Thank you so much. It sounds like you're making every effort to reach them. That was the other part of my question. When they make calls at different times of the day and send someone out to do a face to face, I appreciate that. Thank you so much.
>> Sure.
>> DANNA CASSERLY: Thank you. I think we'll pause for a second. Alease alerted me there is a question for Randy in the chat.
>> ELISE GREGORY: Yes. From Jeffrey. Can you tell us when the transportation call from 274 call that was canceled will be rescheduled? Will the meeting be via Zoom or Teams? Since Teams doesn't seem to work well for the group. Thanks.
>> DANNA CASSERLY: I'm not sure that's an issue for the consumers.
>> I can answer that real quick.
I was going to say I have no idea. But that's not true.
We're working on getting a Zoom license for the Department. And any time the Department does something like this, we have hoops to jump there. So we are in the process of trying to get the Zoom license so that -- because it's a better platform for this type of meeting. We are working on that. As soon as we get the Zoom license, I will reschedule the transportation summit.

We are in the final review of the questions that came through the first transportation summit. So hopefully, very shortly we'll get those reviewed and get those answers out on the question and answers out on the website.
>> DANNA CASSERLY: Thanks, Randy. That's helpful and good context. I was not clear at first too.
All right. Do any consumers have any other questions about the Aging Well reassessments or the data presented so far before we go on with OLTL?
Randy, do you want to move on to some of the questions we had about medical director review?
>> Sure. The next slide starts that discussion.
So internally in the OLTL, we have a medical director review process. We have a unit of nurses that look at that. And they also work closely with our medical director.
So we have had a lot of internal meetings to talk about how to improve this process. What else does that team need to make decisions on these cases?
And these are the cases that come through that we have an NFI and we get a PC that comes in that's NFCE. Since we have two answers, it goes through the medical review process.
The way the process used to work is that the information that the team had to review was only the PC that came in. And then the subset of questions on the inter-RAI. So they didn't have a lot of information.
And a lot of times, when the PCs come back in, they are not very explicit on what the situation is or the doctor just checks a couple of boxes and doesn't put any information on there that helps review the case.
So we do know that last year that the number of medical director review cases that were being overturned and making people NFCE was 5% or less.
And we recognize that is an issue.
So what we have done through a lot of discussion internally and working with the MCOs is for the medical director reviews now, they get the full -- the medical director review team gets the full inter-RAI, the notes surrounding the assessment, and have the physician certification. It gives them a lot of information to take a look at.
So in January, those numbers jumped up from people being found NFC into the 20%, 24% area.
In February, from mid-February until this time period, Dr. Apel reviewed every case himself. And he's looking at a rate for February, the rate jumped up into the 30% area. And now I talked to him the other day, it's about 64% I think is what he told me for the March cases that he looked at.
So he's continuing to work on the process. He's really working with the MCOs and their medical directors to make sure we have all the information to make these decisions.
In the last month, we have really closed the gap from if a FE D was done and we found

