>> ELISE GREGORY: Good morning and welcome to the March 2024 edition of the MAAC meeting. Today is Thursday, March 28. My name is Elise Gregory. 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 avoid disruptions, please remember to keep your microphone muted if you are not speaking. Live captioning, also known as CART captions, are available for this meeting. The link is included in the chat. Presenters should state their name clearly before speaking to assist the captioner. Representing the Department of Human Services today, from the Office of Medical Assistance Programs, Deputy Secretary Sally Kozak. From the Office of Long-Term Living, Deputy Secretary Juliet Marsala. From the Office of Mental Health and Substance Abuse Services (OMHSAS), Deputy Secretary Jennifer Smith. And from the Office of Developmental Programs, Deputy Secretary Kristin Ahrens. And from the Office of Income Maintenance, Carl Feldman. If you have any questions related to this meeting or need any information, please visit the MAAC web page. I will now hand things over to MAAC Chair Deb Shoemaker.

>> DEB SHOEMAKER: Good morning, everyone. The time has come to start our meeting. Happy spring although the last couple of days, it doesn't look much like spring, but welcome. Again, my name is Deb Shoemaker. I am the chair for the Medical Assistance Advisory Committee along with the chair for the Fee-for-Service subcommittee. I represent the Pennsylvania Psychiatric Leadership Council. I also am Government Relations Specialist for the Pennsylvania Rheumatology Society and a parent of a child with mental health challenges.

I will go through the roster. Sonia Brookins, my Vice Chair, is unable it make it. She is the Chair for the Consumer Sub. Danna Casserly, are you on the call?

>> DANNA CASSERLY: Yes, Deb, I'm here, thank you.

>> DEB SHOEMAKER: For those who don't know, Danna is one of the council members for the consumer sub. Kyle Fisher is not here today. I will go through the rest of the list. Jolene Calla? Ok I thought I saw Jolene. Kathy Cubit?

>> KATHY CUBIT: Hi Deb, this is Kathy from the Center for Advocacy for the Rights and Interest of Elders and I'm the chair of the LTSS Sub MAAC.

>> DEB SHOEMAKER: Thanks, Kath. Richard? I'm not sure if he is on the attendee side or not. Joe Glinka?

>> JOE GLINKA: Hi, it is Joe Glinka Director of HealthChoices for Highmark Wholecare and Chair of the Managed Care Delivery System Subcommittee. Good morning.

>> DEB SHOEMAKER: Good morning. We missed you last month, Joe.

>> JOE GLINKA: I missed you.

>> DEB SHOEMAKER: Well, right back at ya. Good, I'm glad you're here. Dr. Goldstein? Sorry, I'm looking at the list so I'm not looking at the webinar. I apologize if there is a pause. I just want to make sure I have the correct list. Mike Grier? Okay. Teri Henning?

>> TERRI HENNING: Good morning, Deb. I'm here.

>> DEB SHOEMAKER: Good morning, Teri. Mike, go ahead.

>> RICHARD EDLEY: Deb, this is Richard. Sorry, I was on the other link. Now I'm pulled over. I'm here.
>> DEB SHOEMAKER: Wonderful. As was I earlier. So, I hear you. Okay. I thought I heard Mike Grier as well but maybe not. Heather King? Okay, Julie Korick?
>> JULIE KORICK: Good morning, Deb. Julie Korick with the Pennsylvania Association of Community Health Centers.
>> DEB SHOEMAKER: Thank you, good morning, Julie. Minta Livengood?
>> MINTA LIVENGOOD: I'm here. I'm the co-chair of the Consumer Sub.
>> DEB SHOEMAKER: Wonderful, so glad you're here. Russ is on vacation. Ted Mowatt?
>> TED MOWATT: Good morning, all. Ted Mowatt, Weidner Associates. I'm the Executive Director of the Pennsylvania Association for Home and Community Based Service Providers.
>> DEB SHOEMAKER: Thank you. And Nancy has retired. Deron Shultz? Okay. Nick Watsula? Okay. Mark Yester?
>> MARK YESTER: Mark Yester, I'm the General Pediatrician representing the Pennsylvania American Academy of Pediatrics.
>> DEB SHOEMAKER: Okay. And I'm checking to see if I missed any members so let me know. Just as a heads-up, I'm getting construction done in my house today. Oh, Nick Watsula. So hopefully I will have that to a minimum. Nick?
>> NICK WATSULA: Hi, Nick Watsula here with UPMC. I was muted earlier. Sorry about that. But I am here. Thank you.
>> DEB SHOEMAKER: Wonderful. Thank you. Did I miss any members? Okay, then if I did not miss any members, I would like to...do we have a quorum, Elise?
>> ELISE GREGORY: I have at least 10 at this point. So, I believe we do have a quorum.
>> DEB SHOEMAKER: Wonderful. Okay, the minutes from February meeting should have been distributed through the ListServ. Can I please have a motion to approve the minutes as they were distributed?
>> KATHY CUBIT: This is Kathy, I make a motion to approve the minutes.
>> DEB SHOEMAKER: Thanks, Kath.
>> JOE GLINKA: This is Joe. I second.
>> DEB SHOEMAKER: Thank you, Joe. Ok, all in favor?
>> MULTIPLE PEOPLE: Aye.
>> DEB SHOEMAKER: Any nays or abstentions? I should have asked for the abstentions first, I apologize. Okay. Well as many of you know, this is usually our -- March is usually the month to present budgets. So, the first office we will hear from is Carl Feldman from the Office of Income Maintenance.
>> CARL FELDMAN: Hello, good morning. This is Carl, can you hear me?
>> DEB SHOEMAKER: Yes.
>> CARL FELDMAN: Thank you for having me this morning. I will be here to share some information as you've requested. For those of you on the Consumer Sub MAAC yesterday, you will hear a little bit of the same but that's okay because I think it is all the stuff we want to talk about. I will start by talking about the unwinding information I shared yesterday.

I think the pertinent thing that I expect everyone to have on their minds is the end of the unwinding of the continuous coverage period and that's because March is the final core month of the unwinding. And we will not be extending the unwinding period that Pennsylvania has elected to take, and this will be the final month's renewal cohort for that core period. We have always had set aside, if you look at our unwinding plan on our website, the months of April and May for clean-up of all unwinding activities and that work will likely continue on into June, but all unwinding-related activity will be completed in the month of June at the latest. We think by doing it this way, we are not rushing through the need to process eligibility on cases. This is the fairest way to handle it for our clients and the most reasonable way to handle it as it relates to the workload.

What that means technically speaking, if you had a renewal that was due in, I'll just say before April, so February, March, possibly before that and we have not yet processed eligibility on that renewal, we will continue to take our time to do our due diligence in the processing of that renewal but we expect it to be completed by the month of sometime in June. That's what we are shooting for in terms of our timeline of activities and finalizing the unwinding.

We will continue to have our website available on this at least until June-July timeframe.

We will continue to do renewal unwinding cohort reporting until June, and we will be discussing the continuity of that information along with kind of paying attention to information that CMS (Centers for Medicare & Medicaid Services) communicates about what they want to do with it. We heard a call with CMS that they are interested in extending renewal reporting, but we don't know what that is going to entail so we are just waiting and listening at this point.

I think it was said in other places, but I just wanted to convey that all activity related to the individual ex parte restoration of coverage has been completed and resulted in the restoration of coverage to 45,532 individuals. And when I say all activities complete, that means all of the noticing that goes along with that has been sent. And if someone needs to resubmit a claim for a period for which we are closed and reopened they are able to do that and they have the information necessary to have that claim handled properly.

Then finally, related to unwinding activities, we know that this group, the Consumer Sub MAAC, the IMAC are all very interested in the status of our backlog of hearings and appeals. We had a very large increase in the number of hearings and appeals over 90 days without adjudication going into the end of the calendar last year but subsequently managed to complete a really big effort to work down that figure to the lowest that it's been throughout the unwinding. We are now under 200 appeals with over 90 days without adjudication. Like I said, that's the lowest it's ever been and at this point in time, because of that success, we're not interested in taking a waiver that we were looking at and discussing with CMS which would extend the timeframe to have hearings and appeals adjudicated.

And in terms of how that was accomplished, we had new ALJs (Attorney Law Judges) join, and that opened up hearing slots and BHA (Bureau of Hearings and Appeals) hired temporary clerical staff - BHA is our hearings and appeals unit - to help close out cases that were really already acted upon. And maybe somebody withdrew and maybe adjudication

was actually done by a judge but paperwork closing that out was not completed. BHA's vendor, FHA (Federal Hearings and Appeals) was given greater access to our data systems to do data entry and assist, which helped quite a bit. And of course, we authorized overtime. And we had pretty close monitoring over the entire period. So that is the information that the appeals unit conveyed to me. I'm speaking for them a little bit but any time we talk about a big spike in appeals and work done, that is definitely understandable to want to have a better sense of how that happened and that's the information that we have to share with you about it. I think that's the unwinding update. Are there questions that you have for me about unwinding related activities.

