>> KAREN LOWERY: Good morning. Welcome to the January edition of the MAAC (Medical Assistance Advisory Committee) meeting. Happy New Year. Today is Thursday, January 25th. 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 keep your microphones muted if you are not speaking. Live captioning, also known as CART captions, are available for the meeting. The link is included in the chat. Presenters should state their names clearly before speaking to assist the captioner. Representing the Department of Human Services (DHS) today, from the Office of Medical Assistance Programs (OMAP), Deputy Secretary Sally Kozak. From the Office of Long-Term Living (OLTL), Deputy Secretary Juliet Marsala. From the Office of Mental Health and Substance Abuse Services (OMHSAS), Deputy Secretary Jennifer Smith. From the Office of Developmental Programs (ODP), Deputy Secretary Kristin Ahrens. And from the Office of Income Maintenance (OIM), the Director of the Bureau of Policy, Carl Feldman. If you have any questions related to this meeting or need additional information, please visit the MAAC web page. I will now hand things over to the MAAC chair, Ms. Deb Shoemaker.
>> DEBORAH SHOEMAKER: Good morning. Happy New Year. Nice to see that it's not snowing today. So, I will go over the list of MAAC members. Thank you for your dedicated attendance. I like to sometimes formally recognize that and while I'm doing that, I want to say with a little bit of sadness, but excitement for them, Nancy Murray, our long-time MAAC member, sorry, Nancy, I don't think you knew I was going to do this. But Nancy Murray is retiring. I will miss her. She's been a great voice on this MAAC committee, but long overdue. I want to thank you for that. Since I'm talking about you, Nancy, do you want to say hello and say a word or two? If you would like, if not we will go through with the attendance.
>> NANCY MURRAY: Thanks, Deb, for your kind words. As I said to Secretary Arkoosh last week when I informed her that I was retiring and I needed to sign off on the MAAC, Yyou know, it's been an honor, privilege to serve on the MAAC. I think I have served on the MAAC now going all the way back to Gary Alexander. It's been a long run. It's been a privilege to have a voice, to give a voice for people with intellectual disabilities, autism, and their families. I know that the Secretary is considering somebody else right now upon my recommendation. I hope that she will be able to join your next call. So good luck to everybody. Best wishes and everybody stay healthy.
>> DEBORAH SHOEMAKER: Thank you, Nancy. We will miss you. Big shoes to fill. I'm sure that she will do a good job. But long deserved retirement. I will go through the list. Our vice chair, Sonia Brookins, I do not know if she is on yet, she had an emergency she had to attend to. So next, Kathy Cubit?
>> KATHY CUBIT: Hi, this is Kathy Cubit chair of the LTSSS (Long-Term Services and Supports Subcommittee) and from CARIE, the Center for Advocates for Rights and Interests of Elders. Good morning, everybody.
>> DEBORAH SHOEMAKER: Good morning. Thank you. Kyle Fisher?

>> KYLE FISHER: Good morning. Kyle Fisher with the Pennsylvania Health Law Project, counsel to the Consumer Subcommittee. Thanks.
>> DEBORAH SHOEMAKER: Okay. Thank you, Kyle. Joe Glinka?
>> JOE GLINKA: Hey, everybody, it's Joe Glinka. Highmark Wholecare Plan Administrator for PA (Pennsylvania) HealthChoices and chair of the Managed Care Delivery System Subcommittee (MCDSS) otherwise known as the MCDSS.
>> DEBORAH SHOEMAKER: Thank you. Mike Grier?
>> MIKE GRIER: Good morning, everybody. Mike Grier, Executive Director of the Pennsylvania Council on Independent Living (PCIL). I'm also the chair of the MLTSS (Managed Long-Term Living Supports and Services Subcommittee) SubMAAC.
>> DEBORAH SHOEMAKER: Okay, thank you. Richard Edley?
>> RICHARD EDLEY: Yes, I'm here Deb. Richard Edley with RCPA, the Rehabilitation and Community Providers Association (RCPA). Thanks.
>> DEBORAH SHOEMAKER: Thank you. Sorry if I'm going out of order. I was doing it from memory and then I went back and checked, and I was right. Perfect. Dr. Goldstein? Okay, I don't think he's on yet. Teri Henning?
>> TERI HENNING: Hi, good morning. Teri Henning here with Aveanna Healthcare.
>> DEBORAH SHOEMAKER: Good morning, Teri. Russ McDaid?
>> RUSS MCDAID: Russ McDaid, immediate past chair and principal with WRMc Strategies. Pleasure to be on the meeting today, thanks.
>> DEBORAH SHOEMAKER: Thanks, Russ. Julie Korick will be late. Minta Livengood?
>> MINTA LIVENGOOD: I'm here. I am co-chair of Consumer Sub and I represent low-income welfare rights for Indiana County.
>> DEBORAH SHOEMAKER: Wonderful. Thanks, Minta. Great to hear from you again on the call. Ted Mowatt, newest member.
>> TED MOWATT: Good morning, Ted Mowatt, Wanner Associates on behalf of the Pennsylvania Association for Home and Community-Based Service Providers.
>> DEBORAH SHOEMAKER: Thanks, Ted. Deron Shultz? Okay. Nick Watsula?
>> GWEN ZANDER: Deb this is Gwen Zander. Alex Naismith is attending as a proxy for Nick Watsula who is out on leave right now.
>> DEBORAH SHOEMAKER: Wonderful. Thank you. Marc Yester?
>> MARC YESTER: Hi, this is Marc Yester. I'm a pediatrician in the Pittsburgh area representing the Pennsylvania American Academy of Pediatrics. I will be in and out of the meeting. I got called into clinic unexpectedly this morning. Good to be here.
>> DEBORAH SHOEMAKER: Wonderful. Did I miss anybody? I see Danna Casserly on but I'm not sure if Danna if you're a presenter or representing Consub.
>> DANNA CASSERLY: Hi, yep. This is Danna Casserly with the Pennsylvania Health Law Project. I'm joining Kyle as co-counsel for the Consumer Subcommittee. Thanks.
>> DEBORAH SHOEMAKER: Wonderful. Welcome.
>> HEATHER KING: Deb, this is Heather King.
>> DEBORAH SHOEMAKER: I'm sorry, Heather.
>> HEATHER KING: That's okay. For those who haven't seen for me a while, it's Heather

King from Pennsylvania Medical Society and also President of the board for the Center for Independent Living of Central Pennsylvania.
>> DEBORAH SHOEMAKER: Wonderful. That's great. Wonderful. Start off with that one the next time. That's awesome. So, if I didn't miss anybody, it looks like we have a quorum. So, what has been distributed I think through the LISTSERV was the minutes from our December meeting. If you remember, it was earlier in the month. So, I would like to take a motion to approve the minutes as they have been distributed.
>> MINTA LIVENGOOD: This is Minta Livengood. I make a motion that we accept the minutes for December.
>> DEBORAH SHOEMAKER: Wonderful. Thanks, Minta. Okay, second?
>> NANCY MURRAY: Nancy Murray seconds.
>> DEBORAH SHOEMAKER: Okay, we're going to give Nancy the second since this might be her last time.
>> NANCY MURRAY: There you go.
>> DEBORAH SHOEMAKER: All right so, all in favor to approve the minutes, please say aye.
>> UNANIMOUSLY: Aye.
>> DEBORAH SHOEMAKER: Okay, any nays?
>> DEBORAH SHOEMAKER: Okay, any abstentions? Okay, I think we have it. Then first on the agenda will be the OLTL update by Deputy Secretary Marsala.
>> JULIET MARSALA: Thank you. Good morning, everyone. Good to be here together. Before I get started and into our customary slide deck of updates, I have been asked to provide additional information on the status of the LTSS Subcommittee and the MLTSS Subcommittee. We didn't have a lot of time in the last meeting and there's been a lot of great work that's been happening. So for folks, our new folks on the committee, in 2015, the MLTSS Subcommittee was set up by the Office of Long-Term Living in order to provide a dedicated space for advice and an open forum for participants, providers, and many stakeholders who were interested in and a critical part of, helping ensure that our full systems transformation from a Fee-for-Service – from the Fee-for-Service waivers impacted into a managed long term service supports, which is the Community HealthChoices (CHC), was done in a very thoughtful, intentional, and successful way. So, the MLTSS meeting was created so that there could be a dedicated time focused on that incredible body of work that OLTL and many others partook in. It was supposed to be a temporary MLTSS Subcommittee with that focus and the intention that once that system transformation had concluded, that OLTL's work would be sort of addressed in all the other original subcommittees of the MAAC. So, it's been nine years of incredible work for the MLTSS Subcommittee, and I commend the staff and the committee members, all of our stakeholders and providers over those nine years for really helping to advise and guide the process.
After the Community HealthChoices implementation phases had concluded, it was recommended by a former deputy that the MLTSS Subcommittee conclude their work. However, soon after, the public health emergency (PHE) occurred and there was a decision that there was a lot of value in the MLTSS Subcommittee to continue through the PHE

where there needed to be rapid responses, significant decisions and there was a lot of value. Again, I commend both the OLTL staff for the resources they put into continuing the MLTSS Subcommittee and the dedication of the committee members who helped that process through the unprecedented public health emergency. The public health emergency concluded early in the spring of last year. That's not to say we are without COVID, but certainly the public health emergency portion has concluded. So, at this time we see that the time is kind of right for the MLTSS Subcommittee to merge their work back into the Long-Term -- or merge their work into the Long-Term Services and Supports Subcommittee. In evaluating that, OLTL and our team and stakeholders and with great support from the MLTSS chair and the LTSS chair, we took a moment to evaluate best practices that we learned from the MLTSS Subcommittee and best practices we have learned from the LTSS Subcommittee. We have had a thoughtful, intentional approach of keeping the best elements of both. Also hopefully achieving some new goals that were difficult to achieve before.