them to be NFC78% of time to a medical director review process it's now 64% of the time, it's not even yet, but we have closed that, improved the process enough that we have made consistency no matter which way we go, whether it's the medical director review, whether it's through a new FED being done. We'll continue to improve that process.
I know that's an update on the figures that are on here. Like I said, we had 28% in January. 44% in February. And the March ones that he just did he's looking at 64% he's seeing as NFCE.
We took a look at improving that process and gaining more information. He'll continue to work on training with the staff so we get the better documentation and working with the MCOs to make sure we get the specific documentation that we need.
>> DANNA CASSERLY: Thanks, Randy. This is helpful to hear. We were looking for that update on how many folks were being found NFCE compared to last time.
And we appreciate all the strides the Department is taking from every angle you can come at this to approach this issue.
I want to if we can move to the next section with the last couple of minutes we have. And thank you, Carl Feldman. I know you're waiting in the wings to start presenting.
So Randy, I just want to wrap up and move on to the piece about the folks who didn't appeal and their terminations. I know there was updated information presented at LTSS. But if we could since our folks weren't there, if we could go through that piece.
>> RANDY: Yeah. We wanted to take a look at the individuals that came back as NFI that got notices taking them off of the LTSS program.
As of end of February, we had 1,231 cases that we came back and needed to take a look at. We sent these cases out to the MCOs to follow up on. And they reviewed the cases to determine was the person already reassessed and found to be still getting services? Are they still active with the MCO? Are they NFIs? Or are they no longer with the MCOs?
And you can see for Amei health, they have 134 participants on the report. 95 were with Keystone First and getting home and community-based services. And 40 participants were NFI duals. And there were other participants that transitioned out of the program.
So numbers are similar for UPMC. So again, we're doing a lot of that outreach to take a look at. We have asked the MCOs to reach out to them just to make sure that they utilize their appeal rights if they want to. And if they didn't, to provide them the ability to do that. So we continue to try to close those cases to make sure that if people want services or need services that they have the opportunity to apply or reapply. A lot of times, some of these individuals are being referred back to the IB so they can start the process over again. I know that's not the most ideal way. But we can get them fairly quickly through the system to determine and get new FEDs on them. There's a lot of pieces to try to address the individuals who are NFI and didn't appeal it.
And the last slide shows the numbers for PHW.
>> DANNA CASSERLY: Thanks, Randy. I just want to look quickly so I don't say the wrong

number.
Actually, I'm going to move on. I think it was about the pending cases. So we will move on from that in terms of the number going up where they were pending at the CAO.
The last piece I think we're most interested in is what came up at the LTSS. I don't know if you have more slides to present.
>> No, that was the last one.
>> DANNA CASSERLY: Okay. At LTSS, we had sent this question over, it was noted that four people who were found NFI and didn't appeal were once investigated found that they were in a Medicaid covered nursing facility.
We just would like to hear from OLTL about that in terms of what OLTL may do or the MCOs may do to offer to transition these folks back home. Are they still in nursing facilities? Kind of the point being that since their nursing facility eligibility was found demonstrating the waiver purposes.
>> Yeah. I reached out to PHW and they are researching that for me. I don't know how much information I will be able to provide you since it's four cases and it's a small number statistically speaking.
What I can tell you is that once I get the information back from them that we will follow up if these are situations where we need to work on transitioning the person back into the community, we will certainly do that.
I think part of what I need you to understand, though, is that there's individuals that go into nursing facilities and it could have been because they had another illness or catastrophic event that led to the need for admission to a nursing facility. It could have been a decision made by the person and their families to do that.
And I know some of the ask here is well, if they were found NFI and lost services, was that the primary reason they went into the nursing facility? I can't say yes. I can't say no to that. But I will have a better idea once I have the research back from PHW on that.
>> DANNA CASSERLY: Great. Yeah, we understand that there could be, of course, a person is choosing to go into a facility. It could have been a change in circumstance or a catastrophic event. It sounds like what you're getting from PHW, what is the situation, were those the causes, is there something else going on?
Sonia, go ahead.
>> SONIA BROOKINS: Thank you for that. But I think that PHW should have gave y'all something for the four people so that you could have gave us something in reference to the four people. Because they should have known something. Why these folks was not supposed to be in there or was. They should have gave y'all something. So I think you need to get something from them if they haven't gave y'all something. I don't know. But I would like to know more information on these four folks and what's the process and what's going to take things going forward. Thank you, Randy.
>> Yeah. If it's feasible to share, I will certainly do that. Just understand that I can't share