>>DEB SHOEMAKER: Any MAAC members have any specific questions? Minta? Okay. Maybe you addressed a bunch. I missed the consumer subcommittee meeting. I know there's been a lot of discussion related to a lot of the ex parte and other things. Anyone have any questions before Carl continues? Any in the chat Elise?

>> ELISE GREGORY: Yes. One question from Tia Whitaker. Has there been additional efforts to increase the ex parte rate?

>>CARL FELDMAN: Thank you for that question. I think there have been additional efforts to increase the ex parte rate over the course of the unwinding period. This started when we entered into the mitigation at the beginning of the unwinding around ensuring our workers completed back-end ex partes for cases that would have otherwise closed and approving cases if the only thing outstanding was a signature.

Then in the summer of 2023, we added system updates to loosen string matching requirements and make it easier for FEIM matches to occur. Those efforts were put into place. Then, of course, in the August timeframe, the activity wanted to do a mitigation to ensure our workers are doing ex parte activity at the individual level was a major shift and required a lot of new activity on our part manually.

But also, the individual restoration of coverage was a significant undertaking over several months to restore coverage based on our ability to conduct ex partes. As we wrap up the unwinding period with all of this new policy that's been issued, I think we have said before in other places that we expect in September to have new capabilities for our system around ex parte that will allow us to conduct ex partes for combination cases which was a big obstacle for us to do systematically before. This means that if you have Medicaid and SNAP on the same case, today and up until the time the release comes out in September, you cannot do a system-driven ex parte. That has to happen manually. But as of September, those ex partes will be capable of occurring based on computer matching and we hope that will take some effort off of our County Assistance Offices and will just overall result in better customer service.

>>DEB SHOEMAKER: I do have a question. I was thinking about a couple of things, and I was trying to formulate my thoughts, if it's okay, Carl. And one, these may be on the dashboard. I didn't get the chance to look recently but do we know the numbers of those found ineligible that actually went to Pennie and received, you know, new insurance through the Pennie system?

>>CARL FELDMAN: Yes. I think that Pennie reports on this at their Pennie board meetings. And I would need to kind of look at their information. I also think that if you are to look at our unwinding web page, we have a number of kind of statistics about outcomes related to the unwinding, and Pennie transitions, I believe, is one of those. So, I think I would encourage you to look in those places.
>>DEB SHOEMAKER: Okay. That would also have information about how many people were transferred to MAWD or SNAP or TANF (Temporary Assistance for Needy Families) or any of those or have received information to have as an alternative program?
>>CARL FELDMAN: Well, we do show transitions to alternative programs. So, we would have information on transitions to Pennie and we have information on transitions to the CHIP (Children's Health Insurance Program) program. We don't have information on transitions within the Medical Assistance program and SNAP is totally separate, so a person's SNAP eligibility isn't necessarily contingent on their Medicaid eligibility.
>>DEB SHOEMAKER: Do we have MAWD on there?
>>CARL FELDMAN: If they are eligible for MAWD, they are not losing coverage. It just says that the person had a renewal, and their eligibility continues which is what would happen if someone transitioned from regular Medical Assistance to MAWD. So, it doesn't indicate, these are all of the people who moved from a non-MAWD category to MAWD, it just says that these are all of the people who are in Medical Assistance whose eligibility continued. >>DEB SHOEMAKER: Okay, I will look at the dashboard and that will probably answer all my questions. Do you have more to report on for your presentation?
>>CARL FELDMAN: I was asked to share additional information around MAWD and if you're ready for that I can talk about that.
>>DEB SHOEMAKER: Since I opened the floodgates anyway, you may as well talk about it. >>CARL FELDMAN: Okay. So again, repeating myself from yesterday, but I think is good to discuss, there were about 75 individuals who were on home and community-based services (HCBS) that had a closure due to earned income who we did a re-evaluation of to see if they could shift to MAWD when they did not, when they closed. And of those, 26 were identified to need to be reviewed for MAWD and 12 of them couldn't be reached on the phone. Everyone got a letter, so they have the ability to come back in the door based on the letter sent and have their coverage re-established back to the date of closure. For the 26 who I referred to earlier, 13 have not been reopened for MA. That means they didn't respond to the letter. One has been opened but does not have a waiver at this time. Eight of them are open in waiver coverage and seven of them are open in base funding. There is another group of individuals who are still enrolled actually in HCBS. I don't know if it was because of our letter or because they just appealed or asked for reconsideration. 24 of those individuals are still in HCBS, nine moved to Act 150, and 7 are in another category of Medical Assistance. Kind of a wide range of activity within that 75 who we did outreach to and at this point, all of the activity related to that is complete.
There is a letter that we have going out to the non-HCBS population, about 2,000 individuals, which says essentially the same thing as the letter which went out to individuals receiving HCBS. If you cooperate with us and need verification in which to have

eligibility re-established, we will open your coverage back to date of closure. The letter has not yet been sent but it is in the development process to be sent and they will have a month from the date of the letter being sent to have their coverage reestablished.
>> DANNA CASSERLY: Carl, thank you. This is Danna Casserly with the Health Law Project. Can you just clarify on the last piece, who is getting that last letter that is about to go out?
>>CARL FELDMAN: When we first started talking about this, there were two groups of people who this group was interested in. There were people who were closed for earned income and had a disability that were receiving HCBS, and which we understood that to be the priority of this group because their personal assistance services or other waiver services were important to their activities of daily living. Then the secondary group which has certified disability, closed for earned income but they are not on a waiver case because maybe they are not eligible for a waiver or maybe didn't need a waiver, but they too could potentially transition to MAWD, so we have been working on reaching out to them as well. There is about 2,000 of them. They will be getting a letter that says something similar to what the HCBS letter says.
>> DANNA CASSERLY: Thank you very much. I appreciate that.
>>DEB SHOEMAKER: Any other questions for Carl? Okay. Did you have more Carl? I just started to say, do you have any questions. That was not very nice of me to ask.
>>CARL FELDMAN: Those were the two items I was asked to share information on. I don't have anything else to share. But I'm happy to answer any questions that the group has.
>>DEB SHOEMAKER: Okay. MAAC members? Any questions before Carl is done today? Any in the chat, Elise?
>> ELISE GREGORY: There are no additional questions at this time.
>>DEB SHOEMAKER: Wonderful. Thank you, Carl.
>>CARL FELDMAN: Thank you all, have a good day.
>>DEB SHOEMAKER: You too. Next up, Deputy Secretary Kozak. Hello, Sally.
>>SALLY KOZAK: Good morning, everybody. So today I'm going over the OMAP budget for you. If we can go to the next slide.
Before we start, OMHSAS and OLTL will present their budgets separately. I am just talking about the OMAP budget. As you can see, this slide represents the 24-25 OMAP budget that has been proposed by Appropriation. The total proposed amount is $28.3 billion, representing a 4.7% increase from fiscal year 23-24 budget and that is about $1.3 billion. You can see the break down there, Capitation represents about $23 billion. CHIP is $399 million. Fee-for-Service is $2.8 billion. Our part of the Medicare part D is $1.1 billion. And MATP is $164 million and Other is $637 million. I will talk about all of these a little bit in the upcoming slides.
But in the Other appropriation, what is included in that is uncompensated care, academic medical centers, expanded services for women, the Medical Assistance for Workers with Disabilities or MAWD, our trauma center payments, burn center payments, critical access hospital payments, obstetric and neonatal service payments as well as physician practice plans. If we can move to the next slide, please.

The Capitation appropriation proposed for fiscal year 24-25 is $23.1 billion, which represents a 6.7% increase over 23-24. It is important to note that the Capitation appropriation consists of physical health, behavioral health and maternity care payments and physical health makes up approximately 75% of total capitation appropriation. You can see there that we had the state and federal splits for 23-24 and 24-25. We also have the difference in the percentage there. You can see the split of federal funds that we anticipate, and you can also see other funds in this line as well.

The Other funds referenced on this slide that contribute to appropriation includes funds from MCO (managed care organization) assessment, the statewide hospital assessment, as well as the ambulance intergovernmental transfer.

Overall, the state funding per capitation increased because the PHE (Public Health Emergency) ended on May 11th of 2023, and the enhanced federal funding phased down in increments through December 31st of 2023. Other factors that resulted in increases include increased utilization as well as an increase in state directive payments. If we can go to the next slide.