So, at this point, I present to the MAAC the updated information that MLTSS is being brought into the LTSS Subcommittee. MLTSS had their last official meeting in January. The first official meeting of the new revamped, revived LTSS Subcommittee, which will begin their work in February. I think it's critically important and very excited about that work because the LTSS Subcommittee will be looking at the entire body of OLTL work that touches the participants that we serve. So, there isn't this subsection on the left and other things on the right. It will be the whole continuum of the service coming together to look at everything. So, we have the bylaws language that has been drafted to accurately reflect that change. That is being put forward. I am very happy and honored that Kathy has agreed to remain as the chair to help continue our work together, very important work together. I wanted to pause here to see if anyone had any questions.

>> DEBORAH SHOEMAKER: This is Deb. Before you take any questions, I want to formally on behalf of the MAAC as chair, thank Mike Grier for his extremely hard work as chair of the MLTSS. If you haven't gotten a letter yet, Mike, I feel your input is invaluable and I want you to stay on the MAAC, if you're willing to, as a member. I just wanted to formally thank Mike for taking that transition and for former chairs before him of the MLTSS to make sure that they know that we do appreciate their hard work even though we are merging that committee.

>> MIKE GRIER: Thank you, Deb. I appreciate it.

>> JULIET MARSALA: We still get to keep Mike on the committee. Just so you know.

>> KATHY CUBIT: This is Kathy. I too want to thank everyone. I appreciate in particular the Department (Department of Human Services) keeping the best elements of both committees. I look forward to working with OLTL and all stakeholders and I just want to make sure everyone feels welcome to join these meetings. We look forward to working to improve the system, thank you.

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

>> DEBORAH SHOEMAKER: Sure.

>> JOE GLINKA: So, realizing that we're taking two subcommittees and merging them

together, what's the composition of the new -- the updated committee if you will, look like? Compared to what we were looking at in two separate committees before?
>> JULIET MARSALA: So, the makeup of the LTSS committee, again, recognizing MLTSS was always intended to be temporary, is 25 members. The intent is to have a majority representation, the individuals served, individuals with lived experience, or advocates. Representation from home and community-based services (HCBS) providers. Representation from long-term care providers. Representation from a community-based health organization focused on SDOH (social determinants of health), because that work will be incredibly important moving forward. Representation from behavior health services. Representation from the health plan. Representation, which is also of significant importance, of direct care workers and staff who carry out the incredible work needed through HCBS. So that's the new representation, again, with a focus of having a majority representation of participants with lived experiences, advocates and/or their family members. There will also be term limits incorporated into LTSS that was not there prior. MLTSS operated on a two, two-year term limit for representation to ensure that there was room for additional voices. There's representation from the Centers for Independent Living on the committee. That is a change from MLTSS -- we brought the 25 from MLTSS. That's the maximum. There's a range I believe from 10 to 25. That's been pretty similar to what MLTSS had before. That's fairly similar to the number and representation that LTSS also had. So, in terms of the size of the committee, that's not changing.
>> DEBORAH SHOEMAKER: Any other quick questions so that we let Deputy Secretary Marsala move ahead? She can probably take one more quick one.
>> RUSS MCDAID: This is Russ McDaid. I hate to use the last question on this. My two questions for the Deputy Secretary were going to be, Joe's on composition. Also, many of you know that MLTSS meeting has been the one consistent in-person forum for individuals in the stakeholder community to have direct access to the Department. What is the format of the combined LTSS group starting in February going look like as far as in person, remote, and how people access those materials?
>> JULIET MARSALA: Thank you. That's a really great question. One of the things that we learned from the MLTSS meeting is the importance of having both in-person and more accessibility actually through a hybrid option. So, we are keeping the same sort of cadence of the monthly meetings. They will be hybrid. They will be in the same location that we have traditionally held the MLTSS meetings because we didn't want to either disrupt the importance of having those in-person meetings. The CHC managed care organizations (MCOs) will continue to attend and present and answer questions. We are actually including two public comment sessions within the meeting structure and agenda. One that happens immediately after OLTL updates near the beginning of the meeting and one at the end of the meeting for public comment to have the opportunities for folks to react, or ask questions, or reflect on new business or additional items that they might have. If someone were to have a delay in attending the meeting, they would have a second opportunity to provide public comment, because that public comment and stakeholder engagement has been invaluable to OLTL at these meetings.

>> RUSS MCDAID: Thank you Juliet. That was very helpful.
>> JULIET MARSALA: You're welcome. Okay. Do I move into the presentation?
>> DEB SHOEMAKER: Yes. If there's other questions, either put them in the chat or provide them to me, and then we can make sure they're addressed here or in future meetings. Thank you.
>> JULIET MARSALA: All right. Great. I will try to move fast but not too fast. We have the updates. I will touch briefly on the procurement updates, bulletin updates, our EBR (Evidence Based Review) report that I'm very excited to present on, update on participant directed workgroup, and our Nursing Facility Quality Incentives (NFQI) program. If we can move passed two slides. I can touch really quick, for procurement updates. We again have no updates on Community HealthChoices. That will be on the eMarketplace in addition to agency with choice. It is still in a black out period. We have awarded the Independent Enrollment Broker (IEB) procurement to the -- for the PA IEB with Maximus. The contract was signed effective January 1st. It's still going through the signatory process. We look forward to working with Maximus for continual improvement of our enrollment processes and beneficiary supports. More to come on that. We can now talk about the contract and the new contract and things of that nature.
If we go to the next slide.
So, this slide as presented seems pretty simple, but its importance is immense. So, every -- when we go towards a waiver renewal process and throughout the waiver, administration of the waiver, the state is required to provide an EBR to CMS (Centers for Medicare & Medicaid Services) to prove to them how we are administering the waiver, how we are ensuring quality, how we are monitoring it, how we are meeting their authorities and assurances for this incredibly important program. This requires a lot of moving parts, a lot of coordination, a lot of data analysis, refining data, looking at policies, looking at regulations, making sure things are working in the right way. The OLTL team led by Jen Hale, our Bureau Director of Policy, and many others, did that work and it is submitted about 18 months before waiver renewal. We received their response back to us, the Commonwealth. CMS had found that Pennsylvania was in compliance with our required assurances. They had no questions, comments, or concerns with regards to areas that we may need to improve. That is pretty unprecedented. Particularly in the MLTSS space. So, I just wanted to say I'm so thankful to particularly the OLTL staff and also all of the partners, providers, the health plans, the participants, the stakeholders who have worked collaboratively with OLTL so all of us together could get this unprecedented report from CMS. It's very rare to do. I wanted to highlight and celebrate that.
If we go to the next slide.
We have at OLTL been working with a participant-directed workgroup. This is kind of a new model to allow us to do a deep dive on certain topics, to get through the experiences, identify pain points, identify opportunities for improvement. We decided to start with the participant-directed work group particularly because we have seen such an incredible decline in the use of participant-direction models within the Commonwealth for potentially a variety of reasons. I mean, we used to have over 20,000 individuals use participant-self-

direction. That number has decreased significantly. And so, all the way down to, in 2019, a low of only -- much, much less numbers. We have put together a work group of 40 people, a cross section of important representation - participants, direct care workers, common-law employers, state staff, the consumer directed vendors - to come together to do some incredible work in a short sprint, but deep, meaningful work that includes journey mapping and it will include a survey. We hope that their work will conclude in mid-March or by the end of March so we will be able to present on a report and the findings of that workgroup. More to come there. I just wanted to present here to let you know that that incredible work is happening.

If we go to the next slide.

I want to hand the presentation over to Jill Vovakes, our Director of Quality and Program Analytics. Very proud of the work she and her team are doing here. I wanted to have her present on this wonderful work. If we can unmute Jill, that would be great.

>> ELISE GREGORY: We're not seeing Jill on the line.

>> JULIET MARSALA: You're not? Oh, no. Okay. Something may have come up then. That's fine. I can go over it. So, the NFQI and the Learning Network is a group that's come together to really lift up our nursing facility industry and provide a space to review and improve and share education and best practices. It's a pay for performance (P4P) incentive program required by our Community HealthChoices agreement with the MCOs, and nursing facilities earn points for meeting performance requirements. Meaning, improving their health outcomes, improving their performance, and attending learning sessions that are hosted by the Jewish Health Care Foundation, which have been really high quality and very beneficial. They need to have met a certain number of nursing facility quality incentive points to be eligible to receive a pay for performance bucket.

If we go to the next slide.

What you will see here on this slide is the incentive program goals. These here are clinical goals with regards to the health outcomes in areas we think are critical from a health perspective to be on top of. Looking at individuals who are re-hospitalized unnecessarily, potentially. Looking at the percent of residents who develop pressure ulcers. That's a very significant concern for us. Looking at residents who experience falls. Looking at vaccination of pneumococcal and influenza. It is important. Vaccinations are important. They're a preventive measure. We know certainly with infectious diseases these are important metrics in a nursing facility setting. Also looking at the residents who receive an antipsychotic medication, bringing that down, making sure that's applied. Utilizing best practices.