stuff that may bring light to PHI on a person. And any time that we have numbers of under ten, we usually redact those cases because of the potential or finding out who the individual is.
But I will try to get at least some general information to be able to answer back of what PHW is doing with these individuals.
>> SONIA BROOKINS: That's all I want. I know all of the confidentiality. I just want -- making sure that these folks are being taken care of. That's all. I get the other part.
>> And I agree. And honestly, if these people went into a nursing facility because we couldn't get services into the home and they should have been NFCE, I'm going to push whatever we can to try to get them back out in the community.
>> DANNA CASSERLY: Thanks, Randy. We appreciate --
>> LIZ HEALEY: This is Liz. Can I follow up real quick on that?
>> DANNA CASSERLY: Sure. Go ahead.
>> LIZ HEALEY: I feel really strongly, we don't need to know who the people's names are, what county, what facility they're in, but I really -- I'm really concerned that four people wound up in a nursing home and lost their independence and there may be other reasons. But I feel like there's a real sense of urgency because if some of those folks went into nursing homes because they no longer had their services in the community, the longer they're in the nursing home, the harder it's going to be to re-establish the support they need back in the community.
I really don't want to wait a month to hear about it. I'm hoping that you can move quickly to determine what caused these four people to go in. And I think we really expect that between the MCO and OMAP that people are going to make every effort to re-establish these folks' independence if there isn't some major catastrophic event that happened.
>> SONIA BROOKINS: Liz, I don't think it's going to be a month. I think that --
>> DANNA CASSERLY: There's a commitment from OLTL.
>> I'm working to identify the situations with the individuals. I will be working with them to see what we need to do to move forward.
>> DANNA CASSERLY: Thanks. And on the PHI piece, just to kind of underscore what Liz mentioned, we recognize the delicacy and aren't looking for really even the reasons why they did go in. What we're trying to do here is roll out as a starting point that it was not -- whether it was a catastrophic event in fact. So maybe not as concerning. Or did they decide that. So hopefully that kind of information can come without the disclosure of PHI.
And we appreciate you connecting so directly with PHW on it. It's helpful to hear that it was one MCO at least. But we'll look for an update. And thank you. Is there anyone else on the committee? Sorry, Juliet, go ahead.
>> JULIET MARSALA: I just want to take the opportunity, I think it's important for folks to hear that OLTL is equally concerned when any individual enters a nursing facility and loses their connections to the communities. And absolutely, 100% agree that the longer

someone is institutionalized, the more difficult it is to transition them back out.
And just want to echo that OLTL is committed to providing services in the least restrictive setting. And that community services are our preferred method of ensuring that people receive the services and meet their goals.
So I just felt the need to echo that OLTL is 100% committed to supporting any individual in the nursing facility to transition back out into the community as much as we can within what we can offer.
And that commitment will be unwavering. Certainly while I'm here, it's going to be unwavering.
>> DANNA CASSERLY: Thank you. Thanks, Juliet.
>> LIZ HEALEY: I had one other question. I'm not sure if this is the appropriate time to ask it.
But one of the things that sort of made me wonder in looking at the number of people who were determined not to be nursing home eligible and then as we dig into it more you're finding that with the redeterminations that many of those people were in fact eligible. I was really curious whether the number of people who were found NFI represents an overrepresentation by race or by ethnicity and whether you can track that.
But I would think it would be important for us to know if that potentially influenced the decision about whether they were eligible or not.
>> Yeah, we do not have data on those individuals by race or ethnicity or even gender. It's something that the -- and I know the MCOs are looking to try to collect that data on their participants. It's something that they traditionally have not collected. We have not taken a look at the data on that front.
>> JULIET MARSALA: Yeah. I can share we're still in the early stages and the data has to go through additional processes. But in comparing the inter-RAIs and talking with folks in the quality assurance department, it appeared that potentially what's been changing has been mobility status.
So they are looking at and continuing to look at Randy's team is continuing to look at the differences and changes to see if we can drill down further. We're not at a place to make conclusions.
Just as an example, we do have folks looking at what changes in one inter-RAI versus another and that information to get a further sense of things and form our process.
>> DANNA CASSERLY: Thanks, Juliet. That insight is helpful.
I just want us to be mindful of the agenda. So the consumers are aware, we have OIM still. I want to flag that for folks.
>> Just to give you a ten-second overview. When you ask these questions -- [indiscernible]
Especially for the individuals that are right there at the borderline. So we do take a look at that. We do recognize that. And that's why we're doing the retraining is to make sure when