So, this is the Fee-for-Service appropriation. Again, for fiscal year 24-25, it is $2.8 billion that has been proposed and this represents a 12.3% decrease from fiscal year 23-24. I will note that does not mean that there has been any decrease in services. The reason that the Fee-for-Service funding decreased is because of impact of nonrecurring payments. There has been the shifting of our academic medical center payments from Fee-for-Service to the Capitation appropriation. And we have also shifted our disproportionate share hospital or DSH payments into our managed care capitation in anticipation of the impending DSH allotment reduction. You can see the breakout of state funds just like on the previous slide as well as federal funds that are attributed to this appropriation and other funds. Again, other funds for Fee-for-Service include the Philadelphia hospital assessment, the statewide hospital assessment, the FQHC alternate payment methodology intergovernmental transfer, as well as the hospital intergovernmental transfer. And just to note, that is only for the 23-24 portion of the budget.

If we can go to the next slide, we will talk about MATP. The MATP appropriation for 24-25 is $165 million, which represents a 3.8% decrease over 23-24. And the reason for that decrease is because again, the PHE ended on May 11th and the enhanced federal funding was phased down in increments through to December of 2023 which resulted in a shift from federal funds to state funds. We have a projected increase in MA (Medical Assistance) eligibility and projected increase in trips for fiscal year 24-25. The state funds also include $4 million in lottery funds for MATP.

CHIP appropriation is proposed at $400 million which represents a 15.5% increase over 23-24. The increase is because we projected increase in eligible children. For fiscal year 24-25 we anticipate enrollment at around 174,000 which is an increase of approximately 28,000 more compared to calendar year 23-24. Folks may recall that immediately prior to the public health emergency we started to see an increase in our CHIP enrollment and so, we expect that we will continue to see that going forward. And also, that funding is showing the impact of a full year of eligibility determinations. The cost of CHIP represents children

who lose eligibility for Medicaid who continue to be eligible under the CHIP program. You can see the break down again of state funds, federal funds, and other funds. And other funds on this slide are the MCO assessment and the vision services donation which is the vision to learn initiative. Next slide.
So, this is the breakdown of all the other appropriations that I talked about for 24-25. It's $638 million which represents 8.2% increase over fiscal year 23-24. The primary driver for this is MAWD and the reason it's driving it is because we project an increase of enrollees in the MAWD program, and we also have a projected increase in the MA Program monthly service cost per enrollee. In addition to all of these hospital payments, OMAP continues to administer the uncompensated care fund which is through the tobacco settlement act. Next slide.
Also included in the proposed budget are the mandated dental services increase. They will begin January 1, 2025. That will be done through our managed care program and that will be done with a uniform percent increase. There will be 31 dental codes that will be identified as part of that.
And that's it. That's the OMAP budget. Little bit of a streamlined version from what we have been doing in previous years. So happy to answer any questions that you might have.
>>DEB SHOEMAKER: Okay. Any questions from MAAC members? You might luck out, Sally.
>> SALLY KOZAK: That would be different, wouldn't it?
>>DEB SHOEMAKER: I know. I'm shocked. Anything else in the chat while we're waiting for a question? Not that I'm forcing you to.
>> ELISE GREGORY: There are no questions in the chat at this time.
>>DEB SHOEMAKER: Oh, my word, Happy Easter to you, Sally.
>> SALLY KOZAK: I was going to say, it's like Christmas in March.
>> DEB SHOEMAKER: That'll work too. Well, I guess you did such a good job that no one has questions.
>> SALLY KOZAK: That's good that we have extra time for folks about the upcoming presenters then.
>>DEB SHOEMAKER: We'll see. We always go beyond. So, we will see. I hope you're right. Thank you, Sally. Have a good holiday. I will talk to you or see you next month.
>> SALLY KOZAK: Okay. Thanks, Deb.
>>DEB SHOEMAKER: Thank you. Okay. Next on the -- and for those in the audience that maybe did not see in the chat, we will have the handouts available after the meeting. I think on the website and probably the ListServ. That was in the chat earlier. I don't know if that went to presenters and attendees. Next on the agenda, can you put it back up, because I know sometimes, we go out of order. So, I know what is next on the agenda. I believe it is ODP, correct? Or OLTL. Okay, it got moved around this time. Okay OLTL, Deputy Secretary Marsala.
>> JULIET MARSALA: Good morning, everyone. Ready to present on OLTL and I will add something to the updates that I'm excited about that was shared at the Consumer Subcommittee yesterday so I apologize to those folks who may hear it again. If we go

ahead a couple of slides, we will do our usual procurement status then give the update on participants self-direction then go very quickly into the budget. Not too much today. So, if we can move forward. Great.

So, these are our current and active ones and there are no updates. Any updates are on the eMarketplace, and so these are ones that are in a black out period. Go to the next slide.

Before I get into the budget, actually, I'm going to be adding just a little commentary about our participant self-direction. So participant self-direction, as many of you know, is the model whereby participants can hire their own attendants and be the employer for their personal care services. It provides the most flexibility and empowerment of our Home and Community-based personal care models and is offered as the first choice of model to participant.

However, over the past couple of years we have seen a continued decrease in the utilization of participant directed services. So, we formed a work group of participants and direct care workers, service coordinators, managed care organization representatives and the fiscal management services vendors and state staff. And they convened a work group to really take a look at participant self-direction, services, operations and come together with their top 10 recommendations to forward to us at the Office of Long-Term Living so we can sort of build a roadmap and move forward with strengthening and supporting that very important model.

As soon as we're able to upload things again to our websites, we will be sharing that report publicly and talking about it more. But I did want to share that that work group has concluded and thank you to all of the folks who participated for their efforts and recommendations that they put forward. So, I will certainly make sure that the members of the MAAC have that report and that link, but wanted to highlight it here before we talk about the budget. Any questions on that?

So very quickly on our budget. If we go to the next slide. The way we did our budget, just so for general awareness for folks, when we talk about the Community HealthChoices (CHC) budget, that reflects the actuarially sound capitation rates for the continuation of the statewide operations for CHC. It includes some of the anticipated changes that Deputy Secretary Kozak mentioned before. When things impact the state plan, it also impacts our plan and waivers as well.

For the LIFE programs, Living Independence for Elderly Program or PACE program, what you see is a slight increase there, that will account for including an additional 180 older Pennsylvanians who we expect to enroll and increase that enrollment in those life programs. That's the underlying assumption. And so, across all of our programs, as we look into the numbers, you are also going to see that we are assuming modest increases in utilization and cost of care across our CHC program, our LIFE program, and our Fee-for-Service programs which do include the OBRA and Act 150 waiver, so we have some assumptions for modest increases in those programs as well. Again, these are more of cost to carry the programs and not significant initiatives contained within. So, if we go to the next slide.

What you will see here is sort of a pie chart of our overall budget spend for the $15.3 billion that we have put forward as proposed for appropriation. And it includes, you know, different funding sources including our state funds, our matching federal funds, funds from the lottery, tobacco, and other augmenting revenue. So, you will see here, as many well know, that the majority of our budget proposed is to be allocated to the CHC or capitated long-term managed supports. And I will go into those in more depth in the next slide.

So, if we go to the next slide, you can see here, this is our CHC proposed budget and how it breaks down between state funds, matching federal funds and our other funding buckets. You will see a very slight change from last year to this year. So, this year the proposed appropriations is $14.875 billion over last year's $14.585 billon. So that is a change of $290.1 million and represents approximately a 2% overall increase and most of that is accounting for the increased utilization that we see and services such as personal assistance services for the members served and accounts for predominantly enrollment changes and other elements that impact services that were actuarially reviewed and put together through the rate determination process.

If we go to the next slide. What you will see here is our Long-Term Living other services, the Medical Assistance Fee-for-Service programs, our OBRA waiver and our Act 150 programs together. What you will see here is a slight decrease for this year in compared to the year prior. Part of this is due to certain enrollment trends and utilization trends, and so it is a decrease here. But again, this is a budget that aims to do the cost to carry. It is really maintaining the program overall from this year to the next and what is needed from that.

And if we go to the last slide, or the next slide, rather.

This is the long-term care managed care portion. This is the portion that is proposed to be appropriated for our LIFE programs which is the national PACE model. As you can see here, the proposed amount is $395.1 million. And that is a slight increase over last year of $3.6 million. And that increase is to account for predominantly our anticipated increase in enrollment of members into LIFE, as I mentioned before, we are anticipating and assuming approximately 180 additional individuals maybe enrolling in the LIFE program. So again, these are our proposed estimates, and again, it is very streamlined, but I will stop there to see if there are any questions.