And if we go to the next slide.

Here is what we're really proud of with regards to the measurement year results. So, of our nursing facilities, 608 were eligible to participate. Of the 608 facilities that were eligible to participate, 79% attended at least one or more webinars. Of the ones who attended those webinars to learn more and increase their best practices, only two of those did not ultimately become eligible for payment in terms of improving their measures to become eligible. The average payment that nursing facilities received as a result of partaking in this

quality improvement incentive was $31,120. We have begun paying out those dollars to the nursing facilities. However, not everyone who is eligible will see those sorts of dollars. They will be awarded those dollars, but the OLTL team is doing what we call an offset. There's a nursing facility assessment fee or tax that is due every year. So, if a nursing facility has not paid or come current with their tax and assessment payment requirements, we first look to apply this money to offset what is still owed to the Commonwealth before dispersing any moneys to a nursing facility.
There are additional slides that show, if we go to the next slide, when the webinars were held. The next slide will show the event schedule of the webinars. The next slide shows an example of invitations on topics that are sent out two weeks in advance with registration and links. If there's anyone from the nursing facility industry that is interested in attending them, we welcome you.
If you go to the next slide.
It'll show you our 2024 quarterly themes. We have a theme each quarter with a lot of webinars under each theme. We're looking at transitions of care, we are looking at survey preparedness for their monitoring, we're looking at enhancing skills. We're also focusing on workforce opportunities because we know workforce is important. And lastly, you will see for January, February, and March, just the different sessions that are being offered for the nursing facility industry for this incentive program that is continuing. And with that, I have concluded my updates. I appreciate the extra time you have provided and willing to answer any questions.
>> DEBORAH SHOEMAKER: Thank you. Any updates -- any questions from the committee members? [no answer] Okay, any questions in the chat?
>> ELISE GREGORY: There are no questions in the chat at this time.
>> DEBORAH SHOEMAKER: Thank you, Elise. Okay. We look forward to hearing from you next month again, Deputy Secretary Marsala.
>> JULIET MARSALA: Thank you.
>> DEBORAH SHOEMAKER: Next up, OIM update. Carl.
>> CARL FELDMAN: Hello. Good morning. Can you hear me?
>> DEBORAH SHOEMAKER: Yes.
>> CARL FELDMAN: Alright. I received a set of questions for the Office of Income Maintenance and I will work my way through those questions and of course, we can stop and kind of talk about the various things you would like to discuss on my way through them. Generally speaking, if you're seeking information about the unwinding of continuous coverage, we have available on our website the unwinding data tracker, all of our federal reports, which should be updated soon and our final unwinding monthly renewal outcomes. We share [audio cutting out]-- the last set of the first round of text messages final unwinding month. We are fast approaching the end of the period and we're kind of undergoing status quo operations.
I think that you asked for some general programmatic and data updates. What I will share on that account is that we were connected with Code for America for six weeks-- [audio cutting out] the state can improve our ex parte rate and that DHS concluded our

engagement with Code for America. We're reviewing the items captured in the report. There are a number of systematic policy and business operations recommendations that we received from them that are both long-term and short-term recommendations. I can tell you off the bat that we know of at least two system recommendations which would include [audio cutting out] increase the rate of ex parte renewal mark we expect to put into place by this year. We hope that that will have a positive outcome on the ex parte rates, not just of course for the unwinding period, but generally and into the future.
We were asked about updates to federal reporting that I have spoke [audio cutting out] and the renewal disposition for case activity carrying over into the following month. As I have said, CMS had been talking for some time about the desire to capture renewal outcome information for the [audio cutting out] in the month of November, we received specific detailed guidance about how they wanted that to be captured. We are somewhat stymied in our ability to provide that to them and will begin providing that for the month of November, which should become available in February. For the previous months [audio cutting out] MS and will provide the disposition [audio cutting out] 90 days after the renewal due date occurred, which is very [audio cutting out] unwinding outcomes. So that is how we will proceed with this reporting to CMS. Once we have gathered that information, it will be placed under the federal report section of our webpage.

We were asked to provide information around the ex parte at the individual level changes that CMS indicated the State, and many states would need to make. What I can say is that as directed by them, we undertook a project to identify and reopen any case which should have been renewed but was not because the ex parte renewal, which was conducted, didn't occur at the individual level. If the review showed that the person who closed at renewal should have kept their eligibility, coverage was restored, and the individual was to be made whole. This resulted in the restoration of coverage for, the final figure which was reported to CMS is 45,532 recipients. This restoration of coverage included the prospective and retrospective coverage as it was needed. Approximately 23,651 of the restored individuals were only required to have retro coverage gaps to be closed because they had already returned to coverage when DHS undertook the project. Some additional elements we think that you would want to be aware of, which is that all coverage restorations placed the restored individual into the category they were in at the time of closure or a higher category consistent with our existing ex parte rules. All coverage restorations resulted in the restored individual's next renewal due date, which would be 12 months from the point at which they were previously closed. All coverage restoration followed existing plan assignment rules and all retro segments were restored into fee-for-service coverage. All coverage restorations received a notice about their coverage restoration and will receive an additional correspondence from us about the ability to use their retro coverage to have providers resubmit bills and reimburse the individual for an out-of-pocket visit or service.
Are there questions on these unwinding topics you would like to discuss more?
>> DEBORAH SHOEMAKER: Any MAAC members? I know there were a couple of times you cut out a little bit. I'm not sure if anybody missed anything. Any quick questions from

MAAC members about unwinding? I missed Consumer Sub yesterday. I'm not sure if you guys talked about it or not, Kyle or Danna?
>> JOE GLINKA: Deb, it's Joe Glinka. I have a couple of hopefully quick questions for Carl. I appreciate the update. He was cutting out there. Carl, if any of these questions are based on things you already reported out, I apologize. You were cutting out a little bit. One is with respect to the reinstatements that were done, the restorations, will the Department be sharing what that looks like to each of the MCOs to better understand who was impacted on each of our enrollments? If so, when would we be able to attain that information from the Department?
>> CARL FELDMAN: We will be sharing that list for each managed care plan. I hope to have that to you soon.
>> JOE GLINKA: Okay. As far as the pace of the unwinding itself, when does the Department project that the full impact of the unwinding will be experienced by the plans from an enrollment standpoint as far as a landing area? Any feel for that?
>> CARL FELDMAN: I think the best we can say to you is kind of reiterate the timeline, which is that we have a 12-month unwinding period that we have elected for. That 12-month unwinding period ends at the beginning of April. We expect there's going to be a two-month cleanup, as has been kind of typical. If you look at our federal reports, we often roll over to the following month. I'm not sure if that aligns to what you are asking about, but that's how we think about it in terms of timeline.
>> JOE GLINKA: No, that's helpful. Cleanup is probably a good term. Thank you for sharing where the Department is with that. One more, if I could. In terms of the flexibilities that have been afforded to the plans in terms of follow-up on procedural terminated individuals and so forth. How long will those flexibilities continue for this year? They have really been helpful in reaching members and being -- assisting them in getting connected with coverage again.
>> CARL FELDMAN: I want to go back and add when I say cleanup, we're not talking about any kind of specific activity that's going to happen that would apply to everybody touched during the unwinding. It just means essentially time to act and take eligibility actions for any cases that are still outstanding at the point in time at which the 12-month unwinding period ends. Just to be clear about that. On flexibilities about outreach, I believe when these were extended, we indicated a timeframe for how long they would continue. I think in the one that I can remember, it was 90 days past the last unwinding renewal due date. If there's a desire to continue that further into the future, I think we will have to have a separate conversation about that. We're open to that.
>> JOE GLINKA: Thank you for that, I appreciate that. Deb, thank you for letting me indulge, I appreciate it.
>> DEBORAH SHOEMAKER: Sure, no problem, Joe. Elise, you said you have a few questions on the attendee side?
>> ELISE GREGORY: Yes. We have some questions from Andrew Kunka. Do you have the restoration coverage numbers by county? And were the Medicaid MCOs notified of the members who were restored? And how will this be shared and with whom at the MCOs?

>> CARL FELDMAN: We will be providing a specific list to managed care organizations, as stated previously. MCOs were notified in the way they are always notified about eligibility actions and changes through the regular 834 file. We will also have information available by county. I think that that covers all the questions.
>> ELISE GREGORY: There are no more questions in the chat at this time.
>> DEBORAH SHOEMAKER: Thank you, Elise. I am sure we will continue to hear from you, Carl, and appreciate the hard work that OIM is doing now and during the time period especially with ex parte and other things. Thank you for that. Next on the agenda would be the ODP update from Deputy Secretary Ahrens.
>> KRISTIN AHRENS: Great. Good morning, everyone. Go ahead to the next slide.
I have got two different topic areas here. One is keeping MAAC posted on where we are with the statewide transition plan and compliance with Home and Community-Based Settings Rule. I don't recall if we shared this last time. We have a little more detail now. CMS had approved Pennsylvania's plan. This is for three program offices. We have home and community-based waivers in OLTL, ODP, and in OCDEL (Office of Child Development and Early Learning). We have the infant and toddler waiver in OCDEL.