you ask the person can you do this and they say oh, yeah, I can go out and cook and do this and walk here and there. Make sure you can see they're doing that. Have the person take you through what they do to cook a meal. See if they can walk through the kitchen and get the pots and pans they need to make a meal. The distinction of having somebody as needing extensive assistance to needing just supervision, you change that on one question, it could change the level of care.
So that's kind of the training that we're doing back with the SCs and emphasizing that the importance of really making sure that you don't just ask the questions, but you actually walk through and act through the questions so you're getting the proper assessment answer for the individual.
>> JULIET MARSALA: And just to add on that as someone who has done SC work for many years, sometimes the relationship between a direct care worker, often times and a participant is so seamless that sometimes folks go yeah, I can do all of these things and forget to add with my attendant because it's just so seamless toward life and living life. So just kind of all of these things need to be factored in as well.
>> DANNA CASSERLY: Well, thank you. We certainly understand how it can really drill down to a very specific piece that changes the outcome.
So I think for next steps we will have an update before next month. And we can follow up on that too.
Sonia, is there anything else before we move on from this subject? Again, I hate to rush folks. I just want to make sure to get to OIM.
>> SONIA BROOKINS: No, that's fine. Thank you, again, Juliet and Randy. Thank you so much.
>> DANNA CASSERLY: Thank you. We appreciate the updates and your time.

OIM Report

>> DANNA CASSERLY: Okay. OIM. Carl Feldman is on. He was having audio issues before. Carl, thanks for being patient. If you're on now, we are ready for you to present.
>> CARL FELDMAN: Hi. Good afternoon. Can you hear me?
>> DANNA CASSERLY: Yes. Thanks, Carl.

1. Unwinding Updates

>> CARL FELDMAN: All right. Well, thank you. I will share some information now about the unwinding and some of the other questions that you have asked about I think now is a good time to highlight that we are in the end of our final month of the kind of core unwinding period. And I think it's important that this group know, as I'm sure is on a lot of people's minds, about the time line for the end of the unwinding period.

And so strictly speaking, DHS will not be extending the unwinding period as that time frame is defined by CMS. And this current month's renewal cohort will still be the final renewal cohort which will be processed in the unwinding.
But I want to convey to everyone that we have always had built into our time line -- I shouldn't say always. But we did ultimately built into our time line additional months for cleanup. If you look in our unwinding plan on our unwinding website, it shows that the months of April and May will be used for that purpose.
We will actually also be using the beginning of the month of June for that.
So that doesn't mean that the renewal cohorts that are due in the month of April, May, and June are included in the unwinding. It just means that we'll be continuing to clean up unwinding renewal cohort activities from those core months up until about mid-June. And that means, I think for all of you to understand that we are not kind of excessively rushing to complete all of the work associated with completing eligibility determinations that are generated from an unwinding renewal cohort, which I think will be in the best interest of our clients and in the best interest of our workers too.
So that's the first thing we wanted to talk about in terms of the unwinding.
The second thing that we wanted to talk about is that there has been a lot of interest in our potential for use of an E-14 waiver authority around waiving the time frame for completing adjudication of hearings and appeals.
And when we looked at this in January, the Department was in a very challenging place. We had seen a rapid increase in the number of appeals over 90 days and the trend was not very good. And at that time, we engaged with CMS as to whether we would be needing to take the E-14 waiver, which would enable us to have more time to handle those appeals. But also came with some compliant protections associated with that.
Subsequently in the month of February, we were able to rapidly decrease the number of appeals over 90 days and I'm happy to say that right now our reported figure for most recent previous month put us under 200, which is the lowest figure that we have ever had throughout the unwinding. And at this point in time, we're not intending to take that waiver and should something change at a future date, we would of course reconsider our decision. But that's we think positive news about the resources that we're able to bring.
I suspect if you would like information about how we went about doing that, I'm relaying this information from the bureau of hearings and appeals, which is not within the office of income maintenance. But it is a major turn around and we understand that it is something significant.
What BHA said to us is that they were really able to do this because they brought on a number of new ALJs to hear more cases, increasing the available hearing slots. They hired temporary clerical staff that enabled us to handle and close out cases that had really already been resolved but were not handled in terms of their paperwork. They will tell you they use an entirely paper-based process for their appeals.