>> DEB SHOEMAKER: Does any MAAC member have any questions?

>> RICHARD EDLEY: Yeah, this is Richard Edley. My question is with a lot of these dollars moving around, as you know, among the long-term care providers that we represent, are the brain injury providers or the providers who specialize in brain injury. Is there any sense that any of the dollars could be earmarked for them? As you know, they have not had a rate increase. There's been program closures, agency closures. I know it is a small group but still it is an important service. Just wanted to get your sense of that.

>> JULIET MARSALA: Yeah, absolutely, Richard, thank you for the question. We certainly recognize the importance of all of our providers and the services that they provide to our participants within our programs.

As you know, in this year, the Governor has directed us to do an HCBS rate study. And in

preparations for sort of future needs and truly understanding the cost of those services. So that rate study will be under way. It will include a study for residential rehabilitation. It is a study focused on our Fee-for-Service programs.
As you know CHC is a capitated program so within that capitation, MCOs can set and evaluate their own rates for residential rehabilitation services for the brain injury folks. And so, you know, certainly the MCOs could take a look at that. We don't kind of involve ourselves so much in the rate settings that they do with their provider networks or any alternative payments pieces.
So, I mean, certainly there could be that possibility that the MCOs would have to look at. But we are excited to embark on the HCBS rates studies for various services this next year and we are really eager and hopeful to get that study done in partnership with the providers prior to the budget process for the next fiscal year.
>> RICHARD EDLEY: I appreciate that. That is an important step. I just would like to go on record at the MAAC that there is also an immediate need. When you have literally agencies going out of business and programs closing and people not able to get service, I would say that the CHC-MCOs are not doing their job. I know you don't want to get involved in rates. All I would ask is that you meet with them and say, fix it, and see where that goes.
>> JULIET MARSALA: I really appreciate that, Richard. We are also waiting on data from brain injury providers. Our staff is committed to looking at individuals in a recent meeting with trade association, it was noted that the providers were aware of numerous individuals who are waiting for services which was particularly alarming for us. The number of individuals that were shared was quite higher than what OLTL was aware of. OLTL and CHC does not have a waiting list for services. And so we have asked and are working through with the brain injury providers in particular for them to share the individuals they've identified so we could take a look at all of the lists that providers may have, sort of referral lists, that they may have so we can dig down into each of those individuals and follow up with MCOs to kind of both verify that there are individuals waiting for these services and why aren't these services being met if that is the case. We did have one provider share a list with us previously that my team worked through, which included a combination of, I think three individuals in CHC that we were following up with. But also included individuals that were not eligible yet for CHC. We are really trying to get a deep understanding, and it certainly is a very important focus for us.
>> RICHARD EDLEY: Thank you. And I don't want to belabor this, I know we have a big meeting. But I want to point out to the group listening in on this. Part of the problem is the way the process works is say a person with a traumatic brain injury contacts one of our providers and the provider knows very well they don't have the staff or funding. They can't serve them. But technically, you are right, Juliet. You don't know about them and the MCO doesn't know about them. But they feel ethically to say you need to go through enrollment process, the evaluation process, get with the MCO, get referred to us and then we will tell you no. And now there is a wait list. It is a strange process, but we will get you all of the names and go from there.

>> JULIET MARSALA: We appreciate that. Again, we agree that people should get the services that they need. And the Managed Care Organizations with CHC are responsible for ensuring there is a provider network to meet those needs. So, that is, we have a shared interest in urgency of this matter.
>> RICHARD EDLEY: Thank you.
>> JULIET MARSALA: Yeah.
>> DEB SHOEMAKER: Thanks Richard. Any other questions from members of the MAAC? Okay. Well, waiting for that list. Any on the chat, Elise?
>> ELISE GREGORY: Yes. We have two questions in the chat. The first is from Mia Haney. The first slide said OBRA and Act 150 would expand the number of recipients but then the subsequent slide showed a decrease by $72.6 million and suggested lower enrollments. Can you please comment.
>> JULIET MARSALA: So, the, let me go back and look. The Long-Term Living line that you see the decrease, that includes both Medical Assistance Fee-for-Services, that includes long-term care Fee-for-Services, Nursing Facility services, OBRA and Act 150 programs. The reason you see the decrease is there are other kinds of funding that are ending that aren't necessarily tied to OBRA and the Act 150 programs. So OBRA and Act 150 programs as you know serve a very small number of people. So, when you take everything together, the other funding changes outweigh increases that would be in the OBRA and Act 150 programs. But the OBRA and Act 150 programs do have an estimate for the similar increases in utilization.
>> ELISE GREGORY: They say thank you. The next question is from Jeffrey Iseman. Will the OLTL rate study include components not included in prior studies such as EVV (Electronic Visit Verification) requirements passed in 2016 and the need for PPE (Personal Protective Equipment) related health safety costs and supplies? Our understanding is these would not have been part of prior OLTL rate reviews done over 10 years ago.
>> JULIET MARSALA: Great question, Jeff, I appreciate the question. When we undertake a rate review, we are doing it with actuarial soundness as well. That will take into account sort of administrative costs and often times administrative costs include the costs of additional supplies like PPE and additional operating requirements such as EVV. So, I would say, yes, absolutely they are accounted for. As we will go through the process and looking at sort of direct services and looking at labor and looking at administrative costs that are direct and indirect costs. And we will look to partner with our providers to ensure we have our assumptions aligned there.
>> ELISE GREGORY: Jeffrey says thanks. No more questions in the chat at this time.
>> TERI HENNING: I would like to ask a quick question.
>> DEB SHOEMAKER: Yes, you may.
>> TERI HENNING: Thanks for the information about the rates, Juliet. Is there an opportunity for stakeholders, providers, or others to participate or provide feedback or be involved in any way?
>> JULIET MARSALA: Yes. So, our intention, as we are putting this together, we have two intentions here. One is the need for speed to get this done so we can get the information

over timely for the next budget processing. We think that is essential if we are going to be able to kind of make the case for asking for additional appropriations to address the need to fund providers within our systems. And address any kind of rate adjustment. So that time schedule is of the utmost importance. We also really want to have stakeholder engagement. I know I was part of the stakeholder engagement of the rate review 10 years ago and it was quite significant. And we intend to engage our providers and our stakeholders in the process and most definitely at the front end as we are kicking things off and probably throughout.
But unfortunately, what is not, what is going to be different from the last time we did this, you know, because of the constraints of time and wanting to get this done prior to the beginnings of the budget development next year, we're not going to have the same kind of robust side by side stakeholder engagement that we would ordinarily like to do. Because in order to do that, it would considerably extend the rate review process at least for this initial one and certainly hopefully, I know there is a lot of work around educating legislators about the benefits of doing this type of study continuously. So, there is right now and there is the hope that we can do this ongoing.
>> TERI HENNING: Thank, Juliet. If we want to ask providers or other stakeholders to participate, when do we expect the opportunities will begin?
>> JULIET MARSALA: We're in the beginnings of designing that. We will be reaching out and notifying folks of that process through our usual channels. OLTL has ListServs that go out to all of our provider groups that sign up for the ListServs. So, I would highly recommend that folks if they have not signed up for the OLTL ListServs, that they do so. They can certainly reach out to us, and we can provide support for that. We will also let all of our trade association partners know as well. So, we will be sure that it is kind of the opportunity is announced widely.
>> TERI HENNING: Thanks.
>> JULIET MARSALA: You're welcome, Teri, thanks for the questions.
>> DEB SHOEMAKER: Any other questions from MAAC members? Okay. Thank you, Deputy Secretary Marsala.
>> JULIET MARSALA: You're welcome.
>> DEB SHOEMAKER: Okay. Next on the agenda, is Deputy Secretary Smith from the Office of Mental Health and Substance Abuse Services. We will try to change that. That is a story for another day.
>> JENNIFER SMITH: That is a story for another day. Thanks, Deb. You can hear me, okay?
>> DEB SHOEMAKER: Perfect.
>> JENNIFER SMITH: Great. Well good morning, everyone. I hope everyone is doing well this morning on a Thursday. I'm anxiously awaiting warmer sunnier weather as I'm sure we all are. So, let's get started. If you could flip to the next slide for me, please. I'm going to first cover budget issues, which was requested by all of you and then I have one final slide about an update that’s something unrelated to the budget. So, we will walk through the budget first.