The primary areas in terms of compliance, the heavy lift fell to OLTL and ODP. Infant toddlers is all done in family homes. Not much concern there because they don't really have provider operated settings covered under those waivers in terms of the benefit package. This is to say we did get our final approval for our statewide transition plan by the Feds in August. In terms of CMS, they shared with us they will be doing a site visit in February. Part of what our obligation is, obviously, with the settings rule was not only to transition into compliance, but to assure ongoing compliance with the settings rule.
For ODP, we did incorporate settings rule requirements into our licensing regulations. I realize here we have got two of our licensing regulations aren't mentioned, but all four of our licensing regulations do incorporate provisions from the Home and Community-Based Settings Rule. The reference here, 6400 is our Community Homes, sometimes referred to as group homes, where residential habilitation is provided. 6500 is our licensed Life Sharing Homes, where life sharing services may be provided under our waiver. The other two chapters in Pennsylvania Code that do incorporate Home and Community-Based Setting Rule provisions are the 2380s and 2390s. Our day programs are pre-vocational settings and adult training facilities.
We also incorporated the settings rule requirements into our own program rules here, which are in Pennsylvania, which is our 6100 regulations. Those govern our program and any funds spent for home and community-based settings. We incorporated all of that. The evaluation, the ongoing assessment, that we do as a Department, is really through both our licensing and then through our Quality Assessment and Improvement process. Additionally, the other way that we assure that we are in continued compliance with Home and Community-Based Settings Rule, is we have incorporated into the individual monitoring tool that is used by supports coordinators, a number of those provisions, to make sure that for individuals who aren't necessarily receiving services in a licensed

setting, that we are still in full compliance of the rule. We have got a multilayered approach that really took that federal rule, put it into Pennsylvania regulations, and our own operations for evaluation. We're feeling pretty good about how we have incorporated that into formally existing processes.

Next slide.

They are coming to visit. CMS will be here the -- [audio cut out] -- their primary focus for the site visit in PA will be to look at our person-centered planning practices and our supports coordination. They are also interested in looking at -- states had the option because of the pandemic, essentially, and some delays, many states are experiencing delays in trying to come to full compliance with the settings rule. CMS did allow states to submit corrective action plans (CAP) in the event that states were going to miss the March of 2023 deadline. Pennsylvania, we did submit both OLTL and ODP, submitted CAPs. For ODP, ours was really just cautionary in that, if we had any settings that were unable to come into compliance by the deadline, we wanted to make sure that we had ample time to transition individuals to a new service location. We did not ultimately need to exercise that, but we did have that corrective action in place if we needed it.

CMS also, in terms of trying to get all states into compliance with the settings rule, also had states establish different milestones in our work toward coming into full compliance. They want to take a look at where we are with any of those milestones and any CAPs that were in place. I can speak to ODP's work on this. Juliet would have to -- if you have questions -- speak on OLTL's CAP or milestones.

I can tell you we have not finalized the list, but I think we're pretty close with CMS. It looks like they will be visiting seven service locations. Seven different provider service locations. They are interested in looking at settings that had been identified to them for heightened scrutiny to see if they met the rule. They had identified they wanted to look at some of our day services and they wanted to look at some of our Community Homes and Life Sharing setting. I think we're close to having the specific sites nailed down and them be in conversation with all of those providers once we have confirmation. CMS has expressed they will be sort of surveying - that what they will be doing will include discussions with individuals, beneficiaries who receive services, direct support providers, and supports coordinators. They have also asked us to coordinate a meeting just with service coordinators and supports coordinators, so that they can dive into some of their inquiries related to supports coordination and person-centered planning here in PA. I don't know if we have met before or after that or during that week, but more to come. It does look like this is sort of the structure of the visits so far with CMS.

One of the things that I should share is that CMS has made it very clear for any providers that we are visiting, that the evaluation that CMS is conducting is on the Commonwealth, it is on the State. It is not about the specific providers or the specific locations. It really is about how the State has and is operationalizing the Home and Community-Based Settings Rule. We will provide a report out at the MAAC after the visit.

Alright. I have one other update for you on Performance-Based Contracting. I already shared, we did, the Residential Strategic Thinking Group, did finalize the set of performance

standards, the draft of that. The Department is working back, there are a number of areas where we need to plug in specific performance targets, meaning certain percentages that we will be asking providers to meet, but the sort of structure of the performance targets are established at this point for their residential side.

On the Supports Coordination side, and again, for timing, we will be implementing Performance-Based Contracting for residential services January 1, 2025, and Supports Coordination, January 1, of 2026. We have the meeting with the Supports Coordination Strategic Thinking group to frame out what the performance standards will be for supports coordination. We began that work in December and we have quite a way to go before those measures are really drafted for greater public distribution.

We are working at ODP to develop a tool kit to support provider readiness, the residential provider readiness. I don't have a timeframe for when that will be released, but we're working to get that out the door so that providers have some tools helping them think about readiness for that January 1, 2025, implementation. We are also drafting -- we do need to submit both a 1915 (b) 4, which is a new waiver authority that ODP has not used and will be using in this regard. We have to draft that. Then we have some corresponding amendments to our 1915 (c) waivers, for residential, that would be our Consolidated waiver and Community Living waiver. We should have that out for public comment in April. ODP typically does anywhere from six to twelve different stakeholder sessions. We will have some specifically geared to hear feedback from individuals and families, providers, our county partners, supports coordination, and then general public provider session as well. We will kind of run our typical course in terms of how we gather public comment on those, the (b)(4), and the amendments.

Finally, in terms of implementing Performance-Based Contracting, the Department does need some additional support related to data analytics, so we have an RFP (request for proposal) out. It is currently on eMarketplace for some performance analysis services. I think that concludes my updates for Performance-Based Contracting. I am happy to take questions or comments.

>> DEBORAH SHOEMAKER: Thank you very much. Before we take any questions, I wanted to do this at the beginning of your presentation, but I forgot. I want to formally recognize and applaud our Deputy Secretary because we know how great she is, but now on the national scene, everybody knows how great she is. Recently, she was appointed or elected to the Board of Directors for the National Association of State Directors for Developmental Disability Services. I saw that when it came out. I wanted to formally recognize the excellence that you have. Now everyone at the national level knows as well. Congratulations, Kristin. You definitely deserve it.

>> KRISTIN AHRENS: I really appreciate that. It is a great honor to be serving on that board. I appreciate your kind words.

>> DEBORAH SHOEMAKER: Thank you. Questions? Richard, I thought I heard your voice but maybe it wasn’t you.

>> RICHARD EDLEY: It wasn't me, but I will say something anyway. Thank you, Deb.

>>DEBORAH SHOEMAKER: I gave you the open door so go ahead.

>> RICHARD EDLEY: Hi, Kristin. Good morning. We recently at the ISAC (Information Sharing and Advisory Committee) had a presentation from the residential steering group and things and there's obviously a lot of new measures in tracking and reporting. In a vacuum, it's hard to argue against any of them. There are a couple that people may have concerns about, but in general, I get it. It's a lot. Not to sound like a broken record, but it does have that feeling again, if you're a really large statewide provider with a lot of infrastructure, you could probably dedicate staff to this and pull it off, but it might be a lot for small or medium sized providers. That's sort of an ongoing concern. How are people going to really implement this and pull it off? Track and report and continually implement things? We continue to look at ways that maybe providers can share some infrastructure or share some things that at some point we want to talk to you about, short of mergers and acquisitions. Providers are coming together and looking at are there ways to do this in coordination because they don't have that kind of infrastructure. I wanted your thoughts on that and what you're hearing.
>> KRISTIN AHRENS: Good morning, Richard. I'm glad to hear as an association you're having that discussion. I think there is a role for some collaborative work in that space. Not every provider is going to need to create this wheel for themselves. I would hope that people could share and collaborate some strategies to it. I know that there are some providers that are already doing that with different vendors. I'm glad to hear that RCPA is having that conversation.
Part of the preparedness tool kit that we will be working on is also to alert providers. We can tell from utilization data, we have a number of tools we have in place, different dashboards that providers can use to look at their own data and run reports, run their own queries. For some of the different data elements that we're looking at, and we can see from usage, I think there are many providers that are not aware of some of the things that are already at their fingertips that the Department has provided for them to be able to do this. Some of that preparedness will be, here are some things that are already available for you to use in this regard. I would welcome the conversation with RCPA, and the associations related to what other sort of collaborative work can we do to make sure that providers have the support to do the kind of tracking and reporting that will be expected under[audio cutting out] performance based.
>> RICHARD EDLEY: Great. I know you're attending our meeting next week and maybe we can continue the discussion then. Thank you.
>> KRISTIN AHRENS: Sounds good.
>> DEBORAH SHOEMAKER: Any other questions from the MAAC members? Okay. Anything in the chat Elise?
>> ELISE GREGORY: There are no questions in the chat at this time.
>> DEBORAH SHOEMAKER: Okay, wonderful. Thank you so much Deputy Secretary for your information. Always appreciated. Okay, next on the agenda would be Deputy Secretary Smith. Welcome, Jen.
>> JENNIFER SMITH: Hi, Deb. Hi, everyone. I'm recognizing where we are in time. I will do my best to keep my presentation short here. So maybe we can get closer to back on track.