They made changes in how FHA, their contractor, was able to do data entry more them, which enhanced their capabilities. They had overtime approved. And they have had aggressive and daily monitoring of all of their regions and hits.
So that's what they shared with us about their capabilities in reducing the appeals backlog and ultimately, we're happy to say that it was successful, a successful effort.
The last thing I wanted to bring up on the unwinding is that I have a note in here that there was just an ask to share any new information about the individual level ex-parte activity taking place mostly at the end of last year as directed by CMS. And I think this was shared before, but I will say again that reinstatement resulted in coverage for 45,000 individuals. And all applicable notices related to that activity have been issued and should someone need to have a bill resubmitted for a period of time for which they had coverage restored, they are able to do that. And they have all the information related to their coverage restoration.
That's everything I wanted to share on the unwinding. I thought that would be a good point in time to maybe stop and answer your questions about it.
>> DANNA CASSERLY: Yeah. That would be great. Thanks, Carl. That's a lot of good information.
I would like to go through this effectively to keep organized. I want to follow up on the second to last piece you just mentioned about the good news that the number of outstanding appeals passed 90 days is down.
You read my mind about what went into that that made the number drop so dramatically. You mentioned that some of them were it sounding like the hearing, the appeals were heard, but they weren't processed clerically to be finally adjudicated within the 90 days. Do you know how many of the previously outstanding approximately were made up of ones that actually had been heard but not decided yet?
>> CARL FELDMAN: I want to make a bit of a distinction. What I'm saying about the clerical close outs is that DHA has always contended there is some meaningful portion of the numbers of appeals pending over 90 days that were either actually withdrawn and that hadn't been documented on their reporting. Or an adjudication was issued and that had not been documented on their reporting. It's not that there was a hearing but there was no adjudication, though I suspect those exist. But the things that they were able to clean up with the additional clerical staff is making sure that we're not reflecting on the report that cases where an adjudication was found or someone withdrew. And then it really becomes truly a kind of paperwork issue at that point for us.
>> DANNA CASSERLY: Okay. That's helpful.
Despite the direction that things are moving is good, will OIM continue to keep tabs on the outstanding cases that go past 90 days? Especially given that the E-14 waiver won't be sought? Just to make sure that things are staying in the right direction.
>> CARL FELDMAN: We will need to continue to do reporting to CMS. I think if this wasn't