My presentation is a slightly different format from my colleagues in OMAP and OLTL. I will start off by talking specifically about some proposed increases that were in Governor Shapiro's budget address. There was $5 million proposed to develop or expand emergency behavioral health walk-in centers. So, the idea is that there would be five $1 million awards to either counties or regions to develop or expand existing walk-in centers. So, this $5 million we know is certainly not comprehensive enough funding to actually build up the capacity of walk-in centers that we need in Pennsylvania. However, the really great thing about these dollars is that they are state dollars, which means they don't come with some of the federal limitations that we have on most of our other funding streams. So, for example, federal funding often does not allow you to spend dollars on bricks and mortar so you can't build something or lease something. Whereas these state dollars would have the flexibility to spend on those types of things. So, the idea is that this would sort of be a one-time infusion of dollars to renovate properties, purchase properties, do what you need to do to sort of expand or start up new walk-in center operations with the intention that then once those services are established there are other sustainable mechanisms to pay for the ongoing support and operations of the facilities.

The second item is about $5.8 million for community forensic projects. I think most of you probably know we have a pretty lengthy list coming from counties of proposals to create community capacity so $5.8 million will dip into that list. We certainly would be happy for the general assembly to give us more than $5.8 million but, we do believe we could probably do a number of projects that would give us at least about 38 additional community slots. So, anything more than $5.8 million that we would get from the general assembly will just increase that number.

This middle bullet is probably the one that folks are most familiar with and excited about. And this is a continuation on the Governor's commitment from fiscal year 23-24 when he proposed, and the general assembly approved, an additional $20 million for county base funds. So, during his budget across last year, he had proposed $20 million last year and a commitment to propose an additional $20 million the following two years. So, he is making good on that commitment for the 24-25 year. This would be an additional $20 million on top of the $20 million that came in the current fiscal year in 23-24. There have been some questions to us around the allocation of that base funding. So just to be clear with folks on the phone, we are statutorily bound by the current allocation so if the General Assembly gives us the authority to alter that allocation, we would certainly do so, but we would need statutory authority in order to change the county allocation formula.

Next are CHIPPS. For those not familiar, CHIPPS stands for Community Hospital Integration Project Programs, a very lengthy title. So, there is $1.6 million in the 24-25 budget to create an additional 20 CHIPP slots. Our budget also includes a sustained $2.5 million for the annualization of prior year CHIPPs. So as of the 23-24 fiscal year, there was a cumulative investment in CHIPPs of $299 million for a total of about 3,600 CHIPPs slots. So, every year when we dedicate additional funding to CHIPPs, that continues to add on to the CHIPPs that are then annualized year over year.

And last but not least, $10 million dedicated to support our 988 call centers. And this money was put in for a couple of reasons. One, because our call centers are currently predominantly federally funded. And you know, we are uncertain as most states are about what will be funded in the upcoming federal budget and whether or not that funding will continue. So, this $10 million is a little bit of a cushion or assurance that if the federal funding would go away, we would still be able to support those call centers. It is also in the budget because many states have moved to a more sustainable method of funding their call centers through some version of legislation. You know, many of them are looking at emergency fees added to cell phone bills, similar to what you would see for a 911 surcharge.

Pennsylvania had some legislation both in the house and the senate last session that was proposed and discussed that never really got across the finish line. And so absent that kind of sustained funding source for our call centers, the governor wanted to ensure that we had the money available to fully support those call centers through 24-25. And the hope is that we do get some legislation, hopefully this calendar year, that will provide more sustainability for those services. Okay. You can flip to the next slide.

So, the first slide there were notable increases to the budget. This is more in line with what you heard from the other program offices just in terms of a quick recap of what our budget looks like. So, we've got $5.65 billion dedicated to Medicaid funding and that includes both the HealthChoices program as well as the Fee-for-Service. Obviously HealthChoices is the largest percentage of that $5.6 billion.

Then we've got a little over $75 million that encompass various federal grants. So that would be where the community mental health services block grant falls. There are also several other types of federal grants that we would receive from SAMHSA (Substance Abuse and Mental Health Services Administration). You can see in the notes that over 50% of those dollars are allocated directly out to counties. And then others of it are used for administrative purposes within OMHSAS and then we put out grant opportunities for RFPs (Request for Proposal) or those kinds of things.

Then we've got $557 million for our 24/7 facilities. That is our six state mental hospitals and one long-term nursing care facility. And this of course, includes, covering personnel, operating, fixed assets, all costs associated with those facilities and that does include both the forensic and the civil populations in those hospitals. Next slide please.

Then we've got $1.4 billion dedicated for the bucket I'm referring to as community mental health services and this incorporates a number of different types of programs. So, county base funds which I had mentioned on a previous slide, the governor is proposing another $20 million increase to this line item. Over 98% of these funds are allocated directly to counties. There is just a really small percentage of those funds that comes to us that we have to use in terms of staff time for collecting reports from counties, and you know, data collection reporting, that kind of stuff.

Then we've got a children's services line item and the full amount of that is allocated directly out to counties. We have the CHIPPs again, total amount of CHIPPs is allocated to counties. The SIPPs (Southeast Integration Projects Program), same amounts being

allocated directly to counties. No overhead goes to OMHSAS for administering those.
We have specialized residents for homeless with mental illness. This is a handful of counties that participate in this program and that total amount is also allocated directly to them. And then, BHSI (Behavioral Health Special Initiative). Again, a total amount allocated directly to counties. The reason that I kind of put those notes there in italics is because I wanted to be really clear. Despite this bucket of funds being over a billion dollars, there is very little allocated for the administration of those monies. That is very important because that means almost all of the dollars are going directly to the communities that are working to build up these programs and to offer services and contract for services. So, it is really important that folks understand we're focused on ensuring that the dollars actually get out to build programs and provide services for the consumers that need them, and you know, they aren't squandered or held within state government by any means.
Next slide, please. We have the Special Pharmaceutical Benefit Program. This is $500,000 flat-funded from the last fiscal year. This program is for individuals who are not eligible for pharmaceutical coverage through MA and it provides payment for certain medications. If you are interested in what those certain medications are, I can provide them but probably better to do so in writing than me attempting to read them because some of them are difficult to pronounce. And we collaborate with aging on an MOU (Memorandum of Understanding) to administer this particular program.
Then we've got the community drug and alcohol services for $53 million. This is an allocation to counties to pay for certain drug and alcohol related services. Next slide, please.
So, there is a slide that I wanted to give some updates. It is not budget-related but important updates that this group very frequently asks for. So, the status of our crisis regulations is that they are still within internal review within DHS. These are, I'll call them a new package of regulations. We do have some type of crisis guidance out there.
But this is a relatively new package. It is based on SAMHSA's best practices for crisis services. So, we are continuing to review those and ensure that we feel like they are in the best possible place they can be. Still fairly early in the review process. The PRTF (Psychiatric Residential Treatment Facility) regs are getting much closer to being submitted to the Independent Regulatory Review Commission (IRRC) which is sort of that last step in terms of looking for approval for regulations. They are going through a signature process right now at those very end stages before they will be submitted to the legislative bodies and IRRC.
And then, just a note about telehealth discussions. We continue to have really robust and important discussions with all types of stakeholders around telehealth policy. We have now had two sets of webinars where we've met with counties, managed care organizations, payers, providers, and consumers to specifically talk about what the needs are, what they're seeing. You know, what they feel is clinically appropriate for folks. How do we ensure choice and all those kinds of sort of difficult conversations. I think we are working towards very positive short and long-term goals to address telehealth. What we are also doing sort of behind the scenes is working with some of our sister agencies in the

Commonwealth to try and ensure that there is some consistency across the Health and Human Services agencies as we begin updating regulations, issuing new policies, you know, maybe doing State Plan amendments. We just really want to be sure that we are all on the same page about the goal that we are moving towards what we want it to accomplish and trying to get all of our policies, procedures and regulations updated to be consistent in that way. So really important conversations and discussions continuing on telehealth.

Then a quick update on the 988 and our call centers. So, the last several months we had been at 89% in-state answer rate, and we slipped just slightly to 88% last month. But there are some changes in the pipeline that we believe are going to increase that rate. For example, we have two new call centers currently going through the onboarding process, Lehigh and Lenape Valley. They are anticipated to be live by July. In the meantime, we continue to make some tweaks to call routing to ensure that call centers that are fully staffed are accepting calls and those that aren't are able to shift some of the call volume around. Really trying to work towards that SAMHSA goal of a consistent 90% or higher in-state answer rate. Okay, last slide.