If you flip to the first slide for me, please, we have a couple of items that we give updates on I think just about every time we meet. One of those is the 988, and it should say Suicide and Crisis Lifeline. I think that was my omission late at night typing. But good news to report on 988. Our in-state answer rate has risen over the last several months. The last two months, we have been consistently at now 89%. To give you a reminder, the goal that SAMHSA (Substance Abuse and Mental Health Services Administration) set for us, which is our federal oversight agency, we are to be at 90%. We are very, very close to that rate. We are above the national average currently by 1 percentage point. We're overachieving right now and that's great news. Just a reminder of how to access that answer rate at any time if you would like to go and check it out yourself. You can see by state what those answer rates look like. While we know that that answer rate is really not the only indicator of how successful the 988 and crisis efforts have been, we do just want to acknowledge how hard the call centers have been working. They're experiencing staffing shortages, just like all of our providers across the system are. To continually see those answer rates climbing while knowing that we're still receiving thousands of calls per month, I think that's really tremendous work. I want to give them credit for that.

Related to the Behavioral Health Council, meetings are underway with that council. There have been two meetings to date. Those meetings are focused on closing system gaps, reducing barriers, and identifying some of those quick win solutions or near-term solutions. If you want to know more about who makes up that council, who participates and when the meetings are, there is a website. I know that at some point, there will be some pictures and bios added on the council members. At least at a minimum right now, you can read about who makes up that council. I also believe that the advisory committee related to the Behavioral Health Council is finishing up its formation and will be meeting here in the very near future. And I believe some of the folks on the call right now have been tapped to participate on that advisory committee. Good work happening there. It is still pretty early in the process. No kind of hard outcomes or recommendations to report just yet. On the next slide, a couple other areas that we typically give you some updates, around the area of children with complex needs.

About six months ago or so, a stakeholder workgroup was formed to really take a close look at complex cases and to develop a report of recommendations. That's the Blueprint Workgroup that I'm sure you have probably heard about. That is led out of the Secretary's office here in DHS by Jon McVey. It includes family members, providers, advocacy groups and of course state partners as well. That report should be coming out very shortly. Something exciting that is quasi-related to that report, but not directly, is that we had applied for some technical assistance through a policy lab. We did receive confirmation that Pennsylvania was selected as one of eight states to participate in that policy lab. What it will do is help those eight states, which includes Pennsylvania, to strategize and promote some of this cross-system work that we have been talking about that will improve outcomes for children and their families. Our team here in Pennsylvania will include folks from the Secretary's office, from my office, from OMHSAS, ODP, OCYF (Office of Children, Youth, and Families), the Department of Education, and JCJC (Juvenile Court Judges'

Commission). A really good swath of people here from the state level. That will kick off next month in February. It is hosted by Health Management Associates and then there's lots of partners in that leading the effort as well. Casey Foundation, Centene, National Association of State Medicaid Directors, and multiple others. It's a really good opportunity for us to use some technical assistance to achieve some of the recommendations that were discussed during the Blueprint Workgroup. Good movement there in the area of children with complex needs.

The other standing update, we like to tell you about where we're headed with our regulations. We're still in the final stages of internal DHS review of our crisis regulations. These are a brand-new set of regulations. Not an amendment, but a creation of new regulations. These have taken longer than most people would like, but because we were trying to align definitions with existing regulations, because it's a new space, because we're needing to look at federal tool kits and guidelines and best practices, it's just taking extra time to make sure they're in a really good place before we formally submit them to go through that process, which will ultimately end with submission to the Independent Regulatory Review Commission or IRRC. Once there, IRRC will put them out for a public comment period. We'll have the opportunity to address those public comments. Then the IRRC board will either approve or disapprove those regulations. If they approve, they become effective. If they disapprove, then we have the opportunity to make some amendments and resubmit to them for future consideration.

The PRTF (Psychiatric Residential Treatment Facility) regulations are in the step right before they get submitted to IRRC. You should see those coming out for public comment in the very near future. Many of you contributed to the development of those regulations. There will not be any surprises. Nothing new that has been added to those draft regulations since we have held conversations. Hopefully, we'll get some positive feedback on those PRTF regs.

The last bit I wanted to share is upcoming stakeholder discussions around telehealth. We want to talk both from a policy and a regulatory standpoint. We want to hear a little bit about what's been learned post-pandemic. We also want to have some conversations with payors, providers, and most importantly, probably, consumers of services to understand how they best consume services. How do we balance the idea that we are responsible for the health and safety of the consumers who are receiving the services, but also be respective of the fact that there are workforce shortages, that technology is much more widely available and able to be used. Some really good, hopefully good, discussions coming up around telehealth and how we might be able to address some of the current challenges.

The next set of slides are just some updates on some initiatives that I don't know that we have talked about with this group. But wanted you to be aware that work is happening. As I mentioned earlier, constant work happening to improve our crisis system and to align with SAMHSA's expectation for us. As we do that work, we are taking a look at all kinds of different efforts and opportunities and also looking at the funding that we have available. We were fortunate that we had some ARPA (American Rescue Plan Act) dollars that we

were able to use to fund NAMI (National Alliance on Mental Illness) Keystone to make sure they have trained program instructors and support group leaders for the three different programs listed here on the slide. Those support groups are offered both in-person and virtually to family members and peers. The funding that NAMI Keystone is receiving will actually end up going to the NAMI affiliates to bring up the programs and strengthen resources in their catchment areas. Hopefully, improving access to resources and building supports. Good stuff happening there.

The next slide is some information around Safer Communities Gun Violence Intervention Funding. This was funding that was designated to Pennsylvania by the federal government through the Community Mental Health Services Block Grant. It was specifically targeted toward the goal of reducing gun violence. The amount was something under $2 million, not huge dollars, but enough to be able to do impactful work. With that funding, we're doing two different things. One of those is supporting Millersville in releasing an RFP that will support our grass roots, non-clinical mental health interventions. The goal is to help identify recommendations on how the state can best intervene and support communities that have been impacted by gun violence.

Then the second area of funding is that we are supporting Youth Move PA to become a Sources of Strength trainer and bring up that program in hopefully ten school districts across the state. Sources of Strength is a curriculum that is focused on building positive school culture. It trains youth to become what are known as allies and adults to become allies within the school district so that if there is a student who is struggling and they don't feel comfortable going to their classroom teacher, or a guidance counselor, or a principal, they have the opportunity to speak with one of their peers or to go to one of these trained adult allies where they can feel as if they're trusted and get some assistance in receiving resources around mental health. We have got those two things happening with these Safer Communities dollars.

One quick plug before we move to the last slide. If anyone on this call is closely engaged with their school district and are interested in this program, either knowing more about it or maybe bringing Sources of Strength to the school district, please reach out to Youth Move. I think they are still looking for a couple of school districts to partner with. You all could be a great source of connectivity for us.

Then last but not least, I wanted to let you know about a positive change that just came this week in the form of approval from CMS related to a language change in the State Plan. You see the language change there. Previously, the eligibility requirement for certified peer specialists (CPS) required that they identified as having a serious mental illness SMI. That language has been revised to say that they need to have lived experience with a mental health diagnosis. It doesn't have to be specifically SMI. I think that's a really positive step. Hopefully, that will open the door for more individuals to be eligible to become certified peer specialists. Then just wanted to point out that we are financially supporting some increased access to specific endorsement trainings for CPS's, particularly in the areas of crisis, forensics, and we're in the process of building an older adults curriculum as well. I think that's all I had for you today. I would be happy to take any questions.

>> DEBORAH SHOEMAKER: Thank you, Jen. You have as always, a full agenda. Appreciate all the hard work your office is doing. I just had a quick comment. I know that Elise said we have a couple of questions in the chat. Maybe I can have one question from MAAC members. I know it's out of your purview, but to bring to your attention although you may already be aware, on the Behavioral Health Council, one thing that we noticed, we as the Psychiatric Leadership Council and some other groups, consumers, families, there is not a representative for community psychiatry. There's not a community psychiatrist on there. And even other health care workers in the community, the organizations that represent them some. Richard is going to be on the advisory committee, which we're glad about. But it's something that there's really not anything for the community psychiatry or community rural community health, mental health, which is our Medicaid providers and Medicaid enrollees and consumers and families of choice. That's something that just to let you know, something that maybe we will want to bring up to Chris Finello, to Executive Director Finello, to see if there's openings in the advisory committee. I think that would be a good enhancement.
>> JENNIFER SMITH: Thanks, Deb. Lloyd had brought that up yesterday on the Consumer Sub meeting as well. My encouragement to him was to reach out directly to Dr. Finello and talk about how they might be able to engage someone either on the advisory committee or if there are other planned ways of seeking input or engaging additional stakeholders just to make sure that she's aware of that potential gap. I think that's really wise.
>> DEBORAH SHOEMAKER: Great. Thank you, I have talked to her, I have known her for a while. Hopefully, that will be a good thing. Appreciate your hard work and your department's, your office's hard work. Is there a quick question from our MAAC members before I ask Elise from the chat?
>> RICHARD EDLEY: This is Richard. I have two unbelievably quick ones.
>> DEBORAH SHOEMAKER: Okay. Go ahead.
>> RICHARD EDLEY: Hi, Jen. The first, I think last week CMS came out with the Innovation and Behavioral Health (IBH) model. I didn't know if that was a question for you or Sally or both of you. They are going to pick eight states and all that. Is that something that Pennsylvania is looking at?
>> JENNIFER SMITH: Yeah. We're definitely looking at it Richard. For those that don't know, this new IBH model that they're going to support some funding opportunity for, is sort of the inverse of what has been attempted through other models. Up to this point, a lot of times when we talk about integrated care, we talk about trying to bring behavioral health into physical health settings. This model actually does the opposite where it talks about using behavioral health providers and settings and pulling in physical health into those settings. I think it's a really potentially promising model. They are picking eight states. Then it will be implemented over an eight-year period. It's a pretty sustained effort here. We are taking a very close look at it and trying to assess how it would fit in with some of the other types of models and demonstrations, specifically the CCBHCs (Certified Community Behavioral Health Clinic) and the ICWC (Integrated Community Wellness Centers). Lots to consider. No official decision but I think that everybody agrees it sounds