the consumer sub Max committee, it may have been the Max question. But reporting will continue related to the unwinding at least until the month of June. And we're hearing from CMS they may be interested in extended reporting beyond that. We don't know the details of it.
We will certainly continue to be monitoring this through the month of June. And then the big change that we expect to bring a lot of benefit not just to the DHA activities around appeals for us, but also for clients is the introduction of the enterprise case management system, which is a new digital service that will be available for hearings and appeals. Like I said previously, DHS does all of their work still in paper. That means CAOs are literally mailing things to the CAO to the bureau of hearings and appeals. That will change over the summer. I'm not sure if BHA talked about this in this group. I think it's been discussed over the years. But I think that's going to be the biggest kind of advancement in terms of appeals efficiency and ease of access that has happened in probably ever.
>> DANNA CASSERLY: Yeah. That's great news.
Is the enterprise case management system, I'm not familiar with the specifics of it, does it have any component that would touch on consumers' ability to request or interface with BHA electronically? Request appeals, for instance.
>> CARL FELDMAN: I think it will are ease of access improvements. I can't speak to what that would specifically be. I would encourage you to talk about the office of administration about this.
>> DANNA CASSERLY: That's helpful to hear. We haven't heard from BHA on that. We can follow up.
Okay. Consumers who are on, are there any questions you want to pose while we have Carl about either the waiver with the outstanding appeals past 90 days or any of the unwinding data that we have been looking at for a few months now? Maybe more than a few months.
>> SONIA BROOKINS: Thank you for that. I just want to ask -- not ask. But I want to be clarified. So as of April 1, everything will go back to normal? As far as with the recertification folks getting back on to their yearly go around? Is that correct?
>> CARL FELDMAN: That's a good question. So as of April 1, some things will return to normal. Some things will not return fully to normal until after June. I will kind of break that out.
So yes, everyone will need to have a renewal completed annually. That was initiated at the start of the unwinding period and that will continue unless Congress changes something or CMS says you have to do this differently.
The COVID maintenance logic and the COVID rules that make it so that you cannot take an adverse action on someone outside of their renewal until their renewal is processed will stay in place until June for people who have not had a renewal completed.
So to be specific about it in an example, if you're one of these people who had a renewal that was due in let's say March, this month, but we don't get to process your renewal until

June and you have a change in circumstances between now and then, we can't act on the change in circumstances until we finish out the processing of your renewal.
So that rule will continue for everyone to whom it applies until we are done with the processing of all renewals associated with an unwinding renewal cohort month.
>> DANNA CASSERLY: And Carl, can you clarify what that month time line is that renewals related to -- or defining them as that versus those that are not. When does that start?
>> CARL FELDMAN: It covers April of 2023 through March of 2024. And then at the beginning we are allowing ourselves until early June to complete any work associated with those renewal cohort months.
>> DANNA CASSERLY: Okay. Thank you.
>> CARL FELDMAN: I think the most important thing is the same now as it was six months ago, which is that people need to return their renewal when they receive it. And that will continue on in perpetuity.
>> SONIA BROOKINS: And Carl, one last question. Do you know how many people is left that needs to be renewed within the unwinding period?
>> CARL FELDMAN: I do. I don't have that in front of me, but I definitely could get that figure to you.
>> SONIA BROOKINS: Okay. Thank you.
>> LIZ HEALEY: And Carl, this is Liz Healey. I wanted to make a request for an agenda item for our next meeting in April.
I was interested in the number of children who lost medical assistance coverage in this process and who have not transitioned on to CHIP and to get a sense of whether -- what's the extent of the increase in uninsured children in Pennsylvania?
>> CARL FELDMAN: I think we can access that information from our unwinding web page, which will continue to be updated as we continue our work. If you were to go to the final monthly unwinding renewal outcomes, we have that information by month, I believe, who is determined eligible, who is determined eligible for procedural reasons. And we have that by male, female, race, ethnicity, and age groups.
>> LIZ HEALEY: Okay. Thank you.
>> DANNA CASSERLY: Thanks, Carl. That came up during our pre-meeting this morning. And we can think more about putting together a request prior to the agenda meeting for next month. Once we look at that. So thank you.
Sonia or other consumers, any final questions as we get toward the end here? All right. Well thank you so much to the Department. Thanks, folks, for sticking with me today. I think it was a great meeting. I appreciate everyone's time from all the program offices that joined.
Sonia, do you want to wrap up and make a motion to adjourn?
>> CARL FELDMAN: I don't want to prolong your meeting. But there was a request around some MAWD figures.

>> DANNA CASSERLY: Yes, I'm sorry. Thank you, Carl.
>> CARL FELDMAN: If you want, I can email them to you. Or I can read them now.
>> DANNA CASSERLY: That would be -- if you want to read them out, I think they're pretty quick data ask. But if you can send it too, I will circulate it.