I wanted to make folks aware of a cross agency initiative that we've been working on in the area of substance use disorder. So, an emerging issue that has been bubbling up really across the nation. Pennsylvania has been fortunate to not experience it to the same degree that some other states in our region are but, it is an issue that individuals on medication for the treatment of their opioid use disorder have difficulty obtaining that when they go to a pharmacy. What is happening is because of some DEA (Drug Enforcement Administration) policies and regulations around how much of a controlled substance pharmacies can have in their possession; pharmacies are reluctant to exceed some of those requirements when it comes to ordering and that often means they can't meet the demand of the clients that are coming into their pharmacies seeking the dispensing of this medication.

So, there is work happening nationally. I know the DEA put out a letter not too long ago and maybe a week or so ago, sort of clarifying for pharmacies that they certainly should be ordering and stocking as much as the demand requires. But we are not going to rely solely on that communication to make a difference in Pennsylvania. So, we are working with folks in the Medicaid program and OMAP and working with the Department of Drug and Alcohol Programs (DDAP), State Board of Pharmacy and keeping the DEA in the loop to create some educational materials that will specifically target pharmacies and provide education on what they can and should be stocking and dispensing to ensure that Pennsylvanians who need access specifically to Buprenorphine to treat their opioid use disorder can have access to it as quickly as they need it. Just wanted to give folks an update on that and I believe that is the end of my slides.

>> DEB SHOEMAKER: Thank you, Jen. Quick question and thank you for your work on the Buprenorphine stuff. It's always appreciated, and you were always a leader, even when you were over in DDAP so that is very appreciated that you support the expansion of medication assisted treatment like that.

>> JENNIFER SMITH: Thanks.

>> DEB SHOEMAKER: I have a question -- well actually, it is one that I'm not sure you can fully answer because it is about the Behavioral Health Counsel. Related to the Behavioral Health Council, I know there is family members and consumers on there, but do you know if there is going to be more of an intentional effort to get consumer and family input on that council?

>> JENNIFER SMITH: Yeah. Good question, Deb. So, you're correct. There is representation from families and consumers. There are three individuals specifically that meet that criteria although I will tell you that there are a number of other individuals on that council that are filling other roles who are also individuals in recovery or family members and most of them are pretty open about that.

So, there are, I would say, five to seven members of that group that are very clearly sort of consumers or family members themselves. Where we are with that council, we have I believe, now it's been, four meetings? Yeah, four meetings. And those four meetings have been a lot of groundwork laying, education for the group as a whole about how the system is structured, what types of funding mechanisms exist and that will continue probably for another couple of meetings. Where it is really just sort of getting lots of information out there and building a foundation for having discussions around recommendations. So, I would imagine that there will be additional engagement of various groups as these discussions progress.

What I can't speak to is the type of conversations or work that the Advisory Council has been undertaking. I believe, I know Richard Edley is definitely part of that group. I don't know how many others on the call might be. So, I do believe there will be other avenues for additional feedback to be considered. I just don't think we're at that phase in the process just yet. We are really just sort of trying to get everybody on the same page about what the system currently looks like so that we can start hashing through what the potential suggested recommendations or next steps would be.

>> DEB SHOEMAKER: Okay. I know Chris Finello did add a little-- sorry Richard, gave us information. Go ahead, Richard. Then I have one more question for you, Jen.

>> RICHARD EDLEY: No, I was just going to add that the Advisory Committee is exactly where you are, Jen, with your committee. Early phase and so forth. Only thing I would add is maybe at some future point when it is at the right phase, to have Chris come to one of these meetings and give a quick presentation on where we are and what we're doing, things like that. Not that Jen and I couldn't present on behalf but may as well get it from the source of the person running it.

>> DEB SHOEMAKER: I think we talked about that before. If not, Elise will put that on the list of ongoing things. I think the budget and other things, put some things in the parking lot so thank you, Richard. The other question I have is more related to the budget and what you presented when you talked about funding for forensic projects. Is there a place where the kind of projects that are listed and is it in coordination with PCCD (Pennsylvania Commission on Crime and Delinquency) or some stuff that magic or VSAC (Victim Services Advisory Committee) are doing.

>> JENNIFER SMITH: We can send this group, sort of a list of projects that we've funded in the past. Because this is currently just a proposed budget, I don't want to send out what projects we are considering for the $5.7 that we proposed in the budget because it might change. And if it changes, that might alter which projects get put forward. But I can certainly give you a list of the projects that we funded in the past, the counties, the types of projects that we used the dollars to support. Some of it is, you know, apartment type living situations. There are lots and lots of different types of projects. We can get that information to you for sure.
>> DEB SHOEMAKER: That would be helpful. Just to have an idea including and then some things that are being proposed including some of the emergency walk-in center things and other things. So hopefully, we will get that funded. That's just my own personal stake for those of us that have the ability to advocate for this and other changes, we can do that. Jen can't do that, but we can.
>> JENNIFER SMITH: Thanks, Deb.
>> DEB SHOEMAKER: Does anyone else from the MAAC have any particular questions?
>> JOE GLINKA: Deb, it is Joe Glinka. I have a question.
>> DEB SHOEMAKER: Go ahead.
>> JOE GLINKA: Jen, I appreciate the update. I will kind of go off script here and ask you a question. With respect to actual provider capacity within the space that you represent, has there been any type of assessment in terms of the size of the gap looking at number of providers in various areas that are available to provide service versus the demand? Would that be tracked at your level? Or because of the county orientation to the system, would that be more housed at the county level?
>> JENNIFER SMITH: Yeah. That's a great question, Joe. We could probably spend the next 45 minutes having a really good conversation about this topic. The challenge, there are a number of challenges. I think we all agree it would be so helpful if we could magically take a snapshot in time and understand what the current capacity is and what the demand is and overlay those two sets of data and see where there are gaps. The challenge is that we don't have either of those sets of information readily at our fingertips. And because it can literally change minute to minute, doing those assessments, is very time-consuming. And by the time you finished the assessment, the landscape doesn't look the same as the data from when you were doing the assessment. And so, you know, we constantly struggle with this concept. I will say we are having really serious discussions about looking at a piece of the population to do something much more in-depth related to this idea of supply and demand in the system. So instead of trying to take the whole state every provider type, and trying to map it out, maybe just carving a piece of it at a time and see if we can get some answers.
We certainly look at licensed capacity across the state. And while there have been some decreases in certain types of facilities or programs, we really haven't seen huge decreases. Which is, I think, what folks expected during COVID. Now what we don't know is whether they are operating at their licensed capacity. So, this is sort of what gets to the crux of the issue, I think. We have an understanding of how many licensed facilities or programs, or

certified programs exist. And we know, you know, in most cases we know how many individuals they would be capable of serving although there are some levels of care, we don't know that for. In general, we would know that. What we don't know is if they are operating at that full capacity or not. That changes really quickly and sometimes very drastically just based on that provider's ability to hire.

So, I think it's definitely worthy of a conversation on how we can do some kind of analysis keeping in mind that it is going to change really rapidly, and you know, it will give us a big picture sense of where there might be really big gaps in the system. Or maybe geographically you know, where we could see there's a desert for a certain type of service in that particular part of the state. I think that could be really valuable for us. But it will definitely take partnership at the state, the county, and the provider level because in many of these cases, it is really only the providers that know information about what their current capacity is. Does that make sense?

>> JOE GLINKA: Yeah. That makes sense. I'm in MCDSS and we have a couple work groups formed and one is studying the provider capacity issue and a few domains. I believe mental health/behavioral health, is one of those. I was recently in a meeting that talked about the issue of overstays and overcrowding in the hospital environment because of the, you know, insufficient community-based resources available. In this context to get children, too, for instance. I just wanted to learn more about from your perspective, what that might look like.

>> JENNIFER SMITH: Yeah, I will definitely say what we have seen in the last few years is an increase in the need for more individualized type programming. So, individuals that have more unique, perhaps more complex, but not necessarily, maybe just more unique needs than what our system had traditionally been designed to meet. And so, you know, there are folks either coming out of our state hospital system or the county jail system or coming out of hospitals, inpatient hospitals, or emergency departments who just don't fit the mold of what our existing programs offer. And so, you have to work individually with providers to, in the moment, build a program to meet that individual's needs.

And often times, building those sorts of one-off programs, not only takes some funding to do that, but also takes the workforce to do it. In many cases you're talking about building a program that is more intensive. It might have a higher ratio of staff to individual receiving the service. And so, you know, on the spot, hiring enough people to staff a program with three staff members to one individual for 24-hours a day, or 12-hours a day, that can be really challenging. So, I think it's great that you've got a work group taking a look at this. Please keep us informed. If you think there's information that would be really helpful for us to know or if you need information from us, don't hesitate to reach out.

>> JOE GLINKA: Appreciate that. Thank you.

>> JENNIFER SMITH: Yup.