like a promising avenue to test.
>> RICHARD EDLEY: Great. We obviously would be glad to be part of the discussion and so forth. You mentioned CCBHC. That was my second one. Is there any update on the CCBHC and possibly getting back into the demonstration? I know Dr. Adair is really the lead on that but, while I have you?
>> JENNIFER SMITH: Yeah, he is. To my knowledge, no. We still have outstanding questions that we were waiting for feedback on around logistics of coming back into the project and whether we would be grandfathered in with some of the requirements from the original demonstration or whether we would have to adhere to some of the newer requirements and those types of things. As most of you know, when you submit questions to the federal government, you don't always get a really timely response on those. I think we're still waiting on some answers to those questions. But I do want to point out, Richard, and I think you know this, that our hope is to expand that model, whether it's called CCBHC or whether it's called ICWC. We really do hope to continue funding and really look at expanding some capacity in that area.
>> RICHARD EDLEY: That's great. Thanks. I will stop. I gathered there were other questions out there. Thank you.
>> DEBORAH SHOEMAKER: Go ahead, Elise. You have a few questions in the chat?
>> ELISE GREGORY: Yes. From Andrew Kunka, do you know when the list of Behavioral Health Council Advisory Council Committee members will be released?
>> JENNIFER SMITH: I don't know the specific date. It may even be posted on the website. I didn't check within the last two days or so. I believe they're nearing finalization of that list. If it's not out there yet today, I would suspect in the next week or so. I think the first meeting is coming up. Richard would probably be able to confirm that for us. I'm not certain if it's posted to the website just yet.
>> RICHARD EDLEY: I don't have it in front of me. I think it's next week. It's soon.
>> ELISE GREGORY: From Lloyd Wertz, will the complex-case workgroup recommendations be shared with the recently formed complex-case workgroup that was recently formed by the MCDSS (Managed Care Delivery Systems Subcommittee) Subcommittee of the --[audio cutting out]
>> JENNIFER SMITH: Elise, you cut out at the end.
>> ELISE GREGORY: Sorry.
>> JENNIFER SMITH: I heard will the recommendations be shared with?
>> ELISE GREGORY: With the MAAC from the MCDSS Subcommittee of the MAAC.
>> JENNIFER SMITH: Yeah. The recommendations coming out of the Blueprint Workgroup will actually be publicly available. Likely through some LISTSERV announcements and maybe even a press release. It will be widely publicized and available.
>> ELISE GREGORY: Last question from Ann Torregrossa. Can you tell us which counties have operating mobile crisis teams and stabilization centers that 988 can refer to? And is there an update on the crisis regulations?
>> JENNIFER SMITH: I did provide an update on the crisis regulations. They are in DHS internal review before they start working their way through the process to leading up to

the submission to IRRC. We're cleaning up last-minute bits around definitions and ensuring consistency with some other regulations. In terms of the question around what counties have and don't have mobile crisis and where to refer folks, that's probably a question best for us to take offline and work directly with you. I wouldn't be able to provide that here in the next 30 seconds or so. The short answer is we don't have a real-time master list of those services and who is providing them and how many people work for them. We are working statewide, kind of a chunk at a time, in talking with counties and regions to really understand what they do have currently in place. Whether it's 24/7 or not 24/7 and what they have planned so that we can help offer assistance, in terms of guiding with the braiding of funding, if they're having regulatory or policy challenges, we want to try to work through those with them. Also addressing some reimbursement challenges and workforce needs. So that's definitely something we can kind of reach out and talk with you about offline. But the short answer is there isn't a master list that's kept up to date in real-time, at this point, that we could just send to you.
>> ELISE GREGORY: There are no more questions in this chat.
>> DEBORAH SHOEMAKER: Wonderful. Thank you again. Next is Sally.
>> SALLY KOZAK: Good morning, everybody. I have a handful of updates here for you. The first being our 1115 In Lieu of Services (ILOS) waiver, which we are calling Keystones of Health for Pennsylvania. The application has been developed and we anticipate that we will be submitting it to CMS shortly. Once the application is sent to CMS, then there is a 15-day review period, followed by a 45-day federal public comment period. After that point in time, almost about six weeks, we expect that we will begin to get some initial feedback from CMS. That does not mean that the waiver will be approved at that time. It means that we will begin to enter into a series of conversations with CMS regarding the details of what it is that we anticipate implementing. Yesterday, there was a question about the feedback that we have got when we submitted for our public comment. What I will say is we received an influx of comments that were overwhelmingly supportive of this initiative. Folks are still going through some of those in terms of formatting them and everything for publication on the web. People will be able to see those shortly.
Next one on the agenda is enrollment of doulas. As I think you have heard me say before, beginning with the January 1st of this year, we required doulas to be included in the maternity care management teams that choose to participate in our maternity care management bundles. In order to continue to help facilitate the expansion of the doula services, beginning February 1st, we will begin to enroll doulas in the MA Program who are certified by the Pennsylvania Certification Board as Certified Perinatal Doulas. This will allow the doulas to actually participate in the managed program as enrolled provider types. Our goal in doing all of this is to build the capacity of certified doulas in order to ensure statewide accessibility so that we can ultimately add them to our State Plan for everybody. As I think you have heard me say before, we are committed to expanding access to services that have demonstrated outcomes in improving care and all the research shows that doulas definitely have positive outcomes, particularly within a Medicaid population. We are really excited that this is all moving forward.

We recently announced that we will enroll and pay pharmacists who are not employed or under contract with a pharmacy to provide a range of services, including medication management, immunizations, disease case management, and education in other settings, non-pharmacy settings like physician offices and clinics. This is going into effect in March. We had originally anticipated it would happen in January, but we have had to delay a little bit, so that will happen in March now. We are having a training for pharmacists on Thursday, February 15th, from 10:00 to 12:00. The announcement for that training is on our provider enrollment website for anybody that's interested in that.

The 2024 HealthChoices Agreement update. This year, we made many changes that pertain to the implementation of Act 146 of 2022 which deals with utilization management and complaints and grievances and fair hearings. We also created a new exhibit relating to ILOS. The reason that we did that is because CMS released a new rule related to ILOS, and all program offices have added similar languages to their agreements so they can comply with this rule making. Just as a reminder, currently, there are no approved ILOS, at least in the physical health plan. For physical health, this is largely placeholder language in the event that we need to add in future. We added language related to PA Navigate, which I'm going to talk about in a minute. The MCOs that use this resource and referral tool should be working to ensure that their tools, to the extent that they actually differ from the PA Navigate platform, will be interoperable as we move forward.

The FQHC (Federally Qualified Health Clinic) conceptual value-based purchasing modeling pilot language now allows for movement into the implementation phase. Before, it was in the pilot phase. That implementation phase is to the extent that there are any FQHCs ready for this phase. Anecdotally, we are not aware that the conceptual modeling conversations have advanced quite this far. That's okay for us because we knew it would take a while. The FQHCs are actually in the driver's seat for this pilot. This is really placeholder language that actually allows for implementation if any of the FQHCs are ready this year.

We have also added language around the new value-based purchasing agreement that was created for the dental schools beginning in 2024. And as you all know, we also made changes to the MCO P4P (Pay for Performance) program in the 2024 agreement. However, these changes will not begin until 2025. What that means is that the MCOs will experience consistency during 2024 and will have the full year to prepare for implementation next year. We want to thank all of the MCOs and other individuals that worked with us to find a path forward towards modernizing our P4P program while still holding ourselves for very high standards for outcomes of care. We believe that we are well on our path to achieve our new set of goals. After hearing the feedback from providers, that MCO requirement for 80% of provider P4P dollars actually go to the provider staff who generated the outcomes were unclear, we added significant detail to those provisions. Additionally, we removed the provision -- I'm sorry, I just lost my place here. Let me find it. I want to make sure I get this

right. Additionally, we removed the requirement for the MCOs to obtain attestations about the disbursement of those dollars and instead are leaving it up to the MCOs on how you would like to confirm the provider compliance. We recognized the attestations were cumbersome and difficult for some of the providers to fill out. We hope that this approach will make it easier. If you want to attest, you can. Just know that now it is not absolutely mandated.

Community-based care management programs will be required to include Community Health Workers to the extent that they already do not. We know that many of our MCOs are using Community Health Workers for the last few years. We have allowed them to use the community case management dollars to do that. This is not a significant change. It helps to ensure that we are using the Community Health Workers.

I talked about doulas. They are required to be part of the team now.
The Regional Accountable Health Centers or RAHCs have actually been “sunset-ed” with this agreement. We have done that in order to leverage the work that is being done by the Department of Health's Regional Equity Action Teams.