2. HCBS & MAWD

>> CARL FELDMAN: Okay. To jump to these. The request was around kind of the break down of the HCBS portion of individuals who did not transition to MAWD. It was 75 people in total. And when you actually looked into the cases, the number that actually would require reinstatement got lower than that.
So 26 of the terminated individuals were identified to be reviewed for MAWD. And you asked about the 12 which could not be reached through the phone call. And all 26 of them received a letter as well. So if they wanted to receive ongoing MAWD back to the date of the closure, they would respond to the letter and follow through the verification required.
Of the 26, we can say that 13 have not reopened MMA. One reopened and does not have waiver status. 8 are open in waiver. And 7 are actually open in base funding.
>> DANNA CASSERLY: Okay. Thank you.
>> CARL FELDMAN: Of the 50 other individuals, there are 24 which are still enrolled in the HCBS waiver. There are nine that actually are now in act 150. And there's seven in some other category. So I can pass it along.
>> DANNA CASSERLY: I would appreciate that. Thanks for getting that and flagging it for me on the agenda.
The perennial question about whether this can be automated tall, is -- at all, is there an update?
>> CARL FELDMAN: It's not a manual override process. But you're right, it is up to the workers' cognizance to follow our policy which states that they should be reviewed for this. And in our review of these cases, while it's hard to tell, we were able to identify at least in some of them that they were in fact reviewed. So we know that workers are diligent and in many cases doing what they need to be doing. At this time, we don't have new information about this as prioritized change. We have a release coming up in September which has been set for sometime. And then the next release after that will not occur until spring of 2025.
>> MARSHA WHITE-MATHIS: I have a question. Carl, when you -- in your formula for realizing who is still eligible, did you take into consideration with MAWD, you age out of MAWD? If you're over 65, you're not eligible. Does that automatic will you let you guys know it's not available to them?
>> CARL FELDMAN: Well, we used the eligibility policy to determine who should have been contacted. But we took into account that they could potentially receive coverage for some

sort period of time too.
So it didn't rule somebody out who would have had MAWD eligible months, to put it simply.
>> MARSHA WHITE-MATHIS: Okay. Thank you.
>> DANNA CASSERLY: All right. Anything else from folks? Again, thanks for the patience as we went over a few minutes. Consumers, any last questions or thoughts?
>> MEGHANN LUCZKOWSKI: This is Meghann Luczkowski. Thanks. Carl, you know you said the next release is September. And then the next release after that wouldn't be until spring.
So forgive me if I get the wrong terminology. When CAO workers were considering MA eligibility, I know MAWD is not currently in the cascade, I think it's called. It was not able to be implemented in this upcoming release because that's already been set for a while. Could we anticipate it being in the next release?
>> CARL FELDMAN: That will be decided upon based on the requirements that we have from the Federal Government, from State Legislation, from our Federal Agencies. At this time, we can't really say what is going to be in the release that's coming up in the spring of 2025.
>> MEGHANN LUCZKOWSKI: Okay. Do you know when does that get locked out? Does that question make sense?
>> CARL FELDMAN: It's a fluid and narrowing process over time. Let's put it that way.
>> MEGHANN LUCZKOWSKI: Okay. All right. There's a lot of players involved.
>> CARL FELDMAN: I sympathize with the desire to make sure this gets prioritized. It's something in the past that we prioritized and haven't been able to put in speaking to the fluid nature of our release schedules. We have many competing priorities for our eligibility system. And it makes it hard and we have to make some hard choices over what gets in and what does not and when that happens.
>> SONIA BROOKINS: Thank you, Carl. And thank the Department for all that you do. Once again, thank you again. We're a little over time. But I apologize for that.
And can I make a motion to adjourn the meeting?
>> I second it.
>> DANNA CASSERLY: Sounds like we had a second just now.
>> SONIA BROOKINS: Thank you all. And have a wonderful rest of the week. And see you soon.

The meeting was adjourned at 3:06pm.