>> DEB SHOEMAKER: Any questions in the chat, Elise?

>> ELISE GREGORY: Yes. We have a few questions in the chat. The first is from Paulette Hunter. For mental health, my county used reinvestment funds from behavioral health to help families in mental health and people with disabilities. They did housing with the

funds, respite care, transition for youth and many more things. My county has had money because of reinvestment funds. Reinvestment funds will go way if you combine physical and behavioral health. Are we combining physical and behavioral health?
>> JENNIFER SMITH: Great question. I have a very simple answer: No, we are not. There are no plans to eliminate the carve out of behavioral health. And you are absolutely correct that the reinvestment program would no longer exist if we decided to eliminate our carve out. So that is one of the hundred reasons, maybe not a hundred, a handful of reasons that we are really not interested in changing the model that we have right now. There actually was a study done, a report issued, probably 2 years ago at this point. Maybe a year and half, that studied carve-in versus carve-out states and really found there is not one that's better than the other. And the recommendation was that states should stay with the model that they have and just look for ways to improve it.
So, reinvestment is definitely one of the great aspects of being part of a carve-out state. It gives counties the opportunity to use funds for lots of creative projects. In fact, we just did a couple of webinars for county folks at all levels, commissioners, CFOs, fiscal officers, mental health administrators and single county authorities talking about reinvestment and reminding them what it is and what it can be used for, how they would seek approval for those projects and giving examples of projects that have been done in other counties so it gives them a perspective on all of the possibilities that they have for the use of those dollars. Great question.
>> ELISE GREGORY: We have one more question from Lloyd Wertz. Is there an intention to return to the CCBHC (Certified Community Behavioral Health Clinics) model and reap the potential benefits of increased federal revenue that might provide?
>> JENNIFER SMITH: Hey, Lloyd, good question. Haven't had that one for a little while. So, we haven't officially made a decision about whether Pennsylvania will be rejoining the CCBHC demonstration. They did update the program and incorporated actually a significant amount of the types of benefits that Pennsylvania incorporated into our ICWC models, Integrated Community Wellness Centers. So, they really have come a long way with the CCBHC model, and I think that we are very interested in potentially rejoining. There are, however, some outstanding questions that we have submitted to CMS that will sort of make or break our decision. We submitted those questions and, I believe we have a meeting that we're working to schedule with them here in the next few weeks to talk through those questions. It has a lot to do with the logistics of having originally been in the demonstration and rejoining it. So, we were one of the initial states that was part of this demonstration and as a result, there were some benefits of being part of that group that future groups did not experience.
And so, you know, we are looking for questions as to whether we would again get access to those benefits since we are rejoining or whether we have been considered more of a new state to the demonstration. So, there is just a handful of pretty significant questions that will really determine for us whether it makes sense for Pennsylvania to pursue that or not. We are hoping to have an answer to that question very, very soon because it's been lingering for a while. And if in fact that is the decision, there is some significant planning

that needs to go into what happens especially with the models that are formed under the ICWC model that we had developed. And will those facilities be migrating to the model? Will they be staying out? There are still some differences between the two. So, you know just lots to consider from a planning perspective so we will let you know as soon as we know but we are getting much closer to having a decision.
>> ELISE GREGORY: Paulette Hunter says thank you, thank you. You make me so happy with your response. There are no more questions in the chat at this time.
>> DEB SHOEMAKER: Thanks, Jen. I'm glad we made Paulette happy today. That's good. Very good. Have a good Easter with your family, Jen.
>> JENNIFER SMITH: Thank you. You too.
>> DEB SHOEMAKER: Thank you. Next on the agenda would be Deputy Secretary Ahrens. I know we are a little behind so sorry that we are not giving you as much time, but I think you can take your time and we can truncate the subcommittee reports and other things if need be.
>> KRISTIN AHRENS: Good morning, I can also go quickly here. You can go ahead to the first slide. Update on performance-based contracting. We believe we are quite close to having all of the materials that will be out for public comment. We are working through the final preparations for the package to be published in the PA Bulletin and just to be clear, this will be quite a few documents. It will be the 1915(b)(4) application which will be new for our office. This is the one that allows us to use the Medicaid authority for select contracting. We will have some amendments to our 1915(c) Home and Community-based waivers in order to implement the change.
Because the federal documents are pretty high level about how this state will be, what the state is requesting to be federal government and how we are operating, we are also going to be publishing an implementation plan which will really be the operational details that I think most of the stakeholders will be most interested in. With it, will also be the rates notice. So the idea here is that when we publish for public comment, what we are doing with residential services moving to performance-based contracting, stakeholders have the high level policy, what we are doing with the federal government, the operations, the implementation plan, and the fiscal component with the rates notice so that people really will have kind of all of the, all of the material they need to look at and make decisions in terms of submitting some public comment to us.
And we are planning to publish those for a 45-day public comment period because it is those three pieces, operations and fiscal that we are putting out and we want to make sure people have time to review that. We will have multiple sessions scheduled for different stakeholder groups that will be published at the same time to give people an opportunity to walk through an overview of the proposed changes and then take public comment during those sessions as well as written comment. At this point, we are still on target for having that package of materials published mid to late April.
The other thing that we've got and will be planning some sessions for late spring, early summer is we have been putting together a residential provider preparedness toolkit. So, we will make that available to providers and hold some forums for providers to walk

through the preparedness toolkit and the use of it. We have, so remind everybody on MAAC, performance-based contracting will be implemented for residential providers on January 1st of 2025. And it will be implemented January 1st of 2026 for supports coordination. So, we have been working a kind of parallel process that we did with the residential group with a supports coordination group. So, the residential strategic thinking work group provides - really was the one - that helped develop the actual performance standards that will be put into place when we move to performance-based contracting for residential services. And we have a strategic thinking group for supports coordination doing that same work. We've got a pretty good set of performance standards. I think we are getting close to being at a place where we can kind of finalize those and make sure that those are kind of out there for people to be responding to. And then, you know, this time next year we will be having the same discussion about supports coordination. We will be submitting amendments to the federal government at that point and just to let everybody know, we've got these two sort of tracks that are about a year apart in terms of implementation.

And then the last thing related to performance base contracting is that we did have an RFP (Request for Proposal) out that was for a vendor for performance analysis services. This is back-end data analysis to support the department in terms of the performance-based contracting. That RFP is now closed. Next slide.

The next slide is, I will start while waiting for it to flip. The next slide is just to give an update on the one-time supplemental payments that the Governor directed us to make as sort of a mid-year adjustment to ODP services.

So, two things. We did publish for public comment the proposed amendment that allows us to make the supplemental payments through our Home and Community-based waivers. And that public comment period was finished. We did submit proposed amendments to CMS on March 14th. We have requested that CMS expedite the review of that, now there is no formal way to do that. We just explained to them what the circumstances were and why we were asking for an expedited review. So, I don't have any kind of guarantee that they will do that, but they did, you know, they did acknowledge that they received the request for an expedited review. The one-time supplemental payments are for recruitment and retention for ODP providers with the intent that they can fill staffing vacancies and accept new participants into service.

We also, this week we published on March 25th, we did publish the payment request form for those supplemental payments. And that was in ODP announcement 24-031. We will be accepting requests for payments through the 15th of May and once CMS approves, which we believe they will approve this waiver amendment, as soon as they approve it, we will begin processing payments in the order that the requests were received. We want to get this lined up to make sure we can get funding out to providers as quickly as possible and provide some financial relief to the ODP providers.

And then I don't have a slide, but I saw there was a question submitted in advance related to ODP transitioning from our current fiscal vendor, which is Palco to PPL who successfully was awarded when we had to reprocure after five years. PPL was the successful bidder.

We have been transitioning individuals who self-direct their services through the vendor fiscal model from Palco to PPL. So, I'll give an update where we are with that. As of today, so the first payroll under PPL, will be on April 5th. As of today, we've got 92% of the Commonwealth employers enrolled. Their paperwork is complete and enrolled with PPL. 76% of the support service professionals are enrolled and ready to go in terms of payroll. So, we've got a little bit of time here to get those up to a hundred percent, which is our intent. We have sent multiple communications to common law employers to try and make sure that all that remaining 8% get themselves fully enrolled. Our team is ready to assist if anybody is having challenges or difficulty. I know our regional team and central office have both assisted when there have been hick-ups in the enrollment process. And I'm happy to take questions or comments.

>> DEB SHOEMAKER: Any questions from MAAC members? Yes, that's construction at my house. I apologize. If there are no questions from MAAC members, is there any in the chat, Elise?