During the public health emergency, we extended the appeals filing timeline from 10 to 15 days due to postal service delays. We have decided to make this change permanent across all the HealthChoices programs. That went into effect with the 2024 agreement.

Credentialing dates will need to be made retroactive to the date a complete application was received. Please note that this retrospective credentialing applies to any applications that are pending as of January 1.

On the topic of credentialing, ordering, referring, and prescribing (ORP) providers must be credentialed using the nine-digit Medicaid provider ID number for all locations where the ORP providers practice, rather than requiring a unique 13-digit number for individual locations.

We have updated the agreement to require that MCOs pay for ambulance services using the MA Fee Schedule as a minimum. Please note that we need to submit this payment methodology to CMS for review and approval. Once approved, there will be a mid-year adjustment to the rates to account for this.

There were also a few important changes made with respect to pharmacy. The MCO and/or PBM (pharmacy benefit management) must report changes to maximum allowable cost rates in real-time to network pharmacies. You must recommend preferred drugs and denial notices when denying a drug because it is nonpreferred. Effective rate contracts are prohibited and unredacted PBM contracts must be submitted to DHS.
Finally, we added a new financial Appendix 20, which pertains to the state directed

payments. All of that has been submitted to CMS. As soon as we get final approval, it will be posted on the website for everyone to have access to.
On the next slide, PA Navigate.
PA Navigate launched Tuesday, this past Tuesday, the 23rd. For folks that are not familiar, PA Navigate is what we were formally calling RISE (Resources Information and Services Enterprise) PA. It is an online, closed loop referral tool that connects Pennsylvanians with community-based organizations, county and state agencies, and health care providers, for referrals to community resources that can help them meet their basic needs like food, shelter, transportation. PA Navigate is not only for use by providers, but individuals themselves can use it and generate referrals to community-based organizations. It is a shared platform where health care providers and social service organizations can track client referrals in order to better understand and assist a client with individual needs. It will also allow health care and service providers to assess an individual's need during a physician's office or emergency department visit or while receiving care management services. At the end of the day, it will, as I said, close the loop. It will be a collaborative effort among health information organizations and multiple state agencies, local and nonprofit community organizations, social service providers, to bring all of this information together to ensure that individuals receive the care and services that they need. If folks are interested in more information on PA Navigate, we can certainly have Martin Ciccocioppo, who leads our e-Health authority, come next month to present on it. Deb, that's all my updates.
>> DEBORAH SHOEMAKER: Wonderful. I know he's on the call, so if anybody has a question, I don't want to put Martin on the spot, but I think he's on the panelist side.
Do we have any questions from MAAC members? [no answer] Okay. Any from the chat, Elise?
>> ELISE GREGORY: Yes. From Nicole Payonk. Could you please review the intent behind dental directors visiting providers?
>> SALLY KOZAK: Yeah, I can absolutely do that. As folks may be aware, we have a new Chief Dental Officer on board, Dr. Sean Shamloo. Part of his strategy in helping to increase the rate of preventive dental care, in particular among children, is to help spread the word about the Medical Assistance Program. He himself has said that as a newly graduating dentist, he was not even aware of the Medicaid program. The way to get that word out is actually to go talk to people. It is part of an overall communication strategy to inform and hopefully recruit and to dispel some of the misnomers that may be out there about treating Medicaid recipients. Does that answer the questions?
>> ELISE GREGORY: We have two more questions. One from Andrew Kunka. Will a summary of the HealthChoices Agreement changes be released?
>> SALLY KOZAK: I'm not -- we historically don't release a summary of the changes. We do make the agreement available on the website. That will be available as soon as CMS approves it.
>> ELISE GREGORY: The last question from Jeffrey Iseman. Can OMAP provide any updates on MATP (Medical Assistance Transportation Program) the Human Services Transportation

Study in which they provided information to PennDOT (Pennsylvania Department of Transportation)?
>> SALLY KOZAK: I don't have that information ready at hand to be able to talk about that. But we can certainly add that to the agenda for next month.
>> DEBORAH SHOEMAKER: Added to that -- just to go back to, I know that Nicole, the question you asked about dental, I have that on a list in a future meeting for the MAAC is to have Dr. Shamloo come back to talk about some of that. I am pretty sure that we can make sure that happens to give explanation.
>> SALLY KOZAK: Absolutely.
>> DEBORAH SHOEMAKER: Okay. Did you have something else, Elise?
>> ELISE GREGORY: Jeffrey Iseman says thank you and Pam Hillary had a comment that as a nursing home, they have a difficult time finding dentists that accept CHC or Medicaid.
>> SALLY KOZAK: You know, that's actually an interesting point. Right now, we have primarily been focusing on pediatric dental needs. I will remind our dental team about the needs for individuals that are in facility-based and see how we better incorporate that into our outreach plan. Thank you very much for that reminder.
>> DEBORAH SHOEMAKER: In the chat, Gwen Zander wrote there are no current updates on the Human Services Transportation Study. It is pending approval to be released. Thank you for that Gwen. If there's no other questions, I think we're ready for subcommittee updates. If my mind serves me correctly. Consumer Sub, are you giving it, Kyle or is Danna?
>> KYLE FISHER: I can give the update. Minta can certainly supplement if I miss anything. Before I start, let me just note Sally since I think you withheld some good information from yesterday's meeting, I certainly applaud the Department for adopting the extended 15-day window for timely appeals across the program offices. Very pleased to hear that was adopted and incorporated into the HealthChoices Agreement. Thank you for that. Consumer met yesterday. As I mentioned, we heard from four program offices. Unsurprisingly, we ran out of time. I will limit the recap here to two issues.
With our conversation with the Office of Income Maintenance, we heard about individuals on waiver who had their waiver stopped because of earned income. The consumers flagged this issue in a previous month that too many waiver recipients have not been reviewed for MAWD, Medical Assistance for Workers with Disabilities (MAWD) prior to closure. OIM had taken activity in the last month, and they identified 75 individuals whose waiver was closed since April, on the basis of earnings. They have outreached to those individuals by phone and with letters, informing them that they can elect MAWD and have their coverage reinstated. Very pleased to hear that. We have additional questions around how many of that population have been enrolled and taken up the offer of reinstatement and how many were previously on MAWD seems that is another issue that has come, folks being closed from waiver and MAWD both. We had good conversation with OIM around why so many individuals are not reviewed for MAWD. We learned that there is some data entry complexity involved. Policy has revisited this issue with the Bureau of Operations to ensure extreme clarity for caseworkers on the steps necessary to open someone in MAWD

and waiver simultaneously. There are also some system bugs that are being addressed in the next release of PROMISe™. The consumers recommended that DHS prioritize PROMISe™ changes to add MAWD to the MA cascade. One issue we discovered is relying on caseworker knowledge and manual activity has proven far too inconsistent.

In our discussion with the Office of Long-Term Living, we talked about waiver redeterminations. This is something we have talked about at the MAAC before. CHC waiver participants whose needs assessment by their plan service coordinator has led to a finding that they no longer clinically qualify for waiver, that they are nursing facility ineligible. Consumers have various concerns that this process has been flawed and far too many people are losing waiver who continue to qualify for services. For example, 80 and 90-year-olds whose conditions very rarely improve or who's functioning rarely improves over time have been found and told that they no longer clinically qualify. Data presented by OLTL yesterday showed this impacted a little over 8,700 individuals last year in 2023. Roughly half or over half of those folks had the process stalled. They had not received termination notices yet because their doctors had not returned the Physician Cert, the PC form. One new development or fairly new development. OLTL has engaged Aging Well in the county AAAs (Area Agency on Aging) to do in person assessments for that subset whose doctors haven't returned the physician cert. We have learned that where the AAA has done outreach and have not been able to get in touch with a participant or participant has refused that new assessment, OLTL is working with AAAs on developing template letters to explain what it is and it has instructed them not to terminate the benefit or initiate the termination before OLTL. They're working on a process to work with the MCOs to make sure they have appropriate updated contact information and to explain why this new assessment is needed. I think that's a positive development. We certainly are happy to hear it. I think one limitation here is it's limited to the roughly half of the 8,700 participants whose doctors haven't returned the form. We have some concern that the other half where doctors have returned the form don't have this additional safeguard of the in-person assessment.
I will stop there. The consumers next meet on the 21st of February. Unless Minta has any additions. I can take questions.
>> DEBORAH SHOEMAKER: Anything, the beautiful Minta? Okay.
>> MINTA LIVENGOOD: No, I don't have anything.
>> DEBORAH SHOEMAKER: Good. I'm sure you're glad that MAWD is being reviewed. That's your special interest. I know that. As Fee for Service Delivery System Subcommittee, as the chair, we have not met. We do meet on the 7th. We will be having our planning meeting or agenda meeting for those people who are members on the 1st. I'm sure you have received the information to participate. Long-Term Services and Supports Committee. That would be Kathy. Kathy? Can you guys still hear me? Did we lose Kathy?
>> KAREN LOWERY: We can hear you, Deb.
>> DEBORAH SHOEMAKER: Okay. Did you hear my report about Fee-for-Service? Or did I mute myself?