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

>> DEB SHOEMAKER: Okay. Wonderful. Thank you, Deputy Secretary Ahrens. Have a wonderful holiday.

>> KRISTIN AHRENS: Thank you.

>> DEB SHOEMAKER: Okay, next would be subcommittee reports. Danna, are you providing it for Consumer Sub?

>> DANNA CASSERLY: I am, yes. Thanks, Deb. Hi, everyone. I will try to keep this brief and touch the points that we want to hear about. Again, I'm Danna Casserly and I am providing the update about yesterday's subcommittee meeting.

During the meeting we heard updates from three program offices, OMAP, OLTL and OIM. Several of those issues that we discussed yesterday were already covered today so I'm not going to go through those. But I will just highlight some quick items that we haven't heard today but that the Department did update the consumers on yesterday.

Some highlights are that OMAP shared with the consumers that there are ongoing contract negotiations between Children's Hospital Philadelphia and Keystone and understandably consumers were alarmed about the possibility that this contract could end given the anxiety and the needs of the folks who get care through CHOP (Children's Hospital of Philadelphia) and how many kids there are. We understand that the contract is set to end on June 30th, but negotiations are proceeding, which is good news. The main trigger here that brought this to our attention was that DHS shared with us that CHOP had moved last week to send communications to about 140,000 folks that let them know that the status that the negotiations were ongoing and sort of what they could do in the event the contract does end.

Again, understandably, consumers are concerned about this process and appreciate the department looping us in to sort of what is going on in terms of what might be expected and how it could impact families if the break does occur. But we have every reason to remain hopeful and hope that the parties will reach an agreement and of course, should the contract end, the consumers are happy to make themselves available to the

Department as we do to collaborate and work on how we could make sure this transition is as smooth as possible for families.
Quickly, next, I will just cover one piece of OLTL's presentation. The consumers did have a productive conversation with OLTL yesterday joined by Juliet and Randy. We talked about the issue that's been on the agenda for many months now about waiver redeterminations and all the work that OLTL is doing to hear the concerns, understand the issues going on with these redeterminations that are causing folks to lose waiver, and taking active steps to address them. They did share updates on some of their specific ongoing efforts in this area, including having MCOs retrain service coordinators who are the ones actually implementing the assessment tool so that they better understand the tool and hopefully the outcomes from those assessments will be more accurate, or in other words, in line with the individual's actual needs.
And consumers were really pleased to hear the update about Dr. Adair's continued personal and individual review of all of these cases that have been terminated based on the annual assessment process. So, he is making his way through that piece and one of the highlights that consumers were really pleased to hear is that back in January, first of all, we heard that about 28% of Dr. Adair's cases that he reviewed were getting found eligible. Now that is up to 64% as of the latest data, which is great. So, closing the gap, making sure that folks would really need waiver services, more folks who really need waiver services, are keeping that coverage.
And clearly, I think the consumers were in agreement that the steps OLTL has taken -- excuse me, I'm in the Hilton right now and there are people walking by, in Harrisburg. Okay, they're gone. Really, the steps OLTL has taken proactively are making a difference, giving Dr. Adair more information for his review. Along the same lines as the service coordination piece of the assessment and just ensuring that things are completely reviewed, accurately reviewed and that the outcomes are accurate and keeping folks connected to the care that they need. [Recording cuts out].
>> JULIET MARSALA: This is Juliet. I just need to make one quick correction. It is Dr. Appel, that is our medical director. Not Dr. Adair.
>> DANNA CASSERLY: Thank you, Juliet.
>> JULIET MARSALA: Yes. We welcome the partnership with the Consumer Sub MAAC through the process. Thank you.
>> DEB SHOEMAKER: Thank you. And Minta, do you have anything to add?
>> MINTA LIVENGOOD: Not at this time. Thanks.
>> DEB SHOEMAKER: Okay, thank you. Does anyone have any quick comments or questions for Consub? Okay, thank you, Danna. The next meeting will be the 24th, the day before the MAAC. Okay, on behalf of the Fee-for-Service Delivery Subcommittee, we did not meet again. We meet quarterly. Our next meeting will be in May, so I will not report for the next meeting either. But LTSSS (Long Term Services & Supports Subcommittee) you have something, Kath?
>> KATHY CUBIT: Yes, thanks, Deb. The LTSS met in person and remotely on March 7th. Deputy Secretary Juliet Marsala provided procurement updates as shared today as well as

an overview of an on-site visit by CMS or the Centers for Medicare & Medicaid Services to assess Pennsylvania's compliance with the federal community-based service settings rule. The visit occurred from February 26th through March 1st. Federal officials visited several community-based services sites, reviewed person-centered service plans, and interviewed participants. CMS also conducted interviews with service coordinators to measure their understanding of the settings rule, including their role in ensuring compliance and how elements of the rule are incorporated into the person-centered service planning process. During the review of preliminary findings, CMS provided positive feedback and overall found Pennsylvania had a person-centered home and community-based system. CMS shared some other minor findings and recommendations that OLTL is beginning to address. CMS will complete a findings report and review it with the state.

The committee also received updates on OLTL's efforts to improve the CHC waiver redetermination process and it's work with MCOs to identify issues in the assessment process including training needs that are leading to high rates of participants assessed as clinically ineligible. Data was shared that includes the number of participants who were assessed as nursing facility ineligible by MCO from May 2023 through January 2024. Multiple strategies are being implemented to address the problem including having Aging Well complete a new functional assessment for some participants and updating the medical director review process and more information is added to the assessment tool results to help ensure an informed eligibility decision. The MCOs are following up with participants who did not appeal prior to these remedies being implemented.

OLTL staff provided an overview of the 2023 statewide CHC CAHP survey, or the Consumer Assessment of Healthcare Providers and Systems. 2,184 surveys were completed across the state and analyzed. CAHPS statewide results from 2021 through 2023 were shared as was data by CHC-MCO. Each MCO presented information about positive aspects of its survey results along with strategies being implemented to improve various measures scored. Meeting materials, including data slides from this presentation, may be found at the LTSS meeting minutes ListServ archives.

Finally, there were two open forum times during the meeting. The next LTSS meeting will be both remote and streaming and in person at 333 Market Street tower on Wednesday, April 3rd from 10:00 a.m. – 1:00 p.m. All are welcome to join us and I'm happy to take any questions.

>> DEB SHOEMAKER: Any questions for Kathy? Thanks for the comprehensive update, Kath. Joe, you did not have a meeting, correct?

>> JOE GLINKA: No, we last met on February 8th, which is quite a -- with the nature of healthcare, that's an eternity anymore with health exchange.

>> DEB SHOEMAKER: Exactly. So, your next meeting looks like it is the 11th?

>> JOE GLINKA: It is the 11th. I will say that due to unforeseen circumstances, our provider capacity workgroup was supposed to meet on March 14th. We have rescheduled that meeting to take place next Tuesday at 2:00 p.m. For those individuals who call in and participate in that meeting, we are meeting on the 11th as you mentioned and our next workgroup as far as provider capacity is on May the 9th. I do believe that the complex care

coordination workgroup is on a similar schedule, but it might deviate a little bit from that. But yeah. For right now, that's our update.
>> DEB SHOEMAKER: Perfect. Thank you. Okay. Eve, any MA Bulletins, or pharmacy documents?
>> EVE LICKERS: Yes. We have one bulletin. That is MA Bulletin 08-24-04 that was issued and was effective on March 1, 2024. And I will say that for some, this has been a long awaited and highly anticipated bulletin and it updates the provider handbook for FQHCs (Federally Qualified Health Centers) and RHCs (Rural Health Clinics). This can be found on the Department's website. The best place to look is on the What's New at OMAP page right on the DHS website. Thanks, and keep an eye out for other bulletins that will be coming out in the near future. Thanks, and have great Easter weekend.
>> DEB SHOEMAKER: You too, thank you. Do we have any new or old business? Okay. Well, if we do not, knock on wood, we are going to be done a little early. I will give you four or five minutes. The next MAAC meeting will be scheduled again for the fourth Thursday, the 25th, by webinar, just for sake of looking updates, we do have tentatively scheduled the May meeting will be in-person, but you will get details about that. So, we are trying to, at least quarterly, have close to quarterly, a couple times a year, having an in-person meeting. But if there is no other new or old business, I would like to take a motion to adjourn.
>> MINTA LIVENGOOD: I will make the motion to adjourn. This is Minta Livengood.
>> DEB SHOEMAKER: Okay, we will take it from Minta and a second from Joe. Everyone have a wonderful holiday; however you are celebrating it. So, with those motions to adjourn, have a wonderful rest of your week and look forward to hearing from all of you in about a month. Take care. Thank you.