>> KAREN LOWERY: Yes.
>> DEBORAH SHOEMAKER: Okay. Long-Term Services and Supports Subcommittee. Kathy is talking. She said, can we hear her. No, we cannot hear you Kath. While we're waiting for Kath, do you want to provide your, do you have a report Mike, or your last meeting was before the last meeting?
>> MIKE GRIER: Yep, I can do that, Deb, if you want.
>> DEBORAH SHOEMAKER: That's perfect. When we hear Kathy, she can jump on.
>> MIKE GRIER: Okay. Our meeting follow-ups from our January meeting, we had OLTL give their January updates. Deputy Secretary Juliet Marsala updated the subcommittee with information regarding managed care quality strategies for Pennsylvania and Pennsylvania's Medical Assistance in Children's Health Insurance Programs. She also discussed updates regarding Pennsylvania's 2024-2028 Workforce Initiative and Opportunities Act state plan. She announced that revisions to the three operations memos, on a functional eligibility determination a FED, is needed for a Home and Community-Based Services Waiver application, nursing home transition and new nursing facilities to HCBS transition procedures and when Community HealthChoices, CHC, managed care organizations must transmit the HCBS eligibility, ineligibility in change form PA-1768. Juliet provided an update February -- excuse me, provided an update on the PA Achieving Better Life Experience (ABLE). The ABLE seminars scheduled for January 23rd, January 30th, and February 22nd, which include eligibility requirements for opening a PA ABLE account, the federal and state benefits of a PA ABLE account, and how the PA ABLE account interacts with current benefits.
Juliet briefed the committee on two Office of Medical Assistance Program bulletins. The ex parte bulletin, which informs MA providers how to submit claims to MA beneficiaries whose MA coverage or Medicare cost-sharing benefit have been reinstated due to changes in the ex parte renewal process. The Carr v. Becerra bulletin which informs the MA providers how to submit claims for MA beneficiaries whose coverage has been reinstated because of the United States District Court case Carr v. Becerra.
We also talked about personal assistance services (PAS) reductions. Randy Nolan from OLTL coordinated integrated services. This is a follow-up from the meeting we had where we absolutely had a lot of people's voices heard. He talked about that the CHC MCOs described in the criteria determined a number of PAS hours and how they changed over the past several years.
We also had a presentation on diversity, equity, and inclusion (DEI). Representatives from the CHC MCOs presented an overview of the DEI training and more culturally competent services and care, and expectation for providers. We also went over the women's health initiative. Dr. Larry Appel, the OLTL Medical Director, and representatives from each of the CHC MCOs regarding the women's health, particularly seniors, the key diseases as it relates and affects elderly women such as cardiovascular, osteoporosis, and breast cancer. Our upcoming meeting will be an LTSS meeting scheduled for February 1st. I can answer any questions if there are any.
>> DEBORAH SHOEMAKER: Okay. Yes, I don't know -- thank you so much and for your

service. I don't know, Kathy, did we get you back?
>> ELISE GREGORY: Hi, Deb. Kathy private messaged me, I think she meant to send it to you. Hi Deb, there is nothing to report other than folks can sign up for February's meeting on the LTSS website, the 2024 meeting dates are posted.
>> DEBORAH SHOEMAKER: Wonderful. Thank you. Okay. Last but not least on subcommittee reports would be Joe Glinka.
>> JOE GLINKA: Deb I will be brief for the sake of brevity. We met on December 4th. We got a number of updates from the various offices within the Department. I will spare the details. One of those details, though, was where the newly eligible group is in terms of enrollment. Now this is as of December 4th. That number was 928,654. Certainly, a decline as a result I'm sure, of the unwinding process. We'll keep track of what the number does moving forward. We got an update on ex parte. At the time, the review was half conducted. We heard from Carl today that has been completed. Certainly, great progress made there.
We had a presentation on the 1115 waiver submission that Sally described the and the Department is finalizing to send to CMS. Dr. David Grande and Stephanie Meyer provided some great details on what that submission will entail. For the sake of brevity, I will stay away from that. What else? I think that's really about the highlights. The workgroups that have been created within MCDSS to address provider capacity and complex care coordination are meeting in the months that we do not meet. There should be an update made moving forward with respect to our cadence. It's no longer monthly. It is a bi-monthly cadence. In between, our workgroups are convening to work toward recommendations later on this year in both of those areas. I'll stop if there are any questions.
>> DEBORAH SHOEMAKER: Thank you, Joe. I think people would be interested in getting any updates, written or otherwise, from those subcommittees on the months that you don't have your full meeting, if that's possible. That would be good.
>> JOE GLINKA: We'll be covering progress made by the workgroups at the MCDSS meetings if people are interested in learning more about what those workgroups are doing.
>> DEBORAH SHOEMAKER: Great. And go to the link on the DHS website for that if you want to join. Before -- since we're almost out of time -- remind people that the next meeting will be the 22nd of February. Since the budget does not go -- the budget address is at the beginning of February. We usually do March or depending on March or April is when we do the budget address. Just as a reminder. To close out, MA Bulletins, pharmacy documents, Eve.
>> EVE LICKERS: Good morning, everyone. I will give you the run-down of the bulletins that have been issued since our last meeting.
On December 11th, we had issued bulletin number 01-23-27 to advise providers of the MA Program Fee Schedule updates related to administration codes for COVID-19 vaccines. There have been some various changes to the coding. We wanted to make sure providers were aware. These things had been done on the Fee Schedule but wanted to bring folks up

to date with the bulletin.
Also, on December 20th of 2023, we issued MA Bulletin 99-23-11. That was Carr v. Becerra - Retroactive Reinstatement of Coverage. That was to advise providers how to submit claims, including those that were outside of the 180-day claim submission timeframe for beneficiaries whose coverage has been reinstated because of the Carr v. Becerra court case decision, which required states to restore MA or Medicare cost-sharing benefits back to the higher level of the coverage they had before benefits were reduced. That was based on guidance that we had received from CMS during the COVID-19 public health emergency.

A related bulletin 99-23-12 was also issued on December 20th and that was the Ex Parte - Retroactive Reinstatement of Coverage. That was to advise providers how to submit claims, which included the claims outside of 180-day claim submission timeframe, for the beneficiaries whose MA coverage or Medicare cost sharing benefits had been reinstated due to changes of the ex parte renewal process.

MA Bulletin 01-23-56 was issued on December 21st. It is effective January 8th. That was the Prior Authorization of Hypoglycemics, Incretin Mimetics and Enhancers. That was from the Pharmacy Services.

On December 27th, MA Bulletin 08-24-01 was issued and effective January 1st. That was advising providers that we would begin covering Interprofessional Consultation Services. This was based on guidance from CMS that allowed us to provide coverage of consultations between providers when the beneficiary is not actually present, and the consultation is for the direct benefit of the beneficiary. Previously, that had been prohibited under the MA Program.
MA Bulletin 99-23-10 was issued on December 28th and that was payment for services associated with qualifying trials. CMS had issued some guidance to states advising that the payment for routine cost for services or cost for routine services and items would be covered under the MA Program when beneficiaries were going through qualified clinical trials. The MA Program here in Pennsylvania had been covering these services for quite some time. The bulletin just formalizes the process and also lets folks know what the requirements are under CMS guidance.
MA Bulletin 13-24-01 issued on January 10th is effective February 1st and advises providers that beginning February 1st, the Department will begin enrolling doulas certified by the Pennsylvania Certification Board for -- I'm sorry, certified by the Pennsylvania Certification Board as a Certified Perinatal Doula. We are enrolling them for participation in the managed care delivery system. We have two more. We had quite a few bulletins.
MA Bulletin 01-24-02, Pasteurized Donor Human Milk Coverage Updates was issued on January 19th. This bulletin was issued to advise providers of updates to the coverage conditions for the pasteurized donor human milk, as a result of Act 32 of 2023, which was enacted on November 21st of 2023. Of note, the human milk banks must be licensed by the Pennsylvania Department of Health. Enrollment is not limited to milk banks certified

by the Human Banking Association of North America, referred to as HMBANA. Prior authorization requests will no longer be reviewed using AAP (American Academy of Pediatrics) clinical guidelines that were identified in donor human milk for the high-risk infant preparation safety and usage options in the United States. We are not otherwise changing payment or billing procedures.
MA Bulletin 99-24-01, Medical Assistance Program Vaccine Desk Reference that was issued on January 24th, effective the same day. We have for many years and historically issued separate bulletins about MA coverage of individual vaccines and their administration. To make things easier for providers, we have created a one stop shop desk reference for providers to use for billing for the administration of vaccines. I think this will be a great tool for folks. When there are updates, we will also update the tool. It's available on the DHS website under the link for Providers. It's a provider resource. That is it for now. Thank you and have a great rest of the day.
>> DEBORAH SHOEMAKER: Thank you, Eve. Is there any old or new business? Okay. As stated, the next meeting is the 22nd. Thanks again to Nancy Murray. We will miss you. For an adjournment, if I could have a motion to adjourn.
>> MINTA LIVENGOOD: This is Minta. I make a motion to adjourn.
>> DEBORAH SHOEMAKER: Wonderful. Thank you. Second?
>> TED MOWATT: Ted Mowatt, second.
>> DEBORAH SHOEMAKER: Okay, perfect. All in favor? .
>> UNANIMOUS: Aye
>> DEBORAH SHOEMAKER: No nays. Have a wonderful month. Talk to you on the 22nd. Thanks for everything. Take care. Bye.